



SPRING HAS SPRUNG!

DRUG SIDE EFFECTS VERSUS ALLERGIES

COMMUNITY RN PRESCRIBING TRIAL

FOOD SAFETY FOR WARMER WEATHER

HEPATITIS ONLINE LEARNING MODULE

TALL POPPY AWARD WINNER 2019

SCDHB PERTUSSIS COCOONING

NELSON-MARLBOROUGH FORUM REPORT

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Chair's Report

Celeste Gillmer
Chairperson

Tēnā Koutou katoa

The executive committee, professional practice committee (PPC) and LOGIC committee met in Nelson on 29 August 2019. We had a very productive day working our way through a multitude of agenda items! Anne-Maree Harris from St Johns gave a presentation on their workforce review and we were amazed at the huge amount of work St Johns do (other than their ambulance service). The committees decided to provide feedback on the St Johns workforce review to support the amazing work they do. The committees decided to send a letter out to all our members to compile feedback for the special general meeting matters.

The PPC and LOGIC committees had their separate meetings as well and finalised their planning for the last quarter of this year, with the PPC signing off the final version of the PHC Nursing Standards of Practice. These standards will be available in the

next couple of months, please keep your eye on our website. We will notify all members and stakeholders as soon as the document is available for download.

The NZCPHCN had a very successful AGM and professional development session that evening. We received 5 nominations from the floor for our different committees – keep an eye on our website and the next LOGIC edition for more information of these new committee members! The presenters that evening were amazing, giving everyone an understanding of the refugee sector in the Nelson-Marlborough sector and across New Zealand. Our 2 awards were all presented, with Melanie Terry receiving the Tall Poppy award and Donna Auld the New to Primary Health Care award. Congratulations to both these amazing nurses and thank you for your work that you do



for our communities. There will be articles on both these nurses and their stories in future LOGIC editions.

On 30 August the committees reconvened to finish off all the other business on our agendas, with the main part of the meeting spend on collating feedback on the NZNO strategy. The feedback will be submitted directly to NZNO before 30 September 2019.

I would like to thank all the fantastic work our committee members do on a daily basis to provide professional support to all our members, including our LOGIC journal and the new PHC Nursing Standards of Practice. These face-to-face meetings are very long days with a lot of work that needs to be signed off, but everyone around the table provide input and feedback and we still manage to have a good laugh and appreciate each other company – thank you ladies, you are amazing!

Editor's Report

Yvonne Little

Nurse Practitioner



Welcome to Spring, the weather is getting warmer (albeit a bit erratic at times) and the allergy, party and barbeque season is beginning.

In this issue we have tried to cover springtime issues alongside our regular articles, we hope you enjoy the articles we bring you. We have some interesting articles on needle phobia, online modules and innovative programmes, also the RN prescribing in community trial. A new edition to our line up is an article from an Ostomy nurse. There are also a few reports this issue as we feel this is important information for our members.

Recently, we held a Forum in Nelson, for the Nelson-Marlborough region which was fantastic, please see the report and photos from that evening later in this issue, also included in this issue is a piece by our Tall Poppy Award Winner. In the Summer LOGIC we will have the Nurse New to Primary Health Care Award Winner article.

We have been fortunate to fill all our committee vacancies whilst at the Nelson-Marlborough Forum but if you would like to consider joining us then please make contact as we aim to continue our succession planning for the future.

The final item I would like to cover is to say thank you for your patience and your feedback regarding concerns about the delay in timing of publication and the recent email format of the Winter Edition. We realise that this has caused some frustration. With illnesses abounding during winter, increased workloads and waiting on articles arriving unfortunately publication was slightly delayed. Also, just before our Winter Edition was due out, we had to say farewell to Rosanne Grillo, our NZNO administration contact who did a wonderful job of getting you your LOGIC online emails. We wish her all the best with her future endeavours. Fortunately, we have another administration

contact who is getting up to speed with her role but was unfortunately trying to get several colleges AGM paperwork done at the same time as our Winter LOGIC. We are working with her to ensure future LOGIC issues come out promptly and, in the format, that Rosanne used to save confusion for you our members.

Take care of yourselves over the Spring season and if you or anyone you know could provide us with an article, any topic or if you feel your area of practice is not featured enough please contact me on the logic editor email at the front of this edition and I will put one of our committee members in touch with you.

Report from The Office of The Chief Nurse

Margareth Broodkoorn has given permission for us to reproduce relevant portions from the Sector Update from the Office of the Chief Nursing Officer. Therefore, I have taken a small selection from this report, you can check the full report on the Ministry of Health website.

August 2019 Office Update

The Office's work programme continues to evolve and develop in response to changes in the sector and to deliver on Government priorities.

In the past few months the Chief Nursing Officer Margareth Broodkoorn has been networking with international nurse colleagues at the Australian and New Zealand Council of Chief Nurses and Midwifery Officers (ANZCCNMO), representing nursing and the Ministry of Health at the World Health Organisation (WHO) annual assembly, and providing national clinical leadership in a number of forums including

strategic Ministry conversations with DHBs and the Surgical Mesh listening circles.

The Director-General has led changes in order to strengthen the Ministry's role as kaitiaki of the health and disability system and better align the structure and functions with the wider health sector governments priorities. The Ministry has undertaken a further intended review of all the Directorates with the clinical cluster being renamed as Office of the Chief Clinical Officers. Equity is a priority for this government and the Ministry, the OCNO is working closely with the Māori Health Directorate across a number of work programmes

We are delighted to announce that Ramai Lord has now been employed in a permanent Senior Advisor role.

World Health Assembly

In May Margareth attended the World Health Assembly (WHA) in Geneva. The theme was "Universal health coverage: leaving no one behind". The WHA is the decision-making

body of World Health Organisation (WHO) and is attended by delegations from all 194 WHO Member States who focus on a health agenda prepared by the Executive Board.

Nursing and Midwifery played a key role at the WHA. WHO's Chief Nursing Officer (CNO) Elizabeth Iro formally launched the 'Strengthening Quality Midwifery Education' document, which identifies strategic priorities for Midwifery education with a seven-step action plan and led the resolution for the WHA to endorse 2020 as the Year of the Nurse and Midwife. Planning is underway to celebrate the year of the nurse and midwife and the Nursing Now campaign. The Office is working with the NNO group to plan a nationwide campaign.

Ms Iro also convened a global Chief Nursing and Midwifery Officer's meeting to discuss in more depth the two WHA nursing and midwifery initiatives. It was the first time

such a meeting was held at the WHA.

Registered nurse prescribing in community health

The registered nurse prescribing in community health roll out was officially launched in June 2019 by Minister Salesa in Otara South Auckland. Margareth had the pleasure of meeting many of the 50+ nurses who had achieved prescribing and acknowledge Karen Sangster, Counties Manukau DHB and Rose Stewart, Family Planning who were integral in supporting this innovation. The prescribing rollout will continue across all Auckland DHBs and PHOs and beyond following the successful trial and evaluation of the prescribing and work-based training model.

Nurse prescribing in the community adds value to the health system by increasing patient access to affordable health care and medicines and to the government's priority on achieving equity.

Surgical Mesh Restorative Justice Forums

For many individuals and families/whānau, the experience of harm and injury from mesh has led to significant distress and suffering. Anyone affected either directly or as a family member/whānau or

friend has been encouraged to participate and share their experience in a series of listening circles co-designed with Mesh Downunder, the restorative justice team at Victoria University and the Ministry.

Independent analysis of a public survey carried out earlier this year concluded that an opportunity to hear from New Zealanders injured and harmed by surgical mesh is essential.

Hearing from mesh injured New Zealanders will assist to better understand the impact, clarify responsibilities and inform action that will improve patient safety in the future.

The Ministry has commissioned the Diana Unwin Restorative Justice team from Victoria University to facilitate and evaluate the process. Using a restorative justice approach to this work is a world first in health.

Margareth and Chief Medical Officer, Dr Andrew Simpson are attending 30 face to face sessions around the country involving over 300 mesh injured people and their support persons, with the possibility of more sessions to follow in September and October. For more information, see the following link:

<https://www.restorativehealth.net/>

Well Child Tamariki Ora Review

The four phases of the Well Child Tamariki Ora (WCTO) were shared in the last update. The analysis phase is well underway and options for possible improvements to the WCTO programme will be developed as a result. Further face to face engagement with the sector is in progress until the end of August. This engagement process will focus on ensuring the issues that need to be addressed have been understood and seeking possible solutions.

Identifying the issues that need to be addressed is key to achieving the Review's aims of a better, more equitable Well Child Tamariki Ora programme. More information about the review can be found on the following link: <https://www.health.govt.nz/our-work/life-stages/child-health/well-child-tamariki-ora-services/well-child-tamariki-ora-review/well-child-tamariki-ora-review-update-june-2019>

Margareth will be chairing the Well Child Tamariki Ora advisory group, the first meeting of this group will be held on the 28 August 2019.

Kaiāwhina workforce

The current five year Kaiāwhina Action Plan has a year left to go and the Kaiāwhina Taskforce is busy reviewing completed actions and remaining work to be done. You can see the current version of the Plan at www.workforceinaction.org.nz

As part of the work of the Kaiāwhina Taskforce, Careerforce sent a submission to Stats NZ for the review of Australia and New Zealand Standard Classification of Occupations (ANZSCO) codes. They note the current occupation codes fail to adequately address the breadth and diversity of the kaiāwhina workforce in New Zealand. The document provides an up to date description of this workforce and is useful reading which Careerforce is happy to be shared.

See:

<http://www.workforceinaction.org.nz/wp-content/uploads/2019/06/Kaia-whina-and-the-ANZSCO-Workforce-Intelligence-Advice-1.pdf>

A Qualifications Review of current Health and Wellbeing qualifications at levels 2, 3 and 4 was completed last year. A high level of support was received for expanding the level 4 New

Zealand Certificate in Health and Wellbeing. The changes are expected to better reflect the responsibilities of carers working at this level and to support career progression of carers into nursing. Proposed changes are currently awaiting approval by NZQA.

New Executive Committee member: Nicola Thompson

Kia ora koutou e te whānau,

I am currently working as a Public Health Nurse/Outreach Immunisation Nurse in the Nelson-Marlborough region. Most of my mahi is with vulnerable families so I see first-hand the impact the social determinants have on the health of our families/whanau. As a result, I work with a number of organisations both from the health sector as well as education, social services and local government. Within my role as a Public Health Nurse, I am currently on the Nelson-Marlborough Models of Care Clinical Working group, National Child Protection Alert team, am a member of the Nelson-Tasman Well Child Interagency group, the Public Health Nursing Quality Group and Public Health Professional Development Workforce group.

Prior to my current role I have a wide range of experience in a number of nursing positions, having nursed in Hospitals and General Practice in Nelson, Canterbury and Waikato. This has given me a broad knowledge of different aspects of NZ's health care system. Prior to nursing I worked as an analyst in the airline industry after gaining a degree in Economics. Last year I completed a Post Graduate Diploma in Health Sciences specialising in Public Health and Nursing,

Ngā mihi nui,

Nicola Thompson.



RURAL MUSTER

#11



Lee-Anne Tait

Welcome to the spring edition of the Rural Muster. I have volunteered to undertake this issue in absence of Kate Stark due to her other many commitments at this time.

I work as a Rural Health Nurse in Eketahuna – which is not as rural as some of the locations many of you are working in – therefore if one of you in remote locations would like to commit to undertaking this write up of rural news four times a year, the LOGIC committee would really appreciate it. Please feel free to contact us if you are interested.

Life in Eketahuna over this last quarter has revolved looking at our rural response to a variety of situations which may or have presented for myself and my work colleges.

Firstly, bi annual updating of our disaster and pandemic plan. Luckily for us, as with most rural

areas we are strongly supported by Civil defence for most aspects of it. We have three venues aside of the health centre all for casualties/ community provision etc and the health centre stock /DHB disaster response box is superb for initial interventions. However something which became apparent recently with a rural road closure due flooding - is that we all live around a thirty minute drive from the health centre, therefore more local nurses might need to step in to support us if roads are closed /bridges lost etc– so we have been working on a MOU around this. Within this there are so many things to consider from where all master keys should be kept and where disaster boxes /emergency bags should be stored through to whether it would be a good idea to keep a basic paper copy of Pts front sheet – classifications/drugs/NOK etc as most of the nurses who may come are hospital based and

may not have access to local med tech data base etc.

Secondly, we are looking at all the MMR status of our community as I'm sure you all are at this time. We are on target and doing all those 15/12 and 4 year ones who are due. However, we realise that this outbreak of measles could escalate further, so we are trying to contact/ locate our transient families who have declined or have overdue immunisations, in order to offer vaccination should we have more stock in the coming days/ weeks. As we go through the database it is amazing to see just how many families have come and gone and all resided in the cheaper farm houses and local rentals for 3-6 /12 only and then moved on, along with childhood descriptions of ill health which can be attributed to their accommodation.

Thirdly, this further highlights the issues we have had. We have been working with one of

our local landlords asking him to address the appalling standard of housing he provides for such families, as \$300 a week for a hovel is no longer acceptable in the government's eyes and we are pleased that many landlords will now be accountable for basic standards in relation to rental accommodation. We have a local social worker who is trying to fight these battles for us. But sadly he and the tenants are all a little concerned that if we rock the boat too much these families will be evicted, and there is little choice in this area in relation to rentals – especially lower price ones. Furthermore if our families move a few kilometres down the road they sit under another DHB, then all booked hospital appointments they have become deferred to another health authority as they no longer reside in the catchment area for a particular DHB.

We have been working with the B4Schools staff in order to catch these families, as we are noticing that within these families some of the children have developmental or behavioural issues that will need further investigation / addressing, mainly to ensure they are supported in their transition to school. It saddens me so much at just how hard it is to contact some of these families due to transience, non-

accurate contact numbers. I worry that some essential appointments may be missed for these children. I wish we had a social worker or a community support worker who could be dedicated to this task.

And finally, what we are working on at the moment, is getting all my paper work together, formulating a new job description and related medication policy and procedure documents, so I can apply to Nursing Council for my Nurse Prescribers licence. As thanks to all your Rural Muster articles, RGPN, RNNZ and PHCN encouragement, along with the support from an NP in Masterton, I finally did the course earlier this year through Victoria. Soon I will be able to get started and hopefully help to address some of our acute presentations, for patients who cannot get out their GP due to lack of transport or money. I feel in some small way this may help towards service equity within this semi-rural community for some of the people we serve.

I hope this season has been better for your practices and your problems have been small ones. Take care one and all, stay safe and enjoy all those wonderful calves, lambs and spring weather and your preparation for docking.

Thanks to Mark Dixon, the CEO of Allergy New Zealand Inc for allowing us to use the following

graphic. They're a great source of information around allergies, both for patients and for nurses who may not have experience dealing with allergies. From

time to time they also offer health professional events. Their website can be found at <http://www.allergy.org.nz>

Annual Pollen Calendar

For information about allergies, please go to allergy.org.nz
or FREEPHONE 0800 340 800 or ph 09 623 3912

 Trees

Pollen allergies are common in New Zealand, and trigger allergic rhinitis (hay fever) and also provoke asthma.

POLLEN DISTRIBUTION

- The pollen season starts in spring, with some trees producing pollen earlier depending on climate conditions.
- The season usually starts earlier in the north and finishes later in the south of New Zealand.
- Grass pollen is usually highest in the early morning.
- Pollen is distributed in the wind and can go a long way, depending on strength and direction.

TIPS FOR MANAGING
POLLEN ALLERGY

As with any allergies, appropriate medications can control or alleviate symptoms. Consult your doctor. Avoiding exposure to the pollen concerned can also help. Here are some tips:

Grasses

- Keep windows closed at night and early morning
- Stay indoors when it is windy
- Stay away from high pollen areas, such as parks, golf courses, farms, country roadsides etc., where grass/weeds are not regularly mown.

Other

- Registration: CCI0748

PALLERTEY New Zealand Inc 2018

 = Producing pollen at this time

Anecdotal only - needs research

Anticoucal only - needs research

**Treat your allergic rhinitis
not just your symptoms**



PRAPUR Inhalation Treatment Sublingual Tablets are a Prescription Medicine, containing an allergen extract. For the treatment of grass pollen allergic rhinitis with or without conjunctivitis in adults, adolescents and children above the age of 5. Allergens has risks and benefits. Additional information and OTC can be obtained from www.wellmed.co.nz. To ask your doctor if OTC is right for you. Always use strictly as directed. If symptoms persist, see your health care practitioner. OTC is a unidirectional medicine. No wellmed, govt.nz or Allergan. Normal dosages: 3 drops 3 times daily. New Zealand EBOS Healthcare 14-18/Nov 2017. STAO18.

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STALLERGENS GREENER

STALLERGENES GREER

Anaphylaxis can be an ACC issue?

Erica Donovan

I was surprised as you might be to hear that there can be situations that ACC will cover anaphylaxis and other allergies.

“Allergy” is an underlying health condition, not an injury caused by accident.

The exception to this is where the allergy itself was caused either by a work-related gradual process disease or infection or by treatment administered by a registered health professional. A special assessment will be required if the condition may have been caused by a work-related situation or treatment injury. (Accident Compensation Corporation, 2017, p. 2). In certain cases, clients may be able to claim back a portion of the cost of an adrenaline autoinjector (Epipen) if they reaction falls under this jurisdiction.

However, as with all ACC claims, patients need to remember that their issues may not be classed as an accident, especially if it's

things like allergic rhinitis or conjunctivitis, which ACC do not cover. Patients also have to know what caused a reaction i.e not be idiopathic.

For more information see www.acc.co.nz/assets/provider/c412d2e413/ACC7822-cover-allergic-reaction.pdf

Image anaphylaxis signs



Allergy New Zealand (2011). Allergy and anaphylaxis guidelines 2011. Retrieved from <http://www.allergy.org.nz/site/allergynz/files/Allergy%20and%20anaphylaxis%20guidelines%20-%20green.pdf>

Life-threatening signs and symptoms

Airway	<ul style="list-style-type: none">• swelling of tongue,• difficulty talking and/or hoarse voice• swallowing difficulties	
Breathing	<ul style="list-style-type: none">• difficult/noisy breathing• wheeze or persistent cough	
Circulation	<ul style="list-style-type: none">• pale and floppy (young children)• shock (pale, clammy)• persistent dizziness• collapse• loss of consciousness	

Other signs and symptoms

Skin	<ul style="list-style-type: none">• hives• welts• swelling of lips, face, eyes	
Gastrointestinal	<ul style="list-style-type: none">• abdominal pain• cramps• diarrhoea• vomiting	
Nervous System	<ul style="list-style-type: none">• anxiousness• confusion• agitation	

Conference report:

Erica Donovan



There's nothing I love more than learning and telling stories. You might think that nursing has little to do with stories, but really aren't we always telling the stories of patients and their experience?

This was part of my motivation to apply as a speaker for the paediatric conference 'Don't Forget the Bubbles'. For those of you not familiar with their work, [Don't Forget the Bubbles](#) are a group of Doctors who both run an annual conference as well as put out regular professional development articles about paediatric medicine. I was delighted in late 2018 that they accepted me to speak in London in June this year at their conference.

My work centered on the late effects of childhood cancer using te whare tapa whā as a model. The work also involved surveying young adults and I weaved their stories throughout. It was really nerve-wracking preparing

The other reason I wanted to speak was that I think it's really important for the nursing voice to be heard. In a conference dominated by doctors, I wanted to speak, to be heard.

The conference was amazing, to be surrounded by such knowledge really opened my eyes to the difference aspects of child health. There's a lot of interesting research coming out of Australasia at the moment, and sadly it takes several years for most knowledge to come in to everyday practice. The conference gave us thoughts about how we can decrease this and talk to others in our workplaces about new developments. We also heard

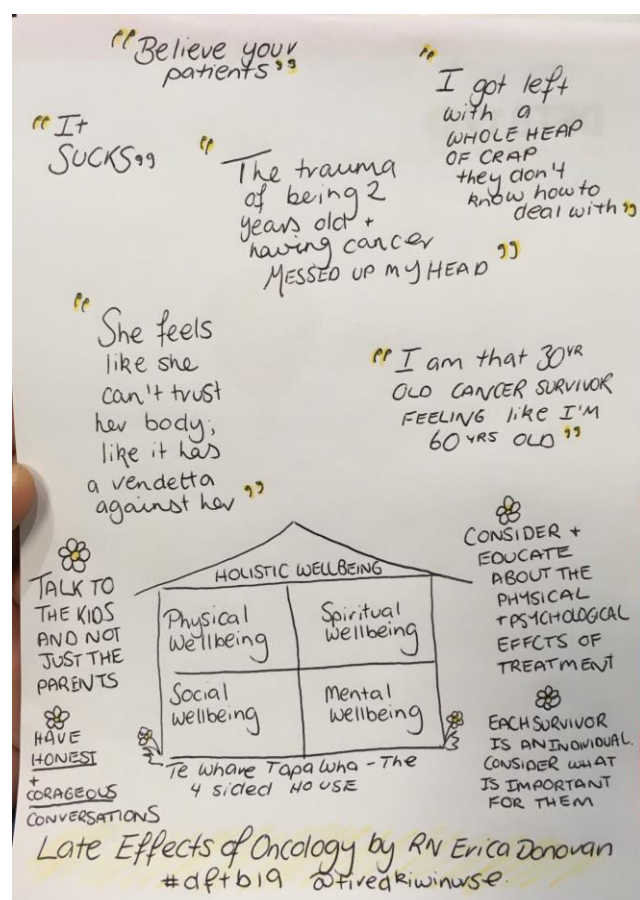


from speakers who spoke on social issues, such as initiatives to curb the rising knife crime wave currently hitting the UK, and what it is like being a parent of a child diagnosed with a life altering diagnosis.

From bronchiolitis to burns, there was such a varied range of topics it was hard to choose which sessions to go to.

The first concurrent session I choose was about paediatric assessment – dehydration, sepsis and respiratory issues. As a nursing working with a large paediatric population these issues are cornerstones of what I do every day during triage and treatment. These advanced assessment skills will allow me to better make triage decisions, resulting in optimal care for patients. Another session that had an impact on me was about eczema management. This is not only an issue that is seen frequently within the paediatric environment, from triage to nursing clinics, but this session

was also presented by a Clinical Nurse Specialist.



Other sessions were more philosophical, looking at quality improvement measures we can make within hospitals such as the NHS Rainbow Badge programme, how to deal with burnout or how to deal with patients who keep re-presenting.

Some sessions really pushed me to the edge of my comfort zone, allowing me to think critically about issues such as anorexia, sexually transmitted infections in youth (and younger), and how to deal with young people who are victims of violence. These things are not easy fixes

as the speakers emphasised, but there was helpful information given, and a chance to reflect on your own practice.

I was also able to see some of the technology that will hopefully filter into New Zealand hospitals in the coming years. Realistic paediatric and neonatal simulation models could be played with, they provide an experience closer to the real thing.

Right down to being able to find veins, and be used as a tool to learn intubation. They also connect to software which is more advanced than what I have seen in New Zealand, providing better feedback on things like oxygenation while you use a bag mask on the 'patient'. An added bonus of the trip was that it also allowed me to see a different health system. I was able to reach out to one of the local health services and have a tour around their hospital. As we both have socialised medicine in New Zealand, we are often compared to the NHS in England, but there are many differences, but also

many similarities. I was able to see one of their new ways of working with patients that require 1:1 care (either from a nurse or healthcare assistant) and how they are working to identify those who are doing that care so they're not taken away from their work to do other tasks.

I was impressed about the amount of play therapists their service has and how they are extending their hours to allow more children to benefit. In terms of Emergency care, they are facing similar issues over increased patients, acuity and staffing. But also have the added challenge of adult only trained nurses needing to look after paediatric patients.

I couldn't write this article without acknowledging how I got there. As someone who doesn't have a work budget for professional development like many doctors, it wouldn't have been possible without the support of NZNO. Grants from NERF, Canterbury Regional Council, as well as the support of fellow members. If an opportunity to attend or present at a conference comes up don't hesitate to apply, and to write in for scholarships if you need them. Head to the NZNO website and there's a list of funds you can apply for.

Community Stomal Therapy Nursing

*Counties Manukau Community
STN team*

Community Stomal Therapy Nursing is governed by the Ministry of Health specifications. In Counties Manukau DHB, the Stomal therapy service provides specialised care to 710 people with stomas, with an FTE of 1.8 clinical specialist nurses. The service works closely with the inpatient settings within the DHB as patient's transition from hospital to home. Our service covers all community settings, home, private care, schools, correctional facilities, GP practices and clinics.

No two days are the same in the life of a Community Stomal Therapist! We cover the lifespan, from neonates through to centenarians. People undergo stoma forming surgery for a number of reasons such as cancer, inflammatory conditions, congenital and trauma. With that, comes a raft of emotions, potential complications from the acute through to the long term stages and the effects on family and friends. People are active within

the community service for the duration of their stomas, this maybe 3 months or lifelong. Once they are in the service, we take referrals from many sources such as patients, GP's, specialists and district nurses.

On a day to day basis, our service sees people in their homes and community clinics for on-going pouching solutions (people regularly start on one and change for any number of reasons), troubleshooting, assessing hydration and nutritional status, the stoma, output and peri-stomal skin conditions. We provide hernia prevention education, engaging back in to day to day activities such as exercise. Assess emotional status, coping and support systems and refer appropriately. Assess ADL's and refer to appropriate health discipline.

Another large aspect of our role is education for our colleagues, carers and anyone else directly involved with a person with a stoma. Our service provides

onsite education as well as running 3 education days a year that are open to everyone. We write guidelines for patients and staff to use and distribute, such as dietary and district nurse home visiting guidelines.

Photo on next page:

Dawn Birchall (Left)- I have been working as a Registered Nurse for over 30 years since graduating in 1987. Having an interest in surgical nursing, I trained as Stomal Therapist in 1996. The bulk of my nursing career has been spent working in the community which I greatly enjoy.

Emma Ludlow (Middle)- I have been a Stomal Therapist for 5 years, 3 of them with Counties. My background is surgical nursing, having worked at multiple hospitals across Auckland, South Australia and the Northern Territory. I get a lot of satisfaction working with patients and seeing them gain confidence and making their life

with a stoma rather than letting it control them.

Erica Crosby (Right)- I have been nursing for 24 years, the majority of them being at Counties Manukau. My background is in surgical nursing. I completed the Postgrad Cert in Stomal Therapy in 2001, and have been in the role of community Stomal Therapist at Counties for 12 years.



Nelson- Marlborough Forum Report

Yvonne Little

Nurse Practitioner

On the 29th and 30th August the New Zealand College of Primary Health Care Nurses held their combined Professional Practice, LOGIC and Executive Committee meetings and on the evening of the 29th a Forum and AGM in Nelson for the Nelson-Marlborough region members. The report and photos that follow will give you an idea of what a great meeting this was.

What a fantastic view flying in, the weather whilst we were there didn't disappoint either.



So, thank you Nelson for the warm welcome and the sunshine, the friendly people from those we met at the

airport, those we met on the streets when we were out getting our meals and of course the wonderful ladies who attended the Forum evening.

The theme for the evening was Immigrant and Refugee Health, we had some wonderful speakers.

The Immigrant and Refugee Health part of the forum started with an interactive session lead by Sheryl Hockey, an exercise to get us thinking about our

knowledge around refugees and settlement in New Zealand and the regions who take these refugees in.



Sheryl was followed by Barbara Whittaker and Deirdre Magee about working alongside refugees in their respective areas of expertise. Barbara informed us about how refugees are selected to be settled in New Zealand, explaining the resettling process from their arrival in Auckland where they have mandatory health checks and general education as well as education on New Zealand laws. For refugees to get NZ residency they need to be here for 5 years and not to have broken the law. The resettlement process includes Red Cross caseworkers (all of whom are former refugees) working with the new refugees for 12 months, the refugees are provided with fully furnished homes and access to benefits and accommodation supplements and re-establishment grants for fridges and washing machines.

Deirdre Magee from Victory Square Pharmacy gave a very



For a very emotional read I suggest you take a look at Zember's story which can be found at

www.huaypukeng.com/mulo_1

. The picture on the left of the screen is Zember in her national attire.

We were given some invaluable pointers on how to work with interpreters. I feel this would be good for anyone who is dealing with interpreters.

informative session from the pharmacist/pharmacy perspective.

As we all know communication is important in life, but even more so in healthcare where there are conditions and medications to understand. In 2013, Deirdre and the team at the pharmacy identified a need for a better service for refugees, she discussed this with the Red Cross who advised getting an interpreter service working, which she managed to do with the help of the PHO and DHB, the DHB continues to support the pharmacy in their endeavours.

The service provided is patient centred and based at the pharmacy with flexibility to provide the health needs of refugee patients. The pharmacy does the regular pharmacy work but also links in with Public Health Nurses (initially for treatment of TB), Social Workers and GP practices. The pharmacy helps these refugees

with making appointments, pre-admission paperwork (even those whose first language is English struggle with these forms), and provide explanations of medical conditions and medications through their Interpreter Zember. Deirdre also discussed the Pharmac Equity Project around Access to Medications and considering medications she went through the complexities of health issues, monitoring of medication levels and informed consent.

Deirdre and her team are true innovators and it would be wonderful to see their approach and innovative ideas be rolled out nationwide. This is helping to improve the inequity to access gap for refugees.

Zember's attends appointments with refugee patients as their interpreter as she speaks several languages, some of which are very obscure and not widely known.

1. Positioning is key: sit in a triangle shape in consultation, this allows ease of interpretation as you can see both the patient and the interpreter.
2. Feedback: always ask for this throughout the consultation to ensure the message is getting through.
3. Give small amounts of information at one time
4. Speak slower than you would for an English-speaking person
5. Appointment times: always allow extra time – if you think the appointment will take 30 minutes then plan for it to take an hour.
6. If possible, pre-brief the interpreter
7. MOST IMPORTANTLY: Always speak to the

patient not the with the work started by our
interpreter. wonderful speakers.



College Representatives. These are available on our website.

We then called for nominations for vacant committee positions and I am pleased to say that all the vacancies were filled on the night. So, we welcome aboard our new committee members.

Nicola Thompson – Executive committee

Melanie Terry – Professional Practice committee

Bridget Wild – Professional Practice committee

Lee-Anne Tait – LOGIC committee

Helen Parry – LOGIC committee

Anne-Marie Ballagh – LOGIC committee

We also presented the Tall Poppy Award to a very surprised Melanie Terry who was nominated by Jill Clendon, please see Melanie's article which is presented in this edition of LOGIC.

This was such a good interactive session with plenty of questions which were expertly fielded that Sheryl was unable to present her case study but we are aiming to bring this to you in later edition of LOGIC.

The meeting also included AGM, voting on remits is now done online due to the difficulty of getting enough members in one room at the time for voting due to our growing membership.

Minutes of the 2018 AGM were



The feedback from the floor from this session was the desire and need for training of staff in medical centres to continue on

tabled, alongside reports from the Chair, Treasurer, Professional Nursing Adviser, LOGIC, Professional Practice Committee, and External



Whilst, we were not able to present the Nurse New to Primary Health Care Award in person to the award recipient Donna Auld, Kelly Robertson, Professional Practice Committee Chairperson read the nomination provided by Annie Tyldesley. We will have Donna's article on her award in our Summer Issue for you.

A wonderful meal was had by most of the committee members at a lovely restaurant along with Deirdre and Zember.



Tall Poppy Award

Melanie Terry

Receiving this award was a total surprise. I sat and listened to the award for the Nurse new to Primary Health Care and thought it was so nice that new nurses are being recognised. I then listened to the tall poppy award criteria and was very surprised when I heard my name. My manager Dr Jill Clendon nominated me for which I am very thankful. The project she talked about in the nomination was the development of the Trial Removal of Catheter (TRoC) in the community initiative.

This came about from my time as a District Nurse working on the road. I met several people who had attended the Day Stay Unit in the hospital to have their TRoC as per the Nelson Marlborough Health protocol. The catheter insertion was usually following, trans urethral resection of the prostate (TURP) or urinary retention caused by constipation, infection or post-surgery, but excluding Radical Prostatectomy.

Often, I would hear stories from patients that reflected their frustration of having this procedure in a hospital setting.

"My husband never drinks cold water and they gave him a jug of ice – he was never going to drink enough".

"I was so nervous and I just could not PU in that hospital toilet".

"I drank so much that I felt that I had just overloaded myself"

"Having to be at the hospital so early in the morning was really stressful".

I therefore started liaising informally with the urology nurses, Day Stay Unit CNM and urologists and we began managing the simplest TRoC in the community – even if this was unsuccessful, the patients felt happier with the process.

With the increasing pressures on hospital beds the specialist urology nurse and I began the formal process of creating a referral that guides all TRoC's. We researched other DHB's TRoC processes and discussed our ideas with the Urologists, they were fully supportive. We devised our 'Referral Form for Trial Removal of Catheter', excluding gynae, as the Gynaecologists were not part of



the process. We presented our ideas at the Health Innovation Awards and received support from Clinical governance to progress further.

District Nursing service purchased a bladder scanner and we are now seeing non-complex patients either in their own homes or at our clinic for TRoC. The referral is colour coded and clearly outlines the pathways for referral depending on diagnosis.

So far I have not met one patient who meets the criteria for TRoC in the community and is wishing to have the procedure in the hospital setting.

We are just beginning to collect data that will hopefully reflect the success of this initiative and the patient feedback will inform any changes for improvement.

Whakamana te tamaiti: Practice empowering tamariki Māori

Nikki Beazley

Māori continue to be over represented in the care and protection system. Although only 15% of the population, Māori were 61% of the children in the custody of the Chief Executive of Oranga Tamariki as at March 2017, which is a 9% increase since June 2012. Applying another measure, in June 2004 Māori were 39% of the children in out of home care. By March 2017, the proportion had risen to 61%, a 22% increase over a 13-year period. The Māori population is predicted to increase by five per cent to nearly 20 per cent of New Zealand's population in 2038. In the absence of real change, the number of Māori children in care will continue to increase. This is heart-breaking and an affront to many principles held dear to in Te Ao Maori including within our tikanga. The law is being amended to help reverse these experiences for Maori

1 July 2019 saw a significant number of amendments to the Oranga Tamariki Act 1989 (formerly Children, Young Persons, and Their Families) new section 7AA of the Act states that there are specific duties imposed on the Chief Executive of Oranga Tamariki in order to "recognise and provide a practical commitment to the principles of the Treaty of Waitangi (te Tiriti o Waitangi)." The CE is tasked with ensuring that all policies' and procedures have regard to mana tamaiti and the whakapapa of Maori children and young persons and the whanaungatanga responsibilities of their whanau, hapu, and iwi.

Oranga Tamariki have been tasked with making a commitment to work differently by providing the opportunity for innovative proposals to improve outcomes for Maori children, young persons and their whanau. From these proposals will come set expectations and targets which will allow for



robust regular conversations between all organisations and Oranga Tamariki.

Tamariki, whānau, hapū and iwi have told us that we need to understand, engage and work with them in order to achieve better outcomes together. As indigenous and bi-cultural practitioners we have a responsibility to build genuine and respectful relationships with whānau, hapū, iwi and the wider Māori community that acknowledge their expertise and enable their full participation in decisions about their tamariki

Whakamana te tamaiti is an approach to practice which focuses on empowering tamariki Māori in their identity and culture. This includes connecting them with whānau and whakapapa and wider support networks that support their wellbeing. We need to be identifying strengths, needs and attributes in order to provide a positive experience and enhance their mana.

Te Tiriti o Waitangi underpins the bicultural partnership between Māori as tangata whenua and tauwi in Aotearoa. As practitioners, we have obligations to work in partnership with Māori in ways that support their participation and protection as indigenous people in matters that concern them.

For tamariki Māori their identity and belonging is embedded in te reo Māori me ōna tikanga (the language, beliefs, values, practices, ancestral stories etc) it is important to include. Strengthening their sense of belonging and identity requires us to ensure that they have real opportunities to access knowledge and activities that promote te reo me ōna tikanga and their whānau connections. This knowledge and these activities help te tamaiti to understand roles and learn behaviours that help them to engage with, and practice tikanga.

To help support this kaupapa, Oranga Tamariki in partnership with others have introduced a Maori Cultural Framework. This framework is a starting point for us to better engage with and respond to our iwi and Maori partners, whānau and tamariki. It will evolve and grow as we mature as an organisation. It gives understanding and

context to our decision making and will guide us to deepen our understanding of key Māori values, practices, concepts and events that have impacted Māori.

To help support this learning and build confidence Oranga Tamariki have created an app called Te Kete Ararau. This app has all the framework information in it, and you can listen to pronunciations, create your pepeha, learn waiata and much more!

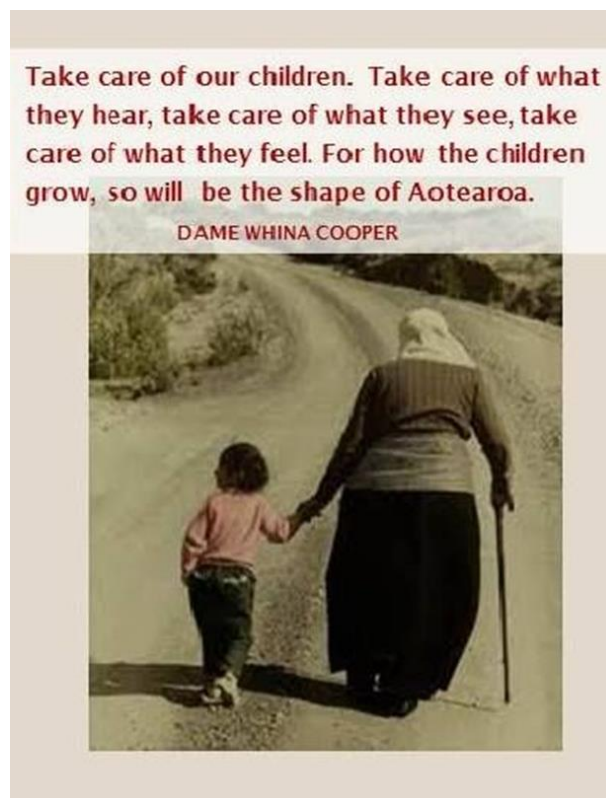
It's available to download for free from the app store, for both Apple and Android devices - just search for 'Te Kete Ararau'.

We will know we are getting it right when engagement is

tamariki and whanau feeling safe, so they are able to speak out. We will observe through this process that the quality of our engagement is impacting positively through seeing more whānau, iwi and cultural services at the table.

With encouraging whanau to own their plan by identifying their strengths, attributes and needs these plans will support tamariki and whanau to be able to participate in their culture, customary practices and language, to experience appropriate support and responsive services which meet their needs.

<https://orangatamariki.govt.nz/assets/Uploads/Documents/Te-Kete-Ararau-app-instructions.pdf>



strengthened shown by a growing confidence in

App: Pain Assessment in Older People.

Erica Donovan

Recently, I've been working with some students within an aged residential care (ARC) care facility, and the topic of pain came up. This is something I'm hugely passionate about, for both professional and personal reasons. As a nurse, seeing a patient in un-treated pain makes me feel upset, we might not be able to eliminate pain completely, but we can get the patient to a more comfortable level.

Pain is a protective mechanism, acute pain can be telling us we have a tooth abscess, a broken bone, or we've got something doing on with an internal organ. Absence of pain can be an unrealistic goal for someone with a chronic disease, but it can also be dangerous.

I'm sure we've all heard stories about the diabetic patient who walked around with a nail in the foot. I've seen that before, the patient thought it could have been there for a whole day.

A student asked me, how would I know if they were in pain if they don't speak?

This is a tough issue to get around for beginning practitioners (and even the experienced ones) how to we know what pain relief to select, or how it has worked?

I had experience in paediatrics, where I used the FLACC scale for young children, the Wong-Baker faces scale for older children and numerical scale for those who were better able to articulate their pain. But to be honest, in other areas I'd practiced in, the majority of the older adults were verbal and able to articulate their pain.

(Retrieved from El-Sharkawi, H. F., El-Housseiny, A. A., & Aly, A. M. (2012). Effectiveness of new distraction technique on pain associated with injection of local anesthesia for children. *Pediatric dentistry*, 34(2), 35E-38E.)

And that is what lead me to this phone app.



The app basically functions like a flow chart, asking you to answer a set of questions about a patient in front of you and giving you pain scores. There's options for both verbal and non-verbal patients.

Can the patient communicate successfully? If so, you're directed to a numeric interactive sliding scale, and a question on rating the pain from absent to severe. Then you're directed to what to do from there including taking a full history, exam, and considering referral.

My only bug bear with this, is that it doesn't suggest different options based on the score that you select. 8/10 pain might be needing more prompt actions that 1/10.

The other pathway I would say is the more useful one, and where I learnt the most, and can see that most nurses would gain value from.

If you select the option that the patient is non-verbal it brings up information about the Abbey pain scale, which is ranging from

0-14 taking into account of several factors. The app is really good at giving you examples of what these behaviours might be.

forget about the issues of acute on chronic pain. It also reminds you to check with people are familiar with the patient, and consider comfort measures that aren't pharmaceutical.

accepted by some patient groups.

Worth downloading?

Yes, but you can also get the same information and put it on a lanyard card for handy use.

Bonus is, that the app is free to use, so no money lost if you find it's not helpful and delete it. Available on IOS (apple). If you have an android it looks like there's similar options out there, or you could try MDCalc medical calculator.

Category	Scoring		
	0	1	2
Face	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant quivering chin, clenched jaw
Legs	Normal position or relaxed	Uneasy, restless, tense	Kicking or legs drawn up
Activity	Lying quietly, normal position moves easily	Squirming, shifting back and forth, tense	Arched, rigid, or jerking
Cry	No cry (awake or asleep)	Moans or whimpers; occasional complaint	Crying steadily, screams or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging or being talked to, distractible	Difficult to console or comfort

The six questions take into account the factors listed below, and you can rate on a scale from absent to severe much like the app offered in assessing a verbal patient.

- Vocalising
- Facial expression
- Body language
- Behaviour
- Physiological changes
- Physical changes

The app then generates a pain score, from 0-14, and also asks if the pain is acute, chronic or acute on chronic. I really like that they acknowledged this, since I think a lot of people

So how user friendly is this app, and would I use it in practice? I think it could be useful for a tool to pull out when writing your notes, or handing over to a doctor about the pain level. I think it's especially good for beginning practitioners, or those who have moved into a clinical environment that frequently sees older adults who aren't verbal for one reason or another. I couldn't bring myself to use it to pull out my phone and use it in front of patient at the bedside or in a public area. Maybe that time will come, but personally I don't feel comfortable using it when phone use still isn't fully

Total Pain Score

13

Select type of pain:

Chronic Acute Acute on chronic

Back Next

Back Pain Thermometer Home

Q: How severe is your pain today?

Most severe pain imaginable 10

Pain **6**

No pain at all 0

Absent Mild Moderate Severe

Continue

Food safety for spring

Erica Donovan

Just as we've gotten through (most) of the winter bugs, spring and summer bring with them new challenges - food and waterborne pathogens, both here in New Zealand or via overseas travel. Obviously, these diseases can happen any time of year, but as temperatures rise, as people eat outside or undertaken outdoor activities, there's more risk of picking something up. For a more in-depth discussion around travel health, see LOGIC 2019 Winter Edition.

Symptoms of food and water borne illness

The symptoms of food borne illness can vary, but generally they commonly include diarrhoea (can be with or without bleeding present), vomiting, aches and fevers. From these symptoms differential diagnoses can consider things like gastritis,

irritable bowel syndrome, or systemic infection (Bpac, 2014, p. 18-20)

Common pathogens



overall cases. (Ministry for Primary Industries, 2019, p.21)

Symptoms of campylobacteriosis can include loose stools which may contain

Table 5. Estimated proportion and incidence of the main foodborne diseases for 2018

	Total notified		Estimated foodborne transmission ^a		
	Cases	Rate ^b	Cases	Proportion (%) ^c	Rate ^d
Campylobacteriosis	6957	142.4	3826	63.8 (44.1-83.2)	78.3 (54.1-102.1)
Cryptosporidiosis	1611	33.0	NE	-	-
Giardiasis	1585	32.4	NE	-	-
Hepatitis A	68	1.4	NE	-	-
Listeriosis	30	0.6	25	87.8 (57.9-98.5)	0.5 (0.3-0.6)
Salmonellosis	1100	22.5	417	62.1 (35.2-86.4)	8.5 (4.8-11.9)
Shigellosis	219	4.5	NE	-	-
STEC infection	925	18.9	236	29.9 (3.5-60.7)	4.8 (0.6-9.8)
Yersiniosis	1202	24.6	718	63.2 (29.0-91.5)	14.7 (6.7-21.3)

NE = not estimated, no information is available on the food attributable proportion in New Zealand.

^a For estimation of food-related cases the proportions derived from expert consultation [2] exclude travel-related cases.

^b Rate per 100,000, mid-year estimated population.

^c Most likely (95th percentile credible interval) estimates of proportion foodborne, from expert consultation.

^d Most likely (95th percentile credible interval) estimates of foodborne rate.

Campylobacter:

Campylobacter is the most common reported food and waterborne illness in New Zealand. In 2018 there were 6957 reported cases, and from those almost 800 required hospital admission. The most affected age group were those between 20-29 years of age, who made up 15.1% of the

blood, crampy abdominal pain, nausea, fever, muscle pain, headache, and vomiting. It is a notifiable disease, so if you come across a case there is a form to fill in, which allows contacts to be traced and asks about travel and occupation. Although we may see cases in New Zealand, the burden of disease is not as great as in foreign countries. The World Health Organisation reports that every year, almost 1/10 people fall ill from

campylobacter, leading it to be one of the most common bacteria implicated in the development of gastroenteritis (World Health Organisation, 2018). However, food preparation is not solely responsible for all these cases. There is also a role to play within the areas of waste management, and meat processing industries.

Cryptosporidium

ESR data New Zealand data show that the number of cases every year typically rises during the months of spring, and most commonly within the South Canterbury, Nelson Marlborough and Tairāwhiti District Health Board areas. The top four ways implicated in transmission in ESR data was farm animals, consuming untreated water, recreational water contact and consuming food from a food premises (Institute of Environmental Science and Research Limited, 2019, p. 16). Efforts are being undertaken to develop a vaccine, but currently the idiosyncrasies around development of immunity are not yet fully understood (Checkley *et al*, 2015).

Salmonella

This bacterium lives commonly in the gut of humans and animals and can be passed from

humans to animals. In usually health individuals, symptoms are generally mild, and will settle with without treatment, however there is concern when the illness is contracted by those who are immunosuppressed or those are susceptible to dehydration (World Health Organisation 2019). When most people think of animal transmission they commonly think of raw chicken in the kitchen. However, pets such as turtles, cats, dogs and domesticated birds may also be carriers (Center for Disease control and Prevention, 2019).

Giardia

Giardia is a parasitic infection, which causes symptoms for those who ingest cysts present in contaminated food or water (Center for Disease control and Prevention, 2015).

Those who are planning tramping or camping trips need to be careful around management of human waste, ensuring that this is disposed of in a toilet or buried away from bodies of water. People also need to think carefully about drinking water from rivers, lakes or streams. Either avoid this or boil and filter the water to ensure it is safe to drink.

Here's a [link](#) to information around keeping healthy outdoors that can be given to

patients who may be heading out this summer.

Hepatitis A

Hepatitis is a broad term for inflammation of the liver, from hepa meaning liver and -itis

referring to inflammation. Common symptoms center around jaundice, abdominal pain, fever, lethargy and pale coloured faeces (The Hepatitis Foundation of New Zealand, n.d),

The outlook for those who contract Hepatitis A is different to those individuals who have contracted hepatitis B or C, the A form is largely self-limiting. There is also a vaccine that can be given, either alone or in combination with typhoid. These are not currently on the immunization schedule, but can be done for those who request it, either within General Practice or at a specialist travel medicine clinic.

Canterbury District Health Board has an interesting [report](#) on an outbreak reported in 2013 in Ashburton, centered around travel and contracting hepatitis A overseas and then the subsequent spread to the small Canterbury town. Vaccination clinics were set up, and at-risk preschool children were offered vaccination to prevent the spread.

At risk groups

Often when people think of who is at risk of foodborne illnesses, they think of those that are pregnant and the dietary advice commonly given. If you work in general practice, then there's information in the Bounty Packs that are commonly given to newly pregnant people around food safety. There's also lots of information around from the Ministry for Primary Industries and the Ministry of Health that you can direct patients to.

However, there are several other groups that are particularly vulnerable. These include:

- People with cancer
- People who have HIV/Aids
- Individuals with Inflammatory Bowel Disease
- People who are neutropenic
- Are post-transplant
- Taking immunosuppressant medications
- People who have low stomach acidity
- The elderly
- Premature babies
- Children with serious illnesses

(Ministry for Primary Industries, 2018, p. 2)

Remember the 3 Cs – Clean, cook, chill.

Obviously, prevention is better than cure. If those who are preparing food, either within the home, or commercially are educated around food safety then that can go a long way to decreasing risk of outbreaks.

Clean

First off in the cleaning section, is something that will be familiar to all nurse.

Hand hygiene, hand hygiene, hand hygiene! We need to be making sure bacteria is not transmitted to others. We need to be keeping ourselves and others safe, so education for the patient and whanau is incredibly important.

Other things that can harbor infection would be kitchen cloths and sponges, cutting boards, knives and things used to store food. Ensure that cross contamination does not occur, by using separate utensils and storage for cooked and uncooked meat.

Obviously, not all foods are eaten cooked. Make sure that produce is washed in safe drinkable water before consuming.

Cook and chill

Pathogens each have their own variable temperatures they thrive in or are killed by. The

World Health Organisation recommends that food should be heated to over 60 degrees Celsius, then chilled below five degrees. It should also be covered, even when in the fridge or freezer (World Health Organisation, n.d).

Avoid foods that have been sitting at room temperature for long periods of time. If eating out, need to ensure that the food is freshly cooked. At risk locations for food borne illnesses include picnics, delicatessens and buffets. If looking around markets, check if food is heated to order or if it is batch cooked and left to sit.

Safe barbecuing

- Make sure your barbecue and cooking tools have been cleaned with soap and water before using.
- Have separate utensils, plates and other equipment for raw and cooked foods – using just one set will mean you transfer pathogens from raw meats to cooked foods.
- Don't place or prepare raw meat on the grill next to cooked or partially cooked meat or other ready-to-eat foods.
- Precook chicken, sausages and minced

meat, then barbecue until meat is steaming hot (over 75 degrees Celsius) all the way through.

- Turn food regularly so that it cooks evenly.
- Marinate meat in a covered container in the fridge and cook the marinade before pouring it over cooked foods.
- Keep all food covered and cool until ready to cook or eat.

(Ministry for Primary Industries, 2019b).

References:

Bpac NZ. (2014, February) *Rural infections series: Investigating and managing people with diarrhoea*. Author.

Center for Disease control and Prevention. (2015). *Parasites – Giardia*. Retrieved 10 October, 2019 from Center for Disease control and Prevention website: <https://www.cdc.gov/parasites/giardia/infection-sources.html>

Center for Disease control and Prevention. (2019). *Salmonella*. Retrieved from <https://www.cdc.gov/salmonella/general/technical.html>

Checkley, W., White, A. C., Jr, Jaganath, D., Arrowood, M. J., Chalmers, R. M., Chen, X. M., ... Houpt, E. R. (2015). A review of the global burden, novel

diagnostics, therapeutics, and vaccine targets for cryptosporidium. *The Lancet. Infectious diseases*, 15(1), 85–94. doi:10.1016/S1473-3099(14)70772-8

The Institute of Environmental Science and Research Ltd. *Notifiable Diseases in New Zealand: Annual Report 2017* Porirua, New Zealand

Ministry for Primary Industries. (2018). *Food safety when you have low immunity*. Wellington: Author.

Ministry for Primary Industries. (2019a). *Annual report concerning foodborne disease in New Zealand 2018*. Retrieved from <https://www.mpi.govt.nz/dmsdocument/36771-annual-report-concerning-foodborne-disease-in-new-zealand-2018>

Ministry for Primary Industries. (2019b). *Tips for food safety*. Retrieved from <https://www.mpi.govt.nz/food-safety/food-safety-for-consumers/tips-for-food-safety/>

The Hepatitis Foundation of New Zealand. (N.d). *Hepatitis A*. Retrieved from <https://www.hepatitisfoundation.org.nz/hepatitis/hepatitis-a>

World Health Organization. (2018). *Campylobacter*. Retrieved from [https://www.who.int/news-](https://www.who.int/news-room/fact-sheets/detail/campylobacter)

[room/fact-sheets/detail/campylobacter](https://www.who.int/news-room/fact-sheets/detail/campylobacter).

World Health Organization. (n.d). *Five keys to safer food*. Retrieved from https://www.who.int/foodsafety/publications/consumer/en/5keys_en.pdf?ua=1

World Health Organisation. (2019). *Salmonella*. Retrieved from [https://www.who.int/en/news-room/fact-sheets/detail/salmonella-\(non-typhoidal\)](https://www.who.int/en/news-room/fact-sheets/detail/salmonella-(non-typhoidal))

Top ten tips for making immunisations a positive experience for life

Jane Sayers, Natal Care NZ

Dr Amy Baxter

Dr. Baxter, Paediatric Emergency Physician and Pain Researcher set out to develop a reusable product to help control the pain of needles. After graduating from Yale University and Emory Medical School, as a double boarded Paediatric Emergency Physician, Dr. Baxter founded PEMA Emergency Research, Scottish Rite, Children's Healthcare of Atlanta while founding Pain Care Labs. Recognition includes Forbes Ten Healthcare Disruptors, Inc. Top Women in Tech to Watch, Top 10 Innovative and Disruptive Women in Healthcare, a Wall Street Journal "Idea Person", and the Most Innovative CEO of 2014 from Georgia Bio. National and international lecturing highlights include MakerFaire, AARP, and TEDMED.

THE RISE OF NEEDLE PHOBIA

No one enjoys getting injections. And yet, over our lifetime there will likely be numerous times when our health will require a medical procedure that involves a needle; whether that's immunisation, a blood test or delivery of intravenous medicines.

Sadly, over the last 20 years, needle phobia has drastically increased; with one in four people suffering from the fear of needles. Perhaps more worryingly, it is believed one in 10 people will avoid vaccinations or needle procedures entirely, due to a fear of needles. This presents a significant challenge for the medical professionals whose job it is to protect us from serious, sometimes life-threatening illnesses.

Like many fears, needle phobia often originates from negative

experiences in our childhood. Which is why it is so important that we do everything we can to make vaccinations as comfortable and stress-free as possible.

THE CREATION OF BUZZY BEE

It was through personal experience of taking her own son for his routine vaccinations, that Dr Amy Baxter came up with the idea of Buzzy Bee; a playful and effective pain management tool, specifically designed to give children a positive experience when receiving those all important vaccinations.

As a medical professional, Dr Baxter was convinced of the need to protect her son from diseases and illness such as measles, mumps, rubella and polio. However, as a mum, she felt ill-equipped to protect him from the traumatic experience of being injected.

Baxter reflects on the irony, *"Every time we had to go to the doctor, my son would get physically ill. There I was, a paediatric physician and pain specialist, and I couldn't even protect my own kid. What were other parents going to do?"*

Motivated on both a professional and personal level, Dr Baxter spent time researching into solutions for reducing the pain and anxiety experienced during childhood vaccinations. As injections and the use of needles play a vital part in modern medical care, she wanted to equip both parents and medical practitioners with a tangible tool that would stop children from developing a fear of needles.

The results of Dr Baxter's research was the creation of Buzzy Bee, a small vibrating bee with cooling ice-pack wings that, along with other proven

pain management techniques, can help reduce injection pain by 75%.



TEN TIPS FOR REDUCING THE PAIN OF VACCINATIONS

So what are the techniques you can use to help children through uncomfortable procedures? How can Buzzy Bee help?

Here are our top ten tips for reducing the pain of vaccinations.

1. Knowledge is power

As it is the parent's responsibility to bring their children in for immunisations, empowering them to play their part during the procedure is going to lay the foundations for success. Any information given to them prior to the appointment, that outlines the procedure and what they can do to help their children have the best experience possible, will mean they arrive confident and calm.

2. Breastfeeding infants

Research shows that breastfeeding can have analgesic effects. Essentially,

the physical connection to their mother, the act of sucking and the sweet-tasting milk all help to reduce pain for the baby. For best results, the breastfeeding mother should start breastfeeding before the procedure and continue during and after the injections.

3. The power of sugar

For infants up to 12 months, who are not breastfed, a sucrose solution given 1-2 minutes before the injections, also has the potential to give pain relief. One approach to preparing a sucrose solution is to mix one packet or cube of sugar with 10 ml (two teaspoons) of water in a medicine cup. Alternatively, sucrose solutions can be obtained from some pharmacies. Again, if the parent or caregiver bringing the child to the appointment is given this information ahead of time, they can come prepared.

4. Honesty is always the best policy

Building up trust with patients is very much on the agenda, so lying to a child and telling them it won't hurt is not recommended. It may keep them calm before the first injection, but the inevitable pain will then come as a shock and the patient will have learnt that medical professionals aren't

honest with them. Equally, parents should be encouraged to be honest with their child for the same reason. The truth is, it will hurt a bit; but it's also true that it's over quickly.

5. The medical practitioner is not to be feared

Once the child and accompanying grown up arrives in the room, it's important to put them at ease. This is your patch, and you are in control. A friendly and happy medical professional will affirm the thought that this is nothing to worry about and certainly nothing to be fearful of.

Introducing Buzzy Bee to the young patient, gives you an opportunity to engage them in conversation and create a rapport with them.

6. Injection order

Generally, children will be receiving more than one injection during their appointment, and some vaccinations are more painful than others. Plus, pain increases with every injection. Studies have shown that, when multiple injections are required, giving the most painful injection last will decrease the overall pain from both injections.

7. Sitting up, not lying down

Research shows that infants and children sitting up during

injections is better for management of pain. Depending on the age and size of the child, helping them to get in a comfortable position whilst their parents hold them will mean the health practitioner is able to focus on giving speedy and successful injections.



As they are settling themselves on their parent's lap, you can help attach Buzzy Bee near to the injection area. For best results, Buzzy should be put into position 30–60 seconds before the injection.

8. Tactile Stimulation

Providing tactile stimulation reduces the sensation of pain. It has been proven that vibration and cold can block the pain of an injection, in the same way that rubbing a bumped elbow helps the pain go away or cold running water soothes a burn.

Buzzy uses a combination of cold and vibration to replace pain with temperature and movement. Buzzy confuses the body's nerves and distracts attention away from the pain, thereby dulling or eliminating sharp injection pain.

9. Distraction

We all know the pain is real, but it's fleeting and distraction away from the procedure can make it feel like it was over in a second. Studies show that when parents focus on subjects that aren't connected to the injection and try to make the child laugh, it's far more effective than when they sympathise and console. Using Buzzy Distraction Cards will help parents to stay away from the unhelpful topics.

With older children and teenagers, audio or visual devices provide effective distraction. This is one of those rare times when they should be encouraged to play on their iPhone.

Why not put together a distraction kit for your clinic, including: a Buzzy Bee, distraction cards, pop-up books, bubbles, pinwheels and party blowers.

10. Breathing Techniques

Slow, deep breathing exercises not only work as a relaxation strategy, if facilitated by toys or activities, for example blowing bubbles, blowing a pinwheel or party blowers, they also serve as a distraction by focusing attention away from the procedure.

Show the child how to “tummy breath”, taking a deep breath in and then blowing it out slowly.

Keep coaching the child to breathe deeply during the procedure.

LASTING MEMORIES

Once the injections are done, lots of praise will go a long way. Positive affirmation as the last part of the procedure is a great way to end.

By using a combination of these top ten tips for pain reduction, patients will remember the needle pain as only a small part of the procedure. With any luck, the lasting memories of immunisations taken into adulthood will be of Buzzy Bees and funny conversations.

For parents and medical practitioners who would like to buy a Buzzy Bee and Buzzy Distraction Cards, go to www.buzzy4shots.com.au or www.moosebaby.co.nz



An emphasis on primary healthcare at NZNO conference

Erica Donovan

As a nurse and union delegate for the past couple of years I have had the pleasure of attending several conferences and education days, and my bug-bear is always the lack of primary care emphasis. There's always a lot around the DHB services, the DHB MECA and as someone working in Primary Care I feel our struggles need to be heard, and our wins need to be celebrated. But this year things have been changing.

September 17th and 18th marked the NZNO Annual General meeting and national conference. This year I felt like the scope and diversity of roles within primary healthcare were promoted to all attendees.

The importance of primary healthcare was first seen with the awards on the Tuesday night, where several of the award honorees were from PHC areas. These included Dianne Noble, a Palliative Care nurse, Angelina Navamoka Hekenu, a nurse who has worked in Niue and New Zealand, and Gae Redshaw also working in Palliative care. Other areas

represented were care of older adults with Kim Brooks who works in aged residential care and Older Adults Nurse Practitioner and Auckland University staff member, Michal Boyd.

It was also heartening to hear many of the speakers working in primary health care who were selected to present at the conference. The first of these was Annalyn 'Ulunga who works at Mercy Hospice in Auckland. Annalyn described the way that their service aligns with those of the Tongan people.

One of the highlights for me was one of the keynotes speakers from Starship Community team, Registered Nurse Seletute Vave-Patterson. The nursing team works over five areas of Auckland, from Ragiototo down to Greenbay, Otatahu and Glendowie.

She presented some interesting case studies that involved rheumatic fever, and the management of enuresis. The role that their teams play in the

lives of children and whanau is fundamental. She is an example of a truly culturally safe practitioner, learning what she can from the families she works with and adapting to their needs. Often as nurses we're getting our patients to suit the needs of our service, and not the other way around.

Other presentations centered around the assessment of female inmates, and another around person centered care for the homeless population. The presentations truly fulfilled the theme of the conference 'Leaving No One Behind - Health For All'. Isn't that something we should all be focusing on every day in our practice?



Illuminating the lived experience of adults with needle fear or phobia.

Deb Batchelor

Introduction

As part of the AVME 785 Research Methods paper Deb explored the question of needle phobia and discovered a means of supporting people with needle phobias to get through the vaccination process having influenza vaccination. She now incorporates this method in her practice.

What is needle fear or phobia?

Needle phobia is often a lay term used to describe a fear of needles. Needle fear or phobia can have a two-pronged detrimental effect on individuals.

Firstly, needle fear can reduce an individual's likelihood to engage in healthcare and possibly not receiving preventative health measures such as vaccinations, diagnostic testing such as venepuncture, or receiving required medical treatments which involve the insertion of a needle.

Secondly, once an individual does engage in health care, they can experience a wide array of



Deb Batchelor, has a background in needs assessment, PHO education co-ordination and immunisation co-ordination. An occupational health business owner, Deb has recently completed her Diploma in Health Science (Occupational Health) through Otago University.

physical and emotional symptoms relating to their fear.

These responses can include; anxiety, hypertension, increased sensitivity to pain, fainting, excessive sweating and nausea. (Fernandes, 2003; Zambanini, Newson, Maisey and Feher, 1999).

How does it affect health outcomes?

Individuals experiencing needle fear are at risk of potentially experiencing poorer health outcomes by delaying detection and/or treatment of health conditions and not receiving public health interventions such as vaccines (Nir, Pas, Sabo & Potasman, 2003).

In the case of vaccine preventable diseases there is an increased risk of contracting infectious diseases not only by themselves but also their families and, for those working in health care their patients.

How big is this issue?

Needle fear or phobia is very common, with around one in six adults experiencing it. This can mean that receiving injections can be very distressing or in severe cases impossible.

A meta-analysis of fear of needles studies indicates that the prevalence of needle fear decreases with increasing age and that needle fear and needle phobia were more common in females.

Needle fear caused 16% of adult patients to avoid influenza vaccination. Interestingly the rate of hospital employees avoiding influenza vaccinations was higher at 27%, as was the proportion of workers at long-term care facilities at 18% (McLenon, Rogers, 2018).

The Ministry of Health has a goal in 2019 of 80% of healthcare workers receiving annual influenza vaccinations (IMAC, 2019). The high rate of needle fear or phobia will have

a significant impact on this goal being obtained.

What can we do to help?

Knowing that needle fear and phobia is having a significant effect on healthcare, what can we do to support those people who have this fear?

With the increased emphasis on delivery and reception of vaccines, how can vaccinators break through the fear barrier?

It isn't always apparent that our patients have needle fear or phobia but sometimes they do tell us they are scared.

Some of the tools used to help people with needle fear or phobia are:

- Visualisation-pretending you are somewhere else while receiving an injection
- Relaxation or meditation techniques
- Medications to reduce anxiety
- Exposure therapy- spending a lot of time around objects or in situation which causes anxiety in order to become familiar with them and reduce the anxiety.

Andrews and Shaw (2010) reported on strategies used in healthcare settings to assist people with needle fear or

phobia to cope with the healthcare events.

They found that "often spontaneous use of visualization techniques

involving a strong and varied emphasis on place ", was used by healthcare professionals. This is the strategy Deb is using now.

It is as simple as asking the patient where they would like to be, other than in the current clinical setting.

But for those people who don't tell us, how does a provider know the client has a needle fear or phobia, other than asking every person?

We must use our assessment skills and knowledge of behaviour to identify those who are afraid, and support them through the healthcare process using the strategies identified above.

Conclusion

Around one in every six adults suffer from a fear or phobia of needles. This can result in people missing out on preventative health care, such as vaccinations, and avoiding healthcare when they are feeling unwell.

If these individuals do present for vaccinations or procedures which involve the use of needles, they can experience

varying levels of anxiety and stress depending on the extent of their fear or phobia.

A positive experience for those people with needle fear or phobia, is likely to have a positive outcome for others, as humans often share their experiences with their friends and family.

The knock-on effect of this may be that people who would never have presented for vaccinations will, in fact, attend clinics and be able to receive health care which will benefit themselves and their families.

References

- Andrews, G., & Shaw, D. (2010). "So we started talking about a beach in Barbados": Visualisation practices and needle phobia. *Social Science and Medicine* 71, 1804-1810.
- Centre, T. I. (2019, April 12). <https://www.influenza.org.nz/>. Retrieved from IMAC-Influenza Information for Health Professionals: <https://www.influenza.org.nz/>
- Fernandes, P. (2003). Rapid desensitization for needle phobia. *Psychosomatics*, 44, 44-47.

McLenon, J. R. (2019). The fear of needles: A systematic review and meta-analysis. *Jan vol 75*, 30-42.

Nir, Y., Paz, A., Sabo, E., & Potasman, I. (2003). Fear of injections in young adults: prevalence and association. *American Journal of Tropical Medicine and Hygiene*, 341-344.

Smith, J., Harre, R., & Van Langenhove, L. (1995). Rethinking Methods in Psychology. In J. Smith, *Semi-Structured Interviewing and Quantative Analysis* (pp. 10-26). Lndon: Sage Books.

Zambanini, A., Newson, R.B., Maisey, M., & Feher, M.D. (1999). Injection-related anxiety in insulin-treated diabetes. *Diabetes Research and Clinical Practice*, 239-246.

New LOGIC

Committee member: Anne-Marie Ballagh

My role is currently Associate Charge Nurse Manager with the Nelson Marlborough Public Health Service – overseeing the Nursing Teams, Vision Hearing Screening Team, Sexual Health Services and supporting the Cervical Screening Team. I have been part of the wider Public Health Service in Nelson Marlborough, which is made up of Health Protection Team, Health promotion Team and the Primary Health Care Team for some time. Since May last year the Public Health Nursing Service has partnered with District Nursing Service as part of the Ambulatory Care Nursing Service. These are exciting times with the public health nursing purpose and focus taking a whole of population health approach by working collaboratively with many organisations from a range of sectors to improve the health and wellbeing of all members of the community (Te Uru Kahikatea). I believe that we have a duty of care to provide health interventions across communities with a focus on both achieving and reaching beyond equity as we support tamariki and whanau as they

work towards better health and wellbeing outcomes.

I trained many years ago at Christchurch Public Hospital and have nursed in various wards both there and here at Nelson Hospital. I have a Post Grad Diploma – Advanced Child and Family Health.

Nga mihi nui

Anne-Marie Ballagh



SCDHB Pertussis Cocooning Project.

Annie Tyldesley



In December 2011, the Primary and Community Services (PCS) of the South Canterbury District Health Board (SCDHB) launched a pertussis immunisation initiative, AKA a cocooning project.

Between May and December 2011, there had been more than 900 cases of pertussis nationwide, the majority being in the previous three months (PCS, 2011), and this formed the rationale for the initiative.

Pertussis is a bacterial respiratory infection (Figure 1), which is highly contagious (Figure 2), and can cause serious

complications including secondary infections, disabilities and death (Figure 3).

Evidence indicates that even amongst those previously vaccinated against pertussis, immunity wanes 4-6 years after the completed primary course of vaccination.

The cocooning project was intended to help control the outbreak and to reduce the risk to children under one year of age of contracting pertussis and, therefore, preventing the complications of infection and admission to hospital.

PCS adopted the recommendations made in the then current Immunisation Handbook and offered funded vaccination to those people who would be providing care to infants.

The target population was, therefore: Parents / caregivers, including family / whanau who may have a role caring for infants; hospital staff,

including midwives, paediatric staff, emergency department staff; primary healthcare staff; and, early childhood education staff.

How dangerous is pertussis?

Pertussis is highly transmissible and it is one of the most infectious vaccine-preventable diseases. The expected number of secondary cases caused by an infectious individual with pertussis (R_0) is approximately 14, similar to measles, and several-fold greater than influenza1 (see section 1.2.1). Transmission occurs by aerosolised droplets, and the incubation period is 7 to 10 days (range 5 to 21 days).

(MOH, 2018)

Figure 2

Vaccination was also offered to pregnant women, after 20 weeks gestation. The intention of this was to boost the mother's immunity before delivery and, therefore, offer passive antibody transfer infant prior to the six-week immunisation event. It would also reduce an infant's exposure

What is pertussis?

Pertussis (whooping cough) is a bacterial respiratory infection caused by *Bordetella pertussis*, a gram-negative bacillus. The bacillus is fastidious (it requires special media to culture), and will often have cleared or decreased in numbers by the time the typical cough develops, making laboratory confirmation by culture difficult.

(MOH, 2018)

Figure 1

to maternal disease (MOH, 2018).

It was not intended to replace on-time vaccination, but to compliment it.

Complications of Pertussis:

At the peak of the paroxysmal phase, vomiting can lead to weight loss.

The physical sequelae of paroxysmal coughing e.g. subconjunctival haemorrhages, petechiae, epistaxes, central nervous system haemorrhages, pneumothoraces and herniae.

Secondary infections, such as otitis media and pneumonia.

Of infants with pertussis sufficiently severe to require intensive care admission, one in six will either die or be left with brain or lung damage

(MOH, 2018)

Figure 3

The trivalent Boostrix vaccine, containing antigens for diphtheria, tetanus and pertussis was, and still is, provided free of charge to recipients. PCS funding both the vaccine and administration.

The local Immunisation Coordinators offered and provided a number of on-site clinics at early childhood centres and in the public hospital, to enable staff to access the vaccine without lost work time.

Primary healthcare staff offered vaccinations through general practices. Midwives were asked to offer information to their clients and encourage attendance at general practices for vaccination.

Has the programme been effective?

It has not been possible to calculate how many boostrix vaccines have been given over the last seven and a half years but PCS reported that 1203 vaccines were provided to general practices for use in this programme between July 2017 to May 2019.

This is an indication that the programme is still both popular and being promoted in primary healthcare and ante-

natal settings.

Since January 2018 there have been no suspected or confirmed cases in the South Canterbury DHB area and, therefore, no hospital admissions (PCS, 2019).

A review of the ESR surveillance data between 2014 and 2017 seems to indicate that the number of cases of pertussis in the South Canterbury area has remained low, despite numbers in other South Island districts rising and falling.

For example, in 2015 there were 236 cases in the Canterbury DHB region and 169 in the Southern DHB region compared to four cases in South Canterbury DHB (ESR, 2016).

Although the population of South Canterbury is lower than other areas, this still indicates a significantly lower number of cases.

The evidence indicates that the vaccine effectiveness for preventing laboratory-confirmed pertussis in infants aged under 3 months was estimated to be 91 percent (95% CI: 84–95) (MOH, 2017) which would indicate that vaccination is effective in preventing disease.

Conclusion

Pertussis is always with us, with peaks and troughs of infectivity in the NZ population. This vaccine preventable disease can cause serious harm and death to the most vulnerable in our communities (Figure 3).

In 2013 Boostrix was added to the national immunisation schedule for Pregnant women (weeks 28–38 of each pregnancy), 18 months after SCDHB started their programme. SCDHB continues to offer pertussis vaccination to people who care for infants.

The proposal by Propharma to change from the ADT to Boostrix

for general tetanus vaccination in 2020 is a positive step towards managing outbreaks in our communities and preventing this infectious communicable disease.

References:

Institute of Environmental Science and Research Limited (2016). Surveillance report notifiable diseases in New Zealand report 2015. Retrieved from <https://www.esr.cri.nz/>

Ministry Of Health (2018). Immunisation handbook 2017 2nd ed. Wellington: Ministry of Health

Primary & Community Services (2019). Personal communication.



MidCentral District Health Board Poster

Ongoing work to encourage people to look after their livers

Lynnaire Matthews

Helen Purcell

The Hepatitis Foundation of New Zealand works continuously to raise awareness of liver disease, collaborating with medical professionals to help people achieve positive health outcomes. As part of this work it has produced a series of online education videos to give health care professionals a valuable source of information about hepatitis B.

The videos were launched on July 26, just ahead of World Hepatitis Day on July 28. They aim to help health care professionals stay up to date with best practice developments. The videos are presented by Hepatitis Foundation clinical and nursing staff and cover various topics including understanding hepatitis B blood testing, priority groups for hepatitis vaccination, patient management and a history of chronic hepatitis B.



Lynnaire Matthews is one of the Hepatitis Foundation of NZ's Wellington nurses. Her role involves engaging with patients to help them take control of their own health and connecting with specialists and GP to achieve positive health outcomes for everyone living with hepatitis B. Lynnaire is also contracted through Compass Health to provide hepatitis C fibroscan services.

The idea came about following the release of similar training modules by the Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM). Working with ASHM and using these modules as a base, the Hepatitis Foundation adapted the content and tailored it to a



Helen Purcell has been with the Hepatitis Foundation since it started 30 years ago. She provides invaluable support to people living with hepatitis and their families. Helen played a key role in a Kawerau study into hepatitis in 1984, which involved testing 96 percent of the town's population for hepatitis B, and was later involved in a similar study in Vietnam. She was also instrumental in setting up the world's first hepatitis B vaccination programme.

New Zealand context. The educational video series is endorsed by the New Zealand Society of Gastroenterologists and has so far met with excellent feedback.

HEPATITIS B
Who is at risk? How is it transmitted?
Session one, Hepatitis B Online Education Series

Lynnaire Matthews

The Hepatitis Foundation of New Zealand
www.hepatitisfoundation.org.nz | 0800 33 20 10

"It is applicable to primary health care nurses and GPs and is an excellent resource to help with professional development," Hepatitis Foundation nurse manager Kelly Hayes says.

The videos, which can be viewed in the health professionals' section of the Hepatitis Foundation's website (www.hepatitisfoundation.org.nz), support the foundation's ongoing collaboration with health care professionals around NZ and internationally. Chief executive Susan Hay says this is very important.

"Collaboration enables a seamless delivery of health services and has been shown to improve health outcomes for patients. The Hepatitis Foundation works closely with many partners to provide effective support for people living with hepatitis."

Last year the foundation switched to Microsoft Azure cloud technology, which means its staff can better communicate with health and other government agencies across NZ. The change also improves the foundation's ability to support the 120,000 New Zealanders living with hepatitis and help it work towards World Health Organisation 2030 hepatitis elimination targets.



The foundation also holds a national conference every year to share news and information relating to liver health. This year's viral hepatitis conference for primary care nurses will be held in Whakatane, where the foundation is based, from October 3-4. This is the first time it has been held in the Eastern Bay of Plenty. Chief executive Susan Hay says it makes sense to hold the event locally.

"This is where the foundation started, so the Eastern Bay has a strong hepatitis history. We want to showcase that history and the attractions of the region."



Nurses in the primary care, prison, public health and midwifery fields will attend, with the presenter line-up

including Hepatitis Foundation clinical director Dr Alex Lampen-Smith and medical director Dr Chris Moyes. The 2019 conference theme is 'engaging communities', to reflect the ongoing work by the foundation and wider health care sector to reach people and improve health outcomes for New Zealanders.

The Hepatitis Foundation has completed many major screening, vaccination and research programmes in New Zealand, the Pacific Islands and Vietnam during its 30-year history, including a 1984 Kawerau Seroprevalence Study that saw 93 percent of the town's population tested for hepatitis B. It now runs a free national long-term monitoring programme that supports people living with chronic hepatitis B.

Hepatitis B spreads through contact with blood or the bodily fluids of someone with the virus. It leads to liver inflammation and scarring and can result in cirrhosis. It can also lead to liver cancer or failure. Chronic hepatitis B is a long-term condition that lasts more than six months and needs regular monitoring. For more information phone 0800 33 20 10 or visit www.hepatitisfoundation.org.nz

Hepatitis study in Vietnam



New LOGIC

committee member: Helen Parry

Originally a newspaper reporter from North Wales, I trained as a nurse at Cairns Base Hospital, Far North Queensland, graduating in 1991.

Since then I have never looked back and have done a whole range of work from medical, orthopaedic and aged care nursing to district, community, clinic and occupational health nursing. I have worked as a part time practice nurse at Titoki Medical in Nelson since October 2017. I am hoping that my skills and experience may be of use in the publication of LOGIC.



Looking Back: Another Milestone in Nurse Prescribing

Elizabeth Pillay

RN, RM, PG Dip Community Health Nursing Science, PG Cert in PHC (SA), PG Dip HSc (NZ)

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Introduction

The recent launch of the Registered Nurse Prescribing in Community Health programme brought back some memories of my years as a nurse prescriber in South Africa (SA). Listening to the nurses describing their prescribing experiences made me feel very privileged to be part of their journey. The opportunity to work alongside Nursing Council (NCNZ) and Family Planning (FP) was a significant milestone in my nursing career. This article is both a reflection of my own journey as a nurse prescriber as well as working alongside the first group of registered nurses

who completed the RNPCH (Trial and Evaluation) programme in Counties Manukau Health (CM Health).

My journey as a nurse prescriber began in 1993. Having completed undergraduate education (hospital based) in Nursing and a Diploma in Midwifery in the late 1980s, I worked in paediatric and maternal health services for a few years. The challenges with shift work and managing a young family led to me seek more suitable working hours. Community health nursing seemed a good option and I moved on to work in a local community health clinic. It was here that I was prompted to pursue post graduate education. Consequently I completed post graduate papers in Community Health Nursing, Primary Health Care (PHC) and Occupational Health. This was the first significant milestone in my nursing career. It was during this time that healthcare in South Africa was undergoing changes. Community-oriented primary care in South Africa dates back to the 1940s. Through the years

this has changed in response to racial and social inequalities. Since the country's liberation there have been significant efforts to focus on PHC (Maillacheruvu & McDuff, 2013).

Nurse Prescribing in South Africa

The health services provided at the clinic I worked at included disease prevention, screening, maternal and child health, health promotion, oral health, family planning and management of long term conditions. The pharmacy and x-ray department was situated within the clinic. This comprehensive service was certainly a 'one stop shop' for many low socio economic families who would travel great distances to access healthcare. Working within a primary health care setting helped me develop a broad range of skills. My prescribing decisions were informed by the use of 'Standard treatment Guidelines' and the 'Essential Drug List' (Sooruth, et al, 2015). These tools catered for the most common health conditions that

patients were treated for. Although the role provided autonomy, working in a multidisciplinary team environment allowed me to consistently evaluate my clinical practice, including my prescribing decisions. Health promotion practice at the time focussed on disease prevention and health behaviour change of individuals. Over the years there has been a shift in this approach. Further education, exposure to various social and cultural factors both in SA and in New Zealand (NZ) has influenced the shift in my approach. Nursing is a dynamic profession and has evolved from a traditional practice to a scientific, research-based practice. It is incredible how the scope is expanding over the years.

The change in emphasis on PHC in SA led to discussions on the extended role of nurses. It was clear that nurse prescribing will contribute towards improving healthcare access as well extend nurses' scope of practice. Nevertheless nurse prescribers and potential nurse prescribers were faced with challenges as a result of complex legislative changes. For a few years there were discussions between the Nursing Council, Pharmacy Council and the government

regarding the existing legal and ethical constraints surrounding nurse prescribing (Geyer, 1998). Consequently my pathway to becoming a nurse prescriber included work-based training as well as tertiary level pharmacology papers set by the Pharmacy Council. Although at the time it was challenging and possibly not fair to have to go through that enormous amount of education, it is reassuring that the rigorous preparation contributed towards quality healthcare delivery. Moreover, work based learning has benefits for patients/community, health professionals and the organisation (Clarke & Copeland, 2003). On a personal note this meant I could work in both private and public health services.

Interestingly nurses in NZ have been on a similar journey. The changing health needs of the population, inequitable access to healthcare and the opportunity for nurses to maximise their scope of practice has shifted the tradition of medical prescribing. Over the years nurse prescribing has been evolving. Legal and ethical issues, education and training have been scrutinised resulting in different categories of nurse prescribing to cater to different

health and population needs (NCNZ, 2019; Ragunandan, et al., 2017). Community nurses are already good at health education, health promotion, health literacy (MOH, 2005). The RNPCH programme provides an opportunity to further develop clinical assessment skills and become effective antibiotic stewards. This allows them to work within the full breadth and scope of their practice.

Working as a PHN in South Auckland

Very briefly after arriving in New Zealand, I worked in the meningococcal clinical trials initiative and later went on to work as a Public Health Nurse in South Auckland. There was potential for Public Health Nurses (PHNs) to work more broadly within their scope, however at the time there were no nurse prescribers nor were there standing orders set up within the service. Thankfully this has since changed! PHNs would assess children/young people and refer them on to the GP for medications. The interaction with the child/young person included clinical assessment, health education, communication with the teacher/relevant school staff and parent. All that was required was a prescription for medication. Most children

would not turn up to the GP for various reasons. This was disappointing and at times made me feel very limited in my capacity as a PHN. It was not fair that a child needing medication did not receive this in a timely manner. Often this would result in the child's condition becoming progressively worse.

A typical example would be a child/young person presenting to school with ear infection. As a result of non-treatment, this may progress to severe infection such as chronic suppurative otitis media (CSOM). Consequently this child/young person may be faced with hearing loss, bullying in school and unnecessary school absenteeism. Skin infection and eczema are common conditions identified in school children. Here again this could have been treated by the PHN. The introduction of the Mana Kidz Programme (school based health services) within CM Health in 2012 has brought about a change to this. The transition from being in a responsible and autonomous role, to working within the protocols of a PHN has indeed been an interesting journey. Whilst working in this role I was constantly reflecting on ways to broaden my scope of practice. The launch of the PHC Strategy

provided opportunities for nurses working in the community and I took advantage of this. I subsequently completed post graduate papers in clinical teaching and PHC.

Working as a Nurse Educator

My inspiration for teaching came very early on in my nursing career. I used to admire one particular lecturer in my undergraduate years and thought "I would love to be like her one day!" The opportunity came whilst working as a PHN. As a nurse educator, I had the privilege of supporting PHNs in their professional journey. Being able to be 'hands on' as well as help them navigate their theoretical challenges made this role very interesting. The role also provided opportunities to work on the HPV vaccination programme, the H1N1 outbreak control and the B4Sch Pilot. Working as an undergraduate nursing lecturer for a few years also provided opportunities to support student nurses. It was an added advantage to be able to help students understand PHC in a more meaningful way. This was a sound platform to be able to link theory with true examples from my own experiences. One such example would be the origins of PHC and the implications of this for the

health system in South Africa (Cueto, 2004).

Mana Kidz Reflections

The launch of the Rheumatic Fever Prevention programme in 2011 was another significant milestone. Working alongside a wonderful team, we had the mammoth task of setting up 63 school health clinics in South Auckland. The role was challenging, yet so rewarding! Supporting nurses to transition from having an individual health focus to a holistic, autonomous approach was probably the highlight of this role. This experience confirmed for me the importance of rigorous and consistent professional development. Mana Kidz nurses assess and diagnose conditions such as sore throats and skin infections and provide treatment using standing orders. Whilst standing orders have their place in certain clinical settings, gaps around quality and effectiveness exist (Wilkinson, 2015). The Mana Kidz journey stimulated my desire to explore nurse prescribing even more. Like many nurses/health professionals I waited in anticipation to hear the outcome of NCNZ consultation on registered nurses prescribing in the community.



Registered Nurse Prescribing in Community Health Trial and Evaluation

The outcome of the consultation and the 'proposal for designated prescriber: registered nurses practising in community health' was such great news! What was even more exciting was that NCNZ announced that CM Health would be part of the managed roll out. The opportunity to work alongside the Deputy Chief Nurse (CMH), NCNZ and FP to develop the RNPCH programme is perhaps the pinnacle of my prescribing journey! Developing knowledge

and skills in the credentialing and governance processes required for an education programme has been a valuable experience. The challenges that came with this work brought back memories of my experiences back home (SA). One that stands out was the concerns from the medical profession, however over time this changed. It is reassuring that this is changing in NZ as well. There is good evidence that nurse prescribing is adding value to the health system by complementing the role of doctors, reducing inequities and improving access (MOH, 2019).

Developing the blended learning programme was a remarkable journey. NCNZ 'Standards for recertification programme in RNPCH', the Medicine List for RNPCH and the 'Guideline for RNPCH' provided direction in the development of the eLearning modules, study days, programme tools and clinical supervision requirements. The move towards a greater awareness on antimicrobial stewardship both globally and nationally (MOH, 2016) and the localising of the Auckland Regional Health Pathways at the time had important influence on designing this guideline based programme. It was vital to

ensure that the education addressed the gaps in antimicrobial resistance and antimicrobial design so that nurses can have good understanding in order to become effective antimicrobial stewards. Drawing from overseas nurse prescribing experiences and the evaluation of Diabetes Nurse Specialist prescribing was also valuable (Wilkinson, 2011). Relationships formed with primary care colleagues over the years was beneficial and helped me understand the challenges nurses faced with the educational requirements. The RNPCH handbook was developed to provide the nurses and relevant stakeholders such as clinical supervisors with the programme content, processes and requirements.

On-going monitoring of the education programme by nursing council, antimicrobial experts and relevant stakeholders helped refine the programme. The eLearning modules consist of health assessment and clinical reasoning, skin conditions, rheumatic fever prevention, ear infections, legal aspects of prescribing and principles of pharmacotherapeutics. While the programme was being evaluated I worked closely with

the nurses, supporting them with prescribing decisions, portfolio development and clinical supervision. Although the prescribing decisions are guideline based, thorough clinical assessment skills are required to make a diagnosis before prescribing medications. This was a challenging time for some nurses and at times a few felt like 'throwing in the towel'. The required hours allocated to completing the eLearning modules, study days, dedicated clinical supervision time and portfolio requirements made this journey daunting for some. Nevertheless, they persevered and some even enjoyed the course as one of them said.....*"I am really enjoying this course and have learnt so much even though it is hard work. Thank you very much for putting it all together for us. It must have taken hours and hours."* It was encouraging to see how nurses were progressing from using standing orders to taking an active part in antibiotic management and being able to question antibiotic prescribing. Support systems are vital for nurse prescribers to be effective. These include collaborative partnerships, effective communication and organisational 'buy in' (Currie, 2008).

The evaluation of the RNPCH programme yielded positive results. Nurses felt that the education and training met their needs, they achieved the necessary competencies and they feel confident about making prescribing decisions. The evaluation recommendations are valuable to further refine this programme (Villa, et al, 2018). It is wonderful that the programme will be expanded nationally (MOH, 2019). I'm looking forward to supporting this initiative as a member of the regional working group.

Conclusion

Registered nurses make a significant contribution to the health of populations. Given the appropriate education and support, they are able to practise to the full depth and breadth of their scope. For this to occur it is also necessary for them to take advantage of opportunities that promote professional growth. This experience has been very beneficial and has helped expand my knowledge and skills greatly. Working in CM Health has afforded me numerous opportunities for which I am ever grateful.



References

- Clarke, D.J., Copeland, L. (2003). Developing nursing practice through work-based learning. *Nurse Education in Practice*, 3(4), 236-244.
- Cueto, M. (2004). The origins of primary health care and selective primary health care. *American Journal of Public Health*, 94(11), 1864-74.
- Currie, L. (2018). Barriers and Enablers to Registered Nurse Prescribing in General Practice: A survey of Nurse Practitioners' perspectives. *Logic*, 17(3), 32-41.
- Geyer, M.N. (1998). Legal limitations for nurse prescribers in primary health care. Retrieved 4th July, 2019 from <https://curationis.org.za/index.php/curationis/article/view/668/606>
- Maillacheruvu, P. & McDuff, E. (2013). South Africa's Return to Primary Care: The Struggles and Strides of the Primary Health Care System. *The Journal of Global Health*. Retrieved 4th July 2019 from <https://www.ghjournal.org/south-africas-return-to-primary-care-the-struggles-and-strides-of-the-primary-health-care-system/#>
- Ministry of Health. 2005. *Evolving Models of Primary Health Care Nursing Practice*. Wellington: Ministry of Health.
- Ministry of Health. (2016). *Combating antimicrobial resistance in New Zealand*. Retrieved from <https://www.health.govt.nz/news-media/news-items/combating-antimicrobial-resistance-new-zealand>
- Ministry of Health. (2017). *Registered Nurse Prescribing in Diabetes care: 2012 Managed National Roll out*. Retrieved 2019 from <https://www.health.govt.nz/publication/registered-nurse->

[prescribing-diabetes-care-2012-managed-national-roll-out](#)

Ministry of Health. (2019). *Access to healthcare a top priority in the rollout of registered nurse prescribing*. Retrieved from <https://www.health.govt.nz/news-media/news-items/access-healthcare-top-priority-rollout-registered-nurse-prescribing-0>

Nursing Council of New Zealand. (2016). *Proposal for Designated Prescriber: Registered Nurses Practising in Community Health*. Retrieved from <file:///C:/Users/epillay/Downloads/Proposal%20for%20designated%20prescriber%20registered%20nurses%20practising%20in%20community%20health%20September%202016.pdf>

Nursing Council of New Zealand. (2019). *Nurse Prescribing*. Retrieved from <http://www.nursingcouncil.org.nz/Nurses/Nurse-Prescribing>

Raghunandan, R., Tordoff, J., Smith, L. (2017). Non-medical prescribing in New Zealand: an overview of prescribing rights, service delivery models and training. Retrieved from <https://journals.sagepub.com/doi/full/10.1177/2042098617723312>

Sooruth, U.R., Sibiya, N., Sokhela, D.G. (2015). The use of Standard Treatment Guidelines and Essential Medicines List by professional nurses at primary healthcare clinics in the uMgungundlovu District in South Africa. *International Journal of Africa Nursing Sciences*. Retrieved from https://www.researchgate.net/publication/282548262_The_use_of_Standard_Treatment_Guidelines_and_Essential_Medicines_List_by_professional_nurses_at_primary_healthcare_clinics_in_the_uMgungundlovu_District_in_South_Africa

Villa, L., Madell, D., Atkinson, M., Hloba, H. (2018). Evaluation of the Trial: Registered Nurse Prescribing in Community Health. *Ko Awatea*.

Wilkinson, J. (2015). Nurses' reported use of standing orders in primary health care settings. *Journal of primary health care*, 7(1), 34-41.

Hawke's Bay

Symposium Report

Yvonne Little

The 2nd Hawke's Bay Primary Care (Raranga te Tira – working together in partnership) Symposium was held over the weekend of the 24th/25th August at the Napier Conference Centre.

The aim of the symposium was to bring together all members of the Primary Health Care Family – Doctors, Nurse Practitioners, Nurses, Managers and Reception staff to learn together and network.

It was a fantastic weekend of learning and networking. With so many great sessions and speakers it was hard to decide which ones to attend. The following is a snapshot of some those I did attend.

Self- Compassion: The initial plenary session on self - compassion was thought provoking. The speaker reminded us that self-compassion is linked to every aspect of well-being. She had us explore what gestures mean, if we think about clenching our fists this indicates tension, open palms make you feel more relaxed. Open arms can feel like emptiness whilst having them

wrapped across our chest can feel comforting and secure.

She also emphasized something most of us as nurses are not good at and that is saying 'NO', also accepting our feelings and stop self-criticism. To care for ourselves we need to stop the 'should attack' self-talk (should do better, should be able to cope etc), which I am sure I am not the only nurse who has ever done this.

Something very few of us do is to give ourselves compassion breaks, these take as little as a couple of minutes regularly throughout the day to breath, relax and re-centre ourselves.

Chronic Fatigue: Similarly, the two sessions I attended on Chronic Fatigue Syndrome made us stop and think, especially when there are 4 in every 1000 New Zealanders diagnosed with this condition. This syndrome cannot be diagnosed before six months post a viral insult. We got some useful pointers as practitioners to help our patients navigate this syndrome and the



medications to avoid such as benzodiazepines which aggravates sleep issues. Diagnosis is made using the Canadian Criteria.

Eyes, Ears, Nose and Throat: I felt the combination of theoretical and practical sessions were beneficial as some things are best learnt by practicing such as the sessions I attended on Eyes and Slit Lamp use, ENT where I picked up some useful techniques which will improve my practice performing examinations of these areas.

Managing the patient with decreasing eGFR: We are all aware I am sure of the increasing burden of kidney disease, so early detection and referral to specialist services was highlighted in this session. Proteinuria samples should be collected from first urination of the day for accuracy. We need to monitor closing our patients who have commenced on antihypertensives and our diabetic patients as high-risk groups.



part of the CAFS team at the DHB, he talked about normalising Mental Health issues with clients rather than having them feel alienated. This was done specifically from a Maori perspective which I found very interesting and informative. I asked if he would be interested in writing a piece about this for

Managing persistent pain:

Chronic pain in Primary Health Care is increasing, some regions do have pain clinics whilst others may not, now Hawke's Bay has a Chronic Pain Team working through our DHB, but patients need to have an OREBRO score of > 70 to be referred. A useful tip from this session was about You Tube clips called Brain Man (on pain medication) which can be used by patients to help them understand pain pathways and medication.

Palliative Care Forum: This session covered the tough questions around Serious Illness Conversations. Whilst nurses won't necessarily be the person

initiating these conversations, I felt it was useful even for those not initiating the conversation to have an idea around what this conversation would look like and how we can support each other. As a Nurse Practitioner I know I will have to have this conversation with someone at some time.

There is a great guide for everyone to access through the Health Quality and Safety Commission New Zealand, New Zealand Government site called Serious Illness Conversation Guide Aotearoa. It is well worth a look and putting into your toolkit for future reference.

Maori Spiritual Health: This plenary session was done by a fantastic speaker who works as

LOGIC, so watch future issues for this.

The other sessions for Nurses/Nurse Practitioners and Doctors which I was not able to attend included the following and you can see they were varied and I am sure just as interesting and informative as the ones I did attend.

Skills Lab: musculoskeletal and shoulder dislocations

Unleashing Nursing Potential

Paediatric Allergy Testing and Bee Venom

ADHD and why coffee is your best friend

Transgender Research Report

Contraception

Direction and Delegation

Benefits? Benefits of work?
Let's work together

Skills lab: Levator Avulsion and
How to fit
pessaries/endometrial pipelle
biopsies

Infection Control

Women in Black (defenders of
Public Health)

Skills Lab: wound care and burns

Kindness Matters: Caring for the
Carer

GoodSAM App

Yvonne Little

Whilst this is not an educational APP, it may be something you would be interested in looking into, to provide extra care in your community. This is something nurses are good at doing.

So, what is GoodSAM?

GoodSAM stands for (Good Smartphone Activated Medics) – St John. It is supported by St John, Wellington Free Ambulance and the National Cardiac Network. This app was developed in the United Kingdom and has been successfully implemented by a number of ambulance services around the world to promote a community of life savers.

As we know, the best survival for someone having a cardiac arrest is receiving immediate CPR and defibrillation within the first five minutes of the event but as we know unfortunately, emergency services cannot always arrive within that time frame especially in the more remote areas of New Zealand.

So, how does it work?

Firstly, the App is free to download no matter whether

you have an iPhone or Android phone.

So, if you can perform CPR and use an AED (and all nurses definitely can do this) and are prepared to volunteer to respond to a suspected cardiac arrest in the community, you can register as a 'responder' on the website and download the app to your phone.

If an event occurs within 1000 metres of your location (they use the location on your phone), you will get an alert and therefore be able to respond. The alert shows the location of the event and the closest AED's.

Simple really. So, if you're interested then go to:
<http://www.goodsamapp.org/registerResponder>

A better way to collect urine samples?

Erica Donovan

Picture this... it's a busy shift at work, like any other day. In cubicle five is a seven-month-old infant, with a fever in absence of respiratory or ENT systems. You knew the order was coming, the Doctor on duty is wanting a clean-catch urine sample. You know that there's a supply of urine bags in the supply closet, so you let them know you're heading over to apply one. "Not so fast," the Doctor says, "I said a CLEAN catch, there's risk of contaminates if you use the bag, and good luck keeping it on a hot, sweaty baby, they slide off and we haven't got all day." So you've got a few choices in this situation

1. Put the urine bag on and hope it works, pretend that it was a clean catch
2. Put a catheter in the baby or a needle into the bladder
3. Use another technique to make sure that you get a midstream sample

But what is the 3rd technique? Hopefully it's less invasive than catheterising a teeny baby, and risking a UTI if they don't already have one. Let alone the distress, both for the patient, the worried young parents, and you as the nurse.

This article came about after reading this piece by Fernández et al., where they described a novel technique for obtaining a clean-catch urine sample from a not yet continent child. More about that below, but first, let us look into some of the other ways traditionally used for obtaining urine.

Wee wee wee – why do we like using urine bags?

I shared something relating to clean-catch urine techniques on Twitter recently and a non-nursing acquaintance commented that it had taken several attempts for her family to get a clean-catch sample from her young infant and there was a lot of urine everywhere. Urine bags might make us feel better as nurses



because they allow us to complete other tasks while we wait for the urine sample (which let's face it, might be a while in the case of a dehydrated child). Urine bags allow children too young to express their need to void, a way to catch a urine sample.

They are also a lightly less messy way to catch urine, and overall may reduce staff time. In some outpatient areas Doctors may also allow families to return home and drop in a urine sample later if they are on the lower-risk end of the spectrum.

So, if we think in terms of patient (or maybe more family) centered outcome, earlier discharge might be a good thing, no one likes sitting in a clinic for hours with a grumpy baby.

What is the evidence against urine bags?

This brings us to the reasons why urine bags might not be so great. Firstly, let's explore the success rate in catching enough urine for a dipstick or culture. A study in 2012 by Tosif, Baker,

A new technique for fast and safe collection of urine in newborns

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► Additional supplementary files are published online only. To view these files please visit the journal online (<http://dx.doi.org/10.1136/archdischild-2012-301872>).

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ABSTRACT

Aim To describe and test a new technique to obtain midstream urine samples in newborns.

Design and methods This was a prospective feasibility and safety study conducted in the neonatal unit of University Infanta Sofía Hospital, Madrid. A new technique based on bladder and lumbar stimulation manoeuvres was tested over a period of 4 months in 80 admitted patients aged less than 30 days. The main variable was the success rate in obtaining a midstream urine sample within 5 min. Secondary variables were time to obtain the sample and complications.

Results This technique was successful in 86.3% of infants. Median time to sample collection was 45 s (IQR 30). No complications other than controlled crying were observed.

Conclusions A new, quick and safe technique with a high success rate is described, whereby the discomfort and waste of time usually associated with bag collection methods can be avoided.

INTRODUCTION

Clean urine samples are necessary to accurately diagnose several diseases in infants, especially urinary tract infections (UTIs). A wide range of clinical interventions for urine collection is described in the literature, including non-invasive and invasive methods. The most common non-invasive technique is urine collection using sterile bags, which is associated with significant patient discomfort and contamination of samples. Obtaining a clean-catch urine sample is the recommended method for urine collection in children able to co-operate. However, in children lacking sphincter control, urine catch is more difficult and time-consuming and invasive methods (catheterisation and needle aspiration of urine from the bladder) are sometimes needed.^{1 2}

There are some stimulation techniques that facilitate emptying of the bladder in situations of bladder dysfunction.³ We hypothesised that the use of such methods in newborns could facilitate the collection of a clean-catch urine sample.

The aim of this study was to determine the success rate and safety of a new non-invasive technique to obtain clean-catch urine samples in newborns.

METHODS

This was a prospective feasibility and safety study conducted in Infanta Sofía University Hospital,

What is already known on this topic

- Vesical stimulation techniques are applied in certain medical situations to obtain micturition.
- At present there are no standardised manoeuvres to stimulate urination in neonates

What this study adds

The manoeuvre described stimulates voiding urine in neonates in a safe, quick and effective manner

Madrid (a secondary centre, with a 16-bed neonatal unit, a 30-bed nursery unit and a 24-bed paediatric ward). The study was carried out over 4 months (January–April 2010). Patients consisted of 90 consecutively admitted infants aged under 30 days who needed a urine analysis according to their attending physician. Exclusion criteria were: (1) poor feeding, (2) dehydration, (3) need for an immediate sterile urine sample obtained by an invasive method or a clinical situation that did not allow time to obtain a midstream urine sample, (4) any medical condition that ruled out manipulation, and (5) drug administration prior to urine collection.

The clinical research ethics committee of La Paz University Hospital, Madrid, Spain, approved this study.

Technique

Two people (trained nurses and/or physicians) were needed to perform the procedure, and a third to measure the time taken. This technique involves a combination of fluid intake and non-invasive bladder stimulation manoeuvres.

The first step is either breast-feeding or providing formula intake appropriate to the age and weight of the newborn. In babies fed infant formula, 10 ml was provided on the first day of life, increasing to 10 ml per day during the first week. From the second week onwards, 25 ml/kg were administered before the onset of stimulation. Twenty-five minutes after feeding, the infant's genitals were cleaned thoroughly with warm water and soap and dried with sterile gauze. A sterile collector was placed near the baby in order to avoid losing urine

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Herreros Fernández ML, et al. *Arch Dis Child* 2013; **98**: 27–29. doi:10.1136/archdischild-2012-301872

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Oakley, Donath & Babl explored this and compared the rates of contamination between the different urine collection methods. For urine bags they found contamination rates in their study the rate were 43.9%, which is concerning as this can cause inappropriate treatment where true infection is not

present. Clean catch on the other hand only had a prevalence of 14.1%, which coincidentally was the same as catheter samples, but more than suprapubic aspirates at 9.1%.

Urine bags can be fiddly, and slippage can happen for a few

reasons, we can break these issues down into staff error, patient factors and anatomical reasons.

Putting on a urine bag is a skill just like any other nursing task. We need to ensure that staff are trained well in order to make sure the urine bag is best placed

to catch urine. Common mistakes include being placed too low or too high, or wrong way round.

Patient factors can include the amount of sweat, skin temperature or amount of distress during and post application.

Thirdly there's the anatomical reasons, namely that it's easier to apply a urine bag on males. Anecdotally I've found there's a much higher failure rate on females, due to the needing to correctly secure on the labia. On males, the bag can fully enclose the scrotum and penis.

RCH has gone as far as not recommending urine bags for catching urine for possible urinary tract infections as they state the contamination rate can be as high as 50% (The Royal Children's Hospital Melbourne, 2019). Their use in cases where we need urine for a non-infective testing is permitted according to their parent advice fact-sheet which is available [here](#).

Other collection methods

There are other ways to collect urine in the infant, but they can come with more staff time, distress, risk of infection and cost.

One method would be a simple catheter inserted, which is fine if there's someone who feels

confident in doing them. They come with a risk of iatrogenic infection and the process is upsetting to the patient and sometimes family. There is a lower risk of contamination compared to urine bags, of 14.3% (Tosif, Baker, Oakley, Donath & Babl, 2012).

The other slightly more invasive method would be the suprapubic aspirate. Put simply, this involves inserting a needle into the child's bladder and pulling out some urine. This might be a slightly harder sell to parents, requires a confident and competent practitioner and ideally the availability of ultrasound. The rate of contamination in the study cited above was 9.1% (Tosif, Baker, Oakley, Donath & Babl, 2012). This was the lowest prevalence found, but we need to weight up the risks and benefits of undertaking such a procedure.

The research

The Fernández et al method involved two medical or nursing staff to obtain a sample. One to hold up the infant under the axilla, with legs dangling and one to capture the urine in the specimen cup. Their first step is to provide analgesia in the form of sucrose syrup or feeding. Then followed by tapping the suprapubic area for 30 seconds at a rate of 100bpm. For reference, the Australian Resus

council recommends CPR is done at 100-120bpm, so think along those lines. Then massage the lower back in a circular motion at the paravertebral zone. In their study the mean time to produce urine was under one minute, which is quite impressive.

The RCH guideline to non-invasive clean-catch urine collection is slightly different to the one by Fernández et al.

In the RCH parent guideline, from the diagram it looks like you lie the infant on their back while you either 1. Just wait for a wee. Or 2. Try the trick with rubbing gauze soaked in cool water over the lower abdomen. With method number one you could be waiting a long time and risk the aforementioned weetsunami described above. This would have the advantage about not requiring two people to assist and distress to the infant of someone holding them upright. The RCH site states that even clean-catch can have a contamination rate of 25%, which is still significant, but far less than the 50% they state can occur with urine bag collection.

Why this works:

For this let's look back at some pathophysiology. In adults, micturition is caused by a feedback loop, as the bladder fills with urine the bladder stretches. It is this stretch that causes the signals to the brain to create the feeling of needing to urinate. From there generally we are able to choose at a convenient time to pass urine (in the case of nurses, we often hold on a bit longer than we should). However, in infants under two years of age, full bladder control by voluntarily urination is not possible. One of the nerves responsible for bladder control, the pudendal nerve, responds involuntarily to an increase in abdominal pressure or bladder stimulation. Development of urinary control does not usually occur till over 2-3 years of age (Tran et al., 2016). After that age, developmental and neurological changes occur which allow children to learn the process of being continent.

References:

Fernández, M. L. H., Merino, N. G., García, A. T., Seoane, B. P., de la Serna Martínez, M., Abad, M. T. C., & García-Pose, A. (2013). A new technique for fast and safe collection of urine in newborns. *Archives of disease in childhood*, 98(1), 27-29.

The Royal Children's Hospital Melbourne. (July, 2019). *Urinary Tract Infections*. https://www.rch.org.au/clinicalguide/guideline_index/Urinary_tract_infection/

The Royal Children's Hospital Melbourne. (March, 2018). *Urine samples*. Retrieved from RCH website. https://www.rch.org.au/kidsinfo/fact_sheets/Urine_tests/

The Royal Children's Hospital Melbourne. (January, 2019). *Suprapubic aspirate*. https://www.rch.org.au/clinicalguide/guideline_index/Suprapubic_Aspirate_Guideline/

Tosif, S., Baker, A., Oakley, E., Donath, S., & Babl, F. E. (2012). Contamination rates of different urine collection methods for the diagnosis of urinary tract infections in young children: an observational cohort study. *Journal of paediatrics and child health*, 48(8), 659-664.

Tran, A., Fortier, C., Giovannini-Chami, L., Demonchy, D., Caci, H., Desmontils, J., ... Berard, E. (2016). Evaluation of the Bladder Stimulation Technique to Collect Midstream Urine in

Infants in a Pediatric Emergency Department. *PloS one*, 11(3), e0152598. doi:10.1371/journal.pone.0152598

Allergy, Side Effect or Intolerance – Which is it?

Yvonne Little

Documentation of allergies is an important part of any patients notes as we know it prevents any potentially life-threatening events when prescribing medications, therefore correctly classifying these as an allergy (an immunological response) or intolerance (a non-immunological response) is clinically important for future treatments. (4)

If we mislabel a side effect or intolerance as an allergy, this “may result in unnecessary avoidance of an effective drug, resulting in prescribing of a second-line therapy which may be less effective, or more expensive, and may potentially lead to higher rates of adverse effects”. (2). Also, if it is a side effect we may be able to manage or minimize and still benefit from the medication (5)

More often now we are seeing patients claiming drug allergies or simply seeing it documented on their notes from a previous visit or practice. But only a handful of bad reactions to medicine are due to an allergy (1), and only a few people

develop what is termed a true allergy (3), according to the American Academy of Allergy, Asthma and Immunology this number is about 5-10% (5).

Therefore, the questions we as nurses (we can't always rely on the doctors) need to be asking: Is it a true allergy, a side effect or an intolerance? Could the symptoms relate to the illness or a medication interaction and has the patient previously tolerated the same medication or similar? (6).

Knowing the answer to these questions can help the health provider make decisions about medications. By working together, we can educate patients about the differences so classifications of allergy are exactly that ALLERGY, not side effect or intolerance.

As practitioners we also need to ensure we do not confuse patients by interchanging the words adverse events and side effects, adverse events (these



are the allergies) are more serious and require intervention whereas a side effect will spontaneously resolve, according to literature read this interchanging of words in healthcare is more common than we think. (4)

So, what is the difference between an allergy, a side effect and an intolerance?

ALLERGY:

A medication allergy is more serious than a side effect or intolerance, an allergy or adverse reaction is an immunological reaction (IgE-mediated hypersensitivity) to a medicine, where the body produces either an exaggerated or inappropriate response to a medication or one with a similar structure and can be reproducible. (6, 3). The World Health Organisation (WHO) define it as: “a response to a drug which is noxious and unintended and which occurs at doses normally used in man for the prophylaxis, diagnosis, or therapy of disease, or for the modification of physiological function.” (7)

Allergic reactions rarely occur the first time we take a medication, it requires exposure to the drug to develop the immune response, therefore most severe reactions will occur with subsequent doses. (3, 5). These occur not only with prescribed medications but also natural products.

Symptoms of allergy can be as mild as hives, rash, itchy skin or on the more severe end of the spectrum the symptoms can include swollen face, throat tightness, trouble breathing, light-headedness, blisters, reddened skin or whole-body shock with life-threatening low blood pressure (1,5,10).

Beware, the **pseudo allergic reactions**, these mimic those caused by IgE antibodies but are not initiated by IgE, these occur as a result of histamine release and other non-immune mechanisms and these can occur the first time a drug is taken. These are as potentially life-threatening as a **true allergic reaction**; the symptoms and the treatment are the same for both. The most common drugs involved include: morphine, opiates, anaesthetic muscle relaxants and contrast media. Non-steroidal drugs and aspirin have been noted to cause urticaria and asthma and

anaphylaxis in susceptible people. (3, 8).

There are two allergy response types:

Rapid onset within 1-2 hours of ingestion, this is IgE mediated. This is the one which needs immediate attention as the symptoms include: abdominal pain, confusion, urticaria, wheezing, hoarse voice, dizziness or fainting, rapid pulse and/or heart palpitations, angioedema, bronchospasm and anaphylaxis. (5, 6)

Delayed onset which often occurs with antibiotics, this is IgG mediated. Can occur up to 10 days after initiating treatment and the main symptom is rash. The confusing factor with this is that the rash may be related to the illness. There are more serious delayed immune reactions involving rash in conjunction with systemic symptoms including:

Serum Sickness-like reaction (most commonly associated with cephalosporins)

Stevens-Johnson syndrome (most commonly associated with sulphonamides)

Asceptic Meningitis (most commonly associated with trimethoprim/co-trimoxazole) (5, 6)

SIDE EFFECT:

These can seem like an allergic reaction but in reality, is just a sensitivity felt by the body to a new medication and is not immune mediated. (1,5) According to the World Health Organisation a side effect is an unintended effect of a drug occurring at a dose which is normally used and is related to the pharmacological properties of the medication. (7)

Side effects are more common than allergy but often misinterpreted and reported by patients as an allergy.

The most common symptoms include: nausea, lack of energy, muscle aches, hard to sleep, coughing, wheezing, stuffy nose, stomach cramps, diarrhoea, constipation, ringing in the ears, easy bruising. (1, 5).

INTOLERANCE:

This is a sensitivity reaction to a medicine which does not involve the immune system. It is dependent on two factors: the pharmacological action of the medicine and the patient susceptibility factors. This means that these people usually have a low threshold for developing adverse effects or exaggerated side effects or developing a side effect not normally associated with the medication. (6)

Drug (pharmacological) factors include: the nature of the drug; degree of exposure (i.e. dose, duration and frequency); administration route and cross sensitization (10)

Patient factors include: age and sex; genetic factors; illnesses occurring at same time such as Epstein-Barr Virus, HIV, asthma; any previous drug reaction; multiple allergy syndrome (10).

The drug factor and patient factor can and should not be viewed in isolation as it is the combination which can and will give us a clearer picture.

I would highly recommend you to look at the table about immune reaction, mechanism, clinical manifestations and timing of reactions at www.aafp.org/afp, this would be useful addition to include in our knowledge toolkits.

REFERENCES:

1. Is it a Drug Allergy or a Side Effect? WebMed
1. <https://www.webmd.com/allergies/allergy-or-side-effect>
2. Adverse drug reaction classification by health professionals: appropriate discrimination between allergy and intolerance?

- Clinical and Translational Allergy Journal (March 2019) <https://cta.journal.biomedcentral.com/articles/10.1186/s13601-019-0259-6>
3. Allergy New Zealand – Drug Allergy (2006)
2. <http://www.allergy.org.nz/A-Z+Allergies/Drug+allergy.html>
4. Pharmacy Today: Allergy or Adverse Effect: Teach patients the difference (March 2014)
3. [https://www.pharmacytoday.org/article/S1042-0991\(15\)30944-0/pdf](https://www.pharmacytoday.org/article/S1042-0991(15)30944-0/pdf)
5. Allergy or Side Effect; Frieda Wiley (January 2016)
4. <https://medshadow.org/allergy-or-side-effect/>
6. When is an allergy to an antibiotic really an allergy? (BPAC, June 2015)
5. <https://bpac.org.nz/BPJ/2015/June/allergy.aspx>
7. World Health Organisation Definitions: <https://apps.who.int/medicinedocs/fr/d/Jh2992e/2.html>
8. Healthline: What is a Drug Allergy (2016)
6. <https://www.healthline.com/health/drug-allergy>

9. American Family Physician. Riedl et al (Nov 2003). Adverse Drug Reactions: Types and Treatment options.
7. <https://www.aafp.org/afp/2003/1101/p1781.html>
10. World Allergy Organisation. Thong et al (2014): Drug Allergies
8. <https://www.worldallergy.org/education-and-programs/education/allergic-disease-resource-center/professionals/drug-allergies>

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.

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

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1. Allergy immunotherapy: Who, what, when... and how safe? The evidence-based answers to these and other questions will help you to update your knowledge of allergy immunotherapy.

Bright, Dellyse., Pollart, Susan M & Franko, John.

Journal of Family Practice. Jun 2019, 68(5), 270-276.

The article offers information on the use of allergy immunotherapy (AIT) in clinical practice. Topics discussed include a negative effect of moderate-to-severe food and environmental allergies on multiple organ systems; effect on quality of life and financial well-being of patients with allergic diseases; and the role of AIT in providing long-term remission of allergic disease in certain circumstances

2. When Food fights back: Clearing up confusion over food allergies & intolerances.

Dow, Caitlin.

Nutrition Action Health Letter. May 2019, 46(4), p8-11.

The article discusses some important issues to consider about how some foods can harm the immune system. Topics covered include food allergy as an appropriate immune response to a harmless protein in a food according to physician Roxanne Oriel, the use of a skin prick test or a blood test that measures antibodies to help diagnose an allergy, and structures of certain proteins in plant foods similar to proteins in pollen

3. Allergy: Sniffing and sneezing: Is it allergies or a cold? Philpott, Leanne

AJP: The Australian Journal of Pharmacy, May 2019, 100(1183), 34-37

While spring is considered 'allergy season', some of the most common allergens can rear their heads in winter - causing an influx of unwanted symptoms

4. The basics of allergen management

Sherlock, Rob

Food Australia, Apr/May 2019, 71(2), 40-41

Food allergy is a significant concern for the entire food chain, whether you are an ingredient supplier, producer, retailer or food service provider. The requirement for mandatory declaration of food allergens has been in place in Australia and New Zealand since 2000 and a number of useful tools have been developed to assist in allergen management through the Allergen Bureau, FSANZ and AFGC.

5. Anaphylaxis *Australian Nursing and Midwifery Journal*, Apr-Jun 2019, 26(6), 24-26

The following CPD extract from ANMF's Continuing Professional Education (CPE) website describes what anaphylaxis is as well as its causes and symptoms. It also discusses the diagnosis and treatment of anaphylaxis and compares it to different types of sensitivities and allergic reactions.

6. Paracetamol allergy in clinical practice

Thompson, Grace., Bundell, Christine & Lucas, Michaela

Australian Journal of General Practice, Apr 2019, 48(4), 216-219. Paracetamol is a widely used analgesic to which hypersensitivity reactions are rare. Reactions to paracetamol May be due to the pharmacological effects of cyclooxygenase-1 inhibition or, more rarely, due to a selective allergy against paracetamol.

7. Disease state management: Allergic rhinitis
Gowan, Jenny; Roller, Louis
AJP: The Australian Journal of Pharmacy, Sep 2018, 99(1176), 70-78
Allergic rhinitis, commonly referred to as hay fever, is the most common allergic disorder in Australia and New Zealand. Pharmacists should be able to identify the symptoms of allergic rhinitis and provide appropriate advice and options to manage them effectively.

8. Evidence in practice: Sedating Antihistamines - do they still have a role?
Taylor, Donna
Australian Pharmacist, Aug 2018, 7(7), 50-59
Francesca, a woman in her midthirties, has come to the pharmacy to ask for some 'Phenergan' (promethazine) 10 mg tablets to manage her allergic rhinitis. She has used promethazine in the past and it worked well, so this is what she always uses now. She is not taking any other medicines, has no other known medical conditions, and is not pregnant or breastfeeding.

How would you respond to Francesca's request?

9. Food allergy readiness and anaphylaxis management in early childhood education and care in Western Australia
Jacobsen, Karina
Hammershaimb; Sambell, Ros; Devine, Amanda; Vale, Sandra
Australasian Journal of Early Childhood, Dec 2018, 3(4), 43-47
With the increase in prevalence of food allergy (FA) in young children, early childhood education and care (ECEC) providers are likely to have more enrolments of children who are at risk of anaphylaxis.

10. Anaphylaxis in general practice
Hayes, Paul
Good Practice, Dec 2016, No. 12, 14-16
GPs play a key role in the treatment and education of patients who present with anaphylaxis and other allergy related issues.

11. Comparison of the prevalence and characteristics of food hypersensitivity among adolescent and older women
Fujimori, Anri; Yamashita, Tomomi; Kubota, Masaru; Saito, Hiromi; Takamatsu, Nobue & Nambu, Mitsuhiko
Asia Pacific Journal of Clinical Nutrition, 2016, 25(4), 858-862
Although food hypersensitivity is a public health concern, its documentation among the elderly is limited. The current study aims to compare the prevalence and characteristics of food hypersensitivity among adolescent

women between aged 18-24 with among older women >50 years of age.

NZNO Library

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