LOGIC.

LINKING OPPORTUNITIES GENERATING INTER-PROFESSIONAL COLLABORATION

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

Vol 15 No 2

Woman's Health

Immunisation Update

IT helping nurses

Telehealth

E-health

Apps for nursing

Symposiums & AGM information

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

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In this issue….

Chair's Report

Kim Cameron
Chairperson

Tēnā koutou, tēnā koutou, tēnā tatou katoa

I cannot believe we are already half way through 2016; I am left wondering where the first part of this year has gone! Already the winter solstice has been and gone. It seems the older I get, the faster time goes. But I bet there are many of you all who feel the same way as I do.

As current population trends require primary health care clinicians to meet the demands of an ageing New Zealand population, and a significant rise in chronic conditions and co-morbidities, demand a stronger emphasis on treatments in the community. We must have accessible, affordable and appropriate programmes and education for all primary health care nurses. We acknowledge the continuum of learning as the primary health care specialisation evolves and broadens.

Personally, it only seems like yesterday that the College committee decided to put on two regional skill workshops instead of a conference this year, and already our North Island symposium is just around the corner.

Over the last several months these two skill workshops have consumed a considerable amount of the College committee's time and the symposium committee has put in an enormous amount of volunteer hours to pull both these workshops and programme together.

The College committee's aim is to offer nurses working in primary health care an

opportunity to attend a NZCPHC symposia, which did not cost the **E**arth; which would provide a programme that was **E**xciting, **E**nlightening and

Embracive of the many scopes of practice within the Primary Health Care sector and which, in turn would **E**mbolden your nursing practice (*This message was brought to you today by the letter E*). I feel the committee has accomplished this to the very best of our ability; using the constrained resources at our disposal, whilst working within a relatively tight budget.

The symposia programme offers you the opportunity to learn the art of suturing, and

expand your knowledge on topics relating to mental health; sexual health, men's/tane health, I.T, respiratory management, drugs and alcohol, communicable disease and children's health.

Please take the opportunity to join us in increasing our knowledge and skill base in the area of primary care, so collectively we can diminish those barriers which exist for not only health consumers but for all health care professionals and organisations.

Registrations are now open for both symposium and to ensure your gluteus maximus is on a seat I suggest you get in quick as there are only 200 hundred seats allocated for the Auckland workshop and 80 for Timaru!

We look forward to seeing you ☺

Kim Cameron
Chairperson NZCPHCN

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

Chief Nurse's Report

The future of IV Nursing

Jane O'Malley
Chief Nurse

I recently had the pleasure of presenting to an IV nursing conference in Christchurch and later in the day on a panel; the topic of which was "what is the future of IV nursing".

I am no expert in the world of IV nursing but I put it to the audience that there were two possible scenarios based on the knowledge that demand and technology will be key factors that will require nurses to respond or risk becoming irrelevant.

Currently IV nurses administer a wide range of treatment from blood and cancer chemotherapy products, antibiotics, and pre and post-operative infusions and to a range of people from the very young to the very old. Patient safety is the greatest concern with drug reaction the greatest risk. You can imagine the skill set required for such a role and the knowledge required around diseases, medications and a wide range of soothing interventions, mouth cares, pain and discomfort etc. related tasks include blood draws and monitoring lab results before and after treatment.

So in the first future scenario, as described above, the future is now. Demand for IV nursing is fuelled by an aging population, advances in new technologies, consumer expectations and sustainability initiatives. To date IV nursing has been highly responsive utilising experience gained in inpatient care and outpatient settings to offer services for home and alternative-site areas of care; driving innovation; increasing efficiencies and promoting sustainability. Based on current state, the US Bureau of Labour predicts the demand for infusion nurses' services will rise by 26% and with an increasing focus on home services over hospitals.

At the conference I heard about delivery of progressively more IV services in the community to people with increasingly complex need and at an eye watering level of sophistication and knowledge. The challenge to do so sustainably has seen Nurse Maude District Nursing Services in Christchurch offering wider a range of services from the traditional home care to those delivered in an outpatient setting. This is an example of reconfiguring a model of care that satisfies demands for clinical quality, financial affordability and patient choice.

The second future scenario is one where the technical side of IV nursing will be eliminated altogether because nanotechnology could see

medication delivered at the cellular level via an orally delivered device and potentially seeing the IV nurse therapist redundant. Of the second scenario my question to the audience was, are you nurses or are you technicians?

It is worth noting that if the former scenario is the case (nurses not technicians) then while the technical nature of their work will change, nursing work will remain relevant because it is the nursing skill of matching the treatment with whatever is going on for people; managing labs results; titrating treatment doses; working in partnership with people and their families to manage side effects and assess for the deterioration or abatement of symptoms which make nursing more than a technical task.

Early detection and reduction in deterioration will continue to require a revised definition of partnership between informed consumers and services/practitioners willing to combine expert clinical knowledge with expert personal knowledge. Building person, family and community self-agency and self-responsibility will be part of mutual contracts between nurses and populations.

Dealing with complexity, applying knowledge, critical thinking and interpersonal savvy are the competencies of the 21st century health professional. How well nursing is seen to adapt and whether technology becomes an accepted, valued and integral aspect of applying nursing knowledge and skills will be a matter for history.

The College of Primary Health Care Nurses NZNO

Who are we? LOGIC committee member: Marilyn Rosewarne

Commenced nursing training at Tauranga Hospital in 1970. On graduation in 1973 moved to Auckland, worked with a nursing agency for a short time, before becoming a practice nurse in March 1974 as part of the Selwyn Carson initiated practice nurse subsidy scheme worked in 5 Auckland general practice settings until 1998 at which time I returned to the BOP and worked for the following 10 years at Otumoetai Doctors in Tauranga where diabetes and wound management was an interest of mine. In 2008 I joined the IMAC Team as WBOP Immunisation Facilitator June 2008, then in October 2010 became the IF for the whole of the BOP. Completed a PG Diploma in Primary Health Care in 2011. In January 2012 the role was devolved from IMAC into the BOP DHB. I am passionate about immunisation, improving immunisation service delivery and access with a philosophy that “immunisation is for whole of life”.

I have previously been a member of the NZCPNs National Executive, and joined the LOGIC Journal Editorial Committee in 2010

Co-Editor's Report

Co-Editor Yvonne Little

Welcome to our second e-journal for 2016. We would like to thank you for your patience and understanding whilst we worked through our initial teething problems changing from hardcopy to e-journal with the first issue and making adjustments for this second issue.

With the unseasonable weather we have been having it is hard to believe we are midway through the year as for some of us it hasn't felt like winter yet or maybe it is just that this has been a year of change for the New Zealand College of Primary Health Care Nurses and with our new innovations taking shape the Executive and Standing Committees are literally being run off their feet to ensure that we bring everything together on time.

The e-journal will continue to have adjustments made throughout this first year of publication, so thank you to the team for all their hard work and the membership for your input. We value your feedback on what you liked and didn't like about the first issue and have been reviewing this and will continue to work on addressing as many of these issues as possible in as short a time frame as possible. Please feel free to feedback to us with each issue as this is your journal and we want to bring you both a professional looking and informative journal, and whilst producing a hard copy is not currently an option, we have been investigating getting access to a PDF version so that if you should desire you can print one out or email to colleagues.

COMING SOON is the Auckland Symposium and NZCPHCN AGM on 27th August, followed by the Timaru Symposium on 29th October. This is a change to the old format of a conference and hopefully will enable many more of you to attend for the informative sessions planned and to meet your NZCPHCN Executive and Standing Committee members and find out more about who we are and what we do as many of us will be attending both symposia.

NZCPHCN NEED YOU: Also, we would like to use these symposia to encourage you to think about whether you would like to be part of one of our

committees as over the next couple of years we will have members stepping down as their terms end, so it would be great to allow you to "preview" what the committees do. Something we have learnt as members coming onto committees without any prior knowledge of what is involved is that it can be quite daunting and we envisage an introduction prior to commitment may make this less so. Currently, we have 1 or possibly 2 positions coming up on the LOGIC committee this year. You will find in this issue nomination forms and I strongly encourage you to think about joining us. It is very rewarding being part of such a professional and dynamic group.

Please also check out the NZCPHCN website and Facebook page where you can see who we are and what is happening.

In this issue, we bring to you as promised the themed articles around IT helping nurses and Innovation in Business, we hope you enjoy these articles along with our non-themed ones. At this time with the measles outbreaks we felt it pertinent to bring to you the latest information and we plan to include in each issue articles from IMAC.

In the first issue we brought you information about The Vulnerable Children Act and the changes therein – I would encourage you to read the latest legal update which came into effect on 1st July 2016, if you haven't received email traffic about this, you can access it by going to the Buddle Findlay website or http://childrensactionplan.govt.nz/childrens-workforce/safety-checking-and-the-workforce-restriction/

I would encourage you to check the sidebar here about our September and December themes and if you think you could contribute an article please contact one of the committee and we can send you the writing guidelines. We are also very happy to receive non-themed articles to go in each issue so please feel free to contact us.

Happy Reading

Regards
Yvonne Little
Nurse Practitioner
Co-Editor LOGIC

Future LOGIC issue topics for 2016

SEPTEMBER

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

DECEMBER

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

CERVICAL SCREENING: A Maori health perspective

Haeata Climie

Nurse Manager

Te Taiwhenua o HERETAUNGA

It's been well documented that cervical cancer is on of the most preventable cancers, yet Māori women have the highest cervical cancer rate in this country. This rate has slightly fallen over the years, but compared with European women, Māori still have high rates of cervical cancer. In fact, Māori women are four times more likely to die from cervical cancer than European women (BPAC, 43).

Women with lower educational knowledge, low income, inadequate housing and poor access to health services are less likely to attend screening opportunities and this is an emerging trend worldwide (Garland, Brotherton, Skinner, Pitts, Saville, Mola, & Jones, 2008).

In order to improve the screening rates of Māori women in Hawke's Bay, the PHO Hawke's Bay Health and the HBDHB have implemented specific programmes to encourage this. Both sectors are using targeted funding to address under-screening of Māori women in the region. There are, however, criteria for some of these programmes. To be eligible, women need to be Māori, Pacifica or Asian, >30years, and never have been screened or not have had a smear for over five years.

The PHO has provided co-payments to some practices to complete cervical screening in the anticipation that a fee is not charged to the women. It is known that cost has been a

Ko toku pepeha tenei ki te taha o toku papa me toku mama

Ko tainui me kurahaupo nga waka

Ko Tararua te maunga

Ko Otaki me Hokio te awa

Ko punahau te roto

Ko ngati kapumanawawhiti me ngati pariri nga hapu

Ko ngati raukawa me muaupoko oko iwi

Ko tainui me kohuturoa nga marae

Ko Haeata climie taku ingoa

Kia ora kotou katoa

I'm Haeata and I'm Nurse manager of community health services for Te Taiwhenua o Heretaunga.

I have dedicated my nursing career in Maori Health and this is the area of health I'm most committed to . I have recently graduated with a Master of Nursing and hope to submit a portfolio for nurse practitioner status in the near future.

I enjoy nursing and enjoy working alongside other nurses who have a passion and drive to care for those who need it most.

barrier to Māori women being screened. Some would spend that money on other things, such as food, which has higher priority than their own health. Another initiative the PHO has promoted in Hawke's Bay is the distribution of $20 Pak N Save vouchers.

The mobile nursing team at Te Taiwhenua O Heretaunga, a kaupapa Māori provider of health and social services in Hastings, have had a great response to this initiative during the past six months. The cervical screening rates have increased for women enrolled at the TToH GP practice, Hauora Heretaunga. In the first quarter of 2016, Hauora Heretaunga met its IPIF target of 80%.

Although the $20 vouchers have helped in getting women engaged in screening, that is not the only thing required to get Māori women screened. Māori Health nurses know that a lot of contact attempts are sometimes required before the woman is actually seen, and then a whakawhanaungtanga approach is appropriate, to enable Māori women to understand why cervical screening is important.

This approach could also be applied across the general practice spectrum for Māori women enrolled in mainstream general practices. The HBDHB has provided contracts to Māori health providers in Hawke's Bay to support some general practices with women who are under-screened and un-screened, and who meet similar criteria for the PHO fund. Unfortunately, some general practices have not wanted to get on board with this initiative. This is because they operate from a business model perspective, meaning they will miss out on PHO funding or consultation fees if another provider services their women. This is clearly a barrier for Māori women being screened, and a concern for Māori health. We know Māori women are enrolled in general practices all over the region, and we also know women are not attending screening.

Local Māori health providers are also committed to encouraging women to attend cervical screening. They hold a variety of clinics that cater for all different needs, such as weekend and after-hours clinics, smears in homes or at any location the women feel comfortable with. But in order for these clinics to be robust and sustainable, the support of general practice is required to encourage women to attend the available clinics. Sometimes they might have to sacrifice some funding to allow these women to be reached. All general practice can rest assured that all these women are then encouraged to return to their primary care providers for their next smear. If a social issue such as owing money to the practice is the barrier preventing a woman going to her GP, the mobile nurses will usually refer that woman to their social worker, who will aim at getting their bill paid so this barrier disappears.

Māori have previously expressed that a cervical screening programme delivered by Māori providers could better service the needs of Māori women (National Screening Unit, 2004). Māori prefer cervical screening services to be delivered by Māori for Māori. Not all Māori women are going to want that service, but anyone in primary healthcare should at least give Māori women the choice of where they get their smear done. There is not always a charge for the service, it can be done at a location she prefers, and transport can be provided. And, these women can bring along a support person. That support person may need a smear too.

The Challenge of Turning an Idea into a Nursing Business

Katherine Archer RN MN (Hons)

Post Grad Cert in Cardiac Rehabilitation

Certificate in Pacific Nutrition

Smoking Cessation Counsellor Mayo Foundation USA

Kellogg Rural Leadership Scholar Lincoln University

I have a Masters of Nursing degree and a rural background which enables me to consult effectively with businesses across a number primary industries. She is well placed to identify the complex health issues many companies face when trying to maintain a healthy workforce, without compromising on production or performance.

My team of Primary Health Care Nurses and I provide workplace health monitoring and wellness programmes and this makes their practical, hands on approach unique. My team believe in delivering a quality service, valuing the people they work with which is reflected in the results they achieve.

I believe we have defining moments in our careers, where our journey changes course, often leading us in a new direction. Developing a business focused around health care was the furthest thing from my mind, until that fateful day.

It was a Saturday afternoon when Bill* walked into the rural hospital with his wife looking for a Doctor. Bill was tall, slim, wearing a blue summer shirt, jeans and sneakers. He looked pale and said he felt unwell and had been having trouble breathing.

I invited him into the assessment room and the enrolled nurse was completing the paperwork with his wife. Before I had time to explain the assessment process and contact the on-call Doctor, Bill suddenly fell backwards onto the bed and had a seizure before losing consciousness. I had no information on his medical history, but I knew in an instant, as adrenaline surged and I yelled for help, this man's life was on the line. My mind was racing but it was like running in quicksand, if I only I was back in ICU, hitting the red emergency bell. Help would surround us; there would be more people than we needed. But there was no emergency bell; there were no Intensivists

or nurses at hand with high tech equipment and drugs to resuscitate this man. We were rural and we were on our own. The Doctor and nurses from other wards arrived and we went through the motions of trying to retrieve this man's life. However, it wasn't going to be the outcome we all so desperately wanted.

The Doctor talking quietly to a stunned and traumatised wife, explain what she already knew, her husband had died. Two young sons, who were waiting in the car, were brought in to see their father, lifeless, but still warm to touch. The heart wrenching sobs reverberated through the ward. Their father was 42 years old and he had not known he had heart disease until this moment. For his family, life was never to be the same.

My nursing world was rocked by this event. I eventually left hospital nursing; move out into what I believed was an emotionally and professionally safer place to practice, the community. I had been running an outreach Cardiac Rehab programme for some time and I built on this, helping those who had had cardiac events with recovery as well as part time Practice Nursing.

It was during a meeting with the Cardiologist we were discussing how some cardiac patients were struggling to quit smoking. This sparked my interest and he suggested I look at training and setting up a support network for smokers to quit. I attended two World Conferences on Tobacco or Health and completed several courses. The most valuable was going to the Mayo Clinic in Minnesota to train at the Nicotine Dependence Center as a Smoking Cessation Counsellor. I enthusiastically explored some of the concepts for smoking cessation programmes highlighted at the Mayo including workplace programmes. This was gaining momentum in the USA so why wouldn't it work in New Zealand I thought.

On my return I advertised a workplace programme both locally and nationally, it seemed like a good place to start. There was little interest. It seemed to be a dead end. I was near giving the idea up. The farm we lived on was sold and my husband was looking for another managers job. We had to move house, change schools for the kids and my career was on the back burner. Then a breakthrough came. The Health and Safety Manager at a Meat Processing Plant in Otahuhu invited me to quote for a 6 week smoking cessation programme for their staff. International markets were dictating a high standard of food safety and quality controls which included smokefree worksites. The timing was terrible, I'd lost momentum and my husband said "Charge them heaps and they won't want it" as a way out. So I sent them a quote (which I now know was modest by corporate standards) and they accepted it. I now had the beginnings of a business I had no idea how to run.

I travelled to Otahuhu to run a Kick Butt Smokefree programme for employees who smoked over a 2 month period and I loved every minute of it. Workplaces fascinated me. It was a different world. It was industry driven and production focussed. It was my new project.

This experience gave me the freedom to act on instinct, looking outside the square when the company asked what else I could do to improve their staffs health and wellbeing. How could I add value to this company by broadening my approach? I thought back to Bill dying, how he was like the employees I saw everyday with undiagnosed health risks. His death was a loss to his family,

friends and workmates. There was also a financial cost for his employer who had lost a valued member of staff who would be difficult to replace. Was this the beginning of a business and could I make a difference to people's lives like Bills?

I explained to management that many medical conditions like heart disease and diabetes can remain undiscovered for long periods of time and without active intervention can result in unexplained illness, lack of energy and commitment at work or an inability to concentrate and perform. They employed a large number of Maori and Pacific people, many of whom did not engage with primary care due to working long hours, time required off work and cost of a visit. The management team loved the idea of bringing the clinic to the client and our first clinic was held in the Supervisors office on the Slaughter board.

Impact Health NZ Ltd has come a long way since then, now delivering a wide range of services where we focus on linking health with work performance.

Workplace health has progressed from being a 'nice to have' and 'the right thing to do' to become an integral component of performance strategy. It's self-evident that healthy employees make for healthy organisations and you can not have one without the other!

The evidence is clear that employees benefit from participating in workplace health programmes which in turn leads to a greater sense of engagement within the organisation. Employees report improved health awareness and knowledge, improved physical and mental wellbeing and resilience, increased energy and vitality, increased enjoyment and fulfilment, improved concentration and productivity and improved team relationships.

Heart disease, diabetes, gout, drug and alcohol, sleep deprivation, excess weight, physical inactivity, mental health and social issues all have the potential to adversely affect a person's personal life, their relationships and their ability to deliver at work. Once identified, appropriate action can be taken to reduce or mitigate the effects of these conditions.

Benjamin Hardy's Being Unstoppable highlights the fundamentals of breaking out into the business world which aligns with my own philosophy:

- The thought of setting up a business can be paralyzing. Keeping it simple. Don't over complicate things and use jargon to make you sound superior. Aim to want what is best for everyone. This includes the client (patient), their whanau and their employer.
- Trust your gut. Try to do the right thing and am true to yourself and your values. Having the confidence to give it a go and if things aren't going right, change it. Being adaptable. I believe it also takes confidence to bounce back from failures which I've had plenty of. It doesn't matter how many times you fail, aim to succeed no matter what odds are stacked against you.
- Get up and running, figuring out what works and what doesn't. Test your ideas on the market sooner and this allows you to change direction. Its important to be flexible and nimble to adapt and change while keeping an open mind. Learn from your success and failures.

- Don't ask for permission, just do it. You have what you need within you and all you need to do is trust yourself and act. Remaining authentic and as the owner of a business you are responsible when your team messes up, so own it.
- Setting goals and looking for the next challenge. Be practical and just get on and do it. You can over analyse and stall slipping into a passive inertia. You'll figure it out once you have taken action. If you wait until you feel secure, have enough money, or have the right connections you won't get off the ground.
- Remain focused and keep practicing, it is easy to become distracted once you have achieved your goal. Working smarter, being creative and brave. Challenges you to be more than you currently are.
- Even after I have achieved a goal, I'm not content. How about you?
- To do and be the best you can at what you do, never stop learning. I found honing and improving skills and knowledge has prepared me for all the curly things that can challenge you in business.
- Writing lists. They are a fantastic way to - focused on goals, I love them. They give youa time frame to achieve these while maintaining a long term vision.

A colleague once said to me "There is no one who can do exactly what you can do." She was right. I'm in control and have a unique ability to contribute in an authentic way and I'm proud of what I have achieved. Most importantly I haven't forgotten the reason why I undertook this journey into business. If one employee is empowered with the tools and skills to take action that prevents an event that took Bills life, then my job is well done.

Reference:

http://www.success.com/blog/do-these-30-things-if-you-want-to-be-unstoppable

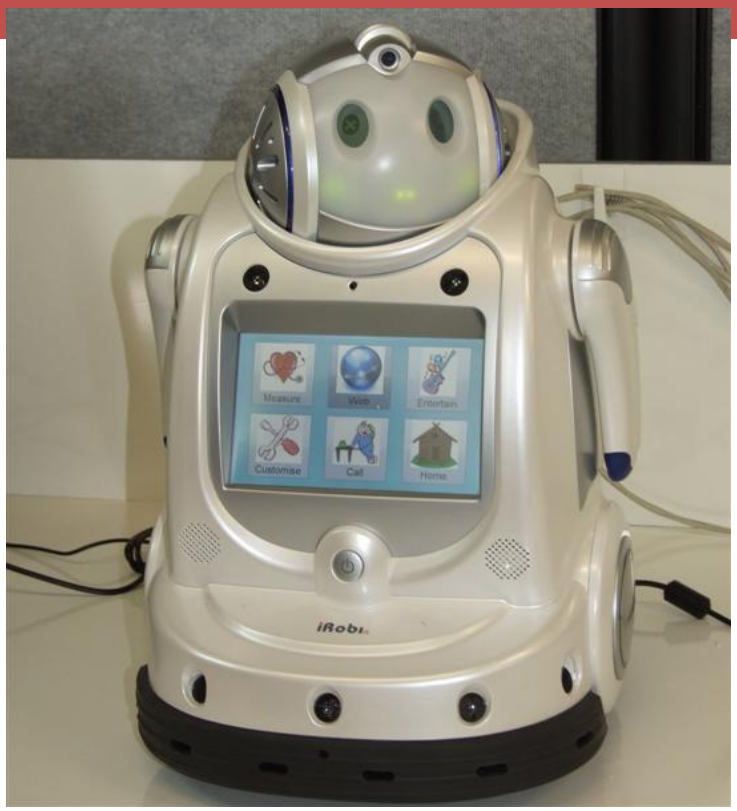
*name changed

Gore Health Robotic Studies.

Elizabeth Broadbent

Associate Professor in Health Psychology

University of Auckland.



In 2014, researchers from the Schools of Medicine and Engineering at the University of Auckland conducted two studies in conjunction with Gore Health Ltd, testing healthcare robots. The aims of these studies were to see whether robots could help improve the delivery of healthcare in a rural area and if these robots could be cost-effective. The two studies have been presented and published at the International Symposium on Robot and Human Interactive Communication conference in Kobe, and the International Conference of Social Robotics in Paris.

The first study was held in the Gore Health Ltd general practice. The Cafero robot was employed to see patients prior to their appointment with the doctor or nurse. The robot assisted the patient to take measurements including height, weight, blood pressure, temperature, pulse and blood oxygen levels. The robot then sent the results to the nurse or doctor automatically. The healthcare professional could then see the measurements on their computer. The results of the study found that doctors could save 2.8 minutes on the average consultation length and nurses could save about 4.4 minutes. A cost-effectiveness analysis showed that if the robot could see 10% of patients prior to the healthcare professional the

costs would break even, and if the robot could see 20% of patients there would be a benefit-cost ratio of 2:1. The majority of patients liked seeing the robot and the staff commented that it was useful to record measurements that the staff might not ordinarily take, although sometimes they liked to take the measurements themselves. There were some software issues and we have worked to improve the robot based on feedback from patients and staff.

The second study was conducted with four older patients in their own homes

with a smaller robot, Irobi. The aim was to see whether giving patients a robot for three months could be useful to help remind them to take their medication, and to reduce the number of times they needed to come to the clinic or hospital. The robots also had games for entertainment and the ability to make skype calls. The results showed that when the patients had the robot they came to the hospital less often than when the patients did not have the robot. We cannot be sure, however that these results were due to them having a robot due to the absence of a control group. There were also challenges providing hardware support to a rural area so far from the University. Nevertheless these results are promising and we are working on improving the software and hardware. We are currently testing these robots in a larger trial in Auckland.

Changes in practice to mitigate pain or distress at the vaccination event

Trish Wells-Morris

I have worked in Neonatal Intensive Care, Infection Control and Nurse Education. I joined IMAC nearly 10 years ago initially as the Taranaki Immunisation Coordinator, Training Coordinator and more recently E-Learning Facilitator. My interests are in applying global research to improve vaccination experiences locally.

Fear of pain on injection with vaccines is more common than once thought for both adults and children. Fear of pain on injection with vaccination contributes to vaccine hesitancy, and lowers immunisation coverage, increasing the risk of vaccine preventable diseases.

Globally parents are concerned about pain on vaccination:

- Parents want to know what they can do to reduce pain for their children
- Parents expect that providers will ensure vaccination is less painful
- Vaccinators are also concerned about vaccination pain and distress

The World Health Organization (WHO) has reviewed strategies for low and middle income countries publishing feasible and equitable for use globally. The WHO recommends that all member countries put in place teaching for vaccinators within current training curricula and advice in immunisation health promotional material for families.

Abdominal breathing

- Place one hand on the chest and the other on the abdomen
- Breathe in through the nose for a count of three, feel the abdomen expand
- Breathe out through the mouth for a count of three, feel the abdomen deflate
- *Teach this repeatedly*

In New Zealand, the Immunisation Advisory Centre is initially promoting 12 key vaccination pain mitigation strategies for children in 2016 vaccinator education along with a new factsheet. This is in line with the 2015 Canadian publication, following an international literature review and updating of their clinical practice guidelines for reducing pain during vaccine injections

1. Avoid aspiration when injecting vaccines. This reduces pain by less contact time with the needle and less chance for movement. The correct choice of site for vaccinations does not involve any major, vessels,

   so aspiration has not been considered necessary for many years.

2. Administer the most painful vaccine last, if known. This is currently assumed to be Measles, Mumps and Rubella vaccine and Pneumococcal vaccines. Feasibility for this recommendation is limited

by lack of knowledge of which vaccines are most painful, so more research is needed.

3. Encourage breastfeeding before and during vaccine injection, if this is culturally acceptable. Breastfeeding during vaccination is comforting, breast milk releases β-endorphins producing analgesia and relaxation. The research found no evidence that babies associate breastfeeding with the procedure. Breastfeeding through the vaccination event will be a change for many New Zealand vaccinators and so consideration will need to be given to how you position the baby and parent and yourself while vaccinating. This also supports 'the baby friendly initiative' promoting the advantages of breastfeeding overall.
4. Hold baby and toddlers during vaccination (preferably by the parent/caregiver) to help soothe them. ***Avoid laying infants on his/her back on a bed or table***. Holding the infant has been shown to relieve distress and is more comforting, avoid restraint. This recommendation (along with encouraging breastfeeding during injection) will require some vaccinators to change their practice and reposition themselves for easier injecting.

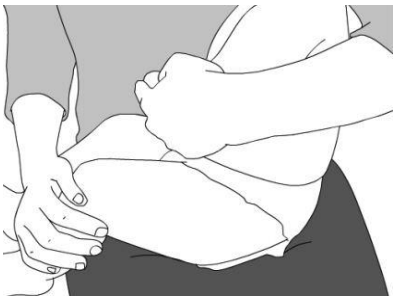


Image of holding a baby from World Health Organization

5. Give the oral rotavirus vaccine before the injected vaccines at the 6 week, 3 month, and 5 month visits. RotaTeq® is high in sucrose and research has shown that sweet solutions can provide short-term (about 10 minutes) pain relief for medical procedures and is used in neonatal units throughout the country. This recommendation has been promoted in New Zealand since the introduction of funded rotavirus vaccine in 2014. This can be given prior to starting breastfeeding when breastfeeding through the vaccination event.
6. Use neutral verbal cues and language to reduce pain and fear.
    - Be honest but neutral, do not focus on the pain
    - Use questions to distract
    - Avoid anxiety provoking language ('here's the sting now')
    - Avoid excessive reassurance, this is just not helpful
    - Avoid false suggestions about pain

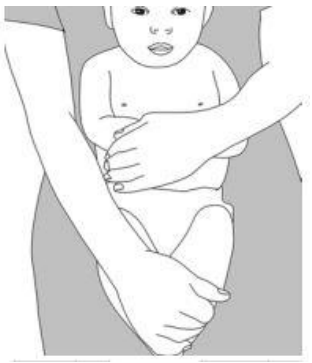


Image of holding a young child upright from World Health Organization

7. Discuss management of discomfort so parent/caregivers can participate. Begin by asking the parent/caregiver if they have any preferences to manage discomfort. Discuss the rationale for strategies i.e. comfort holds or distractions. Encourage them to think about what may help before the appointment and maybe bring their child's favourite toy, book, game, etc.
8. Encourage an anxious parent/caregiver to use relaxation strategies for themselves, such as abdominal breathing, or engage the assistance of another family member.
9. Tell a child aged 4 years or older about the vaccination process in advance. Education in advance has

been shown to reduce pre-procedural fear in children undergoing vaccination.
    - What will happen?
    - How it will feel?
    - How they can cope
    - Sit upright
10. Provide distraction to suit the child during injection.
    - Use a variety of strategies to direct attention away from pain i.e. deep abdominal breathing with counting, a stress ball, singing using a book, a tablet or a toy
    - If using bubble blowing these should be held by the child during the vaccination
    - Download a short video clip and play for the child to watch
11. Consider the use of anaesthetic cream for distressed children, if the cost is acceptable to the family (over the counter pharmacy cost varies). This may be particularly useful for those children who have undergone multiple medical procedures.
12. A calm vaccination experience is the goal. Preparation is essential; consider the process from beginning to end. Use the consent and collaboration of the parent/caregiver and draw up the injection/s out of sight.

References:

- Immunisation Advisory Centre (2016) Mitigating vaccination pain and distress. A factsheet
- Ministry of Health. Immunisation handbook 2014. Wellington: Ministry of Health;]. Available from: http://www.health.govt.nz/publication/immunisation-handbook-2014.
- SAGE working group on vaccine hesitancy. Report of the SAGE working group on vaccine hesitancy [Internet]. Geneva: World Health Organization; 2014. Available from http://www.who.int/immunization/sage/meetings/2014/october/1_Report_WORKING_GROUP_vaccine_hesitancy_final.pdf .
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- World Health Organization. Reducing pain at the time of vaccination: WHO position paper – September 2015. Wkly Epidemiology Rec. 2015; 39(90):505-510.
- World Health Organization (2015) Immunization in practice a practical guide for health staff (for images of holding baby/child) at http://apps.who.int/iris/bitstream/10665/193412/1/9789241549097_eng.pdf

Quick answers to frequent MMR questions

IMMUNISATION ADVISORY CENTRE
THE UNIVERSITY OF AUCKLAND

Please familiarise yourself with the information in the *Measles* chapter in the electronic Immunisation Handbook 2014.

Can we give the MMR vaccine to infants earlier than 15 months?
Yes. The MMR vaccine can be given from 12 months of age if there is concern about high rates of measles or at a parent's request. The second MMR can be given as soon as four weeks after the first dose.

Can we routinely give the MMR vaccine to infants under 12 months of age?
No. This can only be done if a recommendation is made by a Medical Officer of Health. If given, this is considered dose zero. The infant will still require two doses of MMR vaccine from 12 months of age.

If the 4 year MMR is given early, does the child need it again at age 4 years?
No. Only two doses of MMR vaccine are required if they are both given from 12 months of age. The second MMR vaccine is a revaccination for the 5–10% of individuals who fail to become protected against measles after the first dose. Nearly all individuals will be protected after the second dose.

If we give the 15 month MMR early, can we give the 15 month Hib and pneumococcal (PCV13) vaccines early as well?
The 15 month Schedule Hib and PCV13 vaccines are considered valid doses when given from 12 months of age. However, administration earlier than 15 months of age is a Schedule variation and they must be prescribed by a doctor.

If we give the 4 year MMR early, can we give the 4 year DTaP-IPV early as well?
No. It is important to wait until the child is 4 years of age to give the DTaP-IPV to ensure the child is protected against pertussis through their primary school years.

Should older children who have missed one or both doses of the MMR vaccine still have the vaccine?
Yes. A total of two documented doses of MMR vaccine are recommended for all children and adults born after 1968. When two doses of MMR are required, they can be given a minimum of four weeks apart.

Can adults also have the MMR vaccine if they have no measles immunity?
Yes. The MMR vaccine is recommended for any individual who is susceptible to any one of the three diseases covered by the vaccine. Adults born before 1969 are considered to be immune to measles as they were highly likely to have been exposed to the measles virus when they were young.

The parents want the child to have the varicella vaccine as well. Is that ok?
Yes. Both vaccines can be given at the same visit. As both vaccines are live, if they are not given at the same visit, they need to be given a minimum of four weeks apart (refer to chapter 21, section 21.4.4 in the electronic Immunisation Handbook 2014).

The child has an egg allergy. Can they have the MMR vaccine?
Yes. Neither egg allergy nor anaphylaxis are contraindications for receipt of the MMR vaccine.

The child has received a measles vaccination overseas. Do they still need the MMR vaccine?
Yes. Two doses of the MMR vaccine given from 12 months of age are recommended irrespective of previous measles vaccination.

The parents think the child has had measles. Do they still need the MMR vaccine?
Yes. Two doses of MMR vaccine are recommended unless the child has immunity to all three diseases covered by the vaccine confirmed by serology.

The child's mum is pregnant. Is it ok for the child to have the MMR vaccine?
Yes. Viruses in the MMR vaccine are considered to be non-transmissible. It is also important to reduce the risk of the mother being exposed to wild measles (refer to chapter 3, section 3.1.4 in the electronic Immunisation Handbook 2014).

Can a pregnant woman have the MMR vaccine?
No. Live vaccines must not be given to pregnant women.

Can a breastfeeding woman have the MMR vaccine?
Yes. There is no risk to the mother or child from giving MMR to breastfeeding women. However, pregnancy should be avoided for 28 days following the MMR vaccine.

Is there a single antigen measles vaccine available in New Zealand?
No. The measles vaccine is only available as one of the components of the MMR vaccine in New Zealand.

Measles

IMMUNISATION ADVISORY CENTRE
THE UNIVERSITY OF AUCKLAND

What is measles?
Measles, also known as 'English measles'or morbilli, is a potentially serious, highly infectious disease caused by a virus.

How do you catch measles?
Measles is spread through contact with infectious droplets from the nose or throat of a person with measles, often during the first 2–4 days of symptoms before the rash appears. One person with measles can pass the disease on to 12–18 people who have not already had measles or been immunised against the disease.

How common is measles?
New Zealand had large measles epidemics in 1991 and 1997, and continues to have regular smaller outbreaks, with the most recent being in 2014. The last measles related death in New Zealand was one of seven during the 1991 epidemic.

How serious is measles?
Complications from measles are common. They may be caused by the measles virus or a bacteria because the measles virus lowers the body's ability to fight other infections. The risk of complications and death are higher in children under 5 years and adults over 20 years of age. A table listing possible complications of measles is on page two.

Anyone who has a weakness of their immune system is at greater risk of very serious disease. These people are often unable to be immunised and rely on protection from those around them being immunised.

What are the symptoms of measles?
The illness begins with fever, cough, runny nose and conjunctivitis (inflammation in the eyes), which lasts for 2–4 days. It may be possible to see small white spots (Koplik spots) inside the mouth. A rash appears 2–4 days after the first symptoms, beginning on the head and gradually spreading down the body to the arms and legs. The rash lasts for up to one week.

How do you prevent measles?
Immunisation is the best way to prevent measles.

In the event of a measles outbreak, unimmunised children and adults born since 1968 who do not have evidence of immunity against measles and who have contact with a measles case are advised NOT to attend early childhood services, school or public places for 14 days after their last contact with the infected person.

Which vaccines protect against measles?
The measles vaccine was introduced in New Zealand in 1969 and replaced by the combined measles, mumps, rubella (MMR) vaccine in 1990. The combined measles, mumps, rubella vaccine is the only vaccine available in New Zealand to prevent measles.

Two doses of the MMR vaccine are recommended after the age of 12 months, given at least four weeks apart. After the first dose of the MMR vaccine 90–95% of people will be protected against measles, i.e. 5–10 people out of every 100 immunised could still get measles. After the second dose almost everyone is protected.

How safe is the MMR vaccine?
The risk of the MMR vaccine causing serious harm is extremely rare. Immunisation against measles is considerably safer than getting the disease. A table comparing the effects of measles with vaccine responses is on page two.

Healthy close contacts of pregnant women or those with an immune system weakness should be given the MMR vaccine.

Women who are breastfeeding can be given the MMR vaccine.

There is no evidence that the MMR vaccine causes autism. Extensive research conducted into whether the MMR vaccine contributes to the development of autism has not shown a link. More detailed information is available on our website.

Who should get the MMR vaccine?
The first dose of the MMR vaccine is due at 15 months of age and the second at 4 years of age. However, parents can request that the first MMR vaccine be given anytime from 12 months of age and the second any time four weeks after the first.

Infants in whom a liver or kidney transplant is likely are funded for an accelerated immunisation schedule and have their MMR immunisations at 7 months and 12 months of age. Older children and adults who are scheduled for a solid organ transplantation should also receive the MMR vaccine before their transplant if they have not been immunised or are not immune.

During an outbreak of measles, a Medical Officer of Health may recommend that a baby in close contact with measles and aged 6–12 months of age have an extra MMR vaccine dose. When a baby this young has an MMR vaccine, they still need two doses after they are 12 months of age.

It is recommended that adults born after 1968 have documented evidence of two doses of the MMR vaccine given after 12 months of age, even if they have records showing receipt of a measles-only vaccine(s).

- Adults born before 1969 are considered immune to measles because the virus is so infectious and a measles vaccine was not available in New Zealand until 1969.

Individuals who have had a bone marrow transplant, or who are not immune to measles, mumps or rubella after chemotherapy on advice of their specialist.

Can people with an egg allergy have the MMR vaccine?
Yes. Two studies of over 1200 children with severe egg allergy showed that these children safely received the MMR vaccine. Those with a severe allergic reaction (anaphylaxis) to egg can be vaccinated in general practice following the usual processes for safe immunisation.

Who should not have the MMR vaccine?
- Anyone who has experienced a severe allergic reaction (anaphylaxis) to a previous dose of any measles containing vaccine or any of the vaccine components.
- Anyone who is acutely unwell. The presence of a minor infection is not a reason to delay immunisation.
- Anyone with a diagnosed weakness of their immune system.
- Anyone who has received another live injected vaccine, including varicella (chicken pox) or BCG vaccines, within the previous month.
- Women who are currently pregnant (women should delay pregnancy for one month after having the vaccine).
- Babies under 12 months of age, except on the advice of a Medical Officer of Health during a measles outbreak.

continued ...

GET THE FACTS ON IMMUNISATION

Call for Remits and Nominations

MEMORANDUM

TO:	All members of the College of Primary Health Care Nurses
FROM:	The Executive Committee
DATE:	21 June 2016
RE:	**IMPORTANT POSTING – Call for Remits and Nominations**

The NZ College of Primary Health Care Nurses AGM will be held on Saturday 27th August 2016

Symposia Venue – Holiday Inn Auckland Airport, Auckland

Included in this posting are the following documents:

AGM Invitation from Chairperson

Call for Committee Nominations

- Nominations are due by Friday 15th July 2016

Call for Policy and Rule Remits

- Due Friday 15th July 2016
- Please state if you are proposing a rule remit or policy remit
- Please clearly propose the wording of the remit
- Please then clearly state the rationale

Subjects for discussion at AGM

- Due Friday 15th July 2016
- If you are proposing a subject/business for discussion at AGM please make it clear that this is a discussion item and provide all supporting material for the subject. **Send all subjects for discussion by Friday 15th July 2016 to:**

Vicki McSeveney
NZNO
PO Box 2128
Wellington
vickim@nzno.org.nz

Symposia 2016

- The Programme outline & registration form is available on the NZNO College of Primary Health Care Nurses website

AGM Invitation

15TH JUNE 2016

Greetings

All members of the NZ College of Primary Health Care Nurses

I am pleased to invite all members to the NZ College of Primary Health Care Nurses annual general meeting to be held:

Saturday 27th August 2016, 6 pm.

Holiday Inn Auckland Airport, Auckland.

This is an important meeting for College members as the Executive and committees will be sharing our progress, seeking comments and feedback on our proposed plans for the College, including financial and future strategy.

We look forward to meeting with you.

Regards

Chair

College of Primary Health Care Nurses

Kim Cameron

Join a committee

-LOGIC Journal

-Professional Practice Committee

Face-to-face meetings of the Executive and LOGIC and Professional Practice Committees have usually been held at NZNO rooms in Wellington; from 0900hrs to 1500hrs twice a year, usually on a weekday when guest visitors can attend and for flights availability. This year we will be meeting in Auckland and Christchurch.

There is a time commitment; reading material sent out, responding as appropriate, participating in committee teleconferences or skype meetings and the follow-on activity required from these meetings

Once a year there is an AGM and attendance by committee members is expected. AGMs have been held at annual conferences, this year it will be on a symposia day. Typically we have arranged one of our face to face meetings to be held the day before the College Conference or in 2016 before our North Island symposia.

You may need to consider travel time to and from the face-to-face meetings. Travel expenses are reimbursed and lunch is provided. [Flights are booked by the College]

It is recommended you discuss committee representation with your manager before nomination. Only members of the College are eligible to be on a committee.

** If you don't have a nominator, email collegeprimaryhealthcare@gmail.com for assistance.

NOMINATION FORM FOR NZ COLLEGE OF PRIMARY HEALTH CARE NURSES
LOGIC Journal COMMITTEE

I, ...wish to nominate

....
(Surname) (Given Name)
for the position of Professional Practice Committee member, NZ College of Primary Health Care Nurses.

Signed: ..... Date:.....
[Nominator needs to be a member of CPHCN"]

This section to be completed by Nominee

I, ...accept nomination as Professional Practice Committee member of the NZ College of Primary Health Care Nurses

Address (Personal) Address (Business)
....
....
....
Ph/Fax: ..... Ph/Fax: .....
E-mail: ..... E-mail: .....

Area of current work:.....
NZNO Membership No.....
Work Experience briefly:
.....
.....
.....
.....

Signature ..... Date.....

Please return the completed nomination form to the Returning Officer, NZNO,
PO Box 2128, Wellington 6140 by **5pm on Friday 15th July 2016**
Email or post to:

Vicki McSeveney
New Zealand Nurses Organisation
P O Box 2128
Wellington 6140
vickim@nzno.org.nz

NOMINATION FORM FOR NZ COLLEGE OF PRIMARY HEALTH CARE NURSES PROFESSIONAL PRACTICE COMMITTEE

I, ...wish to nominate

....
(Surname) (Given Name)
for the position of Professional Practice Committee member, NZ College of Primary Health Care Nurses.

Signed: ..... Date:.....
[Nominator needs to be a member of CPHCN"]

This section to be completed by Nominee

I, ...accept nomination as Professional Practice Committee member of the NZ College of Primary Health Care Nurses

Address (Personal) Address (Business)

....

....

....

Ph/Fax: ..... Ph/Fax: .....

E-mail: ..... E-mail: .....

Area of current work:.....

NZNO Membership No.....

Work Experience briefly:

.....

.....

.....

.....

Signature ..... Date.....

Please return the completed nomination form to the Returning Officer, NZNO, PO Box 2128, Wellington 6140 by **5pm on Friday 15th July 2016**
Email or post to:

Vicki McSeveney
New Zealand Nurses Organisation
P O Box 2128
Wellington 6140
vickim@nzno.org.nz

APPS Helping Nurses

Yvonne Little,

Nurse Practitioner Primary Health Care.

Have you thought about how nursing practice is changing in this electronic age?

In this day and age, it is unlikely that there would be many workplaces that do not use a computer, long gone are the days of a paper based system although many of us "older" nurses probably still yearn for this. Having said this, I know there will be pockets of the country, especially rural, that often have difficulty with connection to the electronic community because of where they are situated, poor or patchy coverage – no doubt you have probably all found those dead spots when wanting to use your mobile phones when travelling around this beautiful country.

Computers are wonderful until they don't work, which leaves you asking "now what do I do", not only in the face of having a client in front of you but also your resources to educate especially if you don't have large storage space to hold information and many clients do not want to go home with a great big pile of paper to read (although there will be a few who are happier with paper).

Having a computer and printers within a building is one thing, but we have many mobile nurses out there using laptops and mobile phones with no immediate access to printers and I imagine you certainly don't want to be driving around with a car full of paper resources, a few would be manageable, just in-case it is needed.

So, I pose the question – how many of you own a portable electronic resource such as a laptop, tablet, an Ipad or android/Iphone? Yes, coverage can be patchy for many in rural communities but most of us would have at least one of these items and so do many of our clients (obviously not all as many do not have the finances or the desire to be electronically connected) or a home based computer.

Like many of you, I pride myself on keeping myself up to date with the latest information out there and how to access it, BUT I have just discovered that I have been missing a large number of resources via Apps that could assist me and my clients. So I felt it pertinent to share with you.

I have to say a big THANK YOU to Sophie Carty and the team at WellSouth, I received an email about one such App from them about breastfeeding and alcohol (Feed Safe) which I felt was a wonderful resource and therefore asked Sophie if she knew of any other such Apps, whereupon I received an email with numerous other Apps which I am working my way through.

Please read and enjoy the wonderful information provided by the press release from WellSouth and I have included the list of Apps for you to add to your resource list as you desire.

SHOULD YOU PUMP AND DUMP?

All the answers are in Feed Safe, the new alcohol and breastfeeding app

Media Release May 2016

Can I have an occasional drink while I'm breastfeeding? Should I 'pump and dump'? How does alcohol affect breastmilk? How long should I wait after having a drink, before breastfeeding?

These are among the important questions answered in the app **Feed Safe** which has just become available in New Zealand.

WellSouth Primary Health Network has helped bring **Feed Safe** to New Zealand and its Health Promotion and Project Coordinator, Sophie Carty says the free app contains answers to the most common questions about alcohol and breastfeeding.

"**Feed Safe** is a great tool for mothers wanting to regulate alcohol intake while breastfeeding, so that it doesn't harm babies. A number of factors affect how much alcohol gets into breastmilk including the strength and amount of alcohol in drinks, what and how much has been eaten, and how much people weigh".

New Zealand recommendations say that the safest option is to not drink while breastfeeding. However, for those who do want to drink while breastfeeding it is recommended to avoid doing so until the baby is one month old. After this time, mothers may wish to enjoy a drink with a meal, when out with friends, or on a special occasion.

"Alcohol can affect mothers' milk production and breastmilk properties, and babies' sleeping and eating patterns, brain development, and early learning."

Those who decide to have an occasional drink, can enter their height, weight, and alcohol intake to accurately estimate when breastmilk should be free from alcohol. **Feed Safe** includes a timer, which alerts users when they should be safe to breastfeed again. The app has a handy standard drinks guide to help understand how much alcohol is in common drinks. It also contains information about what happens if a mother drinks more than she had planned.

Dunedin mother, Azaria Woodford, has used **Feed Safe** and says; *"What a great tool for breastfeeding mums who want to enjoy the occasional drink. Now we have a visual aid that can help support us! With a quick tap I can either see how long until it's safe to feed my baby, or what the time will be. So helpful that I don't have to try and count back and remember myself!".*

Feed Safe was developed by the Australian Breastfeeding Network, Reach Health Promotion Innovations and Curtis University. WellSouth Primary Health Network has adapted it for New Zealand.

WHAT

FREE app for iOS and Android devices which contains information on breastfeeding and alcohol, to help informed choice.

AVAILABLE

iOS App store appstore.com/feedsafenz & Google Play https://play.google.com/store/apps/details?id=au.com.rhpi.feedsafenz&hl=en

For more information on Breastfeeding Support across Otago & Southland visit: www.breastfeedingsos.co.nz

ENDS.

For more information or to arrange an interview contact:

Sophie Carty on 03 477 1163 or 021 921 596 or

sophie.carty@wellsouth.org.nz

WellSouth Primary Health Network Hauora Matua Ki Te Tonga

Breastfeeding:

- BreastFedNZ (http://www.breastfednz.co.nz/)
- We have an Otago and Southland specific Breastfeeding Friendly App (www.burpapp.co.nz)

Alcohol Harm Reduction:

- DrinkSmart (http://www.drinksmart.co.nz/)
- Hello Sunday Morning (https://www.hellosundaymorning.org/?gclid=CP7jlMDY8cwCFYaXvAodeU0I7Q)

Mental Health:

- Anxiety Sam (http://sam-app.org.uk/)
- ACT App (http://www.actcompanion.com/)
- All Right? (http://www.allright.org.nz/app/)
- BeyondNow – suicide planning (https://www.beyondblue.org.au/get-support/beyondnow-suicide-safety-planning)
- Smiling Mind (http://smilingmind.com.au/)

Healthy Eating:

- FoodSwitch (http://www.foodswitch.co.nz/content/download-foodswitch)

Stroke:

- Stroke Riskometer (https://www.strokeriskometer.com/)

Smoking:

- My Quit Buddy (http://www.quitnow.gov.au/internet/quitnow/publishing.nsf/Content/quit-buddy)

Recording devices are here to stay. Get used to it!

Dr Alastair MacDonald

Just walk down any street. Most of the folk walking towards will have their headphones blazing away, their eyes looking down and their minds elsewhere. If your mobile buzzes, do you feel strange if you don't answer it? We all know you're not supposed to text and drive a car. Less well known is that as a pedestrian; cell phone use increases your risk of ending up in the E.D!

Along with the rest of the community, public health nurses have had to adapt to and accept the recent explosive expansion of mobile technology. These devices have amazing powers of audiovisual capability. So how can we maximise the benefits and minimise the harm when we consider its use in health care? This is actually a fundamental ethical question. A starting point for us could be to look at what determines the rightness of an action.

Maximising human welfare is one way of acting in a manner which can be deemed to be the right way. Human welfare is a broad concept and sometimes many different perspectives need to be examined and balanced to assess whether the greater good has been achieved in pursuing a particular course of action.

How well does this approach serve us? Let's suppose that you are consulting with client. This is a relationship of great importance. Working together in a therapeutic alliance has healing power. As a nurse you have an opportunity to improve a client's quality of life and health status. This relationship has been described as being of a fiduciary nature. "Fiduciary" is derived from the Latin word for "trust". Mutual trust is the basis for effective communication of health information. All of these components are the basis for that most important of

I am a retired renal physician. I am currently a clinical ethics advisor at Capital and Coast DHB, Wellington. I have worked in many different countries including USA, Canada, UK, Vietnam, East Timor, Iraq and Abu Dhabi. For the last 10 years I have been increasingly involved in clinical ethics. I am fortunate to be still working in the public sector, especially so because the first publicly funded health service originated in New Zealand in 1938! I believe that my current passion for clinical ethics and my experience in the public health system will help me to navigate and understand the future challenges in delivering good health care. I think that clinical ethics does not need to be complicated; furthermore I believe that "Clinical ethics is everyone's business"

concepts -“shared decision making”.

As a public health nurse I understand that you are involved in “the co-ordination and case management involving families/whānau and communities, and the health, social and education sectors” (1) As committed health professionals you have to exhibit certain qualities which will enhance your practice. Being good listeners, being empathic, taking time and caring are some of the more important attributes that are needed to ensure that your patients or clients achieve the best possible health outcomes. But most of all; in a variety of ways, you have to be good communicators.

What happens if you find out that a client is actually recording the consultation? Your first reaction might be that suddenly all of that stuff about “fiduciary” relationships and trust immediately vanishes. You might feel betrayed. You might even react angrily. All very understandable. A few moments later you might realise that what you thought was a private conversation has been recorded and could be used in a whole variety of ways that you have little or no control over. All of this might pose a huge challenge to the very basis of your practice and sense of professionalism!

But with a bit of reflection; different thoughts might follow. You might even think that a “fiduciary” relationship actually means that you put the client’s best interests ahead of your own. If the problem that you were dealing with happened to be of a very sensitive nature, it is possible that your angry reaction could actually cause harm to a vulnerable client?

Let’s say you manage to maintain your professional approach. You take a step back. You reflect on things from the client’s perspective.

The complex nature of modern health care is second nature to you but for your client this whole business can be a bit complex and unwieldy. Clients can occasionally be overwhelmed by the unfamiliar nature of some of the issues that you are talking about. This can sometimes be accompanied by a strong emotional reaction. If your client has this type of reaction it could mean that some of the communication subtleties that you have earnestly tried to impart actually get lost in translation. This is particularly the case of the stakes are high. Your client might even think that by simply recording the proceedings that all of these issues will suddenly dissipate.

You might then ask the specific reason why your client used a recording device. If you reflect on some of the issues outlined in the previous paragraph, it might be that he or she was recording the conversation for very appropriate reasons. The fact that the recording could be played back later a number of times means that this could allow time for reflection and clarification. It could mean that at the client’s next visit to you they might engage more constructively in trying to achieve clarification of a specific issue of concern. The very important concept of effective communication could then be fulfilled.

If your client played the recording to whanau or family, any discussion that might follow could be better informed. Could all of this activity go some way in allaying some of your client’s fears? Such conversations might in the long run lead to better decision making.

Realistically, it’s also possible that negative effects could occur such as the perception that the technology use is an intrusion into the consultation

process. As such could it lead to a more defensive decision making process by health professionals? Could this technology be used for litigation purposes? At a more extreme and negative level there might be a more reckless use such as injudicious dissemination of material on social media. It's possible that none of these consequences would be anticipated at the time of the recording. On the other hand a more positive use might be as a tool for practice audit purposes.

In summary what we are observing is the evolution of a new behaviour that can be associated with strong reactions; both negative and positive. The use of recording devices has hitherto been managed with an emphasis on the important issues of the potential erosion of trust, issues of privacy and risk management.

If we reflect on the original issue which was to examine ways that can we maximise the benefits and minimise the harm when this technology is used, it is important to widen the discussion to acknowledge the reality that the use of recording devices use occurs in a huge diversity of health care settings. These include child birth, ICU, acute resuscitation, dying patients and the general ward in addition to the public health context.

This diversity of context needs to be addressed by the generation of policy which is fit for purpose. In the absence of clear guidelines and policy; there is a potential for continuing conflict between staff, patients and families. This is damaging. This scenario is no longer a hypothetical possibility, you and your organisation should be anticipating these realities and how you should respond to this burgeoning technology

Reference

1) Growing public health nursing - Public Health Association

www.pha.org.nz/documents/130718-nursing-discussion-doc.pdf

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 IT helping nurses, Telehealth, E-health, Apps for 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. A brief introduction to ... Assistive robotics for independent living (2016). Perspectives in Public Health 136(2), 70-72.

Assistive technologies are important tools for helping older people to live independently. Praminda Caleb-Solly, Associate Professor in Independent Living Systems at Bristol Robotics Laboratory (BRL) and Institute of Bio-Sensing Technologies, University of the West of England, provides an introduction as to how assistive robotics can address care needs. Intelligent robots, integrated with smart home sensors and healthcare databases, can provide the ability to realise autonomous assistive care solutions to support independent living for an ageing population.

2. Digital health, the new direction in medtech. Is it all about apps? (2015). Australasian Biotechnology, 25(1), 8-9.

While digital health is simply described as ICT that assists in healthcare, this notion obscures the vast array of technology areas that come under this broad 'umbrella'. It includes in its fold, assistive technologies, e-health, wearable technology, tele-health, mobile health and of course smart device applications (apps). The examples are vastly different, from medicines that track ingestion and enable images from inside the body, to smart blister packs that enable tracking of adherence in clinical trials, to an app that assists rehabilitation after a heart attack.

3. Duplaga, Mariusz. (2016). Searching for a Role of Nursing Personnel in Developing Landscape of Ehealth: Factors Determining Attitudes toward Key Patient Empowering Applications. PLoS One 11(4). http://dx.doi.org/10.1371/journal.pone.0153173.

Nurses may play an important role in the delivery of medical services based on the use of ehealth tools. Nevertheless, their taking an active role in an ehealth environment depends on their possessing the appropriate skills and mindset. The main objective of this paper was to assess nurses' opinions and to analyze the predictors of their acceptance of ehealth features relevant to patient empowerment with a strong focus on chronic care

4. Goodall, K.T.; Newman, L.A. & Ward, P.R. (2014). Improving access to health information for older migrants by using grounded theory and social network analysis to understand their information behaviour and digital technology use. European Journal of Cancer Care. 23(6), 728-738.

Migrant well-being can be strongly influenced by the migration experience and subsequent degree of

mainstream language acquisition. There is little research on how older Culturally And Linguistically Diverse (CALD) migrants who have 'aged in place' find health information, and the role which digital technology plays in this.

5. Hendricks, Joyce; Ireson, Deborah & Pinch, Carol. (2016). App challenged: Are midwives prepared? Australian Nursing and Midwifery Journal, 23(7), 32.

In the 21st century, technology will continue to advance rapidly and become the norm in healthcare rather than the exception.

6. Iber, Conrad. How Is Information Management Transforming Sleep Medicine? (2016). Sleep Review (Online) Los Angeles: Anthem Media Group.

In chronic disease management, the United States ranks 11th (in other words, last) relative to other industrialized countries, according to the Commonwealth Fund.3 The current explosion of capability in information gathering and exchange and the rollout of the Information Technology for Economic and Clinical Health (HITECH) Act and the Patient Protection and Affordable Care Act (PPACA) have provided an engine for change and spurred a near doubling4 of the use of EHR in office-based practices

7. Koteyko, Nelya; Hunt, Daniel & Gunter, Barrie. (2015). Expectations in the field of the Internet and health: an analysis of claims about social networking sites in clinical literature. Sociology of Health & Illness. 37(3), 468-484.

This article adopts a critical sociological perspective to examine the expectations surrounding the uses of social networking sites (SNSs) articulated in the domain of clinical literature. This emerging body of articles and commentaries responds to the recent significant growth in SNS use, and constitutes a venue in which the meanings of SNSs and their relation to health are negotiated.

8. McPhee, Ewen. (2014). Telehealth: The general practice perspective (2014). Australian Family Physician, 43(12), 826-827.
Three years ago the Australian Government undertook to incentivise the adoption of telehealth videoconferencing in primary care. The incentives targeted specialist consultations with patients through their general practitioner (GP), nurse, Aboriginal health worker, and aged care facility. Rural and remote patients and their GPs have benefited from improved access to specialist care in an environment where one kangaroo through your radiator can make a compelling case for remote care deliver.

9. Moore, Keith D & Coddington, Dean C. (2016). A progress check on 7 aspects of CINs.
Healthcare Financial Management 70(2), 78-80.

Many healthcare organizations are early in their journey to form and use clinically integrated networks (CIN). Others regard the networks simply as useful and flexible tools. For still others, CINs are the building blocks of the future. Much of the variation among today's CINs is tied to differences in the overall strategies of health systems that formed them.

10. Nam, Yunyoung; Kong, Youngsun; Reyes, Bersain; Reljin, Natasa & Chon, Ki H. Monitoring of Heart and Breathing Rates Using Dual Cameras on a Smartphone: e0151013. (2016). PLoS One 11(3).
http://dx.doi.org/10.1371/journal.pone.0151013

Some smartphones have the capability to process video streams from both the front-

and rear-facing cameras simultaneously. This paper proposes a new monitoring method for simultaneous estimation of heart and breathing rates using dual cameras of a smartphone. The proposed approach estimates heart rates using a rear-facing camera, while at the same time breathing rates are estimated using a non-contact front-facing camera

11. Towers, Carolyn & Tyler, Mathew. (2014). Patients and technology: The broadband-enabled innovation program: A working demonstration of the effective use of technology in community-based patient care. Australian Family Physician, 43(12), 848-851.

Given the socioeconomic demands of the Australian society, both now and in the future, the Royal District Nursing Service (RDNS) has identified the importance of exploring suitable commercial forms of telehealth technologies to enable robust and sustainable models of care for their clients. The aim of this article is to illustrate the practical application of technology in community-based patient care through an overview of a project that the RDNS has trialled to provide remote medicines management.

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