LOGIC.
LINKING OPPORTUNITIES GENERATING INTER-PROFESSIONAL COLLABORATION
The Official Journal Of The New Zealand College Of Primary Health Care Nurses, NZNO
Vol 18 No 1

HEALTHY HOMES & RESPIRATORY

NEW GRADUATES IN PRIMARY HEALTH CARE

ASTHMA AND COPD MANAGEMENT

DIABETES NURSE PRESCRIBING

RURAL MUSTER & PLUNKET UPDATE

REGIONAL FORUMS

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

Editor Yvonne Little

Publisher Celeste Gillmer, 021 245 0587, celeste.gillmer@gmail.com

Editorial Committee

Celeste Gillmer, Irene Tukerangi, Annie Tyldesley, Erica Donovan

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Correspondence

The Editorial Committee welcomes all correspondence intended for publication. Correspondence should be addressed to:

Yvonne Little: logiceditorcphcn@gmail.com

Please ensure the writer's name appears on the title page of any article or letter intended for publication.

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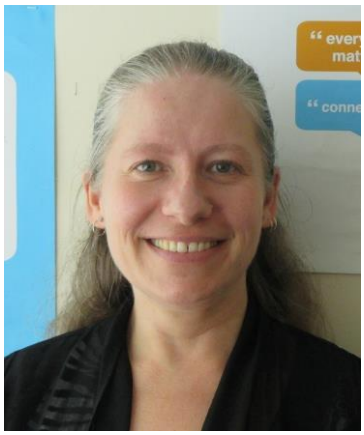
In this issue….

Chair's Report



Celeste Gillmer
Chairperson

Tēnā Koutou katoa

Easter is just around the corner and the first quarter of 2019 is already behind us. This is definitely a busy year with a lot of challenges and changes within Primary Health Care.

I was fortunate to attend the first strategy day for the Federation of Primary Health Aotearoa New Zealand. A decision was made that all the different members of the Federation will compile a submission into the Health and disability System Review collaboratively, with the aim of a united voice across Primary Care. The NZCPHCN is a member of the Federation and my priority will be to represent the voices of Primary Health Care nurses across New Zealand. The Review is focused on four key concerns: **Equity, Sustainability, Wellness and Structural Improvements**.

Request:

We would appreciate -

1. Examples and evidence of solutions of primary health care that we can frame under the four key concerns
2. A description of the elements that support the solutions
3. A description or examples of the barriers that impede the solution.

If you are interested to be involved in the NZCPHCN, NZNO submission into the Health and Disability System Review, please contact me directly: celeste.gillmer@gmail.com – this is our opportunity to stand together as the PHC nursing workforce.

There have been some changes in our standing committees over the new year, so please visit our website and meet your new committee members!

We decided to move towards regional events this year (as preferred by your survey responses in 2017) and will have our AGM in Nelson in August – please see the flyer in this edition and more information on our website. Please see our call for nominations for committee members and our awards – this is an opportunity to celebrate the fantastic work Primary Health Care nurses are doing!

Enjoy the school holidays and Easter with your family and friends. And thank you for all the care you provide to our communities across New Zealand – thank you for caring and thank you for being amazing nurses!

Tēnā Koutou katoa

Celeste

Editor's Report

Yvonne Little

Nurse Practitioner

Welcome to the first issue of LOGIC for 2019.

Firstly, I wish to open this Editors Report with a few words to those nurses living and working, or have family members who were involved on the front lines (Police and St John Ambulance) or whom have family in Christchurch, Muslim and non-Muslim alike that our thoughts are with you after the horrendous events that occurred recently.

As Primary Health Care Nurses we stand side by side with our Hospital colleagues and Police/St John Ambulance in dealing with the events as they unfolded and those still to unfold due to the after effects of this despicable cowardly attack.

There will be many traumatised people young and old in the community for sometime to come and as nurses we will be there to support them but we must also remember to support each other and look after ourselves, so please if you feel that you are struggling to cope or you notice someone else is struggling to cope: remember to TALK to someone and access help from your workplace counselling services.

Please know that we are thinking of you and sending Aroha to all.

Now on to the rest of the Editors Report:

Just a reminder about what **LOGIC** stands for: **L**inking **O**pportunities **G**enerating **I**nter-professional **C**ollaboration and this is our aim with the journal.

We want to hear from all our members about their stories, in this issue we have some great reads from New Graduates and

a Nurse Prescriber about their journeys, so if you have a story or have a colleague you feel should be show-cased for something they have done then please make contact with us as we want to hear about those outstanding nurses in Primary Health.

So, in this issue we have for you:

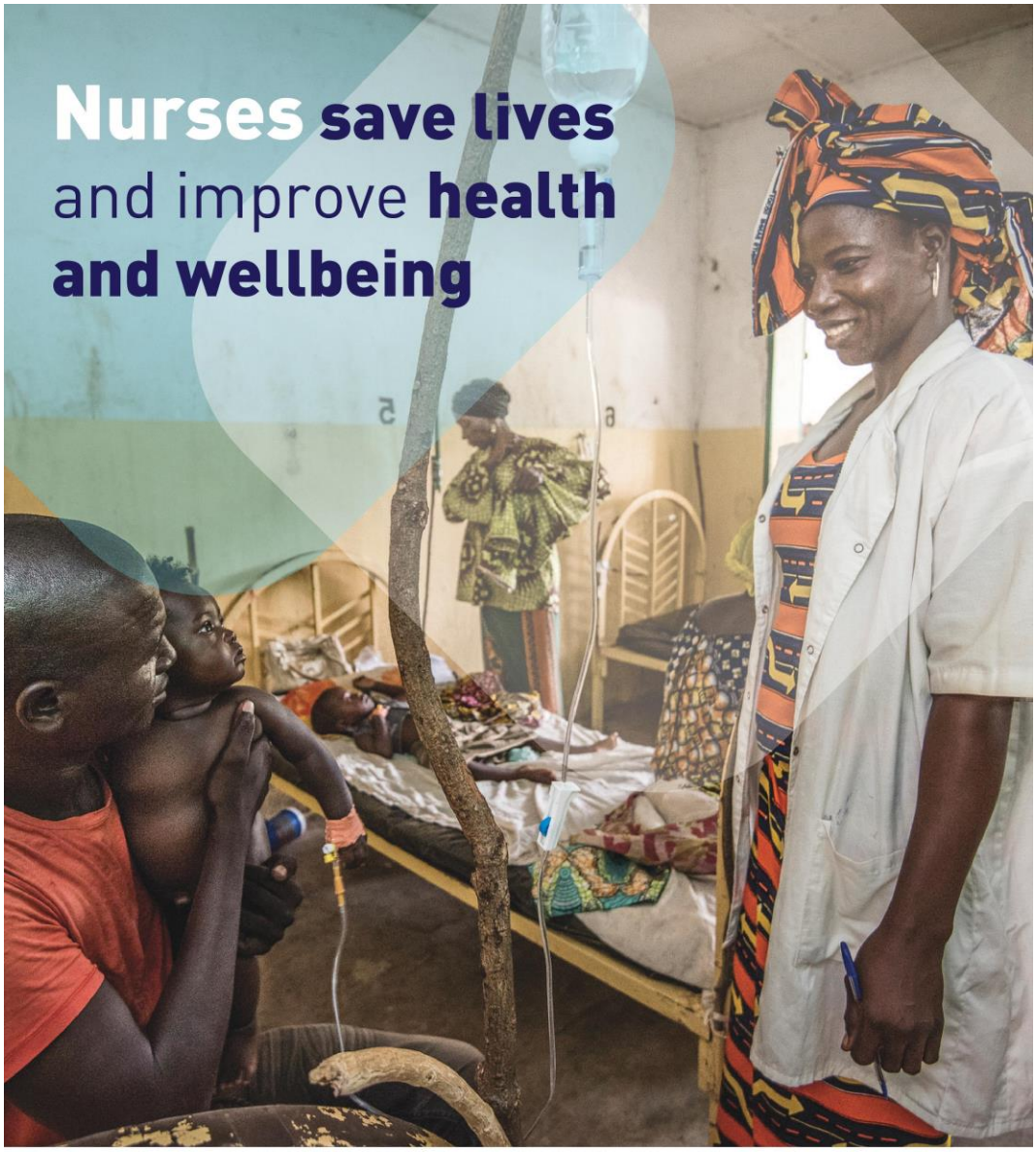
Respiratory Articles on spacers and COPD; Healthy Homes; A Prison Release Story; Jane O'Malley has given us her first article from her new Plunket position; Diabetes Nurse Prescriber; New Graduate articles; a child health app; Professional Practice Update; Health and Disability System Review; Rural Muster; Pharmaceutical Update – which we have divided up and will bring to you over several issues due to its length (there is a lot of good information and not just around the pharmaceutical aspect); Pharmac seminars and online updates for March to June; A regional forum report; NZNO library section PLUS an updated photo of the NZCPHCN Executive, Professional Practice and LOGIC committees 2019.

AND MOST IMPORTANTLY: updates on the upcoming Palmerston North Forum which is coming up fast and a save the date for the Nelson-Malborough Region Forum which is set for August 29th along with our AGM. We would

love to see as many of our members and potential members at these meetings where you can meet the current committee members and find out what we do and see if you would be interested in joining the team now or sometime in the future.

It is with much sadness that we have had a resignation from Emma Hickson from the LOGIC team, I wish Emma well in her future endeavours and we fully intend to keep in touch with her as a conduit to accessing many of her contacts for articles for the journal and hopefully some articles from Emma herself. Thank you from the team Emma for all your hard work with the journal.

Yvonne, LOGIC Editor



NELSON – MARLBOROUGH FORUM

For one night only

Mark the date in your diary

29th August 2019

More details will be in the June issue of LOGIC and also on the Submit an Event Page under New Zealand College of Primary Health Care Nurses (NZCPHCN)/NelsonMarlboroughRegionForum.

If you have any queries or want to let us know what you would like at this meeting then please contact us on: nelsonmarlboroughregioncphcn@gmail.com

NEW ZEALAND NURSES ORGANISATION
TŌPŪTANGA TAPUHI KAITIAKI O AOTEAROA

PHCN
New Zealand College of Primary Health Care Nurses NZNO

RURAL MUSTER #9

Kate Stark – Nurse Practitioner

Happy New Year everyone. In our first Rural Muster for 2019, I want to reflect on the role of the Nurse Practitioner (NP) in rural, and give an overview of where the National PRIME Committee is at, having recently met in December 2018.

2019 has brought an exciting start to rural nursing in the small town of Gore. It is near where I live, and Gore Health is where I work, but this article is not about me. I want to take this opportunity to celebrate the growth of advanced practice and the successful introduction and expansion of the Nurse Practitioner(NP) role within the Integrated Health Care Facility of Gore Health Ltd (GHL).

From small beginnings in July 2016 with their first NP, Gore Health now has three NPs working collaboratively with the medical, nursing and allied health team, providing care to the wider rural Eastern Southland community. At the beginning of 2019, GHL welcomed it's second NP in primary care and at the end of January we celebrated another NP registering and taking up a role in the Emergency Department. As one of those NPs, I have witnessed the ongoing support, implementation and growth of the role, and am proud to say that the role has been hugely successful. A big part of that is the engagement and support by management, other staff within the facility, patients and the community as a whole.

Despite having a hospital in town, Gore Health Ltd (encompassing Gore Health Centre, a general practice), is defined as rural according to the population it serves. It is a widespread area extending from Eastern Southland to West Otago, with some areas dense with farming and forestry and some isolated from primary and secondary care health services.

As we know, being rural has its challenges. Being an NP in rural is a challenge in its own right. It means being a generalist within a team, but sometimes working on your own. In Gore, as in some other rural areas, the NP role makes perfect sense. The way in which the roles have been introduced, utilised and integrated into the collegial Gore workforce is a true demonstration of how it can work really well. In an environment where medical and nursing staff are seen as equal, GHL fosters the sharing of knowledge and skills between disciplines and departments. NP's therefore can feel comfortable about working autonomously while also being able to seek advice when required. By doing so reflection on practice is frequent and this promotes learning in a safe non-threatening learning environment and consequently further role growth and development.

As I reflect on this achievement and the growth of the role, I ask myself how this has evolved. Personally, I started working at Gore Health in October 2013. At this point, I was on my Nurse Practitioner pathway and adamant that the NP role would benefit the organisation as a whole and the Gore community. Finishing my studies and registering as an NP in July 2016, I was fully supported by my workplace but then came the biggest challenge of them all- to work in the role and to demonstrate that the role was going to make a difference, that NPs provide autonomous patient care within the team and that they are an invaluable asset to rural health services. It appears with the addition of two further NPs, that this has been successful and sometimes I wonder how it evolved from a seed being planted one day, to where we are now.

The pathway to NP is challenging both personally and professionally. Along the journey, support from your workplace is paramount. In the South, we were also very fortunate to have an NP led NP support group who put NP candidates through their paces and guide potential NPs through the latter stages of their pathway to NP panel interview and registration. Such support groups are invaluable and the Southland group has now seen nearly all its' NP candidates over the course of the last 5 years registered as NPs. All are working in NP roles in various places in the South in a mix of primary, secondary care and community. If your area doesn't have an NP support group, I urge you to suggest this to NPs in your area and develop such a group for networking and to safeguard the growth of the NP role across New Zealand and going forward.

We now have 360 NPs in New Zealand (Nurse Practitioners New Zealand, 2019), the first being Waikato's Deborah Harris who registered as a Neonatal NP in 2001. We have come a long way, albeit at times a slow journey but it appears that things are changing and the role is being accepted more and more. With an ongoing doctor shortage in rural, an ageing population of both medical and nursing staff, the NP is being seen more and more as a valuable addition to nursing/medical workforce where historically patient care was predominantly led by doctors. Part of this growth has been due to the NP role sharing a mix of medical and nursing skills and knowledge, as well as more and more nurses working in advanced roles. Fortunately, there has been a shift in thinking and gone are the days where nurses are seen as inferior to our medical colleagues. It is always important to remember the value of the nursing role and the importance also to honour and remember where we started our individual and collective journeys.

Workforce development in any organisation is essential going forward. I acknowledge that the NP role is not for all, but with the right support it is definitely achievable. It is important to remember that it is a huge ongoing learning curve but none of us ever know everything and sourcing advice and following guidelines is seen amongst our medical colleagues and this has become a foundation for safe practice demonstrated across all disciplines regardless of area of practice. Becoming an NP means having a responsibility for patient care like nurses have never known before. The tests you order are for you to interpret and manage, it is for you to discuss the medicine you prescribe with the patient, and follow up and ongoing monitoring of patient progress is for you to monitor, and the notes you write and your patient follow up could save your bacon if things go wrong.

Working in rural as an NP can be isolating. I am delighted that we now have three NPs in Gore and this gives us the perfect

platform to share experiences and learn from each other. Together we have full understanding of what the role means and the challenges we face that are different to our medical and nursing colleagues. We don't pretend to be doctors, or to know or do things outside our scopes but we certainly share aspects of both nursing and medicine roles. Working alongside medical officers who are supportive of the role, lends itself to increased teaching opportunities and a chance to build on our skills and knowledge.

At Gore, we work under a management that is forward thinking, innovative and exciting. As NPs we are well supported by all staff and the collaborative collegial model is alive and well. We attend regular peer review and journal club with the GPs and hospital doctors and are fully supported to attend conferences, clinical and professional supervision. At the end of the day, however please remember that as NPs, we are still nurses and will always pride ourselves on coming from a nursing model with an extensive understanding of the bigger picture and how that impacts on health outcomes.

National PRIME Committee (NPC) update.

In Auckland in December 2018, the NPC met face to face at the national St John Ambulance Headquarters with some members joining by videoconference. These meetings to date have been very constructive and provide an excellent opportunity to meet as a group with key stakeholders involved in implementing the findings of the National PRIME Review. Those who attended included representatives of The Rural General Practice Network (RGPN) St John Ambulance, The Ministry of Health (MOH), The National Ambulance Sector Organisation (NASO), Accident Compensation Corporation (ACC) Rural Service Alliance Team (SLAT), Emergency Care Coordination Team (ECCT), PRIME Providers, PRIME GPs and PRIME nurses. These meetings are always fraught with passion and it's encouraging to see the commitment present in the room to improving things for the PRIME service across New Zealand.

Key discussions at these meetings in general are centred around addressing key themes arising from the National PRIME Service Review completed at the end of 2017. At the December meeting there was robust discussion around alternative models for the provision of the PRIME service, acknowledging that one size does not fit all. PRIME sites differ in their unique challenges, needs, available resources and geographical location.

With key goals of ensuring PRIME sustainability as a service, there was also much discussion around PRIME Practitioners and how the current function of PRIME affects the personal and professional wellbeing of those at the coal face while working in isolation. The NPC is striving over time to improve the mentorship and peer support received by PRIME practitioners, improving critical incident support including debrief, improvement in the process of clinical audit to ensure this is a safe, fair and non-threatening process. This includes the process of improving communication around complaints and clinical issues to ensure these are managed in a constructive and supportive manner.

Access to electronic report forms (ePRF) is high on the agenda with St John member numbers to be issued in the near future. This will enable PRIME practitioners to access ePRF forms to enter your

assessments, interventions including drugs, and proposed plan of care. Your local crews can help you navigate your way around the ePRF and this will also strengthen the relationships we have with St John as PRIME staff and provide a collaborative approach to reporting on PRIME calls and the collection of very important data which potentially could shape the future of PRIME.

Training and syllabus were discussed with positive feedback in relation to the changes to both the initial course and the PRIME refreshers. The recent issue of safety bundles to PRIME sites by St John was briefly discussed and in general these have been well received. A reminder that on your cars, magnets need to be adhered to a flat clean and dry surface.

Funding is always on the agenda and the process of funding review is discussed at length at NPC meetings. It would be fair to say that there is no quick fix, however the committee is working hard by taking a broad approach to develop a resolution that will ensure that PRIME is fit for purpose and sustainable going forward.

It's exciting that the National Rural Health Conference is coming up April 4-6 in Blenheim. The next NPC meeting will be held at this conference, and there are also some PRIME sessions planned. Look out also for the possibility of a PRIME refresher in Blenheim over this time.

Stay safe out there. All the work you do in rural is appreciated by so many and individually and together we make a huge difference. See you again in the next issue of LOGIC.

Professional Practice Committee (PPC) recent happenings.

Welcome to new committee members

A call went out to all College members last October for nominations to fill a vacancy on the Professional Practice Committee (PPC) after Tasha Morris the College Treasurer stepped down from her PPC role to concentrate on being Treasurer. Nominees, from practice areas other than general practice were requested, as currently five out of six committee members are practice nurses. The committees were delighted with the enthusiastic response of eight nominations.

Once nominations closed the College's Vice chair Emma Hickson stepped down, to release an additional position, thus supporting a staggered succession replacement of committee members.

It is with great pleasure the College welcomes Nikki Beazley to the Professional Practice

Committee and Dr Jill Clendon, onto the National Executive. Both are secondments until formal voting at the Annual General Meeting in August.

Nikki is a Registered Nurse living in Whangarei who works for Northland District Health Board in the Te Tai Tokerau Children's Team as a Service Broker for Health. She has held this role since its inception almost 5yrs ago. She enjoys working with navigators and services to increase health literacy aiming to improve the health of all whānau especially the vulnerable Tamarki. Nikki's nursing experience in child, adolescent and adult mental will be very beneficial to the committee.

Jill Clendon needs no introduction; previously Acting Chief Nursing Officer with the Ministry of Health is now Associate Director of Nursing and Operations Manager Ambulatory Care with Nelson Marlborough DHB. Jill's knowledge of national Primary Health Care issues, NZNO policies and procedures will be extremely valuable to the College.

Farewell and thank you

At our last meeting Cathy Nichols tendered her resignation as Chair of the PPC, a role she had held since August 2017, having also served as a Professional Practice Committee member since 2015.Her contribution to this committee has been huge and under her leadership the work that this committee has undertaken has in turn supported the advancement of nursing within the College – thank you Cathy.

Current Activities:

It was brought to the Committee's attention that the NZTA had announced, due to law changes that came into effect from November 8th, 2018, that RNs and NPs working within their scope of practice can now issue medical and eyesight certificates for driver licensing. This is in response to changes in legislation under the Health Practitioner Statutory regulations. At this stage there appears to be no work place credentialing or an appropriate training framework to support nurses to do this. The committee will be looking at developing draft guidelines to support nurses to undertake these assessments and will also link with the RNZCGP to ensure a collaborative and supportive approach is taken to support nurses.

With the "soon to be published" knowledge and skills framework completed, the committee will now be looking at reviewing a generic position description for nurses working in primary care. We are often asked for position descriptions and acknowledge that there are over 16+ different nursing roles working in the primary health care sector. It is envisaged that a generic position description is developed and a series of appendices be included which identify the various skills and knowledge required for each of these roles.

Remember to keep in touch via our Facebook page

NZNO NZCPHCN Committees 2019

Spacers – not just for children

Erica Donovan

Erica Donovan is a third year registered nurse currently working in Pediatric Oncology/Hematology. She has an interest in primary health care, late effects of paediatric cancer treatment and nursing education.
Erica is currently a member of the LOGIC Journal Committee for the College of Primary Health Care Nurses

It's a chilly Autumn day, when a woman walks into the Medical Centre to be seen by you, a Nurse. She's on your file as having mild asthma and intermittent hay fever.

"*I'm wheezy, the cough has gone to my chest, and inhaler isn't working, so I'll need a nebulizer*".

Further questioning reveals she has tried some over the counter cough mixture and her sisters' old salbutamol inhaler. A peak flow reading of 350 is revealed, but you wonder if the technique is quite right. When asked about a spacer, she tells you she hasn't used one since childhood, aren't they just for children who can't use an inhaler properly?

Spacers are for everyone, regardless of patient age. In addition to being used for asthma, spacers are also recommended for those who have chronic obstructive pulmonary disease (COPD).

Tessa Demetriou, the Head of Education & Research at the Asthma + Respiratory Foundation NZ says that use of a spacer not only helps medication move into the lungs, it also helps patients focus on their breathing.

"A spacer should be used with all metered dose inhalers (MDI) as this will reduce the amount of medicine from the inhaler hitting the back of your mouth and throat. It also means that less medicine is swallowed".

Spacers can also reduce the side effects from inhaled corticosteroids, which can include sore throat, hoarse voice and oral thrush. Another strategy to decrease the risk is do a mouth rinse or clean your teeth after using a steroid containing inhaler.

Another misconception is that an asthma exacerbation will always need nebulized medications, and some patients will even come into clinics asking for them. Despite their benefits, a degree of medication is exhaled with every breath, but new technologies are looking to combat this (Lavorini, Fontana &Usmani, 2014).

There is also currently a step-wise approach to asthma management, unless a patient presents in a severe exacerbation. Solutions can involve increasing the amount and frequency of inhaler, adding in a preventer, or long acting beta agonist (LABA) if the person does not currently use one. Treatment with oral steroids or other adjuvants may also be considered, however inhaled corticosteroids via a spacer are preferred first over oral steroids due to decreased systemic effects (Pandya, Puttanna & Balagopal, 2014). Clinician Asthma management guidelines for adults and children are easily accessible online.

"A spacer is as effective as a nebuliser for getting the medication into the lungs in an acute attack, it is faster to use, less expensive and is not dependent on a power supply. They are also less frightening, especially for children. Spacers are the recommended treatment for acute asthma, except for very severe/life-threatening asthma when oxygen driven nebulisation is recommended," Tessa says.

Vanessa Searing, a 33 year old asthmatic says that she missed out on using a spacer for most of her life. "During my pregnancy both my asthma and allergies exacerbated possibly due to the change in hormones. I was glad one of my GP's I saw for the first time had given me a spacer, as I actually ended up needing to use it to treat my moderate asthma symptoms with six doses of reliever inhaler."

Despite advances in asthma knowledge, many children in New Zealand are not being well managed. The reasons are diverse and include both home environment and availability of healthcare services, prescriptions and education from healthcare professionals (Asher et al, 2017). But it's not only children that need help controlling their respiratory issues – a European study showed that up to half of patients were not using their inhaler correctly (Crompton et al, 2006). We can be doing better for all patient populations. Studies show that even many Doctors do not adequately teach asthma management (Press et al, 2010) and that incorrect use of inhalers is associated with increased utilization of health services and increased oral steroid use (Melani et al, 2011).

One thing that we can do as nurses is teach good symptom management and spacer use. This can be done both in clinic and reiterated using an asthma management plan which is available in adult and pediatric versions. For patients with COPD disease there is a 'blue card' available with their customized management plan. This can be helpful not only for the patient but also for families and St John's staff.

Another resource that can help patients understand the use and need for a spacer is this one from Health Info which the public can readily access if they want quality online information. Other great places to send people to are Asthma and Respiratory Foundation NZ and for video resources there's some at on the National Asthma Council of Australia website.

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National Student Union/Te Runanga Tauira and NZ College of Primary Health Care

Did you know that students can become associate members of The NZ College of Primary Health Care Nurses? If you have EN or RN students in your workplace, encourage them to get on our website and join up. Equally, it's worth finding out a bit more about the issues students are facing. To find out what the National Student Unit and Te Runanga Tauira have been up to, check out the latest issue of Kai Tiaki, we've got some great nurses coming through.

We would welcome articles coming through to LOGIC from these groups also.

Healthy Homes

Erica Donovan

New Zealand is a world leader in many areas – sport, progressive social policy and there have been plenty of world firsts from Kiwis. One area we shouldn't be so proud of, is our statistics around cold and damp housing. We've all read the stories every winter about elderly folks sitting in cold houses, afraid to turn the heaters on. A number of factors have been highlighted as contributing - including high cost of energy, older housing, climate, poor heating methods and income poverty (O'Sullivan, Telfar Barnard, Viggers & Howden-Chapman, 2016).

A New Zealand study found rental properties are typically in worse condition than ones owned by the occupier. In the study 31 percent of rentals felt damp, compared to 11 percent of owned, and mould was present in 56 percent of rentals and 44 percent of owned properties (White, Jones, Cowan & Chun, 2015).

Sub-par housing has been linked to not only respiratory disorders but also cardiovascular issues such as rheumatic fever and hypertension. Cold temperatures have the duel effect of causing vasoconstriction and inflammation of the respiratory system (World Health Organization, 2018, p.32). However, inadequate housing effects not only physical health but also mental and social health (Bonnefoy, 2007). One study even linked household mould to lower IQ scores in children. However, whether other factors are causal remains to be said, and further research is required (Jedrychowski et al, 2011).

An Auckland Healthy Homes intervention programme consisting of home retrofitting and referrals was able to reduce housing related hospital admissions by 11 percent in the under 4 aged group and almost 30 percent in the 5-34 year old age group (Jackson, Thornley, Woolston, Papa, Bernacchi & Moore, 2011). Similarly, another New Zealand study illustrated a decrease in mortality in patients with pre-existing circulatory or respiratory disorders who also received home warming modifications (Preval et al, 2017).

Healthy homes and decreasing illness are something that successive governments have been trying to tackle for years. In 2017 the Heathy Homes Guarantee Act went through Parliament to ensure that all rentals met a minimum standard. Housing Minister Phil Twyford called the bill the "most important public health reform that we can currently make in this country". Tenancies signed after 1 July 2019 will now need to meet insulation regulations. For a time, there was government part-funding available for home owners to install insulation, however this has now come to an end. Although the central government programme has ceased, several local councils still offer funding. In Canterbury for example, homeowners can

obtain loans of up to $6000 that can be used towards insulation, home ventilation and approved heating appliances.

Another policy that may impact on the health of New Zealanders is the Winter Energy Payment for those who are paid certain Work and Income benefits. These include people receiving superannuation, jobseeker support, sole parent, young parent and veteran's benefits (a full list of criteria is available here). Eligible people who are listed as single with no dependents receive $20.46 a week, while a couple or those with dependents receive $31.82.

So, what can we do as Nurses to help our patients who we feel may be living in housing that potentially is causing ill health? One thing is to spend a bit of time looking into local groups and council initiatives that your patients may qualify for. These can include home insulation funding as mentioned above, as well as things like curtain banks.

On the Energywise website there is a great guide around the benefits and drawbacks of different types of heating, as not all types of heating are created equal. Some forms of heating are expensive, while others can pose huge health risks. Some gas heaters contribute to dampness in homes or have been linked to carbon monoxide poisoning deaths.

The Ministry of Health has also produced a series of videos around creating a warmer drier home, that as nurses we can direct patients to. As a bonus they are available in Māori, Samoan, Tongan as well as English. The Asthma + Respiratory Foundation NZ also has a fact sheet that helps those with respiratory disorders choose homes that decrease the risk of flaring their asthma or allergies.

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Improving access to health and social supports for offenders on release

Written by Canterbury Clinical Network.

People leaving prison in Canterbury will benefit from improved support to navigate and access health and social supports thanks to collaboration between Health, Corrections and the social service sector.

A multi-agency group, the Coordinated Access on Release Design Group, was formed in 2016 with the aim of addressing the barriers that prevent offenders released from prison from accessing appropriate health services, supports and resources in the community.

Jane Cartwright, an independent advisor who chairs the group on behalf of Canterbury Clinical Network, emphasised how important it was to work together to achieve results.

"After an initial workshop we realised that we needed continued collaboration to make progress for these members of our community who often don't know what services are available to them or how to navigate them, or who experience barriers that prevent them from having their health needs met."

The group has worked on several initiatives, two of which include using Partnership Community Workers (PCW's) as key connectors between sectors.

The first initiative sees PCW's working with the Correction's Guided Release Pilot to support individuals who have high and/or complex health needs on release and require additional support to ensure their health needs are met and any barriers they experience accessing health services are addressed.

The second initiative sees the PCW's working from the Justice Precinct with police to identify court attendees and their family/ whānau who have complex health issues and connect them and their family/whānau with a general practice team or community health provider.

The group has also supported work around simplifying the registration process for RealME registration through Ministry of Social Development.

Kathy O'Neill, Canterbury DHB, said there is early indication that these initiatives are working. "We have seen an increase in the number of offenders on release accessing services through their general practice team. What's even more positive is that many of these people continue to engage on a regular basis."

Nathan Tipuna, Senior Case Manager, Canterbury Prisons who is part of the group

Image from FreePik

developing these initiatives, said: “Release from prison can be an anxious and stressful time for anyone and especially for those who have had their health needs effectively managed or supported in prison and who are now expected to do this for themselves in the community.

“We hope to empower these people, and their whānau, to better manage their personal wellbeing and to live healthier, independent lives in their community.”

Jane added: “The group is also working hard to take a more holistic view – we’re not just looking at the needs of this population, but also their whānau and social environment. Support to improve health literacy and advocacy should be available to the entire family/ whānau, with the aim that they continue to engage with health and social agencies for support.”

The group will release more detailed information on these initiatives and share outcomes in the next few months.

Dementia (Part 1)

Karen Kennedy

Clinical Advisory Pharmacist

Background

"Dementia is Everybody's Business" is the catch phrase for the South Island Health of Older People Service Level Alliance (HOPSLA) and the title of a guide (KERR 2017) they have developed for the South Island to improve services for people affected by dementia. The messages are just as applicable to the rest of New Zealand (NZ).

Why does dementia need to be everybody business? Because we have a tsunami of people with dementia coming our way with significant associated costs, both human and economic, and already, there is significant unmet needs in NZ for this condition. (KERR 2017)

The number of people with dementia in NZ is rising rapidly, in part due to increasing life expectancy and our aging population. (HOPSLA 2017) There is evidence in a non-New Zealand population that suggests the incidence of dementia doubles every 5 years from ages 65 to 90 year, and continues to rise exponentially after 90 years of age (CORRADA 2010).

The number of people aged 65 years and over in NZ doubled between 1988 and 2016 to a total of 700,000. NZ statistics predictions suggest this figure will double again. By 2046, there is a 90% chance of there being more than 1.3 million people in NZ over the age of 65 and approximately a quarter of the population over 65 by 2050. (HOULAHAN 2019) Slightly more than 48,000 people in NZ had dementia in 2011 and estimates suggest this figure will increase to over 78,000 by 2026 (MOH 2013).

Alzheimers New Zealand estimated that the total cost to the health system for dementia was $1.7 billion for 2016, 75% higher, dollar for dollar, than the cost in 2011. It is believed that the per annum costs are increasing at a greater rate each year and the rate is even higher than the prevalence rates for dementia. (KERR 2017)

With the expected increase in the number of people living with dementia, our workforce and services will be overwhelmed in the not too distant future if we continue to do things as we are currently. (KERR 2017, HOULAHAN 2019)

A combination of approaches are required to ensure the needs of people living with dementia and their carers will be able to be met. The existing workforce and services need to be utilised well with better integration and collaboration. Enhancing care for people with dementia will be necessary to delay entry to aged residential care, reduce secondary care admissions and length of stay, and to reduce inappropriate medical care. Dementia prevention messaging needs to be promoted. These approaches will be key to reducing pressure on the health system and to enable savings that can be utilised for development of new dementia services. (KERR 2017)

What is Dementia?

Dementia is erroneously thought of as a disease. (ALZHEIMERS NZ 2019)

Instead, the term reflects a progressive condition with a number of symptoms of reduced brain function that arise from physical changes in the brain structure that are progressive. (MOH 2018) Genetics, environment and age may all play a part in dementia developing but the exact processes are yet to be fully defined. While dementia becomes increasingly common with age, it is not a normal part of aging and can affect anyone. Early onset occurs before 65 years and late onset is 65 years or older. (ALZHEIMERS NZ 2019; REITZ 2015)

There are different forms of dementia of which Alzheimer's disease (AD) is the most common, affecting two thirds of patients diagnosed with dementia. Other common forms include vascular dementia, Parkinsons Disease dementia, dementia with Lewy bodies, and fronto-temporal dementia. People may have more than one type of dementia. (MOH 2018; ALZHEIMERS NZ 2019)

In AD there is a build-up of abnormal proteins in the brain including amyloid plaques and tau tangles as well as a loss of neurons, synapses and white matter causing brain shrinkage. In Lewy body dementia, protein deposits called Lewy bodies develop in nerve cells in the brain that are involved with motor control, memory and thinking while vascular dementia is caused by poor blood supply to the brain, either through a stroke or several small ones, or cerebrovascular disease. Parkinsons Disease dementia can have components of AD and Lewy body dementia but the exact causes are not known. (ALZHEIMERS NZ 2019; CRAWLEY 2014; REITZ 2015)

Depending on the cause and the part of the brain affected, a person's dementia symptoms will differ. Memory, mood and emotions, behaviour, thinking and reasoning, and personality are commonly affected. The onset and speed of progression of dementia will be different for each person. (MOH 2018; ALZHEIMERS NZ 2019) People diagnosed with dementia are significantly affected in their ability to undertake activities of daily living including at home, work and socially. This differs from mild cognitive impairment (MCI), a state between dementia and normal cognitive functioning: the change in a person's cognitive function is minimal and their ability to undertake activities of daily living is basically maintained. (ALZHEIMERS NZ 2019; HUGO 2014)

How Can We Enhance the Care of People Living Dementia?

Enhanced dementia care requires an educated workforce that both understands and enables effective early diagnosis, patient and carer support after diagnosis, advance care planning for the patient and whānau, and integrated, collaborative care throughout the person's dementia journey. (MOH 2013)

Primary care is the first point of contact for the majority of people with MCI or dementia. It is well-placed for early diagnosis of MCI and uncomplicated dementia and for ensuring appropriate needs assessment is undertaken and appropriate dementia care and treatments are started. (THYRIAN 2017)

a. Early Diagnosis

Undiagnosed MCI or dementia can increase symptom burden and stress for people and their whānau and carer as well as increase the risk for hospitalisations and early entry into aged-care or dementia care facilities. (GOODFELLOW UNIT; KERR 2017) Receiving a diagnosis can allay anxiety about the cause of cognitive symptoms for the person and their whānau and carer. (LIVINGSTON 2017)

An accurate early diagnosis including possible prognosis

allows appropriate monitoring and supports to be put in place for the person and their whānau. Information can be provided at an early stage to allow them to make life decisions and plan ahead while the person has the cognitive capacity to do so. This allows the person to live as well as they can through their dementia journey. (AAN 2017; LANG 2017)

An early diagnosis of MCI and dementia is important to allow any reversible causes to be determined and treated. (AAN 2017; ALZHEIMERS 2019) Medication such as anticholinergics, steroids, opiates, benzodiazepines and other psychotropic medication, and alcohol or drugs of abuse can all cause reversible cognitive impairment. A medication review is recommended with the aim being to taper and stop these medications where appropriate. Potentially treatable medical conditions that may present with cognitive symptoms include delirium, depression and anxiety, stroke, metabolic causes and structural brain issues such as a tumour or bleed. (CANTERBURY HEALTHPATHWAYS 2019; GOODFELLOW UNIT 2017)

While MCI does not always progress to dementia, there is an increased risk of dementia developing (10% chance every subsequent year post MCI diagnosis (the usual risk is 1%)) (CANTERBURY HEALTHPATHWAYS 2019; GOODFELLOW UNIT 2017). Early diagnosis of MCI allows appropriate annual monitoring of cognitive function to be undertaken. Some people improve back to normal cognitive functioning, some progress to dementia and for some people, their cognitive function will stay the same as at the time of MCI diagnosis. (GOODFELLOW UNIT 2017) Early diagnosis of MCI also allows education and support for early planning and dementia prevention strategies. (AAN 2017)

Health professionals can feel some concern about giving a diagnosis of MCI that may not progress to dementia due to the unnecessary anxiety it may cause, and may want to protect the person and whānau from an early dementia diagnosis for the same reason. But this takes away an opportunity for early information that can allay some of the fears about the cognitive issues a person is having as well as the opportunity to provide the appropriate supports, treatment and time for people to make decisions about how they wish to live their life in the short term and plan for the future. (AAN 2017)

Evidence has shown a large number of people in aged residential care facilities with dementia do not have a dementia diagnosis noted in their care plans. This increases the likelihood of their needs being unmet and more challenging behaviours as well as reduced access to specialist services. The cognitive function of people in aged residential care should be monitored regularly and staff should be trained to recognise dementia so appropriate diagnosis can be made. (LANG 2017)

b. Patient and Carer Support After Diagnosis

A lot of the stigma associated with dementia arises from a lack of knowledge about dementia including symptoms and available supports. Many people associate dementia with the end-stage symptoms only. Much anxiety and fear can be balanced with accurate information and strategies for both the person and their whānau about how to live well with dementia and what supports can be put in place. (KERR 2017; MOH 2013) Primary care, often being the first point of contact for the person or their whānau, is well-placed to provide this with evidence to support the

approach including referral to dementia support organisations. (GOODFELLOW UNIT 2017; THYRIAN 2017) Key contact people for the person and their carer within the general practice and local dementia support services to help them navigate health and social services can facilitate enhanced care of the person with dementia. (KERR 2017; MOH 2013)

Dementia Care Plan

Dementia is a chronic condition requiring medical, psychological, social and nursing input to enable the person to live as well and fully as they can throughout their dementia journey. (THYRIAN 2017) Development of a comprehensive dementia care plan is necessary to support effective management and care, for the carer, as well as for the person with dementia. The cultural needs of the person, carer and whānau need to be considered and included as part of the dementia care plan. (COMMUNITY HEALTHPATHWAYS 2019; GOODFELLOW UNIT 2017; KERR 2017; MOH 2013)

i. Chronic Care Plan

As part of the plan, a chronic care plan should be developed including vital health checks for vision and hearing, management of other chronic conditions and management strategies for cardiovascular risk, diabetes risk, smoking cessation and regular exercise and a healthy diet. There is a small amount of evidence for a Mediterranean diet but the evidence is not robust. (COMMUNITY HEALTHPATHWAYS 2019; GOODFELLOW UNIT 2017; MOH 2013)

ii. Medication Review

A medication review should be part of the plan with a view to tapering and stopping any medications that have the potential to cause impaired cognition, and also to consider starting cholinesterase inhibitors if appropriate. Many commonly prescribed medicines can increase anticholinergic burden for people which can cause cognitive impairment and these medicines should be reviewed. (COMMUNITY HEALTHPATHWAYS 2019; GOODFELLOW UNIT 2017; MOH 2013; NICE 2018)

Some DHBs fund community pharmacy medication management services that include Medicines Use Review (MUR) for adherence support, and clinical medication reviews by a Clinical Pharmacist e.g. Medicines Therapy Assessment (MTA) that are free and general practice can refer into these.

The Community Pharmacy Long Term Condition Service is a free service across the country that identifies and provides supports (at a lesser level than MUR) to patients with adherence issues. If a person has been newly diagnosed with cognitive impairment or dementia, it would be prudent to ensure the person's pharmacist is aware of this so available medication management supports at the pharmacy level can be put in place.

iii. Planning for the Future

- **By-Proxy Decision Making**

The dementia care plan needs to ensure patients are informed and

supported to enable "by-proxy" decisions to be made when the person is no longer able to articulate for themselves or make decisions. This includes the need for early development of an advance care plan (ACP), organising a will, the setting up of Enduring Power of Attorney (EPOA) for health and finances, and to consider the Protection of Personal and Property Rights Act. (COMMUNITY HEALTHPATHWAYS 2019; GOODFELLOW UNIT 2017; KERR 2017; MOH 2013; NICE 2018)

When early diagnosis is made, the person with dementia can take part in these decisions so that their carer and whānau know what is important to them when they are no longer able to make decisions for themselves. Written information, links to electronic information and other supporting organisations can be provided. (COMMUNITY HEALTHPATHWAYS 2019; GOODFELLOW UNIT 2017; KERR 2017, NICE 2018)

- **Managing potential harms**

Managing potential harms needs to be considered as part of the plan with there being increased risk for these as dementia progresses. Carer stress and elder abuse (either by the carer to the person with dementia or vice versa) needs to be monitored as part of the dementia care plan with referral to appropriate supports when necessary.

Carers and ā may need strategies to reduce risk associated with wandering and getting lost e.g. Medic Alert bracelet, tracking system pendant and/ or pressure activated alarm mats. Fire risk may be reduced by installing timers with automatic switch off on electrical appliances. (COMMUNITY HEALTHPATHWAYS 2019; MOH 2013)

- **Driving Safety**

There are legal implications with driving and dementia. Driving safety and a process to manage this needs to be included in the dementia care plan. (ALZHEIMERS NZ 2014, COMMUNITY HEALTHPATHWAYS 2019; FISHER 2014, GOODFELLOW UNIT 2017, NICE 2018)

Some people in the early stages of dementia may be able to safely drive but worsening cognitive function including visual-spatial disorientation and memory loss will eventually mean the person will have to stop driving. (FISHER 2014; SCHMALL 2002)

Part of the dementia care plan may include a process for regular review and assessment of the person's ability to safely drive. This may include an Occupational Therapist Driving Assessment. Agreed guidelines that help support the carer and whānau to monitor the person's driving and know when it is no longer safe for them to be doing so can be helpful as well as strategies to support the person and carer once the decision has been

made for the person with dementia to stop driving. (FISHER 2014; SCHMALL 2002)

- **End of Life Plan**

End-of-life planning needs to be included as part of the dementia care plan. The development of an ACP and setting up of by-proxy decision-making can support end-of-life decisions that enable a person with dementia to die well in a place of their choosing with appropriate supports in place. While enabling reversible conditions to be appropriately managed, this planning can support a palliative care approach. This prevents unnecessary medical investigations or treatments that can be invasive and troublesome for the patient at a time when the focus should be on supporting the patient to die well. (KERR 2017; MOH 2013; NICE 2018)

The plan should ensure the carer and whānau have timely access to education and appropriate information about what to expect at the end-of-life stage for a person with severe dementia. This will enable them to support the person appropriately with respect to their physical needs. The plan needs to ensure the carer and whānau are involved fully in decisions about the person's care. The EPOA should be identified in the plan and activated when necessary. (MOH 2013; NICE 2018)

Seamless care and timely access to social, health and palliative care services can be supported by appointing a key contact person (identified in the dementia care plan) to act as a navigator for the carer and whānau at the end-of-life stage. (MOH 2013) Access to palliative care services should be enabled as part of the plan to support the person to stay in their preferred place of living. These should be flexible in keeping with dementia progression being unpredictable. (MOH 2013; NICE 2018)

iv. Navigator and Signposts

An important part of the dementia care plan to help facilitate enhanced care includes the person and their carer having a good understanding of key sign posts throughout the expected dementia journey and knowing who they need to contact for support and advice at these points. This may be a key person within the general practice who can facilitate integrated collaborative care by acting as a navigator for health and social needs, or it could be a person in dementia support services (or both).

- **Delirium**

Delirium is one signpost that whānau and carers need to be aware of. People with dementia have increased risk of developing delirium. Prevention, prompt recognition of its development and appropriate management strategies should be part of the dementia care plan. (KERR 2017) Carers need to know how to distinguish delirium from dementia symptoms and to seek GP input for treatment.

Dementia symptoms have a slow and progressive onset over months and years whereas the sudden onset of confusion may be due to delirium. (GOODFELLOW UNIT, NICE 2018)

v. Integrated Collaborative Care

As part of the dementia care plan, an integrated, collaborative care approach needs to be formulated. There is evidence for this approach having positive effects on reducing or delaying entry into institutions, reducing resource utilisation and improving health outcomes for people with dementia. (BACKHOUSE 2017) Evidence also shows trained nurses leading dementia care management in primary care using a collaborative, integrated approach can decrease Behaviour and Psychological Symptoms of Dementia (BPSD) and carer burden, and significantly increase quality of life for people with dementia. (CALLAHAN 2006; THYRIAN 2017)

In addition to a navigator for the person, their carer and whānau, an integrated collaborative care approach can be supported by the following:

- **Allied Health Referrals**

The dementia care plan should include as needed referrals to NASC for needs assessment. If there are functional deficits or respite care is needed, a home Occupational Therapy (OT) visit may be necessary as well as a referral to the Work Assessment and Rehabilitation Service if the person is still working to assist them working to the best of their ability. (CANTERBURY HEALTHPATHWAYS 2019; GOODFELLOW UNIT 2017)

- **Early Referral to Dementia Support Organisation**

Most importantly, early referral should be made to dementia support organisations such as local Alzheimers NZ or Dementia NZ who can provide education and support for the person, their whānau and carer, including home visits. (CANTERBURY HEALTHPATHWAYS 2019; GOODFELLOW UNIT 2017; KERR 2017) While GPs and practice nurses have a detailed knowledge of the dementia person and the supports they have at home, dementia support organisations have an excellent knowledge of services that can be accessed by people with dementia and can assist with navigation of health and social services. (KERR 2017)

Carer stress and the behaviour and symptoms of psychiatric dementia (BSPD) are key risk factors for admission into residential and dementia care facilities. (THYRIAN 2017) Local Alzheimers or Dementia organisations can be ideally placed to recognise carer stress or changes in the person with dementia and provide advice about how to manage or de-

escalate challenging behaviours. (GOODFELLOW UNIT 2017) These organisations may also provide facilitated carer support groups that are invaluable for supporting carers in their role, providing education and an opportunity to learn skills for caring for a person with dementia as well as to gain strength from others in similar situations.

Dementia support organisations also provide day programmes with activities for people with dementia as well as social activities. This helps to reduce social isolation and provides interest for the person while also allowing some valuable respite for the carer. A range of programmes are available to assist with respite care with some funding available depending on needs assessment. Respite care may also be provided in a short-term residential care facility funded by the local DHB and in some places, in-home respite care may be provided. (ALZHEIMERS NZ 2019; GOODFELLOW UNIT 2017)

This article will continue in the June 2019 LOGIC issue!

Autumn in New Zealand

Nominations for the New Zealand College of Primary Health Care Nurses, NZNO Committee members

The AGM will take in Nelson on 29 August 2019.

Please nominate your PHC colleagues now to join one of our committees!

We are also looking for nominations for our 2 awards! Recognise the fantastic work your colleagues are doing across Primary Health Care!

NZ College of Primary Health Care Nurses

Award Nomination Form

Tall Poppy Award 2019

The Tall Poppy Award was instigated by Ginny Hinton, a previous practice nurse, who felt tall poppies were not always recognised. It was then sponsored by Diane Newland for a further period of five years. Diane was also a previous practice nurse. Jane Ayling (primary health care nurse) will be sponsoring this $1000 award for a period of five years (2015-2019).

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

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

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

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

Reason for Nomination

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

Nominee Details

Name as on NZNO membership: ……..

Position: ……..…….

Name of organisation: .....…….....

Address of organisation: .....

.....

Work phone: …… Email: ……

Nominator Details

Name as on NZNO membership……..

Position……

Name of organisation: …….

Address of organisation: ……

.....

Work phone: …… Email: ……..

Nominations are to be received by

5pm Friday 12th July 2019

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

Email fax or post all documents to:

Rosanne Grillo
Office Administrator
New Zealand Nurses Organisation
PO Box 2128
Wellington 6140
Fax: 04 382 9993
rosanneg@nzno.org.nz

NZ College of Primary Health Care Nurses Award Nomination Form 2019

Nurse New to Primary Health Care

Purpose of the Award

This award is for a Primary Health Care Nurse who has worked less than three years in primary health.

The winner of this award will be chosen from written nominations and announced at the New Zealand College of Primary Health Care Nurses AGM in Nelson in August.

The winner will receive $500 to support further learning and development and is encouraged to write an article for the college journal LOGIC.

Nominate your colleagues for excellence and creativity in their nursing.

- Nominees must be NZ College of Primary Health Care Nurses (CPHCN) members and currently working in Primary Health care.
- Preference will be given to those nominees who demonstrate clinical excellence.
- All nominations accepted will be acknowledged in a LOGIC journal.
- Winners will be announced at the NZCPHCN event in Christchurch in August.

Reason for Nomination

Please attach a description of how excellence and creativity has been demonstrated in their nursing practice (up to 500 words). Nomination form and typed description must be emailed or posted.

Nominee Details

Name as on NZNO membership ……

Position: .....……...

Name of organisation: .....…….....

Address of organisation: .....……..

……..

Work phone: …… Email: ……

Nominator Details

Name as on NZNO membership……..

Position…….

Name of organisation: …….

Address of organisation: …….

……

Work phone: …… Email: …….

Nominations are to be received by

5pm Friday 12th July 2019

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

Email, fax or post all documents to:
Rosanne Grillo
Office Administrator
New Zealand Nurses Organisation
PO Box 2128
Wellington 6140
Fax: 04 382 9993

rosanneg@nzno.org.nz

NOMINATION FORM FOR NZ COLLEGE OF PRIMARY HEALTH CARE NURSES
NATIONAL EXECUTIVE COMMITTEE

I…….. wish to nominate

…….
(Surname) (Given Name)
for the position of **National Executive Committee member**, NZ College of Primary Health Care Nurses.

Signed: ..... Date: .....
(Nominator needs to be a member CPHCN)

This section to be completed by Nominee

I,..... accept nomination as a Executive Committee member of the NZ College of Primary Health Care Nurses.(Nominee needs to be a member of CPHCN)

Address (Personal) Address (Business)
....
....
....
Ph/Fax: ..... Ph/Fax:.....
E-mail:..... E-mail:.....

Area of current employment:.....
NZNO Membership No. .....
Work Experience briefly:
.....
.....
.....
Signature ..... Date .....

Please return the completed nomination form to the Returning Officer, NZNO, PO Box 2128, Wellington 6140 by **5pm on Friday 12th July 2019**

Email, fax or post to:
to rosanneg@nzno.org.nz
Fax 04 3829993
New Zealand Nurses Organisation
P O Box 2128
Wellington 6140

To be valid this form must be signed by both parties who must be members of CPHCN and be received by the closing date.

NOMINATION FORM FOR NZ COLLEGE OF PRIMARY HEALTH CARE NURSES
LOGIC COMMITTEE

I…….. wish to nominate

…….
(Surname) (Given Name)
for the position of **LOGIC Committee member**, NZ College of Primary Health Care Nurses.

Signed: ..... Date: .....
(Nominator needs to be a member CPHCN)

This section to be completed by Nominee

I,..... accept nomination as a LOGIC Committee member of the NZ College of Primary Health Care Nurses.(Nominee needs to be a member of CPHCN)

Address (Personal) Address (Business)
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....
Ph/Fax: ..... Ph/Fax:.....
E-mail:..... E-mail:.....

Area of current employment:.....
NZNO Membership No. .....
Work Experience briefly:
.....
.....
.....
Signature ..... Date .....

Please return the completed nomination form to the Returning Officer, NZNO, PO Box 2128, Wellington 6140 by **5pm on Friday 12th July 2019**

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New Zealand Nurses Organisation
P O Box 2128
Wellington 6140

To be valid this form must be signed by both parties who must be members of CPHCN and be received by the closing date.

NOMINATION FORM FOR NZ COLLEGE OF PRIMARY HEALTH CARE NURSES
PROFESSIONAL PRACTICE COMMITTEE

I…….. wish to nominate

…….
(Surname) (Given Name)
for the position of **Professional Practice Committee member**, NZ College of Primary Health Care Nurses.

Signed: ..... Date: .....
(Nominator needs to be a member CPHCN)

This section to be completed by Nominee

I,..... accept nomination as a Professional Practice Committee member of the NZ College of Primary Health Care Nurses.(Nominee needs to be a member of CPHCN)

Address (Personal) Address (Business)
....
....
....
Ph/Fax: ..... Ph/Fax:.....
E-mail:..... E-mail:.....

Area of current employment:.....

NZNO Membership No. .....

Work Experience briefly:

.....

.....

.....

Signature ..... Date .....

Please return the completed nomination form to the Returning Officer, NZNO, PO Box 2128, Wellington 6140 by **5pm on Friday 12th July 2019**

Email, fax or post to:
to rosanneg@nzno.org.nz
Fax 04 3829993
New Zealand Nurses Organisation
P O Box 2128
Wellington 6140

To be valid this form must be signed by both parties who must be members of CPHCN and be received by the closing date.

Responding to Maternal Mental Health through Quality Improvement at the frontline

Jane O'Malley Chief Nurse Plunket

The emphasis of the revised New Zealand Health Strategy on *live well, get well, stay well* was widely supported. A truncated strap line could suitably be *born well, stay well* with a nod to the criticality of early, upstream interventions and relevant health services for tamariki and whānau. The motivation for my move to Plunket was its alignment to the 2016 strategy and the emphasis on the very early years. Plunket's vision has three simple but powerful strands *Healthy Tamariki, Confident Whānau and Connected Communities* and sums up the centrality of whānau and community as the foundation of health and wellbeing.

One of my roles in Plunket is clinical quality. Late last year in preparation for a Continuous Quality Improvement project commencing in two large Christchurch teams (Christchurch West Team, including Ashburton and Christchurch East Team including the West Coast), nurses and kaiawhina/ community health workers met together to decide on a clinical indicator to improve on. The project would demonstrate how we might effectively go about bedding-in an improvement methodology for Plunket.

A Delphi technique was used to find a preferred quality indicator for improvement. Every staff member was asked to identify what they considered to be the five most important outcomes for tamariki and whānau in ascending order of importance (outcomes could include breastfeeding, smoking rates, growth and development, maternal mental health, family violence, child protection, SUDI). After individuals identified their preferred outcomes they worked in groups to discuss rationale (latest evidence and professional experience) and negotiate a group consensus.

Multiple groups over three workshops independently chose maternal mental health. This indicator is by no means the easiest thing staff could have chosen but they know how important and foundational it is to the health of tamariki and whānau.

Maternal mental health is a timely focus coinciding as it does with the Mental Health Inquiry and the Child and Youth Wellbeing Strategy. Plunket's submission to the Inquiry can be found on our website and is well worth a read. I have condensed the highlights borrowing heavily from the orginal text which you can source at:

https://www.plunket.org.nz/assets/Submissions/Mental-Health-Inquiry-Submission-FINAL.pdf

Our submission emphasised the strong correlation between maternal and tamariki mental health and the significance of the early years. Growing up in supportive, nurturing whānau environment with positive caretaking relationships and responsiveness to the childs emotional state is likely to produce happy and secure tamariki that can regulate their emotions, develop positive relationships and be healthy; this protects mental health.

Tamariki need to express their emotions freely, know they are going to be responded to, and learn about their emotions and how to regulate them. They learn to have trust and comprehend whānau as a source of security and safety.

Adverse prenatal, infant, and childhood experiences increase the risk of poor mental health later in life. Research and Plunket's own experience shows early intervention can improve outcomes. Plunket nurses routinely assess to identify exposure to known adverse childhood experiences such as family violence, family history of mental health issues, post-natal depression, and substance abuse. They discuss with parents their exposure to adverse experiences during childhood as these can critically impact their own parenting practices. In addition, the nurses assess for child behaviour issues that may benefit from early intervention. Plunket nurses work in partnership with whānau helping them to develop knowledge, attitudes and skills to provide tamariki with secure relationships.

In the submission Plunket recommended a primary prevention and 'life-course' approach to promoting mental health and wellbeing and reducing mental illness, making the point that prevention and intervention strategies applied early in life are more effective in altering outcomes and likely reap economic and personal/community returns over the life course.

Early identification of whānau at risk is essential to initiating appropriate early preventative interventions. Being a guest in homes and communities and having ongoing relationships provide opportunities for Plunket staff to support whānau to be responsive and engaged with tamariki. While early identification of at-risk tamariki is critical, so too is access to interventions and support.

Our submision noted that a mother's mental health is critical and deserves high policy priority. Perinatal depression affects 10-15 percent of women. Approximately 60 percent of Plunket mothers assessed as having postnatal mental health issues have a history of mental health issues; this is consistent with the international literature. Greater attention should be given to identifying and supporting this group of women early in their pregnancy.

The Maternal Mental Health quality improvement project in Christchurch will test current systems and processes and refine an approach for Plunket; an emphasis will be on collaboration and local and national partnerships. Late last year our frontline teams, and finance, workforce and strategy/policy staff participated in a quality improvement workshop facilitated by Iwona Stolarek and Gillian Bohm from the Health Quality and Safety Commission. We were joined by people from Canterbury DHB Funding and Planning, and the Ministry of Health's Well Child Tamariki Ora coordinator for the South Island.

The project is still in its early stages and the teams are currently forming a baseline for Maternal Mental Health data to identify improvement opportunities, but this is indeed exciting times for primary health care in New Zealand

New Graduate NetP within District Nursing and Primary Health Care Nursing

Donna Auld, RN, works in a rural practice in South Canterbury. She has a background in providing community services. Having just finished her first year as a new graduate, she agreed to talk with Annie Tyldesley about her experiences.

Annie Tyldesley & Donna Auld

What inspired you to become a nurse?

I had great role models in family and friends, some who were nurses but others who were in healthcare teams. I saw the work that they were doing, being able to assist people with difficult health issues, and how their work impacted on individuals. I wanted a piece of it.

Were you on a Net P Programme as a new graduate?

Yes, I was part of the SCDHB NetP programme. I was privileged to work in both a GP practice and the SCDHB nursing team as a district nurse. My work experience was interesting because general practice and community care was my focus.

How do you think working as a new graduate in primary care has helped you grow your skills and knowledge?

I was able to focus on both proactive and reactive healthcare and it helped to hone both my communication and education skills. I was part of the client's journey, seeing healthcare across the lifespan and achieving goals. It has been a privilege to do this.

What has been your biggest challenge as a new grad in primary healthcare?

Juggling two working environments with two sets of paperwork was a challenge. One job was a fully funded service, with a culture different from the other. The general practice workplace is partially funded and required referrals to secondary care providers. ACC paperwork in both environments was quite a challenge.

What has been the best part about being a new grad in primary healthcare?

Forming therapeutic relationships with my clients and being able to see the progress the provision of healthcare can provide, even in a palliative setting. Even here I was able to form special bonds with people during vulnerable time in their lives.

What was the worst thing?

It's not the worst thing, but I felt a bit 'green' compared to my nurse colleagues. This was because I was new to this working environment. I only knew healthcare as a user not as a provider. My colleagues offered me amazing support, and continue to do so.

Do you have any regrets in becoming a nurse?

On the one hand I have incurred a debt to become a nurse, I have a young family and it took a lot of work ensuring that they received the support that they needed e.g. childcare, family time, etc. However, I love my work and I see this as a

necessary part of becoming an RN.

Do you have any regrets working in primary healthcare?

None at all. It is great being part of, and working in, my community.

What are your plans for your career?

I see myself consolidating my skills and learning new ones. I don't know if this will be where I am working now, but it will always be in primary healthcare.

What makes you want to stay in primary healthcare?

It's the pointy end, proactive, preventative side of healthcare that I like and I really enjoy providing and making healthcare accessible to my own community.

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

Advice to student nurses would always be to practice where your passion lies. If you have identified primary/community nursing as your passion investigate options available. In your letter/cv to ACE stipulate your skill set and why this pathway is your focus. My DHB have tried hard to make positions available in a variety of settings for new grads which is great

From your experiences how can PHC and NetP improve the process for future nurses?

Having continued education from within the organisation and interaction with other Netp colleagues helped set us up. But having mentors and preceptors who related to your experience and helped hone your practice was, and continues to be, a huge asset to nursing.

"Nurses on bikes" 1904

Emergency Nurse Practitioner App.

Erica Donovan

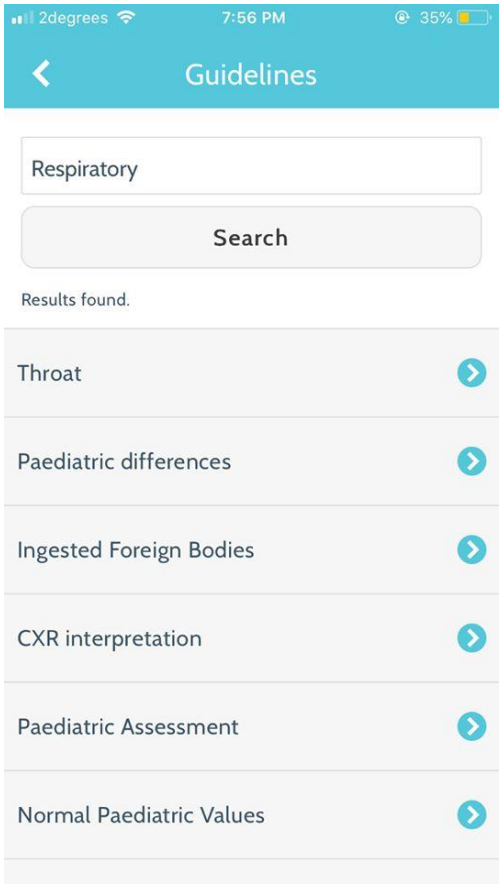
This phone application comes from The Royal Children's Hospital (RCH) in Melbourne, whose guidelines I use often in my work. Don't let the fact that it has Nurse Practitioner in the title put you off. I am far from this level but it has some great information that I'm hoping to incorporate into my own practice. There is also another app from RCH which centres on Paediatric Intensive Care, however I find the Emergency Nurse Practitioner app more useful in the primary health care environment.

The app is 100% free, and I haven't struck any of those terrible ads like some free apps have. I can only speak for using the app via Apple, but it is very functional and easy to read. From a bit of a play around the search function, it seems to be work really well.

Some of the pathways contain refresher diagrams, or charts, both of which are handy because you're not just looking at screeds of text. There are sections based around body systems, and others more centred on specific issues like eczema or constipation. The links at the end of the pages provide great further reading, and other guides that might be helpful. Although certain policies might differ from your specific institution, this app gives a quick overview of the issues you might encounter working with children. For those who maybe don't often assess children so often, the guide has a section with information about paediatric physiological differences and handy hints about how to position children for examination.

There's a couple of screenshots below, but I'd highly recommend taking a look.

If you're interested in downloading the app, the links are as below. https://play.google.com/store/apps/details... And iTunes: https://itunes.apple.com/.../emergency-nurse-pr.../id1364319462...

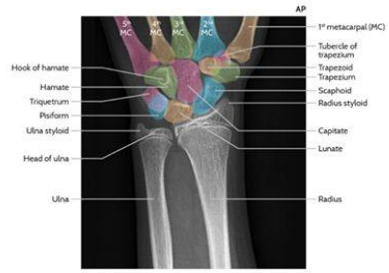


A rule of thumb/hand – to remember carpal bones

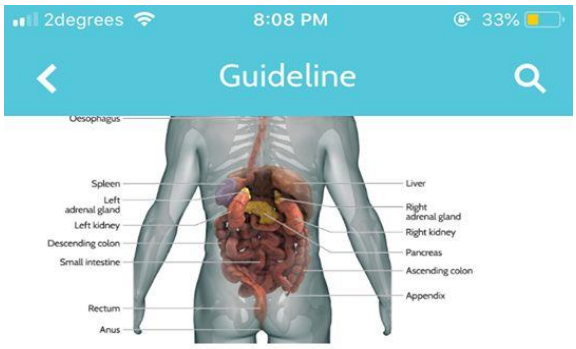
So Long To Pinky, Here Comes The Thumb

Scaphoid Lunate Triquetrum Pisiform

Hamate Capitate Trapezoid Trapezium



Management



Examination: Tips and Tricks

Do not persist with physical exam if child is distressed

- Inspect the patient from afar to assess for pain
- Are they moving about freely?
- Do they have pain at rest?
- Remember children are afraid of strangers (particularly ones with needles!)
- Position the child comfortably
- The child can be cuddled by the parent/carer, then palpate the abdo from behind the child or lying on the carer's

Specific Laceration

Facial lacerations

- Single layer 5-0 or 6-0 nylon sutures are sufficient
- 4.0 sutures should be used for most other areas
- 3.0 sutures for thicker limbs

Scalp

- 3.0-5.0 Nylon
- consider using hair apposition technique for scalp laceration repair
  - strands of hair are pulled form opposite sides bringing wound edges together
  - secure with tissue adhesive

Lip Laceration through Vermilion Border

- Optimal cosmetic result depends on re-approximation of the vermilion border
- First skin suture should be placed at this border.

A personal perspective on my journey to becoming a registered nurse prescriber.

Kim Cameron

I am a Diabetes Clinical Nurse Specialist (CNS), working for Hauora Tairawhiti. At the beginning of 2017, I contemplated embarking on the journey to become a Nurse Prescriber in primary health and speciality teams. Initially I had conflicting emotions as to whether I wanted to do the course. Every nurse, like me who undertakes any form of nursing study will appreciate the time and energy that goes into upskilling. It is often very hard and not to mention incredibly stressful to juggle work commitments, and one's personal life while studying. I also knew my nursing capacity would be further stretched due to the added responsibility of being a nurse prescriber because I would be accountable for the prescribing decisions I would make. I asked myself did I need this additional pressure in my job.

I believe the major factor which helped me to make the decision to become a nurse prescriber was my geographical location and the poor health statistics associated with the area. Tairawhiti is located on the east coast of the North Island and is considered a relatively isolated part of New Zealand. Statistically, Tairawhiti has the greatest proportion of Maori of any district in New Zealand (44 percent) and we are all aware that stark health disparities continue between Maori and non-Maori. Nationally the area has some of the worst health statistics; this also includes some of the poorest diabetes health outcomes. Factors which contribute to this statement are health inequality or should I say health inequities, inappropriate access to some health services, high smoking and obesity rates, high unemployment, as well as high deprivation rates and low socioeconomics www.gdc.govt.nz/assets/CommitteeMeetings/12-239-X3-Appendix.pdf. We are all mindful of the negative impact these health components have not only on an individual but their whānau and the community as a whole.

Another reason why I decided to become a nurse prescriber was the lack of access to prescribing health practitioners in our area of the hospital. Let me explain. The diabetes service is located in Tui Te Ora or the Long Term Conditions department. Tui Te Ora staff consists mainly of Clinical Nurse Specialist and registered nurses. The area is situated away from the main body of the hospital and prescribing Physicians are few and far between. This site makes it extremely difficult to get prescription written and signed when needed. Patients accessing my support with their diabetes management were always enquiring if they could get a prescription for their diabetes medications or other

prescription items, like glucometers and blood and ketone test strips. I found myself getting very frustrated at having to tell them they would need to access their General practitioner. I knew this situation could result in treatment delays, intermittent drug administration or medication cessation. If I became a nurse prescriber this could assist in improving patient's access to timely, appropriate, affordable, and acceptable healthcare.

So in July 2017, I commenced the registered nurse prescribing course. I did the paper through the Eastern Institute of Technology (EIT). The criteria for undertaking the course can be located on the Nursing Council of New Zealand (NCNZ) web page http://www.nursingcouncil.org.nz/Nurses/Nurse-Prescribing.

There were five registered nurses in my class one of them as a colleague. I must admit I found the course criteria extremely challenging and very time demanding (however I understand since the first intake of registered nurses EIT have since streamlined the course). To be honest, if it were not for the encouragement and support of my course tutor, I feel I would have failed the paper. Also, I cannot emphasis enough the importance of finding a prescribing mentor who has the capacity and time to fully assist and support you with your learning. Without their full guidance you will struggle to complete the course.

In November 2017 I received confirmation that I passed the written component of the course now I was to commence a one year practicum under my prescribing mentor's tutorage. However, my colleague and I discovered the DHB had no policy supporting nurse prescribers. Healthcare policies are essential documents which provide clarity, regarding health and safety, legal liabilities and regulatory requirements, as well as providing standardisation in the day to day activities of our working environment. Policies also ensure employees are fully aware and informed of what their roles and responsibilities are within the organisation. To carry out this point of concern we enlisted the help of our union and arranged several meetings with our nurse managers and the organisations Director of Nursing (DON). As my colleague and I were the first registered nurse prescribers in Tairawhiti we wanted to ensure the organisation fully supported what we were doing in our nursing practices. We also wanted to make sure the DHB had "our backs" (so to speak) if a medication misdemeanour should occur. Lastly, we also needed to ensure other future nurse prescribers were safeguarded. Along with my colleague we agreed not to start prescribing backed by the Nursing Council of New Zealand (NCNZ) until the organisation implemented an agreed policy. During the time it took for the document to be completed, I continued to work closely with my prescribing mentor. I gathered the necessary evidence needed to prove that I was a safe and competent prescriber. In November 2018, I submitted my evidence to the NCNZ and "*Whoop, Whoop*" I became an authorised registered nurse prescriber.

Another safety measure my colleague and I felt we needed was a type of 'supervision forum' so we approached various health professionals in the community and asked if they would be interested in guiding us and supporting us with our nurse prescribing. We believed by having regular get-togethers to review case studies and discuss our nurse prescribing activities would help us to become more self-confident and proficient prescribers. I am happy to report a general physician, a pharmacist, a General practitioner, as well as a nurse

practitioner all volunteered their support.

I believe becoming a nurse prescriber has made me more self-assured. No longer am I willing to stand back and listen to those who I perceive to know more than me. I am now able to speak up and to openly discuss my thoughts about patient care and make medication recommendations without fear of being disregarded. Because I have observed, listened, studied and gathered an assortment of nursing skills and knowledge which has all accumulated to boost my self- confidence. With self-confidence comes the knowledge that I am a proficient, empathetic, and conscientious nurse who is capable of prescribing medications based on my clinical findings and assessment capabilities.

My nursing practice is more autonomous. I am now able to make prescribing decisions and I have the freedom to write a prescription within my scope of practice. No longer am I spending valuable time tracking down a prescribing practitioner to sign off prescriptions. Instead I am able to utilise this time to fully inform the patient about the medication I am prescribing them. Research suggests spending time and explaining to patient about the medications they are being prescribed can facilitate in the patient being more willing to administer the medication as prescribed. For the patients I feel they get speedier access to treatment, enhanced quality of care, more pertinent prescribing of medication, improved patient relations, communication and safety, greater efficiency and for most of my patients it is cost effective.

Being a prescriber also means I have to work much more collaboratively and communicate more regularly with all those health practitioners involved in the care of every patient I prescribe medications for. I think this helps to strengthen and build more trusting inter-professional relationships.

Yes, prescribing means a lot more work for me. I am constantly ordering, reviewing, acknowledging laboratory results, as well as writing or ringing general practitioners or pharmacist to advise them or question them about patient's medications regimens. Yes, I have patients who run out of medications (usually in the weekends) and require a prescription or want things done right away but prescribing has offered up a whole new chapter of nursing and I am looking forward to learning more and expanding my nursing horizons further.

NOTE: We (nurse prescribers in Tairawhiti) with the help and support of our union continue to negotiate with our DHB regarding the possibility of remuneration for nurse prescribing. We feel the added work and responsibility associated with nurse prescribing should be recognised and acknowledge by our DHB as it has been by other DHB's around New Zealand (hopefully I will be able to report on the outcome of this matter at a later date).

PHARMAC SEMINARS 2019

2019 Seminars open for registrations

Clinical pharmacology for nurses – Friday 12 April

Addressing health inequity for Tane Maori – Monday 29 April

Maternal mental health and pregnancy complications – Monday 20 May

Online seminars

Pharmac now have a library of 40 seminars available online, which you can access by going to pharmacseminars@pharmac.govt.nz.

A Diverse range of topics has been added since the last update:

Assessing and managing maternity conditions
Dr Janet Rowan covers obesity and GDM, including the NZ GDM guidelines.

HIV update
This seminar also covers sexual health.

Emotional and behavioural disorders, importance of the early years
Covers attachment theory, reflective functioning and ADHD.

Pacific Island health issues in the NZ context
Highlights issues relating to Pacific health, particularly in relation to diabetes and engagement with the Pacific patient group.

Recognition and response to sexual assault and intimate partner violence in primary care
Covers family violence in New Zealand, identifying and responding to IPV in general practice and case-based practical management of adults and adolescents after possible sexual assault.

For more information, contact us on pharmacseminars@pharmac.govt.nz.

New Graduate working in Aged Care

Annie Tyldesley & Abby Dennis

Abby Dennis, RN, she agreed to talk with Annie Tyldesley about her experiences.

What inspired you to become a nurse?

In my last year of high school, I weighed up a lot of different career options. For me Nursing ticked everything that I felt would fulfil me in a career. Such as, people interaction, academic knowledge, the constant opportunities to provide care to people, the diverse roles that Nursing provides, and that it open's doors nationally and internationally.

Were you on a Net P Programme as a new graduate?

Yes, I was in the South Canterbury NETP programme.

How do you think working as a new graduate in primary/Geriatric care has helped you grow your skills and knowledge?

Many things have helped. I have been extremely lucky to work alongside experienced RN's whom I have learnt many valuable tips/skills off.

Also, because there is no Doctor on site, it's been both challenging and growing (with my confidence) in making decisions/plans before requesting that assessment from the GP's.

What has been your biggest challenge as a new grad in primary healthcare?

I think for me it was at the beginning of the year when I was getting orientated around the facility, just thinking to myself, "there is so much to remember" alongside thinking, "I am no longer a student, I'm an RN now" therefore, the responsibility is bigger! However, soon enough, those worries eased as I became familiar with routines/location of equipment. Also, I have felt so supported by management and other staff to bounce off regarding my concerns, questions and knowledge, so I have felt safe in my first year out.

What has been the best part about being a new grad in primary healthcare?

In my area, I've loved the opportunity to create rapport and consistency with Residents.

What was the worst thing?

The timeframes and work-loads which can sometimes disrupt the ability to spend more time talking with residents.

Do you have any regrets in becoming a nurse?

Definitely not.

What are your plans for your career?

As of now I am loving where I am, so to be honest I have not made plans to go elsewhere yet.

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

I highly recommend doing the NETP programme. The six week support time at the beginning is incredibly beneficial and in my opinion necessary, to enable you to have that time to ask questions, and feel safe working alongside an RN preceptor in

that critical beginning stage of standing on your own two feet.

Also, another piece of advice would be, to stay on top of the NETP assignments throughout the year :) the year goes so quickly!

Also, this is cliché, but "no question is a stupid question." Ask, ask, ask. The first year out is big for many reasons, but people DO understand that and will be willing to talk you through things :)

Also, I found it very healthy to catch up with fellow nursing friends/new grads to see how each other were doing and to know others are in the same boat :)

Reflection

Erica Donovan is a third year registered nurse, formally working in Primary Health Care, she has now transitioned into Pediatric Oncology/Hematology. She is a member of the LOGIC Journal Committee for the NZ College of Primary Health Care Nurses (NZCPHCN).

The new year always gets me in a reflective mood, and one thing I've been reflecting on is the dichotomy between primary and secondary care.

My first job within nursing was within a progressive Primary Care Practice within Christchurch. There I not only completed by New Entry to Practice Programme (NetP), but also started on the pathway of graduate study. Before registering I was advised by tutors and other nurses not to go into primary care without working in the hospital first. Some attitudes I've seen online are that Nurses might de-skill if they don't use their 'hospital skills'.

But I think we need to celebrate Primary Care, and Primary Health Care Nurses for the wide scope of opportunities to influence the health of a community.

At time of writing, 93% of New Zealanders are enrolled with a Primary Healthcare Organisation. But services are more than just a gate-way to secondary care services, we're often what stands between patients staying at home and admission to hospital. Daily I am reminded the range of services we provide, from cradle to grave care.

The World Health Organization defines health as 'a complete state of physical, mental and social well-being, not merely the absence of disease or infirmity'.

We cover all those aspects in Primary Care. One aspect of this in practice is the program Senior Chef, which in Canterbury we can refer patients to. Loneliness is a public health issue. Having access to classes for those in the older age group (The program

accepts those over 60, or 55 for Maori, Pacifica, or people who have age related disorders) not only provides tangible skills in food and nutrition, but also valuable connection.

Keeping with the World Health Organization (WHO) theme, WHO has recently released its list of "Ten threats to global health in 2019". Listed among these are: non-communicable diseases, global influenza pandemic, vaccine hesitancy and antimicrobial resistance.

Interestingly enough, number seven is 'weak primary care'.

While I don't believe our New Zealand system is weak, I think there is certainly things we can do to strengthen our primary healthcare system. Hopefully a step in the right direction is the new lower cost General Practice visits for Community Service Card holders and their dependents. However, there is disappointment that reduced fees are still voluntary for practices to adopt, therefore limiting the potential of this change, continuing to create barriers that this policy was designed to assist. The NZCPHCN would like all eligible CSC holders to receive to receive the reduced fees. I also look, with interest, into the future of caring as we extend the scope of our services even further. My Primary Care practice offered services such as fracture management and fracture management, something I think will become more common in the coming years.

So to come full circle, do I feel like I'm 'de-skilled'? Not in the slightest.

Your feedback needed!

It has recently been announced by the Minister of Health, Dr David Clark, that there is to be a review of the New Zealand Health and Disability System.

Health professionals and the public are being invited to consider the future of the sector, looking at new technologies and how we can make services work for those within our communities that are marginalised. An independent panel will consider comments and there is also community workshops that will be held later in 2019.

To read more about this process visit https://systemreview.citizenspace.com/ and complete their survey, which is open till end of May.

Central Hawke's Bay Rural Nurses Network

Yvonne Little, Nurse Practitioner

CHBRNN Facilitation Group

Whilst we currently don't have the Hawke's Bay Regional Forum up and running again, I thought I would share with you some information about a dynamic group of nurses to which I belong.

We are a group of nurses who either work and/or live in Central Hawke's Bay, we meet every second month for one to one and a half hours in the evening where we network with each other (this includes both primary/community and secondary nurses) and find out what the latest news/updates from each work place are; get the latest updates from the Primary Health Organisation (PHO) and the District Health Board (DHB) and have invited speakers on a variety of topics.

This year, we realised we didn't have a Terms of Reference (TOR) for our group, so we worked together to set this up.

We also decided to try to get as many nurses to attend we would do a flyer with who we are and what we do and when and where we meet to be put in all places of work where nurses are. We do not charge any fees but ask members to bring a plate of nibbles to consume during the meeting as most of us go straight from work to the meeting.

At our recent meeting we met and welcomed our new Director of Nursing, Primary Health Care – Karyn Bousefield, who has come back to Hawke's Bay from the West Coast so is well versed in rural nursing challenges. Her role in Hawke's Bay covers the PHO/DHB interface.

We are also working towards having Rochelle Robertson (PHO workforce development) come to our next meeting to lead an interactive session on her role and the needs in our environment.

We are also working to have all our members give a 5 to10 minute discussion on their work and workplace so that we better understand each other's roles and challenges and how we can work better across our respective disciplines to provide a more comprehensive but streamlined service for our population.

Our meetings are not meant as opposition to the NZNO Hawke's Bay Regional Forum but it is difficult for rural nurses to get to meetings at urban settings, we as a group will be working together with the Regional Forum in being able to take information back and forth between the groups once the Regional Forum is up and running again.

The NZNO Library

Resources For Nurse

NZNO Library

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

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

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

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

Books – Healthy Homes/Effect of poverty

These books can be borrowed by current NZNO members for a period of 4 weeks. Please provide a street address so that the books can be couriered out to you.

1. **Bk: Do damp and mould matter? Health impacts of leaky homes**

Edited by Philippa Howden-Chapman, Julie Bennett & Rob Siebers Steele Roberts, 2009

This book outlines:- the extent of damp, mouldy houses in New Zealand
- the history of our leaky buildings health effects — and costs — of exposure to indoor mould
- methods for measuring mould
- likely costs of fixing leaky homes
- what we still don't know about indoor mould, and recommendations for future research

2. Bk: Making healthy places: Designing and building for health, well-being

Edited by Andrew L. Dannenberg, Howard Frumkin & Richard J. Jackson Island Press, 2011

The manner in which we design and build our communities – where we spend virtually our entire lives – has profound impacts on our physical, mental, social, environmental, and economic well-being.

3. Bk: Thinking about poverty

Klaus Serr 3rd edition, 2006.

Invaluable for students of social work, social policy, and community and welfare, this book covers: the effects of neo-liberal policies on families and the unemployed the reason why women are the main victims of poverty the individualistic models on which Australian government policies are largely based the failure to address the structural causes of poverty alternative definitions of poverty which are not based solely on economic measurements

Articles – Healthy Homes

4. Climate change: allergens and allergic diseases.

Katelaris, Constance H.; Beggs, Paul J. *Internal Medicine Journal*. Feb 2018, 48(2), 129-134.

There is now compelling evidence that rising air temperatures and carbon dioxide concentrations are, in some plant species, resulting in increased pollen production and allergenicity and advancement and lengthening of the pollen season. Changes in extreme events, such as thunderstorms and tropical cyclones, will also have impacts on allergic diseases, with, for example, the flooding associated with tropical cyclones leading to proliferation of mould growth in damp homes. The article also considers a range of responses to these health threats, including greenhouse gas mitigation, and adaptation strategies, such as enhanced environmental monitoring and health surveillance.

5. **Exploring the associations between parent-reported biological indoor environment and airway-related symptoms and allergic diseases in children. Weber, Alisa; Fuchs, Nina; Kutzora, Susanne; Hendrowarsito, Lana; Nennstiel-Ratzel, Uta; von Mutius, Erika; Herr, Caroline & Heinze, Stefanie; GME Study Group *International Journal of Hygiene & Environmental Health*. Nov 2017, 220(8), 1333-1339.**

Asthma and allergic rhinitis are diseases which require special attention in childhood. Previous studies have shown associations

between indoor mould and respiratory diseases in children. Besides indoor mould, organic waste storage, potted plants, pets and crowding could influence the microbial indoor environment at home and the respiratory health of children. Our aim was therefore to explore the associations of these factors with airway-related symptoms and respiratory diseases in pre-schoolers.

6. **Clinical digest. Mould in the home implicated in study of middle-age asthma and respiratory problems. *Nursing Standard*. 3/19/2014, 28(29), 16-17.**

An investigation into the role of indoor air pollution in asthma in middle age has found a strong association between the condition and mould in the home.

7. **Health Hazards in the Home: An Assessment of a Southern Nevada Community Sokolowsky, Amanda; Marquez, Erika; Sheehy, Erin; Barber, Casey & Gerstenberger, Shawn. *Journal of Community Health*; New York. Aug 2017, 42(4), 730-738**

The purpose of this research is to characterize housing conditions in southern Nevada, compare data to census data, and to highlight the health outcomes associated with adverse housing conditions. Lead, domestic hygiene, carbon monoxide, damp and mold, excess cold and heat, and structural collapse were the most frequently identified hazards, found in at least 101 (90%) of participant households.

Articles – Respiratory Health

8. Development and validation of clinical prediction models to distinguish influenza from other viruses causing acute respiratory infections in children and adults Vuichard-Gysin, Danielle; × Dominik Mertz; Pullenayegum, Eleanor; Singh, Pardeep; Smieja, Marek; et al. *PLoS One*; San Francisco. Feb 2019, 14(2), e0212050

Predictive models have been developed for influenza but have seldom been validated. Typically they have focused on patients meeting a definition of infection that includes fever. Less is known about how models perform when more symptoms are considered. We, therefore, aimed to create and internally validate predictive scores of acute respiratory infection (ARI) symptoms to diagnose influenza virus infection as confirmed by polymerase chain reaction (PCR) from respiratory specimens.

9. Observed Home Dampness and Mold Are Associated with Sustained Spikes in Personal Exposure to Particulate Matter Less than 10 mm in Diameter in Exacerbation-Prone Children with Asthma
Dutmer, Cullen M; Schiltz, Allison M; Freeman, Kristy L; Christie, Matthew J; Cerna, Juana A; et al. *Annals of the American Thoracic Society*, Supplement 2; New York. Apr 2018, 15, S131-S132.

Home dampness and mold are associated with asthma severity and exacerbations, but little is known about the nature of these exposures in at-risk children. Objectives: To test the hypothesis that observed dampness, water damage, and mold in the home are associated with higher exposure to particulate matter less than 10 mm in diameter in a cohort of at-risk children with asthma.

10. **Indoor Environmental Interventions for Furry Pet Allergens, Pest Allergens, and Mold: Looking to the Future Ahluwalia, Sharon K & Matsui, Elizabeth C.**
***Journal of Allergy and Clinical Immunology*. In Practice; Amsterdam. Jan 1, 2018, 6(1), 9-19**.

Over the last 2 to 3 decades, significant advances have been made in understanding the role that indoor allergen exposures play with regard to respiratory health. In this article, we review recent literature on home environmental interventions and their effects on specific indoor allergen levels and asthma-related outcomes.

NZNO Library
Contact Details
Level 3, Crowe Horwath House
57 Willis Street
PO Box 2128, Wellington 6140
P: (04) 494 8230
F: (04) 382 9993
E: Library@nzno.org.nz
W:

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