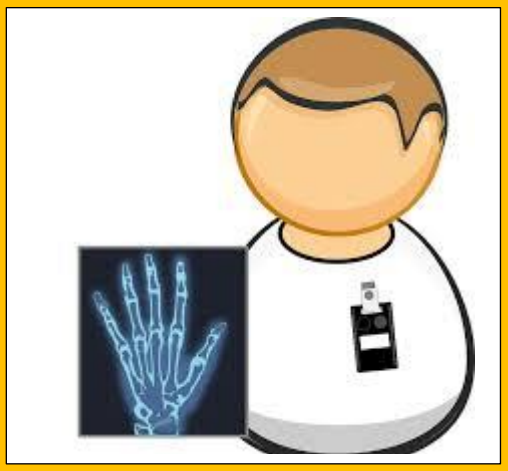
LOGIC

LINKING OPPORTUNITIES GENERATING INTER-PROFESSIONAL COLLABORATION

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

Vol 17 No 1



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

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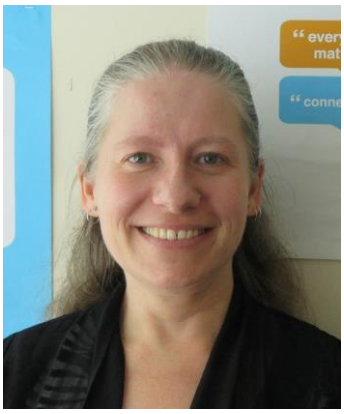
In this issue….

Chair's Report



Celeste Gillmer
Chairperson

Tena Koutou katoa

The leaves are turning golden and red and Easter was already celebrated – 2018 is definitely going past in a blink of an eye.

Nurses said no to the new DHB MECA proposal, there are talks of a Primary Health Care review and Jane O'Malley has resigned as the Chief Nurse. 2018 will be a year of change.

Make sure your voice is heard…don't sit back and watch what happens to nursing (in Primary Health Care in specific) – take part actively, stand up for what you believe in. Stand up for nursing and safe staffing levels. Stand up for being able to work and care as a nurse. Everyone Matters!

As I realise that while time is flying past, we need to reflect on what we, as the NZ College of Primary Health Care Nurses, aim to achieve in 2018.

The Objectives of the NZ College of PHC Nurses, NZNO

- **Organisational:** To be acknowledged as a representative advisory structure for PHC nurses within the NZNO maintaining accountability and transparent processes
- **Leadership**
  To be the lead consultant for PHC nursing
- **Social**
  To strengthen PHC nurses to honour and implement New Zealand's Te Tiriti o Waitangi; to foster PHC nurse's professional responsibility to address health inequalities, to demonstrate partnership, advocacy, and equity with individuals, whanau, communities, and intersectorial agencies.
- Encourage development of PHC Nurse members

NZ College of PHC Nurses, NZNO - Aims for 2018:

<u>NZ PHC Nursing Knowledge and Skills Framework:</u>

The NZ Primary Health Care Nursing Knowledge and Skills Framework is a Joint Venture between MidCentral District Health Board, the New Zealand Nurses' Organisation and the College of Primary Health Care Nurses. The Framework is intended to provide support for best practice by primary healthcare nurses and used alongside other national guidelines and standards of practice.

<u>Primary Health Care Review:</u>

The NZ College of PHC Nurses will aim to be a main representative for PHC nurses across New Zealand for this work to be completed by the Ministry of Health.

Strengthen Regional Activities & Professional Development:

Instead of a formal conference, the College will have an event in Christchurch this year (August 2018) to strengthen our regional networks there. This event will focus on national activities by the Ministry of Health and Nursing Council of New Zealand which will have an impact on Primary health Care Nursing across New Zealand.

Increase visibility across the sector – LOGIC & eNewsletter

The College's electronic journal, LOGIC, will continue to be available on the website in electronic format: https://www.nzno.org.nz/groups/colleges_sections/colleges/college_of_primary_health_care_nurses/logic_journal

This year the College will also start an electronic newsletter to keep members updated on activities across the sector, including consultations on documents and regional events.

Please recommend to all your colleagues to visit our website for further information and to join the NZ College of Primary Health Care Nurses: https://www.nzno.org.nz/groups/colleges_sections/colleges/college_of_primary_health_care_nurses/join_us

Enjoy the April holiday break and all the best for the next couple of months!

Tena Koutou tena koutou tena koutou katoa

Ehara taku toa, he takitahi, he toa takitini

My success should not be bestowed onto me alone, as it was not individual success but success of a collective

A special thank you and acknowledgement to all the members of the NZ College of PHC Nurses, all the committee members and all my health care colleagues and friends. No matter how small your acts, you all make a difference to the health and wellbeing of all New Zealanders.

Chief Nurse's Report

Jane O'Malley
Chief Nurse

Tēnā koutou katoa. This will be my last contribution as the Chief Nursing Officer (CNO). Before reflecting on the achievements of the past seven and a half years I want to express my utmost admiration and gratitude for the work you do in primary health care. Thank you.

When I first started as the CNO there were a number of workforce challenges. Notably, it was difficult to say where the new graduates were going and how many were getting jobs. There were also significant barriers to practice that held nurses from working to the full breadth of their scope.

The review of primary health care this year will, I predict, usher in new models of care and start to address the ideal of 'unleashing the potential of nurses'; not a new idea of course. The work has been done to prepare the workforce and change the legislation and regulation to more fully utilise nurses.

Noting that very little can be done from the centre, I have relied heavily on sector colleagues for strategy and action. An important part of working with the sector has been the National Nursing Organisations' group (NNOgroup); the peak nursing body where policy (CNO, Ministry of health (MOH)), professional regulation (Nursing Council of New Zealand), education (Nurse Educators in the Tertiary Sector; Council of Deans), employment (District Health Board Directors of Nursing; Nurse Executives of New Zealand) and the professional bodies (New Zealand Nurses Organisation; College of Nurses Aotearoa; Te Kaunihera o Ngā Neehi Māori o Aotearoa; Te Ao Maramatanga) have worked together to make decisions and set the strategic direction.

The introduction of the Advanced Choice of Employment (ACE) has provided data to support employment of new graduates and steady progress in growth of the Maori, Pacific and primary care nursing workforces. Health Workforce New Zealand (HWNZ) forecasts the nursing supply to keep pace with the population growth out to 2025 and the nursing workforce to change from an aging to an increasingly more 'youthful' one. In 2016 the majority of nurses were in the 40-59 and 20-34 age group. By 2026 it is predicted that there will be equal numbers of nurses in all age groups with the majority in the 20-44 year bracket.

Removal of historical legislative and regulatory barriers preventing nurses from working to the full breadth of their scope has been a significant step and has paved the way for future

models of care enabling improved access to people. Its impact will be immense.

- The HPSR, enacted on January 31st will enable suitably qualified health professionals, particularly registered nurses and nurse practitioners, to do things formerly only able to be done by doctors: death certification; fitness to drive; sickness certification; prescribing for opiate addiction and more.

- Nurse prescribing has progressed significantly in the past year, primarily the work of Nursing Council of New Zealand and supported by the sector.

- Enabling nurse practitioners to issue standing orders has paved the way for accelerating the work of registered nurses and nurse practitioners to provide greater access and better utilise the nursing workforce.

The critically important work of improving Māori health outcomes can be supported by a priority to support and grow the Māori nursing workforce. This work, in partnership with the sector, MOH Maori Leadership and HWNZ, is being led out of the Office by our newest Senior Advisor Ramai Lord.

Last year New Zealand nursing and health leaders formulated a strategic direction to guide nursing into the future and assist change. It's quite simple and yet very powerful and comprises three key pillars: partnering with consumers; strong leadership to ensure this truly happens; and working with nurses to assist them make the changes to embrace future work.

I will be taking these three things with me to my new role as Chief Nurse at Plunket and look forward to hearing of the work you do to move this important agenda forward. Key will be making sure nurses are in the right place, with the right attitude and authorised to fully utilise their knowledge and skills.

Ngā mihi nui ki a koutou

The NZ College of PHC Nurses wishes Jane all the best in her new role and would also like to acknowledge her contribution towards nursing throughout NZ.

Editor's Report

Yvonne Little

Nurse Practitioner

Welcome to the first edition of LOGIC for 2018. We hope you all had some rest and relaxation with family and friends over the holiday period. It is hard to believe at the time of writing this that we are now a quarter of the way into the year.

It's time to reflect – who are Primary Health Care Nurses (PHC), are we generalists or are we specialists? I believe we can claim to be in both camps, we have a wide range of general health knowledge across the Primary Health Care Sector but many of us have the specialist knowledge that goes with our areas of special interest. Hence, our regular articles each issue and our themed articles which in this issue are: Orthopaedics, Musculo-skeletal and Traumatic Brain Injury, excellent reads all of them.

Which is why this year our aim at LOGIC is to bring you a variety of interesting articles from a wider range of writers/authors, both with a specialist and generalist focus.

The sidebar here shows the themed articles planned for each issue which reflects a specialist interest but we do not intend to be an academic journal so to add diversity to LOGIC we welcome articles from any of you (our members), written in the style that suits you – for some this will be an academic style whilst for others (myself included, despite the years at University) it will be more of a reflective story style.

As PHC nurses we are spread far and wide across New Zealand, for those in urban areas access to colleagues and education is perhaps easier than for our hardy rural nurses who often work in isolation in some of those hard to access parts of our beautiful country. I may be wrong here and if so I would love to hear your stories.

We at LOGIC would like to be able to bridge the gap a little by providing access to articles of interest and connecting PHC nurses across the country. Networking is the way forward, and as it is often hard to get time off to go to conferences/symposiums and the like, LOGIC along with our NZCPHCN website could provide that conduit to connectivity.

None of us need to reinvent the wheel in our "own little part of NZ", there may be an area/s where nurses are struggling to find a solution to a problem, you may have the answer or part of the answer to help your colleagues, so why not share your innovative ideas or projects – we can be the meeting point, so why not (I was about to say put pen to paper – age showing here oops) put fingers to keyboards and contact a member of our LOGIC committee with an article or an article idea that you would like

help to put together and we can help you. Our contact details are at the front of each issue.

If you know of any nurses out there who are PHC nurses who for whatever reason are not accessing LOGIC online – please send them the link or get them to contact NZNO to make sure they are linked under PHC nurses.

In this issue we have the final report from our departing Chief Nurse, Jane O'Malley. It has been a pleasure working with her over the years and she will be missed in this role, but I do intend keeping in touch with her in her new role with Plunket and am hoping that we may still be seeing some reports from her albeit from a slightly different sector. I wish Jane all the best in her new role. In the interim, for the next couple of issues at least we will be getting our Office of the Chief Nurse report from the brilliant mind of Jill Clendon.

Please also keep an eye on this and the June issue and our NZCPHCN website for information about upcoming events, our National Executive Committee are currently working to bring you a meeting later in the year, which is planned at this stage for Christchurch. There will be award nomination forms appearing also, so get those in as soon as you see them, the more entries the better.

In August, we will have some positions on the committees becoming vacant due to current members finishing their terms of office – please think about this and feel free to talk to any current members about what being on a committee involves, then sign up to come and be part of our dynamic team of nurses at NZCPHCN.

Yvonne

June 2018

- Respiratory across the lifespan
- Diabetes
- Nurse Prescriber
- Cultural
- Rural Muster
- Immunisation

September 2018

- Teleheath (general & dermatology)
- EHealth
- Apps
- Diabetes
- Nurse Prescriber
- Cultural
- Rural Muster
- Immunisation

December 2018

- Party Health
- Well Being and prevention
- Sun Protection
- Diabetes
- Nurse Prescriber
- Cultural
- Rural Muster
- Immunisation

Professional Practice Happenings – February 2018

Cathy Nichols,

Professional Practice Standing Committee Chairperson

Members of the Professional Practice Committee met in Wellington on 23 February.

- The Primary Health Care Knowledge and Skills Framework (K&SF) consultation process has been completed. Feedback reinforced the notion that PHC is an umbrella term for a wide variety of practice settings in the community. The K&SF document needs to be an overarching guide to the type of skills a PHC nurse would need, allowing clinical leaders to provide specifics for their area of practice.
- The review of the Electronic Resources document is due to be updated onto the College website by the end of April 2018.
- Work is progressing on updating the "Maximising the Nursing Contribution to Positive Health Outcomes for the New Zealand population" this will go out to the membership shortly for consultation.
- Health Workforce New Zealand. A link has been added to the College webpage under the 'Resources' tab. If wondering how to access nursing education funding for the NETP or post-graduate studies check out this page, with a list of all the DHB co-ordinators.
- The survey monkey is due out very soon, preliminary discussions have begun on a proposed regional network meeting in Christchurch on 23rd August. Those in the greater Canterbury area mark the date in your diary now.

The Survey Monkey is currently live!!! Please complete it online to have your say. Link available on the NZ College of PHC Nurses website.

RURAL MUSTER #6

Kate Stark – Nurse Practitioner

Welcome to 2018!

Welcome to the first Rural Muster for 2018. It is fair to say that many areas across New Zealand have experienced one of the warmest Januarys on record. While we attempt to make the most of what has been an unreal Summer, those living rurally appreciate the challenges that accompany this dry weather. Pressure on rural people physically and emotionally has been at a premium with water shortages, fires secondary to the dry, difficulties feeding and watering farming stock, alongside difficulties working in extremes of heat.

In Southland, and I know this occurred in other areas, we experienced plummeting temperatures from mid 30's to temperatures between 9 and 12 degrees, accompanied by a deluge of rain and floods, all within the space of 24 hours. The rain was welcomed by farmers and fire fighters in particular, but simultaneously caused havoc with road closures, collapsing bridges and landslides in places. Mother nature appeared to be working overtime, and although once again our weather forecasters were amazingly accurate, roading and weather conditions impacted greatly on already stretched emergency services creating extreme challenges that rural areas are known for. Sometimes it's hard to plan for this.

One thing that seems to always be with us in rural, is the challenge of transporting people to accessible health care. Forward planning and having a disaster plan in rural New Zealand, one that will fit with both extremes of hot and dry, cold and wet weather appears to be more and more essential these days. Many rural areas have activated their disaster plan this year already and simultaneously demonstrated their ability to work together in drastic times. This was highlighted in a recent article that featured in The NZ Doctor, showing the West Coast in crisis, but pulling together to get through. This is a true characteristic of rural communities and long may this last.

National PRIME Committee

The National PRIME Committee has met since my last column and this is looking really positive going forward. Key focuses will be to actively address funding concerns while also implementing the recommendations from the

PRIME Review held in 2017. We must be patient as this is a large job that is well underway. It requires consideration of a multitude of factors that impact on all rural areas and practitioners in New Zealand who deliver the PRIME service. There is broad and appropriate representation across disciplines from the North and South, led by Tim Malloy who is passionate and experienced and has previously been known affectionately as 'the grandad of PRIME. So we are in good hands and have every reason to remain positive for great outcomes in time.

National Rural Health Conference

Time is ticking along and we are only just over a month away from the NZ Rural Health Conference for 2018 to be held in Auckland. Undoubtedly there will be, as usual a noticeable representation from nurses from rural New Zealand. This time last year, we met in Wellington and introduced the idea of a national group for rural nurses while this year we celebrate the formalisation of this initiative!

Many of you will be aware that Rural Nurses New Zealand (RNNZ) was formed in 2017 and you may remember in my December issue of Rural Muster, we featured bios of those on the committee as an introduction to the group that was voted on by rural nurses, for rural nurses. There will be an opportunity to meet those involved on the committee and we are always open to hearing the ideas of rural nurses. We encourage you to tell us what you want from your national group.

It's been a huge 12 months for RNNZ who have met regularly by zoom video conference and will meet face to face for the very first time at conference. So far RNNZ has developed a Facebook page, on which can be found its vision and mission statement. RNNZ has also positioned themselves as a sub group under the Rural General Practice Network and we are extremely grateful for the RGPN support we have received to date.

RNNZ is passionate about ALL rural nurses regardless of your expertise, whether it be primary, secondary care or community, we want you to be part of this journey. The group also has protected time set aside with educational opportunities for rural nurses and most importantly time to network. Details of this once finalised will be available on the conference programme. The RNNZ Committee will be clearly identifiable at the national rural conference this year and hope that you as rural nurses will make yourself known to the committee members. We look forward to meeting you all.

NZSSD

Annual Primary Care Study Day

Tuesday May 1, 2018

Distinction Hotel, Hamilton

8:30 – 4:30

"Topical issues in primary care diabetes"

Programme includes: ***subject to change***

Welcome Plenary - Brandon Orr Walker, President, NZSSD

Effects of Nurse led clinics on HbA1c

Diabetes and Kidneys

Vascular disease and diabetes

Communication/Motivation

Type 2 diabetes and youth

Closing Plenary - Professor Lori Laffel - Harvard School of Public Health

Further information and registration details can be found on the website

Or type this address into your browser https://www.ivvy.com.au/event/akB118

Convenor - Kate Smallman

Conference Manager - Ali Copeman - akB Conference Management Limited 03 4745165 ali@akb.nz

Tāne Tatiku Ake (Men standing together) Testimonials

In the December issue of L.O.G.I.C., Tim Ryan wrote about the work of the Tāne Tatiku Ake (Men standing together) innovation program in Rotorua. Now, with the consent of the participants, we present 3 testimonials, in their own words, from men who have experienced this program.

Testimonial 1

My story begins at the end of my sentence. I had just been released from Springhill prison and was standing at the bus stop with my $350 'steps to freedom' chit, feeling bewildered and afraid. It's quite surreal having been in a highly regimented and organised environment, and then suddenly finding yourself standing in the street where every temptation is only a block away.

I hadn't realised the emotional toll that prison life had taken on me until I was out and I arrived home to Rotorua a broken man. My immediate thought was to get trashed so that's exactly what I did. I don't remember much about the next couple of months except that I lived in a haze of alcohol, isolating myself, not answering the phone or the door or even opening the curtains.

One fortunate event had happened for me, although I didn't know it at the time, and that was that the prison had referred me to the local mental health centre to visit with a psychologist. He encouraged me to get out of the house, first just to attend appointments, and then to re-apply for my drivers licence, which I had lost indefinitely, and also to take part in a group, run by the Korowai Aroha Health Centre and known as the Tane Takitu Ake programme.

The psychologist didn't tell me that one of the prerequisites for re-applying for my licence was that I had to stop drinking!

With that crutch gone, I did as I was told and started attending the programme. At first, sitting in a room with a group of men didn't have much appeal for me so soon out of prison. However, I eventually began to notice that I was actually looking forward to these sessions and what I was being taught. Through sessions pertaining to nutrition, the prevention of cancer and diabetes, gathering food in the ngahere and paddling waka out on the lake, I was learning to take responsibility for myself, my health and how I could achieve a more healthy lifestyle.

I was beginning to gain a bit of self-confidence by sharing within the group and hearing the sound of my own voice in this type of setting and then sharing what I had learnt with my partner, who, luckily for me, had stood by my side. I was learning about my Maori side which I had neglected over the years and my sense of pride in being 'who I was' began to return.

Eventually, everything that I had learnt began to rub off onto my partner and she is now actively participating in our healthy eating kaupapa in the house which has also been to the benefit of our mokopuna who we look after.

Since the programme has ended, I have undertaken study in the field of Maori health and Mental Health and Addiction. In 2018 I intend to continue studying. Tane Takitu Ake introduced me to the gym and I continue to exercise while my partner has become an avid gym member and goes religiously every day. I am actively seeking to gain employment in the health industry although I have suffered many setbacks due to my criminal history. In the past these setbacks would have been enough to have made me give

up, but these days, thanks to Tane Takitu Ake, I am made of sterner stuff and my quest goes on…

Testimonial 2

My name is P.K, I'm a mature male Maori aged 47 currently living in Ngongotaha, Rotorua, this is about Tane Takitu Ake (T.T.A) Standing together as Men.

Near the end of 2016 I had a few events that changed my life forever! Personal issues, poor diet and next to no exercise leading to Deep Depression, it wasn't good at all! needed to do something! I was referred to Tane Takitu Ake (T.T.A) course run by Korowai Aroha - Health Centre in Rotorua, I went to my interview Koro Wai and spoke to "Otts" "Stormy" & "Tim" T.T.A course facilitators they made me feel Welcome, they explained to me what the course was all about, let the healing begin starting, January 2017 this is my journey, Dealing with deep depression wasn't easy at all! It was affecting everything connected to my life, the first week we did our "Obs" with "Tim" the biggest concern was Dealing with depression, I weighted 136kgs, high Blood sugars 13.5 levels pre Diabetes, everything else seemed to be fine, Over a 10 week T.T.A course or learning to Exercise safely, Healthy Eating, Cancer education, Looking after your Heart, Team Building Activities, Learning more about our Māori culture, Waka huia, better physical, spiritual, mental, emotional health and how it all connects Us.

After 10 the weeks T.T.A course we did our second "Obs" My weight was down to 126.5kgs and my blood sugar levels were 8 almost back to normal, great results. I found the TTA to be very beneficial for men's Physical, Spiritual and mental health, showing other men that were not alone, giving us the tools to deal with day to day issues, being a better Partner, better fathers, better role models. As I continue my Journey with Waka Huia, Martial Arts and new-found T.T.A brothers, equipped with the new tools to navigating life, in a way better Physical, Spiritual and Mental health way! This course is badly needed by all men needing support, I highly recommend Tane Takitu Ake (T.T.A) Program to all Brothers in need of further Help, thank you for your time and listening to my short story.

P.G.Kaiwai

Testimonial 3

Lester story 1

Tama (not his real name) has lived in Rotorua for the past 24 years after relocating from outside of the region. He has three girls aged 18years, 10 years and 5years old. Tama's partner works as a social worker.

Tama was referred to the Tāne Takitū Ake program from the asthma nurse at Korowai Aroha. A chronic asthmatic for most of his life and a heavy smoker, the asthma got worse as he got older. Tama use to work at a local sawmill, but the work environment was not conducive to his health and his doctor advised him to give up the job as it aggravated his asthma.

Tama was nervous at first in joining the program as he was unsure if he would 'be judged by his size and how he looked'. But once he got into it, any apprehension was soon dispelled. Tama was driven by the desire to get healthier, and to be around family more.

"I want to see my 5year old have her 21st..... I want to be able to do more things with my family"

Tama thrived on the program achieving a 100% attendance rate at all sessions of the program. He lost 5kgs and 2cm around his waist while on the program. His blood pressure had returned to a normal level after having high blood pressure for the past 4.5years. Tama attributed the health gains on changing his diet and more regular exercise.

"my whānau has seen big changes in me.... I have more energy to run after my kids now... my peak flow has gotten better"

"Our household has started eating more healthier, we have added a salad..."

The program has helped Tama's confidence and motivation. Tama commented that he has become more outspoken and more active doing things that he'd never do previously.

"It's opened my eyes up, I communicate better now and I feel good about myself"

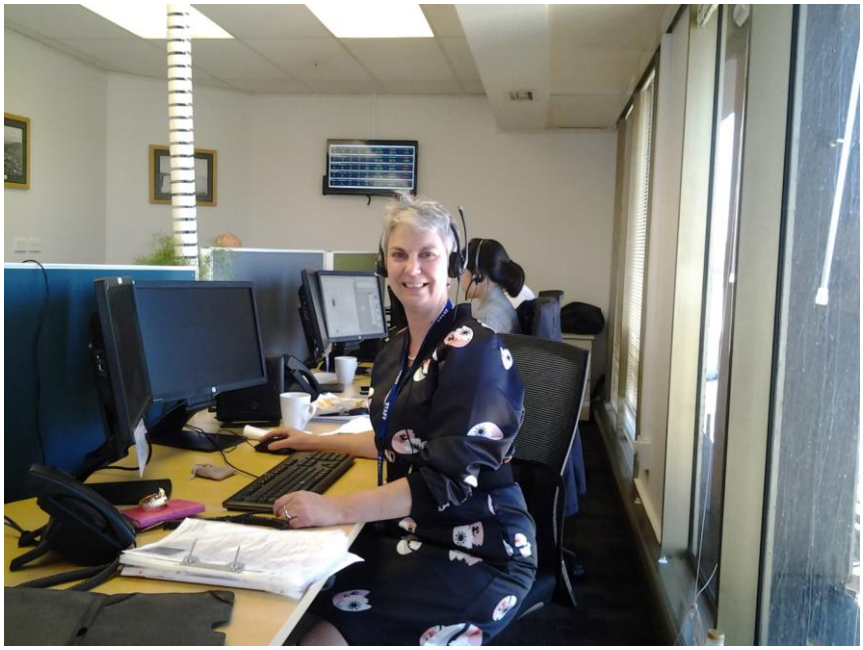
The Aikido sessions stimulated Tama's interest and provided inspiration to keep going on the program.

"I did martial arts as a kid, the [Aikido] reminded me about being disciplined and gave me a push to do things myself"

After completing the program, Tama remained actively involved in mentoring other tāne during the gym sessions. He has become an ambassador for the Asthma Foundation as a motivational speaker. Six months later, Tama has lost a total of 20kg and a further 6cm in his waist. He continues to go the gym on a regular basis.

The doctor has given Tama clearance to go back to work. Tama has since found an interest in helping others. He is currently completing his social work studies and hope to one day work in the prisons. The program has made Tama more resilient and determined to succeed.

The experience of being a telehealth triage nurse



Pip Carter is an RN with 26 years of experience having worked in hospital, prison, mole map service, public health vaccination and telehealth triage roles.

HomeCare Medical is New Zealand's National Telehealth Service provider. For more information see their website: http://www.homecaremedical.co.nz/

I am an experienced Telehealth Triage Nurse. I work in the nursing team at Homecare Medical who run a range of national telehealth services offering free health, mental health and addictions support and also clinical support for General Practices after hours.

During a shift, I deal with calls regarding anything and everything about health, the variety is amazing. My job satisfaction is high as long as staffing levels are appropriate and almost every caller I feel I've been able to assist in some way. I work in a health call center, however, some of my colleagues work out of their own home offices.

TYPE OF WORK:

Telephone triage and health advice is accessible to anyone in New Zealand via a free 0800 service which is also available to cellphones. Occasionally, the service is accessed from boats via ship to shore radio or Skype.

Patients or someone with them rings directly and the service can be very useful for a variety of reasons including for those on home detention. The service covers New Zealand jurisdiction only, however callers occasionally ring from overseas. These callers are advised to access healthcare in their current country of residence as our nursing registration is New Zealand specific.

There is much variety in the telehealth role. Enquiries can range from: pre-and post op issues; medical problems; injuries; seasonal problems such as sunburn and flu; elderly people's issues; pregnancy; sexual health; mental health……you name it, I've taken calls about it! I also work on other specific "lines" in the same tele-triage role, for example, "after hours" General Practice care co-ordination; and Elder Abuse Response Service.

HOW:

I use sophisticated telephony systems and internationally used triage software applications which means I am on a phone and a computer simultaneously. Consent is obtained from the patient to assess their situation and we have emergency procedures to follow as indicated.

Telephone triage provides helpful solutions for people who might otherwise have needed to travel for assessment or wait until their general practice clinic opens. An interpreter service is also available to triage nurses 24 hours a day which is useful as non-English speaking tourists visiting New Zealand often ring for advice or assistance in locating healthcare facilities.

At the beginning of an encounter, I can usually develop a rapport with my caller within a few words by utilizing communication skills, engagement techniques and adapting my approach to their individual needs.

My clinical judgement and decision making as well as the triage software enables me to inform the caller what level of care the patient requires based on the information obtained during the assessment. I can conference through to ambulance, on call doctors, prime nurses, midwives, mental health services, Plunket, poisons services or others as required.

CALL CENTRE:

The telehealth service office provides great collegial support for general and mental health nurses and affiliated health workers such as counsellors. After years of wearing uniforms in nursing I love to dress up now!

WORK FROM HOME:

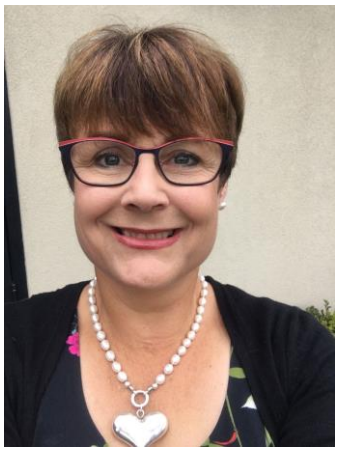
Working from a home-based office is a convenient option for telehealth nursing. There are no travel or transport issues and colleagues tell me they can work more easily around their lives and pick up extra shifts if required or wanted.

HomeCare Medical works hard to ensure staff working from home feel connected to their teams and other staff on their shifts. Telephony group conferences or chat rooms can help with this and are a good means of virtual communication. A shift leader Senior Nurse or Team Manager is available 24 hours a day to support staff whether they are working from home or in the call center office.

In summary, telehealth triage nursing isn't for everyone and nurses require a variety of prior clinical experiences as they rely on accomplished listening and probing assessment skills. However, in this role, I feel I am a valuable resource and support to patients and my hospital and primary care colleagues.

STATINS and MUSCLE PAIN

Karen Kennedy



Karen is a clinical advisory pharmacist and community pharmacy owner, who also works in general practice and locums for hospital pharmacy. She leads education for the pharmacists in her region. She is a member of the South Island (SI) Health of Older Persons Service Level Alliance and SI Palliative Care Workstream and sits on the Clinical Board for SCDHB. She has a Diploma in Pharmacy and a Post Graduate Diploma in Clinical Pharmacy.

Introduction

Statins are prescribed in New Zealand as first-line medicines to lower lipids for the primary and secondary prevention of cardiovascular disease (CVD) (Scott 2017). They inhibit 3-hydroxy-3-methylglutaryl-coenzyme A (HMGCoA) reductase preventing the formation of cholesterol. While statins are generally well-tolerated, adverse effects and in particular, muscle-related symptoms, contribute to non-adherence and a lack of long-term persistence in taking statins. Evidence has shown 5%-20% of patients stop taking statins due to unacceptable adverse effects. (Sweidan 2017). This increases CVD risk with the associated increased risk of morbidity and mortality (Jacobson 2017; Pirillo 2015).

Myalgia

Mild to moderate myalgia (muscle pain and weakness with little or no creatine kinase (CK) elevation) is the most common statin-associated muscle symptom experienced by 7 to 29% of people as observed in practice (Jacobson 2017; Stroes 2015). This is higher than the incidence of SAMS observed in clinical trials, likely due to the selection process used for participants with exclusion of people with increased risk for muscle symptoms including older people, people with comorbidities, people with a history of muscle symptoms and people who showed muscle symptoms during a run-in period of the trial (Jacobson 2017; Pirillo 2015; Stroes 2015).

The higher incidence of SAMS observed in practice compared to clinical trials may also be due to the muscle side effects being a result of another factor and not caused by statin use. The true incidence of myopathy due to statins is difficult to determine as the background rate of muscle symptoms in the general population is high (Jacobson 2017). A nocebo effect is also thought to play a part with patients more likely to report muscle-symptoms due to media reports of statin side effects or if they have been informed by their doctor or another person that muscle symptoms are a possibility (Jacobson 2017; Stroes 2015). A withdrawal of the offending statin and a re-challenge can help to determine if the statin is the precipitating factor (Stroes 2015).

Myalgia may present as muscle pain, stiffness or cramping, tenderness, heaviness, aching or weakness. Weakness can occur without pain and people may experience this as finding it

Muscle Condition	Symptom	Incidence
Myalgia	Muscle pain, cramping, weakness and little or no CK elevation (Pirillo 2015)	Experienced by 7-29% of patients in practice (Stroes 2015)
Myositis	Muscle inflammation with elevated CK >10x ULN (Pirillo 2015)	1 per 1000 to 1 per 10 000 people per year) (Stroes 2015)
Autoimmune Myositis	Progressive symmetric weakness, elevated CK >10x ULN, necrotizing myopathy on muscle biopsy, and the presence of autoantibodies to HMGCoA reductase (Sweidan 2017)	Uncertain but approx. 2-3 per 100 000 people (Sweiden 2017)
Rhabdomyolysis	Break down of muscle cells that can lead to acute kidney injury. CK >10 x ULN with symptoms of kidney injury e.g. myoglobinuria or CK >40x ULN (Pirillo 2015)	1 in 100 000 per year (Stroes 2015)
Asymptomatic CK elevations	No muscle symptoms; CK <4x ULN (Pirillo 2015)	

Table 1 Statin Associated Muscle Symptoms

CK: Creatine kinase; ULN: upper limit of normal

difficult to stand up from sitting or to open a jar (Best Tests 2014; Stroes 2015). Large muscles are usually involved such as the buttock, leg, calf and back with symptoms often presenting symmetrically, but they can be localized. '(Stroes 2015). People may be able to tolerate these symptoms or they may impact significantly on their lives resulting in non-adherence.

SAMS usually appear early in treatment in the first 4 to 6 weeks (Stroes 2015) to 6 months of starting a statin (Best Tests 2014). Typically, SAMS will appear around the 3 month mark (Scott 2017). However, SAMS can present years later, especially if there has been a dose increase or a new medication has been started that may interact with the statin (Stroes 2015).

Statin	Major Metabolic Pathway	Effect on P-Glycoprotein (drug transporter)	Lipophilicity	Drug Interactions with CYP3A4 Inhibitors and Management Strategies		
				*Potent CYP3A4 Inhibitors	**Moderate CYP3A4 Inhibitors	***Minor CYP3A4 Inhibitors
Simvastatin	CYP3A4	Inhibitor	Lipophilic	Contraindicated. Use alternative or temporarily stop simvastatin while taking course of potent CYP3A4 inhibitor	Do not exceed 20mg of simvastatin per day	Case reports of rhabdomyolysis. Use with caution. Monitor for SAMS
Atorvastatin	CYP3A4	Inhibitor	Lipophilic	Avoid if possible or if combination is required, use with caution & monitor for SAMS	Use with caution. Monitor for SAMS	Interactions are not clinically significant
Pravastatin	Sulfation	-	Hydrophilic	Use with caution with CYP3A4 Inhibitors as there are case reports of rhabdomyolysis		
Rosuvastatin	CYP2C9, CYP2C19	-	Hydrophilic			

Table 2. Properties of Statins affecting SAMS. Adapted from: (Best Tests Team 2014; Pirillo 2015; Scott 2017)

***Potent CYP3A4 inhibitors:** ciclosporin, macrolide antibiotics (erythromycin, clarithromycin), azole antifungals (itraconazole, ketoconazole), protease inhibitors (ritonavir, telaprevir, boceprevir)

****Moderate CYP3A4 inhibitors:** Calcium channel blockers (diltiazem, verapamil, amlodipine), amiodarone, nicotinic acid >1g/day

*****Minor CYP3A4 Inhibitors:** Azithromycin, roxithromycin

Myositis and Rhabdomyolysis

More rare but serious SAMS include myositis (muscle inflammation) and rhabdomyolysis (break down of muscle cells that can lead to acute kidney injury) which present with severe muscle pain. Significantly elevated CK is observed in these conditions with damaged muscle releasing this enzyme (Pirillo 2015; Sweidan 2017).

A very rare necrotizing myositis that is autoimmune–mediated can also be caused by statins. The symptoms are progressive with weakness, high elevations of CK and the presence of autoantibodies against the HMGCoA reductase enzyme which statins target for their lipid-lowering effect (Pirillo 2015; Sweidan 2017). Unlike myalgia and non-immune myositis induced by statins, autoimmune myositis does not resolve on stopping statins and can continue to progress. Immunosuppressant therapy is required (Sweidan 2017).

Risk factors for SAMS

a. Statin properties

A number of factors can increase the risk for SAMS including the properties of the different statins. Lipophilic statins (atorvastatin and simvastatin) have a higher risk for myopathy as they penetrate more easily into muscle cells than hydrophilic statins (rosuvastatin and pravastatin) to affect the function of the mitochondria. High doses of

statins and the way a statin is metabolized can also increase risk of myopathy (Pirillo 2015).

A person with high CVD risk being treated aggressively with a high dose and high potency statin is therefore more likely to experience muscle side effects (Pirillo 2015).

b. Concomitant Drugs

Serious drug interactions can occur between statins and other drugs that induce or inhibit drug transporter systems and statin metabolism via Cytochrome P450 (CYP) isoenzymes in the liver. (Table 2) When statin metabolism is inhibited by a concomitant drug, blood levels of the statin increase and therefore increase risk for SAMS. Conversely, if the metabolism of a statin is induced (increased) by another drug, then blood levels will be lower and higher statin doses may need to be used (Pirillo 2015).

Simvastatin is largely metabolised by CYP3A4 in the liver. Interactions of simvastatin with potent CYP3A4 inhibitors (e.g. ciclosporin, macrolide antibiotics (erythromycin and clarithromycin) azole antifungals (e.g. ketoconazole and itraconazole) and protease inhibitors used for hepatitis C and HIV (e.g. ritonavir, telaprevir, boceprevir) can cause myopathy and rhabdomyolysis and are contraindicated. If a person needs one of these medications and there is no alternative, then the simvastatin can be stopped for the treatment period and then restarted (Scott 2017, Best Practice Journal Team 2014).

Atorvastatin is metabolized by CYP3A4 to a slightly lesser degree than simvastatin but caution is required with concomitant CYP3A4 inhibitors. Rosuvastatin and pravastatin are not significantly metabolized by CYP3A4 but caution is still required when prescribing any CYP3A4 inhibitors with any statin as there have been case reports of rhabdomyolysis (Best Practice Journal Team 2014).

***Potent CYP3A4 inhibitors:** ciclosporin, macrolide antibiotics (erythromycin, clarithromycin), azole antifungals (itraconazole, ketoconazole), protease inhibitors (ritonavir, telaprevir, boceprevir)

****Moderate CYP3A4 inhibitors:** Calcium channel blockers (diltiazem, verapamil, amlodipine), amiodarone, nicotinic acid >1g/day

*****Minor CYP3A4 Inhibitors:** Azithromycin, roxithromycin

Another statin drug interaction that increases risks for SAMS is the concomitant use of oral corticosteroids. The risk of myopathy is doubled in males and tripled in females (Best Tests Team 2014).

c. Patient Risk Factors

Patient risk factors for SAMS include older age, female gender, low body mass index and African or Asian ethnicity. Patient genetic polymorphisms in drug transporters or the CYP isoenzymes can also affect blood levels of statins and therefore can increase risk of adverse muscle effects. Dehydration, alcoholism and people who exercise more can have increased risk. Dietary intake of grapefruit and cranberry juice are also risk factors, interfering with statin metabolism and increasing statin blood levels.

Comorbidities including diabetes mellitus, hypothyroidism, impaired liver or kidney function, acute infection, severe trauma, HIV and Vitamin D deficiency increase risk for SAMS. Major surgery is also a risk factor and statins may be stopped prior to this (Best Tests Team 2014; Pirillo 2015; Stroes 2015).

Pathophysiology of SAMS

The mechanism by which statins cause myopathy is not fully understood (Best Tests 2014; Pirillo 2015; Stroes 2015) however it is thought that more than one mechanism may be involved (Best Tests Team 2014; Stroes 2015). The most likely explanation based on current studies is that statins adversely affect the function of mitochondria, reduce cellular energy production and change the way muscle protein is broken down, all of which on their own may cause myopathy (Stroes 2015).

Statins do this by reducing levels of cholesterol which is involved in maintaining cell membrane function. Lower cholesterol levels affect cell membrane ion channels and therefore excitability of muscle cells which can lead to myopathy However, myopathy is not observed when another enzyme involved in the synthesis of cholesterol is inhibited (Best Tests Team 2014).

The inhibition of HMGCoA reductase by statins also reduces the biosynthesis of cholesterol precursors and downstream metabolites such as ubiquinone (coenzyme Q10), all of which may have a role to play in maintaining muscle cells. Reduced levels of them therefore may be a factor in the development of myopathy (Best Tests Team 2014).

Coenzyme Q10 is a downstream metabolite from a cholesterol precursor called mevalonate. It is involved with electron transport in the mitochondria of cells and helps to prevent oxidative stress during cellular aerobic metabolism. Lower serum and muscle tissue levels of coenzyme Q10 have been seen in people taking statins (Skarlovnik 2014). It has been suggested that this may affect cellular respiration and aerobic metabolism in muscles which could cause myopathy (Best Tests Team 2014; Pirillo 2015; Skarlovnik 2014). Evidence is not clear about the usefulness of supplementation with Coenzyme Q10 to prevent muscle symptoms in people taking statins and therefore it is not currently recommended (Best Tests Team 2014; Pirillo 2015; Skarlovnik 2014).

Statins may also affect calcium movement in muscle cells based on animal studies which have shown this reduces muscle strength. Statins may cause apoptosis (programmed cell death) in skeletal muscle which could lead to SAMS. More studies and evidence is required to fully elucidate the mechanism, however (Best Tests Team 2014).

Management of SAMS

a. Check for Non-Statin Causes

If a patient has myalgia, then any risk factors for SAMS should be determined and non-statin causes of the pain should be ruled out e.g. hypothyroidism, Vitamin D deficiency, hypercalcaemia, fibromyalgia, vigorous exercise, infection or polymyalgia rheumatica. If a person has had muscle symptoms prior to starting their statin, then the cause may not be the statin. Patient adherence and history should be checked to see if they have increased their dose of statin or if they are on any drugs that may interact with the statin to increase statin exposure and

therefore risk for SAMS. Dietary risk factors should also be ruled out with education given if required (Best Tests Team 2014; Stroes 2015).

b. Check the Indication for Statin Therapy

It is important to balance the benefits and harms of taking a statin with the calculated CVD risk and to check the indication for a statin in the presence of myalgia (Stroes 2015). The benefit gained from using a statin is highest for those people with the greatest CVD risk. Management of SAMS in these patients is important to reduce CVD morbidity and mortality that may arise from non-adherence or lack of persistence in taking a statin. Accordingly, current guidelines recommend people with a high 5-year CVD risk of > 20% are prescribed a statin at the maximally tolerated dose with the underlying approach that some statin is better than no statin for these people (Scott 2017). A person with a lower CVD risk will not gain the same benefit from a statin and the harms are the same. Therefore these patients may believe the absolute reduction in CVD risk for them may not outweigh the harms of taking a statin. (Best Tests Team 2014; Scott 2017; Stroes 2015).

c. Provide Patient Education and Reassurance

A person who understands the benefits and harms of a statin in relation to their CVD risk may be more motivated to continue their statin therapy and work through a process to minimize or eliminate SAMS. Reassuring and informing a patient about the effectiveness of statins, the actual risks of statin side effects and how they can be successfully managed will support this (Stroes 2015). Patient education is therefore important, not only about SAMS and ways to manage them, but also to inform and allay misconceptions or beliefs about other perceived adverse effects of statins such as cognitive impairment, diabetes risk and sleep and mood disorders that can influence adherence or desire to continue with statin therapy (Scott 2017).

d. Withdraw the Statin and Re-challenge

To determine whether the statin is causing the muscle symptoms, the statin should be withdrawn for 2 to 4 weeks. If the symptoms resolve after this wash-out period, then the patient should be re-challenged with the statin. If the symptoms recur, then a number of strategies can be tried including restarting on a lower dose of the original statin or using a lower potency statin (with lower lipophilicity) such as pravastatin including a low dose of it if necessary. Alternate day dosing, or twice weekly dosing with a longer acting and higher potency statin like atorvastatin could be tried. (Pirillo 2015; Scott 2017; Stroes 2015). Pulse therapy can be considered for people who gradually get a return of muscle symptoms after initially tolerating the adjusted statin therapy. This could be a cycle of 3 months on the statin with one month off (Scott 2017). The majority of people, 90% in one study (Pirillo 2015), will tolerate a rechallenge of statin therapy.

e. Determine CK levels

CK levels should be determined when a patient has SAMS and no secondary cause is evident. If the CK levels are >10x ULN with no non-statin cause, the statin should be stopped but if the CK levels return to normal then a lower dose statin could be started and the patient monitored carefully. If CK levels are >40x ULN or there are symptoms of rhabdomyolysis, the statin should be stopped (Stroes 2015).

f. Other Therapies

While not used first-line for primary and secondary prevention of CVD, non-statin therapy such as ezetimibe (inhibits absorption of cholesterol) can be used as a monotherapy for people who cannot tolerate statins or when statins are contraindicated. Ezetimibe may also be added to a statin for secondary prevention of CVD when maximally tolerated statin therapy and lifestyle changes have not lowered lipid levels sufficiently for a person with a high CVD risk (Pirillo 2015; Scott 2017; Stroes 2015).

Fibrates are no longer favoured for lipid lowering. Bezafibrate is sometimes used with a statin in this situation but the risk of myopathy is increased with a statin-fibrate combination. Gemfibrozil and a statin can cause rhabdomyolysis and is contraindicated (Scott 2017).

New drugs not yet available in New Zealand include proprotein convertase subtilisin/kexin 9 inhibitors (PCSK9 inhibitors) e.g. evolocumab and alirocumab. These monoclonal antibodies have been shown to reduce LDL levels markedly. They increase LDL receptors on hepatic cells and thus reduce circulating low density lipoprotein cholesterol (LDL-C) (Chaudhary 2017; Pirillo 2015; Stroes 2015). Cost could be a limiting factor to their use and more data is needed to determine whether CVD mortality and morbidity is reduced long term (Chaudhary 2017).

g. Supplements

There is insufficient evidence to support the use of supplements such as Coenzyme Q10 and Vitamin D to manage SAMS. Some short-term trials have shown red yeast rice to lower LDL but more evidence is required regarding long-term outcomes and safety data. There are some concerns about variability in bioavailability of different red yeast rice products and also contaminants that could be toxic (Stroes 2015).

Nurse Role in Supporting Patients with Statin Therapy

Evidence

Nurses are in a prime position to provide support and counselling to patients being treated with statins for primary and secondary prevention of CVD risk. Nurse-led interventions for CVD risk and management strategies can take place in a variety of settings including cardiology or CVD clinics, inpatient and outpatient counselling and patient counselling within general practice (either face-to-face or via telephone). Evidence has shown nurse-led interventions including CVD risk counselling can improve statin adherence and lipid lowering to reduce CVD risk. (Harbman 2014; Irewell 2015; Nieuwkerk 2012).

Nieuwkerk et al (2012) found that patients in the extended care (EC) group of their study benefited psychologically by having an increased understanding of their CVD, their modifiable and un-modifiable risk factors and by developing control over the process of their disease. The controllability a patient perceives they have over their illness has been found to be significantly associated with "problem-focused coping strategies such as adherence to self-management techniques" as discussed by Nieuwkerk et al (2012) who referenced the work of Hagger and Orbell. Nieuwkerk et al's (2012) findings were consistent with this. The increased perception of control over the process of their CVD translated into significantly lower anxiety and symptom and concern scores for the EC group, as well as significantly higher statin adherence (95-100% versus 90-95%, $p < 0.01$). In turn, increased statin adherence led to significantly lower LDL-C levels in the primary prevention patients of the EC group

compared to the RC group (2.66 vs 3.00 mmol/L, p = 0.024), but unexpectedly, not for the secondary prevention patients. This was thought to be due to secondary prevention patients starting with a lower LDL-C baseline rate due to a short washout period of 2 weeks of their statin therapy prior to the study.

The interventions used by Nieuwkerk et al (2012) included four nurse contacts with patients in their study (n=201), at baseline and at 3, 9 and 18 months. Patients were provided with an individualized risk-factor passport that showed their 10-year CVD risk, their individual modifiable and non-modifiable CVD risk factors and a target CVD risk they could achieve if they modified all of their modifiable risk factors. At each visit patients completed a self-administered questionnaire to assess statin adherence, symptoms, anxiety, smoking status and quality of life (QoL) and had their lipid levels assessed.

Irewall et al (2015) used nurse-led, telephone-based interventions for secondary prevention after stroke and transient ischaemic attack. Lifestyle counselling and assessment of pharmacological treatment resulted in improved LDL-C and blood pressure (BP). BP and lipids were tested at baseline and at 12 months. If the baseline BP and LDL-C were above target, the nurse initiated a physician assessment and adjustment of the medication. Each physician adjustment of medication was followed up in 4 weeks to see if BP and LDL-C met target levels. The process was repeated 4 weekly until the targets were met. A key factor in achieving success in this study was believed to be timely adjustment of medication and monitoring of patient risk factors. Irewall et al (2015) thought that interventions would need to continue for longer than 12 months to maintain control over risk factors.

Nurse Strategies to Increase Statin Adherence

a. Patient education on CVD risk and management strategies
    - Ensure patients understand their CVD risk and modifiable and non-modifiable risk factors, and associated management strategies. This can be helped by using interactive patient risk calculators and tools such as “Know Your Numbers” (Heart Foundation 2012) or the “Your Heart Forecast” tool (Heart Foundation 2017).
    - Develop a therapeutic alliance by using a patient-centred approach to define the patient’s goals, priorities and preferences and by keeping these foremost in development of management strategies and health plans. This approach is more likely to empower the patient and increase adherence with treatment as well as increase patient well-being and satisfaction with their care (Harbman 2014).
    - In primary care, nurse-led CVD risk assessments can be an opportunity for providing patient education or an opportunity could be taken during a nurse appointment for another reason (if appropriate). Primary care nurse-led clinics, nurse-led patient appointments or telephone follow-ups specifically for high risk patients for primary or secondary prevention of CVD can be used but there is a time and cost factor associated with this to be balanced against other general

practice service delivery requirements.

- Practice nurses may also have the opportunity to encourage patients to access cardiac rehabilitation after a cardiac event or make a referral to a Cardiology Clinical Nurse Specialist.

b. Patient education regarding statins
   - Ensure patients understand their CVD risk and the effectiveness (benefits) and safety of statins so they can make an informed decision about statin therapy
   - Provide information on statin adverse effects and the absolute risks – dispel any myths to reduce anxiety that may impact negatively on adherence.
   - Ensure patients understand their risk factors for myopathy and how to minimize any modifiable risks such as diet. Ensure patients know what to do if they experience muscle pain or other adverse effects i.e. contact their general practitioner (GP) or practice nurse (PN). Explain the different types of myopathy and signs to be aware of.
   - Ensure patients understand there are a number of strategies to follow if they experience muscle pain or other side effects, and for most people, these strategies will allow a person to tolerate statin therapy successfully.

c. Check patients' adherence with their statin (and other therapy)
   - A referral may need to be made for medication management services such as Medicines Use Review or Community Services/District Nursing support for taking medications.
   - Seek physician input for statin management strategies including dose, frequency and potency adjustments if a patient is experiencing SAMS.

d. Monitor risk factors
   - Ensure lipid levels are undertaken at the correct frequency, along with weight, waist circumference and BP. Calculate Body Mass Index (BMI) and seek physician input for any required dose titrations of medication.

Summary

Nurses are an integral part of the multi-disciplinary health team and have a significant part to play in supporting patients to be adherent with statin therapy to maximize lipid lowering and reduce their CVD risk.

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Invitation from the Chairperson

Welcome to the 10th Council of International Neonatal Nurses Conference, Auckland, New Zealand, to be held May 5-8, 2019.

On behalf of the Organising Committee, I would like to extend to you our 'māfana mai', our warmest welcome. This prestigious international event is proudly hosted by the Neonatal Nurses College – Aotearoa (NNCA) in collaboration with New Zealand Nurses Organisation (NZNO) and The Council of Neonatal Nurses (COINN).

Over three-and-a-half-days, an exciting and thought provoking programme consisting of plenary and concurrent sessions and poster presentations will explore the theme Enriched Family – Enhanced Care.

Enriched Family – Enhanced Care (Whannau/Ko e Fakakoloa'o e Famili, share the care) will showcase the innovative neonatal care delivered by you and experienced by families every day around the globe.

The exhibit area will feature the latest products and services available, and the social component will allow you plenty of time to network with the wider NICU family - colleagues, friends and others working or studying in the field of Neonatal Nursing.

New Zealand in autumn is an inspiring and beautiful setting for our Conference. At this pleasant time of year, the weather is just right, whether your interests are to enjoy the amazing scenery and outdoor activities or simply to sit back and enjoy New Zealand's diverse food, wine, shopping and entertainment.

Don't miss your opportunity to join nursing colleagues from around the world to explore critical issues, emerging trends and innovations in neonatal nursing, to share global wisdom, to network and foster new partnerships, and to discover the wonders and beauty of New Zealand

Nau mai, haere mai, whakaeke mai – Welcome to Auckland, New Zealand.

Kind regards, Dale Garton: **Chair, Organising Committee**

On behalf of NNCA Local Organising committee for COINN 2019

Rehabilitation following Mild Traumatic Brain Injury

Pat Hopkins, Clinical Leader and Physiotherapist

Laura Fergusson Trust, Christchurch, New Zealand

Pat is a physiotherapist specialising in the area of traumatic brain injury from mild to severe injury. Pat has worked in this area for over 20 years and has built up expertise in concussion, vestibular rehabilitation as well as general neurological conditions. Pat works for Laura Fergusson Trust Canterbury as Clinical Leader of Insight Rehabilitation, the rehabilitation arm of the organisation. She coordinates the community Allied Health team as well as training and supervising new team members.

INTRODUCTION

Traumatic brain injury (TBI) is common in New Zealand, with many referring to this as a 'silent epidemic' sweeping the nation (Rusnak, 2013). The incidence of TBI in New Zealand is far greater in other high-income countries (Feigin et al., 2013). This has substantial impact on the medical system of New Zealand; the total lifetime cost of all TBI survivors in New Zealand has been estimated at US $146.5 million – expected to increase to US $177.1 million in 2020 (Te Ao et al., 2015). Research is clear there is an urgent need to develop effective care pathways to not only assess, but to provide appropriate rehabilitation for both mild and moderate/severe TBI (Turner-Stokes et al., 2015).

Traumatic brain injury (TBI) occurs when an external force injures the brain. This can be something obvious that injures the head as well, such as being struck with an object, or falling and hitting the head. However it can also happen inside the skull, with no obvious head injury. Forces such as rapid acceleration and deceleration can damage the brain. ACC statistics show that nearly 14,000 people are treated for TBIs each year. The cost of TBI-related claims was $83.5 million in the 2015 financial year (ACC TBI Strategy, 2017). This does not include non-traumatic brain injury, which occurs as a result of internal forces such as strokes, lack of oxygen, infection, brain tumours, and exposure to toxic substances. Between 2009-2013 sports related concussion claims cost ACC $76 million (Sport Concussion in New Zealand: ACC National Guidelines, 2016)

This article will review the basic terminology regarding TBI, care pathways in the rehabilitation of mild TBI in New Zealand and a brief discussion of evidence for rehabilitation in mTBI. Ongoing education about mTBI is critical to enable the primary healthcare team to access the appropriate, specialist, clinical services within the community, thus preventing long term issues for patients and minimising the risk of serious short and long-term sequelae.

Mechanism of Injury

Concussion

Concussion, a mild form of a diffuse injury, is the most common type of brain injury (about 90%). Concussion is also known as mild traumatic brain injury (mTBI). The effects of concussion usually wear off within days or weeks, but about 10-12% of people with mTBI need extra support beyond primary healthcare monitoring after their injuries. Symptoms can affect different areas of people's lives. Some symptoms will be present immediately after the injury, and others may appear later, for example, when people go back to work and find themselves under greater stress. The effects of concussion can also build up if you have more than one. While there is currently a lot of research into the effects of repetitive sports concussion injury, there are no definitive results as yet (Saigal et al., 2014)

Acceleration/Deceleration Injuries

A rapid acceleration or deceleration of the head can force the brain to bounce backwards and forwards within the skull. The movement causes nerve fibres to pull apart and causes damage to brain tissue. This type of injury usually occurs in motor vehicle accidents and in violent acts such as shaken baby syndrome. A child's brain has a higher water content which makes the brain softer and more vulnerable to acceleration/deceleration injuries

Fig. 1: Depiction of an Acceleration/Deceleration Injury

Coup/contrecoup is a term that describes contusions that occur in two places on the brain, including at the site of the impact and on the opposite side of the impact.

- The first contusion forms when an outside force causes the brain to impact against the inside of the skull.
- The second contusion forms on the opposite side of the brain, and happens as the brain bounces against the opposite side of the skull.

Penetrating Injuries

Penetrating injuries may be from an object such as a bullet or tree branch breaking the skull and entering the brain, or can be caused by a skull fracture where bone fragments are driven into the brain.

Effect of Trauma on the Brain

The effects of a TBI depend on what part of the brain has been hurt and whether there has been bleeding, swelling or tearing, or all three of these. With traumatic brain injury (TBI) there can be damage all over the brain – not just in one spot (like a stroke).

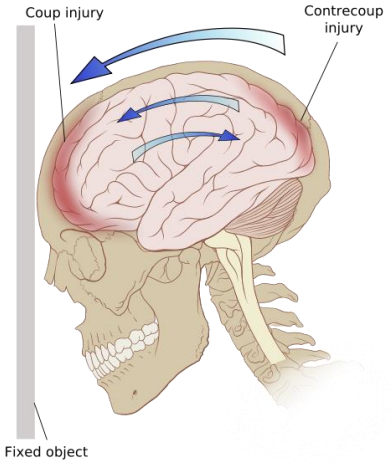

Fig. 2: Coup/Contrecoup Injury

- The brain is like a city with tall buildings and roads and bridges that connect buildings. And a concussion is like an earthquake which is not strong enough to knock the buildings down but enough to cause damage to the roads and bridges.
- On CT scan/MRI, the brain actually looks normal, because the scan actually focuses on the brain cells, the buildings, but it doesn't have a good ability to assess the axons, which are the bridges and roads of the city (Chae, 2013).

Signs and Symptoms of mTBI

These can be subtle and may not appear for a few days following the injury. They may be missed initially as people may look fine but then become more apparent when the person resumes their normal pre injury activities such as work, sports or exams. People may act or seem slightly different to people that know them well and it may be a family member or colleague who is commenting on changes in personality or function.

- Headaches
- Difficulty concentrating, remembering or making decisions
- Feeling tired all the time, low energy, decreased motivation
- Lightheadedness, dizziness (vestibular or neck related) or change in balance
- Nausea
- Blurred vision – can be related to vestibular function
- Mood changes, irritability, restlessness
- Changes in sleep patterns
- Increased sensitivity to light, noise (hyperacusis) or distractions

These may present as:

- “I just don’t feel right”
- “I messed up a recipe I’ve made a 100 times”
- “I hate going out now”
- “I’m grumpy with the kids all the time”
- “My friends annoy me now” or “My friends are avoiding me”
- “I don’t read books like I used to”
- “I can’t watch a full movie like I used to”
- “Johnny is being very naughty since he hit his head”

Factors Affecting Recovery

There are several factors which can affect someone’s recovery from concussion. A ‘more severe’ injury does not always mean a longer or harder recovery. Pre-existing medical and mood issues can make it more difficult, as can other injuries sustained at the same time as the concussion (Wojcik, 2014). Personal psychological resilience in the face of injury has a big influence, as do the support systems that surround the person (Silver, 2014). A student living away from home in university halls may have less support than if they are living at home with family.

The lifestyle and type of work that the person is returning to is also important. A teenager in year 10 at high school will tend to have more flexibility for time off school and be under less obvious stress than a year 13 student who is about to sit NCEA exams. The physical environment/demands of a work place can delay a return to work (e.g. very noisy or working at heights when still dizzy), and roles that require high cognitive demand can be difficult also.

Rehabilitation Options

In a recent Cochrane Review (2015) for outcomes of working-age adults recovering from TBI, results indicate there is strong evidence for rehabilitation, associated with earlier functional gains (Turner-Stokes et al., 2015). Further, evidence suggests that continued outpatient therapy could help to sustain gains made in early post-acute rehabilitation to community settings, critical

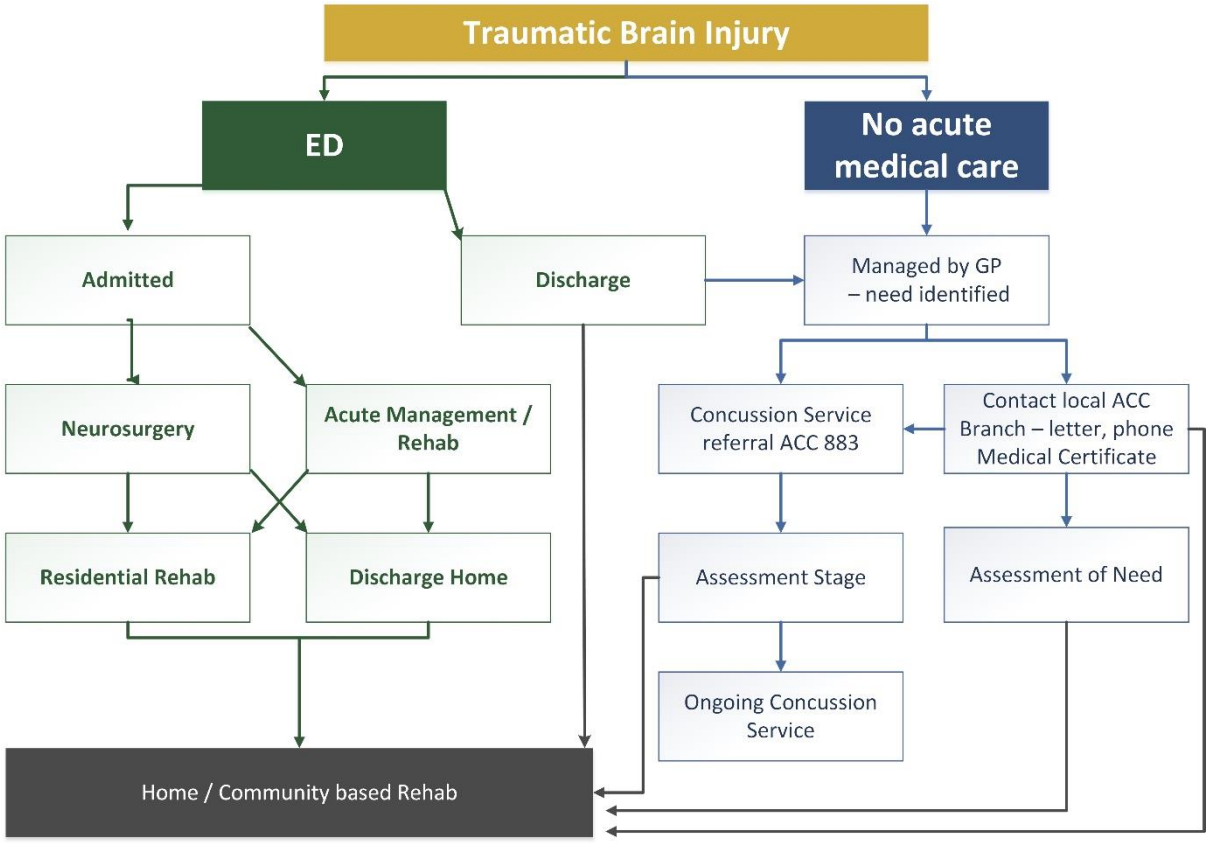

Fig. 3: Schematic Depicting Usual Care Pathway for TBI NZ, Insight Rehabiliation.

when considering return to work and participation in community (Turner-Stokes et al., 2015). There are different pathways a person who has sustained a brain injury can follow. They may be admitted to hospital via the emergency department or be seen by their GP several days after the event. The important thing is that if they are experiencing ongoing symptoms they can get help.

It is important to note that patients who have major orthopaedic injuries and/or spinal cord injuries are often managed with these injuries as priority. Possible TBI symptoms, particularly cognitive issues may not become apparent until they have reduced pain meds and start being more active. A heightened awareness of post-acute and community resources will help continue education and outreach to integrate with the great work occurring in primary care. Collaborative, cross-discipline management will aid in reduction of ongoing symptoms and further presentations, assisting a more rapid return to normal functioning. Providing the right care, at the right place, at the right time will not only enhance patients experiences, but can greatly improve use of resources, which may in the long-term promote cost savings.

Concussion Services

For people who have had a mTBI and have ongoing symptoms a referral to Concussion Services is vital. Concussion providers are experts in knowing what to assess and then how to address the needs identified. This can often prevent ongoing issues. There are also specialist providers for children.

Concussion Services under ACC contract provide an assessment/triage stage where appropriate assessments are used to identify and prioritise needs. The initial assessment may identify that specialised Allied Health assessment, such as vestibular assessment by a Physiotherapist, is required. Further assessments may be carried out by a Neuropsychologist, Medical Specialist or Optometrist. Sometimes all the client may need is education about their injury, reassurance that it will get better and some simple strategies to manage their symptoms as they return to their usual activities.

Others need to continue with a full suite of interdisciplinary input from Occupational Therapy, Speech Language Therapy, Physiotherapy and Neuropsychology, with support from the Medical Specialist and/or Optometrist. Occupational Therapy/Speech Therapy can will tend to focus on cognitive-communication skills, fatigue management and return to usual activity. Physiotherapy will focus on vestibular rehabilitation, cervical spine treatment and gradual return to physical function. Neuropsychology will assess cognitive function as well as providing input for mood and impact of the accident on family/whanau relationships, work or study. The team will work with families, schools and employers to ensure the client is fully supported through their recovery. Often referral for Return to Work input under ACC vocational contracts will be necessary to ensure the client achieves a full and sustainable return to employment.

Strategies and Resources

There are many useful strategies and resources that exist to support recovery from mTBI. These can be discussed and tailored in a rehabilitation programme. Typically without brief education and management of symptoms, frustration at work or at home can build. The most common symptom following a brain injury is fatigue, or an overwhelming sense of physical or mental tiredness. It is important to note, this may be a different sense of fatigue than the one felt after exercising, for example. Brain-injury related fatigue is a mental tiredness, a drained, slowed sensation. This is believed to be due to the extra resources required by the recovery process, forcing the brain to 'work harder' on everyday tasks that were relatively effortless prior to the injury. This can have carry-over effects to worsen memory, mood, coordination, headaches, attention, etc. The good news is there are many strategies to support optimal fatigue management. Some such strategies include:

- Learn the early signs of fatigue. Ask your family and friends to help you notice the signs.
- Take rest periods
- Schedule important, difficult, or stressful tasks and appointments at times where energy levels are at their peak (for most people, this is in the morning)
- Spread work, home, and social activities evenly throughout the week and stick to a routine.
- Plan your activities for the day:
    - What is most important?

    - Will I need extra time?
    - What can I do to make the activity easier?
- Minimise distractions so you can concentrate

For further information and resources, please see the following links:

Laura Fergusson Trust

http://lftcant.co.nz/services/concussion-services

ACC

http://www.acc.co.nz

http://www.accsportsmart.co.nz/concussion

New Zealand Transport Agency - Driving after Brain Injury

http://nzta.govt.nz/resources/factsheets/36/

New Zealand Rugby Foundation - Supporting Seriously Injured Players

http://www.rugbyfoundation.com/

New Zealand Brain Injury Association

https://www.brain-injury.org.nz/

PO Box 2322

Christchurch 8140

Phone: (03) 371 5531

admin@braininjurynz.org.nz

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Snippets from NZ College of Primary Health Care Nurses' National Committees meeting

23rd February 2018

At the last meeting of the PHC National committees in Wellington, the attendees were pleased to have Jill Clendon, the Acting Chief Nursing Officer in the Ministry of Health join the meeting.

Jill outlined changes happening in the Ministry of Health and Chief Nursing Office. Jill will be Acting Chief Nursing Officer until a replacement is found as Jane O'Malley who has been in the role since 2010 has become the first Chief Nurse at Plunket New Zealand (NZ). There will be a new Director General of Health and a new position, Advisor to the Primary Health Care Team is being created to advise Chief Medical Officer.

Jill spoke about the Primary Health Care review which will take place later this year. Jill has made recommendations of primary health care nurses to be members of an advisory group.

Primary health care nurse leaders across the country have begun preparing for the review to ensure the consumer voice is represented and improving access to primary healthcare is a key consideration. Primary healthcare nurses work in urban, rural and provincial New Zealand and in sectors such as Aged Care, Mental Health and Youth Health services. These are all government priorities.

Concerns were raised with Jill relating to the staff and remuneration of midwifery colleagues. The Midwifery Council has presented its co-design project recommendations to the Minister. There is no indication of how this has been received.

Jill made reference to Lord Crisp's NHS Triple Impact of Nursing (2018) report. This report shows how developing nursing can lead to health improvement, gender equality, and strengthening economies. A global campaign for nursing "Nursing Now" is just being launched in the UK.

Jill also reflected on the legislative changes to the Health Practitioners Competency Assurance Act that have enabled Registered Nurses and Nurse Practitioners (NP) to perform activities that were previously only for Medical Practitioners. These changes have allowed nurses to develop their roles and provide increased access to healthcare, an example being able to provide sickness certificates.

Later Carolyn Reed, Chief Executive/Registrar and Pam Doole, Director of Strategic Programmes from the Nursing Council of New Zealand joined the meeting.

Carolyn advised that Nursing Council is starting their 5 yearly strategic review cycle. A comprehensive review was undertaken of Nurse Practitioner roles with the result that no longer will NPs be restricted to specific areas of practice. Instead they will practice within their area of competence and experience. There are now 187 Registered Nurse Prescribers across NZ, with the community nurse prescribing evaluation from Counties Manukau DHB starting this month.

Future work for the Council will include reviewing how best to prepare internationally qualified nurses. Looking at language, culture, competency assessment and transitioning to the NZ health system. Of the 3,000 newly registered nurses in 2017, half were NZ graduates. The majority of the internationally qualified nurseswere from the Philippines or India and overall 27% of the nursing workforce is internationally qualified.

The Council will also review how to register a nurse for the future including education preparation, 1st year of practice and ongoing competencies. The executive asked if there would be a review of the number of competencies required for ongoing PDRP or audits and were advised this is on the table but not immediately.

The HPCA Act is in the process of being reviewed, with some changes expected to regulatory bodies and changes to the way data is collected for the Ministry of Health.

Primary health care nurses knowledge and skills framework

The Professional Practice committee acknowledged the amount of work that has been done in bringing this document to fruition and thanked the author Yvonne Stillwell for her commitment to the project. The consultation process has been completed. We have provided feedback to the MidCentral DHB team and look forward to releasing the updated version in the near future.

Health Workforce New Zealand

A link has been added to the College webpage under the 'Resources' tab. If wondering how to access nursing education funding for the NETP or post-graduate studies check out this page, with a list of all the DHB study fund co-ordinators.

Document Reviews

Work is progressing on updating the "Maximising the Nursing Contribution to Positive Health Outcomes for the New Zealand Population." It has been agreed that this document needs are thorough update and is on the 2018 work plan. The Electronic Resources has been updated and due to be on the webpage by the end of April.

Back L-R. Cathy Nichols, Emma Hickson, Irene Tukerangi, Annie Tyldesley, Bronwyn Boele van Hensbroek-Miller, Linda Reihana, Tasha Morris

Front L-R. Yvonne Little, Tegan Jones, Wendy King, Celeste Gilmer (Chair), Angela Clark and Kelly McDonald-Beckett

MANAGING COMMON HAND INJURIES

Liz Wyllie, RN, Orthopaedic Outpatient Department, CDHB, Christchurch

Annie Tyldesley, RN DOHN Msc PGcert, Family Nurse Specialist, Temuka

Most of us agree that hands are an important part of human anatomy and, as healthcare providers, having an understanding of how hand injuries are caused, diagnosed, treated and rehabilitated enables us to provide the appropriate support to our patients/clients. It also enables us to identify problems when they arise and assess the effects of the casts when needed. This article will explore the way to manage bony hand injuries from assessment to healing, including the different types of casts used in the Christchurch Hospital Bone Shop.

Introduction.

Bony hand injuries are caused in many ways; crush injuries, falls, sports injuries, improper use of tools, blunt force trauma, etc. They can occur in the home, at recreation, at work, anywhere.

Liz Wyllie - I trained in the UK and have been an RN for 35 years. For most of my career I have worked in emergency nursing; in the UK, Bermuda and NZ. While working in this area I developed an interest in orthopaedics and casting and after moving to New Zealand in 2001, and working in the ED for 6 months, I transferred to the Bone Shop where I have worked ever since. I apply casts and splints to acute injuries, follow-ups and congenital conditions and in the OR applying casts when required. I work closely with the hand therapists and surgeons when treating hand and finger injuries and am keen to encourage treatments that ultimately result in good hand function.

Annie Tyldesley: I trained in the UK and worked in orthopaedics, trauma and emergency nursing before travelling and working abroad. I specialised in Occupational Health in the UK and emigrated to New Zealand in 2002. Since then I have worked mostly in the community/primary healthcare, currently as a Family Nurse Specialist. As a general specialist I offer the full range of care to patients of all ages, cultures and conditions. I also support my nurse colleagues in their professional development.

When assessing hand injuries, gathering a range of information enables the healthcare provider to competently assess the situation and build a picture for treatment and rehabilitation planning.

Initial Assessment

After a hand injury, the healthcare provider should undertake a comprehensive assessment of the patient. The patient should be asked to describe the mechanism of injury, i.e. how the accident happened, and their symptoms, e.g. tenderness, pain, weakness, decreased range of movement, etc.

Any medical history, no matter how trivial, may be of use in providing care, e.g. previous trauma to the hand; current medical history, e.g. medications, allergies, etc.; hand dominance; occupation; extracurricular activities, e.g. hobbies/sports; smoking history; social history, e.g. family situation, violence, etc.; use of alcohol and recreational drugs; mental health including presence of confusion or dementia.

The ability to undertake normal daily activities is affected by hand injuries, so check if there are any mobility issues, such as use of a walking frame or stick; whether there are any support people at home; whether provision of or increase in home assistance is required. ACC are responsible for providing home support after an accident, so appropriate referral may be required.

Physical Examination

When undertaking an initial hand examination, always compare the injured hand with the un-injured unless both are injured, which gets complicated, and your best knowledge of anatomy and physiology will be required.

First, a visual examination: check for colour, discolouration, swelling and lacerations. Then, sensory nerve comparison: touch different parts of the hands checking for changes or loss of sensation. Check vascularity: any blanching, coldness, etc. Muscular and tendon exam: looking for motor nerve damage resulting in loss of movement. Bone exam: look for obvious deformities or misalignment of the digits.

The primary healthcare provider will conclude with management of pain and referral to appropriate secondary care, e.g. radiology, ED, physiotherapy, etc, as appropriate.

In The Bone Shop

Assessment of the hand injury is repeated in the Bone Shop and includes tests for sensation, to check if the hand is neuro-vascularly intact; checking the fingers for rotation, by getting the patient to form a loose fist and checking the nails are all following the same plane, that there is no scissoring and the patient is able to extend fingers to neutral. In cases of

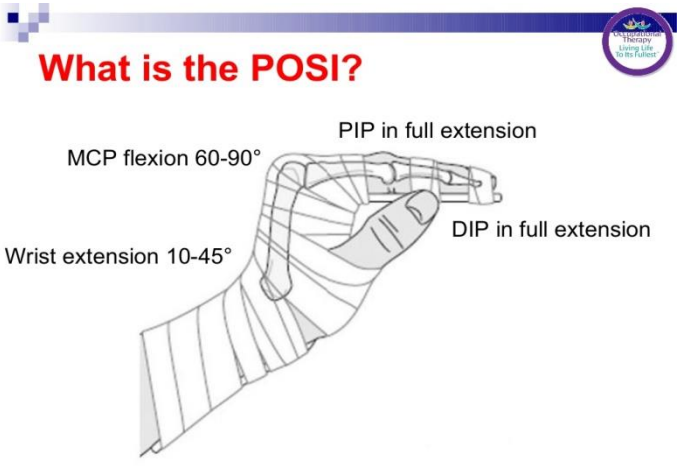

Figure 1: Position of safe immobilisation

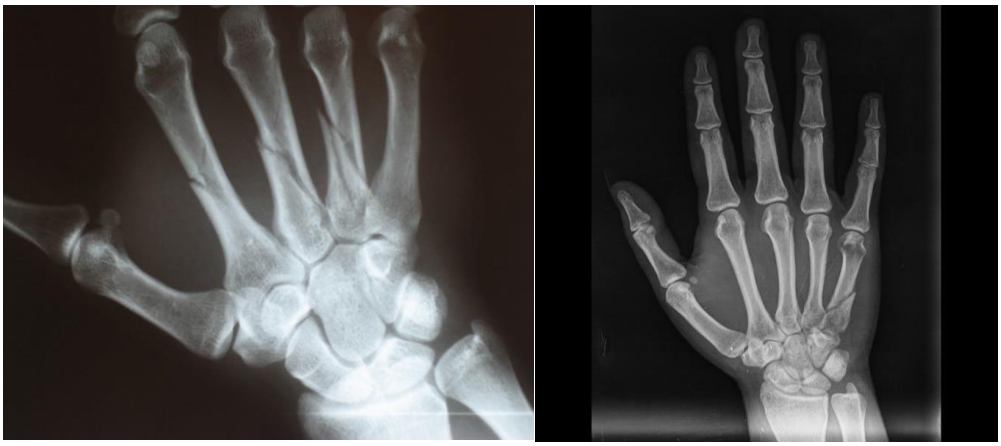

Figure 2: Midshaft oblique fractures: 5th MC fracture

confirmed fractures to the bones of the hand, treatment is dependent upon the bone and the position of the fracture.

Treatment Options

Hands should always be placed in the position of function when they are immobilised. This protects the soft tissues and allows for easier mobilisation when the cast is removed. The metacarpo-phalangeal joint is flexed to prevent collateral ligament shortening and the fingers extended to prevent volar plate damage and shortening. Figure 1 shows the position of safe immobilisation commonly known as the POSI . To manage pain, a local block is normally used prior to reducing acute fractures.

DIFFERENT CASTS v DIFFERENT INJURIES

Volar Slab (Backslab)

In the Bone Shop, metacarpal (MC) fractures (Figure 2) are reduced and treated in casts and rotation if present must be corrected using traction prior to casting or splinting. The cast of choice for us is a volar slab with the wrist in extension and the cast ending at the palmer crease of the hand. The fingers are buddy strapped to prevent rotation and patients are encouraged to flex their fingers. It is important not to extend the cast further up than the palmer crease, because this will prevent the metacarpo-phalangeal joint being able to flex and cause shortening of collateral ligaments. For new injuries, no stockings are used under the casts but felt padding is applied at the point where moulding will take place to prevent pressure sores. With the exception of the thumb, mid-shaft, base and neck of MC fractures can all be adequately immobilised in a volar cast. The moulding of the cast will be dependent on the fracture's location.

Neck of MC fracture reduction can be achieved by traction and volar pressure under the MC head with dorsal counter pressure more proximally. Shaft of MC fracture reduction requires traction and pressure along the MC dorsally. Base of MC fractures can be reduced in a similar way, but may require further imaging afterwards to confirm the joint is enlocated and congruent. Hand fractures, like fingers, generally heal quickly and 4 weeks immobilisation is adequate. However, smoking can delay union and may necessitate longer casting.

Cobra Cast

Cobra Casts are frequently used for MC fractures and many casting departments use them to treat tendon injuries. Fingers should have padding wrapped between them prior to casting to prevent maceration and the hand must be in the POSI (Figure 1) to safely rest the soft tissues and facilitate faster rehabilitation after casting.

Figure 3 shows a full Cobra Cast, which will require splitting for the first week to allow for swelling. The split would normally be along the dorsal surface but not over the fractured metacarpal. In some cases, a plaster slab in this position is used as an alternative.

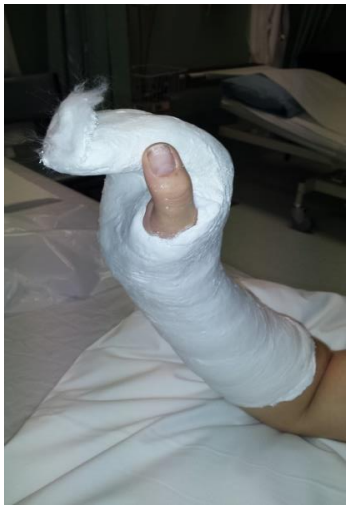

Figure 3: Cobra Cast

Complete or Full Casts

If a full plaster cast is used the cast must be split to allow for swelling. The cast can then be completed at 1 week with synthetic. The cast can stay insitu for the healing period or, providing it can be removed safely, i.e. retaining reduction of the fracture, be replaced with a synthetic cast once swelling is reduced. Complete casts are more sturdy and harder for patients to remove. They, therefore, maintain the reduction better. However, the cast often has to be changed at 1 week because they have become loose due to the reduction in swelling. (See Figure 7 for information on casting materials).

Finger Splints

Finger fractures may be treated with buddy strapping only, but some require splints to hold them out to length and stop displacement. These will normally be buddy strapped after their post reduction X-ray.

Thumb Spica

The most common thumb injuries are metacarpal fractures and Ulna Collateral Ligament (UCL) Injuries (Figure 4 & 5). X-ray should be taken before stressing the UCL because if there is an avulsion fracture stressing it can cause displacement. When testing the UCL the uninjured thumb should be assessed first for a comparison and the thumb should be stressed flexed to isolate the tendon. If there is significant laxity a thumb splint or cast will be needed for 3 weeks. If there is no end point, i.e. the joint keeps opening when stressed because there's no tendon to hold it, referral to hand surgeon for further management is required.

Thumb spicas go from the tip of thumb to wrist area the length will depend on the injury. They are two pieces of plaster slab placed in a T shape on the thumb, one length wise and one across it, then bandaged on. For a UCL, the thumb must not be not abducted (sticking out) as this further stresses the tendon.

Scaphoid Fractures

Although many casting departments include the thumb in a cast for a scaphoid fracture (Figure 6), the Bone Shop has found that this does not improve healing and leaving the thumb out enables more joint movement and less joint stiffness. Unless indicated by pain on thumb movement, a below elbow casts without the thumb included is used. Clinical scaphoid fractures with tenderness in the anatomical "snuff box" but no radiological changes will be treated either in

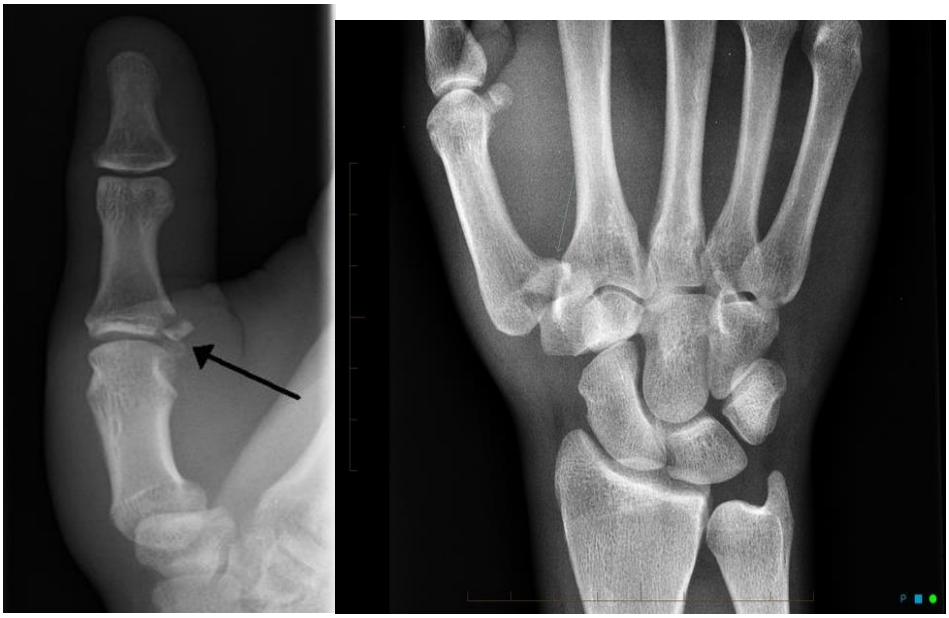

Figure 4: Unar Collateral Ligament avulsion: Bennets fracture

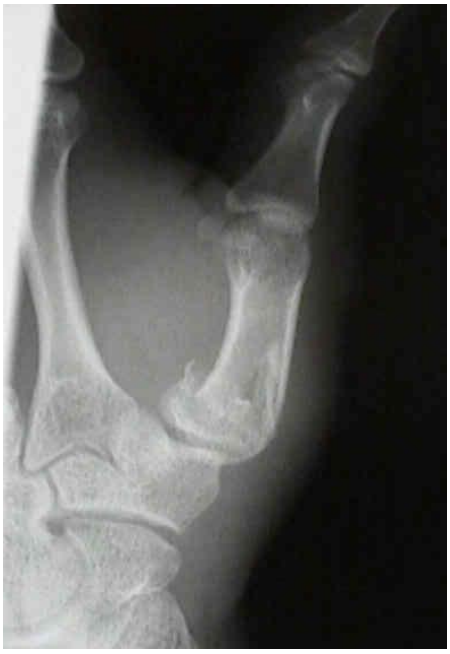

Figure 5: Base of 1st MC fracture

a wrist splint, if not too sore, or a cast, with repeat x-ray and examination at 10 – 14 days to confirm or deny a fracture. Because of the very poor blood supply to the area, scaphoid fractures require up to 12 weeks in a cast. Even then, scaphoid non-union can occur.

Wrist Splints

Minor avulsions from other carpal bones can be treated in a wrist splint for comfort. Velcro wrist and thumb splints come in several sizes and can be used for either side. Thumb splints can also be useful for minor sprains without compromising other joints.

In some cases, adaption of any of the above casts may be necessary to ensure good reduction and immobilisation of the fracture, e.g. patients with dementia are unable to understand why they have a cast so an above elbow cast may be applied in place of a shorter cast to make it more difficult for them to remove.

After Care

Hand casts remain on for a maximum of 4 weeks, with the exception of the scaphoid fractures (see above). Patients are advised on how to care for their cast. The Bone Shop x-ray weekly until callous forms because the fracture can slip as swelling goes down and the cast gets looser. If a fracture slips in the first 3 weeks it can be successfully re-manipulated but after 3 weeks the callous makes the fracture sticky and less likely to slip so no further x-rays are needed until the cast is

removed. Radiological union may lag behind clinical union, so if there is no soreness over the fracture then it is probably healed. A repeat x-ray can be undertaken four weeks after removal to check for callous formation.

Rehabilitation

Once the cast is removed, patients often find that the skin and muscle has been affected by the presence of the cast. Good cleansing and moisturising is required to return the skin to normal condition. Physiotherapy may be beneficial in order to achieve the best possible function in the hand. In some areas, patients can be referred to specialist hand physiotherapists for optimal treatment. This is the patient's choice but the information gathered in the initial consult e.g. occupation, dominant hand, hobbies, etc. will assist the healthcare provider to offer appropriate rehabilitation advice.

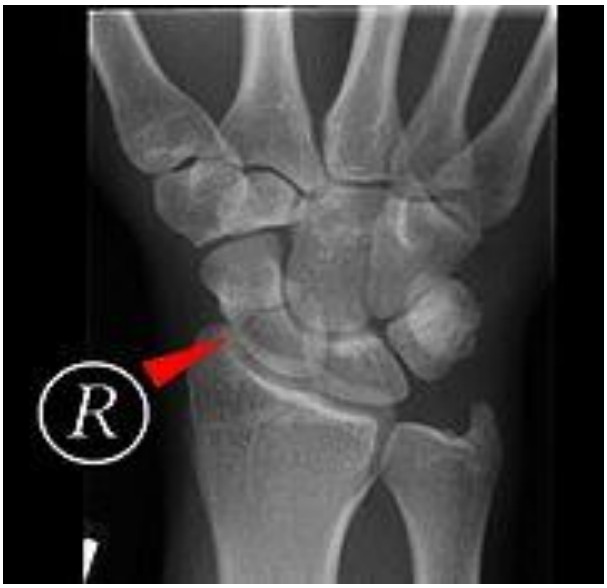

Figure 6: Scaphoid fracture

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Bone Shop Casting Materials: Synthetic V Plaster

Plaster (Gypsona) – Will be applied to all new fractures or swollen limbs and also will be used for most re-manipulations. Most plaster casts will have a split after they have a post cast Xray to allow for swelling.

Synthetic – We use 2 different products both come in a variety of colours and can be used alone or over plaster:

- Nemoa which is a plastic resin
- Delta light which is fibre glass

Injuries more than a week old or with no swelling can go straight in to synthetic casts unless moulding of fracture is required.

Synthetic casts are less dense on x-ray giving better views of the fracture.

Synthetic casts can also be applied with waterproof lining and no padding.

Call for Nominations 2018

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

This background work is illuminating, stimulating, puzzling and challenging at times. Being part of the CPHCN is an opportunity to extend your practice and understanding of health issues, 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. A measure of the value other agencies and organisations have in our work is their willingness to come to our meetings to meet when invited.

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; by video link (via NZNO system) or face-to-face.

Once a year there is an AGM and attendance by committee and Executive members is expected. This years' AGM will be held in Christchurch 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_topics

If you don't have a nominator, or would like any other information, please email collegeprimaryhealthcare@gmail.com for assistance.

Worker Exposure Survey

WE ARE LOOKING FOR COMMUNITY NURSES TO HELP US WITH A RESEARCH STUDY ON WORKPLACE EXPOSURES

Why are we doing the study?

We are conducting an important study to learn more about occupational exposures and workplace practices in selected occupational groups in the New Zealand workforce. We are doing the survey so that effective interventions may be developed to prevent work-related disease and injury.

What does the study involve?

We are inviting about 700 workers aged between 20 and 64 years from seven occupational groups to take part in a confidential telephone interview. The groups are: a) farmers who apply pesticides; b) collision repair workers; c) construction workers, d) sawmill workers; e) hospitality workers; f) clerical workers; and g) nurses.

What will my participation involve?

Participation will involve a telephone interview asking about your current workplace exposures, organisational factors, and your health. The interview will take about ½ hour – 45 minutes and will take place at a time and date convenient to you. **Your employer will not be contacted in regards to your participation in this study.**

What will happen to my personal information?

We will treat all information from the questionnaires as strictly confidential. The data from the questionnaires will be seen by named researchers only. **No individual information or names will be published.** During and after completion all questionnaires will be stored in locked filing cabinets, which will be the responsibility of the Director of the Centre for Public Health Research.

For further information, please contact Dr Amanda Eng on 0800 990 053 or email a.j.eng@massey.ac.nz

Reflections of a Mental Health Nurse Practitioner (NP) and Clinical Leader at Compass Health PHO; how both roles are synergistic

Lynley Byrne is Clinical Leader of the mental health service at Compass Health PHO in Wellington and a Nurse Practitioner. She works collaboratively within general practice teams and provides assessment, diagnosis and prescribing for mental health

She has developed a new model of primary mental health care whilst at Compass Health which has improved access to mental health services by placing mental health practitioners within primary practices. Lynley has worked within community mental health nursing roles for over 20 years and has worked in primary mental health for almost 4 years and was involved in the development of Closing the Loop with colleagues from the 4 largest PHOs in NZ. It is the vision of future primary mental health care in NZ

Lynley Byrne

Three and a half years ago, I was transported through the "portal" from working in District Health Board services to primary health. In many ways, the different organisations have similar ways of working, but in other aspects, it has been like comparing chalk and cheese.

I came from a working environment where the mantra was "there is no money for that" and after 10 years of that experience, morale was very low and the energy to develop new resources and to provide positive ongoing clinical input was also low. I arrived at Compass to be given a project that did not require five layers of management to approve it. Instead, I and the CEO, who put great faith in my ability to rollout a new model of primary mental health care that was more patient centric and utilised the health budget more effectively, were able to instigate change.

Having done years of post-graduate study towards being a Nurse Practitioner, research into the evidence was paramount for me as a starting point for this new project, which proved problematic as I suddenly could not access the medical library. As a senior nurse, used to accessing this resource regularly for every new venture and new presentation, this was akin to living in another dimension. Three and a half years later I still do not have access to the library and neither do any other nurses in primary care which severely impacts our practice and being able to provide the most up to date clinical practice.

Whilst developing the new model of care, I put my NP plans on hold in terms of finishing a portfolio and completing panel assessment. For the first one and a half years I focussed on the leadership portion of my role and developed the mental health service that provides better capability within primary practices to the population. When the service was developed to a point where it began to be self-sustaining and all recruitment was completed, I started working as a NP candidate in one of Compass Health's low decile practices which works within a whānau care concept. The practice population is 65% Maori, low

decile and has high needs in terms of mental health and social services. There is also a primary mental health counsellor in the same practice and we both work one day per week seeing people who have mild to moderate mental health needs.

I provide comprehensive mental health assessments, diagnostic, prescribing and advice to the General Practitioners (GP) and Practice Nurses in that practice. I work short term with those I assess and provide treatment for them in terms of one to two therapy sessions or medication treatment. Once I assess that person is well enough to return to their GP care, I have a conversation with the GP.

I gained NP registration in 2017 in mental health across the lifespan. Although I do see youth under the age of 16 years in the practice, I will complete a triage assessment to ascertain where their needs are best met and refer to more appropriate services for comprehensive assessments and treatment options. I also work alongside the Community Mental Health (MH) Team and Centre for Addiction and Mental Health for those with more complex needs who require a multi-disciplinary team approach including a Psychiatrist.

I work two clinical days and three leadership days with the two roles continuing to develop synergistically, one informing the other. The challenge I have is not having access to psychiatric prescribers as a requirement for NP registration and having to pay for this type of supervision. However, I am hopeful that sometime soon there will be more collaboration between specialist MH and primary health services and I will be able to work side by side in primary care with my specialist mental health colleagues.

As a clinical leader and an NP, I work locally and nationally on projects to enhance the patient journey and assist in developing self-care and self-determination for those with mild to moderate mental health conditions.

I also work closely with Whitireia Polytechnic who have a very strong mental health focus within their faculty and prospectus and have taught MH assessment modules for PG students and often feature on specialist panels for MH nurse's forums through Te Ao Maramatanga. Together with one of the Deans, I am providing specialist input to the diagnostic and treatment sections of a MH manual which his being updated.

I think I have the best of both worlds in leadership and clinical practice. As an NP, I love developing quality services that assist in less navigation of the mental health system for the patient and more services being offered in primary practice where they receive most of their health care. Being able to offer NP clinics in primary practice not only benefits patients but also vicariously upskills practice staff so they have more confidence and knowledge when dealing with those with mental health conditions.

The use of technology as an enabler in integrating teams in Primary Health Care.

Emma Hickson

Director of Nursing Primary and Community

Capital & Coast District Health Board

The introduction of the Health Care Home (HCH) model into Capital and Coast District Health Board (DHB) general practices is representing an ongoing transformation in the way primary care is delivered. Since 2016, an increasing number of General Practice teams have been supported to become Health Care Homes with the aim that 80% of the population will registered in a HCH practice by the end of the financial year 18/19. The integration of community services such as District Nursing and Community Allied Health into general practice as a core element of that model is also changing how community teams interact.

HCHs are required to hold multidisciplinary team (MDT) meetings. The MDT meetings are routinely held to proactively plan care for people with complex needs. However, the challenge for most busy community services team members is the additional time required to travel and be present at these MDT meetings.

After an initial period when integrating team members have developed relationships and understanding of each other's roles by being physically present at each MDT, the use of technology to enable virtual attendance is being trialled. Since October 2017, piloting of the virtual MDT meetings and the trialling and use of different technologies has enabled key findings and lessons to be learnt from early experiences.

An initial decision to use Skype as the application was agreed at the HCH Community Services Integration (CSI) Steering Group meeting. Preparation commenced two weeks prior to the first planned test for a virtual meeting by downloading Skype to the Community Services staff's iPads. Staff had to use new gmail accounts to overcome the DHB's firewall. The DHB's information and communication technology (ICT) staff assisted with the Skype download and connectivity at the general practice setting. A test run was conducted prior to the actual MDT meeting with the Allied Health team video conferencing from the main hospital site and the District Nurse using an iPad and being 'parked' within close proximity to the practice. For the video conferencing capability, the practice purchased a camera and also had to create a new gmail account. A standard Skype application was used and on the day of the first meeting, the

practice Business Manager worked on conferencing and connectivity with all members of the team.

There were several key lessons learnt from this first trial. For example: Wi-Fi connectivity issues at the DHB required video conferencing to be disabled to enable a clearer audio for all; Skype had limited capabilities in terms of real time document sharing; Teleconferencing (audio only) was suitable as long as known clinicians were involved; Community Services staff need training on Skype use; Infrastructure investment is required such as camera, computer, monitor, television, speakers; Technical capability to manage hardware, software and troubleshoot is needed in General Practices; Travel time is saved with use of virtual MDT meetings.

After review of the first virtual MDT meeting, the next steps were to continue the roll out and testing of the process with other practices. Further review and findings were reported to the HCH CSI committee with development of written guidelines for virtual Skype MDTs. In addition, with the organisational purchase of Zoom as a cloud platform for video and audio conferencing, it was planned to trial Zoom as an alternative.

The trialling of Zoom did demonstrate the relative ease of use from a technology set up and application perspective and there were no major issues with connectivity. It was learnt that iPads need to be held at face level for maximum voice transfer through devices and staff are not able to refer to the patient management system whilst using Zoom.

The overall review of using devises for staff to attend the increasing number of MDTs as the HCH model continues to expand remains positive. When space is limited in General Practice meeting rooms, having community staff join virtually can ease overcrowding. Excellent support from the DHB ICT team has made a much more successful outcome of the trials and a guide for the use of Zoom has been developed and will continue to help those new to its use.

The use of technology to support health and healthcare practice is becoming an increasing feature for Primary Health Care and Community Nurses. Healthcare is changing with communication methods to enhance care being developed, technology to support assessment and diagnosis being advanced and self-care and information applications becoming available. The challenge remains for nurses to embrace, immerse, update and be competent with the ever evolving landscape and resources of technology to assist practice.

Dealing with non-consensual disclosures.

Michelle Ihaka

Co-ordinator

Wairarapa Rape and Sexual Abuse Collective Inc.

Rape and sexual abuse can be an uncomfortable topic for many people including professionals who don't work within the specialist field. Therefore it is important to educate yourself on some basics that can have a huge positive impact on a survivor's recovery/healing process.

Unfortunately rape and sexual abuse is very common in New Zealand. It is still not spoken about enough and there are many perceived myths that go along side rape and sexual abuse.

If you have a discloser of rape and or sexual abuse, it is important that the client feels believed and heard while disclosing their story to you.

You have been told because they feel safe with you, trust you and are ready to begin their healing process.

You are possibly the first person they have ever told.

It is very common that disclosures are not made until many years later. This is normal.

It is important that you react appropriately in this situation as your reactions could have a negative impact on a survivor.

Let them tell their story, do not dig for information or details, if they want you to know this information they will tell you.

There are many options to be aware of while respecting that it is important the survivor has control on who they tell their story to and who they want involved.

Keeping that in mind, it is also important that they are given options on what supports are available for them and that they are aware, they have a choice of what type of support they would like.

What may seem right for some is not right with others.

It is important the survivor has control on their story and they are not pressured into making a decision. This has to be the best outcome for them, not yourself.

Options include,

Specialised Support agency's- These are organisations who specialise in working with survivors of sexual abuse. They offer free and confidential information, ongoing support and assist with all options listed below.

ACC Counselling – A survivor is entitled to this at any stage of their life, there does not have to be a complaint to the police or a conviction to receive counselling. Anyone can make a referral to ACC.

DSAC (Doctors for sexual abuse care) - can do a wellness check, heath, sti etc. with the information being kept

confidential. They can also do medical forensic examinations for DNA and evidence collection within 7days of a sexual assault. This can be done without police involvement, kept confidential, and stored for up to 6 months if the person is unsure if they would like to report the offence to police at the time of the medical.

Police – Some people never report to police and that is their choice if they do not want police involvement. It is important the survivor has control on who they tell their story to and it is not told on behalf of them.

If there is a discloser of being in danger, self-harming or a child is possibly being abused or at risk, a mandatory reporting process needs to be followed.

Become familiar with the specialist service in your area which is a free and confidential service.

It is important that you know what they offer so the information can be given correctly and be an option to pass on, or to do referral to an appropriate agency whom specifically specialise with rape and sexual abuse survivors.

There is a National Rape Crisis free calling phone number that gives prompts to Region's throughout New Zealand. Specialist organisations can be contacted via this number 0800 88 33 00

For a list of sexual abuse support agencies nationwide visit www.rapecrisisdunedin.org.nz

Michelle Ihaka

Co-ordinator

Wairarapa Rape and Sexual Abuse Collective Inc.

0800 614 614

Starting Sexual Health Conversations with your patients

Have you ever wanted to ask a question about a patients sexual health and didn't?

Brenda Little

Nurses and Physicians spoke about this very challenge at the Sexual and Reproductive Health Conference in Wellington last November at the roll out of Gardisil9 now free for men under the age of 26.

How do we ask these sensitive questions? How do we raise sexuality with our patients safely?

After 30 years in the Health industry focusing on roles with a Sexuality component I was inspired to suggest how easy the conversations can be with the right tools and a bit of willing practice. I suggested firmly……as Health Care professionals……"If we don't ask the questions about a patient's general sexual health we are not doing our jobs". Seqirus agreed to support this venture.

I set about running a few pilot workshops. A gorgeous group of Practice Nurses in the Wairarapa were keen to pilot the first workshop I put together, working with models and frameworks that

- develop the rationale for having sexuality conversations
- make it easier to practise using the words
- create the affect and the interest required to have sexual health conversations.

On the pre-workshop survey 75% of the attendees answered YES to "Have you ever wanted to ask a question about Sexuality with a patient but didn't" . Most participants stated the reluctance came from

- not knowing how to ask the question of some patients or
- a sense that they were saving the patient from some embarrassment.

During the workshop we discussed the models and frameworks in relation to patient scenarios from examples from my work and more importantly problem solved the scenarios put forward by Practice Nurses attending.

Most related to feeling vulnerable either for themselves when broaching the subject or at least an awareness of their patients vulnerability being interviewed about the subject. A tool developed by Jack Annon, the PLISSIT model highlights the levels of intervention patients might

require regarding a sexual health matter of any kind. The PLISSIT model was designed to help us gain some perspective of the needs of individuals with a sexual health concern and the differing levels of interventions possible, so we aren't always worried about the outcome of asking questions about someone's sexuality.

Jack Annon suggests as health care providers we are offering *Permission* by asking questions and broaching the subject. When we ask the questions we are role modelling the importance of using the language and simply initiating a conversation about it. Usually sexuality is tapu, or a tabu subject. If we don't ask the questions where else will our patients get initial Permission or information from?…..This is a health matter after all, like any other aspect of our patients health. I submit we are denying our patients the opportunity to present these conversations or inquiry if we are not forming some quick Permission giving questions for patients.

Most importantly, as you can see on the model, the first area of intervention with any patient is that of giving *Permission* to talk about sexual health matters. If someone discusses their concern it may be all that is required as an intervention. Discussing the "elephant in the room" eliminates the concern of a question held in silence. When we role model a few simple queries regarding sexual health it makes it easier for our patients to ask us questions. This also could have your patient going home to talk about sexuality with their partner too.

It's important to note the few frameworks I tried out are easy to use and make good sense to back up the workshop content. Those who were already asking questions of patients found the workshop reinforced what they were already doing and appreciated using the frameworks to develop their assessments further.

The most important ingredient for developing good conversations about sexual health is *Permission*.

The next level of concern for the Nurses was "If we ask the initial questions do we have to provide the support required?"

The answer is a clear, no, of course not. When questions or queries come up from a patient you don't have to provide the intervention they need. Interventions offering *Limited Information* or *Specific Suggestions* don't have to come from you. These next layers can be provided by other services or resources. The important thing for your patients is to start somewhere with Permission asking questions; don't be afraid of the patients answers, work with them to find the next level of support to their inquiry.

The post-workshop feedback was positive with 100% of the attendees feeling affirmed, more confident and wanting to ask their patients some of the questions they designed during the workshop. They left with the willingness to be curious about developing further Permission specific questions that may work for them and for their patients.

Feedback from a few Nurses; "I learned how to better engage with patients". "I valued the frameworks, examples and scenarios" "I learned how to be honest and acknowledge the elephant in the room" "Brenda is so real; Reality is so key to my nursing practice".

"Real Sexual Health Conversations" with your patients is a new venture by Brenda Little. The workshops are informative, fun, and interactive and provide heaps of learning. You will leave the workshop with new ideas and the confidence to give sexual health conversations a go in a

new easy way that your patients will appreciate and gain from.

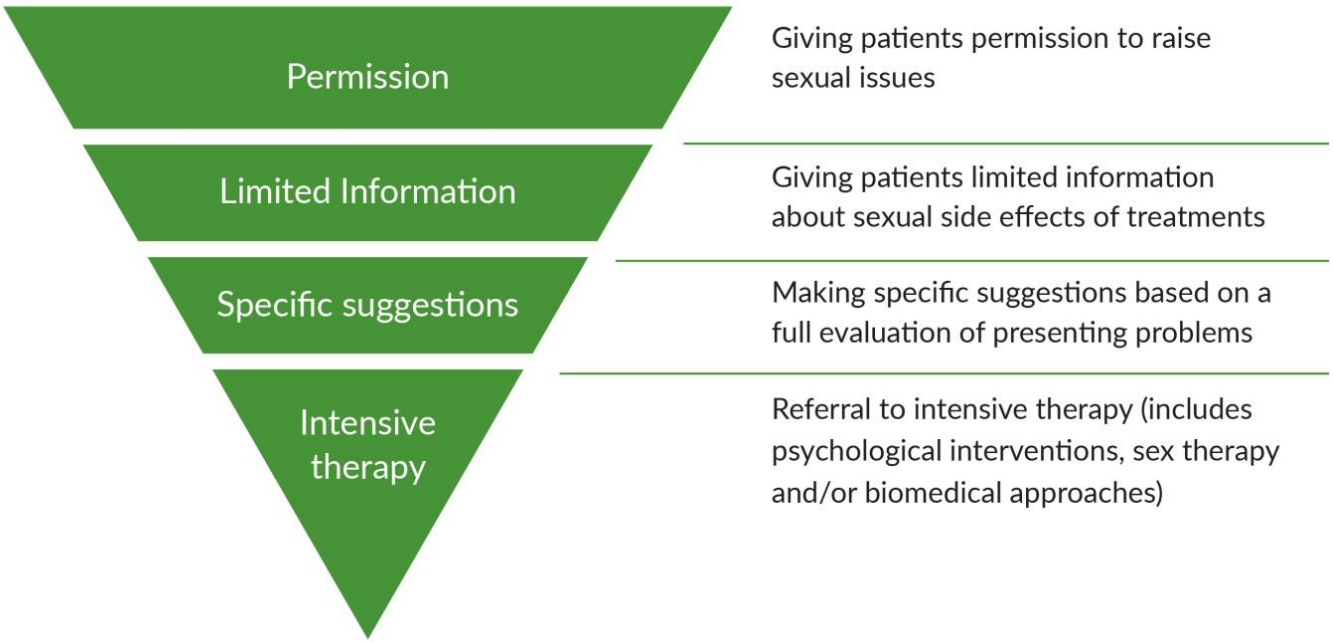
Contact Brenda if you would like to set up a workshop for you and your colleagues or refer a patient for follow up on any sexuality matter they are concerned about.

Real Sexual Health Conversations

Brenda Little *BScN NZAC registered*
029 971 5352
brendalittle6.bl@gmail.com

Web page www.conversationswithbrenda.com

PLISSIT Model of Addressing Sexual Functioning (Annon, 1974)



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

Articles – Australasian Musculoskeletal Medicine Journal

1. Canal stenosis

Vivian, David Australasian Musculoskeletal Medicine, Vol. 21, Sep 2017: 13-17

Canal stenosis is the narrowing of the canal through which the spinal cord and nerves travel. The spinal canal can be congenitally narrow, and whatever its original state, it tends to narrow further over time because of trauma and degeneration.

2. Coccygeal pain

Vivian, David Australasian Musculoskeletal Medicine, Vol. 21, Sep 2017: 29-32

Coccygeal pain (also known as coccydynia and coccygodynia) refers to pain derived from the coccyx. The term defines a symptom rather than a diagnosis.

3. Greater trochanteric pain syndrome

Eivers, Tore Australasian Musculoskeletal Medicine, Vol. 21, Sep 2017: 18-22

Lateral hip pain is a common presentation in general practice and for those practising musculoskeletal medicine. Amongst the most common are referred pain from the lumbosacral spine and sacroiliac joints, hip joint, and disorders of the muscles and tendons inserting near or around the greater trochanter of the femur.

4. Complex regional pain syndrome

Keightly, Jenny Australasian Musculoskeletal Medicine, Vol. 21, Sep 2017: 23-26

In 1994, at the age of 26, Mrs. A underwent a tibialis anterior decompression at her left ankle for persisting lower leg pain related to tibialis anterior tendinopath. Following the surgery, the pain only worsened and she experienced twelve months of severe pain, swelling, coldness and tightness of the left ankle which eventually settled as she worked with her musculoskeletal physician using multiple methods such as counter-irritation, gradually increasing movement in the ankle, choosing supportive shoes and medication.

5. The ineffectiveness of paracetamol for acute low back pain.

Sandhu, Karan Australasian Musculoskeletal Medicine, Vol. 21, Sep 2017: 33-35

KG, a 55yo male presented to his general practitioner following a two-day history of moderate intensity low back pain that initially occurred during a cricket match. On examination, he demonstrated restricted range of motion (secondary to pain) on lumbar flexion and extension

6. Ultrasound imaging in rotator cuff tears

Mathew, Ronnie Australasian Musculoskeletal Medicine, Vol. 21, Sep 2017: 27-28

Musculoskeletal pain is the third most common cause for presentation to a General Practitioner (GP). Of these presentations, shoulder pain is among the most common. Indeed, up to 95% of those with shoulder pain are treated at the primary care level.

Article - Brain injury

7. Early rehabilitation: benefits in patients with severe acquired brain injury.

Formisano, Rita; Azicnuda, Eva; Sefid, Maryam; Zampolini, Mauro; Scarponi, Federico; Avesani, Renato. Neurological Sciences. Jan 2017, Vol. 38 Issue 1, p181-184. 4p

Establish the best time to start rehabilitation by means of scientific evidence. Observational study in patients with a diagnosis of Severe Brain Injury who received intensive inpatient rehabilitation after acute care. 1470 subjects enrolled: 651 with Traumatic Brain Injury (TBI) and 819 with Non-TBI

8. Expanding Clinical Assessment for Traumatic Brain Injury and Comorbid Post-Traumatic Stress Disorder: A Retrospective Analysis of Virtual Environment Tasks in the Computer-Assisted Rehabilitation Environment.

Onakomaiya, Marie M.; Kruger, Sarah E.; Highland, Krista B.; Kodosky, Paula N.; Pape, Marcy M.; Roy, Michael J. Military Medicine. 2017 Supplement, Vol. 182, p128-136. 9p

The objective of this study was to determine whether physical performance during virtual environment (VE) tasks in the Computer-Assisted Rehabilitation Environment (CAREN) could differentiate between service members (SMs) with a history of traumatic brain injury (TBI) with and without comorbid post-traumatic stress disorder (PTSD)

9. Future Planning Among Parents and Siblings of Adults with Acquired Brain Injury: A Comparative Analysis with Intellectual Disability.

Degeneffe, Charles Edmund. Journal of Rehabilitation. Jan-Mar 2017, Vol. 83 Issue 1, p31-40. 10p

This study aimed to understand how future planning among families of persons with acquired **brain** injuries (ABI) compared to family planning of persons with intellectual disabilities by replicating Griffiths and Unger's (1994) study of 41 parent/sibling dyads of adults with intellectual disabilities

10. Increasing Adherence to Brain Trauma Foundation Guidelines for Hospital Care of Patients With Traumatic Brain Injury.

Saherwala, Ali A.; Bader, Mary Kay. Critical Care Nurse. Feb 2018, Vol. 38 Issue 1, pe11-e20. 10p

To explore the relationship in hospitals between participation in the Adam Williams Initiative and adherence to the Brain Trauma Foundation guidelines for patients with acute traumatic brain injury.

11. Information, connection and giving back: peer support outcomes for families following acquired brain injury in South Australia.

Bellon, Michelle; Sando, Sandi; Crocker, Ruth; Farnden, Jennifer; Duras, Melissa. Health & Social Care in the Community. Jan 2017, Vol. 25 Issue 1, p204-214. 11p

This study aimed to identify the experiences and outcomes of participation in Families4Families Inc., a peer support network for families following acquired brain injury (ABI) in South Australia.

12. Is There Hope? Is She There? How Families and Clinicians Experience Severe Acute Brain Injury.

Schutz, Rachael E.C.; Coats, Heather L.; Engelberg, Ruth A.; Curtis, J. Randall; Creutzfeldt, Claire J. Journal of Palliative Medicine. Feb 2017, Vol. 20 Issue 2, p170-176. 7p

Patients with severe acute brain injury (SABI) raise important palliative care considerations associated with sudden devastating injury and uncertain prognosis. Objective: The goal of this study was to explore how family members, nurses, and physicians experience the palliative and supportive care needs of patients with SABI receiving care in the neuroscience intensive care unit (neuro-ICU).

13. Nurse Perceptions of Pain in Pediatric Traumatic Brain Injury: A Pilot Study.

McCaa, Robin. Pediatric Nursing. Mar/Apr2017, Vol. 43 Issue 2, p92-95. 4p

Pain assessment in the pediatric population is challenging because of age, developmental stage, and patient cooperation. Cognitive impairment, impaired communication, and physical disability that may accompany traumatic brain injury (TBI) further complicate pain assessments. A pilot descriptive qualitative research study was conducted to investigate nurse perceptions of pain in pediatric patients diagnosed with TBI. Specifically, this study sought to answer the following questions: a) Is pain accurately assessed in this population? b) Is pain adequately treated in this population? and c) What obstacles exist, if any, to the assessment and treatment of pain?

14. Quality of life in persons after traumatic brain injury as self-perceived and as perceived by the caregivers.

By Formisano, Rita; Longo, Eloise; Azicnuda, Eva; Silvestro, Daniela; D'Ippolito, Mariagrazia; Truelle, Jean-Luc; Steinbüchel, Nicole; Wild, Klaus; Wilson, Lindsay; Rigon, Jessica; Barba, Carmen; Forcina, Antonio; Giustini, Marco; von Steinbüchel, Nicole; von Wild, Klaus.

Neurological Sciences. Feb 2017, Vol. 38 Issue 2, p279-286. 8p

The primary aim of the study was to adopt QOLIBRI (quality of life after brain injury) questionnaire in a proxy version (Q-Pro), i.e., to use caregivers for comparison and to evaluate whether TBI patients' judgment corresponds to that of their caregivers since the possible self-awareness deficit of the persons with TBI.

NZNO Library

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