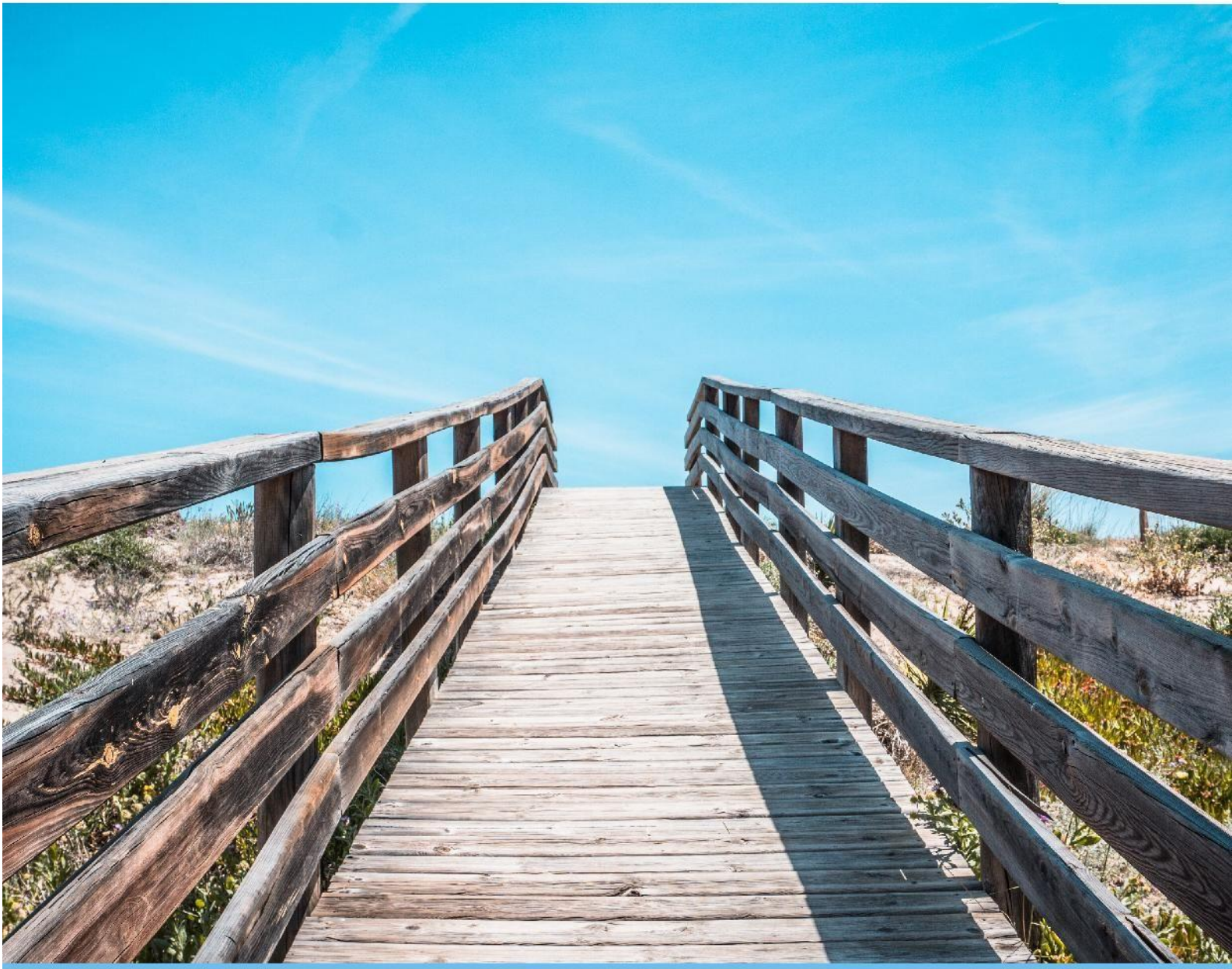
LOGIC.

LINKING OPPORTUNITIES GENERATING INTER-PROFESSIONAL COLLABORATION

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



TRAVEL AND CARE SEAT SAFETY

GROWING NURSES INTO GOVERNANCE

PUBLIC HEALTH NURSING

SHAKEN BABY SYNDROME

SUMMER 2019

LOGIC is the Official Journal of the New Zealand College of PHC Nurses (NZCPHCN), NZNO.

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Summer 2019 - In this issue…

Chair's Report

Tēnā Koutou katoa

2019 has been a busy year! The NZPHCN finally completed the Primary Health Care (PHC) Nursing Standards, which contributed to many consultations and submissions around issues effecting the health of New Zealanders. Thank you to all of the Committee for your dedication and hard work throughout 2019.

Please check out the standards on our website: https://www.nzno.org.nz/primaryhealth

The purpose of the Aotearoa New Zealand PHC Nursing Standards of Practice is to support PHC nurses, by clearly articulating what is expected in the specialty, and to outline a career pathway in PHC nursing. This document is specifically focused on the registered nurse workforce.

We are looking forward to 2020 and the exciting new projects and activities across PHC, including the roll-out of the Registered Nurse prescribing in Community Health, and the recommendations following the Health and Disability Review.

For those nurses working during the Christmas season and summer holidays – thank you! Thank you! Thank you!

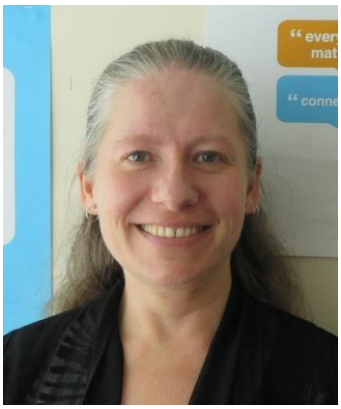
For those nurses working during the Christmas season and summer holidays – thank you! Thank you! Thank you!

For those taking a break and spending time with family, whanāu, friends and loved ones enjoy every moment and be safe!

Thank you to all the staff of NZNO for your support during 2019! We (your members) probably don't say it enough, but we appreciate your support and hard work for nursing!

2019 was not an easy year for you, but you are always friendly, supportive and will go above and beyond to help where you can!

Celeste Gillmer,
Chairperson



Editor's Report

Summer is here, and the festive season is already upon us. It is hard to believe another year has gone by.

This year had many trials and tribulations for New Zealand and PHC Nurses, but we weathered the storms: from the terrorist attack on members of the Muslim community doing their daily routine in Christchurch, to the Measles Outbreak across the country (especially Auckland), and as I write this, the terrible news of White Island eruption causing death and injury. These events added to our already busy and stressful lives have and I believe its made us stronger and more resilient as a country, and as nurses.

As nurses, we are part of our communities, and are not immune to feelings of pain and frustration. We feel what our communities, our whanau, friends and patients are going through, but we remain strong and supportive of each other through tough times.

So, I'd just like to say a big **THANK YOU to all of you for who you are, where you work and what you do every day.**

As with each issue, we try to bring you topical subjects, which we now relate to the seasons and hope you still enjoy these articles. In this issue, we cover the Summer topics of: travel and summer safety, plus our usual array of nurse section articles. In this issue, there are some very emotive articles written for us, of life as a nurse in a variety of settings – well worth the read, and a great article on Governance from Eldred Gilbert – we need the younger section of our nursing community to really think about this, as they are our future leaders. We need to:

- plan ahead to succeed,
- to ensure we stay strong,
- have a voice in our future, and
- the future of health.

We have new Committee members on our team after our successful Nelson-Marlborough Region Forum, and there is an updated group photo, albeit with some members who couldn't be there due to other commitments, and we'll endeavour to bring the individual Committee photos to the editions in 2020.

I'd like to say farewell and thank you to **Irene Tukerangi,** one of our LOGIC Committee members, who resigned due to work pressures.

Also, thank you, farewell and best wishes to **Linda Makiha-Reihana** from our Executive Committee who resigned for personal reasons. We wish them both well in life and their future endeavours.

I hope you enjoy this issue of LOGIC. It was a bumper issue last time and this one may be a bit smaller, but it still has some great articles.

Congratulations again to our Award Winners: **Melanie Terry** (see the Spring issue for her article) and **Donna Auld** who will provide us with her article on her award win in 2020.

I would like to say THANK YOU to the LOGIC Committee members (old and new) for their dedication and hard work, a BIG THANK YOU to our publisher, **Celeste Gillmer** who was pulled in all directions this year with work and college issues, plus starting up her new practice. Also, THANK YOU to the **Executive and Professional Practice Committee members** for their hard work over the past 12 months. Thank you to the NZNO team:

- our NZNO Professional Nursing Advisor (PNA) **Angela Clark**,
- past Administrative Support person **Rosanne Gri**llo,
- the **wonderful ladies who filled in for her and before the appointment of**
- our current administrative support person, **Sally Chapman.**

Wishing you all a safe festive season. Take care of yourselves, enjoy life and time with family and friends.

Thank you to those who are working through the stat holidays as I know some will be.

Looking forward to 2020 and bringing you some great articles.

Please check the sidebar about our feature topics and feel free to contact us if you would like to be published in one of our nest LOGIC journals.

Yvonne Little
Editor

2020 Feature Articles

ISSUE	FEATURE TOPICS	ARTICLE DEADLINE
Autumn	Respiratory Social Determins of Health (Autumn related)	3rd March 2020
Winter	Paediatrics Road Safety	2nd June 2020
Spring	Dermatology Sleep and sleep disorders	8th September 2020
Summer	Skin/wound care Vitamins and Health – effects of lack or overuse	20th October 2020

Rural Round up's

A day in a life of this rural health Nurse starts much earlier than usual, as I'd decided to visit one of the mothers in the Well Child (WC) service that lives at the very top of my valley. I leave my house at 08:00 on Tuesday morning, slightly jaded from a busy weekend, as the on-call Prime (primary response in medical emergency) nurse, after spending four hours bouncing around in an ambulance until 'horrible' o'clock, with an acute alcohol poisoning, and then micro managing three paediatric calls the following day. The drive up uncannily and undoubtedly gives me the opportunity to reflect on the events of the weekend.

I had already brought home the WC 'baby box' full of the tricks of the trade. I kiss my husband and kids' goodbye, grabbed my coffee and drove north up the valley. It was a particularly foggy morning and my head was in the clouds, when I suddenly met a temporary electric fence across the road, to see a herd of dairy cows leaving the dairy milking shed to the paddock, on the opposite side of the road. I stopped, got my 'red bands' out of the car and went over to give 'this Dad' a hand. It also gave me a chance to have a good catch up with him, I'd stitched his hand up the week before, after an 'incident' in the 'man cave', but it had healed beautifully, I gave him a 'Matronly' chat about the fact he wasn't wearing any gloves, but commended his cast iron immunity. Life is a bit crazy for them at the time. They have an awesome 14-month-old 'Houdini' boy and an eight-week-old baby girl. We talked for a few minutes, reading the world to rights, before the last dawdling cow finally made it across, and off I went to his house.

When I arrived, I found Mum in the middle of a meltdown. She'd had a hell of a night with a very hungry baby and a troublesome teething toddler. She'd been cutting meat for the working dogs, and tried to slice the top of her finger off. When I arrived, she was silently crying on the couch with a pressure tea towel in place, a very confused toddler staring at her, and a beautifully peaceful baby girl sleeping in the Moses basket.

I went over, gave her a hug, and when she finally sighed she told me where the first aid box was and I patched her up. It was a case of right place, right time, I briefly looked over this thriving baby, doing the bare essential measurements and ensuring she had the 'tools' to deal with a teething child. I then asked what she had planned for tea that night, which of course she hadn't thought about. I went to the freezer, got some meat out, peeled the potatoes and organised vegetables from the pantry. She stood next to me at the sink, and poured it all out emotionally. It was much harder than she thought it would be. She has an awesome husband and father, but they were struggling. I listened, and we looked at what to organise for the rest of the day. She promised she would try and have a sleep when the kids went down. At the end of the conversation, she decided she'd call her mum and ask her to come for the week to give them a hand. She'd previously stoically turned down the offer of help, but today she realised she needed help and some groceries

I drove back to the Health Centre just in time to meet the mother of a five month old girl for her WC check and vaccinations. She breastfed her after the vaccines and whilst I updated computer records she said she hadn't been feeling well for a few days, but didn't know what was wrong. There were not many obvious symptoms apart from a bit of a "squirmy" tummy. I asked her if she'd had a period yet and she shook her head. I asked if there was a chance she'd be pregnant and she replied "No, of course not." Then her pupils dilated and she said "Oh my God!" The urine test confirmed her very early first trimester of pregnancy. I gave her a pregnancy info pack and told her about the essential "antenatal" things she needed to consider today. She was obviously in shock and needed time to take it in. I made her a GP appointment for later in the week.

Twenty minutes after the vaccination I helped her and the now sleeping baby into the car, and smiled as I heard

her say to her partner as she sat down, “don’t laugh but you’re not going to believe this”.

Time for a well-deserved, belated coffee and muffin in the staff room before I try to:

- get my head around my day so far and attempt to write it all up
- one more baby check before lunch, but thankfully much less eventful this time,
- some problem solving with the Duty Nurse, regarding a complex case they had in the clinic,
- time to do a monthly stock take on vaccination fridge and order enough vaccines for the following month.

After lunch, a scheduled visit to a 93-year-old elderly resident living at home in the township. (I’ve visited her for some time, checking in regularly to see she’s managing well at home. Shes had crippling anxiety during periods in her life, which she puts this down to her post-natal experiences with a difficult birth and a cleft palate baby.

We talk and reminisce and I tell her about my world and she tells me about hers. Nothing major to plan or sort out for her this time). I write in her diary when I will call by next time, take her cat off my lap, get her mail from the letterbox and get going again.

This afternoon I do a Before School check, so on the way to the Health Centre, I go to the kindergarten and pick up the completed SDQ (strength and difficulties questionnaire). The children run over, say hello and show me their latest creative artwork. I have a quick catch up with them and the kindergarten staff, discuss the small issues they’ve had and tell them when to expect the next visit from the Hearing and Vision Technician that I was notified about.

I head back to the Health Centre to do the vaccinations and a Before School check for a really robust, up and coming farm boy! I’ve already prepped mum to prepare him for his vaccines, and I reiterate it to him what he should expect, then I get him to choose the side he’ll have them on (my version of his informed consent). He tells me what he’s getting as a treat on the way home. We uneventfully complete the vaccines and before school check and he leaves with his ‘graduation B4 school check certificate’, balloon and sticker, ‘paw patrol’ toy.

I end my day by completing documents and all the necessary data for this service. I plan my next session and inform parents of upcoming appointments. I upload resources to our Facebook WC group based on todays conversations with parents. I upload a funny and amusing toddler video, and a health info post about the upcoming hearing and vision screening.

New Zealand Rural landscape Wikimedia Commons

Right, it’s time for home, pick up my mail from our central rural PO Box, talk to a few of the community, including school children who wave as they go home.

It’s been a typically rural day, but I 100% wouldn’t change a thing.

Nicky Cooper

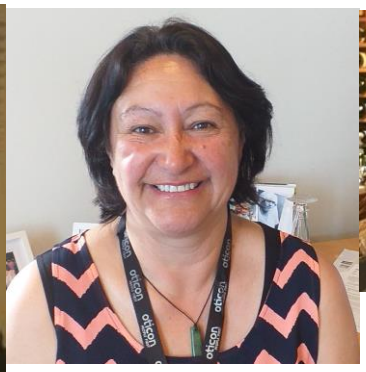
Public health nurses pitch in

Public health nurses Sheryl Hockey, Helen Omlo, Nicola Thompson and Pam McCarlie put the hard yards in to help Southern DHB's Measles outbreak response recently.

Jill Clendon, Associate Director of Nursing and Operations, says the nurses travelled to the Measles-afflicted region to help undertake comprehensive contact tracing with those who may have been exposed, and to provide education Helen Omlo and information to those people.

On behalf of the group, Nicola Thompson says that the work was a great opportunity to gain new ideas and experiences in dealing with a Measles outbreak while supporting their public health colleagues down south.

Nicola Thompson



Helen Orlo

Pam McCarlie

Sheryl Hockey

"It was a privilege to be a part of the Southern Public Health team at such an important time. It gave us good experience that we can take back to our team if and when we have a measles outbreak." Helen Omlo.

So far, Nelson & Marlborough Region is one of the few regions, lucky enough to have escaped the current Measles outbreak, however with pockets of high decliner/unimmunised population, and it reinforces the importance of preparedness and contingency planning, as seen with the recent events of Samoa.

Looking Back: Another Milestone in Nurse Prescribing

As Editor I would like to apologise to Liz and the wonderful nurses and nursing leaders in these photos which were published alongside Liz's article in the last issue of LOGIC, unfortunately the photo titles and names were inadvertently not carried over from the original word document and therefore not published. Please take time to maybe have another read of Liz Pillay's article. We hope to

Celebration: 33 nurses from CMH completed the RNPCH Programme in November 2017.

From far left, picture includes - Pam Doole (NCNZ – Strategic Policy Manager), next to Pam - Karyn Sangster, Deputy Chief Nurse, CMH, Liz Pillay, Programme co-ordinator, CMH (centre)

have an update for you around Nurse Prescribing in one of our 2020 journals

Liz Pillay

Launch of the RNPCH Managed Roll Out in July 2019 at Southseas, Counties Manukau
Associate Minister of Health, Jenny Salesa and Liz Pillay with Mana Kidz Nurses who completed the programme.
L to R: Lyn Loh, Harpal Kaur, Liz Pillay, Sholyn Lal and Associate MOH, Jenny Salesa

Role in Victory Community Centre

Steph Anderson is a Clinical Nurse Specialist working at the Victory Community Centre in Nelson. She loves working with people in the community and is passionate about improving the physical health of people who have mental health issues.

Victory Community Centre (VCC) sits in the heart of Nelson's Victory suburb, a vibrant and ethnically diverse community. The centre is located on the fringe of the local primary school campus and is close to local services, such as the community pharmacy and the district hospital.

The Victory population is more ethnically diverse than the wider Nelson community is, and there has been a rise in the number of people from South East Asia settling here, primarily due to settlement of former refugees with the help of the Red Cross. Families in Myanmar have been arriving since 2005, and, more recently, people from Nepal, Bhutan and Colombia have also resettled here. VCC works closely with the Red Cross to support these new residents, many of whom have complex physical and mental health needs.

The VCC team consists of:

- a manager (a registered social worker),
- a primary alcohol and drug clinician (trained as an occupational therapist),
- community navigator for former refugees,
- activities co-ordinator,
- receptionist,
- volunteers, and
- a community nurse.

The community nursing post has been in place since the beginning of the centre in 2007 and until 2019 this was a part time position wholly funded by Primary Health Organisation (PHO), with a focus on navigating people towards

GP care. In 2019, further funding was acquired through a contract with the DHBs, and Māori and Vulnerable Populations, which meant that the nursing role could be advertised as a full time clinical nurse specialist (CNS) position.

The focus of this contract is to provide health navigation to the more difficult to reach communities. This includes the residents of Franklyn Village, which is a local hostel housing around 200 individuals, many of whom suffer chronic and untreated health conditions

An assessment tool called Hauora Direct has been produced, which covers a large range of screening for chronic conditions, as well as mental health and addiction problems, plus enquiry into such things as living situation and child safety.

In May 2019, I was fortunate to be appointed as the new community nurse at VCC. I had worked for twenty years as a CNS in Mental Health and Addiction services in Nelson and, prior to this, in London. I hoped that my background of hospital based general nurse training, and a keen interest in co-existing physical and mental health issues would help me adjust to this new and very varied role.

As a member of Te Ao Maramatanga (NZ College of Mental Health Nurses) I had been involved in the credentialing programme for PHC nurses, so already had some good links with local practice nurses. VCC became very important in establishing good working relationships with the five practices in the Victory area.

The role is varied and can encompass anything from a B4 school check on a four year old to an eighty year old whos become lonely, and needs help to connect with others to support their mood. When the nursing service started, the price of visiting a GP was much higher, so there was a need to provide services such as:

- ear syringing,
- dressing wounds, or
- giving B12 injections.

As costs for community service card holders has fallen, the focus now is on engaging people with their primary providers and actively navigating them to whatever service is appropriate.

VCC's philosophy is based on the belief that community and connection is powerful. Alongside specific health interventions, visitors to the service are encouraged to join in activities, some as simple as: sitting down for a cup of tea and a slice of cake. We encourage people to be active in making changes to their lives rather than having an expectation that problems will be fixed for them.

Basic needs are important and VCC is part of the local Kai rescue system. Established in 2017, the Kai Rescue programme's aim was to minimize food waste in the community. The team collects food from:

- supermarkets,
- growers,

- manufacturers and
- other food outlets

The food is good enough to eat, but is surplus or non-saleable. Its then sorted by volunteers and given to over 40 recipient organisations within the Nelson area, which distribute the food to those in need.
At VCC, Kai is distributed in individual parcels (an average of 14 per day) and there is also a Kai shed on the edge of the carpark where leftover food is put twice a day for the community to help themselves. It is common to see locals dropping off their excess fruit and vege to the Kai shed to share with others.

Food is a basic necessity for us all, and as a nurse working in an environment where food is distributed to those in need, this gives me a valuable opportunity to open up those tricky conversations about health and stressors.

It's hard to estimate how many times a simple conversation as someone picks up a food parcel, has turned into a health assessment and treatment or onward referral.

During the last five months, it has been interesting to notice that the majority of those seeking help may present with a straightforward physical health issue, but during assessment, it becomes evident that psychological issues are present and often untreated.

There are challenges involved in this area of work. One of the most significant is the risk of working beyond your scope of practice or competence, as it's easy to get carried away and do whatever is needed when you meet people. It is important for me to have good supervision, and currently I have one to one supervision with another senior nurse in a community role, as well as peer supervision with a group of local practice nurses. The rewards of this work are huge. It is satisfying to be in a position where I am able to respond to a person's need and to offer them appropriate, and often immediate, help.

For me, nursing is about having time to listen to people and build relationships, and then being able to respond immediately and appropriately to their needs. This is a job where I am able to do this, which is immensely rewarding- *Steph Anderson*

Governance for nurses in PHC

One strategic outcome of the NZNO Strategy for Nursing 2018-2023 is to encourage nurses into governance roles. As far as I am aware, there has been no focussed document on assisting nurses into governance roles in New Zealand – hence the development of NZNO's *Growing Nurses into Governance – a governance toolkit*. Written by independent nurse consultant, Shelley Jones. It is a comprehensive and encouraging work for nurses in Aotearoa who are in or considering governance roles.

I have been asked to write about governance for nurses in PHC, and have collected a few thoughts that may be helpful to nurses for the future – especially in this time of potential change, signalled by the interim report of the Health and Disability System Review.

I would encourage you to think carefully about the contribution you could make in a governance role in the future health context of Aotearoa – before the release of the final Review report.

My view

- Essential to your leadership/governance journey is your understanding, communicating and conveying of the unique cultural context of Aotearoa, and the emphasis of an equity lens to health provision. Health equity is the issue of our time and must be central to all nurse endeavours, especially for those in governance roles.
- Nurses are skilled, knowledgeable, experienced, and have a connection to people and community. This means they have a global view of the primary health and social care sector.

Many nurses in Aotearoa, New Zealand have been nursing for many years and have developed a community and clinical wisdom that represents a rich and broad experiential skillset to those wanting to extend their talent into the governance sphere.

What every nurse can do?

There are two groups of nurses – those in governance roles and those supporting nurses in governance roles. We need to be intentional about increasing and supporting nurses in governance. It was pleasing to see more nurses standing in DHB elections. Whether or not they were successful, they signalled to their communities and health authorities that they are firmly committed to local health and social care.

Nurses are very good at mentoring and coaching, but not so good at sponsoring. If every nurse said to a colleague, "I have noticed this opportunity and I think you would be a good person to consider it, and I am happy to assist in whatever way I can," health could be transformed in at least 53,000 ways!

- Governance is not a solitary activity, it takes:
- working with others,
- knowledge of a community, and the skills of critical thinking and problem solving.

Nurses work within teams from the get go and use analytical skills constantly in their work.

So what is the elephant in the room?

Many very skilled, experienced nurses have put themselves forward for governance roles in PHO structures. Anecdotally many have stated they did not consider themselves effective in the role.

Inhibiting factors

The employment model in general practice can inhibit the degree to which a nurse can comfortably speak out, because the business funding model takes precedence over the model of care, and this precludes service development and innovation.

The vested financial interests (and risks) of practice owners makes it very difficult for other "actors" involved and there is:

- great variability between PHOs' local contexts,
- how they have evolved,
- the size of their populations,
- the skills and expertise available etc.

The degree of variability is problematic in itself.

Lastly, there has been very little recent research around the effective functioning of the PHO governance model in Aotearoa.

Promoting factors

Thank every nurse you know that has been involved in a governance role, no matter what the agency is. They have gone before you and may be able to support you.

Increasingly, boards are offering a "shadow" opportunity, where you can an observe before formally seeking a governance role. Explore this in your area.

When you are elected to a board, insist on a governance course, e.g. the New Zealand Institute of Directors one-day course (not for profit entities) and a board induction at a local level.

There is planned systemic change on the horizon spanning 2-3 decades, via the Health and Disability System Review. Nurses need to be prepared for new governance opportunities that may present within a changed health system setting. Don't wait for changes and then act. Act now in preparation for change and in readiness for opportunity.

Let's start governance at nursing student and nurse graduate level.

Celebrate governance experience at any level, e.g. mature students who have been on Boards of Trustees for their local school. Nurses who are parents and have governance experience at play centre, Plunket, sports groups, etc, are other examples.

Encouraging younger nurses into health and safety committees or infection prevention and control committees is a great way to start. Nurse professional organisations offer opportunities for growth in this area, e.g. NZNO's 21 College and Section groups.

Provide support and guidance AND sponsor nurses into governance roles. Read, use and distribute widely the NZNO toolkit *Growing Nurses into Governance*.

In summary:
I absolutely endorse the toolkit. It has something for everyone and can be downloaded from the NZNO website.

We need more nurses and greater diversity of people in governance roles. So let's celebrate our current nurses in governance roles (especially in PHC) and prepare immediately to accept the opportunities/ changes on the horizon.

Governance is not for everyone – however it could be for you.

Think, assess, explore, consider – and then go for it!

Christmas peace and happiness to you all over the festive season and thanks to the College of PHC for their work undertaken throughout the year.

Eldred Gilbert, RN BA MBA
NZNO Strategy for Nursing, Project Lead.

What can we advise our clients to avoid weight gain over the holidays?

Holiday weight gain is common, as we tend to treat ourselves and overeat on energy rich foods. On Christmas day alone an individual may consume 25,104 KJ (6,000 calories), which is what we would normally eat over two days1. The research varies on the amount people put on, but most adults usually still weigh more in February and March each year than the previous year and unfortunately do not lose it by the end of that year. Therefore, our weight can accumulate each year after holiday periods. That said, holiday weight gain is not inevitable and there is research showing that if we plan ahead we can enjoy the festivities while maintaining our health.

As health professionals, we have the opportunity to offer brief intervention to help our clients in their goals to improve their health over this period.

Top tips to avoid weight gain over the holidays

1. **Be active with family and friends:**
   Try to include some physical activity daily whether this is a walk, swim or another activity that everyone enjoys. It is great to be able to spend time together and it also helps with our mental wellbeing and not just our fitness.

2. **Watch your portions:**

Those who eat larger portions tend to gain weight more easily than those who don't. Using smaller plates and glasses can help us to not over eat. Try not to overload your plate, but enjoy smaller portions of the foods that you enjoy.

Also include healthy options into your daily meals and snacks, such as:

- lean meats,
- vegetables, and
- salads and fruit

3. **Skip Seconds:**

Holiday meals are sometimes served buffet style or with several options to choose from. Try to limit yourself by not having seconds or thirds. If you are still hungry, try to choose more salads or vegetable based dishes.

Try not to chat near the table of food at an event as you are more likely to mindlessly graze on food in sight. Pop a few items on a napkin or small plate if it's a party with finger foods so you can keep track of your intake better.

4. **Limit liquid energy**

It is much easier to drink a lot of our daily energy intake in the form of drinks, as we do not compensate by reducing the rest of our food intake like we would when eating solid food. These means we often consume more energy overall.

Also being in holiday mode we often we drink more alcohol and fizzy drinks than we may normally do:

- Try to keep up your hydration by choosing more water over other drinks

  Alcohol consumption is often linked to increased appetite and is itself high in energy. Some people find choosing low alcohol drinks an option or having a non-alcoholic low sugar beverage in between can help with decreasing the amount consumed. Explaining to clients that alcohol does contain a lot of energy can be helpful. For example: cider and ready to drink beverages (RTD) is the same energy as eating a small bag of chips.
- Make up your own ice teas, there are lots of options and flavours instead.
- Use club soda or sparkling water with a squeeze of lemon or lime instead

Types of alcohol	**Average Energy**	**Energy intake equivalent in food items**
330mL 5% Cider (1.3 std drinks)	724 KJ	small bag of potato chips (30g)
330 mL 5% RTD (1.2 std drinks)	765 KL	
150mL 14% Wine (1.7 std drinks)	502 KJ	2 chocolate chip cookies
330mL 5% Beer (1.2 std drinks)	385 KJ	More than toffee pop
330mL 2.5% low alcohol beer (0.7 std drink)	217 KJ	Piece of chocolate
30mL shot 42% Whiskey (1.0 Std drinks)	295 KJ	

5. **Limit your desserts and sweets:**

Desserts, biscuits and chocolate are often everywhere during the holiday season. This often leads to excessive sugar consumption.

Where you can keep these items out of view, you are less likely to snack on these because they are in front of you. When you do have a treat choose something that you absolutely love, portion control it and eat it mindfully. It is often the first few mouthfuls that give us the most satisfaction so enjoy the taste, smell and texture of your favourite treat.

By having clients think about how they will manage the festive season, and help them plan ahead so they can make choices to keep themselves on track.

Information adapted from https://www.alcohol.org.nz/alcohol-its-effects/about-alcohol/what-is-alcohol/energy-in-alcoholic-drinks

Reference:BD Association. Food Fact Sheet: Christmas. 2014. BDA November 2014. Review date November 2017. Version 4 www.bda.uk.com/foodfacts/christmas.pdf. *Lesley Perry*

Lemon Basil Ice Tea Recipe
½ lemon thinly sliced 6 fresh basil leaves* 2 green tea bags 3 cups of hot water 1. Steep teabags in hot water 3-4 minutes, the longer the teabag is in the stronger the flavor your tea will be but do remove the teabags as otherwise you will get bitter flavours. Green tea also gets bitter if boiling water is added, let it cool 2-3 minutes before adding tea bags. 2. Add lemon and basil leaves. It is better to remove herbs after a couple of hours as they will start to disintegrate. 3. Serve chilled You can also change this recipe by using different fruits, fruit teas or adding mint or rosemary.

NZNO PHC Delegate Committee

This was my first meeting as representative for the CPHCN, filling the vacancy left by Jane Aylings' resignation.

Representatives provided reports before the meeting and it seemed there was a mix of pluses and minuses. On the plus side: collective agreements had been agreed for a number of sectors with progress on pay scales and conditions, in some cases comparable to DHBs. Other agreements are in negotiation or due to begin in the next couple of months. In some cases, references to Nurse Practitioners, nurse prescribers and health care assistants have been included in these agreements.

On the minus side:

- recruitment,
- retention and lack of relievers are issues for all PHC sectors;
- working conditions for many, and
- trying to do more with the same or less; trying to do more volume and more types of services in the same facility without modification, is a common theme.

Remember what primary care was like 10-15 years ago, and now just think about all the types of things being done, needing to be done or expected to be done by PHC sector that is, the nurses.

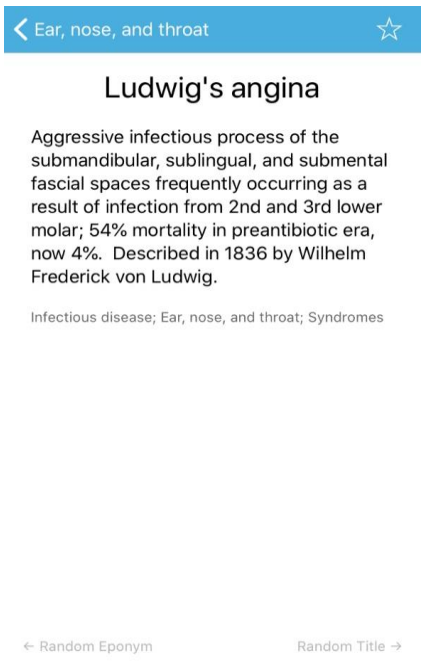
All current PHC delegates attended, although there are three sector delegate vacancies.

Wendy King- Report from Meeting 23rd October, Wellington 2019.

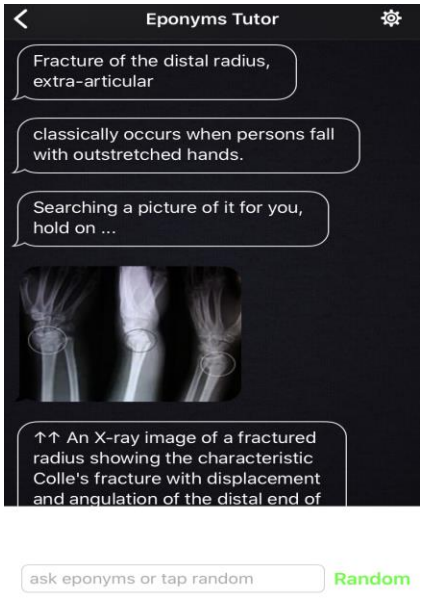
App Review

The apps we're going to look at this edition solve the eternal problem of 'I've never heard of that before'. Let's face it, you can never learn everything within the medical field. Sometimes patient's come through triage with disorders I've never heard of, or a Doctor writes in their notes about some physical assessment test that I've never seen before. That's where the app *Eponyms* comes in, the app is like of like a mini medical text book in your pocket.

Eponyms by nature are disorders, diseases, procedures or equipment which bears the name of a person, usually the person who discovered it. The app namesake breaks things down into categories which include: alphabetically, anatomy, biochemistry, body system, area of specialty or procedures. The app will also let you know if a term fits into more than one category, which is handy.

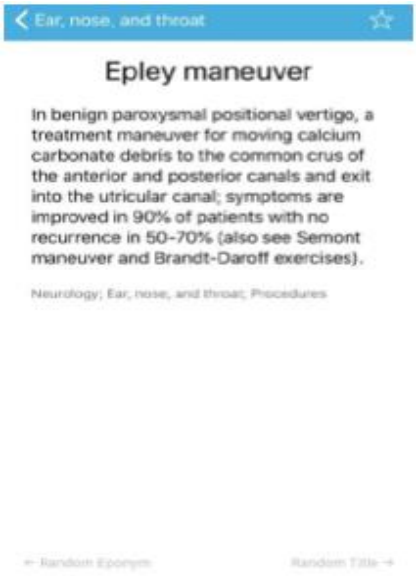


I've already learnt several new things, including the below fact about Ludwig's Angina, which until now, I would have thought was more along the lines of a cardiovascular disorder, turns out the cause is an infection in the mouth



So yes, you may be thinking that you could just Google these things, and yes, you might be right, but I like how this is all in one app. The app can be used offline, you don't need a computer to access it

(though they do also have a website). And you're not going to get any odd results or pictures. But if you are more of a pictorial person, you could consider a more visual app option, which is called *Eponyms Tutor.*



This app has pictures for different symptoms or disorders which can be really beneficial. However, the free version of the app is somewhat limited, restricting you on to only certain pages, while the full version will cost you $8.99 and allow you to see their full content library. I'm thinking of purchasing this when I go back to do my post-graduate studies. *Erica Donovan*

The nursing voice on District Health Boards

As you may be aware, there have recently been local government elections, including those for the District Health Boards. With this voting, several areas around the country are welcoming nurses onto boards, many having experience working in primary care.

Canterbury District Health Board welcomed a PHC nurse, Naomi Marshall (pictured above) Naomi is currently on maternity leave, but before this worked at Riccarton Clinic and After-Hours Medical Centre. She has a background in paediatrics, emergency nursing, and medical surgical care. She believes it is of great importance that the health boards have nursing input. She is passionate about PHC as a whole, and in her statement presented to website, The Spinoff, she said that her top priorities are increasing primary care, increased mental health services and to improve staff and patient safety by ensuring adequate staffing levels and reducing assaults on staff.

Erica Donovan

Nelson, New Zealand
Rob Langdon; Flickr

The P Family Case Study

Another area where a nurse was successful was Nelson Marlborough District Health Board, which welcomed another PHC nurse, Jacinta Newport. Ms. Newport has a background in PHC, including work as a rural and remote nurse in Australia.

Bay of Plenty has also re-elected Registered Nurse Marion Guy, who in addition to being on the District Health Board, was also the past president of NZNO. Ms Guy has already served five previous terms on the board and brings a wealth of experience.

Other nurses serving on boards include Auckland DHB nurse Jo Agnew, who works for the University of Auckland nursing department. Round the country there were also many other nurse, pharmacy and allied health candidates who were unsuccessful in obtaining board seats this time around, and I hope will run again in the future. It is my hope that going forward, the health workforce has a strong representation in local and national politics.

As part of the refugee intake into Nelson, I receive the health screening records from Mangere Refugee Centre as well as the referrals to the hospital departments for every refugee

that settles in Nelson, which is around 120 people a year. In November last year a Burmese family arrived from Mangere. This family who we will call the P family consists of Mr P a 46 year old, Mrs P a 34 year old, three children aged 6, 8, & 10. Also Grandma P who is 78 years old and is the mother of Mr P.

I received four referrals from Mangere for this family which I forwarded to the appropriate clinics/departments for at the hospital for follow up. The referrals were for - Mr P who needed follow up for possible (TB)Tuberculosis (respiratory clinic), his mother Grandma P who had an abnormal Chest x-ray during screening at Mangere, GP referral for further follow up and a referral for the eye department. I later received a referral from the Infectious Disease Specialist for Mr P to have TB Medications under supervision. uring the contact tracing with the family Mr P's mother Grandma P mentioned that she was having chest pain and had difficulty breathing when she was walking to school to pick up the children and would have to stop often to rest. After further questioning from me through the interpreter, Grandma P reported that she was diagnosed with high blood pressure in the refugee camp and had been given medication to take, however these tablets had run out just after arriving into NZ and she had not been prescribed any more. While at the family home, I phoned the GP and arranged an appointment for Grandma P. A week later I received a phone call from the Practice Nurse asking about what follow up was happening around Grandma P's abnormal chest x-ray. After discussions with the Infectious Disease Specialist and the GP it was decided to get three sputum's from Grandma P to rule out active TB. I also received a phone call from the Pharmacist at Victory Pharmacy who had concerns about a future appointment at the hospital eye department for Grandma P that the family were unaware of. The interpreter based at Victory pharmacy, had been booked for three hospital appointments by interpreting

New Zealand, and while she spoke to one of the family members while at the pharmacy she realised that the family did not know about the hospital appointments, which included a surgical appointment. A couple of days later I did a home visit with the interpreter, to catch up with Mr P to check how he was going with his TB medication, and the family showed me the appointment letters they'd received from the hospital. All these letters where in English, which the family could not read. Some required a phone call to confirm the appointment and as the family could not read English this had not happened. I contacted the hospital Eye department and Grandma P had four upcoming appointments with them over the next two weeks. I then rang Red Cross so that transport to these appointments could be arranged with their volunteers.

Eye surgery was then arranged and carried out on Grandma P. The following day I received a phone call from the eye department nurse expressing concern that she did not think that Grandma P completely understood the aftercare instructions the nurse had given after surgery, even though an interpreter was used. I did home visit the next day with the interpreter to see Grandma P. I went over the aftercare instructions with her again to ensure that she fully understood. Grandma P asked several questions about her aftercare and seemed pleased that this happened, as all written instructions that Grandma P had received were in English.

Last week I arranged my last home visit to the family to discharge Mr P from our service as he had finished his TB medication. While speaking to the interpreter based at Victory pharmacy to arrange a time for thishome visit, she mentioned that the family's GP had been in touch with the Pharmacy, informing them that the family had nits and needed treatment. A script was sent from the GP, and as the interpreter was coming to the

family home to interpret for me the pharmacist asked if I would explain to the family how to carry out the treatment for nits.

This is one of the many cases I have been involved in with vulnerable families within the refugee community that required a person to co-ordinate health care for a family recently arrived into NZ.

Sheryl Hockey
Public Health Nurse

Power to Protect: how to support parents and prevent harm to babies.

Anne Tyldesley looks at some of the issues around shaken babies and how we help to prevent harm to the smallest members of our community.

Although the Holmes and Rahe (1967) stress scale does not mention Christmas as being one of the leading stressors in life, most of us would agree that things have changed a great deal since the heady days of the 1960s.

The modern Christmas is wrapped up in the glittering fairy lights of family, fun and festivities. The pressure is on to make it the most memorable so far!

Adding to the pressure is the seasonal closures of many of the usual support networks:

- general practice,
- Plunket,
- district health board services, and more.

This can remove the 'go to' support for many families for up to 2 weeks and for families with a young baby, a situation which presents its own unique stressors, this can only add to their difficulties.

What can you do when the baby cries inconsolably?

A crying, inconsolable baby, can push parents or carers to the edge. It can even result in shaking the baby, which can result in traumatic head injuries, and can result in serious, life-long disabilities for the baby and life-long guilt for the parent or carer.

Although the risk for these events is greater amongst some families, for example:

- single parents,
- young parents,
- mental health diagnoses,
- substance abuse,
- multiple children under 5 years of age and
- women who have missed ante-natal care.

Any parent or carer can be moved to shake a baby given the right circumstances.

Given the public's perception that 75% "good" parents can soothe their babies, the pressure is on to make the baby calm down.

The reality is that babies can't always be soothed and this can result in parents feeling frustrated and 'bad' at the job of parenting, and carers feel they fail in their work to the point of frustration that many of the planned parenting methods go out the window.

As healthcare providers, in any field we work in, we can support parents and carers to gain an understanding of the crying a young baby makes and help them to devise a management plan for when the crying causes serious frustration.

Crying is a normal communication method for a baby. It can increase over the first few months of life and usually settles down around the age of five months. The crying curve (*National Centre on Shaken Baby Syndrome, 2019*) shows the pattern of young babies' crying (Figure 1).

The Period of Purple crying (Figure 2) also emphasises that there is a crying period i.e. there is an end to the event http://www.purplecrying.info/sub-pages/crying/why-does-my-baby-cry-so-much.php

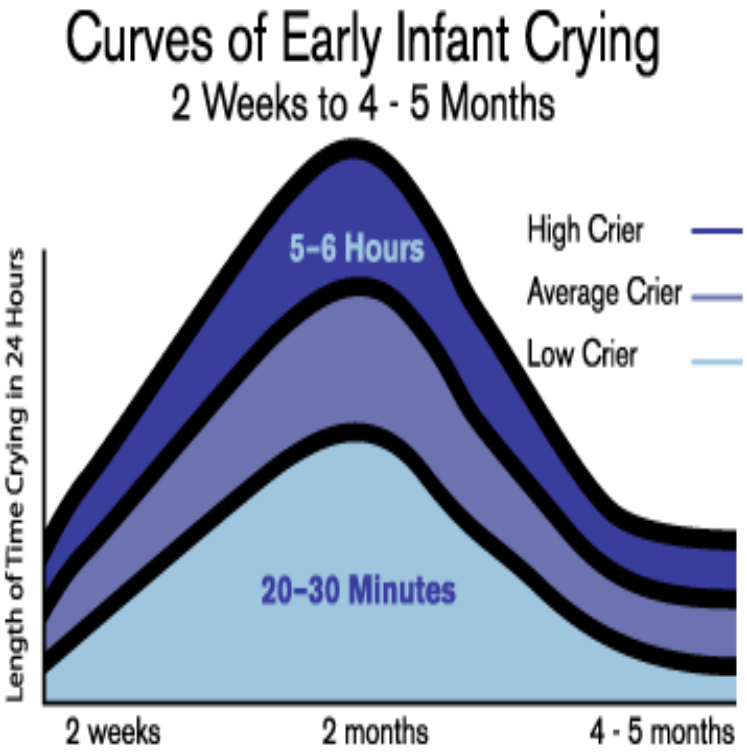
What can we do to help?

The challenge for healthcare personnel is not to judge the family/whanau, but to offer kindness and support to them.

To do this, we need to change our perceptions about crying and accept that when some babies cry it is impossible to calm them – it's in their nature and it is a normal event for them.

Parents and carers of infants need to find a way to get passed the danger time of frustration and realise that the baby doesn't understand their point of view.

If parents and carers can gain an understanding of babies' crying, they can create a plan for what to do if or when they reach frustration point.



By implementing this plan, they can prevent a baby being shaken.

Figure 1

As healthcare professionals, we can reassure parents or carers that taking appropriate actions can prevent harm to the baby. We have the power and authority to assure them that it is okay to implement their plan to manage the crying in a way that is best for them.

For example:

Placing the inconsolable, crying baby in its cot, (which is a safe place for it to be), and leaving the room. The baby is safe: any continued crying tells you it is breathing. Check on the baby every five minutes and give yourself some time to settle your frustrations and then return to the baby to pick it up again. We are giving the carer permission to walk away.

Or:

Have someone you can call and talk with when you are frustrated. Someone who is familiar with the crying issues, someone you can trust.

In New Zealand, ACC fund The Power to Protect briefing for educators. It is intended to provide healthcare providers with insight and knowledge that can help them to recognise the stressors for shaken babies.

The DVD “Power to Protect: Never, ever shake a baby” is available as a download from” https://www.healthed.govt.nz/resource/power-protect-never-ever-shake-baby.

It can be used individually or in education sessions for professionals and families to increase awareness about the causes. Figure 3 lists the key elements for the prevention of shaken baby. We can use this list to help us to help others.

So, as we head into the festive season, lets hope that no one in our community is left without the support and understanding they need. That we all have a happy (and hopefully peaceful!) holiday.

Preventing Shaken Babies

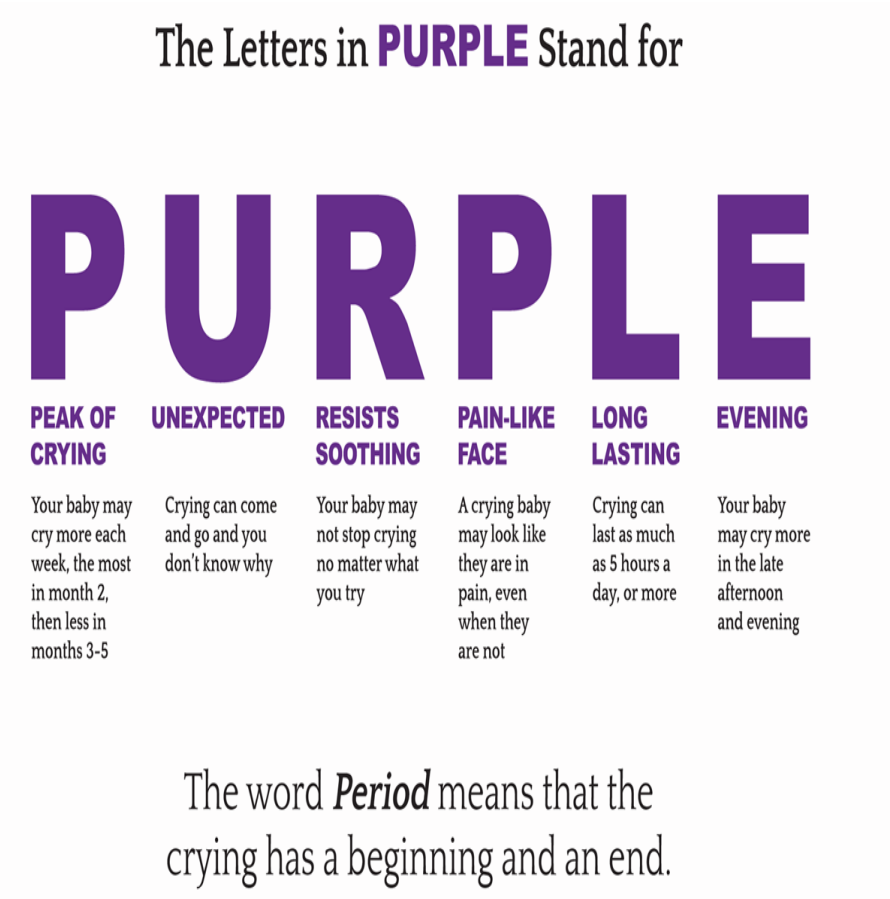
Every parent needs to have a plan to manage the inconsolable crying baby.

Early identification of the at-risk groups and provision of support and education to help those carers to make their own plan for managing their frustrations.

Identification of high-risk family environments when parents present to ante-natal providers, general practice, Plunket, ED, etc.

Recognition at presentations to healthcare of trauma to a baby that could indicate a risk for shaken babies.

Support for parents post-natally: this can be provided at the routine immunisation events by asking some simple questions about how things are going.



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Fresh Minds

Ruth Morse

Joint venture primary mental health partnership between Tū Ora Compass and ProCare Health presents opportunity for nurses with mental health credentials

Back in August this year ProCare Health Ltd and Tū Ora Compass Health announced the signing of an agreement to align their respective mental health services – in order to enable a stronger primary mental health service for communities across Aotearoa.

The aim is that over the next 12 months, ProCare Health and Tū Ora Compass, as two leading providers of primary mental health services nationally, will work towards integrating their services into a single operating model – Fresh Minds New Zealand – that will effectively cater for the various needs of our diverse population in New Zealand within primary mental health care.

The aim of the aligned national service offering is to ensure our communities have ready access to high value, reliable and quality primary mental health and wellbeing services as and when they need it. Tū Ora Compass acting CEO Justine Thorpe, says it's about bringing together and consolidating the two PHOs' expertise, capability and capacity in primary mental health and wellbeing to respond to the new direction in this space, heralded by the Government's recent Wellbeing Budget.

"Given the Government's focus on ensuring barriers to mental health and addiction services are dramatically reduced for New Zealanders, we believe the time is now to work collectively to ensure we have an effective model in place across Aotearoa to tackle mental health and addictions support in general practice," says Ms Thorpe.

ProCare CEO Steve Boomert says ProCare Health is proud of the work it does within primary mental health to develop new models of care, so people have easier access to quality mental health support in a timely manner.

"For us, it's about ensuring every New Zealander gets the right to live well," says Mr Boomert.

"Together with Tū Ora Compass we are committed to ensuring the mental health needs of New Zealanders continue to be supported and integrated within our practices at a primary care level."

Tū Ora Compass and ProCare Health individually provide primary mental health services to more than a quarter of New Zealand's enrolled population in the country's densest population centres (Wellington and Auckland), through established mental health services and our two leading innovation programmes - Te Tumu Waiora and Piki.

For the two organisations therefore, the partnership is an opportunity to ensure the benefits of programmes like Te Tumu Waiora and Piki reach more of those people who need the support.

"The Government's Wellbeing Budget has given primary care the mandate to keep moving forward with initiatives that have proven to help break down barriers when it comes to accessing mental health and addiction services," says Mr Boomert.

"So, it makes sense that we work together to ensure more New Zealanders get the support they need."

Collaboration to achieve better outcomes for more New Zealanders is the founding principle of the partnership between the two PHOs.

“By working together and combining our experience in providing effective primary mental health care programmes, backed by clinical expertise, international best practice, and empathy, we will be able to more effectively reach a larger portion of our diverse communities across New Zealand and give them access to the support they need,” says Ms Thorpe.

Fresh Minds New Zealand is a social enterprise whose purpose is to achieve thriving mind, mood and wellbeing in Aotearoa. The service delivers innovative mind, mood and wellbeing services for at-risk communities, youth and family.

There are exciting opportunities ahead for registered nurses with mental health credentials or those looking to explore a mental health professional pathway.

Johnny O’Connell, currently GM Patient Services for ProCare has been appointed CEO of Fresh Minds New Zealand, effective immediately.

Drowning

New Zealand is an island nation, with a poor record around drowning. For a country surrounded by water you’d think that we’d be doing better. But you’ll be pleased to know, some of the statistics are actually improving. The overall incidence is dropping, with a decrease also in the 15-24 age group. In 2018 there were 204 drowning related hospitalistations, however, this may be under estimated due to non-reporting of incidents. In addition to this, there was 66 fatal preventable drownings, and a further 23 which were largely non-preventable (Water Safety New Zealand, 2018). Males still dominate the statistics, overall their numbers are trending downward, and drownings among women are rising.

The physiology of drowning:
The International Life Saving Federation defines drowning as “the process of experiencing respiratory impairment from submersion/immersion in liquid”, from there it can be broken down to fatal or non-fatal (International Life Saving Federation, 2002, p.1).

Typically, the first thing that happens when someone starts to struggle in the water is panic. I’m sure you’ve been there before, the moment when you realise that (excuse the pun) you’re out of your depth. You tense up, your breathing might quicken, or alternatively you might start holding your breath to try keep the water from getting in your mouth. But this cannot be sustained for long periods of time. From there, fluid is swallowed and may end up being aspirated. Swallowing water and air may lead to vomiting, which could also be aspirated, further exacerbating respiratory issues (New Zealand Resuscitation Council, 2014, p. 1). If the body is starved of oxygen for too long, hypoxia ensues which can lead to cardiac arrhythmia, long-term neurological damage, or death.

If someone is immersed in cold water, this process may be accelerated. Cold receptors sense the drop in temperature, causing people to alter their respiratory pattern, and cause tachycardia and cardiac output to increase, the time to failure of breath holding can come sooner due to this ‘cold shock’ (Bierens, Lunetta, Tipton, & Warne, 2016, p.7).

Assessment of patients who have suffered a drowning event:

As per the fundamental ABCDEF assessment guidelines, the first thing that needs to be done with any patient is ensure safety.

- Is the situation safe? Ensure your own safety if attempting to assist drowning person, plenty of people die trying to save someone else. This also applies in cases where the patient may need defibrillation, you don't want to get a shock from the
- puddles of water around the patient.
- Is there help available?
- Is the airway open, or is it under threat? If the person is unconscious not breathing commence resuscitation following the Australian Resuscitation Council and New Zealand Resuscitation Council Basic Life Support flow chart .
- As mentioned above people may vomit due to gasping down water and air, so ensure the patient is safe. If vomiting does occur, and the patient is breathing, they should be moved to their side to ensure can be cleared.
    - Breathing – Although some people have been taught a compression only CPR, the New Zealand Resuscitation Council warns that in the case of drowning the breathes are fundamental. Their advice is "Compression-only CPR circulates oxygen-poor blood and fails to address the victim's need for immediate ventilation. It is *not the recommended resuscitation method in a victim of drowning and should only be used temporarily if the rescuer is unable or unwilling to perform rescue breathing before the arrival of a barrier device, face mask or bag-valve-mask device.* (New Zealand Resuscitation Council, 2014, p. 4).
- Circulation – obviously vital signs, but also careful inspection. You may notice that the person is pale or blue tinged due to hypoxia. However, many traditional teachings such as this fail to recognise that signs of hypoxia may be different across patients of different skin tones. Some patients develop a grey or green tinge to their skin, or pale conjunctiva may be seen (Sommers, 2019, para 18). Also think about if the person might be hypothermic, they may need to be warmed up.
- Always consider, could this person have a spinal injury or head injury, these may occur from someone diving, hitting an obstacle under water, or an injury before the person was submerged in the water.
- Other associated things to keep in mind are assessing and supporting people with their mental health journey if they have found the experience damaging to their mental health.

According to UpToDate, the following factors are predictors of poor prognosis following water immersion:

- Duration of submersion >5 minutes (most critical factor)
- Time to effective basic life support >10 minutes
- Resuscitation duration >25 minutes
- Age >14 years
- Glasgow coma scale <5 (ie, comatose)
- Persistent apnea and requirement of cardiopulmonary resuscitation in the emergency department
- Arterial blood pH <7.1 upon presentation

(UptToDate, 2019).

Drowning prevention:

Obviously, the best situation is always prevention. Comprehensive swimming teaching, use of correct safety gear when in and on the water, and picking safe places to swim are all important factors. With the latter, Surf Lifesaving New Zealand has created this site, designed to help members of the public know which beaches are patrolled by trained Surf Lifesavers. Those who enjoy boating also have a part to play, with education being provided on the use

of life jackets, emergency equipment and the rules of the water. Interestingly, it isn't just inexperienced or over confident people who die from drowning, studies show that in triathlon athletes the majority of deaths are caused during the swim portion (Moon, Martina, Peacher & Kraus, 2016).

Education around alcohol often focuses around how many drinks, and not drink driving, but people also need to think about water safety and alcohol. Alcohol can cause some people to become disinhibited, and they might attempt things they wouldn't try when sober, or they might not have the astute reaction time needed to avoid an accident occurring.

There are always going to be a number of drownings that can't be prevented. Maybe someone had a seizure, a cardiac arrest, or other unexpected event. So, depending on the situation, they may need to be worked up in other ways, with scans, ECG or other testing.

As nurses we have a role to play in drowning prevention, things like talking about water safety in travel consultations, or even simple things like reminding parents not to leave young children alone in the bath or swimming pool.

K**ey pearls:**

- Ensure your own safety when dealing with patients who have drowned.
- Remember the DRABCDEFG then other factors might need to be explored
- Thorough assessment is key, always keeping in mind red flags that can mark deterioration.
- Prevention is always better than cure.

Erica Donovan

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What are the rules around Car seats and restraints for children???

Lee-Anne Tait, Rural Health Nurse

Over the summertime there seems to be lots more visibility in relation to children. They seem to be everywhere. We have lots of people coming into the Health Centre with other people's children that they have staying for a few days: grandparents with grandchildren, aunts with a niece or nephew, all playing happily in the waiting room or the side of the treatment room whilst the adult is being treated etc...

Often it seems these children travel some distance to stay over for the summer with relatives. I found myself really noticing the implications of this a few weeks ago whilst travelling as I watched a Mother at the airport get off the shuttle bus with her husband and children, then suddenly realize that one of them needed to return to the long stay

carpark to get their 2 children's car seats which they had overlooked. It got me thinking that I didn't know anything on the rules for travelling with children, as mine are now teenagers and wear a seatbelt.

I therefore spent ages looking things up when it comes to restraints for children within New Zealand. I thought it may be of some help to you either in a professional or personal capacity in case you need to put or ensure a child is safety placed in a vehicle. Here's a summary of the rules behind restraints of any kind:

Teenagers over the age of 14 -need to wear a seat belt where there is one available and 'Clunk click every trip'. If they don't it's the drivers responsibility to inforce this until they are 15, also the fine for non-compliance would lay with the driver, as it would for failure to comply to any of the rules below.

8-to 14 years – clunk click and rear sit – wear a seatbelt wherever possible – if there is no seatbelt in the vehicle – definitely must rear sit.

Between 7-8 - if there is a child restraint fitted in the vehicle it should be used, this is usually a seatbelt harness or a booster seat, otherwise a seat belt should suffice so long as the child is above 148 cm. International best practice suggests restraint should be used until 148cm or 11 years old.

7 and under – an approved restraint must be used, appropriate for the child's age and size, this must be a seatbelt harness, a booster or car seat. (The law around this stipulates as in minimum it must be until the child's 7th birthday).

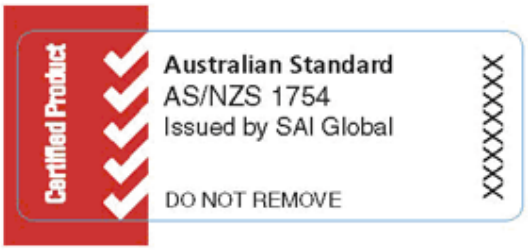
Toddlers- restrained within an approved car seat, ideally in the rear of the car and not near airbags.

Babies – restrained within a capsule or car seat – International best practice suggests ideally rear facing-and should be used for as long as is practical and at least until two years of age, also new capsules and car seats should be approved and ideally fitted by a restraint technician. With checking of this fitting prior to discharge from a hospital or on first Plunket visit.

Legal approved seats – all restraints must comply to an approved standard and display it visibility on the restraint – currently in New Zealand -Australia/ New Zealand -AS/NZS1754, European - E3, and American - FMVSS123 safety restraints are approved for usage.

Air bags –there should be caution around never use a rear facing restraint on a front seat where there is an airbag.

Also be careful if you are needing to sit a child in a front seat where there is an airbag – pull the seat as far back as you can



Also where there are side airbags don't let the children lean out of the seat and ensure that there are no obstacles between the seat and the door.

Exceptions to the law - *Vintage vehicles* –need to have been registered before 1955 before seatbelts were fitted.

Campervans and motor homes: since 2003 all modules have to have the same number of seats belts as there are sleeping births and have to be worn if the vehicle is moving on an open road, also the front seat driver and passenger must have a three-point dual sensitivity retractor seatbelt for extra safety.

Passenger vehicles – taxis buses shuttles coaches – if there is a restraint there it should be used age appropriately and always if the child is under 7. Also be aware when *Hiring child restraints* – not all of them fit all vehicles.

***Exemption orders*-** You can apply for an exemption order where it is either impractical or undesirable for medical reasons to restrain a child, this usually pertains to child with disabilities. (You can apply at a cost of $27.30 to NZTA via the link below and will be charged whether or not an exemption is granted)

Hiring restraints – not all restraints fit all vehicles, so advanced planning is helpful if you have children coming into your car, because as the driver you are responsible for the safety of the child in the restraint. Wherever possible advanced booking with a request for an age appropriate restraint should be made when hiring a vehicle.

When travelling/ hiring restraints in different locations– Many rental companies offer car seat hire and they are fitted in by approved fitters. Plunket have lists of approved restraint fitters at many locations across the country if you are requiring some assistance, just look on their website via the link below.

Well that's about it in a nutshell in relation to restraints. I hope in due course this information will prove helpful, if for nothing else than a winning answer in a Trivia Quiz at Christmas.

Season's greetings, May God Bless to you, your colleagues and your whanau – may you all travel safely and go well Lee-Anne.

References:

https://www.drivingtests.co.nz/resources/seat-belt-law-in-new-zealand/

https://www.nzta.govt.nz/assets/resources/child-restraints/docs/child-restraints-save-lives-english.pdf

https://www.nzta.govt.nz/safety/vehicle-safety/safety-belts-and-restraints/child-restraints/using-child-restraints-in-new-zealand/

https://www.plunket.org.nz/what-we-do/what-we-offer/car-seats-service/buying-a-car-seat/

New Zealand College of PHC Nurses, NZNO

The Executive Committee, Professional Practice and LOGIC committees met in Wellington. Here is a photo of us with the Chief Nursing Officer, Margareth Broodkoorn.

Hot topic – Burns

Erica Donovan

Summer barbeques are great aren't they? Except when someone ends up with a burn (or for that matter, food poisoning – see our Spring 2019 edition for more information on food borne diseases).

Assessment of burns:

As with anything, always remember the ABCs (and the DEFG), make sure that the person is safe and that their airway is safe. They might have a burn to the skin that is a pressing concern, but are they also at risk of an inhalation injury? Injury to the structures of the upper and lower airways can cause swelling that can lead to respiratory compromise.

Carbon monoxide toxicity is also an important factor to consider (Dries & Endorf, 2013). Circulatory function is

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something to always keep in mind, both in the acute and later phrases of treatment, some patients may be at risk of fluid losses associated with burn injury.

Just like any injury, burns need to be well assessed. If I'm the nurse coming in to do a dressing, I want to know:

- Where it is on the body
- Size of the burn
- When it happened
- Depth of the burn
- How it happened
- Is there sensation
- If there's blisters, are they intact or burst?
- Was there interventions after the burn happened

This table from Counties Manukau District Health Board (2017, p. 4) shows the different levels of burns. Burns can be extremely painful, but on the other end of the scale, if a patient has an extensive and deep burn with no pain, it means that the skin has been damaged down to the nerves. I.E it's bad news.

Depth	Colour of DERMIS	Blisters	Capillary Refill	Sensation
Epidermal	Red	Epidermis damaged but intact (dry & no blisters)	Present – normal / brisk	Present
Superficial Dermal	Uniformly Pale Pink	Present – usually small & delayed (hours)	Present – normal / brisk	Painful
Mid Dermal	Dark Pink or blotchy	Present – usually large & appear quickly	Sluggish	+/-
Deep Dermal	Blotchy Red or Fixed staining	+/-	Absent	Absent
Full Thickness	White or black or charred	No	Absent	Absent

Counties Manukau DHB, 2017

With burns it's important to remember that they can occur not just from heat and fire, but also chemicals. I've seen a case in practice where a worker was exposed to a pressurised gas, which similar to liquid nitrogen can cause a cold burn on the skin. In an effort to halt this process, he tipped boiling water over his injury, hoping it would neutralise the temperature. As a clinician, I had experience using liquid nitrogen for warts or other minor skin disorders, but I never heard of LPG or other cold burns. The Australian & New Zealand Burn Association has a great library of advice sheets for both clinicians and the public. These range from the aforementioned LPG burns, hair straightener burns, concrete burns, radiator burns, as well as the more common scalds from oil or hot noodles.

Another good thing to keep in mind is, will this burn even be able to be managed in primary care? The National Burn Service website also has information about the referral criteria for referral to a specialist burn unit (Christchurch, Hutt Hospital, Waikato Hospital and Middlemore). While not many of you will be in a position to complete referrals, it is a good thing to keep in the back of your head if you see any of these burns in your nursing role.

The criteria are:

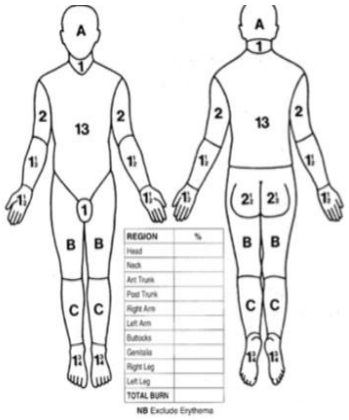
Referral Criteria for Regional Burn Unit:

- Burns > 10% total body surface area (TBSA) OR 5% in a child
- Burns to special areas - face, hands, feet, perineum, over major joints
- Full thickness burns > 5% TBSA
- Circumferential burns of the limbs or chest
- Burn injury with inhalation injury
- Electrical burns
- Chemical burns

- Burn injury in patients at the extremes of ages – children & elderly
- Burn injury in patients with pre-existing medical disorders which could complicate management, prolong recovery or affect mortality

  Any burn patient with associated trauma in which the burn injury poses the greater immediate risk of morbidity or mortality
- Any burn suspected with abuse. (National Burns Service, 2019)

The other factor in burns that is different to other kinds of wounds is the way we measure them. We don't say that 3% of the body is grazed but we would calculate a burn as a percentage. Here is a guide put out by Counties Manukau District Health Board (2017, p.4) on how to estimate the size of burns. Their key, which is emphasised within the larger document is to use the patient's palm size - not your own to calculate the percentage. Each one of the patient's palm with fingers extended is 1%. The body illustration below is what is called a Lund & Browder chart - which divides the body up into 9 areas to also help estimate.



Area	Age 0	1	5	10	15	Adult
A=½ of head	9½	8½	6½	5½	4½	3½
B=½ of one thigh	2¾	3¼	4	4¼	4½	4¾
C=½ of one leg	2½	2½	2¾	3	3¼	3½

Counties Manukau DHB, 2017

Management of burns

A good and thorough assessment, including the factors mentioned above can help others decide on what dressings and interventions need to be put into place. It makes it really hard going into a situation with all the wrong dressing supplies, and not even knowing exactly where the burn is. Management of a burn on the back can be quite different from that of one lower down towards the groin, certain dressings just won't be user friendly for certain areas of the body. I cannot stress this enough, the cooling after the burn matters. I posted a link to an article online recently about the evidence behind the importance of cooling burns in the paediatric population (not to say it's not effective in adults too, but the study just explored children). The study itself isn't open access, but the synopsis by Journalfeed.org is, and the study showed that if a burn was cooled to the recommended standard, the likelihood of needing a skin graft was cut by 40% (Griffin, Freer, Babl, Oakley & Kimble, 2019, cited in Smith, 2019).

From this a burns unit nurse commented that one thing we really wanted patients to know was the importance of cooling, and to not put food items onto burns. Old Wives tails dictated putting butter on burns, but research shows that it can actually make things worse. I've also seen a case where someone put garlic on burns and created a whole new issue with healing.

The bottom line is that while cooling might feel onerous and be distressing for some patients, it works.

There are so many varieties of dressings out there, and in my experience workplaces often stock such different products that it's not worth mentioning anything by name. General products that can be used are hydrogels. it's also important to think that a burn can be not only be a physical trauma, but also a psychological one. For some there may be

- anxiety,
- post-traumatic stress,

- depression,
- prolonged hospital stays, loss of physical functioning or altered body image.

ACC is able to assist people with obtaining counselling if they are needing that support post-injury.

A resource that is particularly relevant to our area of practice is the ACC document 'Management of Burns and Scalds in Primary Care' (ACC, 2007). The guide gives comprehensive but easy to digest information on the management of burns. There's also some quick glance flow-chats detailing treatments on different kinds of burns, well worth a look. The guide explains things far better than I can. As always, there are formal wound care trainings you can attend, but this guide is a free and very usable resource.

References:

- Accident Compensation Corporation. (2007). Management of Burns and Scalds in Primary Care. Retrieved October 30, 2019 from Ministry of Health website http://www.moh.govt.nz/NoteBook/nbbooks.nsf/0/BD251444C120DC0FCC2573210070271D/$file/burns_full.pdf
- Counties Manukau District Health Board (2017).
- Guideline: Initial Assessment & Management of Burn
- Injuries. Retrieved 19 July from http://www.healthpathways.org.nz/Resources/NBS-initial-assessment-guideline-77233.pdf
- Dries, D. J., & Endorf, F. W. (2013). Inhalation injury: epidemiology, pathology, treatment strategies. Scandinavian journal of trauma, resuscitation and emergency medicine, 21, 31. doi:10.1186/1757-7241-21-31
- National Burns Service. (2019). New Zealand National Burns Service Referrals. Retrieved from National Burns Service website.
- Smith, C. (2019). *Simple Cool Running Water Reduces Burn Severity in Children.* Retrieved from Journal Feed website: https://journalfeed.org/article-a-day/2019/simple-cool-running-water-reduces-burn-severity-in-children

Online Learning Module Review: SR eLearning Modules -

Yvonne Little

We are all very busy people and as nurses we need to be continually working to keep our knowledge up to date, but how do we manage to fit this into our busy schedules?

Some areas have a lot of learning opportunities, but for some it requires a lot of travelling or linking into a requires a lot of travelling or being able to link into a video session, and not everything is done at an opportune time for those who have families and/or other commitments.

As we know, PHC Nursing encompasses a wide range of disciplines, some of which include shift work. Getting time off work to attend sessions can also be problematic for some. Therefore, online learning modules are great. The SR e-learning modules are now available for you to access at home. There is no need to be connected to Medtech and this brings with it the freedom to choose when you want to spend 15 minutes doing a single modules. These modules have been developed by specialists and endorsed by RNZCGP's. It really is simple to access and took about one minute.

To register and access the e-Learning modules, click on the **www.SRelearning.co.nz** link, put your details in and you'll be looking at modules in minutes.Do watch the short video and try out some of the SR e-learning modules: Short video - SR e-Learning for Nurses. Also click this Guide to SR e-Learning PDF. It may be helpful.

The NZNO Library

Resources for Nurses

The NZNO Library has a wide range of hardcopy and online resources available to support the informational needs of members. Check out the NZNO Library resource lists.
http://www.nzno.org.nz/resources/library/resource_lists

Copies of these articles can be provided to NZNO members free of charge.
Email library@nzno.org.nz and let us know which ones you are interested in.

Books available for borrowing

- Books can be borrowed by NZNO members for a period of four weeks.
- All books are couriered to you, so please provide your street address when requesting items.
- The NZNO library has other titles in addition to the ones below, so please contact us and we will check the catalogue for you.

1. ***Death and dying in New Zealand*** [BF 789.D4 JOH]
   Edited by Emma Johnson
   Freerange Press, 2018
   Suggests that this collection of essays on the following aspects of death and dying in this country are a stimulus for discussion about how to plan for death as individuals and as a society.
   - NZ's diverse and ageing population,
   - advances in technology
   - medical care, and
   - the social, economic and environmental challenges facing NZ society

2. ***The four pillars of governance best practice for New Zealand Directors*** [HD 57.7 FOU]
   Institute of Directors, 2017
   Equips you with
   - high-level directorship principles,
   - blended with advice on day-to-day governance best practice,
   - global trends and the contemporary operating environment in New Zealand.

   Contents page accessible on this link:
   https://www.iod.org.nz/resources-and-insights/4-pillars-landing-page/contents/#

3. ***The Leadership Challenge: How to Make Extraordinary Things Happen in Organizations***
   [HD 57.7 KOU]
   Kouzes, J. & Posner, B.
   Jossey-Bass, 2012
   Based on Kouzes and Posner's extensive research, this all-new edition casts their enduring work in context for today's world, proving how leadership is a relationship that must be nurtured, and most importantly, that it can be learned.

4. ***Medical cannabis: A brief guide for New Zealanders*** [QV 766 HOL]
   Holt, Shaun & Dalton, Emma
   Potton & Burton, 2019
   An easy-to-read, objective guide to the potential benefits and risks of using cannabis as a medicine. This book gives an overview of its history, and importantly, a summary of what the latest research shows about the use of cannabis as a medicine, and its potential benefits and risks. This book does not take a position on this issue, but allows the reader to make their own informed decision.

5. ***HBR's 10 Must Reads on Emotional Intelligence (with featured article "What Makes a Leader?" by Daniel Goleman*** [HD 57.7 ONE]
   Harvard Business Review, 2015
   In his defining work on emotional intelligence, bestselling author Daniel Goleman found that it is twice as important as other competencies in determining outstanding leadership. If you read nothing else on emotional intelligence, read these 10 articles by experts in the field.

6. ***Relative strangers: A mother's adoption memoir [WZ 100 MUR]***
   Murdoch, Pip
   Gives a nurse's first-hand account of what it was like to become pregnant while training to become a nurse, and having to surrender the baby for adoption. Follows her story throughout the intervening years as she traces her son and becomes a part of his adult life.
   Fern Publishing, 2019.

7. ***The spirit of Maori leadership [DU 423 KAT]***
   Katene, Selwyn
   Huia Publishers, 2013
   Discusses different styles and models of Maori leadership, identifies the qualities and approaches of Maori leaders and describes 6 criteria to guide nascent leaders.

8. **NZNO Publication: New Zealand Nurses Organisation. (2019).**
   ***Growing nurses into governance: A governance toolkit*.**
   A toolkit developed for the New Zealand Nurses Organisation by Shelley Jones December 2018
   The toolkit is a key action of the NZNO Strategy for Nursing 2018-2023. It has a practical focus and provides information and guidance for nurses interested in governance roles in health and social care in Aotearoa New Zealand. Women in Aotearoa New Zealand are under-represented in governance roles within health and all sectors of the community. This has a significant impact on nursing which remains a female dominated profession. NZNO supports the recent Government initiative to ensure half of all directors on state sector boards and committees are women by 2021.

   Free Download

   Additional information on this toolkit - https://www.nzno.org.nz/resources/governance_toolkit

9. **NZNO Publication:**
New Zealand Nurses organisation. NZNO Strategy for Nursing 2018 – 2023
Advancing the health of the nation
Hei oranga motuhake mō ngā whānau, hapū, iwi
Section 5. Leadership development and sustainability – Rangatiratanga
Accessible via this link:
https://www.nurses.org.nz/leadership_development_and_sustainability

10. **Factors predisposing to shared governance: a qualitative study**
Foroozan Atashzadeh-Shoorideh; Mohammad-Mehdi Sadoughi; Sattarzadeh-Pashabeig, Maryam; Khachian, Alice & Zagheri-Tafreshi, Mansoureh.
BMC Nursing (2019), Vol. 18. doi: 10.1186/s12912-019-0334-2
The method of implementing shared governance varies among organizations. Identifying the predisposing factors can facilitate and precipitate its successful implementation and aid educational institutions in achieving their goals. This study determined the antecedents of shared governance in nursing schools.

11. **Supporting primary care nurses to work at an advanced level through changing practices' organisational governance**
Forsdike, Kirsty; Murphy, Tracy Ann & Hegarty, Kelsey.
Australian Journal of Primary Health (2018), 24(2), 171-176.
General practice nurses wishing to develop their careers in general practice are often unsupported, relying on the culture of individual practices. Given the structural diversity of Australian general practice, we qualitatively explored staff experiences of organisational governance, what supports are in place and can be used to assist nurses to advance

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