LOGIC

LINKING OPPORTUNITIES GENERATING INTER-PROFESSIONAL COLLABORATION

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

Vol 17 No 3

Rural Muster

E-Learning & Apps

Nurse Prescribing

Pharmac

Teledermatology

NZCPHCN updates & forums

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

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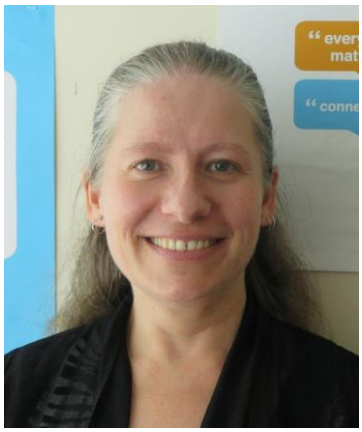
In this issue….

Chair's Report



Celeste Gillmer
Chairperson

Tēnā Koutou katoa

The NZ College of PHC Nurses had our AGM on 23 August in Christchurch this year. Here is my report that I tabled at this fantastic regional event and AGM:

The past year, from August 2017 till today, has been a year of change, challenges and hope.

We welcomed a new government, led by a female prime minister, who fell pregnant and delivered a healthy baby girl in her first year of leading this beautiful country.

A decision was made by the government to do a Primary Health Care review, which led to Annette King forming the Primary Health Care Federation. Although currently we still don't know exactly what the direction of this federation is, we have a strong nurse leader, David Harrison, around that table.

DHB nurses on the NZNO MECA made history on the 12th of July. For only the second time in New Zealand's history, our nursing workforce went on strike after not accepting the initial pay offers. Negotiations for the DHB were finally settled, but now we are waiting for the negotiations to start for the PHC MECA.

The New Zealand College of Primary Health Care Nurses welcomed a new executive committee in August 2017. We worked hard to fill the shoes of our amazing leaders who stepped down at our August 2017 AGM. After conducting a learning needs analysis of our members, we decided not to have a symposium or conference this year, but to focus on supporting our regional forums to grow their regional networks and to deliver professional development opportunities within their regions.

Thank you to Christchurch for hosting us today and we hope our visit to your beautiful city will provide you with ideas and support to strengthen and grow your regional activities.

We hope to have another regional event, this time in the far north in Whangarei, later this year.

Thank you to all our committee members and College members who represented the NZCPHCN at various groups during this year. We know you volunteer to sit on these groups and we appreciate your time and your passion for PHC nurses.

Then, to all the committee members. Thank you. I don't know how to express my appreciation for your hard work and dedication. Cathy and her professional practice committee, thank you for keeping all our documents updated and professional. I know the Knowledge and Skills document was a very big project and it is almost ready to go out for final consultation. Congratulations!

Yvonne and the LOGIC committee, fantastic work ladies! Between busy and demanding work schedules, you still managed to produce a wonderful journal every quarter. I still get compliments after each edition and I truly believe that the decision to distribute an electronic journal was the best decision we made for the future of the College.

Unfortunately, we also need to say goodbye to someone today. She has been a loyal committee member for the past 8 years and our very reliable secretary for the past 4 years. Wendy, we (and especially me) are going to miss you so much. Always organised. Always knows where to find documents. Always prepared to step up and take responsibility for various work pieces that required to be completed. We wish you all the best for the future. Enjoy the break from countless meetings, agendas and minutes! Enjoy focusing on your hobbies and your family. But be warned, it is not the last time you will hear from us!

Then finally I need to say a special thank you to Angela Clark. She has been my rock over the past year. No matter what time of what day, she is able to advice and reassure. Thank you, Angela, for everything you do for the College, for all the extra hours you put in for us and for always being there for us. You have no idea how much we appreciate you.

We are also saying goodbye to Bronwyn from the Professional Practice Committee. We thank Bronwyn for her passion and positive contributions to the work of the College. We have a few vacant positions on both the PPC and the LOGIC committee. Please consider these roles if you have a passion for PHC nursing and would be interested to contribute to this workforce on a National level. For the year ahead, we are planning on publishing the PHC Knowledge and Skills document and continue our focus on regional activities. We will continue to be a voice for PHC nursing throughout NZ, representing the College and PHC nursing on a national level.

Thank you to all our members, your work within your area, whether it is practices, public health, district health, schools, corrections, well child providers, aged care or any other PHC setting, does not go unnoticed! We appreciate your passion and your dedication to the health of all New Zealanders.

Tēnā koutou tēnā koutou tēnā koutou katoa

Celeste

Editor's Report

Yvonne Little

Nurse Practitioner

Welcome to the 2018 Spring Edition of LOGIC.

It's hard to believe we are now well into our second year of providing an e-journal. Without the support of the following this would not have been possible, so I would like to say thank you to the LOGIC committee members for your efforts no matter what life has put in your way to get articles sourced, the National Executive and NZNO and last but not least the NZCPHCN membership whose input to improve the journal has been invaluable.

Our aims for the 2017-2018 year were:

1. To increase reader coverage by providing more diverse articles to encompass those nursing groups within the NZCPHCN umbrella (Public Health; District; Maori Health; Aged Care; Palliative Care; School; Occupational Health; Mental Health; Sexual Health; Respiratory: NGO Sector; Plunket and Prison Nurses) not solely Practice Nurses
2. To celebrate and promote those in our ranks who have achieved in the leadership arena.
3. To provide information and support through collegial sources

I believe our aims for 2018-2019 will be much the same.

Our Theme topics are planned to work alongside our regular reports from the Editor, Chair of NZCPHCN and Office of Chief Nurse. We have new regular/semi-regular sections to be more inclusive of our membership in: RN prescribing; Rural Muster; NZNO library section; and updates on our NZCPHCN committee members as they change due to terms being completed or life changes.

We have also been receiving enquiries about placing advertisements in for research surveys and thus providing membership with access to have their input into this vital part of the health care sector. So, I hope you enjoy and become involved with some of these research and surveys.

In this issue we have a great selection of articles which we hope you enjoy. Our feature articles are around the e-learning and telehealth which are becoming more the norm in today's fast paced world. I hope you enjoy checking these out. Unfortunately, some of our regular contributors have not been able to supply articles but we hope to bring these to you in the next issue.

Also, this time we do not have a report from Jill Clendon, from the Office of the Chief Nurse, as you can imagine she has had a busy time alongside NZNO with the DHB MECA amongst other important meetings.

Finally, as we have some committee members finishing

their terms of office or life changes here is an update on who we are as of our August meeting in Christchurch (you can see more about this article later in the journal).

Our current committee consists of:

Yvonne Little – Editor

Celeste Gillmer – Publisher and Chairperson of NZCPHCN

Emma Hickson – Committee member and Deputy Chair of NZCPHCN

Annie Tyldesley - Committee member who joined the team in August 2017

Irene Tukerangi – Committee member

Erica Donovan – new committee member who joined us at our August meeting in Christchurch (a fellow South Island team member for Annie).

Farewell and Thank you to our valued committee member Katie Inker's whose term of office with LOGIC is now finished. Despite losing her from our LOGIC team I am sure she will be able to utilise your knowledge and contacts for future LOGIC issues and she is staying on with NZCPHCN as part of the Professional Practice Committee.

We look forward to bringing you one more issue for 2018 and are already in the planning stages for 2019, so if you have any thoughts about what you would like to see covered then contact me on my new dedicated email: logiceditorcphcn@gmail.com

Yvonne

December 2018 Issue:

- Party Health
- Well Being and Prevention
- Sun Protection
- Diabetes
- Nurse Prescriber
- Cultural
- Rural Muster
- Immunisations

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

23-24 August 2018

Cathy Nichols

Chair – Professional Practice Committee

Membership is stable at 1778

NZNO's Nursing Strategy has been published and can be viewed via the NZNO webpage or https://www.nurses.org.nz/. There are 98 action points arising from the strategy, the College will work with NZNO to develop these and ensure that the PHC Nurse voice is reflected.

PHC Knowledge & Skills Framework draft has been received from MidCentral District Health Board; committee members have till the end of August to make comments back to the Professional Practice Committee.

The Committees had a 'Zoom' tutorial as there have been problems running Skype sessions for our regular meetings. There seemed to be real benefits in using this platform.

Regional Activities: As a result of feedback received through the survey held earlier this year, the College executive is working hard to re-establish the regional networks. Auckland region will be having a suturing workshop in the near future, spaces will be very limited. Discussions are taking place for a meeting to be held in Whangarei in the near future.

Prior to the AGM in Christchurch the College hosted a very successful information evening. We explained the 'who, what, why and how' of the College. It was a bonus that Chris Wilson was able to join us to share her experiences of being on the District Health Board MECA (Multi-Employer Collective Agreement) negotiating team and how that will influence the Primary Health Care Nurses MECA. The PHC MECA expired at the end of August 2018. To ensure that you are kept fully informed of MECA developments, please make sure that NZNO has your current workplace and contact details including email address. Give the NZNO membership team a call on 0800 28 38 48 – if these need updating.

The Colleges Annual General Meeting (an NZNO requirement) was held on the Thursday 23rd August. Annual reports were tabled; you can view copies of these on the College webpage. Following the meeting two remits (rule changes) need to be voted on via a Survey Monkey this will be sent out to all members shortly. It is important to have your say. For more information the remits can be found here

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

The last part of our evening was to present the New Nurse to Practice award and the Jane Ayling Tall Poppy award. Both have $1,000 attached to them. Unfortunately no nominations were received for the New Nurse award. It is with pleasure that the Tall Poppy award is given to a:

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

This year's winner is Bronwyn Boele van Hensbroek-Miller. Bronwyn works as a Nurse Practitioner at Te Aro Health Centre in the heart of Wellington. Te Aro is a low cost practice which cares for some of Wellingtons most vulnerable people. Bronwyn runs clinics at the Wellington Soup Kitchen and Downtown Ministries. Bronwyn also maintains her midwifery registration.

She is a deserving recipient of the Jane Ayling Tall Poppy award for 2018. Congratulations Bronwyn.

RURAL MUSTER #7

Kate Stark – Nurse Practitioner

What a year for rural health and for rural nursing we have seen so far. It's great to see Rural Nurses New Zealand (RNNZ) gaining momentum over the 6 months since our last Rural Muster. RNNZ consists of nurses working in varying degrees of rurality across New Zealand in both primary and secondary care.

RNNZ has developed strong working relationships amongst its' committee members, and this was strengthened by their very first face to face meeting in April at the 2018 National Rural Health Conference. Monthly meetings have also been held via zoom and the group is also working collaboratively with the Rural General Practice Network (RGPN) with Chair Rhonda Johnson and committee member Rhoena Davis representing the group at RGPN Board level. Rural Nurses NZ has recently appointed a student representative, Kristene Bartlett and they are now seeking a nurse working in secondary care to join the group. Expressions of interest are open until the end of August and can be emailed to Rhonda Johnson the RNNZ Chairperson nzrhonda19@gmail.com

RNNZ has worked hard to encourage connectivity for rural nurses in all areas of rural health care delivery since its inception and with growing numbers now has 360 members on its Facebook page. We have also seen media activity in the Southern Rural Life, The NZ Herald, RGPN Network News and Nursing Review as well as collaboration with Mobile Health and a newly developed webinar series specifically targeting rural nurses. There is also ongoing work in relation to nursing research and time has been dedicated to professional development for rural nurses at the annual National Rural Health Conference.

The last 12 months for RNNZ has seen a vision become reality. The group is to be congratulated on the progress they have made in such a short time. It is safe to say that rural nurses in Aotearoa will benefit from the networking that has already occurred and that will occur going forward. Establishing RNNZ has facilitated the expansion of previously created relationships which are fundamental to achieving connectivity amongst rural nurses while supported by key stakeholders such as RGPN.

There is still a lot of work going on behind the scenes in relation to PRIME. St John in partnership with the National PRIME Committee and RGPN have made progress in addressing some of the key issues, in particular in relation to the PRIME curriculum, shortage of PRIME courses and refreshers, PRIME safety equipment as well as raising the profile of PRIME

nationally. This will undoubtedly take time to further shape the future of PRIME as an essential sustainable service for the health of rural New Zealanders, especially as PRIME sites across New Zealand differ in their operational activity, funding, and their geography and challenges are all unique.

For those of you interested, there is a PRIME study day being held in Dunedin on October 26th/27th by PRIME nurses for PRIME nurses. This historically has been well supported and is a great opportunity to network with others at the coal face and also to learn new things from some of the presenting speakers. For further information, the registration forms and programme can be found on the PRIME Nurses Facebook page. Join up if you aren't already a member and stay informed!

It is encouraging to note that three of the four practices chosen in the south as part of the first tranche for the Southern Health Care Homes are rural. Queenstown Medical Centre, Gore Medical and Gore Health Centre, along with Amity Health in Dunedin have begun their transition to the Health Care Home (HCH) model, with the project being rolled out by WellSouth and the Southern District Health Board to the rest of the southern practices over the next 12 months. As part of the change leadership team at Gore Health, I am confident that we will change how we work for the benefit of our patients. Within the transition, inefficiencies of primary health care delivery will be identified and managed, while bridging the gap between primary and secondary care is also on the agenda of potential outcomes. There is a strong emphasis on relationships within practice teams and also between practices undergoing the transition. Sharing of information, use of patient portals, reduction of waste within practices including personnel and time, as well as financial forecasting are on the agenda as the practices travel the HCH model three-year journey. It is exciting times in the south as we replicate the model that has already been seen on the North in recent years. We are drawing on the expertise of practices who have travelled their own journey implementing HCH, learning the pros and cons of changing from the old model of care to the new.

Have you got a story from your rural workplace that you would like to share?? Rural Muster is your column in LOGIC, and we would love to hear from you what is happening in rural and remote New Zealand in particular for nurses. Rural nurses are an integral part of rural health care and sharing stories is a great way of raising our profile.

Please email me on kate.stark@gorehealth.co.nz if you have a story you would like to share.

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

E-Learning and Apps

Yvonne Little NP

Why E-learning and why Apps? What function do they have in nursing education? Which ones are reliable? Do they have valid and up-to-date information and can we trust them or are we better off with face to face learning sessions?

These are just some of the questions we find ourselves asking. It has always been face to face meetings in our own regions after a long day of working or trying to get to conferences, symposiums or seminars. But this has become increasingly fraught with the inherent difficulties of available time, travel and the ever-increasing cost.

Not only has NZCPHCN found this to be true but even at a local level PHO's are now looking at how to do things differently, my own region this year decided that trying to get Nurses and Doctors to attend after work meetings was becoming less well patronised and therefore held a Seminar, but even this is problematic for everyone to get time off.

So how do we address these issues?

As your official journal of NZCPHCN we decided to investigate what is out there, many of you will know what is available in your region but there are nationwide resources that you may not be aware of, there is also the propensity for patients to now google or find an App to check their symptoms and come to you already armed with "their knowledge" so we as a profession need to be aware of what is out there and what is safe.

The proliferation of smart phones and other hand-held electronic devices means that both your patients/clients and yourselves have ready access 24/7 – unless you live in an area with poor connectivity.

As Primary Health Care Nurses we want to deliver the best health care to our community, thus improving the flow of

information and communication for the benefit of the patient/client, therefore I have checked out a few sites which I will include here, but rather than take my word for it I have enlisted the help of nurses and researchers who are working in the area of E-learning to give you their views and their current learning projects, please have a good read of their articles included in this issue and try out some E-learning.

Some E-learning sites:

Ko Awatea

Most of us are aware of Ko Awatea, it is a learning platform which is health sector focused and has a range of programmes and forums. For those of you not familiar with it, please check out this website address to see if you have access within your area and how to use it:

https://koawatealearn.co.nz

Sureskills

Make sure you have a read of this fabulous article by Pat Mitchell and take a look at the flyer associated with this E-learning package. Whilst this is not free like some other E-learning packages if you are working with children and youth it would be well worth the output. Maria Kekus, a Nurse Practitioner alongside Pat Mitchell saw a gap that needed addressing and have started a business to do just that, this E-learning package is just part of what they do. And we hope to bring you more from them in future issues.

NZ Doctor E-learning courses

Whilst many of you may think these are for Doctors only – let's not forget nurses do a lot of similar work albeit at different levels. This might be one for the Specialist Nurses and Nurse Practitioners but there is no reason that you cannot access it. Again, this is not a free one,

you will need to subscribe to NZ Doctor to access this, the link is:

www.nzdoctor.co.nz

Hepatitis B vaccination online module

This is one of the free online learning modules. Please take the time to read the fantastic article in this issue by Ellen Cadzow, about why this module was developed and log in and do the E-learning. Hepatitis B is definitely something every nurse in PHC should be up to date on and this is specifically designed with travellers and NZ health professionals in mind.

https://www.easy-lms.com/hepatitis-b-vaccintion-for-travellers/course-20951

MOH

https://learnonline.health.nz

Nursing Review: August 30 2017 – working with interpreters is one example

nursing review.co.nz

Heart Foundation

learn.heartfoundation.org.nz

NZNO in association with CPD4nurse.nz and Kai Tiaki

www.cpd4nurses.co.nz

These are just a few examples of E-learning that is out there, no doubt many of you will have other ones you have used, so if you have some you think would be of benefit then please let us know and we can keep the information going out to other members through LOGIC.

Now for APPS, and NO that doesn't mean NAPS even though a few of us could do with those also.

We are all used to using Apps of various kinds on our phones these days and so are patients/clients. We need to know what is out there for our learning and apps that could help our patients/clients with their health issues, so here are a few to look at – again if you have any that you think would be useful to the membership, please let us know and we can keep running an update on Apps the same as E-learning access.

Stop, Breathe and Think

Mindfulness and meditation can be accessed at: https://stopbreathethink.com

There is also You-Tube access for this App also.

Calm

Meditation techniques for sleep and stress reduction (I'm sure many a nurse could do with this after a stressful day). Life is becoming more hectic and many people are now suffering stress related illnesses and depression/mental health is becoming more common place. This may be of use for professionals and

patients/clients alike. It can be found at: https://www.calm.com

Maternal/Pregnancy/Breastfeeding

The following are some NZ apps or places to go to find apps around pregnancy and breastfeeding.

BreastFedNZ website: www.breastfednz.co.nz

Health Navigator website: www.healthnavigator.org.nz

Best Pregnancy Apps: www.healthline.com/health/best-pregnancy-apps

Defibrillator

A vital app for anyone to have on their phone whether a health professional or not. They are so easy to use now.

https://aedlocations.co.nz

Nursing Journal Apps

Here are a few but there are many more out there – just make sure you pick a reputable one with a health background rather than a blog.

Wiley Online Library: https://onlinelibrary.wiley.com/doi/full/10.1111/jocn.13834

Nursing Journal: https://nursejournal.org/community/19-must-have-mobile-apps-for-every-nurse

Nurses – Medscape: www.medscape.com/nurses

The final word on E-learning and Apps – find out what is out there, check it is from a reputable source and has scientific background to support the facts supplied within it.

We all need a little help from our phones at times and this is one way of doing it.

Using the E-learning packages that are available will ensure we can easily keep up our CNE points for our practicing certificates, many of these you can do in small pieces rather than one long session which helps us to manage our busy lifestyles and allow us to spend time with family and friends and find that work-life balance that everyone keeps saying we need.

To be online or not be online – that is the professional development question.

Pat Mitchell

Nurse Practitioner and Director Health Connections & SureSkills LTD

As registered professionals – nurses know and respect the importance of professional development. Having navigated the nursing world in various roles, the directors of *SureSkills* know this too.

With this in mind and brimming with passion to improve outcomes for children and young people – *SureSkills* found ourselves limited in providing professional development opportunities to nurses across New Zealand.

Generally, the barriers are well documented in the professional development (PD) literature and included:

- Cost – travel, accommodation and releasing staff to attend events – a significant factor to the final sign off to attend PD.
  The managers PD gamble – is the event going to be worth it – to nurses professionally and resulting in change in practice for better patient/client outcomes?
- The 'who' should attend dilemma and

Having delivered face to face PD opportunities for many years, *SureSkills* concluded overcoming these obstacles lie in the online learning space. We promptly transferred our accredited programmes, developed over 2 decades, into an easy to use learning management system. It seemed like the obvious step to reaching the masses at low cost - however we have been met with some resistance and questions about eLearning as a valid option to PD.

What is the resistance?

The resistance *SureSkills* has come in many guises – both overt and hidden.

The overt messages included – a lack of budget (despite eLearning being exceptionally low cost); the method of eLearning doesn't fit with teams learning styles and the IT equipment and internet connection were inadequate.

The hidden resistance included the perception eLearning cannot be a credible source of PD, *SureSkills* are tall poppies and are taking traditional PD services away from providers and a true discourse of what organisation say they want to achieve for their children and young people and actually what they are prepared to support staff for PD.

Whats the resistance about?

Budgets are often tight – and with expectations as to how far the dollar should stretch its easy for organisations to fall into the 'no money mantra'.

Content that is not evidenced based, doesn't reflect practice, uses minimal teaching techniques and hosted on unsophisticated learning management systems is common in eLearning – a simple google search will provide you

with a wide range of options – mostly free. The wide range of online learning available has perhaps compromised the perceived quality of online courses and the outdated and clumsy to navigate systems have tarred online learning.

Hurdling the obstacles

SureSkills eLearning offers a range of opportunities to learners. These are not limited to overcoming the challenges of geography but include providing a low-cost option and teaching techniques that focus on building skills to improve outcomes for children and young people.

Using eLearning as part of a blended learning event optimises the face to face time with learners. Being able to be integrated into existing professional development options – for example as pre cursor to university entrance is a valuable way of building the learning foundations for a group learning together.

Committing to updating and ensuring content is evidence based and up to date is the area we prioritise the most. If its not current, its not valid and so a programme of updates are scheduled quarterly for all *SureSkills* courses.

SureSkills are unashamedly innovative and stretch the boundaries – we are both tall poppies and poppy growers. We believe eLearning is one piece of the professional development puzzle – don't use it and your PD picture isn't complete.

Nurses – are you ready for eLearning?

SureSkills believe nurses are ready (and waiting) for good quality online learning. The challenge is for teams to use online learning in a way that suits both the individual and the team. We invite you to be creative about how you use it – learn as a team, consider how your practice is impacted on by the learning and use team meetings to debate the learning.

Look for eLearning that is accredited by a body you recognise and value – College of Nurses or NZQA. Look for companies offering eLearning that regularly update the courses.

The skills for learning – face to face, blended or online - lie in critical critique and reflection – both inherent in nursing - and *SureSkills* eLearning is one good method to offer opportunities to do this.

More about SureSkills – Your learning, anytime, anywhere, any device

SureSkills is the best on line platform for upskilling anyone connected to or working with children and young people.

SureSkills believe that delivering the best outcomes for child and youth health and wellbeing is a skill. Our on-line pathways teach anyone connected to children and young people the skills that result in better outcomes.

With over three decades of experience and expertise *SureSkills* provides 2 skills-based learning pathways comprising 8 skills based courses available in e learning, blended and face to face formats.

All of our courses are accredited, skills focused and valuable to anyone connected to children and young people.

Check us out at www.sureskills.co.nz

Sign up for our updates here http://sureskills.us16.list-manage1.com/subscribe?u=87eff4e02e7f74ae6e8491e62&id=4ddd668b57 -

Contact us contact@sureskills.co.nz

SureSkills®

YOUR LEARNING, ANYTIME, ANYWHERE

SureSkills is the best online platform for upskilling anyone connected with children and young people for better outcomes.

LEARNING PATHWAYS

CHILD

- **HEARTS - A CONVERSATIONAL FRAMEWORK**
  AN INTRODUCTION TO PRACTICE
- **AFTER HEARTS**
  BRINGING INFORMATION TOGETHER AND BRIEF INTERVENTIONS
- **CHILD HEALTH AND WELLBEING LITERACY™**
  IDENTIFY AND RESPOND TO CHILDRENS HEALTH ISSUES CONFIDENTLY
- **SELF CARE**
  LOOKING AFTER YOU

YOUTH

- **HEEADSSS - A CONVERSATIONAL FRAMEWORK**
  A BRIEF INTRODUCTION
- **AFTER HEEADSSS**
  BRINGING INFORMATION TOGETHER AND BRIEF INTERVENTIONS
- **YOUTH HEALTH AND WELLBEING LITERACY™**
  IDENTIFY AND RESPOND TO YOUTH HEALTH ISSUES CONFIDENTLY
- **SELF CARE**
  LOOKING AFTER YOU

VERY HELPFUL LEARNING FOR OUR FAMILY, CHURCH YOUTH, AND COMMUNITY; THE COURSES ARE TERRIFIC!

- YOUTH WORKER

GREAT OVERVIEW OF KEY HEALTH ISSUES, ESPECIALLY INCORPORATING BRAIN DEVELOPMENT AND THE IMPACT OF HOW WE CARE FOR CHILDREN AND YOUNG PEOPLE. GREAT RESOURCES - TOOLS AND RESEARCH.

- SOCIAL WORKER

SURESKILLS HAVE DEVELOPED LEARNING PATHWAYS THAT ARE EXCEPTIONAL. VERY POLISHED AND A GOOD BLEND OF LEARNING FORMATS.

- HEALTH PROFESSIONAL

CONTACT@SURESKILLS.CO.NZ | WWW.SURESKILLS.CO.NZ

SureSkills - EXPERTS IN CHILD AND YOUTH HEALTH AND WELLBEING LEARNING

Regional happenings

Wendy King

Southern Coromandel and Hauraki Nurse Forum had their first event for the year in April.

The guest speaker was Dr Robin Youngson talking about the background to his book "Time to Care".

While some members prefer to have a coffee while listening to the speaker before heading home, the rest of the attendees remained for a meal and some social networking and collaboration [loved the burst B4 School referrals I got after this!].

Attendees included nurses working in community mental health, diabetes, emergency, public health, practice nurses and district nursing.

The forum started in 2016 by a group of local nurses – Esme Moloney (President), Stacey Dunlop, Sue Bowden, Maria Prendergast and Lyn Harris. The aim was to encourage networking within the area and provide relevant nursing education. There are 3 forums per year where there is a guest speaker/s followed by dinner and networking. There are close to 30 financial members which is a real achievement for this rural and geographically challenged area. Forums are moved around different towns to allow easy access to nurses throughout the year.

Pharmac Update

Whilst, unfortunately we have never been able to get anyone from Pharmac to contribute to LOGIC, as part of our ongoing pledge to ensure our members of NZCPHCN are kept informed, I will be updating this section of our journal with the latest information about courses that are available for you to attend or do online, some of you like myself may already be getting these via email from PharmacSeminars if you have ever attended a course run by them, but I suspect many may not.

Seminar to be held in Christchurch – 29th October 2019 is Health and Wellbeing for health professionals.

Face to face seminars all being held in Wellington in November include:

Managing Pregnancy complications
Ear nose and throat (ENT) update
Rheumatology update

If any of the above interest you, then you can register by contacting Pharmac:
pharmacseminars@pharmac.govt.nz

There are currently 35 online seminars which you can obtain CPD points for doing when completing a Learning Reflection Form:
https//www.pharmac.govt.nz/seminars/seminar-resources/

Teledermatology

Yvonne Little NP

What is it, when and where did it start and why?

Do we need it or not?

How will it help our practice?

These are just a few questions that ran through my mind when I started looking at writing this article.

So, what is it?

Recently, at a skin cancer symposium I attended it was noted that there is often confusion between dermatology and dermoscopy/dermatoscopy, so let's clear that confusion up first as if you think this article is about dermoscopy you may either be inclined not to read any further or be very disappointed in the article.

The following definitions are for clarification purposes:

Dermatology: is a "branch of medicine concerned with the diagnosis, treatment and prevention of diseases of the skin, hair, nails, oral cavity and genitals." [2] In its literal meaning it is the study of skin.

Dermatoscopy: is a "noninvasive diagnostic technique for the early diagnosis of melanom and the evaluation of other pigmented and non-pigmented lesions on the skin that are not as well with the unaided eye." [2] It can be referred to as surface microscopy, dermoscopy and epiluminescence microscopy.

Teledermatology: is "a subspecialty of dermatology", it is an "application of e-health and telemedicine where a transfer of medical information is done using telecommunication technologies such as audio, visual and data communication".

"Applications comprise health care management such as diagnoses, consultation and treatment as well as education." [3]

When, where and why?

In a 1995 scientific publication Perednia and Brown first described the value of a teledermatologic service in rural areas underserved by dermatologists and hence the term teledermatology was born. [3]

So, what about New Zealand?

In 2015 a contract was established between NZ teledermatology and GP organisations, DHB's and other health providers to improve access to clinical advice from a dermatologist due to the small number of dermatologists available in the public health arena and the cost of accessing even these due to: time off work and travel for the patient, let alone the long waiting list to be seen.

The reasons for accessing this service have been cited as:

1. "diagnosis where there is uncertainty"

2. "triage prior to referral to face to face services"
3. "tips regarding investigations or management"[4]

Whilst many nurses may think this is only the domain of the doctor, we are often the first to see the patient, so we need a knowledge around what is available.

Teledermatology/telediagnosis is a complex process and there is a risk of misdiagnosis, but it holds value in that it can be used as a triage tool when wanting clarification of a diagnosis from a specialist without the need to be seen face to face.

Applications for teledermatology: [1,3]

1. Specialist referral without the wait time of being seen in the public system
2. Second opinion from a specialist to render a correct diagnosis and thus improve access to care and treatment in a timely manner.
3. Possibly only suitable for certain conditions: according to studies done there is a variability around the diagnosis of skin conditions and suspicious lesions.

How is it done? [1,3,4,5]

There are various ways of communication for teledermatology:

1. Video conferencing – to allow health professionals to communicate or the patient to communicate with the health professional. Also referred to in some articles as Real Time or Interactive.
   Disadvantage to this is that all parties need to be available at the same time.
2. Email – whilst simple to use, security is an issue these days. In some articles is referred to as SAF (store and foreward) where photos are taken and emailed along with medical history to a dermatologist.
   Advantage here is that the referrer and the consultant do not need to be available at the same time.
3. Virtual Private Network – this is used by Molemap NZ and Waikato Hospital's Virtual Lesion Clinic, unlikely to be used by smaller practices.
4. Web-based portal – NZ deletermatology uses a platform called Collegium Telemedicus.

The choice of platform used is very much an individual one, it is dependent on the parties choice and what is available in the area as many rural areas have poor connectivity (although we hope this is improving).

How will it help our practice?

A positive impact of teledermatology is the "accessibility and speed that patients are able to receive care, whilst reducing unnecessary in-clinic visits". [5]

As nursing roles are evolving, we are more likely to be the first one to see a patient with a skin condition/lesion and we need to have an understanding of the resources available so that we may guide our patients and dare I say our other health professionals, you may have locum doctors who are not trained in New Zealand and are not aware of these resources.

So, I challenge you all to have a look at Dermnet – this is a great

website if you are wondering about any skin condition, it has wonderful pictures as you will see that one particular skin condition can have many "faces".

In summary:

Benefits: [1,4,5]

Accessibility – improved access to specialty care; Triage; ease of gaining a second opinion; education for referring health care professional; improved communication between health professional and patient

Limitations: [4]

1. diagnosis and management recommendations are based on less data
2. the referrer needs to have some training in dermatology and dermatological terminology for effective communication of patient history
3. need for appropriate clinical photographs

Challenges: [5]

System interoperability – we need the ability to communicate between health professionals and medical systems.

What can we as nurses do to help our patients with their skin conditions/lesions. Whilst many of us are not in the position or have the inclination to go forward with extended learning on skin conditions or surgical interventions, the more we know about the resources available the better for our communities.

References:

1. MCGOEY ST, OAKLEY A, RADEMAKER M. Waikato Teledermatology: A pilot project for improving access in New Zealand. J Telemed Telecare OnlineFirst, published on June 1, 2015 as doi:10.1177/1357633X15583216.

2. https://www.medicinenet.com/script/main/art.asp?articlekey=32812

3. https://evisit.com/resources/what-is-teledermatology

4. www.nzteledermatology.com

5. https://www.dermengine.com/blog/news/teledermatology-the-benefits-of-connectivity

GENDER DIVERSITY –

The biggest social shift

since Feminism.

Annie Tyldesley

I recently attended a Gender Diversity workshop run by Ari Nicholson of Q-topia. For me this was definitely a toe in the water of a sea I was very unfamiliar with, and this is why I had decided to go. I was the only Practice Nurse there, which surprised me as gender diversity is one of the major emerging issues of the 20th century. So, what did I learn and how can I use this knowledge?

Firstly, sex and gender are not the same. Sex is what we are born with: It is biological: male, female, intersex (100s of definitions). Gender is who you are: It is social, individual, emotional, etc. There are many descriptions: female, male, neutral, pan, queer, demi, and many more. The term 'agender' identifies outside of gender.

The Rainbow community makes up 12 to 12.5% of the NZ population. Therefore, this community makes up 12 to 12.5% of the people we provide healthcare to.

I was surprised to learn that gender emerges between 3-4 years of age. This being the case, children need a good deal of support to enable them to explore who they are. During the journey, gender is often a fluid spectrum and the child may move within it for some time.

The child's identity can change from day to day, so labels should not be used at this age; giving support and affirmation to the four year old leads to much better outcomes. From about 10 to 15 years onwards, the construct of gender will match what young people identify with.

Support is also needed with relationships, both inside and outside the family/whanau e.g. school, sports, church, clubs, healthcare, etc. Ari works with families/whanau to help the child navigate this journey. Trying to change gender to match sex breaks the brain, causing damage to mental health leading to: drug abuse; alcohol abuse; self-harm; risk taking; and more. Supporting trans youth leads to better outcomes for all (Figure 1).

Ari said that the United Nations directive is that no child should have surgery until they are old enough to consent; unless they are unable to urinate or the organs are on the outside. In NZ this is at age 18. However, an individual going through puberty for a gender which they don't identify with can cause phobias and mental health issues, as mentioned before.

Hormone blockers need to be started to prevent puberty and the harm that puberty can cause. The body will still grow, then at 18, the adult can make their own decisions about interventions. For older people, depo provera is used to stop menstruation.

Although access to high level of support is available at 18, it is only with extensive (intrusive) assessments (see MOH

https://www.health.govt.nz/our-work/hospitals-and-specialist-care/high-cost-treatment-pool). Each DHB has own local guidelines and these can be found on Health Pathways.

Most transgender people seek to make their gender expression (how they look) match their gender identity (who they are) rather than their sex assigned at birth. The transition process includes ID, social, medical, and legal, as well as physical change. This can be a really difficult sea to navigate and these folk need tools to help them get through this including; recognition of their place on the journey; support to access information; respect.

Trans individuals are twice as likely to be unable to access healthcare, possibly due to lack of anonymity in smaller communities; possibly because an individual does not identify with the gender choices available, e.g. provision of toilets, choices on forms, etc. Awareness of gender diversity is the key to providing holistic healthcare.

So, heteronormative is the norm, but healthcare needs to consider its place in supporting and providing for the Rainbow community. I was left thinking about the following:

- What do we need to do as an organisation to support these patients?
- What do we need to do as individuals?
- Need to be doubly alert for restrictive culture, e.g. white, middle class, binary, older narrow language
- Include them, e.g. which pronoun do they prefer, preferred name, what does it mean for them, etc.
- How to do this in 15 minutes.
- Does it matter to me what gender identity someone has, when we are providing care it shouldn't matter.
- Some health issues directly relate to the sex of the individual.
- Where does our environment place blocks for this community?
- Does society provide choices for all genders, or is it restrictive and obstructive?

I haven't quite immersed myself in the stormy sea, but I think I've definitely got my foot in it now.

Here are some useful links to information which may help you have a greater understanding of gender diversity:

https://insideout.ry.org.nz/ - videos with people speaking their own words. We all belong.

https://www.ry.org.nz/education/

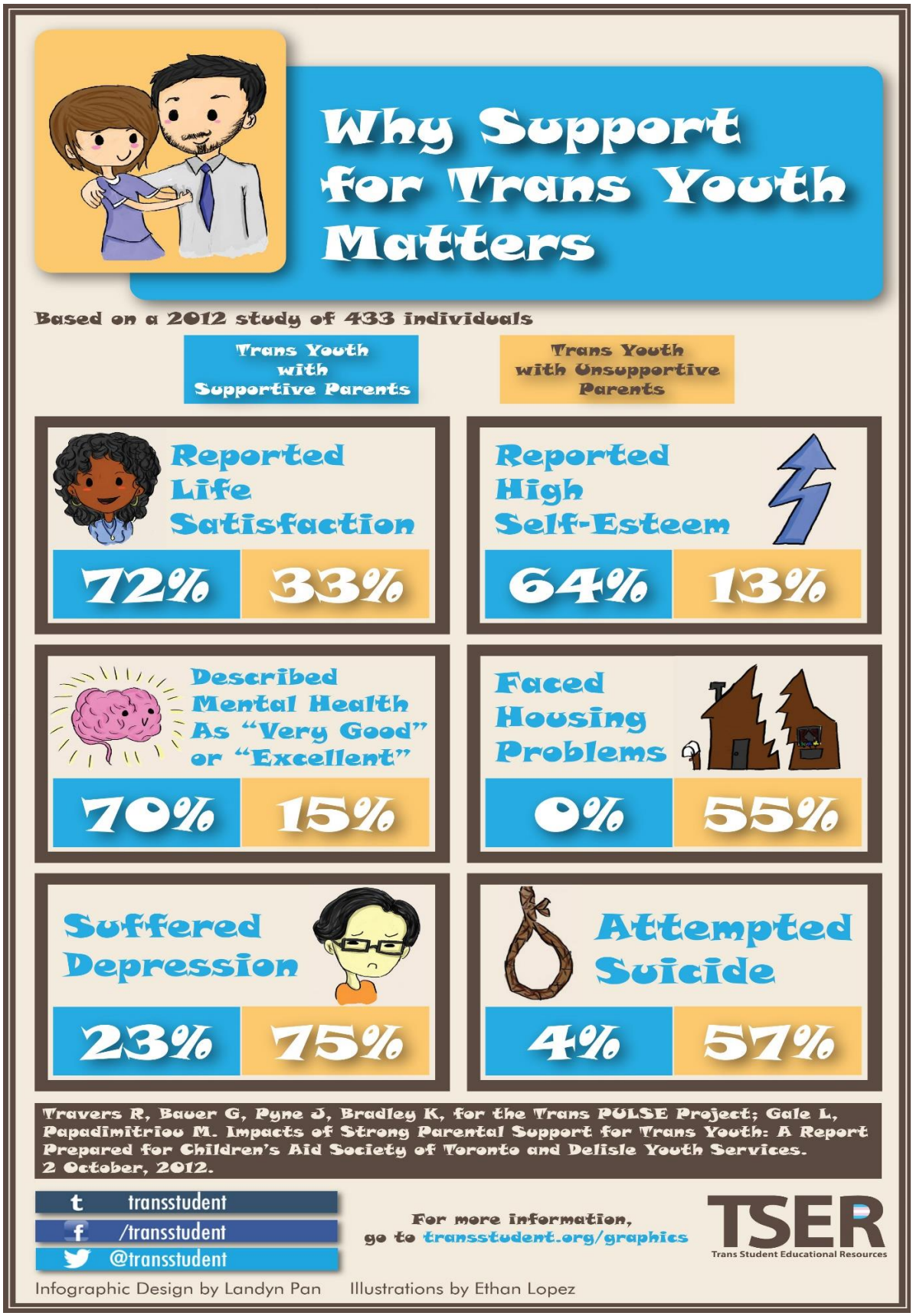
http://www.ianz.org.nz/ - intersex awareness NZ

http://www.tiwhanawhana.com/ - Takatāpui, in modern terminology is a Māori individual that identifies as Queer, Gay, Lesbian, Bisexual, Trans.

http://transstudent.org/ - Canadian website with many resources.

https://www.health.govt.nz/our-work/preventative-health-wellness/delivering-health-services-transgender-people

Figure 1: Support Trans Youth



Professional Practice Report

August 2018

Chair – Cathy Nichols, Linda Reihana, Tasha Morris, Bronwyn Boele van Hensbroek-Millar, Tegan Jones, Lee-Anne Tait and Sarah van Weersel.

Following the 2017 AGM in Auckland the Professional Practice committee had six new members and a new chair. Fortunately we have been ably assisted by our Professional Nursing Adviser Angela Clark, who has guided and nudged us as we "learnt the ropes".

Knowledge and Skills Framework has been a collaboration between Mid Central DHB, NZNO and the NZ College of Primary Health Care Nurses. The first draft was distributed to members for consultation in October 2017; we only received feedback from ten members. It was then sent to several nursing leaders for their input. The comments were evaluated and fed back to the authors to make some alterations. The latest draft was emailed last week; the National executive and committees will review this at our next meeting at the end of August.

Electronic Resources document is found on the College webpage under the 'Resources tab'. It seeks to provide a list of internet web addresses that PHC nurses may find useful. These include online training sites, online journals and websites on specific health information both for nurses and patients/whanau. We are in the process of updating this.

Health Workforce New Zealand. This link is also under the 'Resource Page' to the college webpage. Check this page if you want to access NETP or post-graduate funding streams. We have provided a list of DHB study fund co-ordinators.

Communications. The committee update both the College web page and host the Face book page. If you haven't already please "like" our facebook page.

To enhance information sharing the College has contracted Linda Stopforth a former NZNO Librarian to provide SNIPS a quarterly email bulletin beginning November 2018. The bulletin will have a range of national and international research and news items relevant for PHC nurses.

Regional Networks. Wellington continues to run study evenings 3-4 times each year. They have a growing committee of ten members who gather for one hour, 2-3 months prior to a study evening. Between 60-80 nurses attend these evening meetings. Topics are generally speciality specific examples include sexual health, renal, older adult.

Discussions are underway to start a Regional network group in the Whangarei. Hopefully we will have more news soon. If you are interested in starting a group in your area the committee would love to hear from you.

The National Executive and Committees August meeting is to be held in Christchurch on the Thursday evening we are holding an information sharing evening for local members to a meet and greet your national committee members and what can the College do for you.

District Nursing / Community nursing

Marian Weststrate RN

Community Nurse at CCDHB, Kapiti Coast

It is generally believed that a form of organised community nursing started in 1858 in the United Kingdom when William Rathbone, a philanthropist, employed Mary Robinson to look after his wife during her final stages of life. After his wife died, William asked her to care for the local poor that needed her attention. When Mary mentioned to William that this was such rewarding work, he decided to finance specialist training for nurses to do this kind of work[1]. The profession of community nursing was born. In this reflection I will use the word community nursing instead of district nursing as people that need care within their community are at the heart of community nursing.

Community nurses rely heavily on their accurate knowledge and experience. Although they are part of a wider team, they work autonomously and often must make independent decisions in complex situations. In the future, community nurses will become increasingly essential because of:

- An increased elderly population, requiring complex health care
- Reduced length of stays in hospital resulting in more complex care needed at home
- Complex medical treatment being carried out at home
- Palliative care / end-of-life care increasingly taking place at the home of the patient
- Involvement of multiple healthcare professionals requiring coordination
- The need to advocate for patients at times to assist them navigate their way throughout the healthcare maze

Community nurses play an important part in all the aspects mentioned above. Visiting the patients at home, in their own environment, with their whanau, seems to be the optimal form of holistic nursing. Seeing a patient in his/her own home reveals a more thorough picture of the patient compared to what can be seen when the patient is in hospital. Caring for patients in their home environment requires additional expertise, specific values and behaviours and strong social skills[2]. Community nurses enter the homes and privacy of the patient. Patients

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1 http://www.bbc.co.uk/radio4/womanshour/02/2009_24_tue.shtml

2 Focussing on the future of district nursing. Page 21. https://www.qni.org.uk/wp-content/uploads/2016/09/2020_vision_web_2014.pdf

allow the nurses to come close to who they really are and how they actually live. This makes both parties vulnerable and therefore a great deal of trust is needed on both sides. Community nurses can make a difference in their patients' lives, and the patients make a difference in the nurses' lives.

Observation is a critical skill community nurses develop over time. Each home is different and taking sufficient time to observe the patient's environment can reveal hidden clues as to why certain care aspects do not result in the expected outcome. I learned this skill early in my nursing training. My clinical tutor would take me to patients' rooms and ask me: 'Tell me what you see'. After I gave a description of what I saw in the room, the tutor would ask me questions like: 'Are the patients comfortable in their beds? Are IV fluids needed to be replaced? Are the patients in pain? How do you know?' I learned to assess a situation through observation and respond accordingly to what was needed. That initial period of surveillance was critical in making the right decision about what to do. Community nurses depend heavily on this skill. As each patient's home is different, a 5-10 minute casual conversation at the beginning of a visit to initiate an assessment, directs the community nurse to the right care that is needed.

Maintaining and supporting the independence of the patient is another critical component of the community nursing role. Atul Gawande in his book "Being Mortal" describes beautifully how important this is, especially for the elderly population. The role of the community nurse is to support independence by designing care strategies that enhance independence through the application of patient centred care, and asking what is of value to the patient. Patients are well able to speak for themselves and have lived their lives for many years without healthcare interventions. Nurses ideas of a 'problem' is not necessary theirs. Delivering 'patient centred care' requires awareness and not to only focus on being a 'problem solver', but to listen and ask questions.

Such an approach can conflict with the application of evidence-based care which has become such a focus in medicine and nursing. Unfortunately, for various reasons, evidence-based care does not always work in the home of the patient. Often, we have to take a step back and ask ourselves if the recommended treatment is what serves the patient best and what supports his/her independence at a satisfactory level. When the application of best evidence inhibits the patient's independence or desires it is most likely the treatment will fail. It is up to the creative ability of the community nurse to discover and develop an application supported by the patient which is not necessarily the top one of the evidence-based practice list.

This approach has found traction in the Netherlands with the publication of a document named "No Evidence Without Context" by the Dutch Council for Public Health and Society[3]. Prof Jan Kremer, one of the Council members mentions *"Good healthcare is above all a*

[3] No evidence without context. About the illusion of evidence-based practice in healthcare

question of heart and soul, not merely intellect. It's about what we think is right to do in the vulnerable phases of people's lives. And that's not the same for everyone. Unambiguous scientific evidence does not do justice properly to this moral and personal side of good healthcare. We need to keep talking to each other about what constitutes good healthcare, with the human context as a key input."

Understanding the context correctly is one of the most critical success factors that makes the care provided by community nurses of value to the patients and also to the wider healthcare system. As well as requiring superb nursing skills, this requires a genuine interest in people, their health and the community they live in. This will become of increasing importance in the coming years in order to run successful healthcare systems.

I am proud to be a community nurse. It enables me to provide care to patients that is of value to them and in return creates value to me. Philip Larkin states[4]: *"Empathy and compassion are not the same. Every nurse should deliver empathy, but compassion is giving a little bit of yourself, it costs you."* To make a difference in the life of patients, I have to give something of myself every time I enter someone's home. My goal is to make that happen as much as possible.

Hepatitis B vaccinations for Travellers

Ellen Cadzow

Research Review

Research Review New Zealand has recently released a 'Hepatitis B Vaccination for Travellers' Educational Series Online Module for nurses. It has been endorsed by the College of Nurses for 1-hour professional development.

It has been created to assist nurses with their ongoing education. It provides a detailed insight into evidence-based information and guidance on Hepatitis B vaccination for travellers.

To complete the module nurses read the Educational Series PDF and answer a series of questions in a multiple-choice quiz. Access to the module is available at no cost at: https://www.easy-lms.com/hepatitis-b-vaccination-for-travellers/course-20951

[4] Prof Philip Larkin, President of the European Association for Palliative Care, 29th of January 2016. Institute for Culture and Society, University of Navarra, Spain.

NETP in Primary Health Care

Tegan Jones

"I thought you had to work in the hospital first?"

"I thought only older nurses worked at GP's, like, before they retire?"

"Don't you need some *real* clinical experience before doing that?"

"I heard that you need two years medical-surgical experience MINIMUM"

No, no, no, and no – Primary Health Care is and needs to be the fastest growing clinical area around the world, yet there still seems to be this archaic idea that primary health care is not a place for new graduate nurses? New graduate nurses bring vibrancy, fresh knowledge of best practice approaches to care, energy and drive to their areas of practice – and when adequately supported by their workplaces, preceptors, PHO's and DHB's they grow into the Nurses that Aotearoa so desperately needs.

I entered Primary Health Care in a community health centre setting as a new graduate through the Capital and Coast DHB NetP programme in 2015. I was 23 years old. I was one of the lucky ones. I knew how difficult NetP placements were to obtain and that there were very few available in Primary Health Care. I remember sitting on the couch in my damp Wellington flat when the phone rang, it was the CCDHB NetP coordinator calling – she wanted to know if I would be interested in interviewing for a placement at a community health centre in Porirua. Of course I said yes without hesitation – primary health care with a strong focus on minority and migrant health, I just couldn't think of anything better. My NetP interview consisted of an assessed clinical role play with a fellow candidate, followed by a face to face interview with the clinical coordinator and practice manager of the health centre. I was nervous, I was excited, I was desperate.

We had been reassured throughout our training that we would all have a job and a place on a NetP or NesP placement at the end of our hard work. All of a sudden, weeks out from completing our studies a grim picture of employment likelihood had been painted by ACE (Advanced Choice of Employment), the DHB's and the media – we all seemed to know how many spots were available, and we knew it didn't match our packed lecture rooms of students. We

celebrated with our friends who had several interviews, and cried with our friends who had none. We anxiously waited to received our emails telling us where we would work, where we would live. The day after our state exams our job offers were sent out – I would be staying in Wellington and Primary Health Care it was! I'd got the job – but now what? I had had a 2-week placement at a medical centre over a year ago and that was my only true *experience*, it was also all I had to inform all of my expectations about what was to come.

I knew I would be working in a GP practice setting, however when selecting Primary Health as a preferred area of practice on the ACE program Primary Health care encompasses Practice Nursing, Department of Corrections, GP Clinics, Accident & Medical Centres, Iwi Providers, Pacific Providers, School Nursing, Well Child Providers, Plunket, NGO's and Hospice. There are so many places for nurses to work and thrive outside of the hospital setting, it's surprising that so few NetP placements are available in these areas. Is it because these areas have a low staff turn-over due to an increased level of job satisfaction? Is it because they fear they will not be able to support permanent contracts after the DHB funding concludes? Do managers of these clinical settings genuinely believe that such settings are not places for new graduates to be? Are these roles considered to be too autonomous? It would take a deeper look to truly get to the bottom of it, but I believe the longstanding lack of funding for Primary Health is contributing. More and more services are being reoriented to Primary Care, but adequate funding streams are not always accompanying them. Primary care can use all the nurses it can get! Primary care workloads and job descriptors are continuously growing and evolving, so the workforce should be too.

My NETP year in Primary Health surpassed all my expectations. I honed my assessment and triage skills, I worked not insolation, but as a valued part of a skilled multidisciplinary team, I received formal training and qualifications in a variety of areas including smear taking, sexual health, immunisation, nutrition, advanced wound care, ear assessment, and family violence prevention, I had become a postgraduate student, all the while being supported by an amazing nurse preceptor and NETP coordinator. Don't get me wrong; it wasn't all triumph and success. Workdays were challenging and tiring, as were the study days and assessments. I was constantly sick (although I must say, my immune system is solid gold four years down the line), and the overwhelming reality of poverty in the community was made undeniably apparent, many tears of frustration and worry were shed. But despite all the ups and downs, I couldn't think of a better place to begin a nursing career. Primary care is where we can nurse the way we were taught to do so – to promote healthy lifestyles, to educate, to approach patient care holistically; being the single point of entry to coordinate a number of wrap around services to meet our whanau's needs. I finished the year with experience, a permanent contract, and a passion for primary health which remains strong to this day.

I will be forever grateful for Porirua Union and Community Health Service for taking a chance on me as a new graduate nurse, for their exceptional support and encouragement, and for the Capital and Coast DHB NetP program for providing the funding and support for Primary Health Care to take on new graduates; however there is always room to expand opportunities and promote Primary Health Care as a place for new graduates. No system is perfect, it is blatantly

obvious that we are not future proofing our healthcare system.

There needs to be a place for all new graduate nurses, systems in place to support their development, and desirable pay and conditions to keep New Zealand trained nurses, in New Zealand. I've written about the importance of attracting new graduate nurses and medical registrars to primary health care before. We all see the burden of poor mental and physical health on our people, and we need to grow and enliven the primary health care workforce to help to bring about the change we so passionately desire and urgently need.

Barriers and Enablers to Registered Nurse Prescribing in General Practice

A survey of Nurse Practitioners' perspectives

This is a summary of a dissertation study and acknowledgement is given to Nurse Practitioners New Zealand (NPNZ) and the Nurse Practitioners (NP) who generously participated in the survey.

Lelia has 30 years' experience nursing within primary, secondary and non-government organisation sectors and is currently employed as a Family Nurse Specialist/Practice Nurse

Lelia Currie (MHSc, RCpN).

Aim - To describe the perspective of NPs, working and prescribing in general practice settings, regarding potential barriers and enablers to the implementation of the recently introduced 'Registered Nurse Prescriber in Primary Health and Specialty Teams' scope of practice (Nursing Council of New Zealand [NCNZ], 2017).

Background - Registered Nurse [RN] prescribing has been evaluated within the international literature as a safe and clinically appropriate strategy to improve patient access to medicine/treatment and better utilise the health workforce. Registered nurses, working within general practice teams and authorised as meeting the specific criteria of the NCNZ can now prescribe from a specified list of medicines.

Methods - This research utilised an exploratory descriptive methodology, applying an electronic survey (May 2017) to a non-probability sample of NPs self-identifying as working and prescribing within New Zealand [NZ] general practice (n=36).

Findings - The participating NPs were supportive of RN prescribing within NZ general practice and considered the education and training requirements to be adequate. Concerns regarding role confusion and impact on the NP role including team dynamics were identified as the major barriers.

Discussion - This survey strengthens international research suggesting that best practice is more readily achieved when collaborative partnership, effective communication including information sharing and wider system support networks are facilitated. Consideration must now focus on how supports can improve effective initiation to enhance safe and efficient nursing care.

This formative data provides a basis for further discussion and exploration to support the successful implementation of RN prescribing within general practice.

Introduction

This research responded to a call from a national nursing commentator urging 'lessons from the past' (Wilkinson, 2011) to guide future developments of RN prescribing in NZ. The intent of this research was that by acknowledging the barriers and enablers faced by NPs, within their prescribing experience in general practice, the introduction and implementation of Practice Nurse [PN] prescribing within general practice teams could be more efficiently integrated. The premise of this study acknowledges NPs as having

valuable wisdom to apprise the implementation of RN prescribing.

Recent changes to NZ's legislation (Medicines 'Designated Prescriber - Registered Nurses' Regulations 2016) and regulation reflects expanding international acceptance that nurse prescribing is a safe and clinically appropriate intervention that is responsive to the rapidly changing demands for innovative health care. The 'Designated Prescriber - Registered Nurse' (NZ Gazette, 2016) role is significant to the nursing profession, health care teams and the communities they serve. The Nursing Council of NZ [NCNZ] has amended nursing scopes of practice to allow specifically educated and authorised nurses to prescribe within primary health and specialty teams (NCNZ, 2017) which includes, but is not limited to, general practice settings. Primarily the initiative aims to improve safe patient access to healthcare, including medicines, which is seen as particularly advantageous for patients living rurally or with complex long-term health conditions (Ministry of Health [MoH], 2017; NCNZ, 2017). It also has implications for nurses individually, professionally and within the teams they work.

This research specifically considers the 'Designated Prescriber - Registered Nurse in Primary Health and Specialty teams' level of prescriber (NCNZ, 2017), and references it as such [DPRN] within the clinical setting of general practice. The DPRN role provides an opportunity for PNs, authorised and meeting the necessary educational criteria, to share decision-making and work under the designation of a doctor or NP, to prescribe from a restricted list of medicines (NCNZ, 2016a) that are frequently prescribed for common and long-term conditions.

The literature describes the large international variation in nurse prescribing and clinical contexts. It suggests that barriers exist at a number of levels and have a complex interplay which may be different for each clinical setting including general practice. Earlier national research concluded that whilst RN prescribing is met with enthusiasm from RNs working in primary health care [PHC], successful integration depends on multi-layer support strategies (Wilkinson, 2015). Awareness of potential barriers, as experienced by others, may offer increased opportunity for developing strategies to enhance effective and safe implementation.

The development of RN prescribing has the potential to change the delivery of nursing care within general practice and challenge the current understanding and expectation of the various scopes of practice and clinical responsibilities. This research offers new national data at the formative stage of RN prescribing to potentially guide and inform PNs and general practice teams.

Research method

This research utilised an electronic survey via REDCap (Research Electronic Data Capture) (University of Otago, 2016) to obtain exploratory, descriptive, quantitative data from a non-random sample of NPs, working and prescribing within NZ general practice settings. The survey was a specifically developed, non-validated tool. Participants were accessed via, but not limited to, the membership of Nurse Practitioners New Zealand, a section of the College of Nurses Aotearoa. Data was

retrieved via REDCap and exported as a Comma-separated values [CSV] (with labels) file to Microsoft Excel (2016) for analysis. The survey was active for four weeks (1 - 29 May 2017).

This research is cross-sectional in design, applying the survey at a single point of time with the data describing a snapshot perspective at the time of national infancy of RN prescribing which therefore does not predict the perspective of change (for example impact or altered scope/roles). Approval for this research was received from the Human Ethics Committee and Kaitohutohu Māori of the University of Otago.

Findings

Demographics

The demographics of the participating NPs (n=36) included ethnicity (NZ European n=23/64%, NZ European & Maori n=4/11%, Maori n=4/11%, Other n=5/14%) and clinical setting (Urban n=16/44%, Urban/Rural n=13/36%, Rural n=7, 19%). The participants all self-identified as clinically experienced nurses working and prescribing within NZ general practice with experience ranging from 1 month to 11 full-time equivalent years. The NPs indicated they perform a number of roles including Leader (n=20), Educator (n=16), Quality Advisor (n=13), Policy Advisor (n=12), Manager (n=4) and other responsibilities (n=9) including Business owner, Mentor, Supervisor, Project initiatives including District Health Board [DHB]/Primary Health Organisation [PHO] and Advisory executive representation. Notably the NPs indicated that they had experience in supporting, supervising and mentoring other nurses (83%) including 66% for 88 NP's (mean 2.51, SD 2.9, R 0 - 15); 17% for 8 Diabetes Nurse prescribers (mean 0.23, SD 0.55, R 0 - 2) and 25% for 14 RN prescribers (mean 0.4, SD 0.77, R 0 - 3).

Support

The survey asked participants whether they supported the DPRN role within general practice. The mean percentile of 72% (n=35, SD 25.57, R 5 - 100) suggested the majority of participants support this role. 'Strong support' (100%) was indicated by 9 (25%) participants. There were 20 (57%) participants that gave a score of over 75% and 29 (83%) gave over 50%. There were 6 (17%) participants that provided scores less than 50% and 1 (3%) participant indicating low support by scoring under 25%.

Education and Training

The survey asked "How adequate and appropriate do you believe the education and training requirements are?". The mean percentile of 69% (n=35, SD 26.59, R 0 - 100) suggests participants consider it to be sufficient. 'Very adequate/appropriate' (100% was indicated by 6 (17%). There were 18 (51%) participants that gave a score of over 75% and 28 (80%) gave over 50%. There were 7 (19%) participants that provided scores less than 50% with 3 (8%) participants indicating concern of inadequacy/inappropriateness by scoring under 25%.

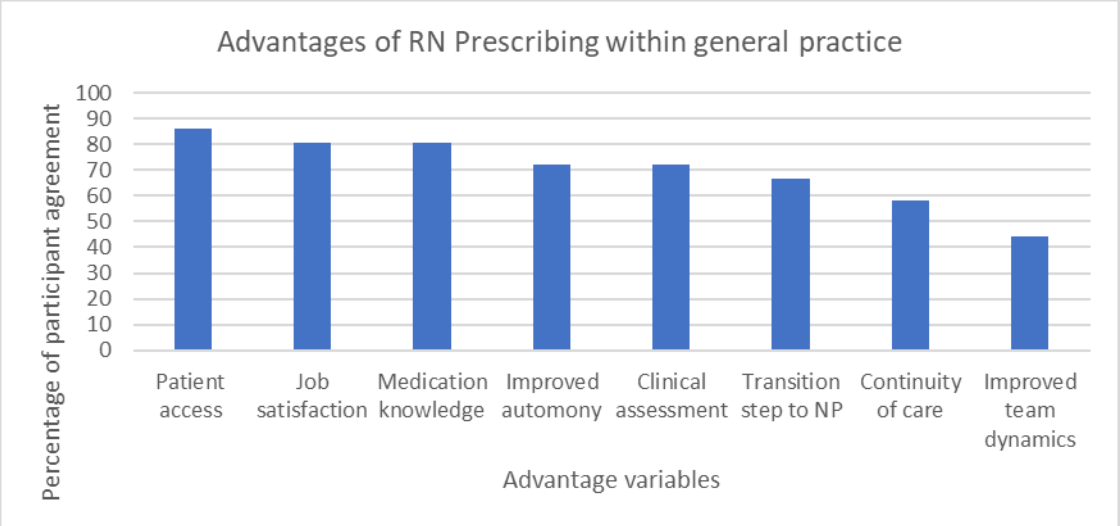
By applying an analysis of variation (ANOVA) no significant association was found for practice setting (Urban/Rural/Urban-Rural) on level of support (F (2,32) = 0.086, p = 0.917), nor training/education (F (2,32) = 0.436, p = 0.651).

Advantages and Disadvantages

The survey asked "please identify which ADVANTAGES you believe RN prescribing

offers within a general practice setting". Eight options were provided. Participants (n=35) indicated the main advantage as 'Improved patient access to the medications/services they need' (86%) followed by 'increased job satisfaction' (80%), 'improved knowledge of medication' (80%), 'improved autonomy/accountability' (72%), 'improved clinical assessment skills' (72%), 'a possible step toward becoming an NP' (67%), 'increased continuity of care' (58%). The minority of participants selected 'improved team dynamics' (44%) (Figure 1).

Figure 1: Advantages of RN Prescribing within general practice



The survey asked "please identify which DISADVANTAGES you believe RN prescribing presents within a general practice setting". Six options were provided. Participants (n=35) indicated the main disadvantage as 'confusion of roles' (86%) followed by 'increased responsibility/role not reflected (e.g. longer appointment times, remuneration)' (64%). The other disadvantages were identified by half or less of the participants; less RN's transitioning to NP (50%), risk of medication errors with multiple prescribers (50%), fragmentation of service provision (39%), increased team conflict (30%) (Figure 2).

Barriers and Enablers

The data for both Barriers and Enablers considered twelve variables and introduced ranking to enable value/priority to be assessed. Participant instruction was to "use 0 for any factors that you don't believe and then number upwards to reflect importance i.e. the item that you consider to be most important will have the highest number" and a scale ranging from 0 to 12 was provided. This section was completed by 29 participants (n=29).

Barriers

The survey asked participants to rank BARRIERS/CAUTIONS to RN prescribing within general practice. The mean ranking of the 12 variables ranged from 5.17 - 8.31 presenting a small variation between the individual barriers which made it difficult to differentiate importance as perceived by the participants. It did however suggest that each of the variables, identified from literature, resonated with this group and were all valued as being of medium to high importance (Figure 3).

Figure 2: Disadvantages of RN Prescribing within general practice

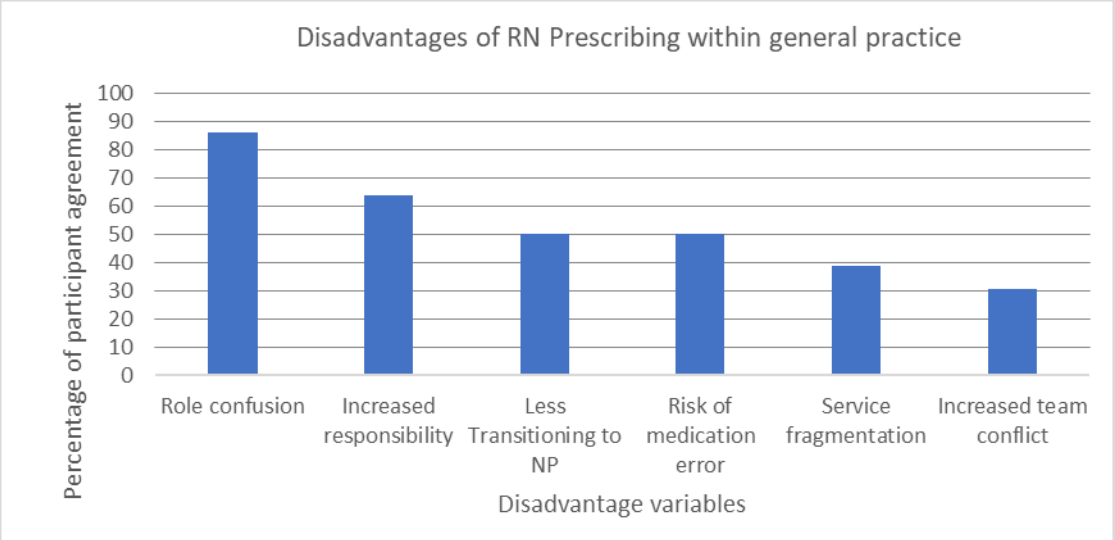
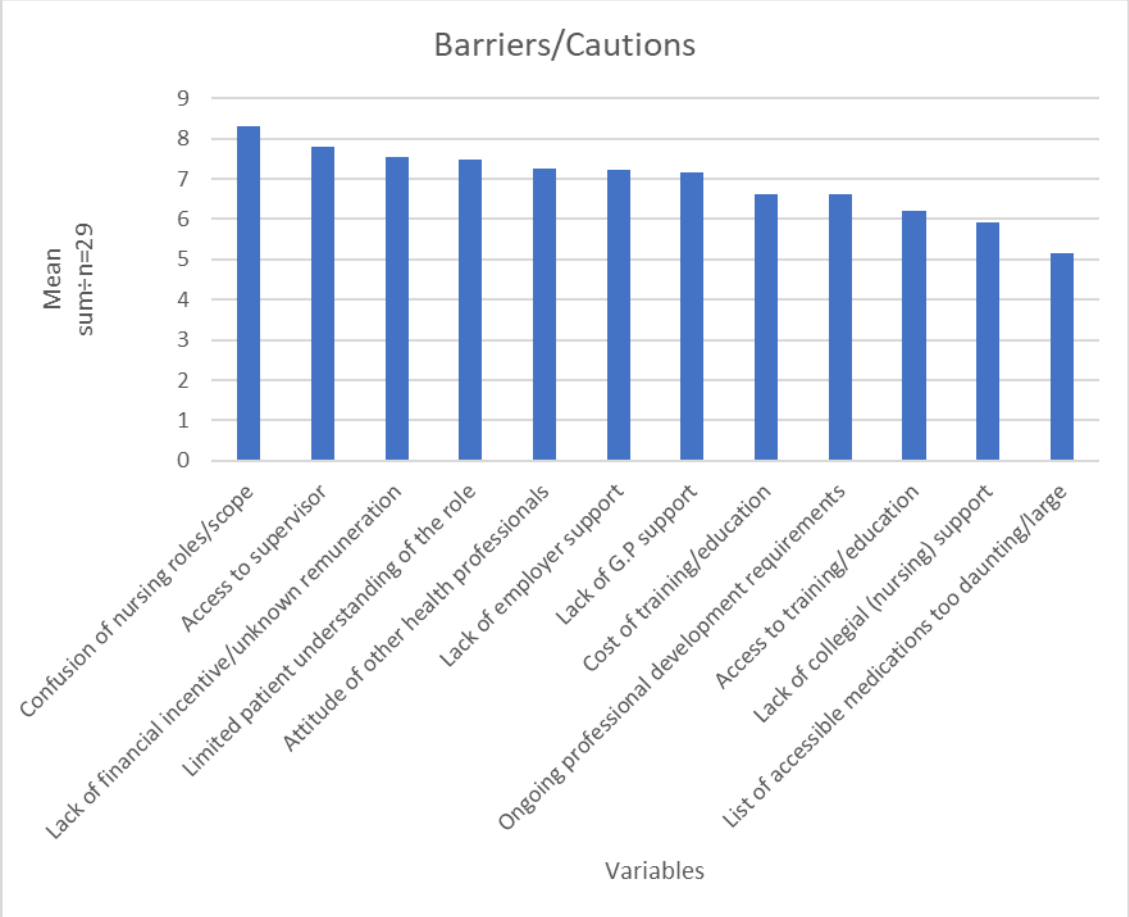


Figure 3: Summary of Barriers/Cautions to RN prescribing within general practice



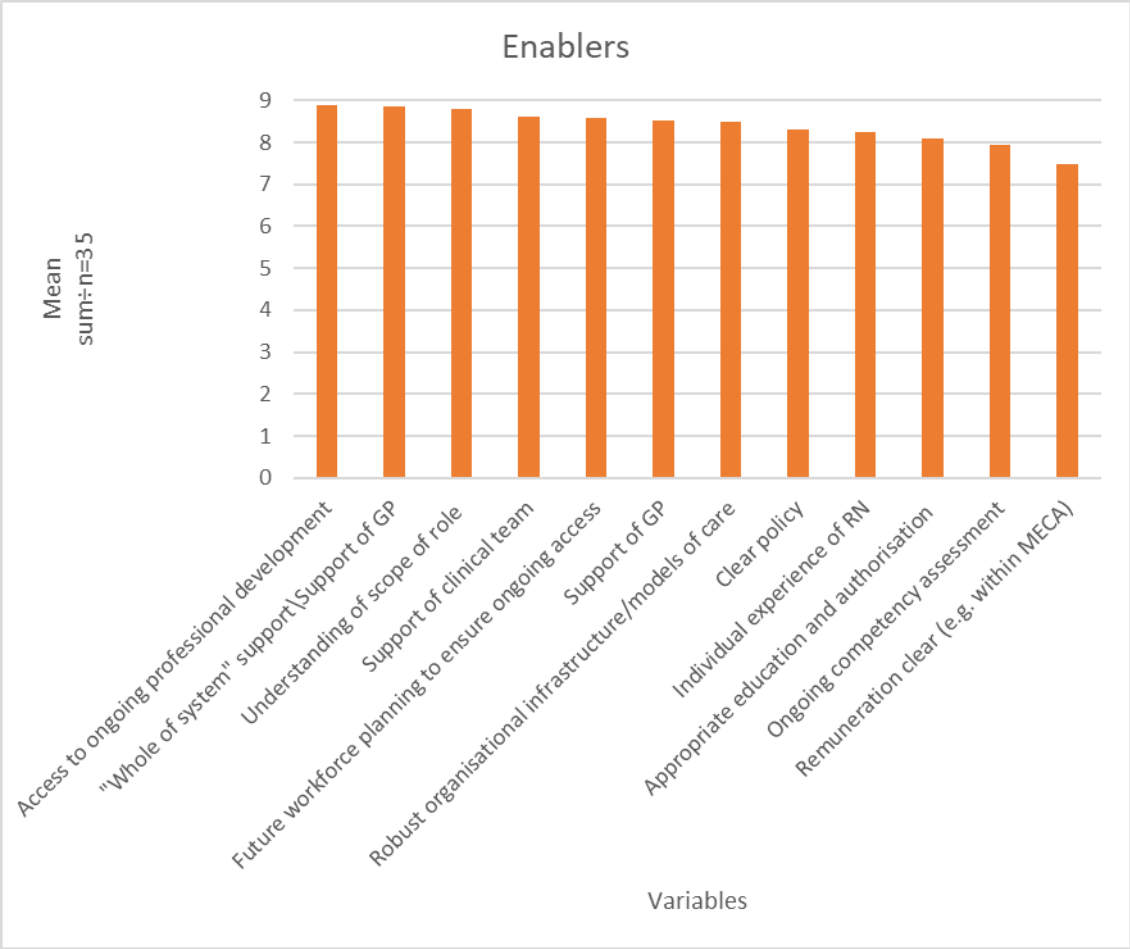
Confusion of nursing roles/scope' was the variable most identified by participants and the highest ranking (of 12) was given by the largest number of respondents (n=7, 24%). 'Access to supervisor (as demand increases)' had the largest number of respondents ranking 10 (n=6, 21%) and 7 (n=5, 17%).

Enablers

The survey asked to participants to rank ENABLERS/SUPPORTS to RN prescribing within general practice. The mean ranking of the 12 variables ranged from 7.48 - 8.89 (Figure 11). Similarly, to the Barriers section, this small variation made it difficult to differentiate importance as perceived by the participants. It again suggested that each of the variables, identified from literature, resonated with this group and were all valued as being of medium to high importance (Figure 4). '

Accessible ongoing professional development' was the variable most identified by the largest number of participants (n=7, 24%). 'Whole of system support' had the largest number of respondents ranking 11 (n=7, 24%).

Figure 4: Summary of Enablers/Supports to RN prescribing within general practice



Discussion

This research reinforces that whilst much has been done to develop RN prescribing in NZ, a paradigm shift must now occur toward preparing and supporting nurses and their teams to actualise improved patient access to medication and care within the varied general practice context. The aim of this research was to explore the potential barriers and enablers to RN prescribing within the NZ general practice setting. The intent of this research was that by acknowledging the barriers and enablers faced by NPs, within their prescribing experience in general practice, the introduction and implementation of the DPRN role could be enhanced. It is accepted that by learning from the past, the replication of the difficulties may be reduced and the supportive actions may be enhanced to maximise efficient integration of the DPRN role within general practice teams.

The findings of this survey were enriched by the substantial nursing experience of the NP participants, all of whom self-reported that they worked in a comprehensive range of roles, including prescribing, within NZ general practice. It must be acknowledged that experience not only relates to roles and responsibilities, but also mastery, which is reflected in the definitions of the NP role (NCNZ, 2017; NPNZ, 2017a). Clinical competence at expert level evidences intuition, high levels of proficiency including analytic ability (Benner, 1984) and consequently NPs are a valuable source of nursing knowledge and wisdom.

The majority of participants indicated support for RN prescribing within NZ general practice and considered the education and training requirements as adequate. This was not affected by the location of their general practice setting. This is noteworthy given that the national RN prescribing initiative is consistent with the NZ health strategy (Coleman, 2016; MoH, 2014 & 2017b; O'Malley, 2016) to improve patient access to medicines and health care including within rural and remote areas (Hundleby, 2015; NCNZ, 2016b; O'Connor, 2016).

The issues identified within the international literature and presented in the survey, appeared to resonate with the participating NPs as relevant to the national general practice clinical environment. There was over 70% participant agreement in seven out of the eight options regarding "Advantages" suggesting improvements could be expected in terms of patient (access, continuity of care), nursing (medication knowledge, clinical assessment) and health care provision (job satisfaction, autonomy). This shows NPs are optimistic about RN prescribing which is consistent with the optimism shown by PHC nurses in Wilkinson's (2015) research.

'Improved team dynamics' was the only advantage that the majority of participants did not identify with. Nurse prescribing is most successful when all stakeholders see the advantages including effective implementation (Coull, Murray, Turner-Halliday & Watterson, 2013; Drennan, Grant & Harris, 2014). Nationally, as at 16 August 2017, there were 27 DPRN in primary health and specialty teams with the majority from primary health (Shanks, A, NCNZ, personal communication, 16 August 2017). This initial enthusiasm in uptake is encouraging with the consequences, including stakeholder experiences and impacts relating to the changing landscape of medicine provision, are being shared via professional journals of nurses (Jones, 2017; Manchester, 2016) and doctors (Hoare &

McKee, 2017; Thomas, 2016 & 2017). It will be interesting to see future trends which may be influenced by the generation of discussion, not only supporting confidence in progression and management of challenges but providing transparency in the process.

The participants also identify potential disadvantages indicating challenges can be expected within the implementation of RN prescribing within NZ general practice. 'Confusion of nursing roles/scope' was identified as main disadvantage, the biggest barrier and a priority requiring support. Greater clarity of the DPRN including better understanding by others is an important priority area to inform PNs and their general practice teams to consider the prescribing opportunity and furthermore to ensure adequate professional development and clinical support is available to new prescribers (Coull et al, 2013; Courtney, Carey & Stenner, 2012; Kelly, Neale & Rollings, 2010; Maddox, Halsall, Hall & Tully, 2016; Wilkinson, 2015). This is not surprising given that this initiative signifies one of the largest advancements for nursing (NCNZ, 2016b), and is at an early stage of introduction and implementation. There is no dispute that a significant effort has been attributed to the planning stages, for example establishing the legislative and regulatory requirements enabling RN prescribing, however the findings suggest that the focus must now shift to the practicalities of initiating and supporting the implementation phase.

The NP participants ranked all of the 12 barrier variables as being of medium to high importance. Concurring with role confusion, the impact of the team was identified as a concern. The participants confirmed the potential barriers of lack of employer and GP support which is consistent with Wilkinson's (2015) NZ research highlighting the importance of the workplace for providing supportive resourcing (including funding). The NCNZ criteria for applying for authorisation as a DPRN requires support letters from both the employer and prescribing mentor (NCNZ, 2017). This offers an opportunity for the RN, GP or NP and employers to clarify the DPRN scope/role at a team level and may include formalised contracts at individual and organisational level (for example position descriptions and memoranda of understanding). Bowskill, Timmons and James (2013) suggest that governance and organisational agreements, for example a local prescribing policy and specific drug formulary, are important to establish and clarify boundaries of the prescribing role. The national governance requirements (NCNZ, 2016c), for example the medicines list (NCNZ, 2016a), are formalised and accessible. In the future the sharing of individual/organisational (for example general practice or DHB/PHO) policy and document templates may communicate a practical implementation strategy.

Integration is a fundamental theme, requiring 'whole of system' support that may involve "significant culture change" (Wilkinson, 2015, p. 305), including at structural and organisational level, to enhance understanding and support from all stakeholders within the wider health system (Bradley & Nolan, 2007; Coull et al, 2013; Drennan et al, 2014; Hughes & Lockyer, 2013; Kelly et al, 2010; Latter et al, 2010; Lim, North & Shaw, 2014; Philips & Wilkinson, 2015; Wilkinson, 2015). Despite agreement within the literature regarding integrative principles there appears to be limited

information regarding models of implementation or specific strategies supportive of efficient integration of RN prescribing into clinical practice. It is however suggested that effective integration of prescribing into PHC setting relies on trust within the relationships between the nurse, doctor, employer and clinical team (Bowskill et al, 2013). Nurse Practitioners must also be included within these relationships as they may have employer and/or mentoring roles within the NZ context.

A finding from this survey was that 72% of the participating NPs supported RN prescribing within general practice and the majority (83%) indicated that they have experience in providing the necessary support/supervision/mentorship. This finding supports a Netherlands study that identified that nurse specialists (n=375) held positive views about nurse prescribing potentially as a direct result of both their experience and eagerness to advance nursing (Kroezen et al, 2014). This bodes well for NPs being recognised as an integral resource to support emergent PN prescribers and provide guidance for the implementation of the DPRN role.

The findings of this survey raise important considerations for future progression (and discussed in more detail within the dissertation) and include:

- A need to protect access to training, supervision and ongoing professional development. Although the number of NPs within general practice is not clearly defined, they are few in number. A survey of NPs in 2016 (n=124) suggested that approximately half are funded or allocated time to teach others and only a third have succession planning in place for their position (NPNZ, 2017b). Nurse Practitioners are vital to supporting, supervising and mentoring DPRNs and strategies are critical to secure their ongoing engagement and support and must be prioritised;
- Strategic and organisational multi-level action plans, guidelines and review processes which is consultative and communicated with stakeholders (for example Health Workforce NZ);
- The potential for a preceptorial/nationally supported roll-out;
- Professional and Industrial leadership including integration of the DPRN scope within the New Zealand Nurses Organisation Multi-employer contracts;
- Impact of extension of prescribing rights to other health professions.

This discussion would not have been possible without the valued contribution and participation of the NPs and provides relevant information to all nurses advocating for optimal patient care.

Limitations

This research utilised a non-validated electronic survey tool and relies on self-reported data from a non-random sample. Therefore, the accuracy and generalisability of these findings to other populations and contexts cannot be assumed.

Conclusion

The introduction of RN prescribing in NZ is responsive

to international evidence suggesting this intervention is safe and effectively addresses the increasing and rapidly changing demands for innovative primary health care. The 'Registered Nurse - Designated Prescriber; in Primary Health and Specialty teams scope' is now actualised and ready to be integrated within the clinical environment of general practice with the aim to increase patient access to medicine and appropriate care by facilitating better utilisation of the nursing, and health workforce. Effective integration of RN prescribing within NZ general practice is dependent on the commitment and support of the general practice team and the existence of DPRN employment positions.

The quantitative data from this survey, timed at the inception of RN prescribing in NZ, suggests that barrier and enabler themes identified within international and national literature, resonated with the NP participants. The NP participants indicated support for RN prescribing within NZ general practice (72%), endorsing the potential opportunity to improve the outcomes of patient care, enhance the contribution of nurses and effect new models of care within general practice care provision. This research also reinforces the existence of a complex interplay of structural, practice and individual issues that require a 'whole of system' approach to be applied and necessitating support at multiple levels to maximise effective and safe implementation for all stakeholders. However, there will be challenges and further work is ahead to ensure effective and safe implementation for all stakeholders. As experienced clinicians, prescribers and leaders NPs are a vital resource for supporting the training of novice RN prescribers and providing the ongoing mentorship to develop the implementation of the DPRN role.

The NP participants in this research have made a worthwhile contribution toward the successful integration of professional and safe RN prescribing within general practice. It is hoped that this research accurately presents the perceptions of the participating NPs and provides a foundation for further dialogue, debate and future exploration.

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NZCPHCN, NZNO Regional Event and AGM

Christchurch 2018

Yvonne Little

Everyday in society we hear the words "plan ahead", plan for the future – in Hawkes Bay as in Christchurch this could be referring to the roadworks of course. In a lot of respects Hawke's Bay and Christchurch have a shared affinity for the need to plan ahead and plan for the future due to our experiences with life changing events – namely earthquakes. But the same can be said for nursing, like other industries worldwide we need to ensure we future-proof our profession.

These are not new words or concepts, just new catchphrases as life becomes ever increasingly busy and with the rapid rate of changes.

As your voice the NZCPHCN committees are also planning some future-proofing and we need your help as members to do this.

Nursing has come a long way since its inception through war and reform, recovery, expanding workloads and in the face of adversity. Nurses of yesteryear did their "networking" and support by living in nurses' homes or flatting together, as time changes so do our practices and how we support each other.

Regional networks are just one way of doing this – Okay I hear a few groans – "oh no another meeting to fit into my already overloaded schedule/life". And yes, whilst we do still have some regional network meetings happening across the country, we realise that one size does not fit all and this is where we hope we can assist you our members.

Whilst we used to have conferences and have tried symposiums these are becoming more of a thing of the past due to time commitments away from family (a most precious commodity), time off work, cost and travel.

Therefore, we need to rethink – "plan ahead, plan for the future" – how do we see ourselves being able to connect in the future, for learning, for support, for "networking".

The NZCPHCN committee members like you lead busy lives and our positions on the committee are voluntary, therefore we need to address the balance.

So, rather than bring "all of you" to "us" in one place we are looking at "bringing us" to "you" in your area or one close by.

So, this year instead of a conference or a symposium we held our Inaugural Meet and Greet Regional Meeting/AGM in Christchurch in a building which epitomises what Primary Health Care Nursing is about (caring for people in the community/caring for the community), the beautiful Nurse Maude Ballroom.

Nurses working in the community is not a modern change to nursing practice, it was being done by altruists as far back as the 1800's through an arm of St John Ambulance Association, Dr King and of course Nurse Sibylla Maude who in 1898 set up the first voluntary nursing scheme.

We had a small but interactive meeting with nurses from varied areas of practices and a diverse group we were; we had Programme Managers, Regional CN Managers, Nursing Workforce Facilitators, Plunket Nurses, Practice Nurses, Practice Managers, Community Nurses, CNS Workforce Development, CNE's, CNS's, District Nurses, Respiratory Nurses, Public Health Nurses, Senior Nurses, Nurse Practitioners, Registered Nurses. Alongside those of us on the NZCPHCN Executive, Professional Practice and LOGIC committees.

It was great meeting these lovely women and we were lucky to be able to fill two of our vacant positions on our committees from those at the meeting.

With permission from the group we have included some photos here of the meeting.

So what did we discuss: well we on the NZCPHCN committees felt we needed to get out there to the members and meet you, explain what the college stands for, what each of the committees does and what we can potentially do to help you set up regional meetings in your area – these do not have to be long and complicated meetings, they can be done at anytime that suits your region and is really there to help with ongoing education, networking with nurses/groups in your area to provide a streamlined continuity of care for the community. We provided reports of our activities and back copies of LOGIC. There were also two rule remits which you will have been emailed about responding to as due to the numbers we could not action on the night, these remits relate to future planning for our meetings and AGM's.

We want to see inclusivity rather than exclusivity in the regions between the different disciplines of nursing.

The regional meetings (as has been done in Wellington) only need to be three to four times a year, you can build yourselves a group who co-ordinate these meetings.

We were also fortunate to have Chris Wilson, Industrial Advisor PHC, NZNO, available on this evening to discuss with the group about the recent DHB MECA negotiations and where NZNO are planning to go with the PHC MECA.

Therefore, what we would like to see is some action happening in other regions and to that end we are planning over the next twelve months to take our NZCPHCN group to various regions to do similar "Meet and Greet" + education sessions. Our aim is to reignite the Regional Forum Networks and be more visible, accessible and transparent in our aims for the college going forward.

Currently, we have vacancies for Regional Representatives in a number of regions. There is training provided if you require it. Otherwise talking to those who are currently in the positions for advice is also useful.

Cathy Nichols, Professional Practice Committee is the Wellington Regional Representative and very experienced in this, so if you are in any of the following areas and would be interested or have any questions please contact Cathy Nichols on cathyn99@gmail.com

Tai Tokerau

Auckland

Midlands

Tauranga

Tairawhiti

Taranaki

Hawkes Bay

Nelson-Marlborough

Canterbury/Westland

Otago/Southland

Please keep your eyes peeled to our website and future editions of LOGIC as we will be bringing

you updates on what is happening, where and when. We intend to have a couple of meetings in the North Island and a couple in the South Island but we will need your input as you are our “team” on the ground.

Yvonne

Patient-targeted Googling (PTG)

Sue Gasquoine, Nurse Policy Adverser/Researcher

Sue.gasquoine@nzno.org.nz

NZNOs Social Media Guidelines are in the process of being revised with support from the National Student Unit/ Te Rūnanga Tauira (NSU/TRT) and Nurse Educators in the Tertiary Sector (NETS). Since they were originally published in 2012 there have been a number of significant developments in the social media space which will be included in the revised guidelines:

- The Harmful Digital Communications Act (2015)
- The advent of dating apps
- The era of 'data harvesting' and 'big data'
- 'cross posting' on multiple social networking sites (SNS)
- The popularity of Twitter

Some of these developments are positive and offer opportunities for nurses to connect with colleagues and to improve communication and information flow for the benefit of patients/clients. For example a practice nurse describes following the Twitter account @WeNurses to benefit from the quality improvement ideas she finds. Also a website for school nurses launched earlier this year includes a blog for nurses to connect with colleagues to reduce the effect of the isolation they experience because they are often the only health professional in the school. https://www.nzschoolnurses.org.nz/

The recent consultation round on the guideline revisions has highlighted Patient-targeted Googling (PTG) as 'a thing' and the guideline will also include consideration of this concept. The Medical Council of New Zealand (MCNZ) have provided the following statement on Patient Targeted Googling in their internet and electronic communications guidelines.

"You must exercise restraint in using social media to seek out information about your patients. Patients have expectations of privacy and may choose not to disclose certain information to you in a clinical setting—even when that information is openly accessible online. If you consider that it is medically necessary to view patients' websites or online profiles, seek their permission before accessing those sites. You should also confirm the accuracy and relevance of online information with the patient before using it to inform your clinical decision-making or entering it into the patient record" (MCNZ, 2016)

Recent research that surveyed and interviewed final year medical students at the University of Otago (Chester et al 2017) concluded that there are varying attitudes to the practice of PTG which is 'ethically problematic' and that when it is used to protect patient safety in mental health or medical emergencies, the use

of the information gained needs to be carefully considered. The researchers also note that *'information found online through PTG constitutes health information if it is collected for the purpose of providing health services ... This information does not necessarily have to be about the patient's health to constitute 'health information,' so long as it is collected in the course of providing patient care. Searching for information about a patient for a reason unrelated to the provision of health care would be an unlawful breech of Rule 1 of the Health Information Privacy Code.'* (p.3) Chester et al propose further research with other health professionals to inform teaching and guidance on this clincal practice issue.

Nurses responsibilities

There are a number of scenarios in which nurses may Google a patient or respond to a request to do so. As identified above, there are legitimate reasons for PTG when that has the potential to provide vital information not otherwise available and which can result in better outcomes for the patient. Basing clinical decisions on information found online can be problematic if that information is not current or accurate and some of the situations in which PTG may be justified do not allow the patient to verify the accuracy of information located.

Future LOGIC editions will explore in more detail some of the social media platforms that can support practice development and extension.

References:

Chester, A.N., Walthert, S.E., Gallagher, S.J., Anderson, L.C & Stitely, M.L. (2017) Patient-targeted Googling and social media: a cross-sectional study of senior medical students. *BMC Medical Ethics* 18:70 DOI 10.1186/s12910-017-0230-9. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5715642/

Medical Council of New Zealand (2016) *Statement on the use of the internet and electronic communication.* Retrieved from https://www.mcnz.org.nz/assets/News-and-Publications/Statement-on-use-of-the-internet-and-electronic-communication-v2.pdf

The NZNO Library

Resources For Nurse

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 NZNO Library resource lists. http://www.nzno.org.nz/resources/library/resource_lists

Copies of these articles can be provided to NZNO members free of charge.

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Articles – Antibiotic Resistance

1. Antibiotic resistance *Ministry of Health*

Antibiotics are medicines that kill bacteria. Antibiotics can be given as pills, ointments, drops or injections. Bacteria can become resistant to antibiotics, which makes it harder to treat infections https://www.health.govt.nz/your-health/conditions-and-treatments/treatments-and-surgery/medications/antibiotic-resistance

2. New Zealand Antimicrobial Resistance Action Plan Published online: 06 August 2017

The New Zealand Antimicrobial Resistance Action Plan was jointly developed by the Ministry of Health, Ministry for Primary Industries and representatives from across the human health, animal health and agriculture sectors. The document draws upon the findings from Antimicrobial Resistance - New Zealand's current situation and identified areas for action, released earlier this year.

https://www.health.govt.nz/publication/new-zealand-antimicrobial-resistance-action-plan

3. Inpatient antibiotic resistance: Everyone's problem. Wiskirchen, Dora E.; Ulysses Wu; Summa, Maria & Perrin, Adam. *Journal of Family Practice*. Feb 2018, 67(2), E1-E11.

Greater efforts aimed at using antimicrobials sparingly and appropriately, as well as developing new antimicrobials with activity against multidrug-resistant pathogens, are ultimately needed to address the threat of antimicrobial resistance. This article describes the evidence-based management of inpatient infections caused by resistant bacteria and the role family physicians can play in reducing further development of resistance through antimicrobial stewardship practices.

4. Stop using antibiotics in healthy animals. *Bulletin of the World Health Organization*. Dec 2017, 95(12), 796-797. DOI: 10.2471/BLT.17.011217.

The article reports on the recommendations of the World Health Organization (WHO) for farmers and the food industry to stop using antibiotics to promote growth and prevent disease in healthy animals, to help prevent the spread of antibiotic resistance in humans.

5. Antimicrobial resistance in New Zealand: the evidence and a call for action *New Zealand Medical Journal*. 28 October 2016, 129(1444), 105-111.

The RACP has released a policy paper highlighting three common pathogens that pose a risk to the health of New Zealanders. Although AMR is a complex and urgent public health concern, RACP identifies specific causes where improved understanding and action would reduce potential threats.

Articles – Telehealth

6. Telehealth impacts ROI, patient safety. Wider, Janette. *Health Management Technology*. Mar/Apr2018, 39(2), 6-11.

The article provides insights from health information technology providers on the challenges and trends in the telehealth industry. Topics covered include security concerns according to Advanced ICU Care Chairman Lou Silverman, interoperability challenges according to eClinicalWorks executive Rakhee Langer, and cost and billing challenges according to Avizia Chief Executive Officer Mike Baird.

7. 'Telehealth is patient empowerment in action'. Jennifer Trueland *Nursing Standard*. 3 May 2017, 31(36), 24-26. doi: 10.7748/ns.31.36.24.s24

As a senior nurse with many years of experience, mostly in general practice, Cathy Gillespie admits to having been a bit sceptical about telehealth at first. Surely the essence of nursing is being face-to-face with your patient, not sitting in an office perhaps many miles away? And how would patients – many of them elderly and vulnerable – cope with the demands of new technology?

8. Barriers must be overcome before telehealth can become routine community practice. *Nursing Standard*. 4 March 2015, 29(27), 17-17. doi: 10.7748/ns.29.27.17.s19

The reluctance of front line staff to accept telehealth as a routine part of patient care is inhibiting its adoption, a UK study suggests.

9. Healthcare via your fridge could be coming sooner than you think. *New Zealand Doctor*, Wednesday 20 June 2018

Health IT enthusiasts from around the country descended on Christchurch last month for the Emerging Tech in Health conference, organised by Health Informatics New Zealand and New Zealand Health IT. Fiona Thomas reports on some of the latest developments.

10. Is telehealth on hold in NZ? *The Dominion Post*, 10/02/2018, pA9

Are regulations holding back online health services or is this a case of GPs protecting their patch, asks Cecile Meier.

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