LOGIC.

LINKING OPPORTUNITIES GENERATING INTER-PROFESSIONAL COLLABORATION

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Child Health

Immunisation Update

Abuse/Violence

Diabetes

NZ College of PHC Nurses, NZNO 2016 Auckland Symposium

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In this issue….

Chair's Report

Kim Cameron
Chairperson

Kia Ora, tena koutou katoa

This report comes on the heels of the NZCPHCN Auckland Symposium, "*Beyond the Barriers*" and College AGM. If you didn't make it "what a shame" you missed an incredibly awesome day. The symposium began with an incredibly beautiful Moteatea (traditional chant) from our very own Vice Chair Dhyanne Hohepa. The Tainui tribe chant paid homage to the Tamaki Makaurau (Auckland) region and was an acknowledgement to the people of Tamaki Makaurau. As the Moteatea rang out goose bumps appeared all over my skin. Thank you Dhyanne for your amazing welcome which unified all of us gathered and set the tone for the rest of the day.

Approximately, 170 PHC nurses from all over the North Island descended on the Airport Holiday Inn for a day of networking, interacting, and learning from various PHC practitioners and professionals.

We listened as Jane O'Malley who reported on the New Zealand Health Strategy and the role PHC nurses have in influencing the future. We heard from Karyn Sangster the Chief Nurse advisor of Primary and Integrated Care as she talked about Counties Manakau "At Risk Patient" programme which is designed to provide early intervention, planned and proactive, patient-centred care by helping primary care identify 'at risk' patients and better co-ordinate services. This has helped to reduce hospital admissions; it focuses on integrated care to provide services closer to home. It also helps support patients to self-manage their conditions and provides GP services with the support and tools to ensure the patients receive quality care closer to home. Karen Hoare a Nurse Practitioner for children and young people illustrated how public health projects and initiatives, and how working collaboratively with school nurses and introducing new graduate nurses into general practice can improve outcomes for the most vulnerable groups.

The concurrent sessions gave us the opportunity to listen, interact and learn new skills. Dr Helen Gardyne taught some of us the art of suturing, while Yvonne Little refreshed our memories about the anatomy and physiology of the lung and how to inspect, palpate, auscultate and do some percussion as well. Theresa O'Leary shared her knowledge and skills around ear assessment and Jacqui Stone brought us up to speed about Viral Hepatitis as to the what, where, who and treatment of.

Other concurrent sessions provided information on mental health, cyber bullying and how social media impacts on young adults. Michal Noonan invited us to learn what we can do better in primary care too improve

children's health. We heard from a young person about their transgender journey and Jane Grant spoke to us about the future direction for cervical screening.

The last speaker of the day was Linda Hutchings who had the skills and ability to keep us totally entertained. I am sure she inspired everyone present with her lecture "You Can Lead – Yes You"!

To all of our guest speakers the College thanks you for giving up part of your weekend to share your extensive knowledge and skills about PHC with the rest of us. Also to all the PHC nurses who joined us in Auckland and to all of our members, thank you for your passion and commitment to PHC. I for one thoroughly enjoyed my learning and I am looking forward to doing it all over again in Timaru on 29th October (for those of you who missed the Auckland Symposium sign up for Timaru).

The NZCPHCN AGM went off without a "hitch". At the AGM two new members were voted onto the committee. Congratulations to Tracey Peters and Irene Tukerangi, we look forward to working with you both. Sadly, we also had to farewell two long standing committee members, Emma Hickson (professional practice) and Lynette Law (LOGIC). Thank you for all your diligence, hard work and commitment not only to the College but also in the delivery of safe, timely, evidenced based, patient and whanau centred care you deliver in your day to day mahi/work as PHC nurses. We wish you well, good health and happiness in your future ventures.

At the AGM, I also had the privilege of handing out two PHC awards. The Jane Ayling "Tall Poppy Award" went to Jane Mitchell from Wellington. The College committee thanks you Jane for your sponsorship of the Tall Poppy award which acknowledges the work and care of an exceptional PHC nurse. The Maori Nurse Leadership Award was won by Jayme Kitiona from the greater Auckland region. Congratulations to you both for being nominated and recipients of these awards and on the difference you make in the communities you serve.

At this stage the College committee is looking at doing another two symposiums next year, so watch this space.

Nga mihi nui ki a kotou.

Chief Nurse's Report

Jane O'Malley
Chief Nurse

live well, stay well, get well

This past two days I have been sick. My body simply refused to work and my resilience went out the window. I slept the first day and woke up the next day feeling so refreshed from my day of sleep that felt an urge to race back to work but a thought that a second day for my body to recuperate prevailed. By midday however, my bad habits got the better of me and I started back on the computer. Having spent a large portion of the afternoon doing stuff for work on my sick day I ended up by the evening with my sore throat and headache returned. Nuts you might say; yes of course but that is the way we roll in NZ. But is it "healthy?".

The theme for International Nurses Day 2016 was "Nurses: a force for change: Improving health systems' resilience". The accompanying toolkit is well worth a good perusal since it contains the essential ingredients and examples of resilience both individual and organisational. Resilience as the ability to cope with life's challenges and adapt to adversity.

Among the many points the ICN document makes, is one that goes something like this: when we practice what we prescribe for others in relation to healthy behaviour we are in a much better position to contribute to patient care and organisational resilience; the link between our individual health and the way we work is critical.

And there is another part to the equation. Engagement with our work is critical and the milieu in which we work impacts on how engaged we feel. Workforce morale has been proven to impact on patient outcomes. Two things contribute to this, the emotional environment in which we work (how safe, supported and encouraged we feel) and the nature of the work we do.

With regards to the emotional environment; organisations as well as individuals have a role in psychological well-being. Evidence suggests organisational factors create high or low risk environments in which psycho social experiences occur. Mental distress is associated with lost productivity so it makes good sense for organisations to take a keen interest in the well-being and resilience of their organisations. This year the Government has introduced the new *Health and Safety at Work Act (2015)*. A feature of the Act is the notion that mental health is an important factor (the Act explicitly defines health as including mental/ psychological health and freedom from mental distress caused by work is as important as physical safety) and the focus shifts from managing issues reactively to a more proactive health promotion and systems approach.

With regards to the nature of the work we do; a focus on well-being and resilience, health promotion and prevention of illness is at the heart of the New Zealand Health Strategy. During the consultation on the health strategy we heard from many of you that the NZ health system is fragmented, focused on service delivery not necessarily on people, and largely caters for people when they turn up with an illness. Many of you, provide care for people who, for whatever reason, were unable to *live well, stay well, get well* (the vision for the new NZHS). I'm not suggesting that work with people who are already ill is not important. It most certainly is. I am suggesting that something has to change if we are going to achieve the vision for the strategy.

Individually and collectively we need to be much more assertive about developing services geared towards wellness and prevention. Working on our own health and well-being is an important first step important first step

So in conclusion; a resilient health system is one that is flexible, adaptable and willing and able to learn. The vision of the NZHS and the H&S Act strikes to the very heart of that vision; that all NZrs have the best shot at a long life and a healthy one. How we work and what we do are key to this vision.

Co-Editor's Report

Co-Editor Kate Stark

It is hard to believe that September is here, and once again we approach the conclusion of yet another year. As the days pass and we become older and supposedly wiser, I would like to remind you all of a new learning opportunity on the horizon. The annual NZCPHCN 2 day conference has this year been replaced by two one day symposiums. We hosted the North Island symposium at the end of August. This day exceeded all expectations and was a huge success. If you missed out on attending, you have another opportunity as we look forward to our South Island equivalent on October 29th 2016. This will be almost a mirror image of the North Island version and is not to be missed! We learned, we laughed and a congregation of fabulous nurses from a variety of primary health care roles totally immersed themselves in the north island event and we want to do this all again in Timaru.

In her report, our Chairperson Kim Cameron makes mention of some highlights of the Auckland event. There was something for everyone and as always a chance to meet with old friends and make new ones as primary health care nurses gather together to share ideas and experiences, while learning new things and refreshing the old. The feedback we have received to date has been fantastic, so If you haven't yet registered for the South Island symposium, please do so quickly, as time is running out and spaces are limited. Information and online registration is found on our website. These days have been hugely popular and work is already underway for similar days for our 2017 calendar, again with north and south events planned.

In this issue of LOGIC we have some excellent articles for your perusal. In particular we focus on child health, including immunisations and the conversations we have as nurses with our families, an expert on paediatric trauma services available out of Starship Hospital and the novel use of calico dolls by nurses caring for children in the acute setting. We also have articles on establishing a community ear health service and reaching a diagnosis of diabetes. We hear from our Chief Nurse Jane O'Malley who talks about resilience and Michelle Tanner, winner of the NZCPHCN Tall Poppy award for 2015.

For those living in rural areas, calving is well underway, and lambing is starting in earnest. In the current economic climate farmers and their families can incur some expected but also unexpected stresses. For those in an occupation directly influenced by mother nature and corporate governance, I urge you to all look out for your neighbours. Be mindful of peoples' individual stressors and reactions to these, as well as the consequences of mother nature and financial downturn. Asking the right questions can identify patients who are

struggling and by doing so, implement help which may be overdue. Nobody should suffer in silence and as nurses in primary health care, we have the ability to prevent such suffering through identifying those at risk. We are in a perfect position to do so.

Along with such stress comes the risk of family violence and child abuse. In this issue of LOGIC, we feature an article demonstrating how child abuse screening is crucial. As primary health care nurses, screening at every appropriate opportunity could well make a difference. We must include this as an integral part of our practice when caring for families.

As a College, we pride ourselves in being open to ideas and suggestions, and endeavour to bring to you a journal that is professional and stimulating. We are always keen to hear from people who are interested in writing an article related to all primary health care disciplines. We are also keen to know how you feel about our new journal format, and invite enquiries and suggestions you may have. These can be emailed to either Yvonne Little or myself. We are also keen to hear ideas for next years' symposiums regarding topics and practical skill stations you would like to see.

Many thanks to all those who have contributed to this issue, and to those who are already working on articles for December. I welcome you to this issue of LOGIC, our third e-journal, and hope you enjoy all it has to offer.

Future LOGIC issue topics for 2016

DECEMBER

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

Reflection on immunisation conversations

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.

Protection from vaccine preventable diseases requires high immunisation coverage, which in turn requires strategies to reach all children, including the most at risk. One important strategy is for the practice nurse to initiate immunisation conversations rather than leave this to someone else. Although practice nurses are constantly communicating with families, this article provides an overview of immunisation conversations along with a reflection guide.

Formal knowledge around immunisation conversations begins with the Vaccinator Training Course. Following on from the course, it is expected that a mentor or preceptor will role-model immunisation conversations for a new practice nurse to observe. A great place to start extending knowledge for new vaccinators is chapter three in the current Immunisation Handbook. This outlines responses to common questions, false beliefs and misconceptions about immunisation. Other useful resources for communication and information on a specific topic are the factsheets and other written resources on the Immunisation Advisory Centre website.

We know from research that the relationship between the nurse and the parent/s or caregivers is crucial to successful communication. First impressions count, from the time the nurse goes to the waiting room that relationship with the family is being established and extended using both verbal and non-verbal skills. For a vaccinator, it is also important l to reflect on their own prejudices about immunisation, otherwise, if not recognised this may hamper the communication.

In recent years the focus of immunisation conversation has changed to focus on effective engagement and how the conversation *feels*; it is no longer acceptable to 'tell' parents to vaccinate, to have a 'standard patter' or to rush the informed consent process. Language should be gentle and conciliatory; we talk less, listen more without interruption or judgement and ask open ended questions to ensure the conversation is tailored to the needs of each person. Nurses provide information if it is needed, however some people don't want information so much as to explore their concerns with a health professional. In 2015 the Ministry of Health published a flipchart resource "Let's talk about immunisation" to aid health professionals when talking to families. It is also important to remember that a positive health professional

recommendation is part of the communication.

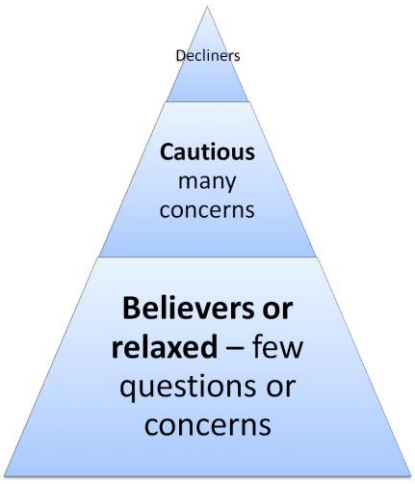

Image developed from research data: Keane et al (2005)

The needs for immunisation conversation have been shown to be quite diverse, confirming recommendations for tailored responses. (Gust et al 2005). Studies support an initial step to clarify who to spend the most time with (Keane, Benin & Leask). At the bottom of the pyramid over 80% of families are either 'believers' or 'relaxed' about vaccination and may not require much information for informed consent. At the top of the pyramid, around 3% of families have decided not to vaccinate and conversations may not change their decision. In the middle is a group of up to about 40% of families who are cautious or have concerns. This is the group worth spending more time with; addressing their concerns can make their choice to vaccinate more comfortable. Health professionals are advised to use plain language and avoid medical jargon as much as possible. Because many New Zealanders have poor health literacy, preparation ensures the message is more easily understood. A small booklet, "Three steps to better health literacy: A guide for Health Professionals", is available to download from the Health Quality & Safety Commission New Zealand website.

Image from CDC website

Universal recommendations for plain language include: talking slowly, putting the most important message first and using language that you know is familiar to your audience, pronouns ('you'), active voice and appropriate visual resources. Another key plain language strategy is breaking information into logical chunks and checking after each one that they have understood before going on to the next one.

Clinical assessors listen to the immunisation conversations of new vaccinators to ensure that essential criteria are covered. For most experienced vaccinators, there may only be themselves and the parent or vaccinee behind a closed door and is therefore, an important subject for individual practitioner reflection. Many will use a broad brush technique: – was everything covered? Was there time for questions? Was the conversation comfortable for both parties? And what might be improved next time?

In line with other health professional reflection tools, the following questions are offered to guide a professional nurse reflection on immunisation conversations:

- How do I initiate immunisation conversations or do I leave that to someone else? What are some of the questions/statements I use when opening an immunisation conversation for the first time?
- How do I recognise what might be preventing this family from engaging in conversations about immunisation – stress, illness, low health literacy, cultural or family norms?

- What techniques do I use to show the person I acknowledge their view point without necessarily agreeing with it?
- What are two resources I have accessed in preparation to ensure I am competent in addressing common immunisation concerns?
- How are my immunisation conversations respectful, supportive and tailored to the person's needs?
- Do I listen actively? If so what tool have I accessed to reflect on this?
- Do I use plain language which is logically organised and divided into easily understood chunks – provide an example of how you do this? If use medical jargon occasionally, do I always explain it clearly?
- What visual resources do I use when discussing immunisation with a new parent?
- What are two examples of open ended questions that I use to draw out more information and check that I understand their concerns?
- Did I and do I always finish with a recommendation to vaccinate and if another follow up appointment is required?

Research is continually providing insight and tools to support immunisation conversations. One of the latest projects is "SARAH", an international collaboration of researchers with expertise in vaccination sponsored by the National Centre for Immunisation Research and Surveillance in Australia. The goal of the project is to support parents and professionals towards the best decisions; it has produced several online written resources.

SARAH

Strategies and Resources to Assist Hesitant parents with vaccination

Image from Julie Leask website

Practice nurses will continue to hone their communication skills for immunisation conversations as families of new birth cohorts begin their immunisation journey: the need is ongoing. The skills for dealing with challenging conversations follow a similar process outlined here but the breadth and depth of information is extended. The basics remain the same, having a face to face conversation rather than delaying it, ensuring respectful communication, taking your time, listening, developing confidence in your depth of knowledge and exploring concerns sensitively. Use the more detailed resources on the IMAC website and contact the immunisation advisors on the 0800 IMMUNE line for extra support when you need it.

Recommended websites:

Australian Government, Department of Health (2015) Immunise Australia Program website accessed June 2016 at http://www.immunise.health.gov.au/internet/immunise/publishing.nsf/Content/fact-sheets-concerns-vaccination

Centres for Disease Control. Plain language tools accessed June 2016 at http://www.cdc.gov/healthliteracy/developmaterials/plainlanguage.html

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National Centre for Immunisation Research and Surveillance (2016*) SARAH Project: Supporting Vaccination Discussions between Parents and Health Professionals* accessed June 2016 at http://www.ncirs.edu.au/research/social-research/sarah-project/

Walsh, C; Shuker, C; & Merry, Al (2015) *Health literacy: from the patient to the professional to the system.* New Zealand Medical Journal October 2015 Vol128 No 1423 pages 10 – 16.

Doll Therapy in the Acute Care Setting

Fran and Donna work at City Doctors. Fran works in the afterhours urgent care clinic. She has worked in paediatrics for a large portion of her career and is enjoying the challenges of the acute care setting. Fran has a particular interest in child health and in managing painful procedures in a positive manner for children and families. Donna is a Nurse Practitioner Intern having completed her Masters in 2012. She has been working in Urgent care and long term conditions since starting in Primary care ten years ago. Donna enjoys empowering people to understand and take control of their health conditions wherever possible. She wants people to leave the practice feeling positive about their health journey.

Tara is a 4 year old child who fell off her bike earlier. She comes into the Practice wrapped in Mum's cardigan, holding her left arm. She looks upset, exhausted and very apprehensive about anyone coming too close to her, especially near her arm.

This is an all too familiar scenario in the acute care setting. Presentations are unplanned; the child is often in pain and shocked and parents/caregivers are anxious and apprehensive as to what will happen and how their child will cope. The child can often sense this anxiety. They are in an new setting, with unfamiliar people while their ability to cope is highly compromised. Nursing children present unique challenges and require added skill in assessment and management, not only of the injury, pain and ongoing care but also of the child's cognitive ability and learning style.

In our Accident and Medical setting one of the tools we use to provide support and enhance understanding for children are "calico dolls". These provide a fun way of presenting information, taking the focus away from the child, making explanations non-threatening and easier to understand.

Effect of pain and trauma

"Medical interventions cause pain, fear, and distress behaviour (such as crying, refusal and isolation)" (Matziou, Chrysostomou, Vlathioti,& Perdikaris (2013, p.470). Pain can cause long term negative emotional outcomes and affect neurological development, resulting in lower pain thresholds in adolescence and adult (Koller & Goldman, 2012). As health professionals we have a responsibility to provide the necessary support to ameliorate negative effects of treatments and future fear of medical interventions. Awareness of the developmental stage of the child helps to direct explanations and care in a supportive and age appropriate way. School-aged children are better able to deal with stressful experiences than preschool or younger children due to their ability to reason,

understand verbal explanations, communicate their needs and express feelings about their experiences. (Potasz, De Varela, Carvalho, Prado, L., & Prado, G., 2013; Depianti, Silva, Monteiro, & Soares, 2014). According to William, Lopez & Lee (2007) children have limited ability to understand, which "can add to their anxiety, fear, anger and feelings of uncertainty and helplessness" (p. 320).

Developmental stages

Piaget (McLeod, 2015), believed that children think differently than adults, describing this in 4 universal stages of cognitive development from birth to adolescence; sensorimotor, pre operational, operational and formal operational.

For 2-7 year olds, in the preoperational stage, pretend play is one of the skills they use to make sense of the world. This is when children learn language, although are not yet able to think logically about concrete events. From about 6-7 to 11 years children are said to be in the Concrete operational stage beginning to "develop logical reasoning skills and to understand cause and effect" (Potasz et al. 2013, p. 76).

In comparison Erikson explains early childhood to adolescence in 4 stages; Trust vs Mistrust, Autonomy vs Shame, Initiative vs guilt, Industry vs inferiority. From 0-18mths the child develops a sense of trust through predictable and reliable care, enabling them to feel secure even when threatened. From 18mths-3yrs children that are encouraged and supported in their increased independence, become more confident and secure in their own ability to survive in the world (Autonomy vs Shame). From 3-5yrs children begin to plan activities, make up games, and initiate activities with others (Initiative vs guilt). If children are encouraged and reinforced for their initiative, they begin to feel industrious and feel confident in their ability to achieve goals (Industry vs inferiority) (McLeod, 2013). "The developmental stages from birth, through childhood and adolescence form the building blocks of healthy and resilient adult life." (Al-Yateem, Issa, & Rossiter, 2015, p. 138).

Tara is given some pain relief. She is settled into a cubicle with her Mum, a calico doll and some felt pens. Initially Mum helps with drawing some details on the doll, and before long Tara joins in. When Tara has settled, the nurse explains the xray procedure using the doll to illustrate the process. The xray confirms a fracture and the doll again provides a means of explaining the plastering technique, using age appropriate language.

According to Renning, (2012) life events such as illness, trauma and death can affect the development of a child. In the medical setting play breaks down barriers, it reduces the impact of pain, providing a way that children can safely express feelings of fear and anxiety. Play is seen as normal part of development. "It facilitates decision-making where children have the opportunity to make sense of the world and provides a sense of normality" (Gill, 2010. p244) "children learn, develop and communicate through play" (p 244). Al-Yateem et al (2015) states that play is a normal part of a child's development and as such, is a basic right of children. The notion that playing is a child's right is supported by UNCROC, the United Nations Convention on the Rights of the Child (Ministry of Social Development 2015). This promotes the rights of every child to grow and be nurtured in an environment providing quality health services, education, equality, and protection. Al-Yateem et al (2015) goes on to suggest that "unresponsive healthcare that

does not support children during care and treatment has been classified internationally as a type of neglect and maltreatment even if not intentional" (p.139). Seeing the effect of play interventions and distraction therapy in our practice supports the use of these simple strategies to decrease stress and improve understanding for children and their caregivers. "A primary goal of any therapeutic play is to assist children to regain their sense of self control in order to alleviate their anxiety" (William, Lopez & Lee. 2007 pg321).

Making the dolls

Using dolls to support coping and understanding is not new to medicine. Our calico dolls are made locally by the Newbury Woman's Institute and Sally & her Mum. They use plain recycled sheets, rather than calico, to save on cost. A single sheet will provide 20-26 dolls.

The pattern is simple, with the body, arms and legs included in one pattern. Two pieces are machine sewn together and filled with recycled pillow stuffing. The small hole used to fill the doll is hand sewn together and the doll is ready for use.

When their care is completed the child takes "their" doll home and is encouraged to bring them back for further treatment. It is important that we look for opportunities to use the dolls in our daily practice to improve stressful situations and help to explain procedures to children. In a more specialist Paediatric setting they use dolls to teach children about more complex procedures, such as insertion of portacaths or hickman lines. There is complex language and concepts involved in explaining procedures and dolls provide a familiar, non-threatening way of supporting the child's understanding. Some children cherish these dolls, bringing them back years after being treated in hospital.

Maintaining a constant supply of dolls is ongoing. The more successful we are at adopting these in our daily practice, so to, an increasing number of dolls are needed to manage the demand. So far we have been fortunate in the support we have gained through individuals and groups we have mentioned. The more we use the dolls to support care and learning, the more we realise the value and effectiveness of these simple additions in our approach to caring for children. We are fortunate to have a culture of support from Management, to improve the quality of care within the practice. Some of the barriers we have found in using the dolls have, at times been supply, but also preconceived ideas and attitudes. These include not having enough time, or doubt as to whether they can add value to situations. The emphasis is often on providing treatment and managing workload /waiting times instead of focusing on the experience from the person's perspective. Ideally we should provide an experience of least trauma, where the process of care flows and the person is confident that the best care has been provided. This increases confidence and empowerment for future medical interventions. Tanaka, Negishi and Hayata (2010) support this stating "Proper preparation reduces misunderstanding and fear, empowers children, enhances their self-awareness and self-esteem and promotes a trusting relationship with the healthcare staff" (p31).

Children find procedures less threatening, display less distress and are more cooperative, so decreasing the long term effects and impacts from medical interventions (Williams et al 2014, Chari, Hirisave & Appaji, 2013).

Tara appears fascinated by the process of plastering, managing well during the application of a backslab and sling to her left arm. Mum appears relaxed and relieved at how well she has coped with the visit. The ongoing care of her plaster is again explained using her doll. Tara leaves clutching her newly decorated and treated doll and Mum will ensure she brings it along for her follow up care.

For our practice, the calico dolls have been effective and useful in supporting children to manage stressful situations and procedures. The dolls help with explanations of procedures, improving cooperation and flow of care, actually saving time. Parents/caregivers are grateful for anything to help the situation and the child leaves feeling more positive about their visit and medical intervention. "Distraction and therapeutic interventions are not… a form of entertainment but to help children cope with painful and invasive procedures aiming to minimize fear and anxiety" (Gill 2010. p 246). This is something we should all be aware of and make use of whatever age appropriate distractions or interventions are available within the practice to improve our daily encounters with children.

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Childhood Skin Infections

Lindsay Lowe
James Scarfe

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James graduated with a BSc and BA from the University of Canterbury in 2005, then qualified and worked as a secondary school science teacher. He completed the Master of Public Health program at the University of Auckland in2012. James has worked as a Public Health Analyst since 2012

Introduction

Compared to other developed countries, New Zealand has high rates of serious skin infections, particularly among children (O'Sullivan, Baker and Zhang, 2011; Simpson et al 2015). Maori children aged 0-4 years carry a disproportionate burden of serious skin infection, both nationally and in the Bay of Plenty and Lakes region. In order to address this situation, Toi Te Ora – Public Health Service (Toi Te Ora) has set a strategic goal to reduce childhood admissions to hospital for skin infections by 2/3 in five years.

To progress towards this goal, Toi Te Ora hosted skin infection workshops in the Bay of Plenty and Lakes in 2015. An updated analysis of skin infection hospitalisation data was also undertaken. This article presents the findings and recommendations of the workshops and data analysis. Resources to prevent skin infections will also be discussed.

Background

In 2011, a health needs assessment was undertaken (Lowe, Ingram-Seal and de Wet, 2011). The following recommendations were made:

- Skin infection prevention and management be made a priority goal in the Bay of Plenty.
- Intervention should focus on Maori children aged 0 – 4 years.
- Prevention and earlier detection, intervention and treatment could be achieved through the implementation of three strategies:

Strategy 1: Increasing communities' awareness and understanding of skin infection prevention and management.

Strategy 2: Increasing skills, capacity and responsiveness of health professionals in skin infection prevention and management.

Strategy 3: Improving responsiveness and effectiveness of primary and community health services in

preventing and managing skin infections in the community.

These three strategies provided a framework for subsequent childhood skin infection work. The following section summarises the findings of an updated data analysis and skin infection report (Toi Te Ora, 2016).

Updated Analysis of childhood skin infection hospitalisation data 2015

An analysis of childhood skin infection hospitalisation data was undertaken in 2015 using the following epidemiologic case definition:

"*A child aged 0-14 years, admitted to hospital with a principal or additional diagnosis of serious skin infection, with a diagnosis code either within the ICD skin infection sub-chapter, or within the categories of skin infection of an atypical site or skin infection following primary skin disease or external trauma.*" (O'Sullivan & Baker, 2010, p181)

Key findings

The incidence of serious skin infection within the Toi Te Ora Public Health Unit area (Toi Te Ora area) has decreased each year since 2011. The difference between the incidence of New Zealand and the Toi Te Ora area has remained unchanged during this time. (Figure 1).

Skin Infection Workshops

Skin infection workshops were held in Whakatane and Rotorua in 2015. The workshops were organised by Toi Te Ora and attended by participants from a wide range of health and community backgrounds.

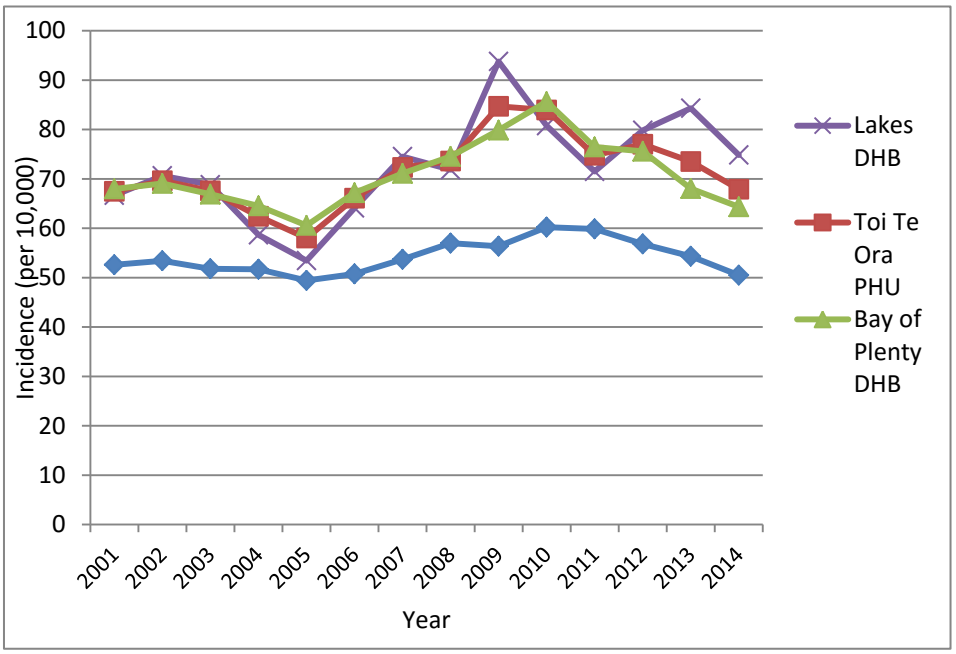


Figure 1: The incidence of serious skin infection in children (aged 0-14 years) in New Zealand and Toi Te Ora area.

The purpose of the workshops was to raise awareness about childhood skin infections and showcase local initiatives. Participants also discussed ideas and provided feedback on how to reduce infections.

Key findings from the workshops

- 'Get back to basics' – teach basic health education messages in schools and Early Childhood Education (ECE) settings.
- Clearly establish who will deliver key messages to ECEs and schools.
- The health literacy and Kiri Ora/Healthy skin resources are effective.
- Aim to reduce fragmentation and duplication of services

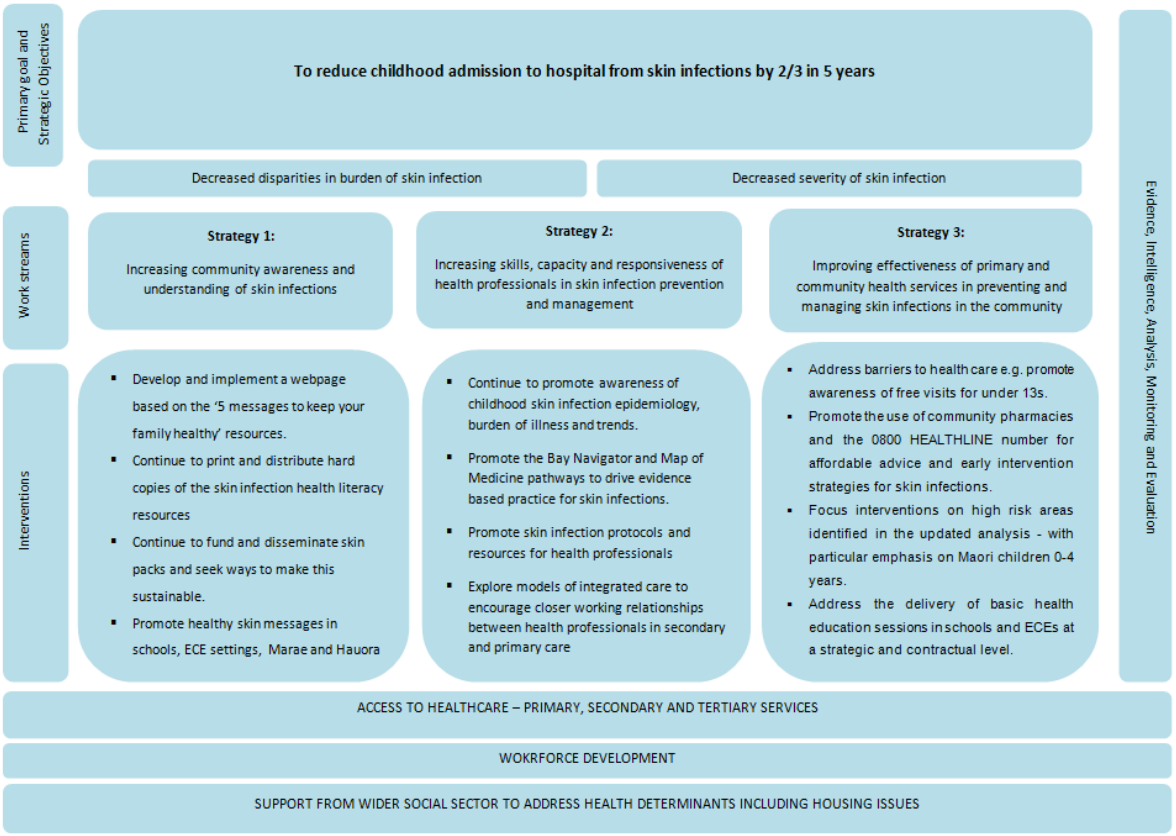
The workshop presentations are available on the Toi Te Ora website.

Skin infection report 2016 - summary of key recommendations

The recommendations from the updated analysis and workshops are presented in the Childhood Skin Infection Report (Toi Te Ora, 2016), and are summarised in Figure 2 below.

The following section provides a summary discussion of a local initiative and resources to address childhood skin infections.

Summary of key recommendations from the Childhood Skin Infection Report (Toi Te Ora, 2016)



Eastern Bay Primary Health Alliance (EBPHA) - 'Kiri Ora' /Healthy Skin Project

This innovative project is delivered through EBPHA's Kawerau Rheumatic Fever programme and utilises the team's experience and relationships with the tamariki, whānau and school communities. Each school is visited two days per week by the team who provide assessment and treatment of skin infections, education and resources. Every child in the area receives 'Healthy Skin' packs, consisting of soap, plasters, chlorhexidine wipes, toothbrushes, nail clippers, nit combs and health information (Figure 3)

Figure 3. Examples of healthy skin packs

An evaluation (EBPHA, 2014) found that the skin packs were well received, practical and re-enforced healthy skin messaging. Following the success of the Kawerau initiative, further funding was provided to disseminate healthy skin packs to schools and ECE centres in high incidence communities in the Bay of Plenty via the rheumatic fever teams.

Initiatives and resources to address childhood skin infections

Health literacy information and resources have been delivered to a wide variety of health professionals, ECE staff and key stakeholders throughout the Bay of Plenty with excellent feedback. The following section provides a summary of key information and resources aimed at the prevention and management of skin infections in children.

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Resource link	Summary information
Toi Te Ora Public Health Service - Skin Resources	English and Te reo Māori resources available to down load. The healthy skin resources were developed by Regional Public Health (RPH) and adapted for use by Toi Te Ora with permission.
Health literacy report and resources	Health literacy report and resources to strengthen the prevention and management of childhood skin infections.
KidsHealth Skin Information	This website provides information on the early signs of a skin infection, what treatment is available and what to do if the skin condition gets worse.
Midland Child Health skin resources	Midland Region Child Health Action Group (CHAG) collation of childhood skin resources for clinical staff and patients/families.
Clinical Models of care	A summary of clinical models of care for skin conditions from the Midland region and across New Zealand.
Protocols for the management of skin infections in children and young people	The protocols aim to provide gui-dance for health professionals and allied workers in the prevention, assessment, management and treatment of common skin infections. The protocols were prepared by Regional Public Health with input from the Healthy Skin in Greater Wellington protocols sub-group.
DermNet NZ	DermNet NZ provides authoritative information about skin diseases, conditions and treatment for patients and their health professionals.
'5 messages to keep your family healthy'	The '5 messages to keep your family healthy' resources were developed by Compass Health and Regional Public Health and used with permission. The aims of the '5 messages' are: • To simplify key health messages • To reduce hospitalisations for preventable diseases e.g. rheumatic fever and skin infections. • To promote the 0800 HealthLine number
PHARMAC Seminar Series - Practical management of childhood eczema	Practical aspects of the management of eczema in childhood in both the primary and secondary care setting.

The Nursing Future

Wendy King

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.

Earlier this year the New Zealand Herald ran an article on the ageing workforce. It quoted Vector human resources putting mentoring programmes in place after finding 20% of their workforce were over 55 years of age (Mathers, 2016).

Several years ago, we did a rough estimate in our area and concluded that 75% of our district nurses (DNs) and public health nurses (PHNs) were over 55 years (Young, et al., 2014, Landry, Lee & Greenwald, 2009). While we had a stable workforce with low turnover we were beginning to get the cues this was would not last; staff indicating they intended to reduce hours or become casual employees in the future and some had family members with significant health issues.

At the same time, there was anecdotal report from rural areas in this District Health Board (DHB) that on occasion there has been no response to job vacancy advertising leading to extended recruitment cost and service constraints. Literature about recruitment issues notes that students who have community or rural placements, have experiences that debunk preconceptions if given the opportunity will consider this as an employment possibility (Reilly, et al., 2011).

A decision was made to commit to supporting nursing students and to finding a way to have a New Entry to Practice (NETP) graduate. Since then this has developed and expanded, to the whole continuum including from supporting high school students interested in nursing careers through to NETP.

1 NETP

Some searching of DHB websites found one DHB NETP had a variety of placements 6 monthly rotations in hospital and primary care settings. There was a verbal account of a hospital NETP changing to PHN NETP placement in Auckland but essentially there was little on DN NETP and two reports for PHNs.

Both DN and PHN teams had some unfilled FTE, this developed into the idea of a combination of both, 2 days and 2 days, as budget arrangements would not allow 6 and 6 month placements for each. An outline of a plan

developed; identify suitable preceptors and provisos such as no students at the same base as the NETP for workload and no DN weekend work as this is solo working.

We are now in our 4th year; there have been some modifications to original arrangement as preceptors changed work hours. All three of previous NETP nurses had a permanent position by the end of the programme.

2 Student Nurses

Students have an allocated Preceptor who has completed the Preceptor course run by Wintec for this area. Currently 2nd year students do 4 days a week for 4 weeks with PHNs or DNs with placement availability shared around bases and according to staffing availability. We have on occasion had students from Rotorua or Tauranga, usually a local connection leading to the enquiry about placement availability. Placements are not always utilised so there has been capacity to take them. For some students the issue is the extra cost of accommodation; they have stayed with family, friends of family, hospital staff hostel, backpackers and in holiday homes of someone who knows someone.

Initially journals were searched for ideas of activities students can do when on PHN placement; discussion with other PHNs has identified and shared identification of possibilities sometimes considered too difficult, technical or inappropriate for stage of education.

3 Integrated Practice (IP)

We offer IP placements with PHN and DN teams, but these placements are not always utilised. The location for this placement varies according to staffing and preceptor availability; typically these students have already had a previous placement in the community.

4 Careers day

The New Zealand Institute of Rural Health offers two careers days; one for health careers in general and a nursing and midwifery careers day. Both are fully attended by students (approximately 35 students) from throughout the region. For the health careers day, they have a tour of hospital and meet representatives from the departments who explain their roles and answer questions.

On the nurse and midwifery day, they have a tour of the hospital and birthing unit and there are presentations on nursing and midwifery, there is also an experiential type stand using equipment such as Dynamap and oximetry; this year they had a mystery quiz to identify objects in common use such as, catheters.

Some students attend both days; it's a surprise how many are interested in midwifery and it was an update for me on the midwifery programme and commitments; also they have some impressive teaching tools models they bring with them (McIntyre, 2011). Another surprise is that while most of the students have some idea of nursing, they never know what a Wellchild/Plunket nurse is, or what they do; they have no idea the variety of nursing roles outside of hospitals.

By the end of the day that some are Very Clear they want to be a nurse, for others, it's not really for them. We make sure they know they can do placements locally and the availability of scholarships such as rural, iwi and support provision for Maori students. They want to know about employment prospects on graduation.

This has led to the facilitator for students on Gateway programmes coming to the hospital asking for some community experience to be available.

5 Gateway

This is a school vocational type programme for Year 12 and 13 students; one morning a week, for six weeks. Some teachers require the student to complete some project work, for example, researching the role and interviewing staff. In this area, they spend a morning with a PHN, this may be school or preschool visits or out immunising; typically self-referral clinic observation is not appropriate for confidentiality reasons.

6 Observations

Many of the nursing students bring significant experience of life events to nursing, yes even the school leavers, these have to some degree shaped them and led them to consider nursing. Not all students are school leavers but have had other jobs or are working part-time. We constantly have to say they have done a three year degree programme, not an apprenticeship. They have good information technology skills and readily learn computer work and help their preceptors on occasions.

We know students are regularly told 'you need two years ward work before going to the community'; the Report of the Ministerial Taskforce on Nursing (p.53, 1998) noted there was no evidence for this. As one colleague says, six months night duty in urology was little preparation for community work.

And what of our situation? Current estimates give 55% of our combined staff are over 55 years of age, still well over Vectors concern level of 20%; and disappointingly, this year it seems we have had no IP student rostered.

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MAKING THE DIAGNOSIS OF DIABETES

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Receiving the diagnosis of diabetes has serious implications both for the patient and for the health care system. Thus, giving someone the diagnosis should be done accurately to ensure certainty. However, over the past couple of years while auditing diabetes management in a number of GP practices, it has been somewhat disturbing to find that around 8 - 10% of patients currently being managed for type 2 diabetes actually did not have diabetes – they never did. They had been given the diagnosis in error.

Is this due to overzealous providers keen to jump on things early? I think unlikely. Subsequent chart reviews suggest the mistakes are due to providers having a poor understanding of just how inaccurate our current diagnostic tests are and, given this inaccuracy, how they should be used correctly to ensure that a person receiving the diagnosis of diabetes does in fact, have diabetes.

Diabetes is a group of metabolic disorders characterised by inappropriate hyperglycaemia that results in vascular disease. However, in trying to establish diagnostic criteria, one of the difficulties has been how to define 'inappropriate glycaemia'. Our current diagnostic criteria are based on a decision to define 'inappropriate glycaemia' as the level of glycaemia that puts a person at risk of developing retinopathy. However, which measure of blood glucose best reflects this risk has not been able to be determined. Consequently, there are several criteria that can be used for establishing the diagnosis of diabetes; a fasting blood glucose (FBG), an oral glucose tolerance test (OGTT) and the HbA1c.

Criteria for the diagnosis of diabetes

1. FBG ≥ 7 mmol/L
   Normal FBG is ≤ 6.0 mmol/L; a person with a FBG between 6.1 mmol/L and 6.9 mmol/L has Impaired Fasting Glucose (IFG)
2. Random/post glucose challenge ≥ 11mmol/L
   Normal blood sugar following a glucose challenge (75 g carbohydrate) is defined as < 7.8 mmol/L; a person with a blood glucose between 7.8 mmol/L and 11 mmol/L has Impaired Glucose Tolerance (IGT).
3. HbA1c ≥ 48 mmol/mol (New Zealand chooses to use HbA1c ≥ 50 mmol/mol (New Zealand Society for the Study of Diabetes, 2011).
   Those with an HbA1c between 39 and 48 mmol/mol are categorised as 'pre-diabetes' (also called 'dysglycaemia' or 'borderline diabetes').

Of note, all of these tests should be done using venous plasma glucose (i.e. drawing the patient's blood). Using hand held blood glucose meters or point of care HbA1c machines is not considered acceptable for making a diagnosis.

Important to understand is that none of these tests are particularly sensitive or specific. There is a 20% false negative

and false positive rate when using a FBG or an OGTT, while an HbA1c ≥ 48 mmol/mol is 98.9% specific, but only 44.3% sensitive (Carson AP, et al 2010). In other words, if a person has a positive FBG or OGTT, there is a 20% chance that it is wrong. Or, in the case of using HbA1c, there is considerable opportunity for a person to have diabetes, but the test will be negative. Thus, **to ensure that a diagnosis of diabetes is being made correctly, any positive test must be confirmed by a second positive test** - preferably a repeat of the same test. If results are available from two different tests and one is positive, and the other negative, the positive test should be repeated for diagnostic confirmation (American Diabetes Association, 2006). Only if a patient has a positive test and is obviously symptomatic (e.g. thirst, urinary frequency) is a confirmation test not required.

From my recent audit of the medical records, the majority of patients labelled inappropriately as having type 2 diabetes had never had a confirming second test to ensure accuracy of their diagnosis. Aside from the inappropriateness of informing a patient that they have a serious chronic disease when they don't, the cost to the health care system for unnecessary retinal screening reviews, podiatry and nutrition appointments - not to mention inappropriately assigned monies for care plus – must be considerable.

As nurses are becoming increasingly responsible for managing patients with diabetes, they must be equally responsible for ensuring each patient they are managing actually has diabetes. Thus, for any patient who is "borderline" or "well managed with lifestyle changes" or with one oral hypoglycaemic – please take the time to go back into the patients records and determine how the original diagnosis of diabetes was arrived at and ensure that there are two positive tests.

Should the patient not have had a confirming test, the patient should be informed that they do not have diabetes; and, the classification of diabetes needs to be removed from their electronic health records along with all the recalls for retinal screening and other diabetes related appointments.

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Community Ear Nursing Service

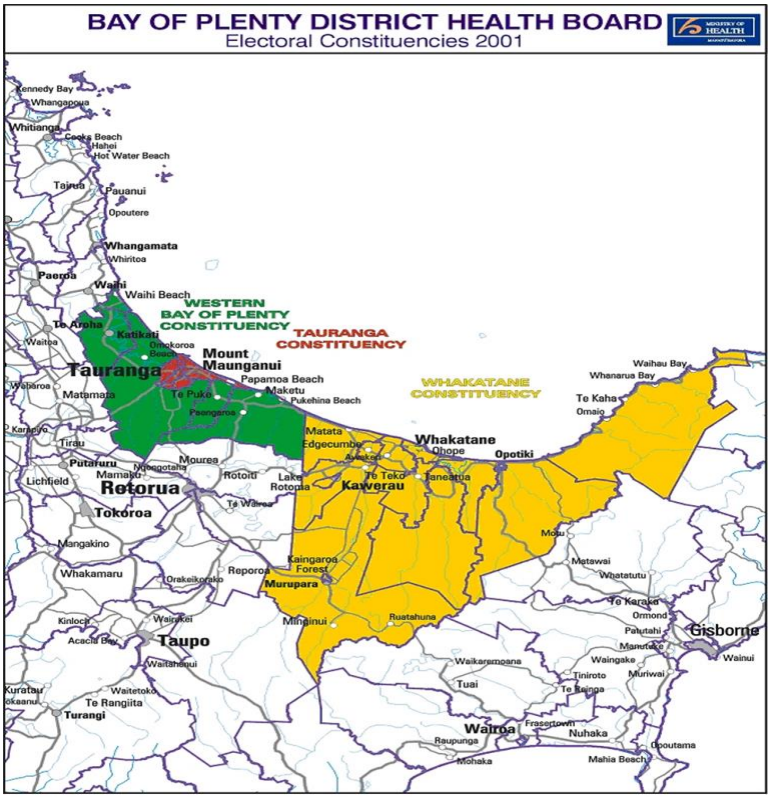
The mobile community ear nurse service was established within the Bay of Plenty District Health Board in the mid 1990's to meet the needs of children in the lower socio economic group who were not engaged in services to address their ear health needs. The mobile ear nurse service covers schools within the Eastern and Western Bay of Plenty providing a service for children and young people who are located in geographical areas that are away from main stream health care facilities. The community ear nurse works as part of a wider team within the Community Child Youth Health Services.

The mobile ear van is equipped with a microscope, audiometry and tympanometry and microsuction capabilities and is stocked with education leaflets and resources which are available when possible in Te Reo and English. The ear van provides privacy and comfort when children are being assessed.

The Community Ear Nurses identifies and diagnoses (where appropriate) and creates a treatment plan to meet the needs of the individual child. This may include:

- Ear health assessment to identify concerns, looking at previous history and service engagement e.g. middle ear issues – Glue Ear, Otitis Media, Otitis Externa, discharging ears
- hearing assessment utilising equipment such as an audiogram and Tymp- due to poor speech development and behavioural issues
- wax removal and follow up preventative treatment
- foreign bodies removal
- grommet assessment
- Hearing aid wearer for wax review and removal if necessary, checking hearing aid is functional, clean and child has adequate supply of batteries. The ear will liaise with Audiology department and family were problems are identified
- liaising with the advisors for the deaf allocated to the child's school
- Provide written and verbal education regarding the individual care the Whanau, teachers and children.
- Liaising with appropriate health care practitioners and social services support when other health issues are identified i.e. Dental Team, General Practitioner, Public Health Nurse, Child Youth and Family.

The community ear nurse follows a referral pathway into Ear Nurse and Throat services for children who meet the criteria for follow care. This includes children with hearing loss, recurrent Glue Ear, and/or other middle ear disease. For children who have hearing loss



and no obvious cause are referred to audiology for an in-depth assessment.

Communication and collaboration is an integral part of the community ear nurse role to support children and their families to engage in primary Care services. The community ear nurse works alongside Public health nurses, teachers and practices nurses to ensure follow up care is provided.

Case Review

6 year old girl presented accompanied by her mother to the community ear van which was situated in a community setting as Mum had seen "something white" in her daughter's ear when washing her hair. On examination using microscopy a solid, white, smooth unidentified foreign object was visualised. Following an assessment and full discussion with parent and child an attempt was made to remove the object using forceps, jobson Horne probe, micro suctioning. These attempts were unsuccessful and a clinical decision was made that continued attempts would not be in the child's best interest as I would more likely cause her to not want to engage in the service in the future. Following a discussion with mum a plan to refer the young girl to Ear Nose and Throat services for assessment and removal was completed via phone. I arranged for mum and child to be seen the same day. The outcome was the young girl had the removal of a foreign object form her ear under GA. causing minimum trauma to the child. The foreign object removed was identified as a tooth. The child was excited because now the tooth fairy would visit!

Case Review

The community clinic was being held at a Kura. A teacher had a concern regarding a young boy aged 9 Years who was complaining of a painful right ear. The process for a child to be seen in the community ear van is generally with written parental consent. The difficulty in this situation was the parents were not answering their phone despite numerous attempts by myself and the school teacher. Using my clinical judgement and section 125 (notice of authorisation of health workers under section 125 of the health act 1956) I felt it was in the child's best interest to have an ear health assessment with a plan to follow up with whānau. Upon examination I discovered he was suffering from a tympanic membrane (ear drum) perforation which had a purulent discharge. The discharge was removed via micro suctioning revealing what looked suspiciously like a cholesteatoma (benign tumour which over time can lead to life

threatening complications such as meningitis or brain abscess). This would require immediate further investigation by Ear Nose and Throat specialist. Due to the potential severity of this diagnosis I liaised with the Public health Nurse to engage the family. The child was followed up by Ear Nose and Throat specialists, a Choleastoma diagnosis was confirmed and child received appropriate management and treatment.

Paediatric Trauma in NZ – a snapshot

Julie Chambers: Starship Trauma Coordinator.

Julie Chambers is currently the Trauma Coordinator at Starship Children's Hospital. She has nursing experience including neonatal and adult intensive care, midwifery and she has also worked as a lecturer in nursing studies. She has a Master's in Public Policy (Victoria University)and has worked in child health policy focussing on community injury prevention

Paediatric trauma is a high stakes event. The arrival of a major paediatric trauma case into an emergency room or clinic can be a stressful and emotional event, for families and staff alike, however New Zealand hospitals have the skills to deal with an acute presentation of even the most severe trauma and specialist paediatric help is always at hand (Royal Australasian College of Surgeons New Zealand Trauma Committee, 2012).

Despite recent reductions in numbers, trauma remains a major cause of New Zealand paediatric hospitalisation and mortality. Every year in New Zealand approximately 84 children (0 to 14) die as the consequence of unintentional injury (commonly referred to as accidents). Leading causes include traffic crashes (vehicle occupants and pedestrians), suffocation and drowning (Safekids Aotearoa, 2015).

Child hospitalisations from trauma are most frequently as a result of falls (from furniture and playground equipment), non-traffic accidents (children hit by cars in driveways) and burns. Poisoning also features as an important 'accidental cause of injury' that results in hospitalisation (Safekids Aotearoa, 2015).

Finding out the detailed history of events for a paediatric trauma patient can be challenging but is important for clinical assessment and later reference. Significant differences in the anatomy and physiology of infants, older children and young adults need to be kept in mind during clinical management and maintaining records of when and why clinical events have occurred is important for understanding the clinical course of events and responses to treatment, especially if urgent onward transfer is indicated (Bevan C & Officer C, 2004; Royal Australasian College of Surgeons New Zealand Trauma Committee, 2012).

There are a number of hospitals who provide specialist paediatric trauma care. On average Starship hospital admits 1,000 paediatric trauma cases each year. Approximately sixty children who present to Starship will be severely injured and of those about half are transferred (or retrieved) from other hospitals. Trauma guidelines recommend the use of specialist services for the transfer of paediatric trauma patients (Royal Australasian College of Surgeons New Zealand Trauma Committee, 2012; Starship Trauma Service, 2013).

Starship multidisciplinary teams regularly use high fidelity simulation to ensure they are practised in the acute management of injured infants and children. Simulation training helps team members routinely review their knowledge and clinical skills while assessing how systems,

resources and local environmental factors interact (Trish Wood, 2016).

In June 2012 the Ministry of Health and Accident Compensation Corporation established and jointly funded the Major Trauma National Clinical Network. The Network has developed and implemented the New Zealand Major Trauma Registry (NZMTR), a national major trauma database. Local Trauma Coordinators have been appointed and trauma data is being entered. This information will assist in the development of improved systems of care and identifying resources required for best practice trauma management (Health Quality and safety Commission: accessed 10 August 2016 http://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/atlas-of-healthcare-variation/trauma).

In addition to the provision of acute services, consider what might be done for promoting injury prevention within your local community. Injury prevention is a scientific approach to reducing the incidence of avoidable trauma and it is important to know what measures are effective. The National Institute for Clinical Excellent (NICE), World Health Organisation (WHO) and European Child Safety Alliance have published best practice guidelines. Safekids Aotearoa (www.safekids.nz) is a national child injury prevention service based at Starship that provides a range of resources which can be accessed without cost (MacKay M, Vincenten J, Brussoni M, & Towner L, 2006; NICE: National Institute for for Health and Clinical Excellence, 2010; Peden M et al., 2008; Safekids Aotearoa, 2016).

Paediatric trauma is challenging for even the most experienced and qualified practitioners. Ensuring services are well equipped and practiced in the presentation of acute paediatric trauma and that the families and children in your community have access to proven ways of reducing injury such as child car restraints, cycle helmets and safe places to walk and cycle will go a long way to ensuring we deliver the best of our children.

Julie Chambers: Starship Trauma Coordinator.

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Tall Poppy Award: 2016 PHAA Conference Report

Michelle Tanner

In September 2015, I was humbled to be the recipient of the 2015 Jane Ayling Tall Poppy Award from the New Zealand College of Primary Health Care Nurses (NZCPHCN) for my work with the Immunisation Advisory Centre and with Rotary International on polio eradication.* Since the $1,000 award was to be used for education purposes, I elected to utilise this to attend the Public Health Association of Australia's 15th National Immunisation Conference held in Brisbane 7th – 9th June 2016. See Twitter #NIC2016.

The theme of the conference 'Immunisation: the jigsaw - fitting the pieces two decades on', was reference to the 20 years since the launch of the Australian Childhood Immunisation Register (ACIR) and the 'Immunise Australia' programme.

The venue, Brisbane Convention and Exhibition Centre on the city's South Bank was impressive. The conference, attended by 525 delegates, was well organised and the food was great! The biggest challenge was choosing which presentations to attend. Four blocks of concurrent sessions provided 116 options, of which delegates could choose up to 29. This took some planning with the inevitable disappointment when two interesting talks coincided.

The range of subjects reflected those topical in the New Zealand environment. In recent years, our understanding of vaccine hesitancy has grown significantly and whole journal volumes have been dedicated to the subject e.g. the April 2015 issue of Vaccine, and the World Health Organization's Strategic Advisory Group of Experts on Immunization delivered a report on the subject in October 2014.[1]. Presentations at the conference contributed further to this knowledge base and were of greatest interest to me. Speakers presented on different approaches and interventions that could be effective in improving vaccine acceptance. The consensus appeared to be that the subject is complex, and there is no 'one size fits all' response. It is evident that vaccinators need to further develop skills and knowledge that allow them to effectively frame vaccine safety conversations to meet the individual/specific needs of vaccine hesitant patients and parents.

Vaccine hesitancy is closely linked to trust in vaccine safety and the transparency of providers, pharmaceutical companies and governments around this. There were both vaccine safety themed plenary and concurrent sessions at the conference.

Presentations on the development and use of digital information technologies where both informative and interesting. Many were in relation to collecting real time data on adverse events following immunisation and active safety surveillance. One example, SmartVax, was a recipient of one of four AU$20,000 immunisation

grants from GSK presented during the conference.

Other technologies/apps presented included biofeedback-assisted relaxation training to reduce vaccine anxiety in adolescents, digital immunisation education resources, and text (SMS) reminder systems. The challenge for immunisation service providers is going to be evaluating the usefulness and cost-effectiveness of these technologies and how to integrate them into current and future information systems.

Influenza vaccines were covered from vaccine safety perspectives and overseas experiences of childhood influenza vaccine rollouts. Presentations from the UK demonstrated significant reductions in influenza-related GP and ED visits and ICU admissions following the rollout of intranasal live attenuated influenza vaccine to children. Influenza vaccine safety studies focused on pregnant women and young children.

Vaccination during pregnancy, to protect both mother and her newborn baby, was covered from various aspects; vaccine acceptability, coverage, efficacy and safety. Studies continue to demonstrate that influenza and pertussis vaccines in pregnancy are safe and effective. However poor coverage is concerning in Australia (as it is in New Zealand), often because pregnant women are unaware of the vaccine recommendations. Findings from one study indicate that primiparous are more likely than multiparous mothers to receive influenza vaccine during pregnancy. These studies are important not only in the current context but to inform potential future maternal vaccination programmes e.g. respiratory syncytial virus.

Another subject that Australian immunisation service providers have been discussing in recent years is their role in vaccine 'debates'. The coverage of anti-vaccine 'arguments' in the media, particularly social media, and the role that may play in parental vaccine decision-making is concerning. Presentations from the Stop the Australian (Anti) Vaccination Network showed how, in response to media requests for comment, by asking who else would be included and declining to comment on anything that also involved anti-vaccine activists or sceptics, may have played a part in the overall decline in the media profile of these groups. Key to this is explaining to media representatives that 'false balance' reporting is more detrimental to the public's trust in immunisation programmes than purely anti-vaccine reporting.

Other topics receiving significant coverage during the conference included varicella, pneumococcal, rotavirus and HPV diseases, vaccines and delivery programmes.

One disappointing feature of the conference was the shortage of New Zealand delegates this year. The registration fee of AU$1,000 may have been a factor in this. In the interest of sharing best practice it would be good to see more kiwis at the Australian conference, and vice versa. See http://www.immune.org.nz/health-professionals/imac-conference-and-workshops for upcoming New Zealand events.

I would like to take this opportunity to thank those who nominated me for this award and the NZCPHCNs for selecting me. I encourage you to consider if any of your colleagues would be suitable for nomination.

* For more information on Rotary International's polio eradication work see www.endpolio.org or contact me michelle.tanner59@gmail.com

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1 World Health Organization (2014) Report of the SAGE Working Group on Vaccine Hesitancy. World Health Organisation: Strategic Advisory Group of Experts on Immunization. Retrieved from http://www.who.int/immunization/sage/meetings/2014/october/1_Report_WORKING_GROUP_vaccine_hesitancy_final.pdf

Michelle was born in the UK and has been a nurse for over 35 years. She completed a Certificate in Intensive Nursing Science at Johannesburg Hospital and commissioned an intensive care unit in the UK which she managed for 9 years. During this time she completed a B.Sc. Honours in Nursing.

In 1996 Michelle qualified as a Health Visitor and worked in this role until 2001 when she immigrated to New Zealand with her husband and two young daughters.

Michelle has worked for the Immunisation Advisory Centre at The University of Auckland for 13 years; initially as a District Immunisation Facilitator, later an Immunisation Educator and now as Projects Facilitator.

Since joining Rotary International in 2008 Michelle has played an active role in that organisation. She is the President of Rotary Matamata and Rotary District 9930 Polio Chair In 2014 she was invited to speak at a Rotary polio conference in Lahore, Pakistan where she also participated in further polio eradication initiatives. She has presented talks to many groups about this visit and the global polio eradication programme.

Kiri *Ora*, Healthy Skin project

The Eastern Bay of Plenty Primary Health Alliance (EBPHA) Kiri Ora, Healthy Skin project in Kawerau, Te Teko and Te Mahoe

Co-authors
Sandra Ball EBPHA RFCL
Kate Dooley EBPHA RN

was created as an outcome of;

- local ASH stats for childhood skin infection highest in EBOP region
- the same pathogenic bacteria Group A strep (GAS) causing skin and throat infections
- potential to utilise the excellent relationships that existed between the sore throat swabbing team and the children, school and community
- potential to utilise the community knowledge held by the sore throat swabbing team

The EBPHA EBOP Rheumatic fever clinical lead nurse who also works as a district nurse had found that when she spoke to mums whose tamariki had impetigo and eczema it was apparent that whilst these parents were very interested to learn about how to treat their child's skin condition they did not have finances available to purchase basic skin care product or to attend their GP. Also attendance at the 2014 Rheumatic Heart Disease conference in Darwin added the understanding that skin infection as well as GAS sore throats could lead to acute rheumatic fever.

When Toi te Ora(TTO) identified reducing childhood skin infections as a goal, and were looking at what intervention to action in the community the RF clinical lead was adamant that resources were equally as important as providing education. A strong working relationship came about between the school sore throat programmes and TTO.

The programmes had the motivation and relationship, TTO the resources and both had the overarching goal of improving child health.

Support to set up the Kawerau, programme came from Lizzie Farrell a nurse leader with the original South Auckland Wiri School project this provided an opportunity to review their school based clinic, along with sharing their protocol document. Tarawera Medical Centre senior nurse Jackie Davis helped develop a seamless referral system into general practice (initially tamariki visits were funded however this was no longer required after 2015 July).

A total of five primary schools are part of the programme with collectively close to 1000 children enrolled – consenting numbers are close to 90%.

Each school is visited two days per week by the team which consists of one Registered Nurse and two Community Health Workers. The team provide assessment, treatment, education and resources. Every child in the area receives 'Healthy Skin packs, consisting of soap, plasters, chlorhexidine wipes, toothbrushes, nail clippers, nit combs and health information at least twice per year (along with the early childhood centres including the kohanga reo).

Over the last two school terms 1,063 visits were made by the tamariki to the school skin clinics of which there were 41 referrals made to the family General Practice for antibiotics (some for cellulitis). The main presentation reasons to the clinic are for impetigo, boils, and eczema. Itchy bites, cuts and grazes being particularly high occur in the warmer months. Most of the children visit the clinic because they choose to, with some being referred by the school, family members or community nurses. Every child that presents and is consented to the programme is seen regardless of the severity of the 'sore' they are showing, this fostering good relationships and confidence to come and see us as it is to get assessed and treated.

CLEAN, CUT (fingernails), COVER and CHECK their wounds at least once daily are the core messages given to the child and their families – reinforcing this message verbally, via stickers, postcards and fridge magnets plus supplying the child with written detailed resources specific to their diagnoses along with enough products if they say they need product (e.g. plasters and antiseptic cream) to last the 'life of the wound'.

The Kiri Ora team do not think a standing order model offered greater benefit for the tamariki who needed antibiotics. The team consider themselves as an adjunct to the general practises; they are the eyes and ears to facilitate access and advocate for the tamariki and whānau to engage; ringing, texting , home visiting whānau to organise General Practise visits when needed. Working alongside and maintaining good relationships with the whānau Medical Practices and Public Health Nurse ensures positive support to the programme and the child where referrals may be necessary. When our service ends we want whānau to be engaged with their own general practise. It is really rewarding for both the team and the child when they present at the skin clinic with a big smile on their face telling you "look it's all better".

Yes, they may have had medicine, yes we may have supplied them with the resources but that child spends the bulk of their time away from us – a key message here is that the tools and education we give them enable them to play a big part in the healing of their sores. Survey of whānau has also found they appreciated the knowledge that the tamariki are bringing home. Recent comment from Te Kura o Te Teko principal Tony Holland is that the Kiri Ora and Sore Throat swabbing programmes combination of "the nurses visiting the school the soaps, the toothbrushes, the plasters, the kutu combs alongside the Weetbix, fruit and milk in schools sees his tamariki being offered a wraparound service; the kids are glowing".

The Marks and Scars We Do Not See

Holly Greenston

Mash Trust, Palmerston North

Holly is currently Clinical Leader at Mash Trust Mental Health and Addictions, and is blessed to work with a fabulous team and honoured to be allowed on the journeys of the people we support. Originally from the Boston area in the United States, she has worked in mental health and addictions, specializing in healing trauma, with various populations over the past 15 years. Holly is married with two amazing teenagers who bring laughter and love to her life on a daily basis.

"If it takes a village to raise a child, it takes a village to abuse one." – Mitch Garabedian, Movie, "Spotlight".

Some statistics that are difficult to swallow. New Zealand:

- Has one of the highest rates of child abuse in the developed world.
- Has one of the worst rates of child death by maltreatment within the family.
- Has the highest rate of domestic violence in the world.
- Is the most dangerous non-war torn country in the world for a child to grow up in.

Additionally, one in four girls is sexually abused before the age of 15.

As community members and health care professionals, it is our legal and civic responsibility to do our part to protect children. This responsibility includes being able to recognize signs and symptoms in children who are living and suffering from abuse, causing toxic stress. Toxic stress can result from physical, emotional and sexual abuse, chronic neglect, caregiver substance abuse and/or mental illness, and exposure to violence. Research indicates toxic stress, resulting from the above, can cause common adult health conditions such as obesity, chronic pain, heart conditions, alcoholism and drug abuse, among others. A healthier nation starts with healthier children.

Health care professionals should understand that presentations of what may seem like ordinary medical conditions or illnesses may actually be symptoms of trauma from abuse (including neglect and living in violent homes). These symptoms listed below arise when there is not enough time, strength, speed, or size to overpower the force (physical and mental) against us. In children suffering from stress due to abuse and violence, we can specifically see symptoms of hyper-arousal, constriction, and dissociation. Overtime the children can experience a combination of these symptoms. Delays in speech, language, and in social skills and stereotypical play behaviour can also be signs of abuse/intimate partner violence and neglect in their environment. Abuse or neglect is a possible cause of the symptoms in the table when they occur outside of the normal developmental stage.

Other effects on children from abuse or violence in the home can include: Denying violence in the home, doesn't invite friends home, self-destructive, substance abuse, promiscuity, feelings of guilt and fear, and poor school performance/attendance.

Take Action! Don't be afraid to ask questions or talk about it. Non judgemental compassion and empathic listening can, in the moment, offer hope. It is hope that someone cares enough to talk about it, and has enough courage to feel with them, not for them, in hearing and helping them carry their pain. It can be as simple as asking "what happened to you" versus "what is wrong with you".

Hyper-Arousal	Constriction	Dissociation
Phobias, anxiety, panic attacks night terrors, nightmares, extreme	Digestive problems, shallow breathing, asthma, bed-wetting/soiling,	Lots of time spent in an imaginary world or with imaginary friends, staring into space/inattentive/distractible, low energy, excessive shyness,

Open ended questions allow youth to share the full story without being influenced by the question itself. If youth sense you are uncomfortable in asking questions, they will not be comfortable disclosing. Some questions which can be helpful include, "You seemed to get angry/upset/mad/sad when I asked you that question (directly referring to complaint)", "Tell me more about your tummy aches, what colour are they, is there anyone in your life that makes them a colour you don't like or a colour that is better for you?", "I can see that you are hurting, tell me about". Be present with the child allowing the child/youth to speak freely. Reassure them that it is okay to talk, they are safe while in the office with you, and often times talking can decrease their physical pain.

The stakes for New Zealand are high. There is an epidemic of child abuse and neglect in our society. As providers if we want to change the health of our nation we must investigate and act on the bio-psycho-social situation of our paediatric patients when they present with these symptoms. It is about partnership and collective accountability with collective power which contributes to the village that protects our youth.

If you are worried or even unsure, consult a colleague and/or advise Child Youth and Family Services or of your observations and concerns. It's not a perfect system and it's easy to think our calls don't matter or won't make a difference. But, what matters is that as health care professionals, you did the right thing. As a nurse, seeing a child who is withdrawn, sad, and complaining of tummy aches, where the mother says he isn't sleeping or she can't control him", You had the courage and took the time to ask questions and made the necessary referrals to the agencies with the right legislation to intervene. Have you done everything in your control as a community member, and within your professional role to protect a child from a potential lifetime of pain and suffering? It's easy to put our heads in the sand and rationalize what our instinct or observations may tell us. Courage heals individuals, individuals heal communities, communities can heal nations.

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NEW ZEALAND NURSES ORGANISATION

We're (NZNO) running a petition at the moment to restore funding to anti-smoking services, particularly Māori and Pasifika providers, that has recently been withdrawn. It's fronted by one of our Registered Nurses at Porirua Union Health centre. The link to the petition is http://www.together.org.nz/smokefree/?recruiter_id=20525 You can sign it really quickly online.

There's also a short video of Litia talking about why these services matter online here; https://www.youtube.com/watch?v=qK20AQsNb5Y

And here's our media release with the key messages on the peitition: http://www.nzno.org.nz/about_us/media_releases/articletype/articleview/articleid/2331/nurses-launch-smokefree-funding-petition-at-indigenous-nurses-conference

NZNO Research, Policy and Publications Report

August 2016

Jill Clendon - Nursing Policy Adviser/Researcher

A busy year has seen the completion of two big projects for NZNO researchers Léonie Walker and Jill Clendon. The first, looking at *combining family caregiving responsibilities with nursing: Implications for management and retention* found that while there were issues for all nurses in this position, there were also additional, and different issues related to this for both Asian and Māori nurses.

The implications for management were presented to the Nurse Executives NZ early August. Other outputs for the project include a paper on implications for management accepted at JONM, a paper on implications for workforce planners and employers of Asian nurses which has been accepted into Kaitiaki Nursing Research and which forms a key-note presentation at the Auckland Asian health conference (in September), and a paper on implications for workforce planners and employers of Māori nurses which has been submitted to AlterNative and will be presented at the Indigenous Nurses Conference in Auckland.

A second project, funded by the privacy commissioner, looked at *Health IT and community nurses' knowledge of privacy issues.* The study found that nurses' knowledge of privacy and confidentiality related to electronic patient records and use of digital technology in the community was sound. There were however many issues affecting the practicalities of implementation that reduced the effectiveness of Health IT to improve patient care. These findings were also presented to Nurse Executives of NZ. Other outputs include a report for the Office of the Privacy Commissioner, feedback (anonymized) to participants, development of a new position statement on Telehealth and updated guidelines on privacy and consent in the use of exemplars, case studies and journaling. Two abstracts have been accepted - an oral & a paper for the Health Information NZ conference in November.

Other projects we are embarking on are the HRC funded *Shift work, fatigue and safety* project with research partners at Massey University, a project on *Cross cultural communication* between nurses also with Massey, and Part 2 of the Māori nurse smoking project – with Whakauae.

It will soon be time to start the planning cycle for the 2017 Employment Survey (fifth biennial!), and we are consulting and planning for projects looking at nurse attrition from the workforce.

The NZNO team have also been asked to join an international (EU – funded) care rationing research consortium, in collaboration with Clare Harvey from EIT and Flinders University in Australia.

In terms of policy, the policy team (ably led by Marilyn Head) have completed 42 submissions so far this year on topics ranging from PHARMAC subsidies for the Mirena IUD to the Health Strategy to the TPPA. If you want to see the submissions we have done, check out the web page at www.nzno.org.nz/resources/submissions.

The publications team have also been busy with the following documents completed this year or underway:

- Transcribing
- Employment policy framework
- Reflective writing
- Standing orders
- Duty of Care
- Guidelines for the administration of medicine (update)
- Obligations in a pandemic or disaster (underway)
- Code of ethics (underway)
- Use of Cannabis for medicinal purposes (out for consultation)
- Documentation (underway)
- Privacy, confidentiality and consent in the use of exemplars of practice, case studies and journaling (underway)
- The role of the nurse in the delivery of end of life decisions and care (underway)
- Nursing and telehealth (underway)
- NZNO and its international relationships (underway)

Please keep your eyes out for your opportunity to comment on any of these documents and on our submissions – we really rely on you to provide us with the realities of practice to make these documents the best they can be.

The final project to mention is the Nurses Making a Difference project. Some of you will have heard of this project that has been underway for a couple of years – last year we trained up many of you as Champions. The project is still happening! This year we have refocused our energies on developing a Strategy for Nursing. The Strategy will:

- identify a set of clear goals for nursing and nurses;
- provide a pathway for achieving the identified goals;
- draw together the excellent work that is already being done across NZNO to support and promote nurses and nursing;
- identify areas that can be further developed (including further development of the nursing champions identified in phase 2).

Our objectives are to:

- demonstrate NZNO's leadership role within nursing and the wider health sector;
- raise the profile and image of nursing publicly resulting in greater professional pride among members;
- promote nursing as an essential asset and key player within the health, social and (where relevant) education sectors;
- promote nursing as a primary career choice; and

- raise the professional association profile of NZNO.

We are in the process of appointing a project leader for this part of the Making a Difference project so keep your eyes open for developments over the coming months. This is a very exciting project and we believe it will really push NZNO's professional profile out there.

Jill Clendon

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 - Ear Health; Continence; Child Abuse; Family Violence

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. Doyle, June & Ristevski, Eli. (2010). Less Germs, Less Mucus, Less Snot: Teachers' and Health Workers' Perceptions of the Benefits and Barriers of Ear Health Programs in Lower Primary School Classes. *Australian Journal of Primary Health*, 16(4): 352-359

This study explored health and education professionals' perceptions of the health benefits and barriers of different ear health programs used in lower primary school classes in two district education areas in the Goldfields South East Health Region, Western Australia. Health and education staff providing services to children in kindergarten to year three primary school classes were sent a questionnaire about ear health programs provided in their school.

2. Edmeades, Lynley. (2016). Case study: The challenge of assessing postpartum urethral symptoms from a physiotherapy perspective. *Australian and New Zealand Continence Journal*, 22(1), Autumn 2016: 6-8

This single case study discusses the physiotherapy management of a patient with postpartum symptoms and signs consistent with urethral and bladder prolapse: a Skene's duct cyst was the final diagnosis. The complexity of differential diagnosis for urethral symptoms emphasises the need for careful coordination between different health professionals, with appropriate diagnostic and management skills.

3. Forsdike, Kirsty; Tarzia, Laura; Hindmarsh, Elizabeth & Hegarty, Kelsey. (2014). Family

violence across the life cycle. *Australian Family Physician*, 43(11): 768-774.

This article aims to address clinical questions that general practitioners (GPs) may have in identifying and responding to patients experiencing family violence. It takes into account the different types of abuse victims experience and how to respond to perpetrators.

4. Goetze, Emma; McLean, Katherine; Thompson, Judith; Jacques, Angela & Briffa, Kathy. (2016). A scoping study of paediatric continence service provision in the Great Southern region of Western Australia. *Australian and New Zealand Continence Journal*, 22(2), Winter 2016: 32-39

The aim in conducting this cross-sectional study was to survey 100 parents of children in pre-primary and year one in the Great Southern region of Western Australia to determine the number of children with urinary incontinence and, of those, how many were receiving treatment. The severity and associated risk factors were also investigated.

5. Piltz, Anne & Wachtel, Tracey. (2009). Barriers That Inhibit Nurses Reporting Suspected Cases of Child Abuse and Neglect. *Australian Journal of Advanced Nursing*, 26(3): 93-100

An integrative review of the literature was undertaken to identify barriers that inhibit nurses from reporting suspected cases of child abuse and neglect. Limited education on recognising signs and symptoms of abuse was found to be a major barrier to reporting. Other barriers include limited experience, poor documentation, low opinion of child protection services, fear of perceived consequences, and lack of emotional support for nurses through the reporting process.

6. Poulton, Skye; Yau, Stephanie; Anderson, Daniel & Bennett, Daniel. (2015). Ear wax management. *Australian Family Physician*, 44(10): 731-734

Ear syringing is a very common practice among general practitioners (GPs). It is used by many as the treatment of choice for cerumen (ear wax), and is usually effective and safe. However, complications from syringing are an increasingly common reason for presentation to ear, nose and throat (ENT) specialists and medico-legal complaints against GPs.

7. Simpson, Judy. (2014). Case study: Mandatory reporting of child abuse and neglect. *Queensland Nurse*, 33(2): 32-34

In July 2012 the Queensland Government established the Queensland Child Protection Commission of Inquiry (the Queensland Commission) to investigate the widespread perception that the child protection system in Queensland was failing vulnerable children and their families. The Queensland Commission published its fi ndings and recommendations in a report Taking Responsibility: A Roadmap for Queensland Child Protection (June 2013). In light of this report and the spotlight on child abuse, it is timely to look at the current mandatory child abuse and neglect reporting for nurses and midwives.

8. Thompson, Janie. (2016). Nursing update: Continence Nurses Society Australia standards for practice. Australian and New Zealand Continence Journal, 22(1), Autumn 2016: 17.

CoNSA is currently working to review our continence nursing competencies 'Australian Nurses for Continence – Competency Standards for Continence Nurse Advisors' 1 developed in 2000. They are being moved into Standards for Practice to reflect the Nursing and Midwifery Board of Australia (NMBA) 'National competency standards for the registered nurse'.

9. Walker, Shonagh. (2014). Family matters: Ear care: Heard it all before? *PS Post Script*: 22-25.

Ear problems are very common and it is something that you will see in pharmacy, mainly people complaining about wax in their ears, common presentations such as swimmer's ear, blocked ears, buzzing, and ear ache. Children are also particularly prone to ear problems, and if not resolved, can actually lead to social and learning difficulties.

10. Wilson, Margaret; Bellefeuille, Lesley-Ann; D'Amore, Angelo & Mitchell, Eleanor KL. (2015). Establishing a continence nurse-led pessary clinic as a new model of care for women in rural Victoria. *Australian and New Zealand Continence Journal*, 21(3), Spring 2015: 75-83.

Use of vaginal pessaries to treat vaginal prolapse and incontinence is experiencing renewed interest in Australia. The premise of this study was that a nurse-led pessary clinic would facilitate this treatment option for rural women who would otherwise have to travel long distances to metropolitan centres to access this therapy. The aim was to establish a nurse-led pessary clinic for rural women and examine patient uptake and health outcomes.

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