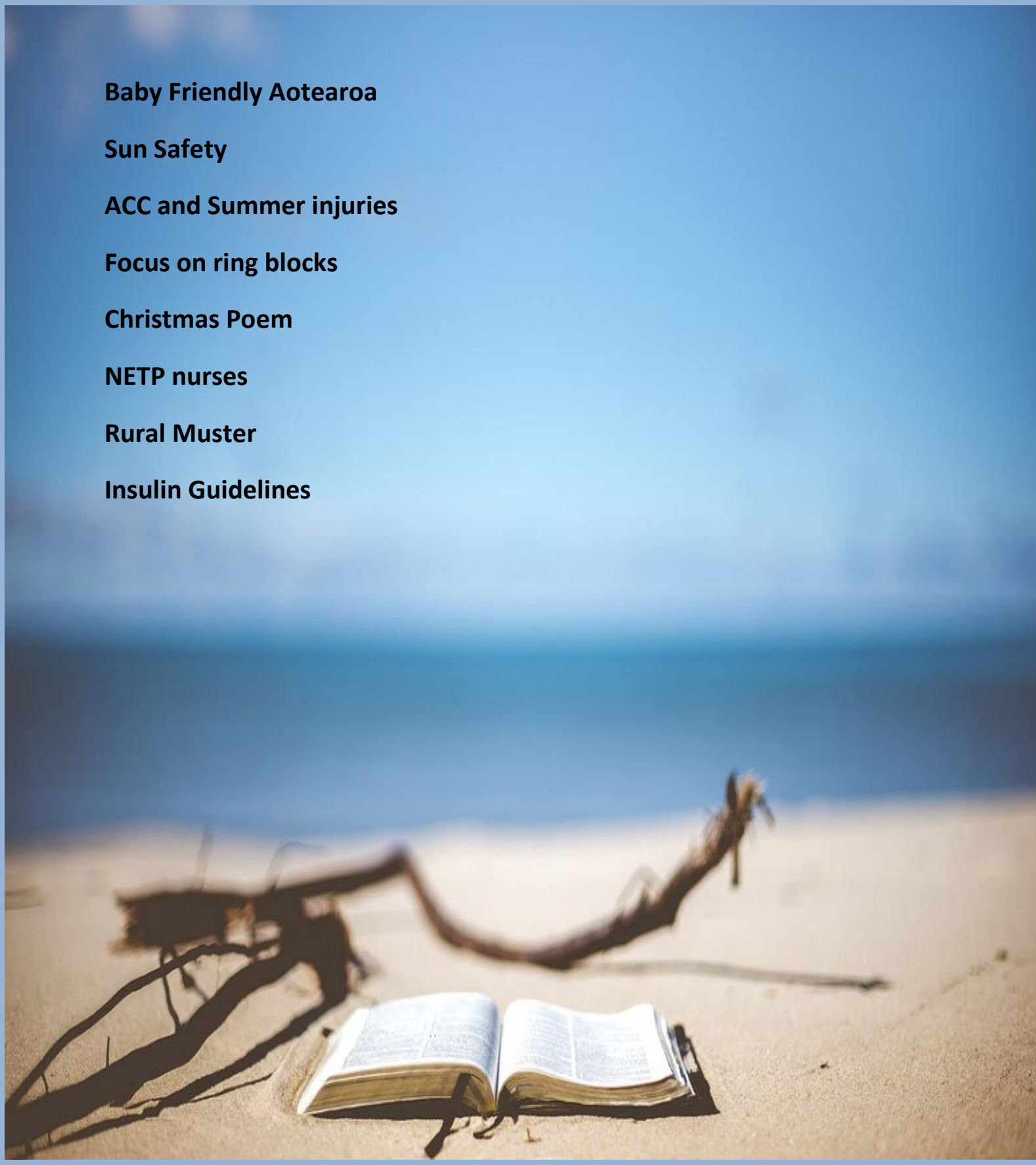
LOGIC.
LINKING OPPORTUNITIES GENERATING INTER-PROFESSIONAL COLLABORATION
The Official Journal Of The New Zealand College Of Primary Health Care Nurses, NZNO
Vol 17 No 4



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

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Circulation

To full members of the NZNO New Zealand College of Primary Health Care Nurses and other interested subscribers, libraries and institutions.

Editorial Matter

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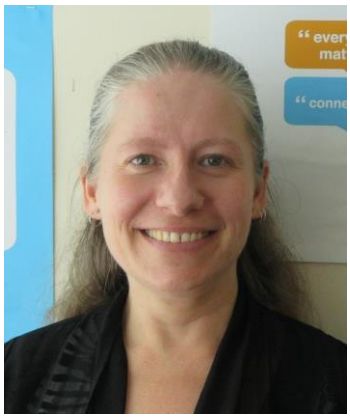
December 2018 Vol 17 No 4

In this issue….

Chair's Report

Celeste Gillmer
Chairperson



Tēnā Koutou katoa

2018 will be a year to be remember! We, NZ nurses, made history this year and hopefully for Primary Health Care nurses, 2019 will be a year where our government and Ministry of Health will focus on our workforce. Enabling us to provide the best possible care for our patients at the right time and at the right place. We will wait in anticipation for updates from the Federation of Primary Health Care and for the outcomes of the review of the NZ Health and Disability Sector.

Thank you for everything that you, as PHC nurses, do for the New Zealand community, we don't recognise your importance and the work you do often enough. On behalf of the New Zealand College of Primary Health Care Nurses, thank you. Thank you for who you are and for what you do. Thank you for your contribution to the health and well-being of all New Zealanders!

I thought I'll look up some interesting information about Christmas in New Zealand for this edition and found the following interesting information:

Christmas comes to New Zealand

In 1642, Abel Tasman's crew celebrated the first Christmas dinner in New Zealand – freshly killed pork from the ship's menagerie washed down with 'extra rations of wine'. In 1769 James Cook's crew marked the occasion by feasting on 'Goose pye' (made with gannet).

The first sermon?

The Christmas Day service given by Church Missionary Society representative Samuel Marsden at Hohi (Oihi) Bay in the Bay of Islands in 1814 is often cited as the first in New Zealand, but did a French priest travelling with Jean François Marie de Surville in 1769 beat him to it?

New Zealand's Christmas tree

The beautiful pohutukawa is regarded as New Zealand's iconic Christmas tree. The pohutukawa also holds a prominent place in Maori culture: an 800-year-old tree clinging to the cliffs of Cape Reinga is reputed to guard the entrance to a sacred cave through which spirits pass on their way to the next world.

Santa parades

Santa or Christmas parades take place throughout New Zealand in November or December each

year. They began in the main centres in the early 1900s. They were established by department stores to promote the arrival of in-store Santas, with the clear aim of drawing customers directly into their stores.

'Sticky Beak the kiwi'

Many traditional Christmas songs have been adapted for a New Zealand audience and conditions. One of the most popular New Zealand Christmas songs of the 1960s was 'Sticky Beak the kiwi' – read the lyrics and listen to the song (a Web first recording?).

Santa goes to the Chathams

When Santa Claus visited the remote Chatham Islands in 1951 he swapped his reindeer for a TEAL Solent flying boat. More than 400 of the islands' 500 inhabitants cheered him wildly as he stepped ashore from a launch in Te Whanga Lagoon with a huge sack of toys over his shoulder.

Politically incorrect Christmas games

Before the time of computers and mass television people played all sorts of games around Christmas time. Some of these games, such as the 'Light the cigarette race' and 'The Slave Market', haven't stood the test of time very well.

Kiwi Christmas cards

Historic Christmas cards combine colourful imagery with reflections on contemporary events, such as overseas wars. Familiar New Zealand symbols – tattooed Maori figures, kiwi, tiki and ferns – add a distinctively local flavour to traditional Christmas greetings and imagery.

Summer holidays

Come late December and thousands of Kiwis get ready for their annual holidays. They look forward to lazy days at the beach or the bach (or crib), games of backyard cricket, food on the barbie and the holiday uniform of shorts, jandals and T-shirts.

Claus in stores

Santa Claus made his commercial debut in New Zealand in 1894 when he took his place, complete with tree and toys, among the furniture in the Wellington DIC store on Lambton Quay. These days, children have the option of sending Santa an email with suggestions about preferred presents.

Christmas in wartime

Christmas during wartime gave soldiers a rare opportunity to relax and enjoy themselves away from the stresses and hardships of combat. It was also a time of sadness for many New Zealanders, both overseas and back home, as they thought of their absent family, lovers and friends far away.

A day off for Christmas

It's hard for most of us today to imagine Christmas Day not being a holiday, but a day off on 25 December hasn't always been a legal entitlement. An 1841 newspaper for 25 December doesn't even mention Christmas, and the day only became a formal public holiday in 1910.

Auckland's giant Santa

In 1960 Farmers erected a giant Santa on their Hobson Street department store in Auckland. He appeared above the store each Christmas for almost 30 years. He left Auckland's CBD in 1990, but was restored above Whitcoulls' store on Queen Street in 1998.

Kiwis' attitude to Christmas

In a 2006 survey, *Reader's Digest* asked a representative sample of 259 New Zealanders 'Just what does Christmas mean to New Zealanders in 2006 – and what do we treasure most?' The results show that dinner with the family is still important to Kiwis, but the Queen's message is losing relevance.

Enjoy the festive season! For those of you on annual leave, enjoy the break and your time with family and friends. For those of you working through this Christmas period, thank you!

Merry Christmas!

Meri Kirihimete!

Celeste

Editor's Report

Yvonne Little

Nurse Practitioner

Welcome to the final edition of LOGIC for 2018.

Another year has flown by and with it there have been many changes, the DHB Meca is finalised and now we await the outcome of our PHC Meca.

Alongside this, we have had changes in the Office of the Chief Nurse, with Jane O'Malley stepping down to take on her new role as Plunket first Chief Nurse, this position was then ably filled in the interim by Jill Clendon who has now moved onto her new role as ADON and Ops Manager in Nelson-Marlborough and now we have a newly appointed Chief Nursing Officer Margareth Broodkoorn. We congratulate her and will be in regular contact as we have with her predecessors, we hope she will be amenable to continuing the tradition of writing a report for us in 2019.

Other changes, which we have discussed in previous issues, is the way in which we plan to continue moving forward and changing how we communicate with our membership. After our successful meeting in Christchurch we are in the planning stages to take these meetings throughout the country, so keep an eye on our webpage and also LOGIC for further updates.

We welcome aboard our new committee members: Erica Donovan to LOGIC; Kelly Robertson to Professional Practice and Fiona Murray to the role of Secretary, taking over from our long serving member in Wendy King.

LOGIC is about linking opportunities and networking for Primary Health Care Nurses and our aim as a committee is to bring you a diverse and exciting journal and wish to be inclusive of all our members as we are no longer about Practice Nursing alone. To be able to do this, to borrow a phrase from the USA's Uncle Sam – WE NEED YOU.

We hope you enjoy your December issue, where we bring you some interesting articles for reading and some for your ongoing education hours.

In 2019, our themed articles include:

March – Respiratory and Healthy Homes

June – Injuries (all manner of) and Travel

September – Gastro and Allergies

December – Travel (local) and Safety

Added to this will be our regular sections and what I like to term our "freestyle" articles, which includes anything any member has a passion about which they wish to share with colleagues, so if you have an article you want to have published then please contact any of our committee members.

Finally, it has already been a tragic year on and off our roads to date, let's hope this trend does not continue over the holiday period. As PHCN's we

are in a fortunate position to try to influence our patients, family/whanau and friends through education to keep safe and stay healthy.

Please remember to look after yourselves as well as patients, family/whanau, friends and also those visiting our beautiful country. We need to bear in mind the hidden wounds, those with mental health issues, those less fortunate or simply being alone.

Stay safe and healthy. If you are fortunate enough to have time off, please enjoy. If you are one of those who are needing to work, thank you and we hope you do get some time to rest and relax with your loved ones.

Yvonne and the LOGIC committee (Celeste, Emma, Annie, Irene, Erica).

RURAL MUSTER #8

Kate Stark – Nurse Practitioner

As this goes to print, I am pleased to report that lambing and tailing / docking is over for another year and we are looking toward Summer. There is no doubt that sunshine makes us want to get out and about and be more active which in turn is good for our mental health.

As we know, being rural can be isolating and again we are rounding off another year where suicide has featured strongly as an area where health care is low on resource but high in need. We all have mental health and preservation is essential to quality of life as well as longevity. Unfortunately, isolation from rurality and stress related to reduced access to health care from living a distance from available care is highlighted in recent statistics which reveal there has been a rise in suicide amongst farmers in 2018. On a positive note, we are now aware that this is a problem and it is reassuring to hear of rural businesses including mental health support and suicide prevention programmes in their strategic plans for health and safety going forward aiming for mental WEALTH, not just health. We have come a long way – it wasn't long ago that depression wasn't talked about as openly as it is today and suicide was something that wasn't brought up in conversation. Creating awareness helps us create a plan to identify those at risk in rural populations and hopefully reduce suicide rates amongst rural people and enable those who live in isolation to access care more easily and in doing so live a longer happier life. Technology will have a part to play in this but we must still place value on the power of face to face encounters and human touch.

Rural Nurses New Zealand has had a busy few months and currently has a number of projects in progress including, but not limited to the following:

- A letter was sent in early October to NCNZ seeking a review of questions asked in the APC to gain robust rural nursing workforce data. We are currently awaiting a response from the NCNZ CEO.
- Work continues to develop a website link from the RGPN website specifically for rural nurses. This has steady momentum and we hope to see this go live in the next months.
- Mobile Health & RNNZ webinar series continue with the 4th webinar being held on October 30th. This was entitled "Recognising Suicidal

Behaviour" and has been reported by attendees to have provided valuable assessment tools for practice. These are available for viewing retrospectively. Current ly the link to these are on the RNNZ Facebook page newsfeed. Once the website is up and running the link will enable access to these webinars retrospectively.

- Active exploration and progression of research in partnership with Origin Research Trust is underway. The purpose of this is to explore and obtain a more detailed understanding of career pathways undertaken by nurses, looking specifically at the perceptions, motivators, and barriers that are associated with rural nursing as a career choice.
- We are starting to prepare for next year's NRHC in Marlborough. RNNZ hope to have increased visibility at the 2019 conference. We will have a nurse's workshop again on Thursday the 4th of April. In collaboration, and with the support of Mobile Health we are hosting Michelle Boltz, an NP who has worked in rural Arctic Alaska and Montana. Michelle will have a session at the rural nurses' workshop as well as featuring as a key note speaker session at the conference.

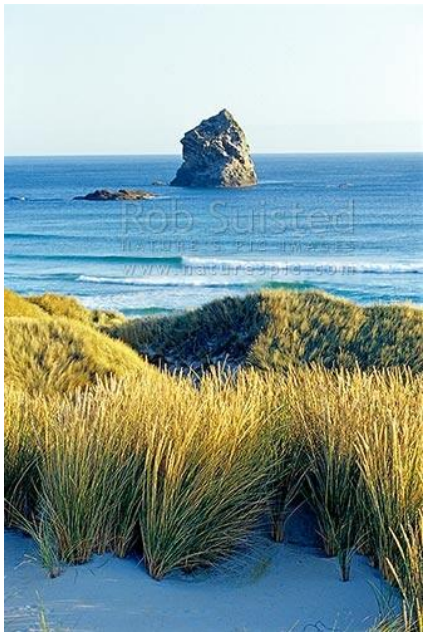
At the end of October Dunedin hosted study days for PRIME nurses for the third time. Over one and a half days they attracted around 30 PRIME nurses mainly from the South Island who had a wonderful time networking and learning. Feedback was extremely positive and everyone is waiting to hear when the next one will be. Despite being the initiative of PRIME nurses in the south, it was open to all nurses practising PRIME across New Zealand and addressed topics including but not limited to trauma in the elderly, pelvic trauma, hand injuries, debriefing, headaches and associated reg flags. This year highlighted the narrowing of barriers between St John and PRIME and we had a number of St John attendees. We heard from St John Ambulance Paramedic and Peer Support Scott Weatherall on the subject of mental health and self-care, Craig Jones on debriefing and changes to the PRIME Curriculum, as well as introducing Lisa Meadows who is the national PRIME Programme Coordinator. They in turn, enjoyed hearing the stories from the field and some robust discussion was had regarding the things that go well and the things that go wrong. Otago Regional Rescue Helicopter Chief Paramedic Doug Flett presented an excellent multi trauma case study which was received exceptionally well, especially by those in the audience who attended the job! This case study highlighted many of the excellent things that PRIME practitioners do in the field that impacts on patient outcomes, including forward thinking regarding transportation/retrieval, early identification of problems both actual and potential and teamwork. PRIME makes a huge difference to patient outcomes and it was great hearing stories to reflect this.

A meal at a local Turkish restaurant was also a highlight on the Friday night where we could relax and get to know some of our fellow PRIME nurses and associate members of the emergency services.

This event has gathered momentum over the last few years, running every other year, and looks set to continue in the future. We all have heavy workloads and so if there is anyone who would like to help organise the next study days in 2020, please contact me. Alternatively, if you live in another area of New Zealand and you think you would like to host a similar study day(s) in the future, we are very happy to share our event planning skills. If we run these in Dunedin again, look out for the next event on the PRIME Nurses and the Rural Nurses NZ Facebook pages. Your practices will also receive notification mid-year so be prepared and get your study leave booked!

The National PRIME Committee has been working hard behind the scenes to raise the profile of PRIME and PRIME Coordinator Lisa Meadows has also recently travelled around parts of New Zealand distributing safety equipment whist meeting with PRIME practitioners. The Committee will meet face to face early December to plan for 2019 and we welcome your feedback regarding issues that affect nurses in the field. I regularly get queries from PRIME nurses from around the country and its great to hear what is happening, or not happening in the field. Please feel free to email me your queries at kate.stark@gorehealth.co.nz.

As this is the last Rural Muster for 2018, I wish you all a Merry Xmas and a safe holiday season with your friends and whanau. See you in 2019.



A Christmas Story
by Anne Elf

A Christmas Story by Anne Elf (Tyldesley)

T'was the night before Christmas, and all through the house

Everyone was busy - even the mouse.

Santa in the lounge room trimming the tree


With elves all around him, helping, you see.

Passing him tinsel, and lights and balls,

Decorations around them and strewn in the hall.

Mrs Clause in the kitchen baking Christmas fare,

Pies, pavs and pastries. Tasty food to share.

All hot and bothered, I wonder why!

Then suddenly from the lounge room came a loud cry,

A crash and a groan and a very large bang!

Mrs Claus thought, "what could make such a clang?"

She 'walked quickly' to check out the scene

To find the elves and Santa rolling round in pain.

Someone had forgotten to check the electrics

And the Christmas tree lights had blown out, toxic!

Mrs Clause took control and sorted them out

With bandages, dressings and things of that sort.

So Christmas was saved by a capable lady (I bet she's a nurse in disguise)

And didn't turn out to be just crazy.

The moral of this story is keep yourself safe,

Eat, drink and be merry but look after your (h)elf.

Let the season be merry and full of good cheer,

And you'll be hearing again from us in the New Year!

Ring Blocks

Erica Donovan

My name is Erica Donovan and I am a Primary Healthcare Nurse, and I work at a GP Practice/Urgent Care clinic in Christchurch. In the past I've written for websites and newspapers and I currently run a support and education FaceBook page for nurses, midwives, students and other healthcare workers called The Nurse Path. I am interested how nurses can use technology in education, through methods like podcasts and Twitter.

One of the first mantras I heard as a student from a nurse in primary health care was that adrenaline should never be injected into 'nose, fingers, penis, toes'. A year later when I started suturing myself, I saw nurses using a blend of lidocaine and adrenaline for injecting into fingers and toes. The one we see most in my practice is subcutaneous digital blocks. This procedure involves injection of local anaesthetic on both sides of the base of a finger (Ahmad, 2017). As with many things in health, we need to examine the evidence.

For or against?

There has been much debate about the use of lidocaine with adrenaline for extremity wounds. Lidocaine is currently a popular product, however in the past cocaine or procaine may have been used. We often think about cocaine as a drug of abuse, but in the 19th and 20th century its use of widespread in medicine. The literature details at the time many nerve blocks around the body could be conducted using a cocaine solution (Yentis, 1999; Redman, 2011).

Proponents of the adrenaline method suggest that addition of adrenaline into the wound aids in blood vessel constriction, leading to decreased bleeding and prolonged anaesthesia (Ricci & Rizzolo, 2013, p. 29). Shridharani et al (2014, p.187) also refute the claims that adrenaline should not be used, stating "very little clinical evidence supports this dogma". Others suggest that the no adrenaline dogma may have been created by confounding issues such as poor technique in injection or tourniquet use, or when anaesthetics other than lidocaine were used (Mohan, 2007). However, Mohan does acknowledge that patients with pre-existing vascular disorder may benefit from an adrenaline free product. In my facility we were also taught to avoid use of adrenaline in crush injuries as they can already have vascular compromise. This still leaves many situations with healthy patients, with no complicating comorbidities and have injuries without vascular compromise that may benefit from adrenaline adjuvant.

In their research Reis Júnior and Quinto (2013) state that due to the possibility of complications, and little perceived benefit of adrenaline, clinicians should consider lidocaine only digital blocks. This is also a view supported by Nicks et al, (2010) who are concerned with the risk of tissue ischemia and Kelly (2016) who is concerned with the risk of complications for those working in rural areas. There's plenty more research where that comes from, from both sides of the fence – so have a look and decide for yourself.

Risks

Regardless of if adrenaline is used, any ring block has potential for complications. The procedure must be done with extreme caution, as systemic lidocaine can cause

cardiovascular toxicity (Donald & Derbyshire, 2004). As with any procedure clean equipment should be used and surrounding skin cleaned prior to infiltration to decrease risk of infection. Hematoma is another complication, which can be prevented by using a needle gauge of 25mm or less, and minimising the amount of times the needle is inserted (New York School of Regional Anaesthesia, 2018, para 10).

What are we using digital blocks for?

The most common need for ring blocks is prior to suturing, however patients may also benefit from it in cases of fractures requiring reduction, cleaning of deep wounds or exploration of nailbed injuries. Wounds of less than 2cm can generally be closed without use of sutures, and achieve similar closure and cosmetic outcomes (Quinn et al, 2002). In these cases steri-strips or wound glue may be more appropriate. Patients are also usually pleased to avoid the need for needles and sutures!

Procedure

After gaining full informed consent, assemble the equipment (brands may vary between facilities).

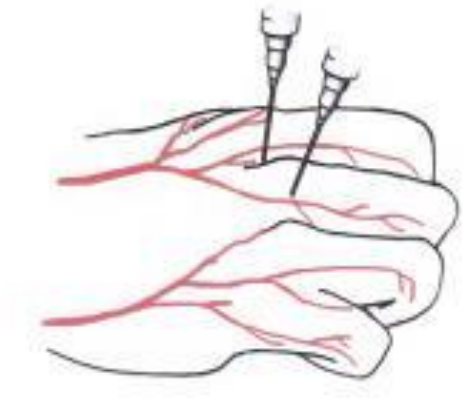
- Syringe
- Dental needle
- Lidocaine or lidocaine with adrenaline (Read the evidence and decide for yourself!).
- Cleansing wipes
- Dressing pack
- Axillary materials – dressings, sutures, other materials depending on reason for procedure.

Just a tip – When positioning the patient, make sure that you make it easy on yourself. Nursing has a high rate of back injuries; bending and craning your neck and back is only going to you cause you grief in the long-run. Place the patient's hand pronated, resting on a flat surface.

For the next part, the New York School of Regional Anaesthesia has a good guideline:

" A 25-gauge 1½" needle is inserted at a point on the dorsolateral aspect of the base of the finger and a small skin wheel is raised. The needle is then directed anteriorly toward the base of the phalanx. The needle is advanced until the it contacts the phalanx. One mL of solution is injected as the needle is withdrawn 1 to 2 mm from the bone contact. An additional 1 mL is injected continuously as the needle is withdrawn back to the skin. The same procedure is repeated on each side of the base of the finger to achieve anaesthesia of the entire finger."

Now the patient's key question – when will it kick in? The onset is thought to be about 2-5mins, with the effect lasting around 1.5-2 hours (Medsafe, n.d).



As a patient has described the procedure as "the single most painful thing I've ever felt" I've always been conscious of how I undertake the procedure. A couple of ways to lessen the pain are to:

- Warm the solution
- Use a small needle
- Give it slowly
- Sub-cut not intradermal
- Manage expectations and have the patient lie down

My favourite pearl of advice from my boss is "Have empathy…but don't let that sway your confidence, they'll

thank you for it. As always, if ya not sure - ask".

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Tall Poppy award 2018

Bronwyn Boele van Hensbroek-Miller

Nurse Practitioner/Registered Midwife

Te Aro Health Centre

Wellington

In September 2018 I was the recipient of the NZNO New Zealand College of Primary Health Care Nurses Tall Poppy award.

There is a Whakatauki (Maori proverb) that says

'Ehara taku toa i te toa takitahi

Engari he toa takimano, nō aku tūpuna'

Success should not be bestowed onto an individual alone

As it is not individual success but it is success of the collective

I am humbled to accept this award but I do it in acknowledgment of Te Aro Health Centre Whānau. I have the great privilege to be a nurse practitioner employed at Te Aro Health Centre (TAHC). I am part of a small but very dedicated whānau of clinicians, non-clinicians and volunteers who provide Primary Health Care (PNC) to the city's most vulnerable and marginalised people. The homeless population and those with mental health and or addictions classifications are our key focus, with 60% of our enrolled population having a mental health and addiction classification and 20% homeless.

TAHC is a nurse led clinic situated in the heart of Wellington City. It has a rich and very colourful whakapapa stretching back to the 1980s of providing health care to the marginalised and disadvantaged in our community. Since TAHC's inception in the early 1980s the focus has been to offer timely, high quality health care in a setting suitable to the needs of the patient. TAHC has a history of over three decades of providing health care in a variety of locations (including the boot of a car), by dedicated workers, to the underserved in our city where mainstream health care was not adequately providing for this group. We know that the homeless population have unquestionably poor physical and mental health with high susceptibilities to severe health problems and untreated co morbidities. Often they have suffered discrimination and racism within their experiences of health and are therefore wary of heath care workers.

The key to what we do is to offer holistic health care within Sir Mason Durie's – Te Whare Tapa Wha Maori Model of Care. This is implemented through whānau ora processes by asking whānau/patients the most important question of 'what is it that you need to be well?' At TAHC we do not separate physical health and mental health. We focus on what the person identifies as a need- not focusing on what we think is

important- definitely not tick box primary health care! Care is therefore whānau centred and whānau driven whereby we gain their trust to allow us to work with them to achieve their health goals.

At TAHC the whānau strives to address the issues of access to health care understanding it is complex and has many layers. As identified by the International Council of Nurses, it involves responding to issues such as; availability of services, meeting diverse needs, identifying unmet needs, quality and affordability of care, timeliness of care, and that the care is people centred.

At TAHC we work to address the issues of access in several ways. It begins by the way whānau are greeted in reception through to the way we structure our clinics, the continuing innovation in how services are delivered and working closely with collaborative partners. TAHC is not a one stop shop, for the needs of our patient population are too wide ranging, complex and diverse to address every issue they are presenting with.

Collaboration is one of the keys to the success of what we do, with collaborative partners/services such as 'Te Kakano o Te Aroha' with which TAHC shares a memorandum of understanding. We have a seamless referral process to and from services which includes, The Soup Kitchen, Kahungunu Whanau Services, Downtown Community Ministry, Wellington Men's Night Shelter, Wellington Homeless Women's Trust, Capital and Coast District Heath Board (CCDHB), Team for Assertive Community Treatment and CCDHB's Te Roopu Aramuka Wharoaroa.

Clinics are held at the main clinic in Willis Street and throughout the city where the homeless congregate to access social services. Outreach clinics are provided in an environment that is familiar and where whānau feel more comfortable and safe to access health care. Street outreach, where we meet people sleeping rough is undertaken when concerns are raised about a particular person. Throughout April this year clinics have been extended to include evening free flu clinics at the men's night shelter and evening clinics at the soup kitchen. These clinics have been undertaken to provide flu vaccinations to this at risk group of individuals. The extra bonus of these clinics is being available to discuss general health questions and to enrol new patients who have not engaged with any PHC service.

We are constantly responding to the unmet needs of this population group and adapting where possible to meet their needs. My weekly morning soup kitchen clinic is an example of where I have changed the times of the clinic to meet the needs of the larger population group having an evening meal at the soup kitchen. The clinics are now alternating between evening and morning to reach a greater group of people.

Another initiative has been responding to our hepatitis C patients. Of our enrolled population approximately 5% are positive for hepatitis C. I have a close collaborative relationship with the community hepatitis nurse Lynnaire Matthews. We have worked creatively to provide alternative fibroscan clinics for our patients as they were experiencing a variety of barriers getting to their appointments. Attending an appointment to have their scan at a venue that was unfamiliar, difficult to access and with people they didn't know was difficult for many. So in collaboration with Lynnaire, we have set up clinics in our outreach rooms and recently at our main base in Willis Street, locations that feel safe and familiar for our patients. The non-attendance rates have dropped significantly and more patients have been successfully

'worked up' for their hepatitis treatment.

The nurse practitioner role has helped address issues of access and equity and timely care as acute presentations can be assessed and treated, repeat prescriptions provided and medical certificates reviewed, this being especially relevant in the outreach clinics. Being a registered midwife has many positive advantages in addressing the needs of pregnant women who are finding themselves in difficult circumstances often late in pregnancy with no antenatal care.

I am proud to be part of the TAHC whānau and what we achieve. More can always be done but we have to work within the constraints of our very tight budget. For us it is about creativity, thinking outside the square, utilising staff and a strengths based approach. A whānau once recently told me TAHC is a place where the judgment glasses are removed, you can be yourself and express what you need to without criticism. Comments like this are what motivates me to keep striving for excellence in what I do and the service we provide.

Te Aro Health Centre
331 Willis Street
Wellington

Reflection:

Student Health

Mauri Ora

Michelle Benson

Clinical Lead Nursing

Victoria University of Wellington

When I came to Student Health I thought that the environment would be very similar to that of general practice, an area of nursing I felt very comfortable working in. In a matter of weeks I realised that youth health was definitely a nursing speciality of its own and one in which that I had a lot to learn.

At Victoria University of Wellington, approximately 22,000 students enrol in study every year, about 3,000 of them in first year study. At the start of every academic year, Student Health transfers in approximately 3,000 new patients and then transfers a similar amount out again at the end of year.

Delivering health services to a transient student population is challenging. The constant flux of students in and out of our health service over the relatively short academic year poses both administrative and clinical challenges. One of the biggest challenges we face is managing students with complex medical conditions over this short time, before they return home for the summer. New patient management is an area we constantly review to manage this workload and resolve the issues.

The primary health care nurse role at Student Health is not only that of the health professional, but also life coach, counsellor and surrogate parent. Many students have a low level of health literacy and need support to learn the skills to care for themselves whilst they are at University.

The majority of the students we see are in the 18-25 year age group, many of them school leavers.

This younger cohort of students is where I feel the role of the primary health care nurse in Student health has the most to offer and personally it is an age group I most enjoy working with.

My colleague refers to the students' experience in their first year of study as "a year of firsts". Students may be living away from home for the first time, have their first sexual experience, first experimentation with alcohol, first time socialising outside of their childhood peer group, first in their family to come to university and, most importantly, managing their own health for the first time.

Nurses play a huge role in supporting these students and assisting them to navigate their way through their university experience.

Nurses are able to give basic health education and advice but also provide the support and reassurance that a student may have received from their family had they been living at home. For some students, taking time to listen and reassure them that the pressure and anxiety they are feeling is 'normal', with some suggestions on how to manage this is all that is required to de-escalate their

symptoms. The provision of more nursing clinic time has enabled students to access this support more easily.

The increasing demand for health services and support from students has encouraged the diversification of our workforce and changes to how we approach the delivery of health care services. The introduction of Student Health's first nurse prescriber, nurses working to the top of their scope of practice using their specialised skills to manage contraception, sexual health, diabetes and mental health conditions using standing orders, has provided extra capacity in our service and increased patient access to healthcare.

When I reflect on my work at Student Health, I am not sure if being a mother of three young adults makes me more empathetic to this age group. When I see young people able to manage their health and negotiate health services to promote their own sense of wellness and achieve academic success, it gives me a great sense of reward. Youth health as a specialty in nursing that I recommend all nurses experience.

New member of the New Zealand College of PHC Nurses, NZNO

Professional Practice Committee

Kelly Robertson

I live in Christchurch and have been nursing for 40+ years, working in both the secondary and primary health care sectors.
I am passionate about nursing in primary care and my 26+ years in this sector has included working as a practice nurse and then for Pegasus Health providing leadership and oversight of nursing workforce development programmes for the general practice nursing workforce. I am now working for Healthcare NZ Ltd as the Nursing Workforce Facilitator, supporting the advancement of nursing practice within the community, including NETP, PDRP and policy development.
In my spare time I enjoy gardening and of course am a devoted "one-eyed" Crusader supporter!

LOGIC Committee

Erica Donovan

My name is Erica Donovan and I am a Primary Healthcare Nurse, and I work at a GP Practice/Urgent Care clinic in Christchurch.

In the past I've written for websites and newspapers and I currently run a support and education FaceBook page for nurses, midwives, students and other healthcare workers called The Nurse Path. I am interested how nurses can use technology in education, through methods like podcasts and Twitter.

A regional approach to nurse prescribing practice – the South Island story

Heather Gray

Christine Andrews

The South Island is home to over a million people or 23.3 percent of New Zealand's total population. Our communities are geographically diverse, our population is ageing and demand for services is steadily increasing. Our workforce too is facing pressures – an aging population means an ageing workforce and we face challenges in attracting and retaining staff in specific locations and areas of practice.

Registered nurse (RN) prescribing presents an opportunity for us to better meet the needs of our population, by making the best use of our health care resources, supporting collaboration in our health care teams and making it easier for people to access the medicines and health care they need.

The five DHBs in the South Island have a strong history of collaboration. We committed to working together in a 'best for system, best for people', alliance approach in 2011 and are successfully working towards a fully integrated South Island health system, with integrated information systems and regionally consistent models of care. We do this so our communities can access the same level of high quality care no matter who they are and where they live.

This alliance way of working has supported the development of a South Island nurse prescribing policy and framework, for local implementation. Our regional approach was driven by a need to ensure that RNs on the prescribing pathway are well supported, both as they are training and while they are practising, and that the RN prescribing service is available where it is needed most.

The early discussions regarding upcoming prescribing legislation changes began locally, with groups of nurses from across education and clinical sectors meeting to provide joint feedback on the draft legislation to the Nursing Council of New Zealand. Through these discussions, core focus groups continued to meet. We quickly realised we were having similar discussions locally and that there was opportunity to network and develop our thinking on a wider scale.

On this basis and in the light of the 2015 legislation, the five South Island Directors of Nursing established a RN Prescribing Group tasked with developing a regional framework for moving RN prescribing from legislation to practice across the South Island. This framework will guide local areas to ensure registered nurse prescribing is well supported during education and in daily

practice to better meet the health needs of the South Island community.

A joined-up approach

Heather Gray

Chair of the South Island RN Prescribing Group
Director of Nursing for Christchurch Hospital

As elected chair of the South Island RN Prescribing Group, it is my privilege to work alongside this highly skilled and highly engaged group of professionals from across the sector – all with a shared purpose and common goal.

We knew that for registered nurse prescribing legislation to translate into practice we needed a common vision and support from the sector as a whole. Our group includes representatives from secondary care, primary care, education providers and the New Zealand Nurses Organisation, facilitated through the South Island Alliance's Workforce Development Hub.

The starting point was a stocktake of work to date and the direction of travel in each of our local areas. All parties were generous in sharing work and we found that together we held many of the pieces for a high level policy and framework, and detailed local process options.

The South Island Alliance's Workforce Development Hub facilitated the work of creating the draft documents, which we completed largely by email and teleconference.

The education providers in the group linked the work back to education frameworks for prescribing and helped to ensure that practice development was consistent from entry, to undergraduate education, through to postgraduate preparation.

So far we have achieved agreement on the following principles:

- South Island health services support RN prescribing as an addition to the collaborative team, to meet identified population health needs.
- All registered nurses who wish to practice as RN prescribers must discuss their intentions with their employer and their professional nursing leader before commencing study on this pathway.
- Supervision, support and mentorship is provided to trainees and certified RN prescribers with specific roles and responsibilities for each of the following: trainees and certified RN prescribers, employers, nurse leaders and mentors.

The South Island policy and framework has been developed to assist services to plan and implement RN prescribing in their local areas. The documents provide guidance for employers, health professionals and collaborative teams to support RNs to become prescribers and achieve the potential health gains for our population. They also detail the agreed pathway for RNs to achieve certification, which begins with a conversation with their employer.

For instance, the support network for a nurse prescriber in Fiordland is likely to look different to that of a nurse in central Christchurch. Likewise, a nurse in the New Zealand Defence Force will have a different process for education support than a nurse working with a Māori health provider.

The principles of collaboration and support are the same, but where you apply, and who supports, your practice may be quite different. In recognising these differences, we are celebrating the variety and

depth of our health service in action.

A primary care focus

Christine Andrews

Member of the South Island RN Prescribing Group
Director of Primary Healthcare Nursing, Nelson/Marlborough
Quality Improvement Manager, Marlborough Primary Health

One of our country's biggest health priorities is the treatment and management of long-term conditions, and primary care is a key area where RN prescribing has the potential to improve the efficiency of care, especially for elderly and vulnerable people. Timely access to safe and appropriate medicines can improve health outcomes and reduce acute demand on hospitals.

From a quality perspective, the great advantage of a regional approach to RN prescribing is to reduce variations in the way it is implemented. However, local flavour will always play a part and this is mostly about developing strong relationships with individual employers in order to build capacity and capability in nursing staff.

The South Island RN Prescribing Framework will be used in local primary care settings as the basis for supporting RN prescribing processes alongside consultation with employer stakeholders.

General practitioner shortages in the provinces are also likely to be a strong driver of the new RN prescriber health care innovation. The good news is that the increasing number of RN prescribers in New Zealand suggests that there is a perceived value to the health care system as a whole.

Concordance has been identified as an issue in the effective use of medicines in primary care. Therefore, part of the ongoing role of the South Island RN Prescribing Group will be to develop a range of regional measures, including investigation around which type of prescriber is more effective for which particular patient group.

We are now proud to report that we have 21 qualified nurse prescribers practising in the South Island and another 21 on the pathway. Each of these is based in a collaborative multidisciplinary health care team across 15 speciality areas including: rural, primary care, diabetes, oncology, hospice and Whānau Ora.

But our work is just beginning, we expect the South Island will need over 200 RN prescribers to help our teams meet the needs of our population over the next decade.

More information about RN prescribing in the South Island: https://www.sialliance.health.nz/rnprescribing/

Sun safety advice from the Cancer Society

Over-exposure to UV radiation (UVR) from the sun can cause permanent skin damage. Levels of UVR in New Zealand are high and a key reason why we have a much higher rate of skin cancers than other countries. It is estimated that over 90,000 New Zealanders will be diagnosed with a skin cancer this year, say the Cancer Society.

New research[1] has shown an alarming proportion of New Zealanders are neither wearing hats nor seeking shade to protect themselves from the sun. The Cancer Society provide some advice on ways to be sun safe and on checking skin.

Check the UV level

UVR, unlike heat and light, cannot be felt or seen. Even on a cloudy or cool day you can still be over-exposed to UV rays. Check the UVR level before going outdoors so you know if the UV level is 3 or more and you need to use sun protection. UV levels can be found: on **the Sun Protection Alert,** by loading the uv2Day app onto your phone, or go to NIWA's UV-forecast page[2].

Follow the slip, slop, slap and wrap rule for sun safety

The Cancer Society say New Zealanders practicing the slip, slop, slap and wrap procedure for sun safety will be better protected this summer. Cancer Society sun smart health promotion measures centre on these messages:

Slip on a shirt - with long sleeves. Fabrics with a tighter weave and darker colours will give you better protection from the sun.

Slip into the shade - of an umbrella or a leafy tree. If you can, plan your outdoor activities for early or later in the day when the sun's UV levels are lower. Usually before 10am and after 4pm.

Slop on sunscreen - plenty of broad-spectrum, water-resistant sunscreen of at least SPF 30. Apply 20 minutes before going outside and reapply every two hours and especially after being in water or sweating.

Slap on a hat - wear a hat with a wide brim or a cap with flaps. More people are sunburnt on the face and neck than any other part of the body.

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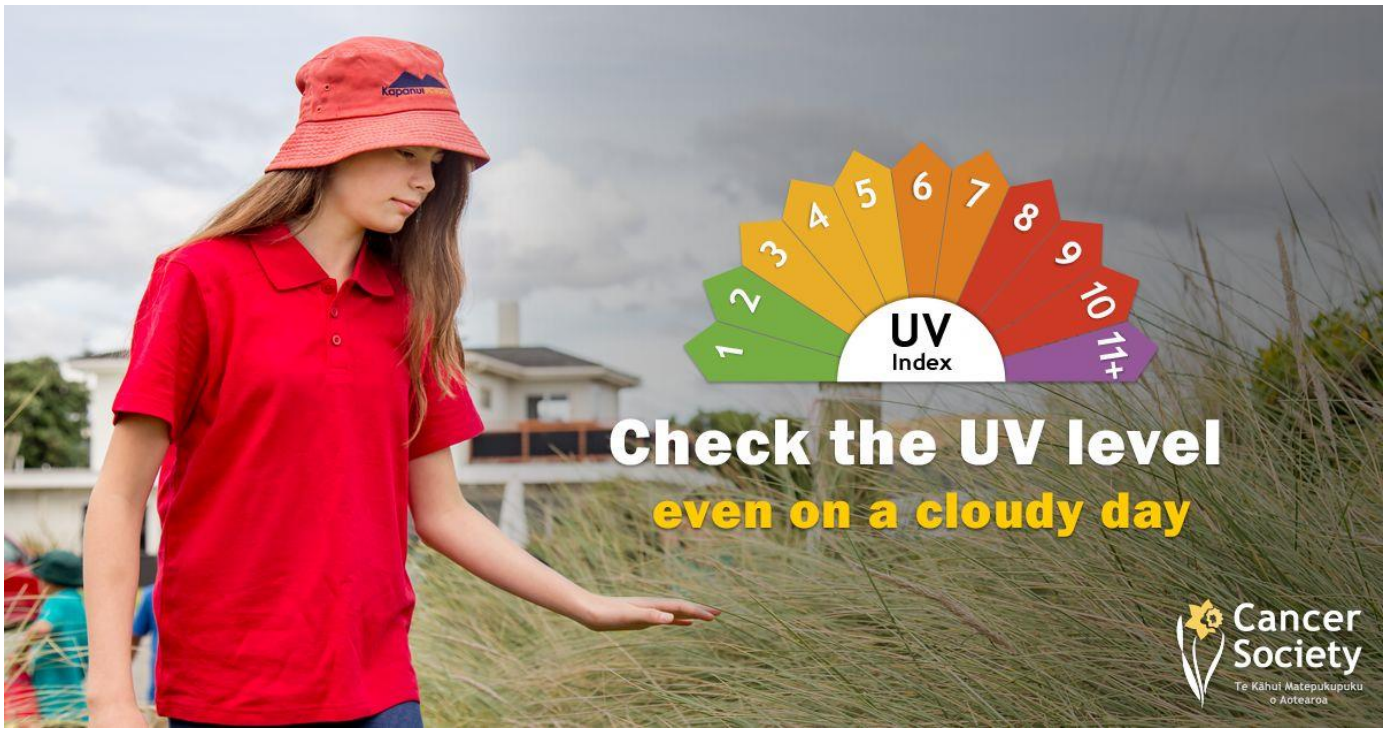
[1] The study, led by public health researchers Ryan Gage and Professor Louise Signal, observed 2635 children and adults in outdoor recreation spaces in the Wellington region between 2014 and 2015, including beaches, playgrounds, and outdoor pools. It found that only 4.3 percent of people wore sun protective hats and just over 10 percent sought out shade during times when sun protection was warranted.

[2] Android - https://goo.gl/XnXn9m

iPhone - https://goo.gl/eQHgJ5

Sun protection alert - https://www.sunsmart.org.nz/sun-protection-alert

The UV Index can also be found at www.niwa.co.nz/UV-forecasts



Wrap on sunglasses - choose close fitting, wrap-around style sunglasses. Not all sunglasses protect against UV radiation, so always check the label for the sun protection rating.

It only takes a minute to check

Skin cancers can be successfully treated if detected early says Cancer Society Medical Director, Dr Chris Jackson. Skin cancers have many variations and changes to look for include:

A – asymmetry - if the spot or lesion is divided in half, the two halves are not a mirror image

B - border irregularity - a spot with a spreading or irregular edge

C - colour variation - a spot with a number of different colours through it

D - diameter over 6 millimetres - a spot that is growing and changing in diameter or size.

"New Zealanders should be encouraged to get to know their skin and regularly check for changes.

"Skin cancers can be in places you can't see yourself and a hand mirror can be helpful to check hard to reach areas like: armpits, behind ears, scalp, the bottom of feet, fingernails and toenails."

The Cancer Society advise the immediate checking of any change on skin by a GP or specialist who will examine the entire skin surface under a good light using a dermatoscope. If they do not use a dermatoscope another GP who does use one should be recommended.

Melanoma New Zealand has a list of accredited skin check providers: www.melanoma.org.nz/melanoma/skin-check-provider.

More information can be found on the Cancer Society website www.cancernz.org.nz.

Investing in a well child nursing workforce;

Anne Hodren Plunket Trust National Educator, RN (Comprehensive), BA, MA (Nursing).

"When we strengthen families, we ultimately strengthen the community. Our goal is that parents everywhere work with supportive providers, feel confident in their parenting role, and form strong, resilient attachments with their children. To help achieve this, providers must be responsive to parents, knowledgeable about child development, and eager to see every parent succeed" (Brazelton, 2018, p.1). The challenge for the Royal New Zealand Plunket Trust is how best to achieve the best health outcomes using the latest research to inform practice within increasing complex community practice.

Early childhood is a key period where social and environmental factors exert their effect on the equity of health and life outcomes providing an important window of opportunity to build a strong foundation for future development. Neuroscience research confirms the importance of the early years and the protective influence of nurturing relationships (Irwin, Siddiqi et al. as cited in Kvalsvig, D'Souza, Duncanson, & Simpson, 2016). The Plunket Trust's strategy (2016-2021) focuses their intent on the first 1000 days of a child's life (Plunket, 2016).

Most parents living in poor circumstances provide a loving and nurturing environment, despite many difficulties. However, children living within a multi stressed family are more likely to be exposed to factors of adversity (Farrington et al; Shonkoff and Phillips as cited in NHS, 2012). When a child experiences chronic, unmitigated adversity without access to stable, supportive relationships with caring adults, toxic stress can occur. Research in the 1980s categorised negative experiences of childhood terming them ACEs, or adverse childhood experiences (Stevens, 2014). ACEs include abuse, neglect, household alcohol or drug abuse, household member in prison, mother treated violently, one or no parent, parent experiencing mental illness, and economic hardship. Research shows these experiences can create toxic stress and negatively affect child brain development leading to the presence of many adult physical and psychological diseases. As the number of ACEs increases, so does the risk for poor outcomes (American Academy of Paediatrics, 2016).

Recent research has shown that even factors previously thought to be unmodifiable, such as genes, can be influenced even modified by the child's environment. This understanding has rapidly evolved into a new field, epigenetics, which seeks to understand how genes and environments interact. There is

now a greater understanding of the profound importance of environments early influences on children's physical health, emotional health and development. (Korosi, Naninck et al., Wang, Walker et al. as cited in Kvalsvig, D'Souza, Duncanson, & Simpson, 2016).

New Zealand children in poverty and vulnerable situations, and the high prevalence of abuse and neglect were identified as concerning when compared with international data (UN Committee on the Rights of the Child as cited in Kvalsvig, D'Souza, Duncanson, & Simpson, 2016). New Zealand research has also highlighted concerns regarding the increasing pressures facing many whānau in particular for Māori and Pacific children with resulting higher incidence of physical, emotional and behavioural problems (Ministry of Health, 2012).

"The long-term goal of public health is to achieve lasting change in the factors and conditions that place people at risk by making changes at the individual, family, community, and societal levels." (National Center for Injury Prevention and Control, n.d., p.2). It would seem timely from the evidence that the health impacts of adversity in early years of life would inform nurses care for children and their whānau, and guide decision making on assessment and effective interventions.

Plunket nurses actively enhance early childhood health and wellbeing as a core component of the primary health care workforce. The New Zealand Government offers whānau a free Well Child/Tamariki Ora (WCTO) universal programme with additional services available according to need/vulnerability ('proportionate universalism'), including assessment, health promotion, family/whānau support and advice, and referral where appropriate and available. Plunket Trust, the largest provider of the WCTO programme is committed to giving every New Zealand child the best possible start to ensure better life outcomes (Plunket, 2016). Gaining the skills for this role can be complex as nurses enter Well Child practice with a variety of knowledge and experiences, some being new graduate nurses. (Fraser, Grant, & Mannix, 2016). Essential is the capacity to work in partnership with clients and communities, to engage families in a relationship that encourages protective factors and reduce risks (Minnesota Department of Health, 2016).

It is acknowledged that gaining the skills required to work as Plunket nurses, in particular with whānau experiencing adversity, is complex. Currently there is a mixed method approach in orientation with mentoring, preceptorship and online learning. This learning is then further developed through the nursing postgraduate programme, an academic-clinical partnership between Whitireia Community Polytechnic and Plunket. Face to face and online learning is being developed to keep pace with education innovation and to reduce barriers for distance learners. Nurses need to find important conduits to bridge the gap between theory and clinical practice, supported through mentoring and supervision (Crick, White, Shaw & Ross as cited in Cameron, 2017).

Emphasis needs to be placed on nurses developing critical thinking to engage with complex practice issues. With the rapidly evolving research related to ACEs, child mental health and neurodevelopment, Plunket staff have expressed a need to have access to up to date knowledge and skills in this area. Being able to evaluate which assessments and

interventions make the biggest difference for whānau and having adequate services to refer to, in particular developmental and mental health services is critical. Central to integration of new knowledge is relational practice, culturally responsive, accessible and affordable care that strengthens whānau and enhances their capacity to support children's wellbeing. (National Center for Injury Prevention and Control, n.d, Minnesota Department of Health, 2016).

Research promotes comprehensive family services that promote children's physical wellness, development, and mental health to help support children to thrive. A focus on environments and reducing toxic stress as targets for intervention would require a more coordinated approach between health, education, social services and funding, collaboration between sectors to work towards a shared goal; the best possible health and life outcomes for the tamariki and whānau of New Zealand (Kvalsvig, D'Souza, Duncanson, & Simpson, 2016). Building on the unique strengths and credible Plunket workforce will create positive benefits to whānau (Plunket, 2016).

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USE OF PREMIX INSULIN GUIDELINES

Research Review New Zealand has recently released a '**Guidance on the Use of Premix Insulin in the Management of Type 2 Diabetes in Primary Care – Research Review Educational Series 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 and those involved in managing patients with type 2 diabetes.

It discusses the use of insulin in this patient group, with emphasis on the use of premix insulin and the concept of patient-centred therapy.

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/guidance-on-the-use-of-premix-insulin-in-the-management-of-type-2-diabetes-in-primary-care/course-25457

ACC and Summer Injuries

Erica Donovan

Summer can mean barbeques, parties and holidays, but also injuries. In fact, from November 2017 to February 2018 there were 506,238 claims lodged.

As nurses we see many injuries, a great majority of which are covered under the Accident Compensation Corporation (ACC). As a Government department there are rules and regulations around what can be covered. In order for an injury claim to be launched the injury is required to be caused by external force (ACC, 2018).

As a nurse working in a triage position, I often see issues that I'm just not sure fit the criteria, so I decided to contact ACC directly to get the information right from the source. The cited statistics used cover December 2017 to February 2018. Thanks James Funnel from ACC for providing these.

One contentious issue at work we've had over the last two summers is sunburn and there's been much discussion about if it is covered. However, sources from ACC say that this can be covered as an accident IF medical attention is required. Despite our high rates of skin cancers, only 25 people successfully claimed for sunburn related injuries last summer. In fact, New Zealand has the highest rate of invasive melanoma in the world (Whiteman, Green & Olsen, 2016). Some areas of New Zealand see high rates per head of population, perhaps in part due to increased population age, and sun seeking habits, or increased awareness of screening (Townsend, 2018, p.208).

Staff working in primary health care may have a role with within skin cancer management by conducting punch biopsies, suturing or providing follow-up results post excision of a lesion. Primary care is well placed to offer excision and care services, but larger or difficult lesions should be seen in secondary care (Brian & Jameson, 2018).

See in this edition for further information from The Cancer Society for patient education.

Insect bites, such as those from sand-flies or mosquitos may also be covered, along with those pesky spider bites.

Last summer saw costs of over $900,000 spent on claims relating to insects. Most bites require nothing but a bit of home TCL, but if medical treatment needs to occur some patients are managed with topical or oral antibiotics. If cellulitis is severe, or persists despite oral antibiotics, intravenous antibiotics may be trialed (bpac nz, 2017). Working for a centre that offers intravenous antibiotics, this is something I've absolutely seen over the summer months.

Commonly used is the cephalosporin cefazolin, given as an intravenous infusion or push. It is worth noting that 2-10% of those with a penicillin allergy will have cross reactivity with cephalosporins, but this is variable between the differing 'generations' of the cephalosporin family (Medsafe, 2016, para 5). An adjunct to this is probenecid which in addition to increasing the excretion of uric acid, also reduces the renal tubular excretion of acidic drugs, increasing their duration of action. Due to its action on the kidneys use should be avoided in those with a eGFR of less than 30ml/minute (New Zealand Formulary, 2018, para 1).

Interestingly, this medication is on the prohibited list for use in elite sports, and athletes should contact Drug Free Sport before taking this medication. The use of cefazolin alone warrants no declaration.

There are a number of interventions that people can use to reduce insect bites. These include chemical repellants and interventions for home such as nets or cleaning of areas known to attract insects. The Center for Disease Control has an excellent guide around mosquito bites that can be a handy resource for those over summer and for those travelling overseas.

Another common pastime is the good old kiwi barbeque. Barbeque injuries peak in December with figures showing 246 injuries at a total of $180,865, then falling to 105 in February, maybe as people went back to work. Burns range in severity, but many can be managed in the community. For those needing a refresher, Starship and Royal Melbourne Children's Hospital both have helpful pediatric guidelines. The New Zealand National Burns service has also featured some further reading and links. It is also worth noting that not all burns involve heat – electrical burns and chemical burns are also possible, so watch out when undertaking any home DIY or working with cleaners.

Obviously, the best thing we can do is to prevent these injuries from happening. Some injuries can be prevented by just having a good think and using common sense. The good weather can tempt people to do activities they don't normally do – but stretching before a game of backyard cricket or wearing the right gear for DIY projects can go a long way to preventing injury. Another factor that we as nurses as well placed to provide, is harm minimization advise around alcohol. Although there is no safe level of alcohol consumption The Ministry of Health recommends no more than two standard drinks per day for women and three for men (Ministry of Health, 2018, para 4). It is impossible to know how many accidents occurred

under the influence of alcohol, but anecdotally there are always a few.

So Merry Christmas! Wherever you're going, if you're working or on holiday, I hope it is a safe and happy time.

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Feeding Our Community at Christmas and throughout the year

Lee-Anne Tait

Rural Health Nurse

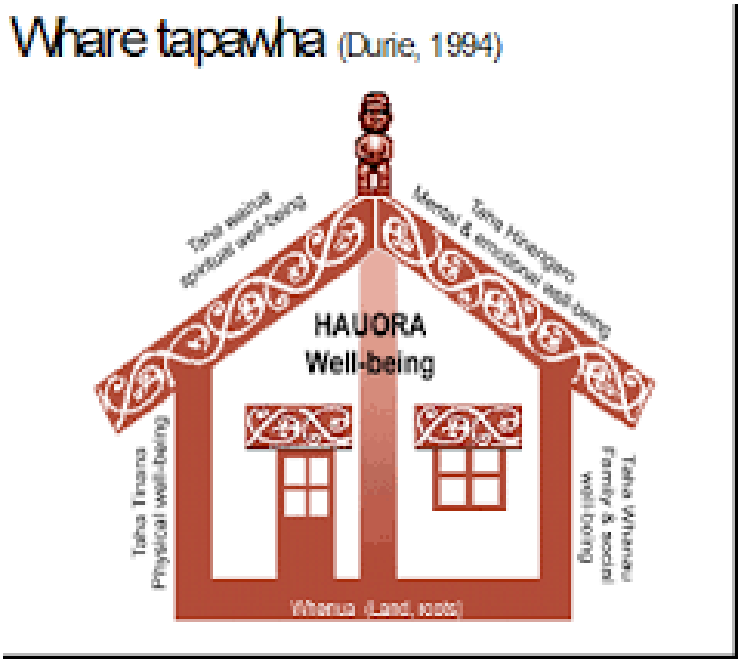
RN, Bsc Health Studies,

Overview- This article explores how Maori health models are utilised when helping to feed our local community.

I work in a small rural nurse-led Health centre in the Tararua district - Te Whare Ora O Eketāhuna - Eketahuna Health Centre or EHC for short. This Health Centre was established 30 years ago when the retiring GP Dr Iyengar could find no replacement. At this point, Dr Iyengar, a representative from the Ministry of Health (MOH) and the current nurses Liz Ramsden and Anne Davies, thought it would be a good idea for it to remain open as a nurse-led health centre with support from local GP's from Pahiatua. Thus, it became the first nurse-led health centre in Aotearoa.

Now 30 years on, EHC is a charitable health Trust. With approximately 80% of funding via the MOH and the rest is sought from income, local community and charitable organisations. Its governance is overseen by an Executive Committee, who volunteer their time to ensure the driving force behind any initiatives is the local community working in partnership with the MOH. The Executive Committee members are predominantly local residents and offer cultural diversity and Maori representation as do the staff.

EHC has a multipurpose building which has become the hub for health and social services within this rural community, both daytime and evening physical mental and psychosocial activities are held within these premises. The model of care utilised by EHC is holistic and is based on the Maori model Te Whare Tapa Whā by Mason Durie (1994)-(1)



This model allows for the four cornerstones of a person to be recognized and valued, as with unstable movement in any cornerstone a person may feel some ill ease or become unbalanced in some way, be it physically -*Taha Tinana*, spiritually - *Taha Wairua,*

mentally and emotionally -*Taha Hinengaro,* or within their family and social structure - *Taha Whanāu,* and lose their sense of or actual wellbeing - *Hauora.*

One of the many functional ways we try to embrace and support positive *Hauora* at EHC is to provide a free food redistribution and a Food Bank for those in need within the community. Those who utilize this service take on various forms throughout any given time period, for example, they could be mums at the local playgroup, elderly residents attending the morning tea group, someone with an overdue EHC account, an oncology patient needing to have a regular supply of healthy food, a family new to the area with limited income, a Traveller passing through who is down on their luck, a family with the breadwinner out of work or with an unexpected bill which is overstretching their budget.

Money and produce from the food bank are given in an entirely voluntary capacity from the local church or community members throughout the year, in order that no person living locally should be without food, or struggling to meet their nutritional requirements if they have a particular health condition which requires a specialized diet. Furthermore, the criterion within the Food Parcel uptake process allows for referrals to external support workers, health professionals and to local budgeting services for those in acute or continued need in a given *hauora*.

Food supplies are collected throughout the year from various sources, such as 'best before' food from the local food store or via "*Wai Waste*" an organisation in Masterton which redistributes excess fresh produce throughout the district just before its 'best before ' time, such as bread, eggs fruit and vegetables. The local community members also drop in with food supplies they would like to donate, otherwise they give at the Street Collection in early December. The Christmas street collection is organised by EHC, the local Blue light services of the police and the fire department. School children assist in the street collection from houses within the local township. More rural households give via the school, the Christmas Carol Service or the Rural Mail delivery. Further fresh vegetable produce comes from our Community Garden which is situated within the grounds of EHC or surplus donated by Eketahuna residents. (Christmas Presents for children come from far and wide and are sourced with age and sex and child's needs in mind, from a non-identifying list within EHC).

Last Christmas we helped 6 individuals and 22 whanāu to have a wholesome food hamper and children's gifts at this special time of year. Throughout the year we give out between 15-30 food parcels and redistribute surplus fresh produce to 10 - 40 people /whanāu almost weekly or as it comes into EHC. Also, people are welcome at any time to help themselves to produce grown in the community garden.

Thus, the food bank works under *Te Whare Tapa Whā* and the *Mauri model* (Morgan, 2006) – which is also nested within the Maori dimensions of well-being. "The Mauri model not only addresses the immediate environment in relation to Health but also the wider complex and interactive dimensions of social, economic, environmental and cultural well-being, from an ongoing sustainable perspective which can be applied to *hauora* of the individual or country. It is our intention to strive towards *Mauri Ora*- wellbeing and oneness

Mauri model (Morgan, 2006) (2)

By having a local food bank and redistribution centre local people are acknowledging there is a need to help one another at various times to reduce the personal potential *hauora* burden brought about by imbalance, inequity or inequality. Our intention is to increase the *mauri* of the community and the ecosystem by thoughtful redistribution whilst reducing waste and landfill by recycling food. Furthermore, within EHC we don't see this food redistribution as a 'handout' but a 'hand up'. We welcome our community to be part of this model of care, whether it be working in the Community Garden, bringing in produce for redistribution, or enjoying eating this redistributed produce.

I feel as nurses working with and alongside a rural community, we are embracing some of the concepts within at the 'NZNO Strategy for Nursing 2018 - 2023' (3). Within EHC we are trying to find both short and long-term ways to make a difference to our community and to Aotearoa.

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New grads exploring the aged care environment: Presbyterian Support Central (PSC) Enliven

Joy Tlapi

Clinical Director, PSC Enliven

Enliven Residential maintains thirteen Aged Residential Care homes in the lower north island from Wellington to New Plymouth. In 2015, Enliven took on the First Year of Practice programme which aims to support recent graduates to make the transition to practice in a supportive environment and see them grow their clinical and leadership skills in this specialty area.

The programme, which is overseen by the Clinical Director's team, sees the participants working at Enliven's homes whilst also taking part in a series of study days and meetings to help strengthen their practice and theory. The nurses work in a supernumerary position alongside trained preceptors for most of the eight months and are supported to have an understanding of

- management of complex and chronic conditions
- emergency and acute episode assessment and support planning
- infection control
- simple and complex wound management
- palliative care
- rehabilitation
- knowledge and expertise in a sector specific set of medico-legal requirements
- direction and delegation

Registered Nurse Madeleine Field says she wouldn't have pursued a career in nursing if it wasn't for Enliven. Working as a health care assistant at Willard Home since 2009, Madeleine explains she was not only encouraged to consider nursing as a career, but that PSC has supported her all the way through her training.

Maddie has been working with Enliven since 2009 and was one of the organisation's First Year of Nursing graduates. In this interview, the dedicated nurse discusses her career path to date and challenges misconceptions about working in aged care.

What led you to a career in aged care nursing with Enliven?

When I was 17, I needed a job, and it just happened that I didn't live far away from Willard. I've never had anything to do with aged care and, like most teenagers, I had no idea what I wanted to do in terms of a career. Fortunately, the manager of Willard at the time, Kate, gave me an interview and eventually hired me as a Health Care Assistant.

I'll always remember when she came to see me in the kitchen and said to me, "Maddie, you remind me a lot of myself at your age. I really think you should consider nursing as you'd be great at it." She then told me about the scholarships Enliven offered for employees to study nursing.

After doing a first-year bridging course to get my health and science knowledge up, I studied nursing for three years while working at PSC on the weekends. As part of my scholarship arrangements, I was then technically obliged to work at PSC for the next three years, but I never had any doubt that that was what I wanted to do.

While you were studying nursing, did you ever discuss aged care nursing as a career with your classmates? What were their thoughts?

Yes, I did, quite a bit…unfortunately the majority of classmates had less interest in working in aged care.

Personally, while I enjoyed my placements in hospitals, I knew that working in one was not what I wanted to do. I really enjoy the relationships you get to build up with residents and families in aged care, and you just don't have that continuity of care with hospital patients.

There's also a lot more responsibility working in a rest home compared to a hospital. People seem to think being a hospital nurse is harder, but they're so much more resourced and tend to work in specialised areas, whereas we take on a lot of different roles, so there's a lot more variety.

As one of Enliven's first-ever First Year of Nursing graduates, we have to ask, how did you find the course?

It was a really good experience for me. I think the programme provides a really solid, guided first year which sets you up well for your later years. We learnt our policies really well and it was a lot of fun too as we had a lot of 'get-together' days as part of the course.

You have now been working as a qualified aged care nurse for four years. What would you like nursing students to know about a career in aged care?

That aged care nursing can be incredibly challenging and there's a lot to learn, but it's also really rewarding.

Woburn Home nurse Tayler Kern shares her work story!

Tayler Kern is a First Year Of Practice Nursing programme graduate who worked for Kilmarnock Heights Home in Berhampore for her programme and is now based at Woburn Home in Lower Hutt.

Prior to joining Enliven, Tayler admits she knew little about what it would be like to work in a rest home.

"We didn't get much education around aged care unfortunately," she says.

"The only real opportunity to learn is when you have placements, but the kinds of duties we're given in those placements are mostly Health Care Assistant (HCA) responsibilities like bed-making and manual handling - you don't really get exposed to the whole therapeutic dimension of care.

"There's much more interaction with residents than I expected and it was much less scary than I was led to believe!

"Like many of my nursing friends, I thought it would be harder than working at a hospital as you wouldn't have much support being the only nurse on duty, but that's just not the case."

In the years she's spent working alongside Enliven staff, Tayler says she's fallen in love with the holistic and collaborative nature of clinical care fostered within the organisation.

"I've really fallen in love with the therapeutic side of nursing

since working here. I've enjoyed the chance to get to know the residents, what works for them and what they're interested in – and knowing that helping a resident doesn't always just mean more medicine," she explains.

"I like that we take notice of things that seem small to some people, but can make a big difference looking at their whole health in general.

Armed with knowledge of the exciting career pathways available in aged care nursing, Tayler is looking forward to exploring her options over the coming years.

"There are so many opportunities to learn about therapeutic nursing and care models like the Eden Alternative, and to work in related areas like palliative and psychogeriatric care.

"I've still got lots to learn, and I intend on staying in the field as long as I can keep doing that," says Tayler.

To date Tayler has completed her post grad certificate and exploring other opportunities to grow as a nurse.

Erin Lyttle (FYOP RN 2016)

Today I was asked what I do for a job. Upon explaining I am a nurse in aged care a woman laughed and responded "why would someone of your age work there?" I looked up in sadness and uttered I wish you could see what I see when I care for these people. I wish you could see their eyes light up with joy as they explain their life story, how proud they are to speak of their children and grandchildren, their expressions of love and happiness as they receive a phone call or get a visit from family and friends. Please remember these are the people that provided us with the world we live in. This job can be filled with such sadness but also so much love. Yes, I get tired, at times I feel completely out of my depth, at times I am sick or have a personal life that needs my attention but when I show up to work and see them smile as you wipe away their tears, brush their hair, hold their hand at a time they need you - nothing else matters. To care for those who once cared for us is one of the highest honours. Just remember one day this will be us and I only hope someone provides me with the love and care I see those I work with provide your loved ones with.

At Enliven we are excited to be able to provide opportunities and support nurses to continue practicing in aged care even when the programme is finished. Since the inauguration of the programme, Enliven has to date employed eight nurses into permanent RN positions, who continue to take great leaps and strides in their professional growth. All the nurses also have a current PDRP (as part of the PSC Nursing Council approved PDRP).

New Zealand College of Primary Health Care Nurses Regional Network Contacts

Regional Networks function

The purpose of the network is to:

- Establish and maintain communication networks with members.
- Contribute to regular coordinated communication between executive and standing committees.
- Provide local education/professional development (where applicable).
- Assist and inform the work of the standing committees.

While we have some regional networks successfully established we still require more energy and support in some areas. See the website under "Regional networks" for what's happening in your area and the local contacts.

http://www.nzno.org.nz/groups/colleges/college_of_primary_health_care_nurses/regional_forums

For further details contact Cathy Nichols, cathyn99@gmail.com

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Otago and Southland	vacant

Managing a busy District Nursing Team – the changing needs of a dynamic environment

Kate Wild
Charge Nurse Manager
Community Health Services
Capital and Coast DHB

As the manager of a mainly urban District Nursing team, I can reflect on the many skills my colleagues are required to have to manage their daily activities. In so doing, I am enabled to consider my own responsibilities and requirements to facilitate and support them.

District Nursing has evolved hugely over the last 10 years and the Wellington Community Health Service is no exception. The changes are a reflection of the larger scale changes going on globally in healthcare and the world that people inhabit. Technological advances, shifting populations, the diverse mix of cultures, changes in focus from healthcare in hospital to healthcare at home and the aging population have all impacted on community health care in the Wellington service. With the shifting focus in health towards better integrated community care, community nurses are key players in this change.

District Nursing is an incredibly multi-faceted role which is what makes it such an interesting and rewarding job and also a challenging one. Life as a District Nurse in Wellington is a constantly moving and variable feast requiring not only great clinical, assessment and communication skills but also the ability to navigate the busy traffic, the hilly streets and the precarious access and walkways to some Wellington homes.

The team

In the Wellington District Nursing team, there are about 35 staff which include general district nurses (DNs), specialist nurses, Health Care Assistants and an Enrolled Nurse., The majority of staff are permanent employees but some have casual contracts. The general DNs are spread over three sub teams which cover the east, central and western areas of Wellington. Most of the permanent DN staff working at .7 full time equivalent and above have their own caseload. There is also a clinic at the District Nursing base for more mobile patients and this forms the equivalent of a caseload.

The key priorities of the service are to deliver safe quality health care that is effective, responsive and enables patients to live well at home and empowers them to be able to self-manage and understand their own health needs.

Technology

The team has recently started to electronically record keep and also use “Silhouette”, an advanced electronic system for the photographing, recording

and mapping of wounds. The nurses also utilise iPads and although these technological tools enhance the ability to provide more integrated care, there are some challenges with the rapidly expanding nature of technological skills the nurses are expected to master. For some, adapting to technological changes can take a while and a few do struggle and need extra time and support to manage the change.

Education

As District Nurses work autonomously, it is essential that they receive effective clinical support through regular up-to-date education and support from both the specialist clinical nurses in the team and each other.

Collaboration

When managing such complex case situations, the nurses are required to liaise with other health providers. Such collaboration is essential to ensure that patients are not only receiving optimal care, but that their care is understood and integrated with other providers and that duplication of services is avoided.

A significant development in this area has been the Health Care Home Project which was started about two years ago. This initiative, has a primary aim to better integrate health services in the community with General Practice teams. Currently in the Wellington Community Health Service catchment area, there are 19 General Practice teams achieving or transitioning to Health Care Home status with more due to be rolled out over the next 12 months. Both the Wellington District Nursing Service and the Wellington ORA team (Older Adult, Rehabilitation and Allied Health Service) have been participating in this project. District Nurses and ORA staff now meet regularly with these General Practice teams for multidisciplinary meetings to discuss complex shared patients.

Palliative care

Our service also works in partnership with Mary Potter Hospice (MPH) and is contracted to provide palliative care to community patients. Joint meetings are held weekly and the DNs and MPH Palliative Care Coordinators liaise regularly. Palliative care nursing can be both highly rewarding and emotionally draining. Time to reflect and debrief are vital to ensure that the nursing staff do not become overburdened and also that opportunities for learning are maximised.

Team support

For staff to be effective community nurses it is essential that they have professional competence with good team relationships and a supportive workplace.

The stimulating and complex nature of community work is extremely rewarding but it's essential that the nurses feel supported and valued and that work loads are well managed. Recent demands for safe staffing have resonated strongly with the team and to avoid staff burn out and stress this has been addressed. A key component of staff satisfaction at work is knowing that they have been able to take the time to provide quality care to their patients. When services become busy and workloads are too high this is compromised. Once staff feel overburdened and dissatisfied in their work, sick leave increases. This management of work volume is not just about staffing but is also about the complexity of the work that District Nurses are expected to do and the time this takes.

Leadership

Alongside the increasing complexity of the patients is the need for effective leadership to ensure that services are able to manage and to continue to develop. As the manager of a community team, I find myself frequently questioning both the role and culture of leadership in such dynamic times. Jacinda Ardern the New Zealand Prime Minister has talked recently a lot about the importance of kind leadership and I believe this is needed in nursing. Clearly however, leadership also requires many other qualities and in my search for what makes a good leader, some other key attributes emerge. These include, effective decision making skills, positive support and feedback, emotional intelligence, resilience and the ability to self-reflect and adapt to changing situations. One article discussed the concept of psychologically empowered leadership and that this tends to empower staff, raising their confidence and increasing their effectiveness at work. (Havaei, Dahinten and MacPhee, 2014).

Resilience

The District Nurses also need to have emotional resilience to cope with their workload and as the manager of a team of these amazing nurses, I am often humbled by the great compassion and clinical skill that they demonstrate in their work. To ensure that they do not become stressed or overburdened emotionally, it is important that they feel valued and confident to seek the support they need.

A recent workshop that CCDHB organized, 'Rebuild the Foundation for Resilient Workforce' outlined some effective tools that other nursing services from around the world have used to provide psychological first aid. One example cited was an "Emotional Recovery Bundle" which had a number of components including time for 'guided conversations' focused on managing routine daily stressors and 'bounce back kits' which are pre made kits that staff can give to each other during times of high stress. In highlighting the need for emotional recovery support, managers were enabled to be more aware of both their teams and their own emotional well-being.

DHB initiatives such as the 'Rebuild the foundation for a Resilient Workforce' will make a significant contribution to New Zealand nursing at a time when many nurses are leaving and expressing dissatisfaction with working conditions. By feeling valued, appreciated and cared for at work, nurses are better equipped to provide care that is holistic, compassionate and of the high clinical standard that is needed to ensure that our people receive the best possible health care outcomes.

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‘Sleep On Side’ campaign for pregnant women launched

Acknowledgement: A previous version of this article was first published in the Midwifery News in September 2018

Tania Cornwall, and her husband Dan, experienced the stillbirth of their first daughter Mia ten years ago. They have since had two daughters and Tania credits New Zealand’s ground-breaking research on pregnancy sleep position for helping her manage her subsequent pregnancies.

Tania, of Samoan/Pākehā descent, was 31 weeks pregnant with Mia when a regular check up detected there was no heartbeat. Tania was sent for an ultrasound which confirmed that Mia had died in utero.

“It was horrific, as she was our first baby. It shattered our dreams as we wondered if we would be capable of having children at all and it started to pain a picture of what the future might be”, says Tania, who had focused on doing what she could to have a healthy pregnancy – no smoking or drinking alcohol, eating right and looking after herself. Mia’s stillbirth made Tania question what she might have done differently during her pregnancy, which is a common response following the loss of a baby.

Within days of Mia’s birth, Tania was invited to participate in the Auckland Stillbirth Study and met midwife Tomasina Stacey, who was undertaking this research for her PhD. This study, led by Professor Lesley McCowan from the University of Auckland, suggested that women who went to sleep lying on their side from 28 weeks of pregnancy, halved their risk of stillbirth compared to women who went to sleep lying on their back.

Preliminary findings of this research were released when Tania was pregnant with her subsequent baby, Paige. She remembers “there wasn’t a lot of control we had within the pregnancy with Mia, but the research empowered me with a bit more control over something I could physically do that was easy to help improve my chances of a normal pregnancy”.

After seeking support through Sands following Mia’s death, Tania has since become the coordinator for Sands Auckland Central, and regularly talks to groups of health professionals about working with bereaved parents and families.

Since the Auckland Stillbirth Study was published in 2011, Professor McCowan and her team of researchers have continued to be at the forefront of research looking at risk factors for stillbirth. A larger New Zealand-wide multicentre stillbirth study was undertaken between 2012 and 2015, with the fieldwork carried out and supported by midwives from Auckland, Hamilton, Palmerston North, Wellington, and Christchurch. This larger study confirmed that going to sleep on

the side in late pregnancy halved the risk of stillbirth, compared to going to sleep on your back.

This risk is thought to be due to the pregnant uterus compressing the inferior vena cava and aorta when a woman lies on her back after 28 weeks of pregnancy. This results in an 85% reduction in blood flow through the pregnant woman's vena cava and around 30% reduction in flow through her aorta. This is thought to reduce cardiac output by 16%. IN turn, this may reduce uterine and placental blood flow, and decrease fetal oxygenation. While a healthy fetus may be able to compensate, vulnerable fetuses may not.

In response to this research, the 'Sleep on Side' stillbirth prevention campaign was rolled out nationwide, beginning with the Te Papa PMMRC meeting in June this year. The campaign was developed with support from the Ministry of Health, the University of Auckland, and maternity care providers. The campaign advisory team included nursing, midwifery and primary health representatives, as well as consumers, researchers, clinicians and public health representatives, in partnership with Cure Kids child-health research charity.

Campaign resources were developed by the team – a brochure for pregnant women, information for midwives, and a social media video featuring a voiceover by broadcaster Miriama Kamo and music by award-winning musician Claudia Gunn.

Safe sleep messages to share with pregnant women are:

Going to sleep on your side (either left **or** right side) from 28 weeks of pregnancy halves your risk of stillbirth, compared with going to sleep on your back

The important thing is to start **every** sleep (daytime naps and going to sleep at night) lying on your side and settle back to sleep on your side if you wake up

Feedback from women and health professionals about the pamphlet and video have been overwhelmingly positive. Women especially liked the video's simplicity, music, and colourful graphics, and midwives have commented on how quick and easy it has been to show the 53 second video during antenatal visits.

It's estimated that if all pregnant women in New Zealand went to sleep on their side from 28 weeks of pregnancy, there would be around a 10 percent decrease in late stillbirths nationally. This simple change to going to sleep on the side may save the lives of approximately 16 unborn babies a year in New Zealand.

In Tania's words, "sleeping on my side in late pregnancy was easy, free, didn't require any equipment or technology, and is something that any pregnant mum could do".

'**S**leep **O**n **S**ide' resources are available free to health professionals through HealthEd, the Health Promotion Agency at the Ministry of Health:

Pregnant women's pamphlet - https://www.healthed.govt.nz/resource/sleep-side-when-babys-inside-0

Health professionals' pamphlet - https://www.healthed.govt.nz/resource/sleep-side-when-babys-inside

To view the video or download PDFs of the brochures, go to www.sleeponside.org.nz

Sleep on Side - Pamphlet for Health

cure kids

SLEEP ON SIDE WHEN BABY'S INSIDE

FROM 28 WEEKS OF PREGNANCY

www.sleeponside.org.nz

MINISTRY OF HEALTH
MANATŪ HAUORA

THE UNIVERSITY OF AUCKLAND
NEW ZEALAND

Information for Health Professionals

Maternal Supine Going to Sleep Position and Late Stillbirth Risk

Key messages for health professionals to discuss with all pregnant women:

- Going to sleep on your side (either left or right side is fine) from 28 weeks of pregnancy halves your risk of stillbirth compared with going to sleep on your back
- The important thing is to start every sleep (daytime naps and going to sleep at night) lying on your side and settle back to sleep on your side if you wake up

EPIDEMIOLOGY

Late stillbirth (≥28 weeks') occurring in singleton non-anomalous pregnancies affects approximately three in every 1000 women, resulting in deaths of approximately 160 New Zealand babies annually. Identification of modifiable risk factors has the potential to reduce this tragic pregnancy complication.

Four published studies from New Zealand (n=2), Australia (n=1) and the United Kingdom (n=1) have now reported that women who go to sleep lying on their backs in the third trimester of pregnancy have an increased risk of stillbirth, that is independent of other stillbirth risk factors.[1-4] This consistent finding is biologically plausible (see below) and is important as going-to sleep position is a modifiable risk factor for late stillbirth.

PHYSIOLOGY

When a healthy mother lies on her back (supine position) in late pregnancy the uterus compresses the main abdominal vein [inferior vena cava (IVC)] reducing the IVC blood flow by >80%. The aorta is also partially compressed by the pregnant uterus with an approximate 30% reduction in flow.

The mother's circulatory system compensates for this reduction in IVC flow when lying on her back by increasing blood flow back to the heart through collateral veins below the obstruction and increasing her heart rate.[5] However, this does not fully maintain optimum blood flow.

The physiological response to the supine maternal position in late pregnancy includes:

- Reduction in venous return to the heart by approximately 24%
- Reduced cardiac output on average by 16% which is likely to reduce uterine and placental blood flow leading to reduced oxygen delivery to the fetus

THE FETAL RESPONSE

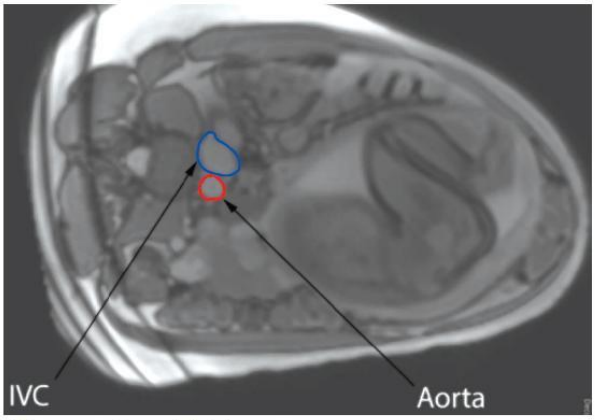
When healthy pregnant women lie on their back in the third trimester the fetus responds by spending more time in a quiet behavioural state (non-reactive fetal heart pattern) and rarely exhibits a very active behavioural state. This suggests that the healthy fetus responds acutely to the reduced blood flow by conserving oxygen consumption.[6]

We speculate that whilst the healthy fetus can compensate adequately for periods of reduced placental perfusion an at risk or vulnerable fetus is likely to become acidotic and decompensate.

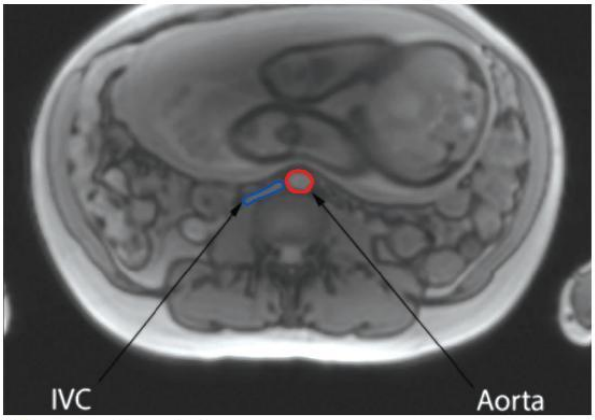
SLEEP-DISORDERED BREATHING

Sleep-disordered breathing increases in pregnancy, can be associated with maternal hypoxic episodes and is more common when lying on the back. Sleep-disordered breathing has been associated with pregnancy complications including fetal growth restriction, hypertensive disorders and gestational diabetes which are all associated with increased stillbirth risk.[7] Sleep-disordered breathing while lying on the back could therefore add to the adverse effects of reduced blood flow.

Figure 1: Magnetic Resonance Image showing IVC and aorta with mother lying on left and on back



MRI scan: mother on left side



MRI scan: mother on back

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Sleep on Side - Pamphlet for Parents

SLEEP ON SIDE WHEN BABY'S INSIDE

FROM 28 WEEKS OF PREGNANCY

www.sleeponside.org.nz

MINISTRY OF HEALTH
MANATŪ HAUORA

THE UNIVERSITY OF AUCKLAND
NEW ZEALAND

cure kids

Research shows that going to sleep on your side from 28 weeks of pregnancy halve your risk of stillbirth compared with sleeping on your back.

Why should I go to sleep on my side?

Lying on your back in the last three months of pregnancy (from 28 weeks) presses on major blood vessels which can reduce blood flow to your womb and oxygen supply to your baby.

Is it best to go to sleep on my left or right side?

You can settle to sleep on either the left or the right side – any side is good from 28 weeks of pregnancy.

But what if I feel more comfortable going to sleep on my back?

Going to sleep on your back is not best for baby after 28 weeks of pregnancy. Most women find side sleeping is more comfortable in pregnancy, especially in the last three months.

What if I wake up on my back?

It's normal to change position during sleep and many pregnant women wake up on their back. The important thing is to start **every** sleep (daytime naps and going to bed at night) lying on your side and settle back to sleep on your side if you wake up.

What is the risk of stillbirth if I go to sleep on my back?

Stillbirth in the last three months of pregnancy affects about one in every 500 babies. However, research has confirmed that going to sleep on your side halves your risk of stillbirth compared with sleeping on your back.

For more information please contact your midwife, nurse or doctor.

www.sleeponside.org.nz

The experiences of a NETP nurse working at Te Waiora Community Health Services

Keisha Bell is an RN working at Te Waiora Community Health Service. She started working there as a new graduate on the NetP programme and offered to write about her experiences for L.O.G.I.C.

What inspired you to become a nurse? Were you on a NetP Programme as a New Graduate? If so, with whom?

I left college not achieving much qualification wise, I started work full time and did that for four years until I had kids. Once I became a mother something inside of me just clicked and I made the decision to start my bachelor of nursing once my kids were 4 and 2 (old enough to leave them full time).

I wanted to show them that you can achieve anything no matter what your circumstances to get ahead in life. I was fortunate enough to get a job offer while on my transition placement and do my NETP position in the MidCentral DHB at Te Waiora.

How do you think working as a new graduate in primary care has helped you grow your skills and knowledge? What has been your biggest challenge as a new grad in primary healthcare? What has been the best part about being a new grad in primary healthcare?

I feel working in primary healthcare, you are exposed to numerous conditions/illnesses, every day is different, it has expanded my knowledge base and skill level greatly, learning all the different medications, what their indications, adverse effects to assessing patients conditions and acute presentations.

With this it can also be quite challenging as a new grad; you are constantly learning more every day. We see people of all ages (right from new-borns to elderly) for sore throats, respiratory conditions (LRTI &URTI), asthma & COPD exacerbations, cardiac related conditions, chest pains to acute walk ins (cuts, lacerations, head knocks), mental health related issues.

Ensuring I assess appropriately is my biggest challenge. As well as been the most challenging this is also my favourite part of being in Primary Healthcare (PHC): The exposure to numerous conditions/medication, whereas working in other areas, I feel you are only exposed to specific conditions to those areas.

Do you have any regrets in becoming a nurse? Or working in primary healthcare? What are your plans for your career?

I have absolutely no regrets in becoming a nurse or working in PHC. It suits my lifestyle as a working mum with kids at school, I don't work weekends and I get to eat dinner with them every night.

You are exposed to all aspects of health and wellbeing. It also helped me gain confidence as a mother, knowing I could achieve my bachelor in nursing and complete my NETP year while raising a family. I plan to become certified in all things related to my practice nurse role, and eventually - postgraduate study.

From your experiences what advice would you give student nurses in regards to Net P and primary health care? From your experiences how can PHC and

NetP improve the process for future nurses?

From my experience, I would say PHC is an awesome option to start your nursing career. Not one day is the same, you gain so much experience from being exposed to a wide range of illnesses/diseases increasing your skill level/knowledge base.

I feel it was never really pushed as an option when I was a student nurse, it was more hospital based jobs. The NETP process was a little confusing in that you get told to not list primary healthcare as first option for the ACE process as your chances of getting interview will decrease (within the DHB), yet that was my first option that I wanted to work in. So I guess, in that sense, having clearer guidelines in place with the ACE process to ensure PHC is a viable option would improve the process for future nurses.

NEW ZEALAND WOUND CARE SOCIETY

The New Zealand Wound Care Society (NZWCS) is a non-profit organisation supporting advancing wound practice and knowledge. The Society warmly invite healthcare professionals working in primary health care to join us! The benefits of joining the Society include reduced costs to attend national conferences and seminars, research grants, scholarships for under and post graduate education, access to a wound specialist in your area for clinical support and advice, our newsletter 'Tissue Issue' to keep you updated and access to international wound journals!

Additionally, the Society have many working groups if you are interested in contributing professionally. For more information please contact us or view our website: www.nzwcs.org.nz

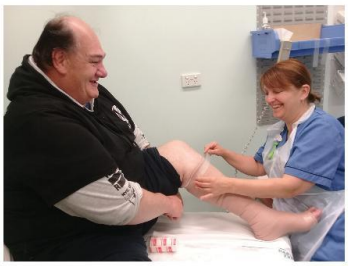
Keep this date free for the NZWCW conference in Dunedin May 23 to 25 2019! The conference will include workshops on sharp debridement, product selection and lower leg assessment, pressure injuries, skin care and much, much more!!

Advancing practice and knowledge
in wound management

Te whakapai ake i te mahi me te matauranga taotū

NZWCS Advisory Groups & Projects

- Education Advisory Group
- Leg Ulcer Advisory Group
- ANZ Venous Leg Ulcer Guidelines
- Leg Ulcer Assessment Form
- Diabetic Foot Assessment Tool
- Pressure Injury Advisory Group
- International Pressure Injury Guidelines
- Supporting National Stop Pressure Injury Day
- Wound Bed Preparation Guidelines



Membership Plans

- **Full:** health professionals with an interest in wound care.
- **Corporate:** A membership for Groups of between 5 and 20 health professionals who share a common employer.
- **Commercial:** available to companies or employees of companies where wound care products sales or marketing is a source of income.
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Education and Professional Development

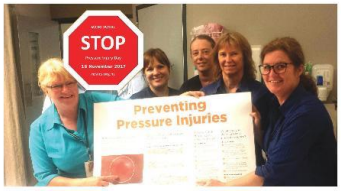
What we offer

- Reduced fees to attend the national biennial NZWCS wound conference
- Reduced or free registration to regional study days/seminars
- Links to under and post graduate wound care courses
- On-line access to wound-related education modules
- On-line access to wound-related webinars
- Advance notification of education opportunities
- Opportunities to join project groups
- You can contribute to our *Tissue Issue* newsletter and evidence this to your professional development
- Applications for Awards, Scholarships and Research Grants

Awards, Scholarships & Research Grants

What you can apply for

- Wound-related published articles
- Articles published in our newsletter — *Tissue Issue*
- Wound-related under graduate study
- Wound-related post graduate study
- National NZWCS conference attendance
- International Wound Conference attendance



A Baby Friendly Aotearoa Programme and updating the NZ BF Documents to Align with new BFHI operational guide WHO / UNICEF 2018

Jane Cartwright

Jane holds a leadership role in the Canterbury Clinical Network and holds directorships in the health, disability and education sectors. She is Chair of Brackenridge Services Ltd, Council Member of Ara and deputy chair of Nurse Maude Association. Jane was appointed as NZ Breastfeeding Alliance Executive Officer in May 2017 in a part time role and is Registered Dietitian. Jane has held executive and senior roles in the health system and local government. She works to improve the health and well-being of people in partnership with others.

Breastfeeding has a positive influence on the health status and social wellbeing of the baby, mother, whanau and community. New Zealand recognises this and the Ministry of Health recommends that infants are exclusively breastfed for their first six months of life. Despite this, and the known risks of not breastfeeding, just 9 percent [1] of New Zealand babies are exclusively breastfed during their first half year of life. Māori and Pacific peoples, low-income families and young mothers have lower breastfeeding rates than other groups. These discrepancies contribute to poorer child wellbeing and disparities in health status.

The influences on breastfeeding rates are complex. Breastfeeding is a highly emotive subject because so many families have not breastfed, or have experienced the trauma of trying very hard to breastfeed and not succeeding. No parent should have to feel the pain of any implication that they have not done the best for their child,

but the NZ context has become fraught and conversations about breastfeeding are polarising.

Powerful new evidence about the benefits of breastfeeding provides a compelling case to alter prevailing attitudes and practices. Ground-breaking research highlights the practical, emotional and cultural barriers that still stand in the way of women breastfeeding and underline the importance of breastfeeding in improving health, saving lives and reducing costs for families, communities and NZ.

The '10 Steps to Successful Breastfeeding' [2] have been revised and released. NZ needs to align its BFHI and BFCI with these. This alignment, the need to modernise the BFHI and increase the scope of Baby Friendly work has provided the opportunity to create a Baby Friendly Aotearoa Programme.

The Ministry of Health have signalled the updating of the National Strategic Plan for Action on Breastfeeding and the NZ Baby Friendly Documents are due to be reviewed and relaunched for 2020 so the timing is opportune to do more.

NZ's birthing population is changing. Babies born in NZ today are ethnically diverse. NZ's maternity and well child systems are evolving and provide mothers/whanau with the opportunity to birth at home, in community hubs and in primary/ secondary/tertiary facilities. The independent LMC model of midwifery care continues to be the cornerstone of maternity services however there are significant workforce shortages across the country especially in rural communities.

The provision of WCTO and community services for babies and mothers varies across the country with a growth in Maori providers

and Peer Support services. Data capture, IT Tools, education opportunities/modes of delivery and quality assurance requirements have changed since the BFHI was established in 2000. There is also a strong desire for 'Baby Friendly' to be pursued as a quality marker supported by continuous approach and that the process adds value to a service.

The proposed Baby Friendly Aotearoa Programme will provide a framework for the BFHI and BFCI. It is part of drive to encourage breastfeeding from birth and sustain breastfeeding for babies and mothers. The Baby Friendly Aotearoa Programme aims to cover more locations than hospitals and support mothers who do not/are unable to breastfeed their babies.

It is time to work collectively and ensure that the BFA contributes to the wider initiatives that will increase breastfeeding rates in NZ.

The MOH and NZBA are jointly leading work to establish the BFA with the input of panel which bring a range of perspectives to the discussions. These perspectives include, consumers, policy makers, analysis, educators, Infant Feeding experts, DHBs, researchers, Midwifes, paediatricians, WCTO providers, Maori, Pacifica, Culturally and Linguistically Diverse Populations, and Neonatal services .

This document contains the basis of the Baby Friendly Aotearoa Programme and the impact of the new 10 steps on the NZ Documents as they relate to BFHI and BFCI.

This document will be used to consult with the sector prior to implementing the Baby Friendly Aotearoa Programme and NZ's interpretation of the new 10 steps from 2020.

The MOH and NZBA Board are responsible for signing off the Baby Friendly Aotearoa Programme and NZ Baby Friendly Documents 2020.

[1] NZ Ministry of Health Data - Breast Feeding Status for Infants at Six Months July-December 2017

[2] http://www.who.int/nutrition/publications/infantfeeding/Baby_Friendly_Hospital_Initiative_-implementation/en/

Eczema

Erica Donovan

Eczema (or atopic dermatitis) is a clinically diagnosed inflammatory skin condition categorized by itch, erythema and edema. Symptoms may range from mild to severe and can occur acutely or chronically. The word eczema is defined from the Greek word for 'to boil over' and as someone who has been diagnosed, that feels pretty apt at times when your skin feels hot and volatile.

New Zealand has a high rate of childhood eczema. It is more common in females, and there Maori and Pacific children are also over represented in the statistics (Clayton et al, 2013). There is often the thought that children 'grow out' of eczema, which in some sense is true, 60% of children go into remission by adolescence (Barker, Palmer & Zhao, 2007).

It is not a contagious disease, but there may be a genetic link for some individuals.

The causes of eczema are not fully understood. It is thought that inflammatory cytokines and Langerhans Cells play a role, causing the inflammatory symptoms that manifest in the skin (Stanway, 2004). Those with eczema typically have impaired skin barrier function. There are a myriad of triggers, depending on the individual. Common triggers are stress, itching, dry and temperate environments, irritants in household products, and certain fabrics such as wool. House dust mites and animals may also be a trigger for some patients (Australasian Society of Clinical Immunology and Allergy, 2018).

Treatments:

For anyone out there who struggles with, or has a family member who struggles with eczema, you know that it always seems like you're constantly looking for 'the one'. And by 'the one' I mean the one treatment to rule them all.

It seems like every month there's a treatment on the pharmacy shelves. At one point I even did a clinical trial for a skin cream made from New Zealand natural ingredients.

Those of you in general practice, public health or school nursing may be familiar with the Asthma Action plans, and there is actually a similar document for eczema available from the Australasian Society of Clinical Immunology and allergy. These outline the personalized treatment plan, ways to prevent infection and the strength of bleach baths.

Eczema treatment is generally provided in primary care; however poor healing, treatment failure or severe cases may be referred through to dermatology through the public or private system.

Common treatments include:

Emollients – these are preparations that moisturize and soften the skin. The texture may vary from lotions to heavy ointments (Dermnet, 2008). One common example is

Sorbolene, which is available on script. As for the most efficacious preparation? Bpacnz (2009, p. 28) says that it would be the one most preferred by the patient, as they are more likely to apply it regularly! A Cochrane Review also found no overwhelming evidence for the benefit of one preparation over others, but there was evidence that using a steroid in combination of emollients was more effective than steroid alone (van Zuuren, Fedorowicz, Christensen, Lavrijsen & Arents, 2017).

Topical steroids– These creams act to decrease and inhibit the inflammatory proteins responsible for skin symptoms, while increasing the production of anti-inflammatory. production However, their very benefits can also cause their harms, as inhibition of T-lymphocytes can cause immunosuppression (New Zealand Formulary, n.d). Patients should be advised against facial application unless advised by their prescriber, but if they are required to use on the face, to use them for shortest duration possible and avoid use around the eyes (Medsafe, 2005). Despite having eczema from early childhood, it wasn't until attending a pediatric assessment course that I heard about how much steroid cream to actually apply – the Fingertip units rule. A table guideline for this is available from patient.info and gives the measurement for children and adults (https://patient.info/health/steroids/fingertip-units-for-topical-steroids)

Soap free products –

Avoidance of soap related products is something that is mentioned in many advise sheets for patients. A common treatment is 'fatty cream'; like many other eczema products, it is available over the counter, but is also subsidized on prescription.

Wet dressings –

This method involves covering the skin areas with steroid or anti-inflammatory creams, followed by emollients, then wet tubular bandages. A guide to doing this can be found here: https://www.rch.org.au/uploadedFiles/Main/Content/derm/Wet_dressings_eczema.pdf

This method may be time-consuming, but for some it may be worth considering (Andersen, Thyssen & Maibach, 2015, p. 938).

Occlusive dressings –

This is one method I've found to be effective, after being introduced to it via an Occupational therapist friend. This method allows topical preparations to sit on the skin, then be covered with a film dressing such as tegaderm or hyperfix. A benefit to this approach is the dressing does not absorb the ointment and the areas of irritation remain covered.

Systemic treatments:

At times, topical treatments are inefficient at controlling systems and systemic treatments should be tried. While topical steroids are a common treatment, some patients do require short courses of oral steroids. Like any steroid prescription, patients need to understand the role of tapering the doses to end the course. Steroids are endogenous hormones, and increased levels can cause altered fat deposition and decreased bone density, as well as the aforementioned immunosuppression.

After consultation with dermatology medications such as azathioprine, methotrexate, or biologics may be prescribed to those with eczema. However, they may not be suitable for all patient groups due to side effects or contraindications (Gooderham et al, 2017). Though primary care nurses may not be involved in the administration of these drugs, we may be responsible for sending out testing recalls or

taking blood for testing. For example, methotrexate requires close monitoring of liver function, renal function and complete blood count (Waitemata District Health Board, 2017). Some patients may also respond well to phototherapy. In a study of dermatologists, phototherapy was preferable to systemic medications in moderate to severe eczema (Taylor, Swan, Affleck, Flohr & Rynolds, 2016). Though respondents would like further studies to be done.

Future treatments:

There are many studies and meta analyses on the use of probiotics or prebiotics in the management of eczema (Dang et al, 2013; Cuello-Garcia et al 2015). Cuello-Garcia et al (2015) feel that although their meta-analysis noted reduction in eczema rates with prenatal supplementation or post-natal infants, they also acknowledge that further and more rigorous studies should be conducted on the topic. Many blogs and websites also hype the role of other supplements, but further study is required.

Complications -

Any areas of broken skin have the potential to develop infection, and eczema is no exception. The most common infective pathogen is Staphylococcus aureus, typically found in on our skin within our regular skin flora (bpac nz, 2017, p.1). Antibiotic resistance has been a hot topic for several years, and there certainly has been a push towards topical antibiotics in recent years, but they are also not without risk as reactions or resistance may still occur (Everts, 2017, p.4).

Stress to patients and family -

Dang et al (2013, p. 1437) state that "*high rates of recurrence, bleeding, scarring and even infection (due to scratching) can seriously affect health-related quality of life".* Body image issues can occur in both adults and children. Sufferers may modify their clothing choices to cover up their skin or avoid activities where their eczema presents. As someone who has eczema ever since I remember, this is a very real disruption. There are times that I've felt embarrassed, both at the severity of my skin problems and for the areas that they present in. At several points swelling and irritation has sprung up on my face, which was very disruptive when I was previously working in luxury cosmetics and skincare but looking like I was a snake shedding my face. I also had to take time off work due to not being able to work when my skin was infected – it can become an occupational health and safety issue. Sleep may also be disrupted due to itch or pain, and for some there may be a benefit to sleep aids, such as sedating antihistamines.

Having a child with eczema may also impact the wider family unit. The treatment can be 'time consuming and tedious' but best results will be achieved if regimes are regularly maintained (Eczema Association of Australasia Inc, n.d). Children may have absences from school or miss out on activities such as camps and sports (Mackey, 2018).

For families there is support available from groups such as the Eczema Association New Zealand. There is also financial support some may qualify for, via the child disability allowance. This is a non-taxable and non-income tested allowance, available to the parents or caregivers of children with serious disability, and that require care above that of other children their age.

Further reading:

Allergy.org.au

Eczema Association Australasia.

Eczema Association New Zealand

Healthinfo.org.nz

Pediatric Specific information is available on the Starship or Royal Melbourne Children's Hospital website.

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2. Art. No.: CD012119. DOI: 10.1002/14651858.CD012119.pub2

Information for General Practice

New ACC contributions from 1 December

General practices treating patients under ACC's Cost of Treatment Regulations (CoTR) will receive increased contributions from 1 December following approval by Government.

General Practice (doctor, nurse practitioner and nurse visits) will be paid a higher rate for patients with Community Service Cards, with the expectation the patient will pay no more than $18.50 for a GP visit. Their dependants (aged 14 -17 years) should be charged no more than $12.50. Additional contributions will also mean the current zero-fees scheme for under 13s can be extended to under-14s.

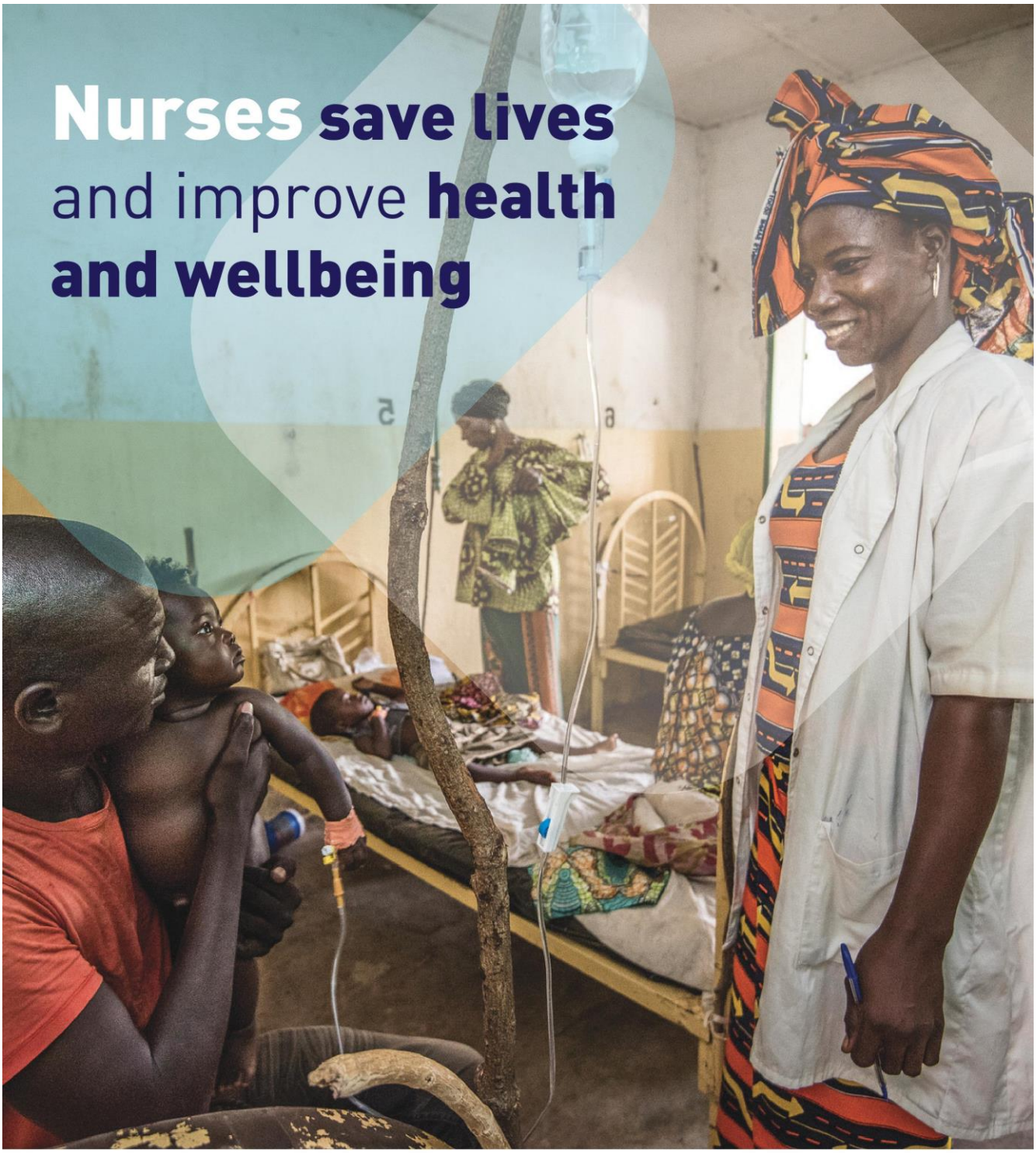
It is up to individual practices to set their co-payment levels, however ACC says the contributions are set at a level to encourage practices to pass on the benefits to their patients.

These new rates will also apply to practices working under contract – Rural General Practice and Urgent Care Clinics. Contract holders will need to meet the terms and conditions of the contracts.

ACC is reminding practices to invoice at the correct rates from 1 December. "It's important that all health providers know about these invoicing changes to avoid a delay in payment," said Graham Dyer, ACC Head of Provider Services Delivery.

The changes are part of announcements made by the Government in Budget 2018 and apply to both health and injury-related visits.

The new rates can be found at https://www.acc.co.nz/for-providers/provider-updates/new-rates-for-treatment-providers-confirmed/. Ministry of Health also has information about the initiatives available on the TAS website.



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The NZNO Library has a wide range of hardcopy and online resources available to support the information needs of members.

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

Email Library@nzno.org.nz and let us know which ones you are interested in.

Articles – Eczema

1. Eczema: Ditch the itch! Philpott, Leanne *PS Post Script*, Aug 2017, 36-37
From the annoying itch to the frustration of a flare up, eczema can have a huge impact on quality of life if not managed well, writes Leanne Philpott.

2. Eczema management in school-aged children Leins, Liz & Orchard, David *Australian Family Physician*. Dec 2017, 46(12), 896-899
Atopic eczema is a relapsing inflammatory skin condition that can be lifelong. Management of eczema is often focused on infants, with many school-aged children undertreated. This article will describe how eczema manifests in school-aged children, focusing on when to suspect triggers and how to manage these from a general practice perspective, and when to refer the child on to specialist services.

3. Healthy living: Eczema: Taking the sting out of eczema! *PS Post Script*, Aug 2016, 24-26
Almost a third of the population suffers from eczema and this number is growing. While there's no cure for eczema, there is plenty that can be done to help manage the condition

Articles – Sun Protection

4. Public Parks and Shady Areas in Times of Climate Change, Urban Sprawl, and Obesity Heckman, Carolyn J. *American Journal of Public Health*. Dec 2017, 107(12), 1856-1858
An editorial is presented which addresses the relationships between shady areas, public parks, and skin cancer risk factors as of 2017, and it mentions other articles in the same issue of the journal which examine topics such as the use of sunshine-related shade sails in recreation areas in Denver, Colorado and Melbourne, Australia. Climate change, obesity, and urban sprawl are assessed, as well as sunscreen and protection from sunlight-based ultraviolet radiation (UVR) exposure.

5. 6 ways to improve and protect your vision. *Harvard Health Letter*. Jul 2018, 43(9), 1-7
The article offers ways to improve and protect vision specially aging increases the risk

for vision loss and eye problems, including cataracts, diabetic eye disease, glaucoma. Topics discussed include eating an antioxidant-rich diet, wearing protective glasses, get regular eye exams and views of Matthew Gardiner, an ophthalmologist with Harvard-affiliated Massachusetts Eye and Ear.

6. The science of sunscreen Lin, Jennifer. *Harvard Women's Health Watch*. Jul 2018, 25(11), 1-7
The article presents question and answers related to chemicals present in sunscreen which should be avoided; association between sunscreen and skin cancer; and advice regarding sunscreen use.

7. Stay Protected! Maffei, Heather Muir. *Health*. Jun 2018, 32(5), 25-27
The article offers information on several products including the Sport Performance Lotion Sunscreen SPF 100 from Banana Boat, the Defend & Care Sunscreen Stick SPF 50 from Coppertone, and the Dawn Patrol Classic Makeup Primer SPF 30 from Coola Suncare

8. Sun Exposure and Protection Practices of Caregivers for Young Children Living In South Florida. Kleier, Jo Ann. *Pediatric Nursing*. May/Jun 2017, 43(3), 137-142
Children are particularly susceptible to the harmful effects of sun exposure, which drastically increases the likelihood of developing skin cancer. Sun protective strategies may be helpful in reducing risks, but children are dependent on caregivers to consistently implement these strategies. We described the sun exposure and use of sun protection that caregivers implemented for their young children and compared these practices between groups based on children's age, sex, and the racial/ethnic groups living in South Florida

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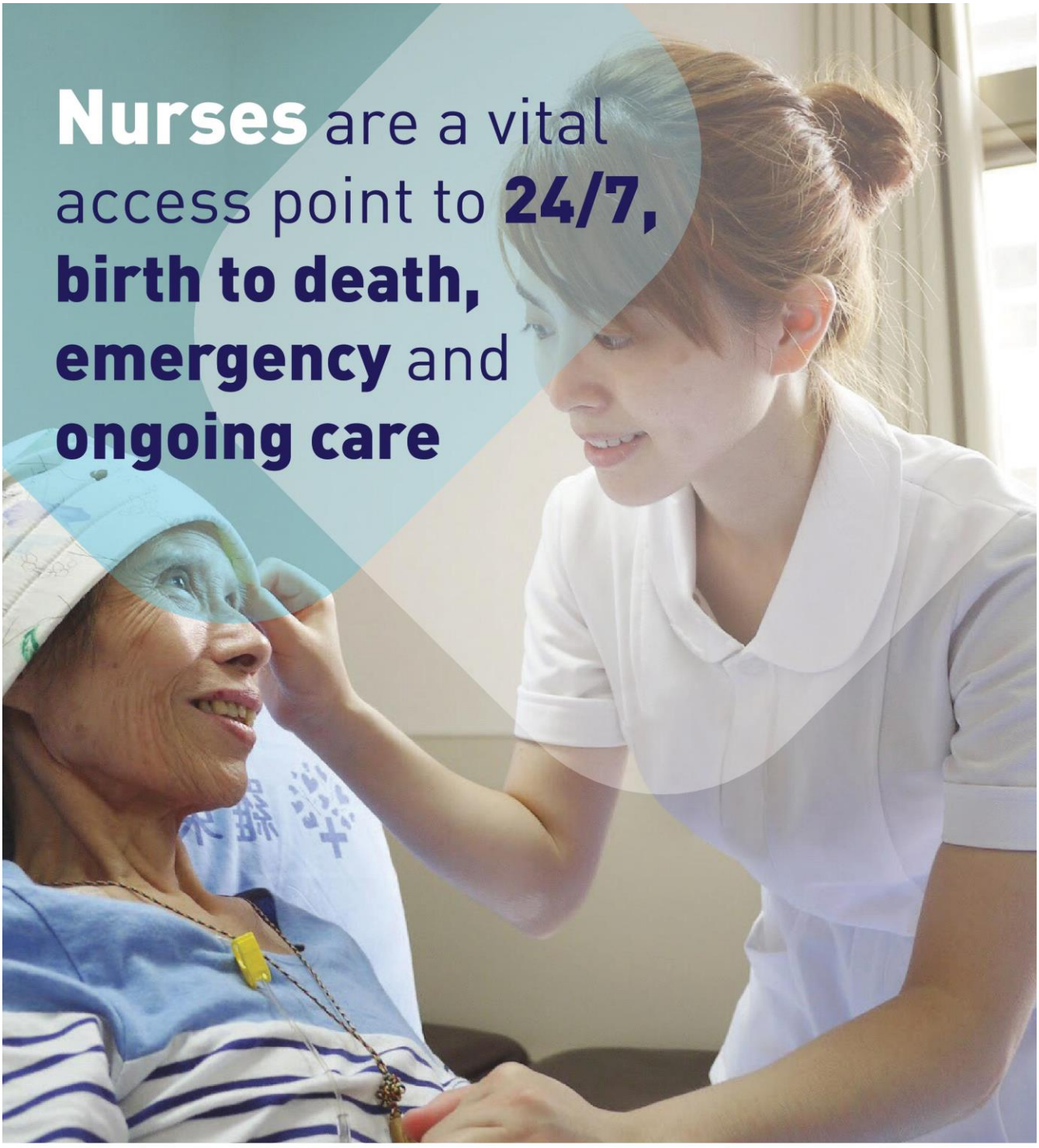
W: http://www.nzno.org.nz/resources/library/resource_lists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