LOGIC

LINKING OPPORTUNITIES GENERATING INTER-PROFESSIONAL COLLABORATION

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

NURSE LEAD FOOT CARE FORUM

PASIFIKA -EQUITY

DHB CYBER ATTACK

TEACHING DURING A PANDEMIC

WINTER 2021 EDITION

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Chair's Report

Jill Clendon
Chairperson

Kia ora te whanau

I didn't think I would be writing another editorial quite so soon, but Celeste has taken up an exciting opportunity as a Principal Advisor in the COVID-19 Response Team at the Ministry of Health and can't quite manage to fit everything in so has had to step down from the College. We wish Celeste all the very best in her new role and it is good to know that Wellington will be getting the best advice possible!

I thought I might talk a little about unconscious bias in this editorial. For those of you that are not deeply familiar with the term, unconscious bias occurs when the brain makes rapid judgments about people and situations based on their own personal background, experiences and environment (Levy, 2001). Our perceptions cause responses that we are consciously unaware of. As a result, we are likely to favour groups we perceive as similar to our own group and display discrimination against groups that are dissimilar without being aware of it (Houkamau & Clarke, 2016). Whether we like it or not, we tend to like people who look like us, think like us and come from backgrounds like our own. You may have seen an article I wrote on the topic last year for Kai Tiaki. I don't want to repeat that article here so please do look it up if you want more detail on this topic.

The reason I wanted to discuss it here was due to a couple of things that have happened at work lately that reminded me that addressing unconscious bias in ourselves is an ongoing, never ending journey. One was an incident with a staff member who made some comments to a client that were completely inappropriate and resulted in quite significant harm for the family. On reflection, the nurse recognised what she had said was inappropriate and wasn't sure why she said what she did. The second example arose following a review into care at one of our local aged and residential care providers that identified that unconscious bias may have been present in the decisions that were made about the care a resident received.

Both these examples underlined to me the importance of continuing to increase people's understanding of unconscious bias and the impact it has on those we work with.

Understanding unconscious bias in ourselves means having insight into our own behaviour, values and mores and their impact on others. Once we have some understanding of our own behaviour and thinking, we can use reflective practice to actively analyse our actions and identify areas for improvement. Have you ever had that sinking feeling you get when you realise you've just said something completely inappropriate but it's too late to take it back? It's that moment that we need to take away as homework and reflect

on what we said, why we said it and what we can improve on. It's also important not to be too hard on yourself, addressing unconscious bias in yourself is a lifelong journey and we won't always get it right. But the most important thing is to recognise it when it occurs and take steps to try and prevent it from happening again.

Recognising and addressing unconscious bias is also an element of culturally safe practise, an essential element of safe nursing practise. As leaders (and every single one of us is a leader), we are also role models. So, be open to acknowledging unconscious bias in your own life and work, discuss unconscious bias and what it is in your workplace and at home, and together we can reduce the impact of racism, bias and unsafe practice across our system.

Nga mihi nui

Jill

Charleen Waddell – Executive Committee Member 2021

Ko Maungakahia toku maunga
Ko whangawehi toku awa
Ko Kurahaupo toku waka
Ko Kaiuku, Tuahuru, mea Nga Hau e Wha ki Murihiku oku marae
Ko Rongomaiwahine, Kati Mamoe, Kai Tahu, Ngati Kahangunu oku iwi
Ko Charleen toku ingoa

I have worked full time in various nursing positions mainly in primary health, Practice Nurse at Bluff Medical Centre, Māori Health providers and PHO Community Linkage over the last 20 years. I am also employed currently as a Clinical Nurse Specialist-Diabetes at Southland Hospital since 2010. Recently have been involved in development of Diabetes Foot Clinic and Local Diabetes Team. I am also involved in our local marae whanau. I have an interest in equity, improved health outcomes and well-being for Whanau.

Editor's Report

Yvonne Little

Nurse Practitioner

Well Winter is definitely upon us now with the weather providing more challenges for us, adding to the moving feast of COVID-19 and RSV.

I hope everyone is keeping safe and well. If you find yourselves struggling in these pressing times, I hope you feel you can reach out for help. Remember, you are never alone.

As you can see this edition is slightly leaner than our autumn one, as like you our committee members have ever increasing workloads and obtaining articles has been fraught with barriers, but we will continue to work on providing you with regular editions filled with interesting articles.

As I have said before, we are interested in expanding our article/author bank to include as many areas of nursing as possible, so please make contact with myself or any NZCPHCN committee member.

We are also looking to get our LOGIC committee up to full numbers again, for some time now we have been functioning with less than half our numbers – so thank you to the team Erica Donovan, Lee-Anne Tait and Anne-Marie Ballagh for continuing to try to get articles despite their heavy regular workloads.

Here, I would also like to say thank you to Celeste Gillmer for continuing in her role as our publisher until we are able to find her replacement. Celeste has unfortunately resigned from the position of Chair of NZCPHCN due to her change in workplace.

A big congratulations to Celeste in her new role as Principal Advisor at Ministry of Health (MOH) – COVID19 directorate. I know the MOH will find you and your knowledge invaluable. Celeste was an invaluable member of NZCPHN for 5 and a half years, starting out as LOGIC committee member in 2015 and working her way into the role of Chair of NZCPHCN in 2017 and Publisher of LOGIC. As well as representing NZCPHCN on various external committees.

All the while working as Nurse Educator at Auckland District Health Board (DHB), then Team Leader/Nurse Educator Primary Health Care at Waitemata DHB then adding to that role with the COVID19 operations and logistic lead at NRHCC and also starting her own business Family Health Matters Ltd.

Another thank you, to Dr Jill Clendon for stepping up into the Interim Chair role, another very busy and much in demand lady and a great leader and example to all. Congratulations Jill on being asked to be a speaker at the International Nurses Conference (just a shame you have to do this via video link and not actually get to go to Geneva.

Take care and stay safe.

Rural Muster

Nicky Cooper, Rural Nurse Specialist RN MSN, Murchison Health Centre

Family harm - team effort....

As part of my role, I do a snapshot HeEADSS (psychosocial) assessment for year 9 students, I had one female student that I was deeply concerned about, it wasn't so much what she said but more my gut feelings about what she wasn't saying, I took my thoughts to a meeting with our own version of a (multidisciplinary team) which includes the principal, SENCO (special education needs coordinator), local police and school counsellor. From that the police officer promptly spoke to the mother of the girl, which just happened that it was the morning after a heinous FV attack, so she told him everything. This family had endured 18 years of physical violence and addictions. This ended up as a wraparound team effort to deal with this particular family and highlights the need for community team efforts and gut feelings.

Stoned students....

On my day off, the principal of the school rang me concerning a 13-year-old boy that had recently enrolled there. He had been removed from two schools previously due to behaviour and cannabis use and that morning they had discovered cannabis on him again.

The principal believed he could have been protecting another student and 'taking the rap for her'. He apologised for interrupting my day off but said he wondered if I would do a 'Nicky' thing on him. I came in to see him and had a good honest chat, we watched a video on cannabis use on adolescence and used the (Substance and addictions choices questionnaire) to gage where he was at. We used the 'Pot Help' website and written resources and he worked though these during the day. he had told me his 'whys', family history of addictions and his regrets, we looked at what he wanted to his future. He agreed to an AOD (alcohol and drug) youth clinician referral and I now have 5 students engaged with this AOD clinician who had never previously been involved with any of our students here before and he is making great progress with them. This young lad has stopped using and re-joined a sports team and appears to be thriving.

Aunty Noo Naa at the post boxes.....

In my community I can't ever just pop in and get my post, we have rural delivery and because we live on a farm, I pick up from the PO boxes in the township. A little after 3 o'clock in the afternoon, on my way back to the health centre, I stop to pick up my post and sometimes a parcel, which I commonly do. This is never a quick event, numerous conversations occur here, as I am somewhat known as 'Aunty Noo Naa' as the children walk home from school, "Hi Nicky" I hear repeatedly as I chat to

locals outside with my bundle of post and parcels. This is often where I hear what I need me to hear, where they are at, and about what their thoughts and needs are and as yet have never managed to just pick up my post and leave.

I just wanted to also end on, what an incredible community we have, which is not unusual in a rural community, but ours is so incredible in fact that during lockdown, the mothers I support in our community set up their own facebook (fb) group to support me, I didn't know about this until September last year, but this is what they wrote in their bio for this fb group.....

"Tiny Miracles are everywhere, especially here in Murchison where we are inundated with amazing people taking the risks and working hard to keep our Community going.

However, one lady who supports us and our families now needs a little extra support in return...

Our beloved Nicky Cooper is currently stretched beyond imagination...

Thanks to her incredibly huge heart she is being all things to all people, without saying no. Nicky is currently in high demand in Murchison and possibly will be called to ICU in Nelson because of her previous nursing experiences overseas. As well as this she is providing a huge amount of extra support to the families in our community.

Nicky has a lot of knowledge about what will likely happen with this virus and amongst other healthcare professionals she will no doubt be seeing a lot of tragedy over the coming weeks, potentially months.

As you can imagine Nicky is currently being inundated with questions from our Community as we are all understandably worried about our families.

This is our time to shine folks... Nicky needs our support. This woman wants to personally respond to everyone who messages her, stops her in the street, sees her in ICU etc etc. She wants to protect us, to care for us and generally love on all of us. Not just those of us who know her well, but EVERYONE she comes in contact with.

This group is being set up as a way to share ideas, keep an eye on her and generally love her in return.

Can we use the knowledge she has shared with us previously to help each other? Instead of checking in with her.

Can we do something nice for her if we know she's been in the ICU all night or on a PRIME call helping those that are critical, only to then return to looking after us?

Share any ideas, ask any questions... ALL welcome.

She doesn't need to know... This is not about getting credit for good deeds. This is about looking after those that we love and who give so much to us.

Nicky is our Tiny Miracle worker... It's our turn to give some back...

NOTE: ALL medical advice should go via appropriate channels such as the Health Centre, Healthline or the Covid-19 line".

Nurse New to Primary Health Care Award

By Alexia Tran

I did not think much of my nomination for the award when my colleagues informed me, and I had forgotten all about it. So, when I received the call about winning, I was pleasantly surprised.

It was not always a dream of mine to become a nurse, in fact, it was a last-minute decision. I never knew what I wanted to do with my life. I just wanted to become successful and help others. When I graduated high school, my ambition pressured me to attend university. I enrolled into a Bachelor of Health Science, thinking it would keep my options open in the health sector. However, the degree was not what I thought. The day before the semester started, I had to choose between nursing, dentistry, physiotherapy, and podiatry. Nursing was most appealing among the options and so my journey began.

Throughout my studies, my placements were based around secondary and tertiary care- from the respiratory ward to endoscopy clinic and orthopaedic theatre. My peers always came back bright-eyed, telling of their experiences, while I never had much to say about mine. Nursing was not something I could see myself doing. There were days I thought about discontinuing my studies, regretting not giving thought to my career choice. This uncertainty haunted me until I graduated. However, the nature of nursing aligned with my morals and goals. I wanted to make it work so I persevered and applied for jobs in general practice. I thought this was my last resort and if I did not enjoy it, I had wasted three years of my life- but this was it.

My first few weeks at Manurewa Healthcare were filled with doubts. I had never been in a general practice, so everything was new to me. Already, I thought I could never become a great primary health care nurse and wanted to skip to a time where I could provide the best care to patients. Despite my worries, my colleagues created an environment which allowed me to thrive. As a team I was always supported, and as a practice there was a genuine care for people. Everything aligned with what I wanted to be. Fast forward to a year later, I can say I have found my purpose and what a blessing it is to not feel like I am working a day in my life.

At present I am taking a break from further studies to focus on developing the skills I have gained. I plan to recommence my studies next year, working towards my ultimate career goal of a Nurse Practitioner. Above all, the award has reminded me of the work I am doing and serves as an encouragement for me to push further.

Teaching During a Pandemic

By Erica Donovan

I didn't sign up for this.

Coming from a clinical background working in Primary Health Care and Oncology/haematology, masks aren't foreign to me. But having to teach with masks on, is another thing entirely.

Outbreaks like Norovirus also weren't uncommon in healthcare facilities, but I never thought I'd be teaching during a pandemic.

During early 2020, I, like many of you started to hear about a strange respiratory infection, starting in China, then seen in Italy. Patients in my clinical job started asking about what we thought of the rates, and if we thought it would end up on our shores.

Prior to this, I'd done my first semester as Clinical Lecturer, a big learning curve from working on the floor as a nurse. Despite the challenges of dealing with anxious first year students on their first ever placement, I really enjoyed it. I loved working with student nurses and seeing their work, skills and confidence develop.

As we got into March 2020, I started with my next batch of students. Our first item of the day was to attend a facility wide meeting on COVID, and how we'd manage if there was an outbreak. Staff were optimistic, they'd manage it just like they manage any other outbreak, whether gastro or respiratory. I remember using my lunch break one of those early days to sit in on a global webinar about what we knew about COVID, and how it might affect children.

I had to laugh, there was a sign at the front door that along with the usual advice to stay home if you were sick, encouraged people "To avoid touching MEN". While some people avoid men for different reasons, the sign was reminding us not to touch our MOUTH, EYES or NOSE.

Residents came down with respiratory infections, but no one had travelled to China, COVID wasn't even in New Zealand at that point. Sadly, I had to fight for masks for the students when they were dealing with residents who had respiratory infections. It was even inferred that I was being paranoid, hadn't I seen the news, how would they have COVID? My arguments that regardless, staff and students could get sick fell on deaf ears. But it was also the principle, my students deserve to be safe and not miss placement hours if they contracted Influenza or other infections.

My students were pulled, part way through their placement, so I never went back to that facility to see if masks suddenly became the norm. I assume they would have, after word spread about a facility in Christchurch having an outbreak.

The next few weeks saw students being orientated to the world of Zoom classes, both for debriefing our placement,

and for their regular scheduled classes. Activities meant to be done on placement got abandoned, competencies now had to be marked during simulation, rather than with real patients.

I followed forums for educators online, as others tried to adapt their skills teachings to an online environment – making fake blood and wounds from things around home for wound assessment, demonstrating skills on teddy bears, and trying to make up clinical hours without seeing patients. Is this really what students signed up and paid thousands of dollars of fees for? This time worried me, as I wondered how many students would be left out, without access to a laptop, or reliable internet. At our institution laptops were able to be provided to students, but I do wonder how many previously relied on going into Polytech to access their technology.

Learning science or pharmacology online is one thing, but one thing students struggled with was learning practical skills. Later that year I taught my first ever class at the polytech, fully masked, and socially distanced. Teaching percussion over Zoom, obviously didn't help the students, as they struggled to pick up practical skills. At least one student was honest when she told me that they didn't do the pre-reading, because after being on eight hours of zoom classes, in front of a computer, then having to do further classwork on a computer took too much of a toll.

While all this was going on, I myself was a student too, doing my own post-grad study. And yes, it's not always that easy. In fact, I had to pull out of a semester because the work-load of COVID swabbing and reduced face-to-face patient contact made studying health assessment difficult and I wasn't practicing the skills I needed to learn.

So now it's 2021, we've been into level three once, and fully masked up. The next facility I was at gave students and lecturers K95s, when most of primary health care (including those swabbing) usually only had surgical masks. We also always have a contingency plan, in case things change last minute or we have to pull students out of clinical.

It's been a topsy-turvy 18 months, but we might not be out of the woods. Whatever happens, I'm sure my students won't forget their experiences of studying during a global pandemic.

NZNO's Publishing Process

Sue Gasquoine,

Nursing Policy Adviser/Researcher,

Review of the NZNO publications process.

A draft of the revised guideline 'Publication Development Process for NZNO', previously named 'Document Development Process for NZNO' will be distributed to members for feedback later in the month. The opportunity to profile in this column the significance of NZNO as a publisher of well researched and member focused guidelines; factsheets; position statements; research reports and knowledge and skills frameworks presents itself. NZNO Librarian, Heather Woods says that NZNO is a significant publisher and regarded by the National

Library of New Zealand as such based on the number of ISBN numbers issued for allocation to the various publications generated by this organisation.

The publication process is supported by a Publications Team staffed by: an Administrator; Policy Analyst – Māori; a Professional Nurse Adviser; a Lead Organiser; Member Support Centre Adviser; Communications Advisor; the Professional Services Manager; Librarian and Nursing Policy Adviser/Researcher. They bring diverse skills to the responsibility of publishing on behalf of NZNO members to ensure a consistent process with appropriate quality controls that maintain the credibility of our publications. In addition to updating the publications process, the Publications Team is currently auditing all of NZNOs publications and prioritising those that need updating, archiving those no longer relevant and identifying 'gaps' in the publications portfolio. Google Analytics tells us that the top ten downloads of NZNO publications in a week of May this year were:

- Guidelines for Nurses on the Administration of Medicines 2019
- Guideline – Code of Ethics 2019
- Brochure – Join the New Zealand Nurses Organisation 2019
- Fact Sheet – NZNO Indemnity Insurance FAQs 2016
- Primary Health Care Nursing Standards of Practice 2019
- NZNO Constitution 2020-2021
- Position description for NZNO delegates 2012
- Guideline – Documentation 2017

- Standards of Professional Nursing Practice 2012
- Delegates Handbook 2013

Here is a link to all NZNOs publications https://www.nzno.org.nz/resources/nzno_publications

Publishing through NZNO

The NZNO brand book, available on request, says:

'The NZNO brand represents the organisation and is symbolic of NZNO values. The NZNO brand is therefore more than a logo, a colour or the words of our name: It becomes linked to what we stand for and what we do. Using the correct font, heading styles, kōwhaiwhai and layout of publications enhances the NZNO brand and also the branding associated with the colleges and sections.'

A copyright statement is included in all publications to acknowledge the intellectual property rights and hard work of NZNO and/or the college or section that were involved in the writing and preparation of the publication concerned.

Prior to sign-off by the Chief Executive there is a robust review and editing process to ensure each publication addresses equity, reflects NZNOs responsibility as a te Tiriti partner, includes up to date evidence and uses APA referencing – see referencing examples at this link https://www.nzno.org.nz/resources/kai_tiaki/kai_tiaki_nursing_research

Once finalised, NZNOs Chief Executive signs-off each publication and notifies the Board of the publications release.

The medico-legal team at NZNO emphasises the importance of the publications review cycle. The currency and therefore relevance and usefulness of NZNOs publications must be maintained, for example the 'Guidelines for Nurses on the Administration of Medicines' which is listed above as the most frequently downloaded of NZNOs publications. It is used as a reference in legal processes when nurses find themselves involved in, for example, a complaint about a nurses practice to the Health and Disability Commission or Nursing Council. And in a recent Ministry of Health consultation on amending regulations in the Medicines Act to enable non-regulated health workers to administer vaccine, these Guidelines were used to support the rationale for this regulation change.

The reputation and credibility of NZNO as a professional and industrial voice for nursing in Aotearoa New Zealand rests in part on the quality of the publications we produce. They are a demonstration of what nurses and nursing contributes to the health, well-being and safety of our communities. Preserving the organisations reputation will be supported by high quality, current publications that are accessible primarily to members but also other stakeholders who seek a nursing perspective.

Profile:

Sue Gasquoine is the Nursing Policy Adviser/Researcher in the Professional Services Team - one of her responsibilities is chairing the Publications Team. She has worked at NZNO for 4 years and in addition to her involvement in publications, supports the Nursing Education and Research Foundation (NERF) Board, and contributes to the work of the Policy and Research Teams.

Going dark

By Wendy King

As I arrived at work, the receptionist called out to me "the computers are down". Later in the morning, while I was talking to the student "the computers are down and its really big". Later in the day a verbal direction came to turn off and unplug all computers and phones.

Incrementally through the day there were announcements; they think it'll be a couple of days, then, they hope it'll be sorted by the weekend, then, maybe during the weekend, a week later they were saying 1-2 weeks. By this stage, as I had time, I'd looked up google and there were reports of hospital cyber-attacks lasting 3-4 weeks and still in recovery months later.

In the early stages we were told the cyber-attack was from the opening of an attachment and there were a few comments in the press about how or why it happened. The organisation has an education package about computer safety which is part of the orientation set. Information Services regularly required password changes, and when Information Services picked up issues with staff, they would contact their manager to recommend education. In the week prior to the cyber-attack, I had active contact with Information Services about the terminals in my office with intermittent faults coming up and slow running. Staff with iphones require the Authenticator app loaded to enable the phone.

Due to the cyber-attack, access to libraries and data bases was not possible, so a google search was used. There was a quantity of items directed to nurses; not logging off, not updating passwords, sharing passwords and more; the focus of the items was on protection of privacy. But what was reported as the sources of cyber-attacks was stolen laptops, stolen USBs, unapproved use of storage and one unapproved attempt to modify personal laptop.

The healthcare sector has become the leading target in having data attacks and that these attacks and these attacks have accelerated; incidents of various types affecting a range of health care service providers are reported from primary care to secondary services. While some are publicised others are not, nor is the successful defence of cyber-attacks.

There was little about functioning or being in such a situation, apart from Boston Children's Hospital experience. Their event was anticipated; attacks commenced in March, to computers down April, May and June, until mitigation in July. (Gibbons, et al)

Initially some of us carried on with work as previously booked or scheduled, but we noted it was very quiet, no phones ringing, no printer or sticky label printing. Staff in other areas who were unable to work went home, so the corridors were quiet. Initially, as we'd been told the situation was going to be a couple of days we deferred activity in case the computers came back on; I wrote down: waiting, still

Vermont 71 beds	Ransom paid	Nothing before or since
Boston Children's Hospital	Malicious – child protection case related Conviction 10yrs prison	Social media, staff briefed and prepared; sustained attacks for weeks until overloaded
Norway – 2.8 million records of a regional health service	Back door attack via health service to obtain access to military records	defended
Health Services Eire, Republic of Ireland	Ransom demanded not paid	14 May – was continuing still as at 19 June

waiting, still waiting. Which turned into frustration – everything that was thought of as something to do while waiting, was not available so we did other things, like cleaning. Nothingness and frustration. No information or communication.

There had been active work to put resources, documents, rosters on computer which was worthwhile as duplications and deleted documents were cleaned up. Procedures went online to remove multiple versions to keep practice current. We had been doing electronic discharges for years, but client Enotes and electronic school records were implemented in the last 12 months.

No activity was able to be logged for contractual purposes. No rosters were available if they hadn't already been printed off. No client alerts, medical or social. No history was available even for current clients with open files if it hadn't previously been printed off. No leave forms. No discharge letters. No communication. No electronic car bookings. No payroll. No eftpos in the café. No National Immunisation Register access. No B4 School site access. No access to Policies and Procedures. Frustrating and there was an element of shock (Branch, pg 67) and disbelief with the shut-down revealing what now seems to be huge over-connectivity.

Communication seemed to be word of mouth and parallel, but not always congruent. For example, we were told to turn off and disconnect computers and phones, but another service in the building only got a turn off computers message. Some communication was confusing like the message to continue to lodge incidents using our Datix programme, which is wholly electronic. When communication did start it was one short message a day that only staff with iphones were able to access; there were no printers available.

As the Public Health Nurse (PHN) covering schools for other PHNs doing covid vaccinations, I realised I didn't have access to the school files for the phone numbers or names of key school staff; I was unable to review work the PHN had previously done regarding a student, or document my contact and visits made.

One report noted rerouting and improv (Collier) to continue working with computer shut down; for referrals rerouting was developed with medical centres printing off their referral and then taking it by hand and passing it to the hospital or community services.

Ironically, the next rerouting was the reconnection of faxes for transmitting some information and referrals. This was ironic as they'd been actively discontinued for some months as a privacy risk and clinical risk. For example, our fax used to receive 1-2 faxes a month with no cover sheet, not meant for our service or facility, sometimes with quantity of significant medical information, with no sender details, no idea who'd sent it so we were unable to inform them it had not gone to where it should have gone.

And rerouting was done for key email communications; a staff member sent it to the staff members partner, who was able to print it off and drop it back to the workplace for distribution to staff with no access to work email messages.

We improvised; the back page of the BCG care plan had a clinical summary page, we photocopied it and distributed it for recording notes manually. An example of a fax cover sheet was found on computer at home (we'd discarded ours when the fax line was discontinued), searching through storeroom and file drawers, old paper copies were found of school visit recording sheets. Leave forms were obtained from another service in the building, a discharge letter was formatted from old documents when E discharges were implemented. A regional decision was made to not transcribe notes of district nurses when computers came back online.

Recommendations from hospitals who have experienced cyber-attack includes keeping a stash set of paper forms and documents that have been retired, have computer safety as part of orientation and add a cyber-attack scenario to your emergency planning and preparation. One facility suggests the testing of your computer safety education by sending out mock phishing emails.

While you will depend on Information Services to have processes and counter measures, do you know what programmes you use, all of them? Do you have alternate way to access those programmes? Do you have access to an alternate teleconference, they are also subject to attacks? (Nigrin) It can be challenging to identify phishing when you're tired, in a hurry, and can be subjective, you may have to look twice - remember they're trying to trick you.

Other learnings from our experience not mentioned in any google article items; print off rosters with names of all staff and know who and how to communicate with even though they're not in your silo professional group or service.

At time of writing over 4 weeks later; there are some landlines functioning, many records began working at the end of last week but not all programmes have been reactivated, we've been told it will take 12 weeks for payroll to reconcile our pay and then they will begin to calculate and manage the overpayments. I won't grumble anymore about renewing passwords.

Footnote: in USA they use 'downtime' to describe computer shutdown.

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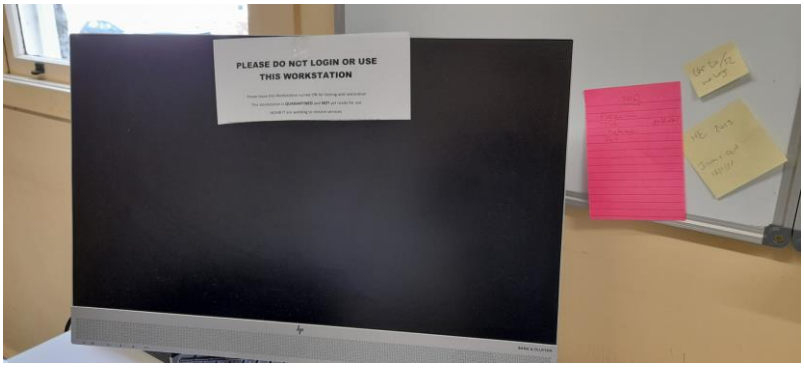

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App review:

By Erica Donovan

This edition's app review is NZCOVIDTracer…. Just kidding.

Thought maybe it should be, from as we see in from the cases in Melbourne (and that includes almost 5000 Kiwis who have since flown back to New Zealand) contact tracing is still something that we need to keep in the back of our minds.

The app this month is actually MDCalc. Some of you may have seen this before as a website but it also comes in an app form. If you're not sure about a person's risk of developing a PE or DVT, or if this chest pain could be an MI then there's guidance for all those things. With more and more nurses initiating x-rays, there's also guidance around when to xray various joints. The app is easy to navigate and has an extensive list of calculations, some I'd never heard of before.

Cons: you need to create a log-on to access the service. But there is an option not to receive any emails, with the amount of email overload we all get, is a welcome reprieve.

However, having the log-on does save your most used calculations.

Also, not all the calculations are relevant to primary health care, but given that there's a good search function and ability to save your favourites so this isn't that much of a downside.

Would I recommend this app? Yes, though maybe save checking your phone till the patient is out of the room.

What will the new National Health System mean for School Nursing?

Christine Cammell.

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Introduction:

School Nursing has existed in NZ for over 100 years (Clendon, 2005). In the last few decades, there has been a rapid professionalisation of the role and scope of the school nurse, yet what is in-scope and out-of-scope varies significantly nationally. Kool et al (2008) identified serious gaps in the national design and governance of school nursing as a specialty, including no specific post-graduate school nursing qualification in existence, no professional college or national association of school nurses and no national policies or guidelines to guide practice, and these same issues remain unaddressed by the government and current health system over a decade later. These are desperately needed in order to ensure that all young people have equitable access to affordable and acceptable health care in schools, and to ensure safety for clinicians and their patients.

Background:

The enhancement of School Based Health Services (SBHS) over the last few decades began as part of AIMHI (Achievement in Multicultural High Schools) which was an education initiative to increase academic achievement in nine low decile secondary schools in New Zealand (Hawk and Hill, 1996). Co-locating services that met health social and educational needs of young people within schools intended to improve health and social service outcomes, thereby increasing effective learning time and more strongly connecting schools with the interests and aspirations of their communities (Anderson et al 2008). School Nursing services in Secondary schools were extended by the then Labour/progressive government in 2008 with provision of a school nurse in every decile 1- 3. In 2011 the then National coalition government announced a reduction of SBHS funding excluding decile 3 schools (The New Zealand Herald, 2011). The same government then reinstated funding for decile 3 schools, between 2013 (Denny, Grant, Galbreath & Clark, 2014) and 2016 (Cassie, 2013) under the prime minister's mental health project. The incoming Labour-led coalition government of 2017 continued the expansion of Nurses in Schools to include decile 4 schools as part of their pre-election campaign promise, and decile 5 schools in 2019 (NZSN, 2019). This roll-out has occurred by provision of funding from the Ministry of Health (MoH) to District Health Boards (DHBs) who establish contractual relationships with relevant schools in their catchment area. Some decile 5-10 secondary schools, have chosen throughout the last 20 years of development to employ their own nurse/s through their education budget due to increasing mental health

and wellbeing needs of their students. The funding model provided through DHBs includes the provision of Nurse Educators and Programme Managers to oversee the nurses within the geographic catchment, but for nurses funded through education, this support is lacking. Nursing Services within primary and intermediate schools are equally patchy; there are no minimum standards nationally for schools to offer their students a health service. Some DHBs do provide health services in schools located in areas of high deprivation, and similar to their secondary school counterparts, some primary and intermediate schools choose to fund a nurse through their education budget, yet some school staff have indicated concerns about education money going into health services (Buckley, 2009).

Health and Education:

School Nursing services are unique in that they provide communities with healthcare in a non-health care setting. The nature of providing healthcare in school facilities is a challenge in itself from an environment perspective; health facilities in schools are often re-purposed classrooms, corridors, or unused dilapidated education buildings, well behind in standards of infection control, temperature regulation, and certainly not fit for health care services.

Working in a non-health care setting is significantly different from working within a health care setting. School nurses often work in isolation, absent of other medical colleagues for easy access to support or advice. The nature of a health professional, being employed by an education organisation can often generate frustration, confusion and very uncertain terms about to whom the nurse is accountable. In reality, a School Nurse is a dual-commitment professional; he or she holds both educational and health care responsibilities at the same time (Tseng, 2014). In countries such as New Zealand there is no significant inter-service collaboration between health and education; therefore, the delivery of health services remains fragmented and underdeveloped (Williams & Dickinson, 2017).

A new era:

The New Zealand Nurses Organisation's 2012 submission to the Green Paper for Vulnerable Children proposed that every New Zealand school and early childhood center should have a full-time nurse (Cassie, 2013). With the government's recent announcement of a health system reform, including the disbanding of DHBs and establishment of a National Health Service (The New Zealand Government, 2021), this could provide a much-needed catalyst for tangible and long-lasting improvements to the structure, governance and ongoing sustainability of School Nursing, ultimately resulting in better patient care, and better health outcomes for the future generations of New Zealand. School based health services need to become a universal service for Children and Young People through schools; there is good evidence for the effectiveness for this, both from a health, education and financial perspective.

The provision of nursing services in schools reduces the cost-burden on secondary services by provision of appropriate, accessible timely youth friendly healthcare. SBHS are also effective at reducing poor mental health outcomes (depressive symptoms) and suicidality (Denny et al, 2018). Furthermore, on-site school nursing services also contribute to the unmeasurable impact of positive health promotion and acquisition of health literacy skills for the next generation, in addition to improved

educational outcomes (Kocoglu & Emiroglu, 2017; Puskar & Marie Bernardo, 2007).

Significant investment and a multi-sectoral approach are needed to achieve an effective universal School Nursing Service in New Zealand. It requires ring-fenced funding to avoid fractures in service associated with funding instability.

One of the greatest challenges is the perception of the role of the school nurse by the local community. The perception held by some of the school nurse as someone who provides 'Panadol and band-aids' and who can also assist with some of the administration tasks has helped sustain the low levels of professional support and lack of clinical oversight and has also helped maintain the low levels of pay of some nurses in schools, part-time nurses in particular (Buckley, 2009, Tseng 2014). The role and scope of a school nurse now encompasses a number of complex responsibilities requiring ongoing professional development and skill building to deliver effective care at the top of the nurse's scope. This includes acute-chronic disease treatment, health screening, health improvement-protection, health education, mental health assessment and management, sexual health assessment and treatment, guidance and counselling and case management (Kocoglu & Emiroglu, 2017). A number of School Nurses are in the process of attaining competency in LARC insertion procedures increasing contraceptive options for students in schools. Six School Nurses were involved in the Nursing Council led Community nurse prescriber pilot in Counties Manukau DHB enabling them a suite of commons medications they can prescribe for their patients (Crawford, 2020). These excellent examples of nurses working towards the top of their scope and the evolving specialist nursing roles provide an excellent future of care that can be delivered in schools. The establishment of a formal training pathway would help School Nursing to be recognized as a specialty in its own right and further workforce development is needed to recruit, train and retain nurses to work in schools. A nationalized pay scale would be a welcome addition nationally by the workforce, many of who are paid well below appropriate standards (Cammell, 2020).

School Nurses all need access to professional support to ensure their own 'safe practice'. Most nurses employed by schools do not receive clinical oversight, and many do not report to anyone in a professional capacity. The professional isolation of school-employed nurses is an issue that needs to be addressed (Buckley et al, 2009).

Schools operate with a 5-year building plan. Notice should be given to all schools now by the government, to include purpose-built health facilities into their 5-year building plans, so that by the time a national school-based health service is developed, the facilities are ready to go. Schools and Health care service providers need clarity of where funding will be provided from for the facility development, and for the ongoing service costs.

In order to achieve quality governance, robust, accurate and timely data is needed to inform ongoing service delivery. A purpose-built, nationwide patient management system for school health centers with ability to interface with primary and secondary care clinicians involved in patient care, and with national governance and oversight, would enable a much smoother, safer and time efficient platform, resulting in

improved patient care and health outcomes.

Conclusion:

School Based Health services in NZ are currently fragmented, and variable. In 2009, a report to the MOH on the state of school health services found a number of issues in existence that are still pertinent today (Buckely et al, 2009). As funded health services for all schools are region based, and non-health funded services are ad-hoc, service delivery has occurred without national oversight of governance, and the development of SBHS within the primary/elementary school sector particularly has received minimal attention in New Zealand (Williams and Dickinson, 2017). The current funding of secondary school nursing (decile-dependent) is under impending threat as the decile system is set to be abolished and replaced with an improved model by the Ministry of Education. The government's recent announcement of a national health service reform provides a timely opportunity to rectify this and replace the current ad-hoc, patchwork of services with an improved, cohesive and purpose-designed Universal School Nursing service.

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Foot Care Forum

Whakatu October 2021

Foot Care Forum Whakatu October 2021

Application for Registration

Te Piki Oranga

Foot Care Forum for Registered Nurses

Saturday 30th October 2021

Venue: Nelson Tasman Hospice, 331 Suffolk Road Stoke, Nelson

8:30am Registration

9am - 5pm Foot Care Forum

Guest Speakers

Heather Woods NZRN Foot Care Nurse Specialist
Lyn Harris NZRN Foot Care Nurse/Specialist Nurse Amputee Care
Charlotte Russell – Podiatrist/The Shoe Room
Claire O' Shea - Waikato DHB Lead Podiatrist

Space is limited to 75 attendees
$120 per person
Lunch provided

To secure your place send your registration to:

Te Piki Oranga Whakatū
E admin.whakatu@tpo.org.nz
P +64 3 546 9099

Registrations Close 23rd October 2021

Applicant Details	***FOOT CARE FORUM WHAKATŪ 30th October 2021***
Name	
Full Address	
Phone	
Email	
Organisation	
Current Qualifications	
Ethnicity	
How did you hear about this Forum	
Are you interested in future forums/training	☐ Yes ☐ No
Would be interested in being part of an ongoing group for further development	☐ Yes ☐ No
Any Dietary Requirements	
Application Fee of $120	Te Piki Oranga Internet banking number TBA on your registration
For more information you can contact any of the committee	Heather Woods NZRN Christchurch hjwoods@gmail.com 0212889618 Karen Davidson NZRN Whakatu Nelson karen.davidson@tpo.org.nz 0278017751 Dianne MacDonald NZRN Whakatu Nelson dianne.macdonald@tpo.org.nz 0274725100 Lyn Harris NZRN Waikato feetretreat4u@gmail.com 0212587007

Signed : _____ Date: _____

Foot Care Forum for Registered Nurses

Nelson Tasman Hospice **Nelson 30 October 2021**

8.30 – 9am	Registration	Tea and Coffee avail
9am	Whakatau/Welcome Address	
0920	Nurse Mobile Foot Care Ltd	Heather Woods NZRN Clinical Nurse Specialist Foot Care
1020	Cultural Care	Carl Baker Pou Taki Te Piki Oranga
1045	**Morning Tea**	**(Sponsored by Aesthetikonzept/Spirularin®)**
1100	Starting from Scratch	Lyn Harris NZRN Foot Care Nurse
1130	The Shoe Room	Charlotte Russell Podiatrist/The Shoe Room
1215	The MDT Clinic	Claire O' Shea Lead Podiatrist Waikato DHB
1pm	**Lunch**	
1.30 pm	30 Minute Rotational Groups	
	1. Nail Cutting Demonstration	Heather Woods NZRN Clinical Nurse Specialist Foot Care
	2. Aesthetikonzept/Spirularin® 3. The Shoe Room/Dermol US Medical/QV Products Douglas/Bio Oil Douglas	
3pm	Foot checks by Nurses	Lyn Harris NZRN Nurse Specialist Amputee Care Peke Waihanga
3.30	**Afternoon tea**	
3.45	Q & A and Ideas with Panel - Heather Woods NZRN - Lyn Harris NZRN - Charlotte Russell - Claire O'Shea - Dianne Macdonald RNBN - Karen Davidson RNBN	 Clinical Nurse Specialist Foot Care Foot Care Nurse Podiatrist/The Shoe Room Lead Podiatrist Waikato DHB Nurse Lead Te Piki Oranga Pukenga Kaiwhakahaere Te Piki Oranga
4.30	Surprise Time	
4.45	Karakia/closing Networking and drinks (Venue walking distance from forum TBA)	

Nurses in Foot Care: an update.

From Heather Woods
RN;BN;CCPC;Dip.Coun.
Mobile Foot Care Ltd.

Much has happened since your Symposium, so I would like to share this with you.

The Foot Care Forum for Registered Nurses in Nelson on October 2021 is coming along well, and registrations are trickling in. Please see the information in this issue. We would love to see you there.

Here in Canterbury, I have been training three Nurses who are all setting up their own Foot Care Businesses, and will provide Community Clinics and Home Visits. They are all coming to the Forum. This means that there are now 12 Community Clinics available, which cover all parts of Canterbury, up from 4.

For the latest clinics we are aligning ourselves with Community Organisations which provide functions, activities, and support for older people. It's great to be working in collaboration with these dedicated people, and to be able to bring the Foot Care right to where older people are, so it becomes part of their overall health routines.

We have been working more closely with Podiatrists too, and a pattern is evolving which we hope to build on. Many Podiatrists are concerned that for many people no-one is checking their feet, so by the time they present to a Podiatrist an issue is often serious.

Podiatrists acknowledge that Registered Nurses often see feet as part of Personal Cares, and are in a great position to evaluate them, and organise foot care. They are very happy for Registered Nurses to do initial evaluations, Care Planning, education regarding care of the feet, and to provide Basic Foot Care – nails especially. Podiatrists also acknowledge that this intervention brings patients to them for advanced care, at a stage when much more can be done.

We work with a number of Podiatrists where a shared care arrangement has developed. For example, we will provide the Basic Foot Care, and the Podiatrists will provide only the advanced care, then send them back to us for ongoing regular Basic Foot Care.

We also get regular referrals from Podiatrists about frail clients who require Home Visits.

We are aware that many other areas of health also require Foot Care, such as Mental Health, Spinal Units, General Hospitals, Residential Care for Intellectual Disability, Palliative Care, even Maternity patients have difficulty reaching their feet.

Charlotte Russell has been a Podiatrist in Christchurch for 30 years, and has set up "The Shoe Room" where she stocks shoes specifically for people with feet issues, such as size, shape,

bunions, overlapping toes, painful feet, etc. Maxine manages this shop, which has a good online presence now. Many clients are so pleased to at last have comfortable feet.

Charlotte is aware that NZ now has a shortage of Podiatrists and are exploring the concept of Providers of Basic Foot Care. They are very aware that Registered Nurses are a great fit in this position, because of the Holistic Care they provide, and their willingness to work collaboratively with other Health Professionals, for the benefit of the patient.

At The Foot Care Forum, we intend to discuss the role of Basic Foot Care Provider more thoroughly, and how courses might be developed to develop this role in a more formal way. We would like to see Modules regarding Foot Care that can be completed in 6-hour sessions with a Certificate of Attendance or Attainment issued, which would build skills and provide post graduate study hours for Registered Nurses. We need to find an Education Provider willing to provide these courses. I have the theory content and the Foot Care skills, but not the Educator Experience or the time to provide what is needed.

The Canadian Foot Care Nurses Association now has their theory available to Nurses online, outside of Canada. Their organisation is well developed, and they even have an Education Department. I have been keeping in touch with them, and they are very keen to help the development of Foot Care Nurses in New Zealand.

NZOHNZ

As primary health care nurses you may already have an interest in Occupational Health Nursing or be carrying out some practice in this area. The NZOHNA is made up of over 300 nurses who work within the primary health care setting of Occupational Health in a variety of workplaces.

We are grateful to your Executive for agreeing that NZOHNA may adopt the Aotearoa/NZ PHC Nursing Standards of Practice, we now have a nursing framework and standards of practice that provides a foundation from which any Registered Nurse's (RN's) could enter the specialty of OH Nursing. We also now have a proposed post-graduate education programme that supports the development of nursing practice from those entering the specialty through to expert nursing practice.

We welcome you to participate in consultation on the two documents 'Education Document 1' & 'OHN Framework Document 2' Click Education (Doc1) and OHN Framework (Doc2) SURVEY HERE. We anticipate, once the reading is complete, this feedback should not take longer than 10-15 minutes.

DIABETES – Management in the Community

By Vicky McKay

Kia ora! I work as a Community Long Term Condition nurse in Palmerston North. I work with patients from 4 different practices, and receive referrals from the primary health care team (PHC), from the District Health Board (DHB), and via reports (eg avoidable Emergency Department (ED) presentations; patients with elevated HbA1c; patients with multiple long term condition classifications etc).

I have great respect for primary health care nurses, with their broad knowledge and skills, and value their insight into our shared patients. They have usually known the patient and their whanau for several years (decades in some cases!).
The majority of my patients have Type 2 diabetes with an elevated HbA1c (<65 mol/mol). I enjoy working with these patients and have the luxury of time and flexibility in regard to where we meet. My appointment slots are generally 1 hour long, and can be at the general practice, at the patient's home or workplace, at our Primary Health Organisation (PHO) clinic room, or occasionally at a café.

Often taking the time to discuss diabetes, medication mode of action, lifestyle modifications can turn things around for the patient, minimise elevated blood glucose symptoms and delay the progression of long-term complications. I work with an awesome team of healthcare professionals at the PHO, and often refer patients to our Clinical Exercise Physiologists, dietitians, and podiatrists.

Whilst I have many successes with patients, sometimes I don't. The old adage of 'you can lead a horse to water, but you can't make it drink' springs to mind. I always try to leave the door open, so that when the patient is ready to tackle their diabetes management, I can be there to support them, or support the primary health care team to support the patient.

I worked as a Diabetes CNS in Wellington for approximately 2 years (at the DHB and the PHO). There are definite pro's and con's to both workplaces. The DHB is a slow-moving dinosaur, but I was working with a team of exceptional nurses and doctors. The PHO is more isolated professionally/collegiality speaking, with less renumeration, but does awesome work/projects and is very equity driven. I have also found access to Health Work Force New Zealand funding for post-graduate study is easier to access from primary health care (possibly due to fewer primary health care applications for funding). I

have been lucky enough to complete my Master of Nursing and an RN prescribing practicum.

The most attitude/paradigm/life-changing paper in my Masters was Māori Centred Practice – a paper I only read as it suited my schedule (a summer school paper). I grew up in NZ but undertook my nursing training in London (thanks no study fees NHS!), so no indigenous/Tiriti of Waitangi undergrad studies. During the Māori Centred Practice paper, I read an article on historical trauma theory applied to Māori – huge game changer for me, as I finally truly understood the impact of colonisation and how colonisation effects contemporary Māori. I have now read many papers, books, had conversations, challenged racist comments, and presented on the topic. I think now is a time for making real change, there's a real global movement for indigenous peoples and marginalised peoples.

An example of this in the Aotearoa diabetes space, Pharmac recognising people of Māori/Pasifika ethnicities as being an independent risk factor for poorer outcomes, and being their own special authority criteria for the new recently-funded/available medications.

The new medication that was funded in February is empagliflozin, a sodium-glucose co-transporter inhibitors (SGLT2i). Their mode of action is by reducing the renal tubular glucose reabsorption, producing a reduction in blood glucose without stimulating insulin release. The excess glucose is excreted in the urine. Empagliflozin is now the preferred second line agent in Type 2 diabetes – as well as improved glycaemic control, there are cardiovascular and renal protective factors, weight reduction, blood pressure reduction and is unlikely to cause hypoglycaemia. Empagliflozin can also come as combination tablet with metformin, reducing the pill burden for the patient. In my six-month clinical experience with this medication, empagliflozin is generally well-tolerated, and my patients have been very happy with the results on their blood glucose levels, weight, and medication reduction.

Going forward, all diabetes health professionals are eagerly awaiting the availability of liraglutide (a GLP1-RA injectable medication), and all designated nurse prescribers are eagerly awaiting the updated medicines list (still under review by Nursing Council). Our service will be much more efficient when we can prescribe these newly funded medications (and vildagliptin which was funded in 2018).

Outside work, I have 2 beautiful little griffon-x dogs, am a bit of a petrol-head (used to be into cruiser motorbikes, now into muscle cars – I have a 1967 Mustang convertible I also have Dupuytrens Disease (a Viking disease – ha, saved $$ on ancestry dna-type tests – that's the Scottish side coming out). I only mention this as there is a common misconception nothing can be done for Dupuytrens until you have the contractures (then its operations). Low grade radiation therapy before contractures occur can halt or slow the disease progression. Little known treatment, but well-researched and available in Aotearoa New Zealand in several DHBs.

Equality- Equity ?– A Pasifika Nurse Perspective.

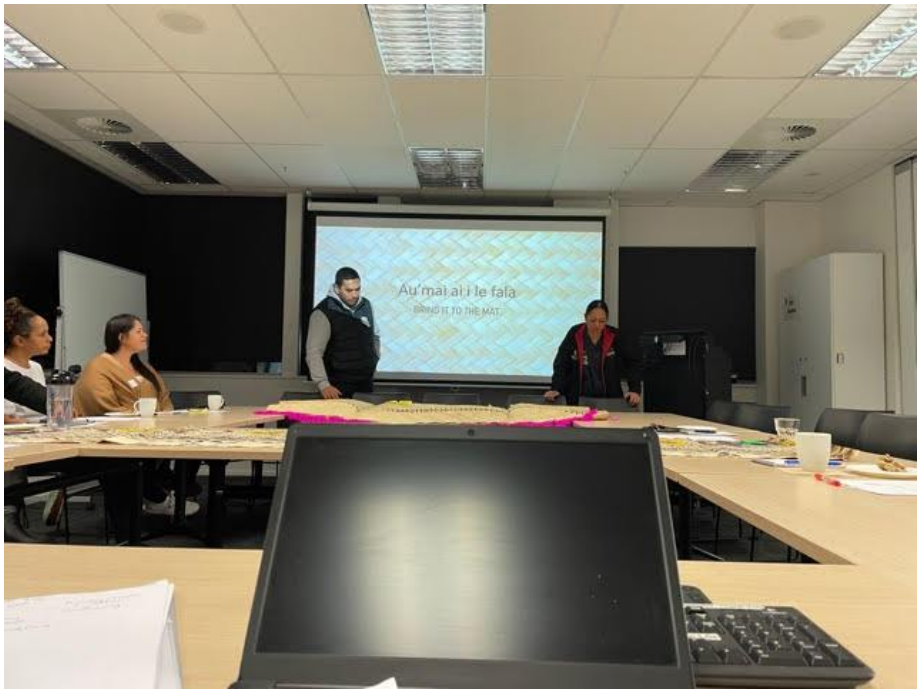
By Karen Carpenter

When we consider the equality, one may think of human rights and leaders who have stood up to societal values and laws which disempowered minority groups. These pioneering thinkers set the scene for future generations to influence social change, from this it has bought about equality for all especially here in NZ. However, equality indicates we should all be treated the same, but this does not provide equity. Having equity, it results in better health outcomes for all through sharing health resources looking at an individual or group in a socio-political context. Which in turn describe the definition of health and cultural safety. The Canterbury Pasifika Nurses Fono was born out of inequity due to what appeared to be to the lack of culturally appropriate support systems for nursing students/enrolled and registered nurses in Canterbury. Many Pasifika nurses would agree there are many challenges of being a Pasifika nurse in the health system, experiencing feelings of isolation in the workplace, institutional racism and many institutions not acknowledging diversity. These experiences coincidently are the same our Pasifika people face. I am of the belief that if you are being affected by an individuals or institutions actions it has flow on affects and filters down to the service users.

Our Fono provides a forum to address any issues of inequity, affecting nurses and our Pasifika communities, provide support and nursing development. We represent most of the Pacific and all bring skills of clinical practice as we work in all areas of health and from novice to expert. Everyone is acknowledged and valued. We recognise inequity in health and have the tools to navigate not only Pasifika but all who encounter a health system which has barriers to obtained equity. We see the gaps whether it be knowledge or practice, we collaborate and find solutions and apply these to practice. Some of the inequities that exist are health literacy, translated resources, hours of operation, cost, transport to name a few. I believe our innate ability of navigation is one we carry from our ancestors who migrated around the Pacific in waka, Va'a alo (Samoan), Drua (Fijian), and Vaka (Tongan) sailing vessels, with their knowledge of mother nature, they navigate uncertain waters and arrived at their destination by working collaboratively together.

How do we improve these? Through building relationships, thinking critically, outside the square, and using supports in the community which reduces barriers to access. The advice I would give is not to be afraid to ask the questions as that leaves the door open to assumptions. Many patients report “I didn’t know”, that there indicates inequity. A prime example “Did Not Attend (DNA’s)” of booked appointments and this could come down to transport to appointments. Through asking the questions such as, do you have transport? If this is not the case refer to your community supports if your organization has them. The

people in the community have immense skill and knowledge. Getting to know what services are available in your communities is invaluable, we often work in communities but have little awareness of what can be accessed for support. Furthermore, health and social systems need to take this into account when developing screening and pathways for populations. Accessibility is improving in some areas of health, but it appears others not taking into the human factor and sociopolitical factors of individuals, whanau, and aiga. In addition, there are many frameworks for models of health care for Pasifika, Fonufale and the Fonua, is an example of the Pasifika world view, which can be used with implementing clinical practice or contribute to the design of screening tools for populations. “E tabu te aomata” the person is sacred-Kiribati saying.



RN Edwin Elia and RN Matty Teata – Discuss COVID lockdown- the positives and negatives and its effect on nursing practice and Pasifika communities.

From left: Ateca Sher, Pua Le'aliki ,Simione Tagicakibau, Edwin Elia, Marama Saukuru, Karen Carpenter, Luana Homan, Matty Teata, Phoebe Singh, Suli Tuitaupe, Jen Pareira ,Amy Henry.

Nurse Prescribing

By Lee-Anne Tait

I really enjoyed doing the Nurse Prescriber course, however when it came to initially using it in my daily practice I was reluctant to do so as I was scared. I made every excuse in the book as to why I shouldn't get started until one day...

I work in a Rural Nurse led health centre in Eketahuna, in which all patients have their own General Practitioner (GP) at a practice elsewhere, usually within 30-40 mins drive away from here. However, if the patient is new to the area their GP can be some physical distance away until they relocate. Due to the lack of GP's within this region, many chose not to relocate if they are only staying for a short time, as was the case with this gentleman- in his late 60's with multiple comorbidities.

I had met him on several occasions in recent weeks as we were trying to get his heart failure under control whilst he was down here from the Waikato. I had his front cover sheet, along with a nice letter from his Cardiac Nurse Specialist over his care plan. I had consulted with her and felt I could support him and his wife as needed.

His wife called me early one morning saying I had to see him to treat his foot after what happened yesterday. Intrigued I asked her to explain. She said she couldn't now, but had photos and would send him in so he could tell me in person and she would show me the photos after. All very odd I thought - but I've seen some crazy things here in Eketahuna - as I'm sure many of you have in your day to day of work -so I let it go and awaited his arrival.
Pretty soon he hobbled into the health centre, sat down in the consulting chair.

"What brings you here today? I've heard from your wife it's about your foot is that so?"

"Yes. Yesterday morning I woke up and me legs were a bit swollen with all the fluid on them, you know how bad they can get, so I thought I'd wear me crocks as they are a bit looser than all me other shoes, and they don't hurt me feet when me legs swell up lots more during the day. So I put them on, got a drink and started doing a few things. I was walking around when suddenly I got these terrific pains in me right foot as though I was having a heart attack in there. It was worse pain than when I actually had me heart attack, much worse...

"What sort of pain?"

'It was really sharp and stabbing like needles piercing into me foot - oh it hurt so bad... I didn't know how to stop it, I thought if I got a bit more air and blood into my foot it might go away, like I do when a have me angina..."

"So what did you do?"

"I sat down and took some really deep breaths - pushed me feet really hard into the crocks and splayed open me toes really hard and wide, with

lots of pressure on them. I did this really hard for about 5 minutes, pushing all my pressure into the foot and splaying me toes until the pain wore off. Afterwards me foot was still a bit sore, but nothing like before so I got up and got going. I had lots to do that morning, so I didn't really have time for this...."

“Why at the time it hurt did you take your crock off and look at your foot? Or the colour of your toes?"

"What do you mean at the time? I let this go on from about half eight to around eleven thirty. I'd get up and get going and it'd start again. I tried doing me jobs to distract me but it didn't work. I'd have to stop every few minutes, lean against the bench top, breath in, press hard into the ground and really splay me toes out. It wasn't like a cramp; it was so hard and piercing. If I pushed really hard with loads of pressure through me toes it would stop, go away for a few minutes and then start again. I didn't think it was me heart as it stayed there the pain, in me right toes all the time...Like I said, I thought it was angina or one of those clots things in me toes -not me leg, so I kept on working till it all got too much and I thought I'm gonna have to get (said his wife name) to call an Ambulance. She was so worried about me and had been pacing and telling me to stop all morning. I would have come to see you but as it was the weekend I knew you wouldn't be here..."

'So did you call the Ambulance?"

" No, I didn't need to, as in the end I went out into the garden and sat down and slowly eased me foot out of the crock and looked at me toes, with her fussing all around me and wanting to see how she could help, when out crawled a Rat....

"What!!!!?”

"Yeh a rat. I'd had a bloody rat inside that shoe all morning, and I'd been pressing against it and irritating the shit out of the poor little bugger and hurting it so much that it would bite me every time I moved. I think the hard splaying of me toes squashed it and for a bit and then it tried again to bite its way out of there...."
With that he laughed and laughed, long and loud. So did his wife and I. She then produced the picture of a very dazed rat lying in the grass- we all laughed some more. We looked at his foot and the multiple bite marks across his toes.... I started cleansing then dressing them, calling my prescribing mentor, he relayed his story once more, we had more laughter, we discussed his condition, current drugs allergies etc and we agreed on Augmentin, Boostrix and daily review. I also referred him on for his peripheral neuropathy. I had in an instant, realised the role of the Nurse Prescriber in the rural setting and overcome my irrational fears.

If you’re curious, the rat died later on the morning of his misdemeanours, his wife put it out if its misery, but I'm pleased to say this gentleman is still alive and enjoying retelling this tail.....