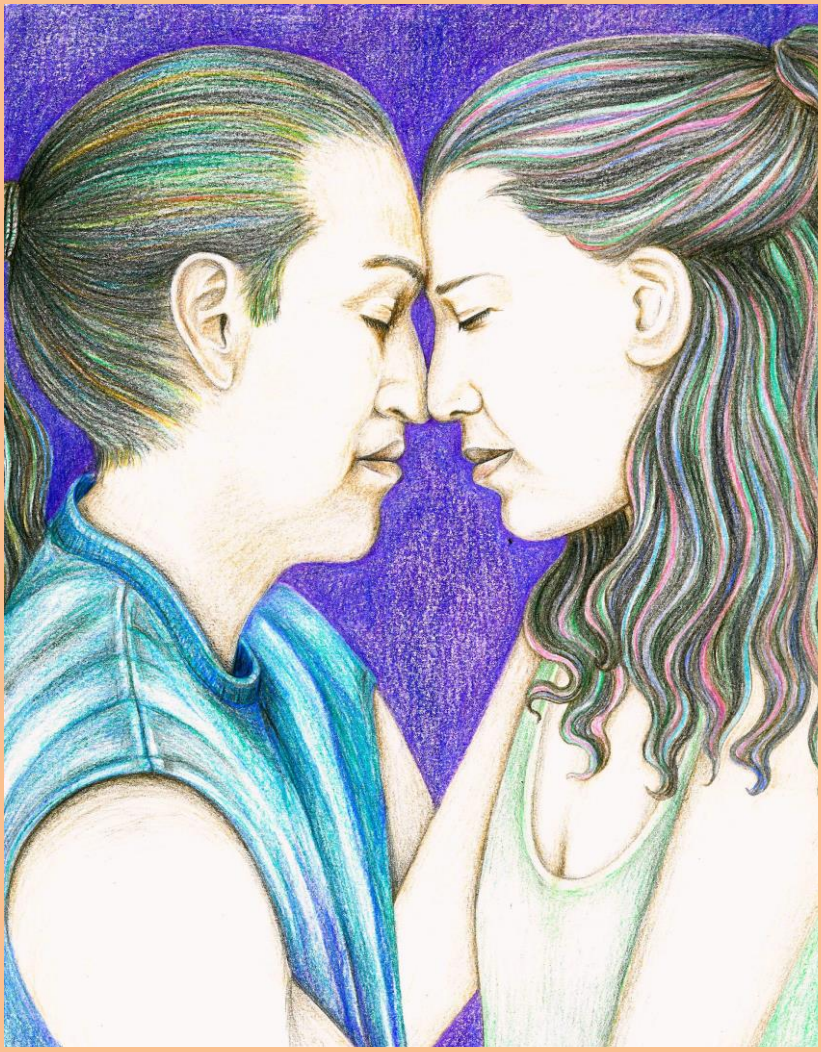
LOGIC.

LINKING OPPORTUNITIES GENERATING INTER-PROFESSIONAL COLLABORATION

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

Vol 16 No 2



Mental Health **Stroke**

Māori Health **Immunisation**

North Island Symposium

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

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In this issue….

Chair's Report

Kim Cameron
Chairperson

Greetings to you all

This will be my final report as in August at the NZCPHCN AGM I will be stepping down as Chair.

To all College members; past and present committee members and anyone who has assisted the College or contributed to its ongoing work in any way I would like to say a big thank you for your support, dedication and commitment to ensuring PHC has a voice in the healthcare arena. Without your support there would not be a College.

Without PHC there would be no first point of contact or principal point of continuing health care for New Zealanders accessing health care.

Without PHC there would be limited resources to provide health consumers with the broad spectrum of preventative and curative care each New Zealander will need at some point in their lives.

Without your PHC knowledge and skills in acute, chronic health conditions, as well as socioeconomics, health education, research and screening more and more New Zealanders would suffer ill health.

Without PHC there would be no one to co-ordinate required patient care

You are all an integral components that play and amazing part in delivering safe, timely, accessible, appropriate and holistic care to all New Zealanders.

Pupuri ake te mahi pai - Keep up the good work.

For those of you who know me you know I'm not really big on formality and I like to have fun so why should my last report be any different.

"The ocean is a central image. It is the symbolism of a great journey and I can choose to be a wave in the ocean or the ocean itself."

(Enya and Oprah Winfery)

I took some time to reflect on my journey

At the very beginning I considered myself a very small, insignificant fish swimming about in an aptly sized tank where no one expected too much from me. However, this feeling of safety suddenly changed when I was scooped up and thrown into a huge aquarium (thanks Judy Hattie) where there were much larger and cleverer fish than me. Like in the movie "Finding Nemo" I was the worrisome dad Marlin, scared of what was out there and how I would cope when meeting other species of fish and whether I would sink or swim.

Well it appears I "just kept swimming."

Now for a little poem

Yesterday I went swimming and who should I meet

A unique school of fishy's whom I found very sweet

They were all of various shapes and sizes and their colours where unique

But all of them had porpise and a voice in which to speak

Some swam behind the scenes and did their fishy thing

While others liked to demonstrate their amazing fishy zing

One or two were fearless and not afraid to say

But they all helped me find, my little fishy way.

Not swimming independently, instead we swam as one

And we kept on swimming until our fishy work was done

Swimming with these special fishy's at my fishy side

I am eternally grateful and full of fishy pride

Had I not met you all, this little fishy would have, sunk and died.

To the most amazing, clever, unique, caring, hard working group of women, I have had the privilege of getting to know YOU ARE ALL MY "DORY's" my best friends, who swam beside me and never let me get eaten alive - Dhyanne, Karen, Kim, Yvonne, Wendy, Kate, and Mere thank you for support, leadership, commitment, and most all your awhi. To the beautiful women who are the foundation of the College executive committee, Cathy, Trish, Bronwen, Katie, Emma, Irene, Donna, Marilyn, Karry and Celeste, I applaud you for all your volunteer time and dedication to the College. Angela our incredible NZCPHCN professional Nursing Advisor, without your guidance and knowledge of NZNO documentation and all things legal, I would have been caught up in the net of despair. Vicki McSeveney and to all the other NZNO administration team a huge thank you for all that you do on a daily and annual basis for the College my gratitude is in whale proportions.

To the NZNO executive Team Memo, Kerri, Grant and Rosemary – keep fighting the tide that is unfairness, inequality and injustice.

A special "whale call" out to Rosemary Minto, Rosemary you once stood on stage and proclaimed me to have more guts than you ever would. This was said following my little stint of walking out onto stage at the PHC 2015 conference "Hang Ten for Health" in a pair of surfing shorts and a blonde wig the look on your face was priceless. You didn't know it then but what you said gave me the fishy guts to ride the "swirling vortex of terror."

To the incoming Chair (whoever you may be) I wish you all the best and "Just keep swimming, swimming, swimming."

I am confident the present committee has not left the College 'floundering' but in a 'sound' financial state along with a growing membership of 'tsunami' proportions.

Please don't forget to register for our next conference "Future Direction: Your Road Map": I look forward to "catching" up with you.

Message from National Executive Committee NZCPHCN

It is with regret that we have to inform you that despite a very successful Symposium in Timaru in 2016, we have found ourselves unable to repeat this experience in 2017 due to a variety of circumstances, as our attempts to resolve the situation have been unsuccessful. Please be assured that the newly elected National Executive (AGM in August) will be reviewing this and making plans to provide a North and South Island Symposium in 2018.

Chief Nurse's Report

Jane O'Malley
Chief Nurse

A nursing leadership narrative to support change

Warm greetings to you all. It's hard to believe summer is over and the first flush of snow is on our mountains. Your work, no doubt, will be governed to a certain extent by the change in season and with it changes in emphasis. In this edition of LOGIC, Yvonne has indulged me by allowing a few pages devoted to the Office of the Chief Nursing Officer (OCNO) nursing leadership narrative developed to support the New Zealand Health Strategy (NZHS).

The background to the narrative outlines its purpose. The narrative itself is deliberately short and to the point, highlighting first, that the NZHS has a strong emphasis on primary prevention and early intervention; secondly, that the workforce needs to be aligned with knowledge, skills, competencies and attitudes that support a change in emphasis; and finally, that the shift required is substantial and so too will be the way in which we currently work. The narrative calls for leadership; individual, collective, local and national, to herald in a new era of health care provision.

An adjunct set of key discussion points accompany the narrative to provide strategic notes for nurses, and others, to use when talking about the changes needed and the rationale behind the obvious role nursing can play in supporting the shift.

I would love to hear what you think about the narrative and how you might use it to bring about the conversations necessary to shape future directions in health care. I am thoughtful about how we might support an ongoing dialogue with the sector on the OCNO website. More about that later.

Nursing leadership narrative for change

Background

In collaboration with nurse leaders in Aotearoa/New Zealand, the Office of the Chief Nursing Officer has developed a nursing leadership narrative to support the progression of the New Zealand Health Strategy. The narrative is to be used in conjunction with the key discussion points that follow. The narrative will remain a work in progress as we continue working with nurse leaders, consumers and others to refine and develop it.

The narrative is aimed at nurses and:

- supports a shared understanding of nurse's contribution to implementing the strategy
- captures our current work and the future work we will need to do

- provides nursing leaders a narrative to draw on and share as they engage with others
- enables an individual and collective response to health system change.

Leadership narrative

Every place is the right place for responding to the health needs of people.

The 2016 New Zealand Health Strategy (NZHS) has a strong emphasis on primary prevention and early intervention to ensure New Zealanders *live well, stay well,* and *get well*. Realising the vision of the NZHS requires a fit-for-purpose, responsive health workforce and system that makes the best use of everyone's knowledge and skills.

While recognising that significant achievements have been made, a radical shift in the way we work is needed to ensure that nursing is equipped to embrace the future. This requires substantial shifts in thinking and practice from traditional places of care (hospitals) to care closer to people's homes, and from an illness focus to a prevention focus.

Nurses are well placed to support a far more pre-emptive health service that works to protect, restore and maintain wellness from birth to death. Nurses use strength-based approaches to enable and mobilise individuals, whānau and communities and need to build on this to co-design new models of care delivery with them, putting their views at the forefront of decision-making.

Nurses can influence change through:

- advocating a shift in emphasis from illness to wellness
- focusing on primary prevention and early intervention
- driving innovation and supporting access
- engaging in clinical leadership with colleagues to ensure quality and safety

Leadership is required to ensure a workforce and system relevant to the needs of people. This means services that are people centred, integrated with the health, social, education, justice and community sectors, responsive to Maori, Pacific and those with high health needs, and support equity of access to, and quality of, services.

Meaningful collaboration, flexibility and the use of new technologies herald a new era of health care provision.

Key points underpinning the narrative

- The New Zealand Health Strategy envisages a more integrated and person centred model of care and early intervention and prevention focused health services.
- An integrated model of care is one that blends health, social, education, justice and community services; is responsive to high needs populations; supports equity of access to, and quality of, services; and has a focus on determinants of health, particularly early childhood that sets a pattern for later life.
- The government is committed to a social investment approach which means investing early in people's lives (including pre-conception through early childhood).
- Key drivers are persisting inequalities, a growing and ageing population, the unsustainability of a siloed and disease focused model, and developments

in technology (such as genomics, robotics and nanotechnology) that will change health care in ways not yet imagined.

- The narrative recognises peoples' desire to be active participants in their health care and the importance of building health literacy to enable people to better manage their health.
- Realising the vision of the New Zealand Health Strategy will require maximal effort from a health workforce with the right skills, in the right place, at the right time to meet the needs of the population.
- As the largest health professional workforce, Nursing is well placed to contribute to new models of care. Work has been done to remove statutory barriers and enable nurses to work to the full extent of their scope of practice, and a focus on workforce data has provided us with a good base for planning to meet future need.
- There are opportunities for nurses working in all settings to influence the development of services, demonstrate clinical leadership, drive innovation and collaborate with sector partners and users.
- Nurses combine their clinical and interpersonal skills to engage, educate and work with people and their families/whānau.
- To improve responsiveness and assist families to self-manage their health and life goals, nurses will need to further develop their skills in assessment, motivational interventions and brief counselling; rapid response for management of acute care in homes; and long term conditions management.
- Nurses and others will also need enhanced skills in system navigation and will need to be capable of working with a wider variety of community, iwi, and public service agencies to deliver more integrated interventions.
- Key enablers to nursing's contribution include opportunities to undertake advanced education, increased opportunities for experienced nurses to support the development of graduates' skills, knowledge and expertise; and more Maori and Pacific nurses in leadership positions.

Editor's Report

Yvonne Little

Nurse Practitioner

Welcome to our mid-year edition of LOGIC. It is hard to believe we are half way through 2017.

I hope everyone is managing to stay safe and well at one of the busier times of the year and having a little "ME" time with a cuppa and enjoying reading LOGIC.

As nurses we are all aware that despite planning and careful management sometimes a change of direction occurs due to unforeseen circumstances and in this instance whilst we endeavoured to get the proposed articles into the June issue, unfortunately our authors were unable to accomplish this for our orthopaedic and musculo-skeletal articles. Our team are still working to get these articles to you in a later edition.

We hope you enjoy what we have in this issue and please feel free to send us your feedback. Shortly, we will be asking our members through NZNO to complete a survey to help us find out if you are enjoying reading the e-journal, what you like or don't like, changes you would like, and suggestions for us to investigate for articles. It would be great for as many of you to complete this survey as this will help us to improve the journal.

This year at AGM in August, at the Auckland Symposium we will be saying goodbye to many of our long-standing NZCPHCN committee members as they will be completing their term in office, so I would like to say a heart felt thank you and best wishes to this group of fantastic, inspirational and dynamic ladies who have given of their time despite often hectic work and study schedules, and who have become close and dear friends.

Kim Cameron – Chair person,

Dhyanne Hohepa – Vice Chair,

Kim Carter – National Executive Committee

Karen Smith – Treasurer

Karry Durning- Professional Practice Committee

Kate Stark – Co-editor, LOGIC

Donna Mason – LOGIC committee member

Marilyn Rosewarne – LOGIC committee member

Keep well through the winter season and looking forward to seeing as many of you at our single symposium for 2017, which is being held in Auckland on August 19th this year, come and enjoy comraderie, networking and some great learning experiences.

September 2017

- Skin; Telehealth
- Cervical & Prostate Screening
- Mental Health; Diabetes
- Rural Muster
- Education – cultural linked to feature topics

December 2017

- Party Health (sexual health, alcohol, recreational drugs, violence, gastro bugs)
- Mental Health; Diabetes
- Rural Muster
- Education – cultural linked to feature topics

Call for Nominations 2017

This year a number of committee and Executive positions will become vacant at the August AGM with representatives having completed the permitted two 2year office term.

This work is illuminating, stimulating, puzzling and challenging at times. Being part of the CPHCN is an opportunity to extend your practice, contribute to nursing, advocate for other nurses and the communities we serve. A measure of the satisfaction derived from this work is the number of representatives who have completed two terms.

Positions that will become available in August 2017 include:

-LOGIC Journal

-Professional Practice Committee

-Executive

Face-to-face meetings of the Executive and the LOGIC and Professional Practice committees are held twice a year from 0900hrs to 1500hrs, usually on a weekday to facilitate the attendance of guest speakers and also for flights availability. Meetings have been in Wellington, Auckland and Christchurch.

The Executive additionally meets two other days; one of these via video link once a year (via NZNO system).

Once a year there is an AGM and attendance by committee and Executive members is expected. AGMs have been held at annual conferences; this years' AGM will be held on the same day as the Auckland symposia day in August.

There is an expectation that there will be active participation by committee members; reading materials sent out, responding as appropriate, participating in committee teleconferences or skype meetings and the follow-on activity required from these meetings

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

It is recommended you discuss committee representation with your manager before nomination. Only members of the College are eligible to be on a committee. Nominations need to be made using the CPHCN Nomination forms. You do not need to be present at the AGM to be eligible.

http://www.nzno.org.nz/groups/colleges/college_of_primary_health_care_nurses/hot_topicsIf you don't have a nominator, or would like any other information, please email collegeprimaryhealthcare@gmail.com for assistance.

RURAL MUSTER #3

Kate Stark – Nurse Practitioner

Having recently attended the NZRGPN national rural health conference in Wellington, I reflect on how rural nursing has grown into a mature, highly educated, dedicated, self-motivated, autonomous being. It is also gaining increased recognition by other health professionals as a profession that is and has greater potential to hugely impact on the health of rural communities. I feel proud of all the hard work that my rural nurse counterparts do around me in all genres of rural nursing. We must support each other to stand tall and remember that being rural is unique, and that providing care to rural communities takes intestinal fortitude (ie bravery), tenacity, breadth of knowledge and through innovative practice, can reduce inequities experienced by rural populations in relation to accessing health care.

At conference, rural nurses had a wonderful collegial opportunity to network with other rural nurses. Highlights included the panel discussion with rural nurses from Dunstan Hospital in Central Otago. They engaged with nurses and began planning a national rural nurses working party. This has got off to an impressive start. A newly generated Facebook page entitled 'Rural Nurses NZ' already has 109 members from near and far and networking has begun. Information has been circulated requesting expressions of interest to be part of this working party. With nominations/expressions of interest closing on May 22nd, it is expected that the already great response is only going to grow and be something fabulous for rural nurses of New Zealand.

Rhonda Johnson and her team at Dunstan are undoubtedly passionate about rural nursing and like many before them have identified a gap in nurse networking amongst those that live and nurse rurally. They want to put rural nurses on the map as unique and valued and crucial to all aspects of rural health care. Within this issue of LOGIC you will also find a brief regarding what these nurses are trying to achieve along with details of how to become involved. Please take the time to read this and consider being part of the group.

NZRGPN rural health conference was also an opportunity for a panel discussion related to the national PRIME review. With chattering teeth and shaky knees I addressed the group of rural health practitioners from a nursing perspective, focussing on the recommendations within the review that affect nurses directly.

Standing orders, scope of practice and the proposed national PRIME Committee were the hot topics I was asked to talk about while Jared Stevenson (NASO, National Ambulance Sector Organisation), Tim Molloy (Royal New Zealand College of General Practitioners) and Tony Smith (St John Ambulance Medical Director) discussed issues such as funding, national governance of PRIME, kits, syllabus and training, and where to from here once the Review was complete.

Like other members of the PRIME Review National Steering Group I am delighted that the final report has now been submitted for consideration by NASO and the Ministry of Health. We await the outcome of 6 months work where a large number of people have given their voluntary time over and above their normal work commitments to provide, consider, discuss and collate the feedback received from key rural stakeholders. As is normal for rural people, a great deal of voluntary time and good will has gone into the PRIME Review and I am grateful to have been part of it.

Driving to Twizel for my PRIME weekend on call gives me four hours to reflect and think about what it means to be rural. Long stretches of windy road, isolation from general amenities such as shops and even toilets, lack of cell phone reception makes me ask myself why I do this! My answer centred around making a difference to the health of communities who are challenged by being rural, and that without all the usual amenities at their fingertips. Being rural makes us different to that of urban centres. This also reminded me how as rural nurses we go the extra mile to make a difference. We should applaud what we do and be proud that the fundamental factor that underpins our actions is centred around caring and providing for our communities who would otherwise miss out on health care on many levels.

I hope you all had the opportunity to somehow celebrate International Nurses Day in style in May. It remains important that we remember the beginnings of nursing and the foundation that was laid so many years ago, upon which we have built. We have come a long way and should be proud of both the then and now, and all that has gone in between to make nursing what it is today.

memo

To: All NZ Nurses working in a rural context

From: Rhonda Johnson and Debi Lawry

Date: 19 April 2017

Re: Rural Nurses NZ working party – Expressions of interest sought

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Following the recent National Rural Health Conference in Wellington, Rural Nurses were supportive of the need to establish a working party to commence work on raising the profile of NZ Rural Nurses nationally; assist in providing national connections; and contribute to career pathways and support for nurses working in a rural context.

In order to represent NZ Rural Nurses, the working party needs to have a membership of 8-10 currently practicing Rural Nurses that reflect the variety of contexts that rural nurses work in across the nation. We are therefore seeking expressions of interest to achieve representation for the following areas:

- Primary Rural Nurses
- Secondary Rural Nurses
- Remote Rural Nurses
- North Island Rural Nurses
- South Island Rural Nurses
- Educators/Academics with Rural interest
- Maori Rural Nurses

If you are interested in membership on the Rural Nurses NZ working party; please send your expression of interest together with a brief biography of your rural background, and what you are able to contribute to the working party by the 22nd of May 2017 to:

Rhonda Johnson

Dunstan Hospital
PO Box 30
Clyde 9330

Or email: rhonda.johnson@cohealth.co.nz

Expressions of interest will be collated and distributed widely to Rural Nurses for nomination to the working party.

‘Ikura, the lifeblood: Traditional Māori understandings of menstruation.

Ngahuia Murphy (Ngati Manawa, Ngati Ruapani ki Waikaremoana, Tuhoe, Ngati Kahungunu).

57 Hillcrest Road, Whakatane.

0277218614
poitahu@gmail.com

Ngāhuia Murphy is a doctoral candidate at Waikato University examining the reclamation of whare tangata ceremonies and philosophies. She is a recipient of the Health Research Council New Zealand Māori PhD scholarship and the Sir Hugh Kawharu Auckland War Memorial Museum Award.

Ngāhuia has published two books Te Awa Atua: Menstruation in the pre-colonial Māori world, and Waiwhero: A Celebration of Womanhood. Both publications can be purchased by emailing poitahu@gmail.com

‘Dirty’, ‘shameful’, and ‘gross’ are words some Māori women use to describe how they feel about menstruation. For many others there are simply no words for the blood ‘down there’ (Kent & Besley, 1990; Murphy, 2014a). Alarmingly, some Māori women and girls believe that this attitude is cultural, that our ancestors considered menstruation as ‘dirty’ and a source of female inferiority. Nothing could be further from the truth.

For our ancestors’ menstruation was a powerful symbol of whakapapa (genealogy) assuring the continuation of the whānau (extended family) (Murphy, 2014a). It was regarded as a sacred river linking Māori women to our deities. Whilst today the most common name for menstruation is ‘mate wahine’ (translated as women’s sickness), ancient names reveal powerful cosmological origins and an entirely different attitude.

Cosmological Origins

One example is the pre-colonial term ‘ikura’. Ikura is derived from the saying Mai-i-Kurawaka (which translates as ‘from Kurawaka’). Kurawaka is the name given to the origin place of humanity at the pubis of the earth mother, Papatūānuku. Kura can be translated as a precious treasure, sacred knowledge and red ochre (Williams, 1991, pp. 157-158). Waka can be translated as a vessel, a medium of atua (a supernatural power) and is often used as a metaphor for female genitalia in its capacity to convey the generations (Murphy, 2014a; Williams, 1991, p. 478). The term ikura implies a precious, sacred red medium that conveys the generations, a medium that originates at the pubis of the earth mother, Papatūānuku. It was from this sacred medium, according to some traditions, that the first human, Hineahuone, was created.

Traditions of Nurturance

Like other societies around the world, when menstruation appeared for the first time it was greet with various ceremonies such as the cutting of hair and piercing of ears, the

Hineahuone, by Regan Balzer, 2014. Reproduced with Permission.

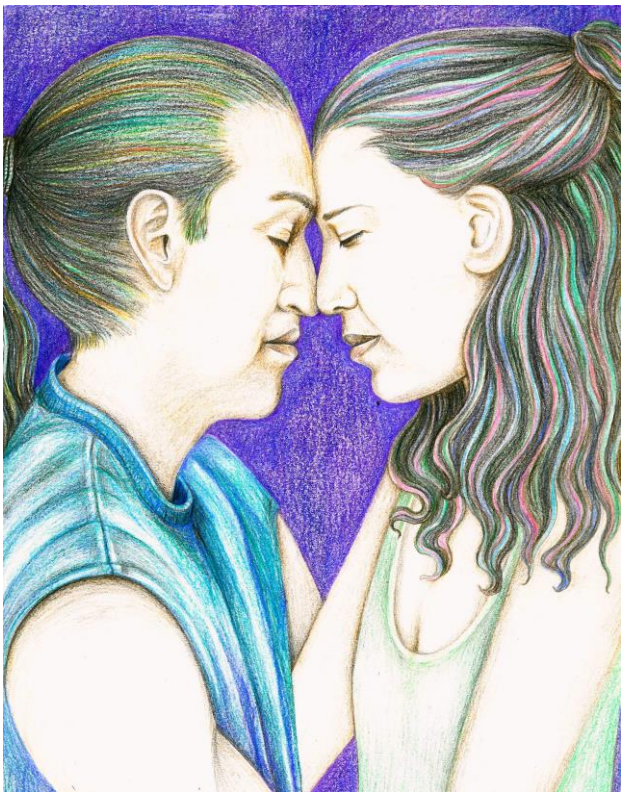
receiving of moko kauae (traditional chin tattoo), whānau hakari (family feasts) and presentation of taonga (gifts) (Murphy, 2014a, 2014b).

These practices reflect the positive and respectful attitude our tīpuna (ancestors) had toward menstruation as a symbol of the continuation of life. Menstruation, and sexuality more generally, was spoken about openly and without squeamishness or shame (Papakura 1938). Tamariki (children) learned about menstruation through osmosis, listening to their parents, aunties, uncles and elders at home and in the meetinghouse. Sexuality was discussed within the wider contexts of whānau and hapū history, whakapapa, philosophy, cosmology, science, spirituality and social values (Pere in Murphy 2014a, 2014b). Learning in these intergenerational spaces fostered a bond between the genders that was reinforced by certain tikanga (traditional practices). For example when women bled, men procured special foods (Pere in Murphy, 2014a, 2014b). Traditionally menstruation was a time of rest and renewal supported by the whānau who acknowledged the whare tangata (womb) as paramount. Perhaps this is partly why Māori women in the pre-colonial era did not suffer from pre-menstrual tension, endometriosis or other afflictions that are common today (Gluckman, 1976; Riley, 1994).

Colonial ethnographic representations

Many Māori today are reclaiming ikura ceremonies and traditional practices, but disturbing and contradictory attitudes continue. Two of the most unsettling stories that I have heard from Māori working in the health sector are the following

- a prominent Māori male leader declares to Māori working in the health sector that it is inappropriate for a Māori father to climb into a birth pool if there is birthing blood in the water least his tapu (sacredness) be 'polluted' by the blood;
- a Māori cultural advisor to a district health board states that because the vagina is tapu it is inappropriate to talk about with Māori girls who are afflicted with sexually transmitted diseases



Hongi, by Regan Balzer, 2014. Reproduced with permission

The stony wall of silence implicated by one, and the derogatory tone explicit in the other, are both the direct consequence of three significant factors: the omission and censorship of histories that reflect the power and central role of Maori women (Simmonds, 2014; Yates-Smith, 1998); the misogynist Victorian values of the colonial ethnographers who wrote about Maori women (Mikaere, 2003; Pihama 2001); and the systematic reproduction of this distorted material for almost two centuries. This has created powerful narratives of Māori female inferiority that impact on the lives, choices, health and wellbeing of Māori women and girls today.

Nurses and health care professionals working with Māori women and girls need to be aware that notions of shame attached to menstruation have nothing to do with traditional Māori concepts of womanhood, rather they reflect the internalisation of colonial narratives of female menstrual 'filth', 'pollution' and inferiority. Sensitivity is required in navigating the complexities of this colonised reality as well as compassion for Māori whānau who, through no fault of their own, have been severed from their ceremonial, philosophical and cultural traditions.

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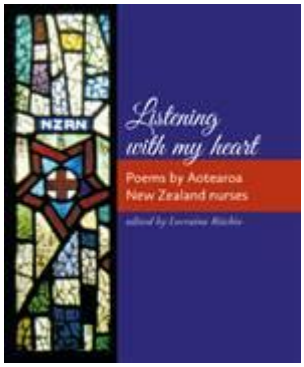
NZNO celebrated International Nurses Day in Wellington with the launch of ***Listening with my heart: Poems by Aotearoa New Zealand nurses***. Edited by Professional Nurse Advisor Lorraine Ritchie, this fabulous new book features the work of 35 nurses. Moving and poignant the poems offer deep observation and insight into the diversity and lived experiences of our nurses. Production of this poetry book is part of NZNO's Visibility of Nursing Project.

'Listening with my heart' : Poems by Aotearoa New Zealand nurses

A beautiful book to delight your soul

To order copies:
http://www.nzno.org.nz/resources/nzno_publications/listening_with_my_heart
Queries: Publications@nzno.org.nz



'Listening with my heart' – poems of Aotearoa New Zealand nurses

Selected verse by nurses in Aotearoa New Zealand. Expresses a variety of views of nurses and nursing through experience of people, place and circumstance.

The prices are:
NZNO members: $25
NON NZNO members: $30

LIVING WELL WITH DIABETES WORKSHOP –

A combined workshop

Paula Nilsson

Marlene WhaangaDean

Paula Nilsson (Diabetes Nurse Specialist) and Marlene WhaangaDean (Community health worker) both work in the Wairarapa region. They are both passionate about their communities and both combined forces recently to deliver a tailor made workshop that shoulder tapped high risk Type 2 diabetics. Below are their summaries, rationale and reflections of that workshop.

Reports tell us fifty per cent of New Zealanders are now overweight or obese (Ministry of Health, 2014). Currently 7% of the population has Type two diabetes (T2D) and if prevention measures prove ineffective then a 50% incidence increase by the year 2021 has been predicted (Health Workforce New Zealand, 2011). Maori and Pacific Island people are three times more likely to develop diabetes than New Zealand European (Ministry of health, 2014) and the factors contributing to this are multi determinate. Factors include socio economic status, poor health literacy and ethnic predisposition (Harwood & Tipene-Leach, 2007).

Effective long term self-management of diabetes is pivotal in the prevention of long term complications particularly for those diagnosed early to mid-adulthood. Here lies the challenge. How do individuals develop tools and manage this lifelong condition alongside stressors of normal life? Economic hardship only increases the obstacles to effective self-management. More immediate priorities and a lack of access to resources that many of us take for granted, create enormous barriers for those who live in deprivation.

Paula Nilsson / Clinical Nurse Specialist

My job as a clinical Nurse Specialist in the Wairarapa is broad, encompassing patients with all types of Diabetes across their lifespans with greatly varying levels of diabetic complexity. Considering above statistics, Maori and Pacific populations are a priority for our service and yet are not the patients we always get to see. Our service depends on referrals from primary and secondary health services. One of my advantages working in a small community is the relationships I build with other health professionals. I met Marlene, a community health worker working within a Maori health Organisation in 2012. In March of this year, she asked me if I would work alongside her to run a diabetes workshop for Maori, Pacific and low socio-economic Type 2 diabetics.

This workshop was very much driven by Marlene, who knows best the population she works with and how to deliver an education program that would best meet their needs. All participants had T2D, some

long term on insulin, others recently diagnosed and lifestyle managed. Both Marlene and I personally invited each participant. I also invited members of our local Diabetes NZ branch to attend and provide resources and information.

Although I had an existing presentation for persons with diabetes I knew to adapt this to become more appropriate for the group I was delivering too. I sought Marlene's advice on this. Rather than stand and deliver a presentation with questions left until the end, we decided on an informal korero (chat). Each slide just became a topic for discussion and each participant was encouraged to share their own experiences and knowledge with others in the group. I highlighted the truths, dispelled the myths and provided education where gaps became apparent. This seemed to work very well. Older participants shared food tips; younger women raised concerns about medications and family history. Feedback suggested that even those who had received diabetes education before learnt new things from this group workshop.

I too learnt. For example, on my suggestion of cooking extra vegetables at teatime, so leftovers could be eaten for lunch the next day, one young wahine (woman) informed me that with seven people in her household, there were *never* any leftovers. As a health professional; putting yourself in the shoes of patients you work with is essential if you wish to understand the barriers that prevent their self-management. Finding solutions to barriers will more likely come from societal change and communities, rather from well-meaning health professionals but let us try avoiding placing our values and expectations on those whose choices are limited.

Working collaboratively is not a novel idea and I am sure many readers will have worked in this way. Forming relationships with those immersed within their communities and who understand their learning needs is more likely to lead us to successful outcomes. We cannot underestimate the value in sharing our expertise, resources and strengths to provide certain populations not just with information, but with tools, motivation and self determination to improve their health. I am looking forward to working with Marlene again and running the next diabetes workshop.

Marlene Whaanga –Dean/ Community Health Worker

My role as Community Health worker within our Pae Ora team within our Maori Health Organisation is to support whanau and individuals with their goal setting around any health conditions or social circumstances. My role is to reduce disparities and inequalities so that health is not further compromised. I am the eyes and ears of the community and can help health professionals to identify health care gaps. My role is to navigate, facilitate, educate, advocate and reconnect people to services and their health care homes.

What I saw and heard in the community is that whilst some clients have some understanding about their diabetes; many compare having diabetes to 'pushing a rock up a hill, and then watching it roll back down again'. This made me think of ways to make diabetes easier to understand and therefore easier to manage. I asked myself how we as health professionals could provide a more holistic service to provide better care for our diabetic whanau.

My focus became working with Paula, as this would bring the best advice and expertise to clients. I began building relationships with whanau to begin engaging them and

getting them interested in a session. Paula and I decided a smaller workshop with ten clients would keep people safe and make them more willing to ask questions. I felt strongly that separate wahine (women's) and tane (men's) workshops would be important. It would create a more culturally safe forum for women to talk, ask small or personal questions and keep their mana (dignity) respectfully upheld. Lots of Maori women get shy around Tane (men).

Each client was shoulder tapped to attend. Patients were identified either from Paula's database or from the Pae Ora team's client lists. Inviting each client individually helped us to get an attendance rate of 100 percent.

A Maori approach, with karakia (prayer) and mihi whakatau (welcome) as our introductions set a safe space for us all. Our workshop ended with beautiful, nutritious kai (food) to seal everyone's newly shared knowledge and morning together.

Feedback suggested whanau felt respected, the session was very informative, they all learnt something new and one person who was too shy to even speak within a small women's group said "I thought I knew lots about my diabetes but from listening to the other stories, it was really helpful to hear others open up and tell us how they coped with their own diabetes. I learnt new stuff from Paula and the other ladies which was really good. "

All clients who attended the morning were followed up after the session and either reconnected with Paula or re-engaged with their health care homes.

Paula and I look forward to running the Tane (men's) group later this year. I have learnt so much working alongside her. This is great for whanau to see and be part of.

Developments in community pharmacy services in New Zealand

– Primary health care nurses' view

A team of researchers from Victoria and Otago universities has recently received a Health Research Council grant to investigate developments in community pharmacy services in New Zealand. Community pharmacies are expanding the range of services they offer and the aim of this research is to understand the extent to which this expansion is occurring successfully, what any enablers or barriers to progress might be and how these changes are expected to influence health and health system outcomes.

As part of this work we are interviewing key stakeholders and would like to include representation from the New Zealand College of Primary Health Care Nurses.

Have you been involved with any new pharmacy services in your community or through your primary health care service?

Would you like to contribute to this research by being interviewed?

For more information or if you are interested in taking part, please contact Janet McDonald by email janet.mcdonald@vuw.ac.nz or phone (04) 463-6596

Paediatric Epilepsy Training 1

In March 2017 the NZ College of Primary Health Care Nurses was invited to attend a Ministry of Health Technical Advisory Group Complex Epilepsy National Service Improvement Project meeting. Included in this groups work is the development of draft guidelines for the management of epilepsy in children; the College was asked to participate in the first Paediatric Epilepsy Training day and give feedback on its suitability to support this work. This training day was held on 12th May in Auckland.

The British Paediatric Neurology Association has been offering this course, Paediatric Epilepsy Training 1 (PED1) for twelve years. This is the first time it has been offered in New Zealand. Presenters came from the United Kingdom and presented PED1 to a number of participants earlier in the week in addition to Train the Trainer development. These participants then took turns to present the material at the PED1 day to the 35 participants of mostly paediatricians and paediatric neurologists.

Prior to the day, a pre-reading PET1 Precourse Workbook was sent out as part of the training package. The reading material was interspersed with mini quiz questions and included precourse questions that participants used to evaluate their learning at the end of the training day.

The day itself comprised presentations with breakout workshop sections using case example vignettes to discuss and reinforce key points in the presentations. A complete PET1 Course Handbook was provided for each participant. There was time and opportunity for participants to engage with the material being presented. Additionally the training day covered what is not epilepsy. There were United Kingdom references in the materials, such as 'dial 999' and some differences in medication presentation availability, but they were not obtrusive.

Prior to attending the day I decide I couldn't remember when I last attended education on epilepsy; the pre-reading was useful as a refresher and update on some aspects of paediatric epilepsy.
There was some material on EEGs that was technical, but I was comfortable about how much I understood and was immediately able to relate to recent situations in my practice. Material included touched on current medication now available and video clips of a variety of seizures as examples. There was the introduction of an acronym for standardising seizure description which would be useful both in giving information but as a format in communications such as clinic letters and referrals. Content also covered included what is not epilepsy, such as faints, febrile seizures and funny turns.

This training programme is suitable for nurses employed in a number of primary health care settings working with children, young people and their families including: practice nurses, school nurses, public health nurses, Plunket nurses and nurses working under Wellchild, Whanau Ora or Long Term Conditions contracts. The format, content and method of delivery of this training was an example of best teaching and learning practice. It is yet to be announced how this training will be rolled out but it is anticipated it will be offered to nurses in primary care.

Wendy King
Registered Nurse, DN BSocSci MPH

The low down on the Cold Chain Standards

Bernadette Heaphy

RN, BN, PGDip Health Sci.

Advisor – Immunisation

Ministry of Health

Bernadette Heaphy is registered nurse currently on secondment with the Ministry of Health Immunisation Team, working a number of pieces of work including the vaccine cold chain. Prior to the secondment Bernadette was the IMAC Regional Immunisation Advisor for the Central Region and will be returning to that role in July. Bernadette has worked in Immunisation Coordination and Education roles since 2007 when she started with Canterbury Immunisation and worked as a Cold Chain Accreditation (CCA) assessor during the initial CCA roll out in 2004.

Vaccination helps protect against the spread of serious diseases. Its introduction and widespread use has made a significant contribution to improving rates of child mortality and increased life expectancy. Diseases such as polio, measles, pertussis, tetanus and rubella can have serious health consequences even in well-nourished infants, children and adults. However, for vaccination to be effective, vaccines need to be stored and administered correctly.

The *National Standards for Vaccination Storage and Transportation for Immunisation Providers 2017* (the Standards), affectionately known as the Cold Chain Standards, were rolled out in early 2017 and outlines the required vaccine storage process for Immunisation Providers in New Zealand. For those working closely with cold chain the publication of the Standards has been long awaited. Since the National Guidelines for Vaccine Storage and Distribution 2012 were published there have been many changes, developments and recommendations.

The evolution of the Standards has occurred over many years, starting back in 2004 with the roll out of Cold Chain Accreditation (CCA) for general practice providers as part of the meningococcal B immunisation programme.

Since then the following have occurred;

- In 2011, the Immunisation Handbook 2011 clarified that CCA was expected of all immunisation providers – some areas were already undertaking this.
-
- In 2012, the National Guidelines outlined that a pharmaceutical fridge was expected, as was the use of a data logger.
- Between 2012 and 2014, there were a number of significant cold chain excursions and failures resulting in the Ministry of Health (the Ministry) undertaking a cold chain review which was completed by Price Waterhouse Coopers (PWC). A summary of this review can be found on the Ministry web page www.health.govt.nz/coldchain
- In 2014, the Immunisation Handbook 2014 advised that a pharmaceutical fridge was not just expected but required for vaccine storage.

- In 2016:
  - CCA documentation was updated to include the requirement for a replacement plan for pharmaceutical fridges (every 7-10 years), and that new or loaned pharmaceutical fridges should be monitored prior to the ordering of vaccines.
  - the concept of Cold Chain Compliance (CCC) was introduced for those providers who store vaccines over a short period of time (usually occupational health nurses delivering influenza vaccine programmes)
  - late in the year, as the Standards were being finalised, there were two significant cold chain failures which placed a level of urgency on the publication of the Standards and their implementation, and supported the need for weekly data logger downloads.

The Standards came into effect immediately on publication (February 2017), with the expectation that many of the new requirements would not be a surprise to most providers, as they were related to many of the recommendations and expectations that the Ministry, the Immunisation Advisory Centre (IMAC) and PWC have reiterated for the last couple of years.

To clarify and reduce the conflicting requirements across district health boards (DHBs), the Standards are more prescriptive than the 2012 guidelines. A number of expectations and recommendations that were not being routinely implemented are now requirements and this should allow for more standardised processes for CCA/CCC assessment and cold chain maintenance.

Within the CCA/CCC processes there is a built in remedial plan with the recommended time frame for resolution of up to a maximum of three months. This time frame allows a provider to work on any issues identified during their CCA/CCC assessment. During this time a provider may continue to store and give vaccines provided the Immunisation/Cold Chain Coordinator is confident they have processes in place to pick up any cold chain breaches. This is an important clause for those providers whose CCA/CCC review is due soon after the Standards were published.

2017 Standards Highlights:

- Pharmaceutical fridges must be used and replaced every 10 years.
- Data loggers are to be downloaded weekly, reviewed with appropriate action taken and documented
- Data loggers are required for any off-site vaccination clinic (eg school based immunisation programmes, workplaces and outreach)
- Outline of the monitoring process for off-site clinics. The Standards will be updated at the end of the year, following the COOL Project* completion if required.
- Outline of the equipment requirements for off-site versus temporary chilly bin storage.
- All DHBs are required to develop a process for working with cold chain non-compliant providers by 1 February 2018, they are expected to work with Primary Health Organisations, Immunisation/Cold

Chain Coordinators, IMAC and the Medical Officers of Health to ensure a local plan is available.

The National Immunisation Programme team would like to take this opportunity to say thank you to all those who participated in the development of the Standards, we appreciate your time, expertise and knowledge. We would also like to say thank you to all the immunisation providers for your continued efforts to achieving great immunisation coverage and in ensuring that vaccines are stored to protect them from potential thermo damage, which may cause them to be less or ineffective.

*The COOL Project is looking at storage and transport of vaccines in chilly bins for off-site vaccination clinics, IMAC are reviewing different products including loggers, chilly bins and insulation materials.

Submitted by:

Bernadette Heaphy

RN, BN, PGDip Health Sci.

Advisor – Immunisation

Ministry of Health

We have the pleasure of having received this recent communication from one of our 2014 Conference speakers Therese Meehan, who spoke to us on Careful Nursing. If you happen to be lucky enough to be having some well-earned time off work and happen to be going to the United Kingdom or Ireland this would be an interesting summer school.

Subject: Careful Nursing Summer School in Ireland

This is a voice from a few years ago (2014). I trust all of the great work that you do in the College of Primary Health Care Nurses continues to go well.

I'm wanting to let you all know that there will be a Careful Nursing Summer School here in Ireland in July in case anyone will be over this way on a trip and would be interested in attending. Information can be found at this link http://www.carefulnursing.ie/go/blog/2017-04/save-the-date-careful-nursing-summer-school-25-27-july

With all best wishes,

Therese Meehan

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CHILD POVERTY IN AOTEAROA/NEW ZEALAND

Sue Gasquoine, Nursing Policy Adviser/Researcher,

New Zealand Nurse Organisation (NZNO)

Sue Gasquoine was recently appointed as Nursing Policy Adviser/ Researcher to the Professional Services Team at the New Zealand Nurse Organisation (NZNO).

Prior to this I worked in nursing education teaching child health and research to undergraduate and postgraduate students of nursing. Research interests include online professionalism, inter-professional education, child health and stroke. Qualifications: RN, MPhil (Hons)

"Child poverty is fixable but it's expensive… Simply fixing children up when they come into the health system, then sending them back to the same conditions that caused their health problem in the first place is not good enough." (Turner, 2017)

Turner repeated this message at the NZNO Auckland Regional Convention in April and reminded delegates that it is election year.

<u>Why does child poverty matter so much?</u>

Poverty in childhood affects their whole life

- every health outcome
- educational outcomes
- secure relationships
- future jobs and income

The internationally renowned Dunedin Multidisciplinary Health and Development Research Unit concludes "… tackling the effects of childhood disadvantage through early-years support for families and children could benefit all members of a society by reducing costs."

If child poverty continues at the rate it is - 29% living in severe or significant hardship in 2014 – then the 12% of adults 65+ years living in severe/significant hardship in 2014 is likely to double as the current generation of children become grandparents. Without opportunity and multi-sectoral intervention poverty becomes embedded and intractable.

The Expert Advisory Group on Solutions to Child Poverty published 'Solutions to Child poverty in New Zealand: Evidence for Action in 2012. It gives 78 high level recommendations to Government across 14 focus areas but the more pragmatic issue of how primary care nurses contribute in their day to day work is not specifically identified. The focus areas of 'Health and Disability' and 'Local Communities and Family' are the 'practice arena' of nurses who can bring their expertise to assessing needs of individuals and whānau, recommending and advocating change and resource allocation and then evaluating benefit.

Specific recommendations of the Child Poverty Action Group include:

- Universal health services for children, with targeted extra services based on assessment of further need
- National housing plan
- Housing WOF
- Increase minimum wage and address the needs

of children in low income families through well- supported benefits and tax credits

- Review social welfare benefits for adequacy
- Abolish sanctions which reduce the income of beneficiary families with children

What can nurses do? What should nurses do?

NZNOs election year manifesto will be published in a few weeks and specifies seven priorities for nursing and public health – **'best start for children'** is one of them.

'The nursing and nursing support team must be represented at all levels of planning, policy development and decision-making. They must be supported in their practice and workplaces to realise their potential to improve health and health equity across the nation, within our Asia Pacific region, and globally.' (NZNO, 2017). This is about nurses using their individual and collective voice to ask questions, sometimes awkward questions, about funding priorities and why the avalanche of evidence about care for the under-fives being a care investment in the whole of life, continues to be ignored.

June 2017 L.O.G.I.C

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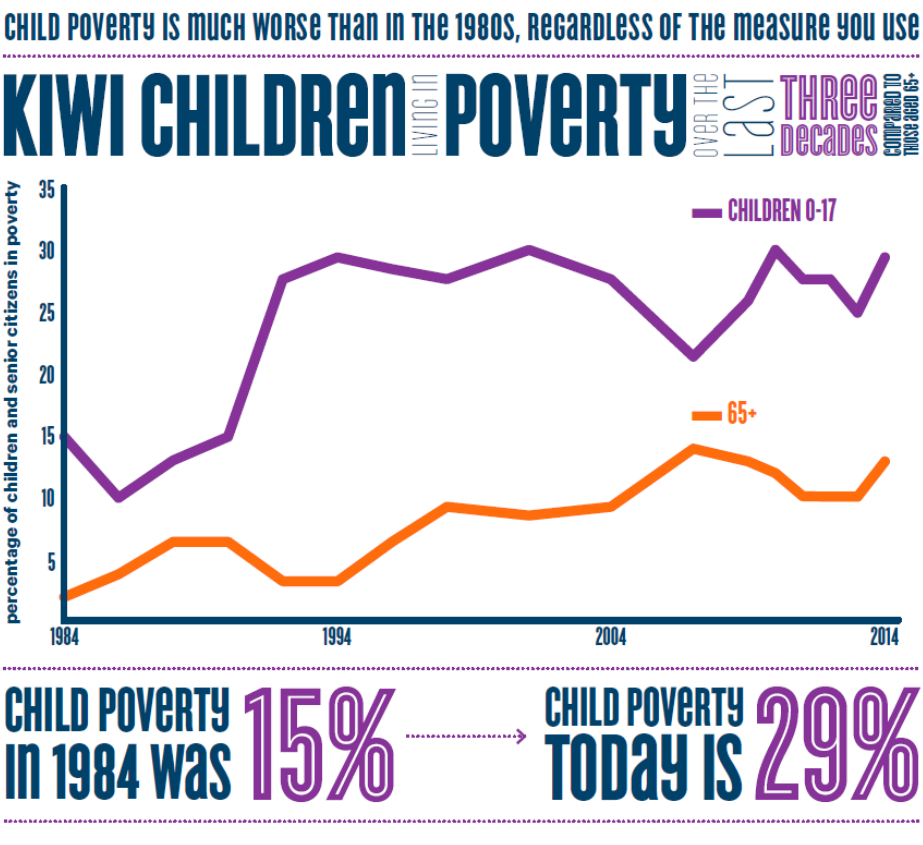

(reproduced with permission from Associate Professor Nikki Turner, Child Poverty Action Group)

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Green light for repeat of successful stroke awareness campaign

The Minister of Health has approved a national awareness campaign for stroke based around the stroke FAST check.

The campaign will begin on Sunday 4th June and run for approximately three months. It follows the extremely successful national campaign last year.

Once again the FAST mnemonic will be promoted. (Face drooping, Arm weakness, Speech slurred, Time to call 111). Promotion will be across a number of channels, including television, radio and online.

Although the primary audience is all New Zealanders, there is a special focus on Māori, Pacific Island and Indo-Asian communities.

Effective thrombolysis treatment depends on getting the stroke patient to hospital within a four-hour window.

The message is one of urgent action. Any stroke is a medical emergency and people should call 111 rather than their doctor, family and friends, or waiting for it to pass.

Calling 111 is the best means of achieving a positive outcome. If a stroke is identified by the caller to 111, then an ambulance or helicopter can be dispatched to the location to uplift the stroke patient, and give them the best chance of receiving thrombolysis in hospital.

We know that FAST works. Last year there was considerable anecdotal evidence that the advertising campaign was reaching people, but also that it was saving lives and improving outcomes.

Several people came forward to say they remembered the FAST message when someone near them had a stroke.

A Taranaki resident credited know the FAST message with saving her husband's life when he had a stroke in the middle of the night. She told the Stroke Foundation that had she not known to call 111, her husband would not have got to hospital in time for urgent treatment.

In another case study, Staff at a supermarket who had seen the FAST advertisement recognised that a customer was having a stroke. Although she wanted to leave, they kept her in the store and dialled 111 – action which resulted in a very positive outcome.

The National campaign follows successful and widespread use of the FAST message overseas.

The Ministry of Health, Stroke Foundation of New Zealand and Health Promotion Agency are partnering to deliver the campaign and appreciate your support with the campaign and these important messages.

For further information on the campaign or to register your interest to support please contact Julia Rout on julia.rout@stroke.org.nz.

The Role of Nursing in Environmental Health

Wendy King

Wendy is a public health nurse working in Thames. Professional interest includes PDRP, succession planning, practice development and public health. Wendy was also a Nursing Officer in the Territorials for 11 years and had a stint in Vanuatu with the New Zealand Defence Force.

Weekends finds Wendy at markets looking for a garden bargain, at a craft fair, or out enjoying the mountains, bush or beaches.

Introduction

Is an environmental issue a nurse's concern? Is it part of a nurse's job? If so, what is their role? What happens when a contaminant is discovered in a community? In this example, these questions were asked of the public health nurse. There are communities in New Zealand listed as having environmental concerns (Sharpe, pA1, 6, 2011) and there will some yet to discover their community has issues. This example is presented for primary health care nurses of what can happen.

The subdivision of Moanataiari was on the Ministry of Environments' list of possible contaminated sites and therefore eligible for funding for investigation and remediation. A single site test in 2007 indicated there was no cause for concern, testing in late 2011 was expected to be a formality, to confirm removal of the area from the list. Instead, arsenic, lead were discovered in levels that marginally to substantially exceeded National Soil Contamination Standards and thallium levels were above Canadian Soil Quality Guidelines.

History

Gold finds were first recorded on the Coromandel Peninsula in 1842, mining activity in earnest in 1867, continuing into the early 1900's. The Moanataiari Gold-Mining Company, Thames, first reported in 1869 and reclamation of the Moanataiari area from Firth of Thames was done using mullock (waste rock from gold mining) and mine tailings (processed mine waste) from then. Buildings identifiable in contemporary photos still exist today, including a processing plant which is now adjacent to a childcare centre today. The area was transferred to the Council in 1936 and development of Moanataiari as a subdivision began in 1960.

I've always known I lived on mine tailings; it was the family joke not to get too hopeful when digging in the garden as I am not entitled to anything I might find. When a newspaper story reported proposed testing, it was 'whatever'; everyone knows the subdivision was built on reclaimed land from gold mine tailings; mine shafts are clearly visible in the hill adjacent to the area from the street. It was a surprise however when I opened a letter from the council saying they had found levels of arsenic that were of concern.

Through this whole event I was acutely aware at times that I

VIEW OF THE THAMES, TAKEN FROM MOANATAIARI, SHOWING THE BIG PUMP WORKS AND MOANATAIARI AND WAIOTAHI LARGE AQUEDUCT IN FOREGROUND.

lived in the area and that I worked as Public Health Nurse in this affected area. Neighbours came and approached me at the letterbox or over the fence about the issue (Nursing Council 2012b, p 12). After receiving a letter from the council on Monday afternoon as a resident, I was contacted early the next morning as Public Health Nurse by the manager of the early childhood day care centre that is in the subdivision asking for assistance (Hill, Butterfield & Kuntz, p127).

Arsenic coexists with gold; when extracting gold from quartz it is inevitable that there is arsenic. This was discovered to be new territory; New Zealand has no standards for safe arsenic or thallium levels. Arsenic is a naturally occurring element in the earths' crust; it can cause acute arsenic poisoning or chronic arsenic toxicity. As a gas, arsine, it is lethal; it is tasteless and supposedly in sufficient concentration smells of garlic. Arsenic may have a confounding effect with other elements. It comes in an organic form and an inorganic form; the organic being of concern; typically found in sheep dip and timber treatments so that it can be absorbed and the insect infestations killed. (Ling, et al., Murray et al)

Arsenic

- Kills cells, acutely or chronically.
- Can be ingested, inhaled, or dermally
- Used as chemical weapon in WW1
- Herbicide in Vietnam War Lung disease odds increased x 10
- Persisting effect 15+ years after exposure
- Antenatal exposure causes foetal loss
- Insecticide in sheep dip
- Timber treatment

Lead poisoning causes developmental delay in

children, haematological disorders, nephropathy, encephalopathy and neurotoxicity and has also been implicated as a cause of spontaneous abortion and infertility (Sattler & Del Bene Davis, p330).

Nothing was found in toxicology references for thallium; online wikipedia searches noted thallium as tasteless, water soluble, highly toxic - a poisoners poison that can be absorbed dermally, also used as an insecticide and for rodent control.

Moanataiari Creek, Sir George Grey Collection

Environmental Health

For nursing, environmental health draws on the sciences and arts of nursing, for instance; toxicology, the effect of age, exposure route and dose-response, persistence of effect and epidemiology and factors such as confounding. It requires understanding the risk, to prevent risk of further exposure and being able to communicate this to others.

Environmental health response includes assessment of individual and community health, communication and working with many disciplines. Referral of individuals for help and assistance; medical and social may be needed. Additionally, an understanding of local and central government roles in setting policy, monitoring, enforcement, as well as their obligations and ability to access information and resources.

Risk - the Precautionary Principal

The Precautionary Principle (Chaudry, p261) states that "when credible doubt exists, act on the side of caution", discovering that safe and unsafe levels for some of these elements did not exist was a surprise but not atypical and therefore using the precautionary principle was appropriate for the situation and information that was currently available.

The arsenic levels varied with the highest closest to where the mines were, lower levels where fill had been brought in to complete the subdivision; the school located centrally had little to no arsenic. This was attributed to the fact that the school playing fields were documented as having extra fill layers when it was built and that they had had little disturbance, unlike on surrounding properties where roads, drains, sewage, water, underground power, buildings, driveways, garages, fences and so on had been excavated.

In this case children were identified as most at risk at risk; their relatively large body surface area, developing neurological system, lots of

activity on the ground or close to the ground, play including testing things orally. (Shendell & Pike-Paris, p179). Other subgroups of risk identified were identified; plumbers, builders, street construction workers and electricians.

This is an example where land and increasing population makes areas previously not considered becomes availability with repatriation, or becomes possible, as in this example, is created. In doing this, an area with little population at some risk becomes a subdivision with a population, with several identified sub-populations vulnerable and exposed.

Risk Communication

GPs were briefed in advance, as it turned out, rightly, as several residents who missed the community meeting contacted their GPs wanting to be tested for arsenic. Lots of people knew you can test hair for arsenic poisoning; too much TV I'm afraid, it turns out hair can absorb arsenic from the atmosphere. Other community responses were: I feel fine; everyone is ok, so it is ok, to asking what to say to contractors working on their property, for example, the drain-layers disturbing the soil (Abraham, p605). Some residents organised their own testing and wanted remedial action, now. The community response initially was very cohesive with nearly every household represented at the first meeting; a strange way to meet and see all your neighbours at once, some you knew, others by sight and others you didn't know before. Everyone was given the same information at the same time which was supportive and focussed the attenders together as a group.

Everyone had updates by email, posted and via the council website. Weekly update meetings were attended by smaller numbers and their composition varied. Absentee landlords were just that; having identified their occupants were not at meetings; information updates from the council were dropped in neighbourhood letterboxes as well as being posted to ratepayers.

Longer term the response became variable. The lack of certain data, unknown exposure times, the chemistry of the elements identified and the small population making epidemiology extrapolations statistically inconclusive and frustrating. Some seemed quite distressed for their children and could not be reassured; some were worried about property values and the impact on the value of their greatest asset.

Multidisciplinary response

There was an almost immediate response and it was significant. Representatives from Environment Waikato, the Waikato Regional Council, Members of Parliament – the local member and a locally residing List member, Ministry of Health, Ministry for the Environment, Ministry of Education, the local territorial authority and staff from private companies - testing laboratories and environmental engineers, arrived in the area promptly, that is, within 24-72hrs. This was reassuring and at the same time almost overwhelming.

Influences on nursing practice

It was expressed several times that this situation wasn't the remit of nursing. The many agencies involved however, identified that the potential adverse effects on health was the issue. During the events the questioning of the nurses role lead to contemporaneous review of guiding documents, goals and principals for nursing care. The stated District Health Board vision was to "…improve the health and quality of life of the communities it serves by addressing the needs of the population…" and its statutory

objectives – to improve, promote and protect the health of communities".

The World Health Organisation; Ottawa Charter for Health Promotion notes the linkage of people and their environment and so the environment is a socioecological determinant of health (Hill & Butterfield, p121).

Using te whare tapa wha; there were social and mental effects from this situation, in addition for example; real estate listings were withdrawn and no properties were listed in the affected area during this time. In addition to the health concerns while waiting for results, the second most frequently expressed concern was the effect this would have on the value of residents' largest asset and their financial provision for their future. Nursing Theorist: Florence Nightingale (Stanhope & Lancaster, p224) is quoted "… the symptoms or the sufferings generally considered to be inevitable and incident to the disease are very often not symptoms of the disease at all, but of something quite different…" noting the need for fresh air, light, quiet"; all environmental elements.

Using the Public Health Interventions Model (Keller, et al); nursing actions were individual and community focused, this included counselling, health teaching, advocacy and consultation for the population in the affected area and wider community as mining had occurred throughout the area.

Applying the Code of Conduct for Nurses Nursing Council of New Zealand (2012a, p17, 32); identifying that not only were their physiologically vulnerable individuals, but the science of the situation as well as the policy power imbalance between residents and government lead to residents expressing their vulnerability in multiple dimensions.

Whichever theorist, models, goal or vision was applied there was relevance to nursing; it was conceded that as a Public Health Nurse there was a 'fit' for the role.

Summary of Nursing Actions

Nursing Council Registered Nurse Competencies

Domain one

Promotes an environment that enables client safety independence quality of life and health

Practices nursing in a manner that the client determines as being culturally safe

- reported to Medical Officer of Health and GP concerns about

  specific residents

- sought by childcare staff for support and advice

- supported manager of childcare centre, interpretation of health advice guidelines into interventions specific for client group

Domain two

Provides planned nursing care to achieve identified outcomes

Undertakes a comprehensive and accurate nursing assessment of clients in a variety of settings

Ensure the client has adequate explanation of the effects consequences and alternatives of proposed treatment options

Ensures the client has adequate explanation of the effects, consequences and alternatives of proposed treatment options

Evaluates clients progress toward expected outcomes in partnership with clients

Provides health education appropriate to the needs of the client within a nursing framework

- worked with manager of childcare centre to meet

recommendations of Medical Officer of Health and licensing requirements of Ministry of Education

- provided information for parents of children in childcare centre
- researched nursing journals for evidence of similar situations principles to guide practice
- consulted with Medical Officer of Health
- reviewed health status of children attending child care centre
- assisted individuals interpreting of results
- reviewed measures taken by childcare to reduce exposure

Domain three

Establishes maintains and concludes therapeutic interpersonal relationships with client

Practises nursing in a negotiated partnership with the client where and when possible

Communicates effectively with clients and members of the health care team

- contacted for support after initial results were released
- supported Medical Officer of Health in pre-school and school site visits
- provided letter of support as requested for funding support
- liaised with council project staff and Medical Officer of Health in aspects of health information, health services, education providers in the community,

Domain four

Collaborates and participates with colleagues and members of the health care team to facilitate and coordinate care

Recognises and values the roles and skills of all members of the health care team in the delivery of care

- consulted with Medical Officer of Health regarding individuals with health concerns
- referred clients to the appropriate primary health providers for support

To summarise in New Zealand due to our early industrial history as well as little understanding waste management more recently, it is likely that other contaminated sites or sites of concern will be identified. Nurses in these communities will be called on either formally or informally for support (Hill & Butterfield, p124, 127, 129). This will require the nurse to be objective and balanced, empathy, repetition and reiteration, to become familiar with unfamiliar type material at short notice, but above all as a nurse; presence and the response of being there.

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Let's get real and Wellbeing

Jo van Leeuwen – Programme Lead for *Let's get real* at Te Pou o te Whakaaro Nui

The recent launch of Te Pou's *Let's get real* e-learning module saw content that has evolved and taken a fresh direction in its offerings.

Thinking about what people from our mental health and addiction sectors had been telling us about what really matters, the team at Te Pou realised a much more intentional focus was needed when we embarked on refreshing the *Let's get real* programme of knowledge, skills and attitudes in 2016. We looked at what has been happening in wellbeing approaches to holistic healthcare around the world in recent years, and listened to lots of people who have used services, work in services, and leaders and people who have been change agents, such as Robin Youngson http://www.themhs.org/resources/1471/keynote-paper-the-heart-of-healing-a-compassionate-approach-to-mental-illness , Arthur C. Evans http://www.themhs.org/resources/1444/keynote-webcast-beyond-the-black-box-the-transformation-to-a-population-health-approach and Joe MacDonald http://www.themhs.org/resources/1446/keynote-webcast-clarity-and-complexity-being-a-non-binary-transgender-person

As a result the *Let's get real* resources being launched this year are remix of Real Skills styled through a three pronged approach to learning : Engaging for Wellbeing (the e-module), Engagement Essentials and Values informed practice (paper based resources available for down loading). Each stands alone, however ideally are used together for optimum learning.

All practioners new to working in the New Zealand mental health and addiction sector will enjoy these resources, and there is also plenty for nurses like me who have been in practice for many years.

Wellbeing is about feeling good and functioning well. In other words, quality of life. It exists in two dimensions:

- Subjective wellbeing… asks how people think and feel about their own wellbeing, including their satisfaction with life; positive emotions and whether their life is meaningful.
- Objective wellbeing… is based in basic human needs and rights such as enough food, warmth, shelter, physical health, the ability to get around, safety and education. It is measured by mortality rates and life expectancy.

A key lightbulb moment for me in this work was learning about 'wellbeing set points' : that is, higher levels of wellbeing mean that we are all more resistant to illness, more creative, better at problem solving, more connected to each other and live longer. That wellbeing levels are modifiable because 60% of overall wellbeing is a combination of genes, upbringing and our circumstances BUT 40% of our wellbeing is determined by how

we choose to spend our time and our attitudes.

So, why is a wellbeing approach so important? Well, although I was very familiar with the Mental Health Foundation's campaign "Five Ways to Wellbeing" I also learned other things such as:

- Subjective wellbeing can add 4 – 10 years to a person's life.
- Wellbeing can protect against developing illness – those with a high level of wellbeing are more likely to recover and survive serious illness, this includes surgery.
- Being a normal weight and perceiving yourself to be the right weight are both associated with higher levels of wellbeing.
- Smoking is associated with lower levels of wellbeing.
- Higher wellbeing is associated with fewer risky health behaviours among 15 – 17 year olds.
- Excessive screen time is linked to lower wellbeing.
- Happiness is contagious - a nearby friend who becomes happy increases your probability of being happy by 63%.
- Personal Freedom and Quality of Government - how effective the rule of law is, levels of violence and corruption, effectiveness of government services, and opportunity effects subjective wellbeing.
- Caring about others rather than caring about one's self, a belief in God (or equivalent higher power) has a positive impact on subjective wellbeing.
- Education has been found to be a virtually universal correlate of wellbeing.
- A workforce's wellbeing is important in its own right: it can improve the quality of both work and people's experience and health outcomes.
- People want prompt, kind and compassionate care and they are aware of the influence of the workplace on staff behaviours towards them.

Check out *Let's get real* on Te Pou's website….. The module may be of interest to nurses working in the primary care sector too.

https://www.tepou.co.nz/initiatives/lets-get-real/107

and e-learning…….

https://www.tepou.co.nz/initiatives/e-learning/188

Mental Health and Crisis: A Brief Intervention for the Primary Care Nurse

Lorelei Olafson

Lorelei Olafson is a Primary Mental Health Nurse for Compass Health. She trained in Canada as a Registered Psychiatric Nurse and holds a Bachelor of Arts degree in psychology.

She gained her postgraduate certificates in Alcohol and Drug Studies and Cognitive Behaviour Therapy at Otago University.

Working with clients who present to a medical centre in crisis can be a difficult situation for the practice nurse. As a Registered Mental Health Nurse who provides clinics in the medical practice, I am approached by nurses who would like to feel more confident in dealing with these urgent situations. As nurses, we all have the skills needed to assist distressed clients but it may be useful to have a structure to follow so that nurses feel reassured that they are not missing important information or saying things that may escalate the situation. The use of a simple assessment tool with a Strengths-based approach to care may provide a starting point.

When a patient presents to a medical centre in a distressed state, it easy for us, as humans, to be drawn into that person's emotional state especially when we are trying be empathetic to the patient's view of their world. This may be a narrow, negative perspective descriptive of what that person is experiencing at the moment. Often when people become overwhelmed they feel the world is closing in on them and that they have no options. The extreme of this emotional state may result in thoughts of hopelessness or even suicide. Sometimes looking in from the outside, we can see many options but it isn't helpful to tell the patient this as it is an external reflection and may be seen as "a misunderstanding of their experience".

When a patient becomes distressed, the first step is to open the door to discussion. All nurses have communication skills but not all nurses are comfortable with distress. Some will be comfortable sitting with it and quietly supporting the patient whereas others want to fix it. Nursing is a profession that is based on the medical model of care so it implicitly requires us to provide a solution to the problem. This isn't always possible and for a nurse to become the problem-solver, she/he would inevitably take ownership of the problem. This is not in anyone's best interest. Patients need to be encouraged to arrive to their own solutions. Each person's ability to problem-solve is a strength. Everyone has skills, resources, and strengths available to them but in times of crisis, they may have trouble identifying these. So how can we help them to do this in a brief encounter?

The first step is being present. Allow your patient to tell their story, cry, get angry, feel hurt and resentment. Often people are uncomfortable with intense emotion as they don't know

what to say. Just being present, paying complete attention to the person in a nonjudgmental way, is helpful. Check your nonverbals, look at your patient, not the computer screen. If you need to check the time, reassure your patient that you are not rushing them. Be mindful of your own emotional state so that you can address it if needed. The key to defusing crisis is validation. Validation is the recognition and acceptance of another person's thoughts, feelings, sensations, and behaviours as understandable.

Accurate reflection is a type of validation that can help a person sort through their thoughts and separate thought from emotion. Accurate reflection means you summarise what you have heard from someone else or summarise your own feelings about the situation. When done in an authentic manner, with the intent of truly understanding the experience and not judging it, accurate reflection is validating.

Another useful form of validation is normalisation. For the emotionally sensitive person, it is validating to know that other people would feel the same way in a similar situation. People often worry that they are "going crazy" when life gets overwhelming so it is reassuring to hear that this a normal response.

Once a person's emotional state starts to calm, we can focus on getting more information using a brief assessment tool. Patients in crisis will present in an aroused emotional state and will discount pertinent information.

I ask the patient for permission to ask more specific questions so that I can gain a better understanding of what things are like for them. I use a simple assessment tool that covers the following areas: presenting issues, current management, risks, family, social, cultural, and physical. This assessment may not be appropriate for every situation but it is useful to get a better picture of where this person is at this moment in time. Remember that the patient will only tell you what is of most importance to him or her and may not share other relevant information.

Presenting issues: What is on top for this patient? Has this gone on for a long time or is it something new? Have they been in a similar situation in the past? What affect does it have on the person's mood? If the person's mood is low, how long has it been like this? Has this happened before? How long does it last? Do they have times when they are anxious? Do they worry, fret, panic? What do they worry about (external stressors, physical health, fainting, dying, heart attack, going crazy? - let them tell you) Does it affect their ability to do things or to go to certain places (such as the supermarket)? Has it always been like this? Has it gotten worse? When did they notice it was worse? Did something happen at that time?

Current management: What helps you to feel better? What activities do you like to do? (Some suggestions are music, reading, gardening, walking, housecleaning.) When you are doing these things are you able to turn off the thoughts? Can you think of an activity you do where your mind stops worrying?

Risks: Are you drinking? Using cannabis? Any other drugs? Gambling? Sometimes when we think things are really bad we start to have thoughts that it would just be better if we weren't here. Do you have thoughts of hurting yourself? Do you think of suicide? Do you have thoughts of hurting anyone else.

Family: Who do you live with? Do you have a partner? Children? Is there any family history of mental health issues?

Cultural: Where are you from originally? Where are your family?

Social: Do you work? How do you fill your day? Do you have friends? Supports? Any hobbies? Spiritual connections?

Physical: How have you been sleeping? What time do you go to sleep? Do you wake during the night? Are you able to fall asleep again? What time do you get up? Are you eating okay?

Impression: by this point you will have some first impressions of what is the most pressing issue for this person and it may or may not be in line with what the patient is thinking.

Plan: What do we do with this now? Give the patient some choices such as a medication review, counselling, or a follow up appointment with you. Things may have improved in a weeks time, or they may have deteriorated and require a referral to the secondary mental health service.

"A strengths-based approach to care, support and inclusion says let's look first at what people can do with their skills and their resources and what can the people around them do in their relationships and their communities. People need to be seen as more than just their care needs – they need to be experts and in charge of their own lives."

Alex Fox, chief executive of the charity Shared Lives

Rather than focussing on their weakness, we need to help people use their strengths. Think about the person who comes to you in dire financial straits but finds the resilience to carry on with support of family. Another may have suffered incredibly poor physical health but enjoys life volunteering and helping others. People may need help to find their strengths and resilience but we all have it. As nurses, part of our job is helping people to find where their own strengths lie. It is up to us to hold the belief that each person is able to find their own strength and solutions. We can do this by reminding people that they need to take care of themselves by eating properly, drinking enough fluids, having healthy sleep patterns, and getting some exercise. People tend to discount the importance of their physical health but it is essential for the brain to work properly and for the emotional state to be strong. Majority of people can remember a time when they felt strong and can identify steps for change to achieve that sense again. Sometimes we need to tell them "I believe you can get through this".

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ASCIA2017

Nurses Update Program

Friday 15 September 2017

07.30–09.00	**Registration**	
07.45-08.45	**BREAKFAST MEETING: ASCIA Nurses Committee** Chair: Val Noble Deputy Chair: Sacha Palmer	
09.00-10.30	**FOOD ALLERGY SYMPOSIUM** **– combined with Dietitians Update Program** Chairs: Anna Richards, Pauline Brown	
09.00-10.00	New ways of challenging food allergic children	Prof Jonathan Hourihane
10.00-10.30	New food allergy resources: e-training for food service, e-training for community, website for teens and young adults	Sandra Vale
10.30-11.00	**Morning Tea – Exhibition Hall**	
11.00-12.30	**PSYCHOSOCIAL AND EMOTIONAL RESPONSE OF PATIENTS** **– combined with Dietitians Update Program** Chairs: Susie Lester, Simone Stephens	
11.00-11.30	Avoidance restrictive food intake disorder (ARFID)	Noeleen Glubb
11.30-12.00	The difference between being looked at and seen: The patient	Galia Barhava-Monteith
12.00-12.30	Challenging food challenges	Sharon Carey
12.30-13.30	**Lunch – Exhibition Hall**	
13.30-15.00	**NURSE WORKSHOPS - ALLERGY** o Food Allergy – Adults and children o Allergic Rhinitis o Immunotherapy - Aeroallergens and Venoms o Eczema o Anaphylaxis - eLearning o Allergies at school o Managing skin infections at school o UniSA Professional Allergy Certificate o Allergy New Zealand and Allergy & Anaphylaxis Australia **NURSE WORKSHOPS - PRIMARY IMMUNE DEFICIENCY** **o** Understanding antibiotic use in this specialised population o Managing community treatments IVIg and SCIg (pump or push and support required) o Adolescent management – choosing careers, relationships, travel and risk taking behaviour within framework of chronic disease and ongoing treatments. o Teaching self-care, responsibility and personal control of treatment (all ages) o IDFNZ and IDFA	
15.00-15.30	**Afternoon Tea – Exhibition Hall**	
15.30 – 17.00	**NURSE WORKSHOPS (continued)**	
17.00-18.30	**Closing Function – Exhibition Hall Foyer**	

Real language, real hope

Adapted by Caro Swanson, service user lead, from 'Recovery Language' by Otto Wahl

Language reflects our beliefs and the way we view people. We are often unaware of the impact that the words we choose can have on our own attitude as well as on those around us.

The way we speak to and about people is a window into what we are really thinking. Communication is a highly complex thing. The words we choose can convey the fact we truly value people – we believe in them – and we genuinely respect them. Or, the words we choose can make it clear we do not.

People who experience mental health and/or addiction problems can feel and be put down, discouraged, demoralized, and marginalized. People can either reinforce that with the language they choose or they can fight it.

None of us should be defined or limited by our challenges, labels or diagnoses, or by a single aspect of who we are. We are people first and foremost.

Consider this...

DO NOT portray successful people who experience mental health and/or addiction problems as super-humans or special. This carries the assumption it is rare for people who live with these problems to do great things. It is also patronising to those who make various achievements.

DO NOT sensationalise mental health and addiction experience. This means not using terms such as "afflicted with," "suffers from," "victim of," and so on. These terms create and convey a sense of helplessness and victimhood that negate the positive experiences, growth and powerful learning that experiencing these challenges offer people.

DO NOT describe people as their label or diagnosis. Say, for example, "person who experiences psychosis" rather than "schizophrenic." We are people NOT a set of symptoms or a disease. Schizophrenia is increasingly seen as a negative label that has been sensationalised and overused. A more generic "person who has experience of psychosis" or "alternate reality" is more acceptable.

DO emphasise abilities, not limitations. Terms that are patronising, "othering" (them, those people etc.) or condescending must be avoided.

- DO focus on what is strong instead of what is wrong.
- The most respectful way to refer to people is as people.
- Whenever possible, use the person's name.

There are times when other language has to be used, particularly when putting things into writing.

Conveying respect

Some options you can use that still convey respect are noted below.

When referring to a group of people

Think about what you're trying to say about the group – who is it you are defining?

Are you referring to people with experience of mental health or addiction problems?

- Individuals who experience mental health or addiction problems.
- People who experience mental health or addiction problems.

Are you referring to people who are using mental health services?

- Service users.
- People receiving mental health services.
- People being served by the mental health system.

Are you referring to people who are using your programme?

- The people in the programme.
- The individuals we serve.
- The people we work with.

When referring to an individual

Again, what is it you are trying to convey?

That someone experiences mental health and/or addiction problems?

- Ian is working on his recovery.
- Cathy experiences addiction issues.
- Manu has lived experience of mental health problems.
- Sione has experience of mental distress.

That someone receives services at your agency?

- Joshua receives services at our agency.
- Natalie is one of the people we serve.

That someone has a specific diagnosis?

- Alice experiences bipolar disorder.
- Nick experiences depression.

How about not using labels at all?

Samples of recovery language

The following are some of the terms we have traditionally used to describe people and/or their behaviours. These terms place judgment and blame on the individual and generalise their actions. It is more helpful to describe the specific situation a person is facing than to use generic and punitive clinical terms.

Worn out language	Language that promotes acceptance, respect and uniqueness	Comments
Max is mentally ill. Max is schizophrenic. Max is a bipolar. Max is...	Max experiences mental health problems. Max experiences psychosis. Max has been diagnosed with bipolar. Max is a person who experiences...	Avoid equating the person's identity with a diagnosis. Max is a person first and foremost, and he also happens to have lived experience of bipolar. Very often there is no need to mention a diagnosis at all. Avoid using the term 'mentally ill' or 'mental illness' as this limits the experience to a bio-medical perspective rather than the holistic encompassing experience it is. Experience of mental health and/or addiction problems often include physical pain, spiritual crisis, loss of connectedness, emotional distress and loss of hope as part of the experience, these are not bio-medical only in nature. It is sometimes helpful to use the term "a person diagnosed with," because it shifts the responsibility for the diagnosis to the person making it, leaving the individual the freedom to accept it or not.
Alex is an addict. Alex is in denial. Alex is an alcoholic.	Alex has been diagnosed as meeting the DSMV criteria for substance dependence (name the substance/s). Alex is in recovery (remission) from addiction (or dependency) to substance/s (name the substance or gambling).	Always put the person first. Avoid defining the person as an addict or alcoholic. If they choose to name themselves – that's okay – it's not for others to use that language. Avoid defining the person by their challenges.
Mark is normal/healthy.		Referring to people without diagnosis, mental health problems, addiction problems or disabilities as normal or healthy infers that people with these are not normal and not healthy.
Sarah is decompensating.	Sarah is having a rough time. Sarah is currently experiencing...	Describe what it looks like uniquely to that individual – that information is more useful than a generalisation. Avoid sensationalising a setback into something huge.
Mathew is manipulative.	Mathew has developed strategies to get his needs met. It might be useful to Mathew to discover more effective ways of getting his needs met.	Take the blame out of the statement. Recognise the person is trying to get a need met the best way they know how. Under most other lenses the ability to get your needs met is seen as success. Under the lens of mental health or addiction services this becomes a 'behavioural problem'.
Kyle is non-compliant.	Kyle is choosing not to... Kyle would rather... Kyle is looking for other options.	Describe what it looks like uniquely to that individual – that information is more useful than a generalisation. Does Kyle have the lead in developing any treatment or recovery plans the service initiates?

Worn out language	Language that promotes acceptance, respect and uniqueness	Comments
Megan is very compliant.	Megan is engaged in and working towards the aspirations she has set towards a self-determined life.	Being compliant means someone is doing what they were asked or told to do. The goal of recovery-oriented services is to help the person define what they want to do and work towards it together. Someone being compliant does not mean they are on the road to recovery, only that they are following directions.
Mary is resistant to treatment.	Mary chooses not to... Mary prefers not to... Mary is unsure about...	Describe what it looks like uniquely to that individual – that information is more useful than a generalisation. Remove the blame from the statement.
Anne is treatment resistant.	In partnership, Anne and the service are working towards finding the right strategies to best support her recovery.	Remove the blame from the statement. Describe what it looks like uniquely to that individual – that information is more useful than a generalisation. Never ever give up.
Allie is high functioning.	Allie has many strengths...	Describe what it looks like uniquely to that individual – that information is more useful. High functioning is a loaded term.
Jesse is low functioning.	Jesse experiences challenges in taking care of himself. Jesse experiences challenges in learning new things. Jesse is still early in his recovery journey.	Describe what it looks like uniquely to that individual – that information is more useful than a generalisation. Avoid defining the entire person negatively based on the fact that he (bravely) faces challenges in some areas.
Michael is dangerous.	Michael can become aggressive when he feels distressed and contained. Things that help are... Michael can sometimes strike out at people when he is hearing voices. Strategies to help him manage this are...	Describe what it looks like uniquely to that individual – that information is more useful than a generalisation. Remove the judgment from the statement. Avoid defining the person by the behaviour.
Harry is mentally ill chemically abusing (MICA).	Harry experiences co-existing mental health and substance use problems.	Put the person first. Avoid defining the person by their diagnosis and challenges.
Sam is unmotivated.	Sam is not in an environment that inspires him. Sam is working on finding his motivation. Sam has not yet found anything that sparks his motivation.	Describe what it looks like uniquely to that individual – that information is more useful than a generalisation. Avoid defining the person by the behaviour. Remove the blame from the statement.
Andy is manic.	Andy is experiencing mania currently. Andy hasn't slept in three days. Andy has not slept or eaten in three days and is really busy and energetic.	Describe what it looks like uniquely to that individual – that information is more useful than a generalisation. Avoid defining the person by the behaviour.

Worn out language	Language that promotes acceptance, respect and uniqueness	Comments
Kate is paranoid.	Kate is experiencing a lot of fear that appears to be unwarranted or heightened. Kate is worried that her neighbours want to hurt her.	Describe what it looks like uniquely to that individual – that information is more useful than a generalisation. Avoid defining the person by the behaviour.
Hailey is a cutter.	Hailey expresses emotional pain through hurting herself. Hailey hurts herself when she is upset.	Avoid defining the person by the behaviour. Recognise the reason behind the behaviour.
Jordan has a chronic/persistent mental illness.	Jordan has experienced depression for many years.	Avoid conveying a prognosis. It is difficult to accurately predict an individual's prognosis and it only impedes their progress to define them as someone who will not recover (or will not recover for a very long time). There is no need to address prognosis in describing a group of people or an individual.
Tom is very difficult.	Tom hasn't reached agreement about treatment, plans, diagnosis... I am finding it challenging to work with Tom.	Avoid making a judgment, which may be based on your dissatisfaction with the fact the person has not met your expectations (which may be different from what he wants for himself).
Manipulative Grandiose In denial Passive aggressive Self-defeating Oppositional Lacking insight	The person is trying to get their needs met, or has a perception different from the staff, or has an opinion of self not shared by others.	These labels are often the result of people's attempts to reclaim some shred of power while being treated in a system that often tries to control them. These are labels for strategies and perceptions we all have about ourselves, although possibly more subtle and effective. We all present information to achieve a desired result to some degree (manipulation), or have an inflated opinion of ourselves, or are unable to see or agree with something presented to us by another.

The NZNO Library

Resources For Nurses

NZNO Library

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

Selected Articles: Diabetes; Mental Health

Copies of these articles can be provided to NZNO members free of charge. Email Library@nzno.org.nz to request specific articles, telling us that they are from this LOGIC column.

DIABETES

Butler, Javed. (2017). **Cardiovascular Safety of Medications for Type 2 Diabetes Mellitus**. *Journal of Family Practice*,66(4), pS16-S21

The article offers information on the cardiovascular safety of medications for type 2 diabetes mellitus. Topics discussed include high risk of developing heart failure and heart failure related death in patients with diabetes, and potential cardiovascular benefits gained by lowering glycated hemoglobin.

Daly, B., Arroll, B., Kenealy, T., Sheridan, N., Scragg, R. (2015). **Management of diabetes by primary health care nurses in Auckland, New Zealand.** *Journal of Primary Health Care, 7*(1), 42-49.

The increasing prevalence of diabetes has led to expanded roles for primary health care nurses in diabetes management. AIM: To describe and compare anthropometric and glycaemic characteristics of patients with diabetes and their management by practice nurses, district nurses and specialist nurses.

Diabetes: A ticking time bomb (2017). *Australian Nursing & Midwifery Journal*, 24(10), p22-27.

The article discusses the prevalence of diabetes in Australia and what is being done about it. Topics discussed include the massive change in lifestyle and the risk profile in the country, a National Diabetes Strategy released by the federal government, healthcare costs associated with diabetes and a nurse-led education program in Queensland that is helping women with Type 2 diabetes manage their condition

Higgs, C., Skinner, M., Hale, L. (2016). **Outcomes of a community-based lifestyle programme for adults with diabetes or pre-diabetes.** *Journal of Primary Health Care, 8*(2), 130-139.

Diabetes, a long-term condition increasing in prevalence, requires ongoing healthcare management. Exercise alongside lifestyle education and support is effective for diabetes management. AIM: To investigate clinical outcomes and acceptability of a community-based lifestyle programme for adults with diabetes/prediabetes at

programme completion and 3-month follow-up.

Skolnik, Neil; Jaffa, Florence M.; Kalyani, Rita R.; Johnson, Eric; Shubrook, Jay H. (2017). **Reducing CV risk in diabetes**. *Journal of Family Practice*,66 (5), 300-308

The article presents questions and answers related to changes to the American Diabetes Association (ADA) 2017 Standards of Care aimed to help physicians in their approach to patients who have or at risk for atherosclerotic cardiovascular disease (ASCVD), including the need to routinely screen asymptomatic patients with diabetes for heart disease, the benefits of lifestyle interventions and when to initiate hypertension treatment in patients with diabetes

MENTAL HEALTH

Arroll, B., Chin, W., Martis, W., Goodyear-Smith, F., Mount, V., Kingsford, D., et al. (2016). **Antidepressants for treatment of depression in primary care: a systematic review and meta-analysis.** *Journal of Primary Health Care, 8*(4), 325-334.

Evidence for the effectiveness of drug treatment for depression in primary care settings remains limited, with little information on newer antidepressant classes.

AIM: To update an earlier Cochrane review on the effectiveness of antidepressants in primary care to include newer antidepressant classes, and to examine the efficacy of individual agents.

Bardi, J; Moorley C R. (2016). **Improving the physical health of people with serious mental illness.** *Primary Health Care, 26*(10), 28-33.

Individuals with severe mental illness (SMI) die on average 20 years younger than the general population. The aim of the review was to examine relevant literature on the physical health of those with SMI and identify areas for improvement. Four electronic databases were searched and areas identified included side effects of psychotropic medications, obesity, cardiovascular diseases and diabetes, risky sexual behaviour, poor dietary intake and physical inactivity. The authors conclude that physical care of people with SMI can work well when physical health needs are assessed.

Wheeler, A., McKenna, B., Madell, D., Harrison, J., Prebble, K., Larsson, E., et al. (2015). **Self-reported health-related quality of life of mental health service users with serious mental illness in New Zealand.** *Journal of Primary Health Care, 7*(2), 117-123.

Although people with serious mental illness (SMI) have a high prevalence of physical illness, health-related quality of life (HQoL) has not been sufficiently explored.

AIM: To explore the self-reported HQoL of mental health service users in New Zealand.

NZNO Library

Contact Details

Level 3, 57 Willis Street

PO Box 2128, Wellington 6140

P: (04) 494 8230

F: (04) 382 9993

E: Library@nzno.org.nz

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

23.

NZ College of Primary Health Care Nurses
Award Nomination Form

Tall Poppy Award 2017

The Tall Poppy Award was instigated by Ginny Hinton, an ex-practice nurse, who felt tall poppies were not always recognised. It was a $500 award that Ginny offered for a period of five years. It was then sponsored by Diane Newland for a further period of five years. Diane was also an ex-practice nurse. Jane Ayling (primary health care nurse) will be sponsoring this $1000 award for a period of five years (2015-2020).

The winner of this awards will be chosen from written nominations and will be announced at the respective New Zealand College of Primary Health Care Symposium in Auckland.

The winner will receive $1000 to support further learning and development and is encouraged to write an article for the college journal LOGIC

Do you know a colleague of genuine merit who is elevated above or distinguished from their peers? Nominate such a colleague who has shown leadership and exceptional commitment to patient care, who stands out and warrants acknowledgement and support of their growth.

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

Reason for Nomination

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

Nominee Details

Name as on NZNO membership: ……

Position: ……

Name of Employer/organisation: ……

Employer Address: ……

……

Work phone: …… Email: ……

Nominator Details

Name and position: ……

Name of Employer/organisation: ……

Employer Address: ……

……

Work phone: …… Email: ……

Nominations are to be received by:

5pm Friday 28th July 2017

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

Email or post all documents to:

Vicki McSeveney
Office Administrator
New Zealand Nurses Organisation
PO Box 2128
Wellington 6140
DDI: 04 494 6394
vickim@nzno.org.nz

Reviewed: March 2017	Next Review: 2018	By: Professional Practice Committee

NZ College of Primary Health Care Nurses
Award Nomination Form

Nursing Excellence Award 2017

The winner of this award will be chosen from written nominations and will be announced at the New Zealand College of Primary Health Care Symposium in Auckland.

The winner will receive $1000 to support further learning and development and is encouraged to write an article for the college journal LOGIC

Do you know a colleague who displays excellence in their practice? Is an inspirational leader? Engaged in innovative research? Is an amazing clinical teacher?

Nominate a colleague who warrants acknowledgement and support of their nursing excellence.

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

Reason for Nomination

Please attach a description of how this colleague displays nursing excellence in her/his area of work (up to 500 words). Nomination form and typed description must be emailed or posted.

Reviewed: May 2017	Next Review: 2018	By: Executive Committee

Nominee Details

Name as on NZNO membership: ……

Position: ……

Name of organisation: ……

Address of organisation: ……

……

Work phone: …… Email: ……

Nominator Details

Name as on NZNO membership……

Position……

Name of organisation: ……

Address of organisation: ……

……

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Vicki McSeveney

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vickim@nzno.org.nz

Reviewed: May 2017	Next Review: 2018	By: Executive Committee

Current NZ College of PHC Nurses, NZNO, Executive Committee

Kim Cameron

Kia Ora

You can all call me Kim or Kimmy for short (my sick sense of humor)

I live in Tairawhiti (Gisborne) the first city in the world to see the sun and I am currently working as a diabetes nurse for Hauora Tairawhiti.

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

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

Working on this committee has offered me the opportunity of getting to know and working beside some amazing nurses. This journey has also helped me to gather an array of knowledge and skills and my kite continues to grow fat. I encourage you all to think about joining a College/section or participating on a committee such as the CPHC committee. Hopefully I will get to meet some of you at our skill workshops this year.

Wendy King Secretary

Wendy is a public health nurse working in Thames. Professional interest includes PDRP, succession planning, practice development and public health. Wendy was also a Nursing Officer in the Territorials for 11 years and had a stint in Vanuatu with the New Zealand Defence Force.

Weekends finds Wendy at markets looking for a garden bargain, at a craft fair, or out enjoying the mountains, bush or beaches.

Dhyanne Hohepa

Tena Kotou my name is DhyanneHohepa and my tribal affiliations are Ngati Raukawakiwharepuhunga, Ngapuhi, TeArawa, NgatiTuwharetoa and Tainui, I currently sit as the vice-chair of the National Executive of the NZCPHC with a fantastic group of nurses. I graduated in 2007 with a bachelor of health science (nursing) and began my career as a practice nurse within an iwi provider based on a Marae. I then moved into the department of corrections working as a staff nurse where i also completed my Masters of nursing, where my dissertation looked at the health impact of methamphetamine on New Zealand Maori. My passions are Te Reo Maori and Kapahaka, Maori health, Primary health care and the further development of the Maori nursing workforce.

MARYLINDA [MERE] BROOKS

Ko Taranaki te Maunga

Ko Waingongoro te Awa

Ko Okahu/Inuawai nga Hapu

Ko Aotearoa te Marae

Ko Tauke teTangata

Ko John Kerehoma toku Matua

Ko Gloria Reihana Laison toku whaene

Tena ra koutou katoa

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

Mere has been working in nursing and health since 1988 in many and varied roles. Her passions have led to many years involved in Maori communities, as a health advocate, and as part of her Marae, Hapu and Iwi affairs.

Having recently relocated to Christchurch and now working for corrections, Mere continues to work in challenging environments highlighting parallel needs and health pathways for some very vulnerable people.

Nga mihi aroha ki a koutou

Yvonne Little

I live in sunny Hawke's Bay and work as a Nurse Practitioner, Primary Health Care Across the Lifespan, across two practices (rural and urban), enjoying the flexibility and interesting cases across both sites.

My other roles include being current Co-Editor on the LOGIC journal and part of the NZCPHN Executive, this year taking up the NZCPHCN representative role on the National Cervical Screening Advisory Group.

Outside of work and NZCPHCN obligations I have an eclectic collection of hobbies and enjoy spending time in my garden, with family and friends.

Kim Carter

Kim works in a semi rural general practice that she co-owns. She has been working in general practice for 10 years having previously held several DHB leadership positions.

She loves the mix of clinical activities, the longevity of relationships with her practice population and the chance to work with people as a generalist to affect change through the lifespan. Kim cares deeply about the professionalism of nursing and enjoys working with the College Executive to advocate for and represent nursing at a national level.

In Kim's spare time she milks dairy goats and lives on a lifestyle block with chickens, dogs, cats and sheep.

Kate Stark

Kate is a Nurse Practitioner Candidate working in primary health care within an integrated health centre in the rural area of Gore. She also works as PRIME Practitioner (Primary Response in a Medical Emergency) in Central Otago and West Otago in the rural towns of Roxburgh and Tapanui. As well as being on the National Executive for the College of Primary Health Care Nurses, Kate is Co-Editor of the journal LOGIC. She is the liaison person between the College and the New Zealand Rural GP Network and is also on the National Cervical Screening Advisory Board as the CPHCN Representative.