LOGIC.
LINKING OPPORTUNITIES GENERATING INTER-PROFESSIONAL COLLABORATION
The Official Journal Of The New Zealand College Of Primary Health Care Nurses, NZNO
Vol 15 No 1

The NZ College of Primary Health Care Nurses Committees

BULLYING

PRISON NURSING

VULNERABLE CHILDREN'S ACT

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

Co-Editors Yvonne Little & Kate Stark

Publisher Celeste Gillmer, 021 245 0587, celeste.gillmer@gmail.com

Editorial Committee

Celeste Gillmer, Katie Inker, Lynette Law, Donna Mason, Marilyn Rosewarne

Circulation

To full members of the NZNO New Zealand College of Primary Health Care Nurses and other interested subscribers, libraries and institutions.

Editorial Matter

Prepared by the Editorial Committee and the Editors from submitted and invited material. Whilst every effort is made to ensure the accuracy of this information, the Publisher take no responsibility whatsoever for errors, omissions or any consequences of reliance on this material or the accuracy of the information. The inclusion or exclusion of any product or advertisement in no way means the Publisher or the New Zealand College of Primary Health Care Nurses advocate or reject its use in any way.

Correspondence

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

Yvonne Little: kirkcud04cairn@gmail.com

Kate Stark: Katestark12@gorehealth.co.nz

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

ISSN 2463-5642

April/May 2016 Vol 15 No 1

In this issue….

Chair's Report

Kim Cameron
Chairperson

Kia Ora tena koutou, tena koutou, tena koutou katoa

Firstly…..

To all you amazing hard working nurses' out there....HAPPY NEW YEAR!!

We hope you and your whanau had a safe and joyous festive season and you ALL managed to have a break and get some well-earned R & R (that would make a great Tui Ad – YEAH RIGHT!).

We the College committee took a little time out to spend time with our loved ones and significant others but be assured we have not stopped for long and there has been some hard work going on behind the scenes.

Any way…..

Welcome to the Colleges new look, LOGIC journal (yes this is the very first e-copy). By transitioning to an online e-journal we the college committee expect to reach a wider number of professional nurses working in or interested in primary health care. Through the Journal, the PHC committee aspire to keep you well informed of what is occurring in the area of Primary Health Care, as well as wider nursing workforce.

What's even better is that you no longer need to pay a levy or be a college member to receive the journal; all you need to do is tick the box on your NZNO membership that you are interested in primary health care and it will be delivered right to your email address (WHO WOULD HAVE THOUGHT IT WOULD BE AS EASY AS THAT…..)

Our hope is you all embrace this new transition. I am sure everyone reading this first issue, as well as the issues to follow, will relate to an article or story written; learn something new; acquire another nursing perspective; heck, it may even stir some emotions.

But.....don't think that you can get off that lightly.....in return we hope that a larger number of you will share your stories, articles, and experiences with the rest of us so we can all increase our knowledge, up skill and improve nursing services across Aotearoa and beyond.

We also welcome your comments and thoughts about this new on-line journal (after-all we cannot improve if we don't know what needs improving!).

One of the topics covered in this issue of LOGIC is bullying, and I am sure that a majority of us have at one time or another been subjected to bullying, either in our professional or personal life or even both.

Bullying comes in many forms it can be verbal, physical, relational aggression, sexual, emotional intimidation, prejudicial or discrimination, ageist, covert or hidden and of course we now have to contend with cyberbullying.

NO ONE deserves to be bullied. We all have the right to live, study, work, and play in an environment free from bullying, persecution, violence and discrimination.

I did a little research and came up with a list of things to do if you are being bullied.

1) Report or tell someone you trust
2) Surround yourself with people who care about you
3) If possible ignore the bully and think and stay positive
4) Identify strategies that work or help you to cope with the situation
5) Be confident (bullies hate that); use positive self-talk and remain true to who

you are, do not lower yourself to their ill-informed level.

6) **REMEMBER YOU HAVE RIGHTS**!!!!!

Moving on… and on a more positive note.

In February the College Committee gathered together for their first face to face meeting of 2016. We had a lot on the agenda and managed to wade through it successfully. All- in- all it was a busy but very productive day.

We also invited Grant Brooks (NZNO President), as well Carolyn Reed (NCNZ Chief Executive/Registrar) and Pam Doole (NCNZ Strategic Policy Manager) to meet with us to discuss matters arising; concerns and issues facing PHC nursing; and to find out more about programmes and projects which are going on the sector. Go to our web page (below) and read all about it, in our College Snippets.

WHILE YOU ARE CHECKING OUT THE SNIPPETS…..

Take some time out to update yourselves about the planned North and South PHC skill workshops

http://www.nzno.org.nz/groups/colleges_sections/colleges/college_of_primary_health_care_nurses

The North Island symposium will be held in Auckland on the 27th August 2016. The Auckland venue will also host our annual AGM meeting.

The South Island workshop will be held in Timaru on the 29th October 2016. So clear the calendars and start making arrangements to attend one of these workshops. We would love to see you there ☺…

Committee members organising these symposiums, have been working hard to secure venues and gather an array of primary health care professionals to share their knowledge and skills with you.

We will keep you updated about these two events on our website or Facebook page.

The College continues to support several other professional organisations and forums

Jane Ayling – PHC National Delegates Committee

Rosemary Minto – MoH Prostate Cancer Working Group and Primary Care sub group

Kate Stark – National Cervical Screening Programme Advisory Board

Emma Hickson – Otago University Post Graduate Review Group and NZ Leg Ulcer Advisory Group

Miriam Lindsay – Auckland Faculty of RNZCGP

Melanie Terry – National Trendcare for District Nursing Working Group

Victoria Santos – was nominated for the NZCPHCN rep on NZNO Membership Committee

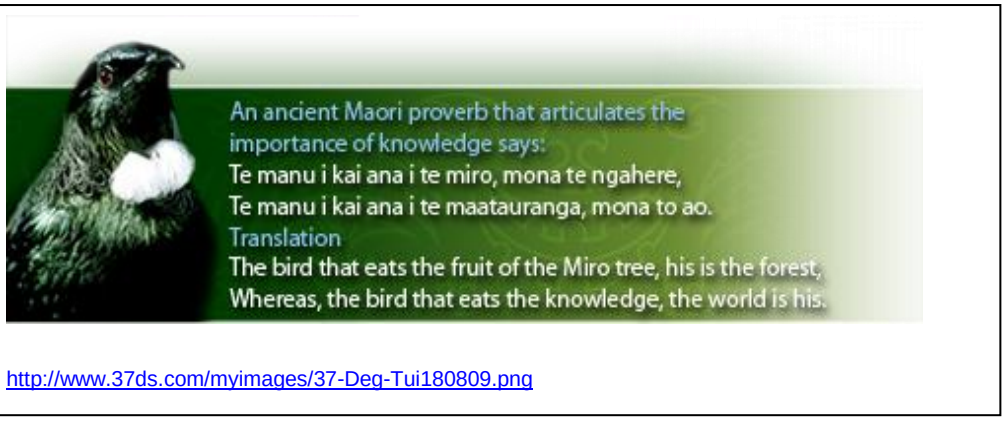
Yvonne Little – Community Pharmacists Services – National Stakeholders Forum

Last but by no means least…..

The College executive committee would like to welcome Mere Brooks to the team. Mere is the new Te Runanga representative on the committee and we look forward to working with her. Read her brief biography on page ????

Me haere atu au (got to go)

Ka kite a tona wa (see you soon).



http://www.37ds.com/myimages/37-Deg-Tui180809.png

Co-Editor's Report

Co-Editor Kate Stark

Welcome to the inaugural on-line edition of LOGIC. For those of you who have been members of the College, you will by now be aware that the annual subscription fee has been removed, and membership is FREE! As a result we have changed to an online journal accessible through the College of Primary Health Care Nurses (CPHCN) website and via the link you will receive by email from NZNO three times a year, as long as you are a member of NZNO. On behalf of the LOGIC committee, I wish you all a very happy New Year and hope you managed time spent with loved ones over the festive season.

Although our mode of delivery has changed, we endeavour to ensure the content remains as informative and invigorating as always. As a committee we want to keep you up to date with information relevant to all facets of primary health care nursing. Please feel free to give us feedback in relation to articles we have published, topics you would like to read about, and that you will also consider writing about your own experiences working in primary health care.

I would like to thank the members of the LOGIC Committee for all the work they do both sourcing and writing articles for publication. In this issue, you will find an introduction to the team directly involved in the production of LOGIC. Without the dedicated work of this team, LOGIC would not be as successful.

The title L.O.G.I.C stands for Linking Opportunities Generating Inter-professional Collaboration and reflects what we aim to achieve as a College for and with our members within NZNO.

Change seems to be a common theme for the CPHCN this year. Not only are we changing the mode of delivery for LOGIC, but we also see a new format for national conference. Instead of one conference over two days, this year we are holding two symposiums, one in Auckland in August, and then in Timaru in October. We are hoping that this will give more primary health care nurses across New Zealand the opportunity to attend such an event. CPHCN conferences are a wonderful opportunity to meet with like of primary health care, to share knowledge and stories, and to like minded nurses from various realms strengthen old friendships while developing new contacts through networking. Within this issue of LOGIC, there are links to enable you to register for the symposium of your choice. Be in quick, as places are limited!

In this issue, we also present articles related to prison leadership, bullying, the Children's Diabetes Action Plan, reflective practice and we also will update you with regards to the activities the College Executive is currently working on and towards from our Chair, Kim Cameron through her Chairs report and Vice-Chair Dhy Hohepa through our column "Snippets'.

Co-editor Yvonne Little and committee members Katie Inker, Donna Mason and myself all preparing for her interviews with Nursing Council for Nurse Practitioner, it is exciting to hear of proposed changes to the Nurse Practitioner scope of practice, changes that if implemented will remove many barriers to achieving registration and also to practice. These changes also align nicely with the review of the Health Strategy, a very topical issue amongst the health sector in 2016.

As nurses we are affected directly by these changes and therefore it is important to have a collective voice. In order to ensure the changes reflect the needs of health professionals who are all aiming to improve patient outcomes, we need the tools and funding to provide healthcare which is reflected in the needs of our patients and communities. We must drive forward and promote the profession of nursing as the central pivot of primary health care, while keeping in mind that care must be sustainable in a constantly changing health environment which is driven also to a point by the burden of chronic disease. Being a member of the College of Health Care Nurses Executive Committee has given me the insight into how the wider health sector works and is an opportunity to advocate on behalf of other primary care nurses. I urge you to become involved. It will strengthen your knowledge and understanding of the challenges we as nurses face and also enlighten you to what can be done if we all work together.

Enjoy this issue of LOGIC. As Co-Editor along with Yvonne Little, we urge you to feed back to us in relation to this online journal. Moving from hard copy to online is a learning curve for us, and we want to deliver to you all a journal that is easy to read but informative and about primary health care nursing. Please feel free to email either of us with your feedback.

Contact details for feedback:

Kate Stark:
kate.stark@gorehealth.co.nz

Yvonne Little:
kirkcud04cairn@gmail.com

Kate Stark

Co Editor

LOGIC

Journal of The College Primary Health Care Nurses.

Future LOGIC issue topics for 2016

JUNE:

- **IT**
- **Innovative Business in Health**

SEPTEMBER

- **Paediatrics**
- **Abuse/Violence**

DECEMBER

- **Sexual Health**
- **Skin**

The College of Primary Health Care Nurses NZNO

Who are we??? Committee members of the NZCPHCN

NZCPHCN Executive Committee 2016

Kimmy C – Chairperson

Kia Ora

You can all call me Kim or sense of humor)
I live in Tairawhiti (Gisborne) the first city in the world to see the sun and I am currently working as a diabetes nurse for Hauora Tairawhiti.

I am married to Warren and between us we have the "Brady bunch" in the exact order.....BGGBBG (B= boy: G= Girl). Us oldies get it!!!!

I have been on the NZCPHCN committee since 2014 and was made Chairperson in August 2015.

Working on this committee has offered me the opportunity of getting to know and working beside some amazing nurses.

This journey has also helped me to gather an array of knowledge and skills and my kite continues to grow fat.

I encourage you all to think about joining a College/section or participating on a committee such as the CPHC committee.

Hopefully I will get to meet some of you at our skill workshops this year.

Marylinda (Mere) Brooks – Committee Member

Ko Taranaki te Maunga

Ko Waingongoro te Awa

Ko Okahu/Inuawai nga Hapu

Ko Aotearoa te Marae

Ko Tauke teTangata

Ko John Kerehoma toku Matua

Ko Gloria Reihana Laison toku whaene

Tena ra koutou katoa

I have recently been seconded onto the NZ College of Primary Health Care Nurses NZNO, from Te Poari and Te Runanga of NZNO. I have also been an active member of National Council of Maori Nurses, College of Nurses and now NZNO,

I been involved in nursing and health since 1988 in many and varied capacities and note the personal passions, hard work and commitment of some amazing women and men in the health fields during this time.
I have recently relocated to CHCH and now work for corrections so am very interested in working with NZPHC and how this aligns with Corrections to assess parallel needs and pathways for some very vulnerable people.

Wendy King - Secretary

RGON ADN BSocSci MPH

Public Health Nurse (11 years)

My initial nursing education was at Taumarunui Hospital, with post-graduate nursing and non-nursing study following. Most of my work has been with children and families; ranging from neonatal retrievals to the school MENZB immunisation programme. Work experience includes orientating, precepting, staff education, shift coordination, peer reviewer, scholarship panel member, clinical nurse leader and manager; including time working in Australia. When PDRP was implemented at Waikato DHB I was the NZNO representative on the Implementation Subcommittee; currently I am an assessor. Alongside this, as part of my 11 years as a Nursing Officer in the Territorials I had a stint in Vanuatu with the New Zealand Defence Forces.

NZCPHCN Executive Committee 2016

Dhyanne Hohepa –Vice Chairperson

Tena Kotou katoa my name is Dhyanne Hohepa and my tribal affiliations are Ngati Raukawa ki wharepuhunga, Ngapuhi, Te Arawa, Ngati Tuwharetoa and Tainui, I currently sit as the vice-chair of the National Executive of the NZCPHC with a fantastic group of nurses. I graduated in 2007 with a bachelor of health science (nursing) and began my career as a practice nurse within an iwi provider based on a Marae. I then moved into the department of corrections working as a staff nurse where i also completed my Masters of nursing, where my dissertation looked at the health impact of methamphetamine on New Zealand Maori. My passions are Te Reo Maori and Kapahaka where I enjoy doing this with Nga Ringa Awhina, the maori student nurse contingent at Manukau Institute of Techonolgy. I am also passionate about Maori health, Primary health care and the further development of the Maori nursing workforce

Kim Carter – Committee Member

I currently work in a semi rural general practice that I co-own. I have been working in general practice for 10 years having previously held several DHB leadership positions. In PHC, I have found the clinical setting I will finish my career within, as I love the mix of clinical activities, the longevity of relationships with my practice population and the chance to work with people as a generalist to affect change through the lifespan. I care deeply about the professionalism of nursing and enjoy working with the College Exec to advocate for and represent nursing at a national level.

Other members of the NZCPHCN executive Committee 2016 include:

Karen Smith – Treasurer

Vicki McSeveney Administrative Support, NZNO

Angela Clark – Professional Nursing Advisor, NZNO

Yvonne Little – Co-Editor LOGIC

Kate Stark – Co-Editor LOGIC

Professional Practice Standing Committee 2016

Trish Wilkinson –

Committee Member

RGON.B.N.P.G.Dip Nursing

The delivery of primary health care by suitably qualified practitioners is an passion of mine and to this end I am dedicated to promoting improved training opportunities for Primary Health Nurses, who in turn can facilitate the patient/client to obtain the best possible health outcomes.

I am in the process of setting up a new Community Health Centre which will be Nurse led . We will be providing accessible affordable health care in a clinic and a variety of outreach settings .Part of this new business will involve the employment of New Graduate Registered Nurses, under the NEtP programme, who will be apprenticed to a wide range of Primary healthcare settings.

Emma Hickson – Chairperson

I have recently been appointed as the Director of Nursing for Primary Health and Integrated Care at Capital and Coast DHB. I have worked in community nursing for over twenty five years both in New Zealand and overseas. I have been involved in clinical practice for all of my nursing years supplemented by education, research and management activities.

I believe that nursing is in a pivotal position to develop and support the health of our nation and that Primary Health Care (PHC) nursing is fundamental to delivering that support. As a sector, I think we need to know better our diverse population of nurses, develop our workforce, grow our leadership, and especially support our Maori and Pacific nursing capability. PHC nurses need to be well educated, embrace role developments, understand the whole of health system, integrate with other health/social care providers, and always keep the consumer as their priority at the centre of their world.....

Cathy Nichols – committee member

I have always lived in Wellington, originally trained as an EN at Wellington Hospital. I completed my BN at Massey in 2005, after having my family. I've been a member of NZNO and its predecessor NZNA since my EN days. I joined the College of Practice Nurses in 2006, which merged into CPHCN, I've chaired the Wellington Regional Network since 2009. My current nursing position sees me back at Massey University as the Wellington Campus nurse with Student Health.

Bronwen Warren – Committee Member

I have 25 years nursing experience predominately in primary care. During that time I have worked in general practice, school nursing and public health nursing.

Over the last five years I have worked for several Primary Healthcare Organisations (PHOs), which has offered the opportunity to develop my project, programme and people management skills.

I am committed to the delivery of health care via a patient centric model.

It is exciting to see more and more care delivered in the community.

Other members of the NZCPHCN Professional Practice Committee 2016 include:

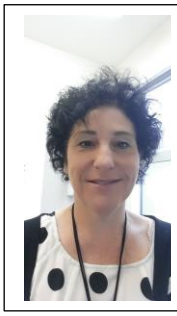
Karry Durning – Committee Member

Vicki McSeveney Administrative Support, NZNO

Angela Clark – Professional Nursing Advisor, NZNO

LOGIC Editorial Committee 2016

Kate Stark – Co-Editor



Kate is a Nurse Practitioner Candidate working in primary health care within an integrated health centre in the rural area of Gore. She also works as PRIME Practitioner (Primary Response in a Medical Emergency) in Central Otago and West Otago in the rural towns of Roxburgh and Tapanui.

As well as being on the National Executive for the College of Primary Health Care Nurses, Kate is Co-Editor of the journal LOGIC. She is the liason person between the College and the New Zealand Rural GP Network and is also on the National Cervical Screening Advisory Board as the CPHCN Representative.

Donna Mason – Committee Member

My name is Donna Mason and I am currently working as a Nurse Practitioner Intern at an A&M/GP clinic in Palmerston North. I have worked in a variety of settings; Secondary care, District nursing, teaching and some time overseas. I think this is an exciting time to be working in Primary Health and I relish the challenges that the Nurse Practitioner pathway provides. I consider myself privileged to be part of the LOGIC editorial team and look forward to increasing participation and membership with our new e journal.

Katie Inker – Committee Member

My name is **Katie Inker** and I have been living in the Wairarapa for the last 13 years. I work for a Maori Health Organisation providing health care for predominantly Maori, Pacific and low income families.

I completed my Masters qualification in 2014 and have been working as a Nurse Practitioner Candidate since the start of 2015. I am currently awaiting an exam date to enable me to achieve my Nurse Practitioner status. My scope of practice will be "**Primary health care across the lifespan"** with a particular focus on the vulnerable client.

In today's complex world, achieving and maintaining good health can be complicated. I love working alongside clients, communities and other health practitioners to make health journeys less complicated.

Yvonne Little – Co-Editor

My initial training was through Hawke's Bay Community College, now better known as Eastern Institute of Technology. I graduated in 1984 with my Diploma in Nursing. From there I went to work at Middlemore Hospital in Auckland where I worked initially in the Burns/Plastics Unit and Surgical Ward. In 1986 I ventured offshore and spent the next 15 years working in Western Australia, completing my Paediatric Postgraduate Studies, then my Midwifery qualification and finally before returning to New Zealand I completed my Bachelor of Nursing (Edith Cowan University). On return to New Zealand I initially did some ward work in midwifery and SCBU but then found my niche in Primary Health Care in 2002, starting off in an afterhours service and then on to my current position with The Doctors, Hastings and Waipawa. In the process I completed my Postgraduate Diploma in Advanced Nursing (Auckland University) and finished my Masters of Nursing in 2012 (Massey University). I am currently preparing for Nurse Practitioner Panel.

I enjoy working on LOGIC starting off as a committee member for a year before taking on the Co-Editor role and becoming part of the Executive.

I have an eclectic collection of hobbies for when I need downtime or when time allows.

Celeste Gillmer - Publisher

I completed my nursing degree as general, psychiatric, community nurse and midwife in South Africa and continued with post graduate studies in Trauma and Emergency Care.

In 2008 we moved to New Zealand and I started my nursing career in Primary Health Care. I worked as a Practice Nurse, School Based Youth Health Nurse and Nurse Educator across the Auckland region.

My current role includes leading the Waitemata DHB PHC Nursing Development Team across Auckland and Waitemata DHBs, providing Professional Development opportunities to all PHC nurses. I also the lead for the PHC NEtP programme across these 2 DHBs. I am the Co-President of the Auckland School Nurses Group, supporting the professional development of school nurses throughout New Zealand.

LOGIC Editorial Committee 2016

Lynette Law RN MN – Committee Member

Community Clinical Nurse Long Term Conditions

Lynette has worked in primary health since 2006, and has been a member of the LOGIC committee from 2012.

Based in a large rural practice, the role of the community clinical nurse is supporting people to self manage their conditions well, supporting general practice teams and connecting people to their community.

Comprehensive health assessments and care plans are used, and with a person centred approach, guide and determine care provided.

Other members of the NZCPHCN LOGIC Editorial Committee 2016 include:

Marilyn Rosewarne – Committee Member

Karen Smith

WARNING!

Workplace bullying is a health and safety hazard

TAKE STEPS TO RAISE AWARENESS

1. Join NZNO
2. Let your team know you stand for **dignity and respect at work**
3. Don't stand by, **stand together!**

PINK SHIRT DAY IS FRIDAY 20 MAY 2016

nzno.org.nz/bullyfree
pinkshirtday.org.nz
bullyfreeworkplaces.org.nz

NEW ZEALAND NURSES ORGANISATION

Transforming Primary Health Care Behind the Wire

Kay Sloan

I have been nursing for 35 plus years with nursing experience in both the primary and secondary health sector. I'm a wife, mother, and grandmother in Hawkes Bay with active sporting interests. My clinical background is in paediatric, respiratory and orthopaedic nursing and I have been employed with the Department of Corrections Health Services in a Clinical Quality Advisor role since 2004.

The Department of Corrections provides a primary health care service to over 9 thousand prisons on a daily basis. The funding for Health Services comes from Vote Corrections.

Each year:

- Up to 22,000 prisoners are received and released
- Over 12,000 transfers between prisons
- Over 30, 000 offenders are managed on community based sentences

(www.corrections.govt.nz)

Corrections own goal is to 'Reducing Re-offending by 25% by 2017'. Health Services are critical to this as our patients need to be physically and mentally well to participate in rehabilitation, reintegration, learning and industry which is the basis of our Working Prisons model.

We have 16 prisons operated by the Department of Corrections and two privately run prisons in New Zealand. They range from the top of the north to the bottom of the south. Each prison is required under legislation to have a Health Centre – every site has their own population and environment challenges.

Prisoners are among the most socially disadvantaged people in New Zealand presenting with high and often complex health needs.

(Ministry of Health: Results from the Prisoner Health Survey 2005).

While we have legislative requirements to provide services that are equivalent to the community we aim to do better. As per the Corrections Act (2004) the standard of health care that is available to prisoners in a prison must be reasonably equivalent to the standard of health care available to the public. The Health Centres are all different in design and age. Spring Hill Corrections Facility in Hampton Downs is one of the newer prisons.

The Health Centres are staffed with a Health Centre Manager, who is a registered nurse. Corrections employ Registered Nurses, Administration Support Officers, and some sites also have Health Care Assistants.

Our service is nurse led with other health professionals contracted as required. There are 230 health staff, including 175 registered nurses, over 200 nurses as a number work part time. Every year we complete more than 150,000 nursing consultations (face to face with a patient not involving medication) and more than 20,000 doctor consultations.

The Health Centre is situated inside the prison where nurse lead clinics are held and medications can be issued from. In most case this is also where the Doctor,

Dentist, Psychiatrist, Forensic Nurses, Physiotherapist, and Podiatrist hold clinics.

All prisoners are seen by a registered nurse on the day of arrival to prisons for an assessment of immediate health needs.

A more comprehensive health assessment is completed within 7 days.

The Health Centres functions very similar to a GP practice with appointments for consults and treatments. We are primary care + we do the General Practice but we also do emergency call outs (100 per week).

Health Services in prisons provide a range of services:

- physical assessment
- mental health assessment
- management of long term conditions
- health education
- health promotion
- screening
- immunisations
- risk assessment
- referrals to secondary services
- emergency responses.

Access to patients can sometimes be problematic. Prisons contain some of the most difficult and dangerous people in society – the health staff must always be conscious of safety and security and they work very closely with custodial staff. Some offenders are locked up for 23 hours a day and some require 3 Custodial staff to attend any movements to the health clinic.

Our patients are first seen in the Receiving Office. This might mean multiple patients need to be seen following their arrival from Court, some with very complex health needs, medication requirements, and withdrawal management for alcohol and or substance abuse, chronic conditions, mental health and at risk for suicide.

We deal with emergencies, from major trauma to cardiac arrest, as well as running a primary healthcare practice. Some prisons run work programs and industry jobs so workplace accidents can and do occur.

In 2002 this was a health service that needed a rebuild and had once been suitable for purpose but the systems if any, and services were outdated and needed improvement and reviewing based on the review by Deloitte Consulting (2002).

The Clinical Quality team was led by Debbie Gell, Clinical Director, on the left, Kay Sloan Clinical Quality Assurance Advisor centre and Kirsty Fraser Clinical Quality Assurance Advisor on the right.

We were aiming for a:

- A nationally consistent health service for all prisoners
- A high standard of clinical care
- •To aligns with health sector standards
- Quality framework to support quality care

Our Challenges:

- achieving standardised clinical care across 16 prison sites
- developing a clinical governance structure and quality framework
- designing a system that would align with the wider health sector
- supporting clinical leadership and staff development
- creating a vision and a plan for change that would engage staff long term
- developing clinical practice in a restrictive prison environment.

We have transformed healthcare for prisoners by:

- We offer clinically excellent, patient-centric services to all prisoners
- We have a nationwide clinical governance framework that supports staff to continue developing their service
- We have developed clinical leaders
- We have standardised clinical systems and processes to support patient safety and improve clinical effectiveness
- We have made a sustainable difference that supports reintegration of prisoners into society and reduces re-offending
- We are externally accredited– this provides assurance that our service is the same

standard as any other accredited provider in New Zealand

- Our prison health centres have a national identity - supports engagement with the wider health sector and the community.
- We are the only prison health service world-wide that is nationally accredited against an external community standard
- First country to introduce national smoking cessation in prison

We also think that we are the only country with Prison health services with a:

- National electronic clinical record system
- National Incident Reporting system
- National Clinical Governance Framework

We are not perfect and there is always room for improvement and we would be the first to acknowledge that. While we are in a secure and challenging setting we aim to align ourselves with the wider health sector.

References:

Deloitte Consulting. (2002). Public Prisons Health Services Review. Wellington

Department of Corrections.

Ministry of Health. (2005). Results from the Prisoner Health Survey 2005. Wellington:

Ministry of Health

www.corrections.govt.nz / about us

Have you ever felt like the square peg in a round hole?

Have you ever felt left out because you were different?

We all know someone that has been discriminated in some way. We discriminate the nerds for being too smart, the slow learners for being dumb, mental health sufferers for being too weak. Poor are discriminated for their poverty. Being born different or having autism or any other health condition is seen as a barrier.

Well, it's time to change that and it will take efforts of many to change the global mind-set but we need to start somewhere 21st March each year is designated as the international day for elimination of racial discrimination.

However, "discrimination" of all forms should be eliminated. This campaign is to raise awareness and start the conversation to celebrate its OK to be different

#owdsocks is a simple campaign and you can participate by adding the hashtag to all your post starting now until the 31st of March 2016.

You can also post message and participate as follows:

Twitter: @owdsocks2016

Instagram @owdsocks

Facebook: https://www.facebook.com/OWD-SOCKS-Opportunities-without-Discrimination-191222867899852/

Lets eliminate all forms of discrimination –

Start today - be #OWD, support #owdsocks so that everyone can enjoy "Opportunities without Discrimination"

For more information contact: Arish Naresh on 0226248145 or acnaresh@hotmail.com

My Experience nursing in Prisons

Dot Galloway

Dot was born in Waiuku, New Zealand and trained at Middlemore Hospital. Registered General and Obstetric nurse in1972 with a Post-Graduate certificate in Cardio-thoracic nursing in 1980.

In 1974 went overseas for 3 years and worked in London as an agency nurse.

Experience gained in many areas including orthopaedics, plastic surgery, Maxillo-facial surgery, gynaecology, mental health and ENT surgery.

On returning from overseas worked in Coronary Care at Middlemore for 4 years then moved to Greenlane Hospital to complete the Cardio-thoracic post grad cert. Since then Dot has worked in a chelation clinic and then general practice for 6 yrs.

From there joined the Department of Justice (now the Department of Corrections) in 1987 and for the past 28yrs has been part of the health team looking after the health and welfare of prisoners.

Dot is married to Dave and is passionate about patchwork and quilting. They have a small online business supplying products to complete patchwork quilts. This is Dot's retirement goal.

At Mt Eden

I came to the Department of Justice in June 1987 with a background in Coronary Care,

Cardiothoracic nursing and six years experience in a busy general practice.

One of the doctors at the practice asked me to work at Mt Eden Prison. I was reluctant at first but I "scoped" for half a day at Mt Eden Prison to see if I would like to work there.

I had all of the preconceived ideas that the majority of the public have, if they have never been exposed to the prison environment. I decided I was up for the challenge and it really wasn't as daunting as I expected. That was the start of my sentence. No interview, just rock up to the gate and fill in the forms. The process is certainly different now.

My first day I was shown the routine and off I went. No such thing as orientation in those days. The Health Service (Medical) basically operated by the integrity of the nursing staff. There were no Policies and Procedures that were related, to health services.

There was a custodial manual, Penal Institutions General Orders (PIGO) available. Any health issues in the manual were focused around the custodial management ofprisoners e.g. all prisoners will shower at least twice a week.

The nursing responsibility was to ensure that prisoners were seen on arrival in prison.

Their health history was taken and baseline recordings such as BloodPressure, weight, height, urinalysis, and visual acuity were taken. Immediate health needs were met as required. Medication was managed appropriately. All documentation was paper based.

Health promotion for patients was on a one to one basis when you got the opportunity as they may not be there the next day.

I stayed for six months at Mt Eden Prison then moved to Turangi.

At Tongariro / Rangipo Prison

I was asked by the prison superintendent to start, the day I arrived in Turangi; however I started two weeks later.

There was a Prison Officer Nursing in charge of the prisoners' health on long term sick leave and this was a Prison Officer that had a First Aid certificate.

I worked part time with another nurse for five months when the incumbent in charge took medical retirement and left a vacant position. I was asked to apply and was later advised by the superintendent that I had the job. No interview and I was now full time and in charge.

The prison was predominantly a working prison and the population reflected that. The health service was basically a reactive one. We had "medical parades" each day and treated what was presented and dealt with accidents as they arose. We now have daily clinics and function as a general practice in the community would.

A doctor visited the prison once a week and the general health of the population was managed by myself and another part time nurse.

There were no official 5 rights in those days but our nursing integrity ensured that our practise was as safe as it could be. We nurses were working in a custodial environment that was related closely to the forces in the early days. The hierarchy of the service mirrored an army model. We were answerable to the Prison Superintendent.

Health Services or Medical as it was known was seen as a “bunch of dogooders” that was tolerated in the prison system. They were not part of the team as we are today. We had a nursing advisor, who was a registered nurse, employed part time in National Office to oversee the health component of the department.

We were, and still are advocates to ensure that patients get what they are entitled to and to achieve good health outcomes. We are now a Cornerstone accredited service that is equal to the best in the community.

In 2004 Medtech (an electronic patient management file) was introduced to health services. We now became computer literate and all our documentation was electronic.

This was a great advantage when patients were transferring in as we had access to their file so we could prepare for their arrival.

From 2005 there was a move to align the health service in prison with the health sector at large. Policies and Procedures were written up and signed off with all the appropriate consultation and collaboration. We now have a Health Services Manual and each site has a Health Services Local Operations Manual.

The last restructure in 2015 reduced the size of Tongariro Rangipo Prison to 300 prisoners and a secure perimeter fence was erected. Rather than the open spaces of yesteryear we are now all behind the wire, a real prison. The Rangipo part of the prison was closed.

Over the past 28 years I have been nurse, Charge Nurse, Team Leader, and HealthCentre Manager. I have been through three major restructures with many smaller changes. I have gone from a paper world to computers. I have been responsible to the Prison Superintendent, Regional Health Manager, Corrections Health Manager, and Prison Manager to Prison Director. I had a staff of 0.5 in the early days, to now with eight nurses and two administration support staff.

I have managed my budget then not managed my budget back to managing my budget. We have gone from 160 inmates to 550 back to 300. It is a wonder I am not schizophrenic or maybe I am.

I would not have lasted this long with all the changes and upheaval if I didn’t enjoy my job and couldn’t see that we, as Health Services, do make a difference to peoples’ lives.

We do get patients that have complex health needs that do not have optimal health status on reception and it is very satisfying to see them leave in a more healthy state.

A picture of Dos receiving the Cornerstone Certificate with her Manager at the time, Grant Aitken, in 2012

NZ COLLEGE PRIMARY HEALTH CARE NURSES, NZNO

NORTH ISLAND SYMPOSIUM & AGM, 27TH AUGUST 2016

SOUTH ISLAND SYMPOSIUM, 29TH OCTOBER 2016

"Beyond the Barriers in Primary Care"

Topics: Skin, Information Technology, Suturing Workshop, Drugs & Alcohol, Communicable Disease, Respiratory, Children's health, Men's Health, ENT, Primary Mental Health, Sexual Health

http://www.nzno.org.nz/groups/colleges_sections/colleges/college_of_primary_health_care_nurses/conferences

Please note: Fees are subject to change between regions.

HCN New Zealand College of Primary Health Care Nurses NZNO

NEW ZEALAND NURSES ORGANISATION

SAVE THE DATE

Registrations: 8am

Start: 9am
Finish: 5pm

Wine and Wisdom 5.30pm

AGM: 6pm (Auckland only)

VENUE:
Holiday Inn Auckland Airport

Education Centre SCDHB Timaru

$175 members-Auckland
$150-Timaru
$225 non members

Winning, when dealing with bullies

Nurses have choices when dealing with bullies. They can remain victims or take an empowering approach, learning to be assertive and seeking help when they need it.

Craig Waterworth

Reproduced with permission from: Kai Tiaki Nursing New Zealand vol 20 no 5 June 2014

Bullying has been identified as a problem within nursing (1). Nurses say it can result in reduced job satisfaction, unhappiness at work, premature resignation or departure from the nursing profession and mental ill health.

Bullying is also a problem in wider society, especially with the advent and proliferation of social media where people, sometimes thinking they are anonymous, act as "keyboard warriors". They attack people via internet platforms where communication is instantaneous and can be directed towards specific individuals.

Bullying takes many forms. It can come in the guise of put-downs, stand-over techniques and also exclusion and ritualised ignoring Bullying can also come from any level of the team; it could be a peer, a junior or senior staff member.

Bullying can also come from patients. This is very concerning in areas where there are high levels of aggression towards caregivers (2). So, why is bullying a problem, specifically in nursing? Is it that we are the oppressed professional group (in relation to medical doctors) and that the internal conflict is a sign of our own fears in addressing this power imbalance? Is it the organisation's or the profession's cultural ethos? Is it a result of high workloads and stress levels, or individual factors such as not "liking" the look of someone? Or is it a combination of all of the above, and more, that we need to address? The cause of "horizontal violence" is difficult to pinpoint (3) and challenging to overcome.

Teams where bullying or negative communication styles (bitching!) is an accepted part of the workplace culture are impaired when it comes to patient care, as these attitudes can hurt good relations and the ability of professionals to communicate appropriately and effectively. This can lead to errors, omissions and mistakes in the organisation and delivery of patient care (4).

So what can we do about this? The answer could be to look at what is going on in the communication patterns of bullying and to think about how we can change these patterns to neutralise and prevent bullying tactics from socially "infecting" people and teams in the first place. A former colleague of mine introduced me to the "drama triangle" (5). This is a model, based on the theory of transactional analysis, that describes how bullies operate and maintain dominance over others.

We can all recognise the three positions in the triangle, shown in figure 1 below.

The persecutor is the archetypal bully, who acts like an irritated lion. Others need to know the persecutor has (or wants to show they have) power and control. The persecutor will make sure others know the persecutor is "superior" and the targets of the bully are "inferior" and will be made to feel inferior.

The victim is the person who is suffering as the result of one, or many, problems or life events. This person is not willing to help themselves, though. They behave like a wounded mouse, making sure others are fully aware of how tough they have it. They may even act as if there is no solution and focus primarily on enlisting the efforts and attentions of others.

The rescuer is the perfect person for the victim. A rescuer will take over for the victim, do the thinking and the problem-solving, providing a great deal of concern and support, like a St Bernard's dog. The rescuer will expend a great amount of emotional energy helping a victim, possibly using more energy than they want to because they are so concerned about the supposed acuteness of the victim's plight.

People can stay in one position during a conversation or they may flip from one position to another. A team leader might speak to a shift co-ordinator like this: "This roster is no good; you need to change it. I have told you time and time again that nurse Jones can't do nights. Sort this out double quick. I have enough on my plate with two resignations and a restructure to worry about, without having to deal with this as well!" In this brief dialogue, the team leader has moved from the persecutor to the victim position.

Promoting patients' independence

Nurses can also, understandably, easily get themselves into the rescuer position. This is the case for our work with patients, as well as colleagues. Many nurses,

however, take an empowering approach, promoting the patient's independence and ability to care for themselves. They provide knowledge, choices and resources that enable the patient to maximise control over their own well-being. Alternatively, in the case of bullying, they will respond in a style that negates the bully's ability to perpetuate their behaviour. This is where the "winner's triangle" (see figure 2) comes in (6).

In the winner's triangle, we adopt positions that are constructive, positive and empowering for ourselves as people and professionals, and for our colleagues and the patients we care for. These positions can stop bullies and bullying in their tracks. Make use of them and you will notice how quickly you can defuse a negative dynamic or change a challenging situation. Figure 2 shows the three winner's positions.

Vulnerable: This recognises that no-one is superhuman and no-one can "do it all" by themselves. We do, at times, need help from others. This position represents a "resilient individual" – it describes a person who will do their best to deal with problems, or contribute to solving problems, even if they need help to find the best solution.

This person is self aware, knowing when to ask for help. They do not give in at the first hurdle, though, as a "victim" might, and they always recognise that part of the answer to the problem will lie in how they respond to it.

Assertive: This represents the "mature adult". The assertive person knows what they want, knows how they feel and will express their position clearly without punishing others (unlike the persecutor). They are also open to negotiation with others, although they will not do things they do not want to do. They have some "red lines" they will not cross, although these are reasonable, rather than extreme positions, which become clear during negotiation and discussion.

Caring: This position nicely describes a "professional nurse". The professional nurse is concerned about vulnerable people and undertakes functions that support the needs of patients. However, they do not take over the thinking and problem-solving for the patient, unless it is absolutely necessary (ie a clinical emergency or in intensive care). This is the opposite of "rescuing", as the rescuer creates dependency. The carer promotes autonomy as their default position when delivering care.

Again, people can flip positions within the winner's triangle. A team leader may say: "I'd like to talk to you about the roster – I think I mentioned this to you before. Sylvia is doing a few nights which we want to avoid as she has a lot of pressures on at home. Do you think it is possible to change it? I know we are short-staffed at the moment which makes things challenging, but let's see if we can work this out together." In this dialogue, the team leader is being assertive and also caring.

How can you respond?

If you are confronted by a persecutor (bully), stop and think about what is going on and how you can respond.

When a bully demonstrates bullying behaviour, consider your response. Will you become a victim and let the bullying continue, while also whining and complaining about your situation to others? Or will you move to the winner's triangle – acknowledge you are vulnerable, enlist the help of a support person and also think about what you could do to address the situation yourself, in terms of being assertive? There is also nothing wrong with being caring towards the bully. For example, if you think that acknowledging the pressures in the work environment is helpful, then do that.

Some additional things you can do about bullying include: document what happened and when. Reflect on what is going on. Is the problem to do with the way you are reacting to or perceiving the situation, or are your concerns valid? If you feel your concerns are valid, the best thing to do is to talk to the bully directly. If you feel unsafe, ask a support person to go with you. When you do this, make sure you are staying in the winner's triangle by being mainly assertive. State your specific concerns, find out if there is a valid reason for whatever is happening and also state what you want to happen (take some notes with you if you think this will help). It is also very important to be reasonable and open to compromise and negotiation. You may think you are being bullied because you get all the "bad" shifts, but maybe it was bad luck. The team leader may not be able to change the shifts until the next

roster is formulated. Accepting a situation like this might be a good compromise.

Taking a direct approach

In the vast majority of cases, talking to the bully directly solves the problem (7). If the situation deteriorates or is not resolved, then talk to a more senior person within your organisation, or with NZNO, WorkSafe New Zealand (the country's workplace health and safety regulator) or your employee assistance programme provider, if you have one. NZNO has guidelines you can access from its webpage (8).

As social media increasingly affects our lives, we can also become more vulnerable to cyber bullying. The Nursing Council has produced some useful guidelines on social media and electronic communication (9). You should presume all comments you make online, including instant messaging services and emails, could become public. If you make comments about someone, think how they would react. Any negative communication, verbal, written or online, can adversely affect a nurse's position. This is stated more explicitly in section 6 of The Code of Conduct for Nurses, which is titled "Work respectfully with colleagues to best meet health consumers' needs" (10).

If you are bullied online, or via your mobile phone, don't respond. Instead, block the person if you can, take a screenshot of the abuse, report it to the provider of the software you are using (be it Facebook, Twitter, Google or Microsoft etc) and also call Netsafe for advice on 0508 638 723, or the police, especially if the bullying is threatening. Don't "friend" people you don't know and be careful about "friending" the ones you do know. Don't friend patients. On the whole, the internet is a wonderful tool with incredible resources for improving aspects of our lives, but we need to treat it with care and respect.

Nurses are the biggest health care professional group. The public regards and trusts us highly, and we have influence and power. We need to use our power to change the system and work politically to ensure we correct intra-professional power imbalances, rather than turning in on one another and "eating our young". Why can't all nurses prescribe? Why aren't there adequate numbers of nurse-entry- to-practice positions? Why aren't nurse practitioner in-training positions more widely available? Why don't we tackle the media when it portrays us in stereotypical and demeaning roles? We have a wonderful profession, with bottomless potential, that can change all of these things and many more, if we direct our energies towards finding solutions, rather than perpetuating problems.

I have worked in teams where the drama triangle rules and in many other teams where the winner's triangle dominates. Teams full of drama are miserable and toxic places, whereas teams full of winners are happy and vibrant; this also benefits patient care. If we have spent a long time living in the drama triangle, it can be uncomfortable shifting to the winner's triangle. But once you make the change, you will find it hard to go back. Happy teams comprise people living and breathing the winner's triangle, whether they know it or not. Give it a go. You have nothing to lose. •

Craig Waterworth, RN, MSc, is a professional clinician at Massey University's school of nursing, Wellington.

References

1) Nixon, J. (2014) Looking at the culture of nursing through fresh eyes. Kai Tiaki Nursing New Zealand; 20: 1, pp26-27.

2) Burgess, R.C. (2005) A model for enhancing individual and organisational learning of 'emotional intelligence': The drama and winner's triangle. Social Work Education; 24: 1, pp97-112.

3) Longo, J. & Sherman, R.O. (2007) Leveling horizontal violence. Nursing Management; 38: 3, pp34-37, pp50-51.

4) Alvarez, G. & Coiera, E. (2006) Interdisciplinary communication: An uncharted source of medical error? Journal of Critical Care; 21, pp236-242.

5) Karpman, S. (1968) Fairy tales and script drama analysis. Transactional Analysis Bulletin; 7: 26, pp39-43.

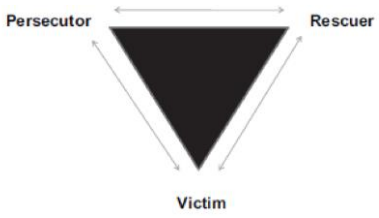
6) Choy, A. (1990) The winner's triangle. Transactional Analysis Journal; 20: 1, pp40-46.

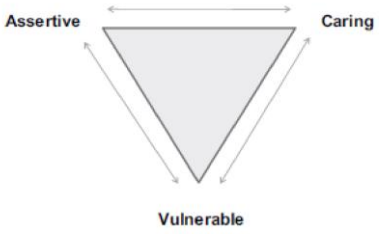
7) WorkSafe New Zealand. (2014) Preventing and responding to workplace bullying: Best practice guidelines. Wellington: The Author.

8) NZNO. (2014) Workplace bullying. www.nzno.org.nz/Portals/0/publications/Workplace%20bullying.pdf. Retrieved 23/03/14.

9) Nursing Council of New Zealand. (2012) Guidelines: Social media and electronic communication. Wellington: The Author.

10) Nursing Council of New Zealand. (2012) Code of Conduct for Nurses. Wellington: The Author.





History of Prison Nursing

Deborah Alleyne

I trained as a Psychiatric Nurse at Cherry Farm hospital then bridged to comprehensive registration in Invercargill. My clinical practice has been in mental health, predominantly forensic services. I joined the health services team at the Department of Corrections as a clinical quality advisor in 2006 before moving into health management and now working as Practice Director across all professional groups, including health. I completed a Masters in Health Sciences, my dissertation being a history of prison nursing in New Zealand. firmly believe that prison based primary health nurses deliver an essential community service, supporting a high health need and hard to reach population. I am married to Chris, between us we have 6 children and 4 beautiful grand children.

Registered nurses employed by the Department of Corrections along with contracted GPs and other health professionals, deliver health services every day to over 9,000 men and women held in New Zealand's prisons. Prisoners are a high health needs population largely drawn from our most deprived communities. They present with a high incidence of mental illness, substance abuse, chronic or infectious diseases and brain trauma. Many have complex social issues and are disengaged from support networks.

Additionally prisoners are parents to more than 20,000 children so the potential impact of improving their health outcomes is significant not just for the individual but for their whanau and our communities.

Nurses have been in prisons since 1957 when the first formal organisation of prison health services was implemented. The first nurses employed were male ex-military medics who were soon joined by a small number of experienced registered nursing sisters. This female presence was considered likely to boost the morale of prisoners and prison staff. In the late 1960's Psychiatric nurses were also employed predominantly because this provided a pool of male nurses at a time when females,

weren't considered well suited to the prison environment. The nurses worked alongside GPs who visited the prison. Activities undertaken by these pioneers included seeing all prisoners who required medical attention, maintaining records and undertaking treatments. Sick prisoners were locked in their cells and cared for by other prisoners who brought them their meals and medication, and emptied their pots. Service gaps identified in a contemporary account were the lack of attention to public health issues and prisoners "emotional upsets", lack of confidentiality and low levels of confidence by prisoners in the GPs.

In response to concerns about health services two reviews were commissioned in the mid-1970s. These identified the core nursing activities undertaken in prisons as assessment, treatment, referral, medication administration, counselling, health education, management of infectious diseases and providing first aid to prisoners and staff. Male nurses also had custodial responsibilities including escorting prisoners to external health appointments. Recommendations from the reviews included improving health facilities, employing increased numbers of qualified staff and removing all custodial duties.

In 1986 the first Principal Nursing Advisor was appointed and before the position was disestablished 10 years later work was undertaken to standardise nursing practice, establish realistic staffing levels and improve nursing education. Recognition was also given to a health rather than medical focus of service delivery.

A 1988 report noted that each prison had at least one nurse working part-time 5 days per week and that there were a total of 61 FTE nurses employed across the country.

This included two prisons that had 24 hours nursing cover with plans to extend this to a third. The report recommended an increase in

nursing numbers in response to prisoners' increasingly complex health presentations and education in the areas of emergency nursing, substance abuse and cultural needs.

In 2000 it was recommended that prisons focus on delivery of primary health services to prisoners. Specifications for this were established along with a clinical governance framework. It was also recommended that nursing numbers be further increased from the 87 FTE then employed to 137 FTE, that new reporting structures be established and that nurses continue to be employed directly by the Department of Corrections.

This focus has been embedded in subsequent reviews and the Department now employs around 215 FTE nurses who are supported by a national policy and clinical advisory team and regional practice development teams.

Nursing practice in prisons is driven both by the environment in which it operates and relationships. Environment includes legislative requirements, the socio-political context and the physical

environment. Health care while essential is not the primary function of prisons and therefore has to be adaptive and able to accommodate different priorities while maintaining the integrity of its own. Nurses are at times conflicted by prisons' necessarily strict safety regimes and physical security and the raw behaviour that they sometimes witness in that environment.

Functional relationships with non-health staff are necessary to ensure nurses safety, aid navigation through the complex regulatory environment and enable completion of daily activities. Recognising prisoners as patients and engaging therapeutically is critical but can be a challenge for nurses who are often perceived as being part of a punitive system. Effective interaction with the wider health sector enables prisoners to access their health entitlements but can be hindered by lack of knowledge, inflexibility or prejudice from outside agencies who are unfamiliar with the prison or prisoner context.

Breaking down barriers and advocating for their patients is therefore an important function of prison based nurses.

The role of prison nurses has evolved from a largely unqualified, unregulated and unsupported workforce into a skilled and professional team of specialists working from accredited health practices which service communities of patients who reside in prisons.

Overcoming the challenges that prisons provide has led to the development of a branch of nursing with a unique knowledge base.

Grant Brookes

Introduction to the new president of NZNO

Ko Kapukataumahaka te māunga

Ko Ōwheo te awa

Ko Cornwall tōku waka

Ko Ngā Kaimahi o Te Ao tōku iwi

Nō Ōtepoti āhau

Ko Don rāua ko Helen ōku mātua

Ko Grant Brookes tōku ingoa

Nō reira, tēnā koutou katoa.

Thanks to the College of Primary Health Care Nurses for giving me this chance to introduce myself to you. My name is Grant Brookes. I am descended from Scottish settlers who arrived in Dunedin on board the *Cornwall*, in 1849. I grew up in Dunedin and graduated in nursing from Otago Polytech in 1996. From here I entered the Mental Health NESP programme at Auckland DHB, and from 2002 up until my election as NZNO President last year, I worked as a Staff Nurse at Te Whare o Matairangi Mental Health Recovery Unit in Wellington.

I have previously held many roles in NZNO, including Workplace Delegate, Relief Organiser, Convenor of the National Delegates Committee for the DHB Sector, Member of the Mental Health Nurses Section Committee, Chair of the NZNO Greater Wellington Regional Council and Member of the NZNO Board of Directors.

Across these roles, my strong interest in the social determinants of health has led me to successfully promote public health policy development within NZNO – including support for removing GST from healthy food, the development of an NZNO position statement on obesity and most recently the creation of a statement on climate change and health.

But for all that, my only clinical experience in Primary Health was a single District Nursing placement as an undergraduate student.

As President, I am responsible for ensuring that NZNO fulfils its constitutional Mission to represent members and to promote nursing and midwifery – including through the work of the Colleges & Sections. You can be sure that I will faithfully represent you on issues which NZCPHCN asks me to raise – whether it be in my regular meetings with the Nursing Council, the Minister of Health and opposition health spokespeople, or at the Ministry.

Fortunately I also have a Vice-President, your past College Chair Rosemary Minto, who can bring Primary Health expertise to the NZNO Board table, on your behalf. You'll need no reminder from me about what a great channel she is for your issues.

My roles outside of NZNO are probably where my personal commitment to Primary Health has developed most fully. In 2012 I stood in local body elections, as an NZNO-endorsed candidate for the Capital & Coast District Health Board. Although I narrowly missed winning a seat, I used the election to promote the shifting of attention and resources towards the Primary Health Sector, as part of an "ambulance at the top of the cliff" approach to healthcare.

Since 2012, I have also represented the NZ Council of Trade Unions on the Board of the Newtown Union Health Service. Updating the Strategic Plan for this pioneering PHC service, and steering it through a challenging period for VLCA practices, stand among my proudest achievements.

Now that I've introduced myself, I hope you feel more able to communicate with me – either through the College, or directly. You can reach me by email (grantb@nzno.org.nz) or phone (027 536 2851), although it seems that many members these days prefer to communicate through Facebook, which is why I'm also at www.facebook.com/nznograntorg.

At the end of the day if you're an NZNO member, then I'm here to work for you.

Report of Wellington Region of College of Primary Health Care (PHC) Nurses

February 2016

The committee met at the end of January to plan our education sessions for 2016. If anyone would like to join this fun group of nursing colleagues we would love to have you on board. We only meet about four times per year, so the time commitment is small as 'many hands make light work' as they say. The collegial support and friendships gained from this group over the years has been truly amazing – thank you team. I'd highly recommend joining.

Our study sessions are free for college members and nursing students, we charge $5.00 for others. Numbers attending range from 20-70; it's encouraging to see more nursing students coming. Occasionally other allied health professionals including podiatrists, midwives and doctors attend. We usually have 2-3 presenters, speaking on different aspects of a broad topic which we believe is relevant to all PHC nurses.

Our latest study evening was entitled "Renal health: and what PHC nurses need to know". Our presenters were Clinical Nurse Specialists from the Renal and Diabetes teams at Wellington Regional Hospital. Whilst it was sobering to see the burden that patients have to endure when they are on dialysis, PHC nurses can and do play a significant role in screening patients for Chronic Kidney Disease. Take home messages were, Diabetic kidney disease is preventable, common, expensive and treatable.

Dates/topics for this year are:

19th May (Tuesday) - Sexual Assault response

17th August (Wednesday) - Respiratory conditions

15th November (Tuesday) - Palliative Care

Our membership is steadily growing, now at 121. As well as our traditional base of practice, public health and district nurses our membership currently covers a wide variety of workplaces including tele nurses, occupational health, aged care, disability services, well child, educators and nurses working in the insurance industry.

Recently we've been trying to reach nurses who may be working in isolation, some examples those working for NGO's and school nurses where they may be the only nurse in their workplace. As people register for the study sessions we encourage them to join (if eligible) by providing them with the link to the College webpage. Thanks to the wonderful Karen Smith the college treasurer who keeps us updated with a current membership list – no small task.

You will have read about the upcoming symposiums in Auckland and Timaru.

We encourage you all to take the time to attend these symposiums - they will be fantastic. The Wellington regional forum will be offering some free registrations to enable a few nurses to attend. Therefore we encourage all members to join before the end of March, to be eligible. See below one of last year's recipients of the free registration.

I was very happy to have won a free registration to attend the conference last year. It was my first time at conference and I had a fantastic weekend. It was full of high calibre speakers with a good variety of seminar choices as well as speakers for the general programme. It was a great opportunity for networking with fellow nurses. I also enjoyed the take home resources and meeting with some great people in the exhibition area. Angela Ross

So if you're not already a member of the college and are reading this and considering going to the symposiums (which I know will be fantastic) then quickly go to the CPHCN page on the NZNO website to become a member.

Wellington committee members can be contacted at: wgtnregioncphcn@gmail.com

Reference group email address: phcnrg@gmail.com - sign up to this to be informed of relevant nursing Kind regards

Cathy Nichols

Chair of the Wellington Regional Forum

25 February 2016

School and Diabetes: The New Zealand National Clinical Network for Child and Youth Diabetes Action and Management Plans.

Rosalie Hornung

Clinical Nurse Specialist, Starship Children's Health

Nursing Lead. New Zealand Clinical Network for Child and Youth Diabetes

Rosalie Hornung has been a member of the PSNZ Clinical Network Clinical Reference Group since September 2014. Soon after being accepted onto the Reference Group she took up the position of Lead for the Nursing work-stream to lead the exploration of innovation and initiatives for a National approach to care within Paediatric diabetes in NZ.

Rosalie trained as a registered nurse in Melbourne, Australia. Over the past 25 years she has worked in a variety of both clinical and research based professional nursing positions in Australia, the United Kingdom and Canada before settling in New Zealand. Rosalie holds a Masters in Nursing and is almost at the completion of her Postgraduate Diploma in Health Science towards planned endorsement as a Nurse Practitioner. Rosalie has been working as a Diabetes Nurse Specialist in Paediatric Endocrinology at Starship Children's Health since 2003. Her areas of interest are in youth health and transition of care.

Diabetes mellitus in childhood is a complex condition that can potentially make school life complicated and stressful. Schools generally provide quality care for children and young people with diabetes, however sometimes issues arise that upset the balance of care provided. Families, healthcare professionals and school personnel need to work together towards a common plan of care.

This short article will provide essential information for Primary Care Nurses to enable positive changes for children and youth with diabetes within school environments in New Zealand.

The International Society for Paediatric and Adolescent Diabetes (ISPAD) provide clear guidance as to the necessary requirements for all children with diabetes at school (Pihoker, et al, 2014) as follows:

- All schools need to make provision for children and youth with diabetes to be able to access appropriate monitoring and treatment therapy equipment.
- All healthcare requirements need to be incorporated into the daily school plan.
- Children with diabetes have the right to participate in all school activities and school sponsored events and have a right to receive appropriate adult supervision and support during school hours.
- School personnel must be able to undertake testing of blood glucose levels in young children and older newly diagnosed children and adolescents until they are able to do this independently. Appropriate training and specific instructions about how to respond to blood glucose data is required.
- School personnel must receive adequate training by specialised healthcare personnel to provide or supervise care. This includes access to food in case of potential hypoglycaemia (for example increased levels of physical activity), insulin dose confirmation and administration by injection or as a bolus with an insulin pump. Staff should be aware of possible factors that affect glucose levels, such as food intake and physical activity, and support young people with insulin dose decisions or have a plan to communicate with parents as required. Families must provide to school personnel contact numbers for family members and for the relevant healthcare providers in the case of emergencies.
- All school personnel should be trained to recognise hypoglycaemia symptoms, initiate treatment, and know when to call for assistance or manage severe hypoglycaemia. Although most young people are independent with diabetes management at school, assistance with management of moderate to severe hypoglycaemia will be required.

In 2015, the National Child and Youth Clinical Diabetes Network, in consultation and collaboration with consumer representatives, examined diabetes health

resources being used in schools within New Zealand. This work was undertaken alongside a National survey targeting consumers, nurses and school personnel in order to ascertain the breadth of availability of diabetes specific resources and the identification of areas of perceived need. The results of the National survey will be available in early 2016. The major outcome of this work has been the identification of significant educational gaps with a focus on the need for formal resources to support consistent standards of care so that children and young people with diabetes across New Zealand have the same opportunities at school as their peers.

The development of a collection of diabetes action and management plans to address educational gaps and inconsistency in standards of care across New Zealand, is intended to provide a formal guide that can be used by schools in collaboration with families and healthcare providers towards high standards of consistent care and management of children and youth with diabetes in schools and early childcare organisations.

Diabetes action and Management plans

The diabetes action and management plans are the original work of collaboration between Diabetes Victoria, The Royal Children's Hospital and Monash Children's Hospital, Melbourne, Australia. They have been adapted in consultation with the Paediatric Society of New Zealand and the National Clinical Diabetes Network for use in New Zealand. They are based on current best practice evidence for diabetes care for children and young people with type 1 diabetes (Pihoker, et al, 2014; Craig, et al, 2011). Starship Children's Health Paediatric and Adolescent Diabetes service are also in the early development phase of creating an online educational module for school personnel based on the standards of care in the action and management plans. It is anticipated this online module will become available by mid-2016 via the Starship website.

Families of children and young people with diabetes and/or school personnel can access the diabetes action and management plans either through their local specialist Paediatric diabetes team or via the Kidshealth website, Diabetes in Schools (2015, May 14) Retrieved from http://www.kidshealth.org.nz/diabetes-overview. The plans are provided for use in secure PDF format only. They need to be printed and individualised by hand (filling in name and other details, ticking relevant boxes where indicated) by the diabetes treating team in consultation with the child/young person and their family (for children under 13 years), or by the young person in consultation with their family and relevant school health personnel (i.e. school nurse, health care assistant/first aid officer) for those at intermediate or college level school. Action and management plans for early childhood and kindergarten settings are currently in process and due for release across New Zealand in early 2016.

There are three sets of diabetes action and management plans that address care requirements for the three main types of insulin regimens used within Paediatric and adolescent diabetes (twice daily injections, multiple daily injections and pump therapy). The action plan is a one page document with a photograph that is designed as a quick guide to summarise generic aspects of care for diabetes at school and act as an identifying medical document. The accompanying management plan is a much longer document designed to capture specific individualised information regarding each child's care. It is important that families are closely involved in putting this part of the plan together so that any special requirements are clearly documented for school personnel. Each year, families should initiate with their healthcare team a review of the plans to reflect any developmental changes in care requirements.

The provision of consistent standards of school based healthcare is central to improving the lives of children and youth with diabetes, removing inequalities and supporting the right to a good education. Primary Health Care Nurses have a pivotal part to play in the promotion of safe environments for children and young people with diabetes at school, and can make a significant difference to how the future of healthcare within schools in New Zealand is managed.

Additional Notes

The Paediatric Society of New Zealand (PSNZ) has developed a national clinical network to promote and support quality care for the treatment of diabetes for children and youth in New Zealand. The Network has been in operation since 2012 and updates of aspects of its work can be viewed at

https://www.starship.org.nz/for-health-professionals/national-child-and-youth-clinical-networks/.a

The Network is a national network of paediatricians, registered nurses, scientists, allied health and consumers who have strong clinical, research interest with children with diabetes and are either consumers or support

consumer interests. The network aims to be broadly representative of a range of professional disciplines and organisations as well as geographic areas and aims to enhance services for children with diabetes and national data collection.

References

Craig, M.E., Twigg, S.M., Donaghue, K.C., Cheung, N.W., Cameron, F.J., Conn, J., Jenkins, A.J., Silink, M., for the Australian Type 1 Diabetes Guidelines Expert Advisory Group. (2011). *National evidence-based clinical care guidelines for type 1 diabetes in children, adolescents and adults*, Australian Government Department of Health and Ageing, Canberra.

Kidshealth, Diabetes in Schools (2015, May 14) Retrieved from http://www.kidshealth.org.nz/diabetes-overview

Pihoker, C., Forsander, G., Fantahun, B., Virmani, A., Luo, X., Hallman, M., Wolfsdorf, J., Maahs, D.M. (2014). The delivery of ambulatory diabetes care to children and adolescents with diabetes. Pediatric Diabetes 15 (Suppl. 20), 86–101.

Vulnerable Children Act 2014

This summary is from Buddle Findlay Legal Team.

The **Vulnerable Children Act 2014** introduced a number of changes for organisations that provide services to children. The most significant change for these organisations will be the requirements to conduct safety checks on staff.

The safety check provisions will come into force on 1 July 2015, as will the Regulations that set out the safety check requirements (the Regulations were published last week).

Once the safety check provisions are in force, all State services and all organisations that they fund to provide 'regulated services' (including those that only receive partial or indirect funding) will have to:

Carry out safety checks on all new 'children's workers' that they employ or otherwise engage. A 'children's worker' is defined in section 23 of the Act; essentially, a children's worker is a person whose work involves regular or overnight contact with children without parents or guardians being present.

Carry out safety checks on existing children's workers.

Continue to carry out periodic safety checks every three years.

The list of regulated services is set out in **Schedule 1 of the Act** and is very broad, encompassing welfare, support, justice, health, education, transport and policing services.

The requirements to safety check new and existing children's workers are being phased in over time. The key dates are:

From **1 July 2015** all new 'core workers' must be safety checked before their employment or engagement commences. A 'core worker' is a children's worker who, in the course of their work, will be alone with children or has primary responsibility for, or authority over, children.

From **1 July 2016** all new children's workers (ie core and non-core) must be safety checked before their employment or engagement commences.

By **1 July 2018** all existing core workers must be safety checked.

By **1 July 2019** all existing children's workers (ie core and non-core) must be safety checked.

Organisations must ensure that children's workers are re-checked every three years.

The safety check requirements are set out in the new **Vulnerable Children (Requirements for Safety Checks of Children's Workers) Regulations 2015**. Under the Regulations, organisations will be required to confirm the identity of children's workers and whether they have any criminal convictions. They will also have to collect and consider other specified information including referee checks.

Identity confirmation

An effective safety check depends on individuals being who they say they are. Organisations must confirm an individual's identity either through an electronic identity credential, or through original identity documents (the individual must provide both a primary and secondary identity document). If the identity documents do not contain a photograph of the

individual, the individual must provide further proof that the documents relate to them. If the individual's name is different from that on an identity document, name change documentation is also required. The list of acceptable identity documents is set out in the**Schedule to the Regulations**.

The organisation must also search its personnel records to ensure no other person connected to the organisation uses that identity.

Previous convictions

A Police vet of a children's worker from the New Zealand Police Vetting Service is required unless:

- the organisation has obtained a Police vet for that individual in the past three years
- the individual belongs to a professional organisation that conducts Police vets of all its new members and of existing members at intervals of not more than three years, or
- the individual is currently licensed or registered by a licensing or registration authority that is obliged to obtain a Police vet for the people it licenses or registers as well as for those holding a licence or registration at intervals of not more than three years.

Other specified information

Organisations that seek to employ or otherwise engage new children's workers must conduct interviews with candidates (this can be face to face, by telephone, or by using other communication technologies). They must consider the work history of candidates and must require candidates to provide a summary of their previous five years of employment (if any). Organisations must also require at least one referee that is not related to the individual or part of their extended family, and must contact at least one of the referees provided.

For both new and existing children's workers, the organisation must establish whether the individual has obtained a relevant licence, registration or practising certificate from a licensing or registration authority or is otherwise a member of any relevant professional organisation. The organisation must seek information relevant to the assessment of that individual from at least one of these bodies.

Once the details above have been checked, organisations must use this information and any applicable risk assessment guidelines to assess whether the individual poses any risk to the safety of children (and, if so, the extent of that risk).

Organisations who do not meet these requirements will commit an offence and will be liable for fines up to $10,000 (for each offence). Organisations will need to carefully consider who at their organisation is a children's worker and build the safety check requirements into their recruitment and HR processes.

Useful guidance material, including a copy of ***Safer recruitment, safer children***, is available from the **Children's Action Plan website**.

If you have any questions, or would like further information, please contact a member of our national **employment** team.

Reflective Practice: When comfort isn't enough.

Kate Stark

Nurse Practitioner Candidate

Gore Health Centre.

"*the greater danger for most of us lies not in setting our aim too high and falling short, but in setting our aim too low and achieving our mark*"-Michaelangelo

Amidst a health environment where 'integration' is one of the current buzz words, we are witnessing primary health care nurses expanding their nursing roles and working to their potential. While expanding scopes of practice, knowledge and skills, they strive to remain confident and competent to work across a variety of areas. Without a doubt, practicing in one workplace for a long period of time has advantages to a community and to health practitioners, both individually and collectively. With the growth of evidence-based medicine regardless of profession, there is always the potential to become stale, static and tunnel visioned in one's approach. Being all that we can be as primary health care nurses optimizes the provision of seamless patient care that is accessible, affordable, and that simultaneously meets a communitys' needs. Nurses in primary health care are central to optimizing patient care and must be grown and nurtured to be all they can be.

As I reflect on my 25 plus years of nursing, I am grateful for the opportunities I have had to work in different areas of practice and gain new knowledge and skills. We all come from different backgrounds and regardless of this, we all have something to offer and there is always more than one way of doing something which generates identical outcomes. Being open to this is crucial to learning. I applaud those who have the ability to remain in the one workplace for a length of time. This shows true commitment to a role and a community. Areas who rely heavily on nursing input, such as rural areas also benefit hugely from invaluable local knowledge especially at times of crisis. On the other hand, I have experienced that change is healthy, and that moving beyond one's comfort zone can provide rewarding outcomes for both nurses and patients.

Opportunities to grow our practice professionally and personally are paramount and we must seize these chances as they arise in order to grow. Leaving your comfort zone is initially daunting but undoubtedly rewarding. Circumstances however, I acknowledge may be limited in certain areas, and ties such as family and business may preclude some from having the luxury of choosing where they work. Distance to travel elsewhere to work in rural areas is a valid example of such a dilemma for primary health care nurses.

Taking risk to initiate change and move out of our comfort zone can be extremely lucrative for staff and patients, for this is how we grow professionally and personally, expanding our knowledge and skills. This is inherently reflected in our practice and the care we deliver. It is natural to feel secure within our 'safe zone' as we naturally value safety and security above all in virtually all aspects of our lives. We must however evolve our practice to align to the health care needs of our community. Populations are ageing and services are stretched. What a satisfying feeling to broaden ones' horizons and reach for the stars, but most of all to be confident, competent and skilled enough as nurses to facilitate a seamless patient journey where patient pathways are improved and patients' holistic needs are met.

On reflection I think about where I started and my journey to where I am currently. Have I grown? Yes. Did I take a risk? Yes. Did I move forward ? Yes. Was I nervous about leaving my safe place, a HUGE Yes! But most importantly as I approach the final step in my Nurse Practitioner journey, has my community benefitted? Yes. To provide the entire realm of nursing care to patients is daunting but exciting and I embrace the opportunity to become a Nurse Practitioner within my collegial team.

A big part of this change and evolution in practice has been about reflecting on my practice and allowing myself to identify gaps in my knowledge (of which there are plenty). In order to extend myself within nursing to learn, grow and fill those knowledge gaps, reflection has become my best friend, a simple tool which enables me to scrutinize my practice, make changes and move forward. I have had to be stern with myself consistently and repeatedly, to shift my thinking that once was safe, in order to move outside my comfort zone, challenge my thinking and in turn my practice. It's the best thing I have ever done and the rewards so far have been huge for patients and for my job satisfaction. Reflection is now an integral part of what I do every single day.I encourage you all as nurses to do the same and to reap the benefits. With reflection comes

the benefits of expanding clinical practice, maximizing nursing contribution and the quality of service we provide to our communities.

"Twenty years from now, you will be more disappointed by the things you didn't do than by the ones you did. So throw off the bowlines, sail away from the safe harbour, catch the trade winds in your sails. Explore. Dream. Discover."

The NZNO Library Resources for Nurses

The NZNO Library has a wide range of hardcopy and online resources available to support the information needs of members.

Check out the updated NZNO Library resource lists. http://www.nzno.org.nz/resources/library/resource_lists

Articles on Prison Nursing

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

1. Australia's nurses and midwives sharing our stories (2012). Australian Nursing Journal. 20(4), 28-33.
The article presents information on the Australian Nursing Federation's "Australia's Nurses and Midwives: You Couldn't Be in Better Hands" campaign, which debuted in August of 2012. Profiles of several federation nurses and midwives, including registered nurse Ben Gorrie, clinical nurse specialist Lizzie Barrett and registered pediatric nurse Jenna Fanning, are presented

2. Collins, A. R. (2014). Emphasizing Health and Wellness at the Louisiana Correctional Institute for Women. Corrections Today. 76(1), 51-57
The article discusses the move of the Louisiana Correctional Institute for Women, noted to be the only state-operated female facility for felony offenders, to focus on improving the health and wellness of female inmates. Physical fitness, health and wellness opportunities being offered include programs that are both ordered by medical providers for medical purposes and those that are chosen by inmates. The establishment of the facility's nurse-led offender Wellness Group is highlighted.

3. Fedele, R. (2015). Healthcare on the inside Australian Nursing & Midwifery Journal. 23(2), 31.
The article offers the insights of registered nurse and manager Dianne Orr of Dhurringile Prison's Health Services regarding the health service to the inmates of Dhurringile Prison in Victoria, Australia. Topics discussed include aside from being a minimum security prison they are preparing the inmates before releasing to the community, providing primary care, emergency care and chronic diseases management, and being a nurse in a prison is a great job.

4. Healthcare equality for prisoners. (Dec2015/Jan2016). Australian Nursing & Midwifery Journal. 23(6), 37.
The article presents a study by the University of Melbourne, University of New South Wales, and Griffith University as of December 2015, which showed that prisoners in Australia do not receive certain treatments and medications due to high costs and the absence of access to Medicare. Under existing laws, prisoner healthcare is the responsibility of state and territory governments. Also cited is the comment by Professor Stuart Kinner on their study.

5. Leach, B. & Goodwin, S. (2014). Preventing malnutrition in prison. Nursing Standard. 28(20), 50-56.

Vulnerable patient groups are at increased risk of malnutrition. This article focuses on the importance of ensuring that the nutritional needs of those in institutional settings, in particular prisons, are met. Offenders often present with

a number of health and social factors which can lead to a high risk of malnutrition. The consequences of malnutrition are significant, ranging from delayed recovery to increased mortality.

6. Manchester, A. (2014). Improving mental health in prisons; Enhancing nurses' clinical expertise Kai Tiaki. 20(8),12-13.
Speaks to the nurse about her role as the first in-reach mental health clinician in a new pilot programme at Spring Hill Corrections Facility and Waikeria Prison in the Waikato. Explains the aim of the programme, which is also being piloted by a clinical nurse specialist at Christchurch Men's Prison and by an occupational health therapist at Auckland Region Women's Corrections Facility.

7. Perry, J., Bennett, C. & Lapworth, T. (2010). Nursing in prisons: developing the specialty of offender health care. Nursing Standard. 24(39), 35-40.
This article, the first in a five-part series, examines offender health care as a specialty. It explores the role of the nurse and the developments that have occurred over the last ten years in this field. In later articles, the authors discuss leadership skills for nurses working in the criminal justice system, assessment of the acutely ill patient, management of long-term conditions, and the future of **nursing** in offender health care.

8. Smith, E (2010). Care versus custody: nursing in the Prison Service. Practice Nurse. 40(7), 33-35.
The article discusses challenges faced in prison nursing and the skills prison nurses should possess. Since prison nursing involves dealing with people who have a wide variety of complex needs, nurses should be able to make clinical decisions with a clear rationale and to be resistant to pressure to do things to suit prisoners or prison staff. Prison nurses commonly have to deal with anxiety, depression and self-harm.

9. Williams, B.A., Stern, M. F., Mellow, J., Safer, M. & Greifinger, R.B. (2012). Aging in Correctional Custody: Setting a Policy Agenda for Older Prisoner Health Care. American Journal of Public Health. 102(8), 1475-1481.
An exponential rise in the number of older prisoners is creating new and costly challenges for the criminal justice system, state economies, and communities to which older former prisoners return. There is a need to identify knowledge gaps and to propose a policy agenda to improve the care of older prisoners.

10. Yoho, H. R. & Backes, C. R. (2015). Achieving BABY Care Success: The Only Ohio Prison Nursery. Corrections Today.77(3), 40-43
The article features Achieving Baby Care Success (ABCS), a prison nursery in Ohio that was started at The Ohio Reformatory for Women (ORW) in Marysville. Topics include the program's aim to allow mothers of convicted nonviolent crimes to keep their newborn babies with them, ABCS' role to design an attachment-based programs for mothers hat had nonviolent fourth- or fifth-degree felonies, and ORW's success in its nursery program.

NZNO Library Contact Details

Level 3, 57 Willis Street

PO Box 2128, Wellington 6140

P: (04) 494 6398

F: (04) 382 9993

E: Library@nzno.org.nz

W: http://www.nzno.org.nz/resources/library/resource_lists