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LINKING OPPORTUNITIES GENERATING INTER-PROFESSIONAL COLLABORATION
The Official Journal Of The New Zealand College Of Primary Health Care Nurses, NZNO
PHCN
Vol 16 No 4

Diabetes in Pregnancy

Family Violence

Immunisations

Regional Forums

Verification of death

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

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Circulation

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

Editorial Matter

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ISSN 2463-5642

December 2017 Vol 16 No 4

In this issue….

Chair's Report..

New Zealand College of Primary Health Care Nurses – Committee Photos.................. 2

Chief Nurse's Report 3

Editor's Report 5

RURAL MUSTER #5 7

Education & Upcoming Events 12

Tāne Tatiku Ake (Men standing together) health and wellbeing program 13

Preserving a therapeutic relationship with parents who decline childhood vaccinations: a literature review. 16

Starship Nursing Education Symposium 21

Research Request – Nurses' views of Community Pharmacists 27

Diabetes in Pregnancy................................ 30

Reflecting on the journey to Registered Nurse Prescribing (RNP) 35

Regional Networks 38

Dignity in Death: RN Verification of death to reduce the wait times for verification of expected patient death in the community.. 42

Family violence and how we can make a difference 44

What's on top in the immunisation world?... 46

The NZNO Library...................................... 49

Chair's Report

Celeste Gillmer
Chairperson

Tena Koutou katoa

It is incredible to think that another year has come to an end. When I sat down to prepare this report, I thought I'll reflect on 2017. Personally and professionally this has been a very busy year – and I am sure you will all agree. We have a new government, changes in the Ministry of Health, DHBs, PHOs, funding streams, NETP programme and HWNZ funding (just to name a few).

Some of the highlights for me this year were the NZNO College of PHC Nurses Symposium in Auckland in August, the College and Sections Day, NZNO AGM & Conference in Wellington, the increase in PHC NETP nurses across Waitemata & Auckland DHBs and the mumps project in Auckland which enabled us to already immunise almost 700 young people in West Auckland against mumps.

I encourage you to reflect on 2017 yourself – what were your highlights and what difference did you as a nurse make? Write your own report on 2017 and your achievements, take time to sit back, relax and enjoy this special time with your family and friends.

Thank you for your contribution to PHC Nursing throughout 2017 and for the service you provide to the people of New Zealand.

Ngā mihi o te Kirihemete
Te Tau Hou

Kia hora te marino, Kia whakapapa pounamu te moana, kia tere te Kārohirohi i mua i tōu huarahi.

May the calm be widespread, may the ocean glisten as greenstone, may the shimmer of light ever dance across your pathway.

New Zealand College of Primary Health Care Nurses – Committee Photos

Having fun and working hard!!!

Chief Nurse's Report

Jane O'Malley
Chief Nurse

Taking Care of Ourselves and Others

Kia ora koutou

It's hard to believe we are only a few weeks off Christmas and many of you will be having a much deserved rest as you open your LOGIC journal. Like many health and other workers across the country, some of you will be providing care during a period which, second only to the middle of winter, is the busiest time of the year. It's ironic that holidays seem to attract quite a lot of risk, between overdoing it on the good things in life, over extending on the terrain of our gorgeous country, or experiencing distress that close proximity, financial pressures and alcohol and drugs can place on people, families and communities.

It makes me think about what people have been saying repeatedly about the response they wish for when they are in front of health professionals. They want us to attend to the things that matter for them. When it comes to day-to-day stressors, this may be what is most troubling to them but the one thing we miss when attending to what seems to be the event that brought them to us in the first place.

Primary health care staff have a vital and unique role in delivering services for people. The work is by its nature unique and challenging. You are on the frontline of health, and in fact social services, for those in need of your care. Primary healthcare is a busy space and you need to balance your responsibilities to manage everyday demands with that of recognising underlying issues and promoting wellbeing. Amongst your patients will be some of the most vulnerable people in your community. Brief interventions, including alcohol, suicide and family violence screening, in small ways build community resilience and reinforce a focus on getting well and staying well. You can help enable people to get the support they need. Primary Health is a place where vigilance and understanding of the signs of abuse can mean enlisting the help of services and improving outcomes for children.

It is worth spending a moment to also think about your own health and that of colleagues as you go about your work over the holiday season. The amendment to the initiated Geneva Declaration (the modern Hypocratic Oath) by kiwi doctor Sam Hazeldine in October, added a clause: *"I will attend to my own health, well-being and abilities in order to provide care of the highest standard"*. In doing so, doctors joined a movement that recognises the importance of looking after yourself as a

prerequisite for looking after others.

The International Council of Nurses (ICN) also makes it clear that: *"when we practice what we prescribe for others in relation to healthy behaviour, we are in a much better position to contribute to patient care and organisational resilience".* And so too, the 2015 *Health and Safety at Work Act (HSWA)* explicitly defines health as including mental/psychological health and freedom from mental distress caused by work.

The culture of the stiff upper lip is a double edged sword; it gets us through the tight spots but it can lead to dark places both organisationally and individually. But the amended Geneva declaration, the ICN and the HSWA, signal a sea change for a healthier approach.

A number of things should be said about cumulative stressors and the need to take care of ourselves and our colleagues while we take care of others. The relationships between staff health, low morale, poor engagement and burnout, and mistakes, complaints, staff turnover and patient outcomes, mean work stress and self-care are serious moral and quality endeavours to be understood and managed. An important point to note is that while work stress and life stress is inevitable, a negative sequelae is preventable. And people who love you; family, friends and colleagues, can help you identify the signs and also assist interruption and recovery.

The final point I would like to make is that moderating the environment is an important part of the combined action that clinical leaders, managers and all staff can take. As people responsible for the primary care ecosystem I salute you for attending to your health and that of others and thank you for the wonderful work you do. I wish you a very happy, healthy and restful Christmas.

Ngā mihi

Jane

Tēnā koutou i tēnei ahiahi.

I am delighted to announce that Ramai Lord will be joining our Office as a Senior Advisor, on a one year secondment from her position as Māori Health Manager, Pegasus Health in Christchurch.

Ramai is an experienced registered nurse with a unique and extensive background in Māori health and primary health care. She is of Ngāti Kahungunu ki Wairarapa, Ngāi Tahu, Te Whānau-a-Apanui and Ngāti Porou descent and has a BA Māori and Indigenous Studies and Te Reo, PG Dip Health Sciences and is currently completing her Masters of Health Science (Nursing Clinical).

In addition to the Senior Advisor role Ramai, will hold specific responsibility for advancing the Ministry's Māori Workforce Development Plan.

Ngā mihi

Dr Jane O'Malley
Chief Nursing Officer; Ministry of Health

Editor's Report

Yvonne Little

Nurse Practitioner

Welcome to the final edition of LOGIC for 2017.

It's that time of the year when we reflect on what has been, our achievements, also our trials and tribulations and resolve to make changes for the year to come.

Back in August we had an almost complete change of guard within the NZCPHCN Executive, Professional Practice and LOGIC committees and I believe we are now settling into our new roles and I am sure our newer members are feeling more comfortable.

Further changes have occurred with a new Government being elected soon after our NZCPHCN changes. We look forward with anticipation to see what happens in the health sector under this new leadership.

We love innovation and we know we have many innovative nurses out there, we ask you to think about what you can offer in the leadership and innovation arena. So why not contact us about doing an article. In this issue we have brought you articles from our Award winners from our August symposium in Auckland. And we will continue to bring to you articles by leaders in our midst.

I have been asked to add a small piece in this issue about writing articles:

Firstly, let me reassure you we are not an academic journal, whilst we do accept academic articles you don't need to be able to write in this vain, we are looking for real-life scenarios and life/work stories.

As an e-journal we no longer have a word limit as we did in the print version of LOGIC, so you can write as much or as little as you like.

SO HOW DO YOU WRITE AN ARTICLE FOR LOGIC: IT'S SIMPLE

1. Find a topic you want to write about (a personal or work experience, your area of interest, an update of information, an innovative idea, or check out our annual planner alongside the Editors Report for feature topics)
2. Contact the Editor or one of the committee and give us a brief description of what you want to write about and we can guide you.
3. Start writing, add references, photos (please get photo permission from anyone whose photo you intend to use – forms can be supplied by the Editorial committee).
4. Submit your article to whichever committee member you have been in contact with, they will proofread it and give you feedback (if we want to change any of the wording we always liaise with you as we

don't want to lose anything in translation). Once you and the committee member are happy with it then they will forward to the Editor for a further proofread and we will again discuss any changes we would like to make with you so we don't lose the intention of the article.

5. Submit a photo and short biography about yourself to go with the article.

It really is that simple. You can then add being published in a journal to your CV. We sometimes get interest from NZ Doctor about articles we have published and if your article is one of these we will be in touch with you to get permission to reproduce it in NZ Doctor. Likewise, we have a close link with Kaitiaki and often reproduce articles with authors permission.

We are looking forward to an exciting 2018 with many more articles from you are membership

FINALLY

This time of year brings its own challenges for us, our families, friends, work colleagues, patients and their wider network from the financial to the emotional and physical stressors with expectations from others, hence why we have included in this issue articles around parties and acceptable behaviour to food, drink and illnesses. We hope these articles assist you should you be required to deal with the fallout from the party season.

Please think about your own health and take care of yourselves – if you don't look after yourself then in reality you cannot look after others to the best of your ability. As health professionals we are prone to putting ourselves last as our families, colleagues, patients and their whanau are at the forefront our minds – that is what a nurse does.

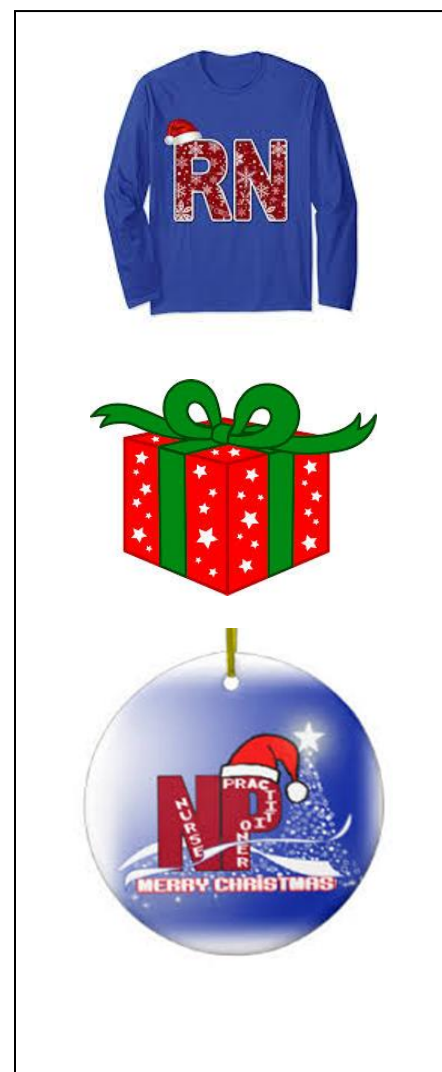
Looking forward to receiving articles from you and bringing you 4 jam packed issues in 2018.

Thank you to all our hard working committee members, both past and present.

Take care. Enjoy time with your family and friends.

Thank you to those who will be working over the holiday period.

Happy Holidays: from Yvonne and the LOGIC Team.



RURAL MUSTER #5

Kate Stark – Nurse Practitioner

Welcome to the December issue of Rural Muster. It is hard to believe that another year has almost gone and that as I write this, Christmas is fast approaching. As we know, 2017 has resulted in a new Government and I'm sure you are all as interested as I am, to see how health services across the country will be affected by this, given the brief we have already received in relation to health from the parliamentary cohort.

For rural nursing it's been an exciting year with the formation of a rural nurses working group, Rural Nurses New Zealand (RNNZ). This group promises to be of huge benefit to nurses of all rural nursing disciplines. It is an exciting project born out of rural nurses *for* rural nurses working in all aspects of rural nursing across Aotearoa. A dream became reality early this year at the National Rural Health Conference when rural nurses Rhonda Johnson and Debi Lawry from Dunstan Hospital expressed a desire to get such a group together. Already the group is gaining momentum and it looks exciting!

Working Party Objectives

Key aims from the outset are to reduce the siloed approach to rural nursing, by improving the interface between primary and secondary rural nurses. Going forward, the group aims to improve collegial relationships and networking, to strengthen rural nurse education, and to develop support for nurses who work in varying degrees of isolated rural New Zealand. It is hoped that all rural nurses will benefit in some way from the work this group does to put rural nurses on the map, providing better support and resources accessible to all while promoting rural nursing as a desirable career for up and coming graduates as well as experienced nurses.

Survey.

Following the National Rural Health Conference, a survey was carried out to gather crucial information from a variety of rural nurses working in different contexts. The survey aimed to find out what unique issues rural nurses face, what rural nurses want and need, and where there might be gaps in support and education. With a total of 130 responses, including 60 by email invitation and 76 by web link, the findings were interesting and extremely helpful as a starting point for RNNZ to move forward and establish a group with some work to do! If you are interested in the survey results, a summary will be made available on an RNNZ website which is currently under construction. The survey also

linked with rural nurses via a newly developed Facebook page (Rural Nurses NZ) which also has a link to the NZNO Facebook page. Word of mouth was relied on to share the link to the survey and its completion. The survey has enabled an initial data base to be created from the contacts generated from survey responses.

Group Members.

A nomination/vote process via the survey was carried out to elect the RNNZ working party and from this RNNZ was formed as follows. The brief biographies demonstrate the breadth of practice and national representation we have on this exciting group. More in-depth biographies of each member will also be available on the RNNZ website in the future.

Rhonda Johnson: Chairperson

I have been immersed in rural nursing since 2002 and held the role of Charge Nurse at Dunstan Hospital for a total of 11 years. I recently moved into project planning and am now involved in the early stages of the Dunedin Hospital redevelopment project. I bring my rural knowledge and experience to this role.

I love the diversity and challenge that rurality brings and am committed to supporting staff and guiding professional practice in our unique context. I completed my PG Dip through the Rural Institute of Health and Auckland University in 2008 and am now working toward my Masters of Nursing. I see the benefits of increasing the rural nurse profile in NZ and a need to establish better connections across the country to develop initiatives key to rural nurses in all contexts. I am currently on the Rural Hospital Network Executive team and am enjoying the new challenge of working with our enthusiastic group of rural nurses on the working party.

Emma Dillon: Secretary

For the past two years I have been working in Colville - a small village 30 mins north of Coromandel. With an enrolled population of 700 patients, the clinic is owned/operated by a sole GP, and employs two nurses plus support staff. Working as a rural nurse here includes practice nursing, district nursing, public health, palliative care and after hours/PRIME nursing. I was born and raised on the south coast of the South Island, and graduated my with Bachelor of Nursing from CPIT in Christchurch in 2010. Currently I am studying at the University of Otago (Christchurch Campus), doing my PgDip specialising in rural nursing. At the end of August, I moved back to the deep south to take on the exciting challenge of working as a rural nurse specialist based mostly on Stewart Island, and in Tokanui in the Catlins.

Kate Stark: Communication / Liason

Currently I work as a Nurse Practitioner (NP) at Gore Health Centre, part of an IHCF in rural Eastern Southland. I also work as an NP / PRIME Practitioner in Twizel, South Canterbury, and Central Otago. Prior to this, I worked in Roxburgh and Tapanui in rural primary health care.I am currently on the RGPN executive committee and hold the following positions of external nursing representative on behalf of the CPHCN.

- Liason Rural GP Network (RGPN) Executive Board.
- Member Rural Health Advisory Group. (NZRHAG)
- National PRIME Review Steering Group.
- PRIME Clinical Governance Working Party.
- NASO Air Ambulance Co-

Design Clinical Advisory Group.

I believe it is crucial to improve the heath care of rural populations and to reduce the barriers for the health of rural people while simultaneously working for rural nurses to promote the unique role that rural nurses carry out individually and in teams. I am delighted to be involved in RNNZ and look forward to making a difference to rural nurses working in all contexts.

Virginia Maskill

Since graduating as a RComp.N in 1992 I have worked in a variety of clinical settings including the Nelson-Marlborough District Health Board. During this time I gained significant experience working in rural settings including a dual role as an Ambulance Officer/Registered Nurse in a busy Accident and Emergency Department and After Hours General Practitioner Service. For six of these years I was also employed part-time at the Hospital's Alcohol and Drug Outpatient Clinic as a Registered Nurse/Counsellor. These positions provided me with extensive experience of the challenges specific to rural nursing due to wide geographical regions, a dispersed population often under serviced with health resources.

In 2009 I joined the Centre for Postgraduate Nursing Studies at the University of Otago, Christchurch and the Department of Psychological Medicine, University of Otago, Christchurch from 2006 - 2016. I have a special research interest in the rural nursing workforce, hence my keenness to contribute to the Rural Nurses New Zealand working party. I am currently a member of the Rural Health Plan Working Group for the future development of rural health, Division of Health Sciences, University of Otago.

Cathy Beazley

Tena koutou katoa. Ko Cathy Beazley toku ingoa.

I began working as a Nurse Practitioner in 2013 and currently work in primary health care for Hokianga Health (a Maori Provider) in the remote north-west of the North Island. Hokianga Health provides health care for an enrolled population of approx 6,350 plus the all year round visitors.

Having started work in rural practice in 2000, I have gained experience in a number of positions including working as an inpatient RN on small acute ward; rural practice nursing and community nursing.

At a local level I am a member of our rural GP, Clinical Governance and Significant Event groups. Regionally I am a member of the Primary Options Programme Northland group and Manaaki Manawa Heart Care Clinical Governance Group. I am also involved in a new rural research project, focused on the impact of introducing a haematology analyser at a rural hospital. I believe we need to work collectively to inspire future growth of this particular area of specialist nursing and I look forward to being part of Rural Nurses New Zealand.

Rhoena Davis

I am a Nurse Practitioner working in the northern rural area of Whangaroa in Whanau Ora. I have been a Nurse Practitioner for 8 years, working in rural areas for approximately 25 years.

I have completed a Masters in Clinical Advanced Nursing with First Class Honours through Auckland University and my Expert PDRP for Primary Health Care. I have completed a Post Graduate Diploma in Maori Business Studies through Auckland University, Post Graduate Certificate in Well Child Health through Whitireia

Polytechnic, Graduate Certificate in Specialty Nursing Practice (Child and Family Health) and a Graduate Certificate in Nursing Practice (Public Health).

I am excited about what the newly formed Rural Nurse New Zealand working party can offer rural nurses and am already enjoying being involved.

Debi Lawry

I came to rural nursing late in my career after spending much of my nursing life working in Auckland. I have been a bedside (incubator side) nurse, a Clinical Nurse Educator, a Charge Nurse and a Nurse Consultant. Along the way I also became a midwife. I completed an Advanced Diploma in Nursing and have since had a varied academic journey with a number of post graduate papers in Neonatal Science, Health Management, Ethics and Health Policy. I moved to Dunedin in 2002 to help establish the newly created Nurse Director role. Five years later I achieved my dream of moving to Central Otago and working at Dunstan Hospital.

My eyes were opened to the complexities, challenges and joys of rural healthcare. Much of my career has been spent in nursing leadership roles where I strive to ensure nurses have the education, resources (human and consumables), skills and equipment to do their job well.

I am now very keen to be part of a working party to identify the issues for rural nurses, particularly hospital nurses (but not exclusively so) and to advance our cause.

Christine Dorsey

Kia ora. Ko Christine Dorsey toku ingoa.

I live in the Hokianga, in rural North Island. I am currently employed at Hokianga Health as the Hospital Services Manager for our small rural hospital. My roles include overseeing the 24/7 accident and emergency, acute inpatients, and residential care services.

My background is in emergency care and midwifery across both primary and secondary care.

At an organisational level I am a member of the executive team and co-ordinate internal meetings and ongoing professional development for staff. I am also currently the chairperson for the South Hokianga St John- an endangered service in the current climate.

With regards to rural nursing my interests are in developing standardised clinical guidelines and standing orders for safe, effective use in rural New Zealand. In addition to this I am supportive of further work and resources to improve easily accessible professional development options for rural nurses, something that is one of the aims for the Rural Nurses NZ group, hence I am very pleased to be involved.

Rachael Pretorius

My name is Rachael Pretorius and I am a Nurse Practitioner working in a rural general practice in Martinborough, South Wairarapa where I have worked for the last 2 years. I am also PRIME trained. I am acutely aware of the issues that impact on rural living, nursing, and practice. Living and working in a rural area means working to the top of your scope, dealing with everything that comes through the doors, hoping your internet will work at home (or work) and that you might be able to do some online learning sometime, and hoping the roads aren't flooded out so patients can get to the practice over gravel roads.

I am the College of Nurses representative for the Rural Health Alliance Aotearoa New Zealand (RHAANZ) and a RHAANZ council member.

I love working in a rural

practice. Even though I haven't lived in rural NZ for very long I know what we miss out on compared to our city counterparts and I think a rural nurse working party is an excellent way for rural nurses to get their voice heard and ensure that rural nurses enjoy the same support that urban nurses do.

Future Plans

RNNZ has already had several videoconferences since its inception and has developed a Terms of Reference, elected office bearers including position descriptions for the office bearers, a mission statement and the groups' objectives going forward. We are currently working on development of an RNNZ logo and website. We are under negotiation with other groups to enable us to make informed decisions as to whether RNNZ should stand alone with links to other groups, or if we are to fit under the umbrella of an existing organisation. The Facebook page has been a great initiative that has already seen rural nurses sharing and networking with others.

It has been a very busy time to date, and the group works amidst challenges that many rural nurses face such as geographical separation and telecommunications and the failures that can occur when working rurally. These challenges make the RNNZ working party more determined to work with and on behalf of all rural nurses regardless of context. RNNZ welcomes feedback with regards to what you would like to see put in place to support you in your roles now and in the future. If you wish to contact the group, please use the following contact details. We would love to hear from you.

Rural Nurses New Zealand Email:ruralnursesnz@gmail.co m

Facebook Page: Rural Nurses NZ.

PRIME Review.

Rural nurses have also been waiting eagerly the outcomes of the national PRIME review to determine how this will affect their practice in the future. As part of the National PRIME Review Committee I am happy to report that the first step in going forward has been achieved with Tim Malloy, Chair of the Royal College of General Practitioners and PRIME provider in Wellsford being appointed to the Chair of the National PRIME Committee. Tim is passionate about PRIME and has been involved in the service from its inception, both as a rural provider of PRIME, and in the development of the PRIME service nationally.

The role of this Committee will be to implement the final outcomes of the PRIME review document that was finalised and accepted by the Ministry of Health earlier in the year as well as ensuring there is a sustainable service going forward. It hopes that the reviewed service represents the needs of all rural populations in New Zealand, while recognising that there are unique rural geographical differences. These changes will not happen overnight but the potential for improvement over time is huge.

As nurses, we represent a large part of the PRIME workforce and I am happy to say that nurses will also be represented on this national committee in order to ensure that our views as rural practitioners are represented and concerns addressed appropriately. A robust governance structure that will better support PRIME Practitioners is essential to ensure that PRIME providers have the tools they need to do

their jobs safely and effectively. It is expected that in order to do this, PRIME funding will be reviewed to ensure it is fair, cost effective and sustainable, as well as reviewing PRIME kits and training.

There is a big job ahead of this group to implement the outcomes of the PRIME review and having been involved in this process from the outset, I have no doubts that the group will do the very best for rural communities and the PRIME service by implementing actions that are in the best interest of optimal patient outcomes.

On that positive note, I would like to take this opportunity to wish you all a very safe and happy festive season and all the best for 2018.

Education & Upcoming Events

Dear Members

The NZNO Medico-Legal Forum 2018 is now open for registrations.

Please could you register by following the link below:

https://www.etouches.com/medicolegal2018

Cost: Members $120

Non Members: $150

Student member registrations should be made directly to Philippa Ireland by phoning 0800 28 38 48.

14 February	Auckland #1 – Holiday Inn Auckland
15 February	Auckland #2 – Fair Way Conference Centre
21 February	Christchurch – Rydges Latimer Square
22 February	Dunedin – Otago Golf Club
28 February	Wellington – Te Whare Waka
01 March	New Plymouth – Novotel Hobson Hotel
07 March	Hamilton – The Narrows Landing

Free online cultural competency course

http://members.mauriora.co.nz/lesson/module-2-making-a-difference-and-cultural-diversity/

Tāne Tatiku Ake (Men standing together) health and wellbeing program

Tim Ryan

Long Term Conditions Nurse

Korowai Aroha Health Centre

NZCPHCN Clinical Excellence Award 2017

Tim is a Long Term Conditions Nurse at Korowai Aroha Health Centre, Rotorua. Tim has a varied background in secondary care Nursing. Since leaving the Hospital Tim has worked in primary care as Clinical Facilitator for the Rotorua PHO. Tim is studying towards a Master's in research, through the University of Auckland.

His current role is working alongside Paewhiriwhiri (community health workers) Tracy and Kevin, as the Clinical Advisor for Tane Takitu Ake (Men standing together) innovation program.

Introduction:

The research I am currently exploring is looking at the experiences of Māori men who have engaged in the Tāne Tatiku Ake (Men standing together) health and wellbeing program, in particular examining the influence of environments in relation to health promotion and what role the nurse plays.

Health statistics indicate men's health especially that of Māori men's health, are poor in comparison with other groups. Māori men are at greater risk of disease, higher rates of mortality and prong more to psychological distress (indicative of anxiety or depressive disorders) (Ministry of Health., 2015), Tatau Kahukura: Māori health chart book.

There are many reasons why Māori men do not engage effectively with primary health care providers often it is related to cultural issues. The Tāne Takitu Ake program aims to address this problem by combining cultural (tikanga) and western health (clinical) interventions to improve health and wellbeing while at the same time developing a new care delivery model for primary health.

Background Tāne Takitu Ake:

My co-workers and I began developing a program that would deliver health education in a format that would engaged effectively with men. We decided to run a pilot program that was delivered over ten weeks which included a limited cultural component, six week gym course with a mix of group and personal development workshops. The pilot program had some successors and from this Korowai Aroha Health Centre decided to apply for innovation funding through the Ministry of Health, Te Ao Auahatanga Hauora Māori Innovation Fund. This fund seeks new ways to improve Māori health and wellbeing.

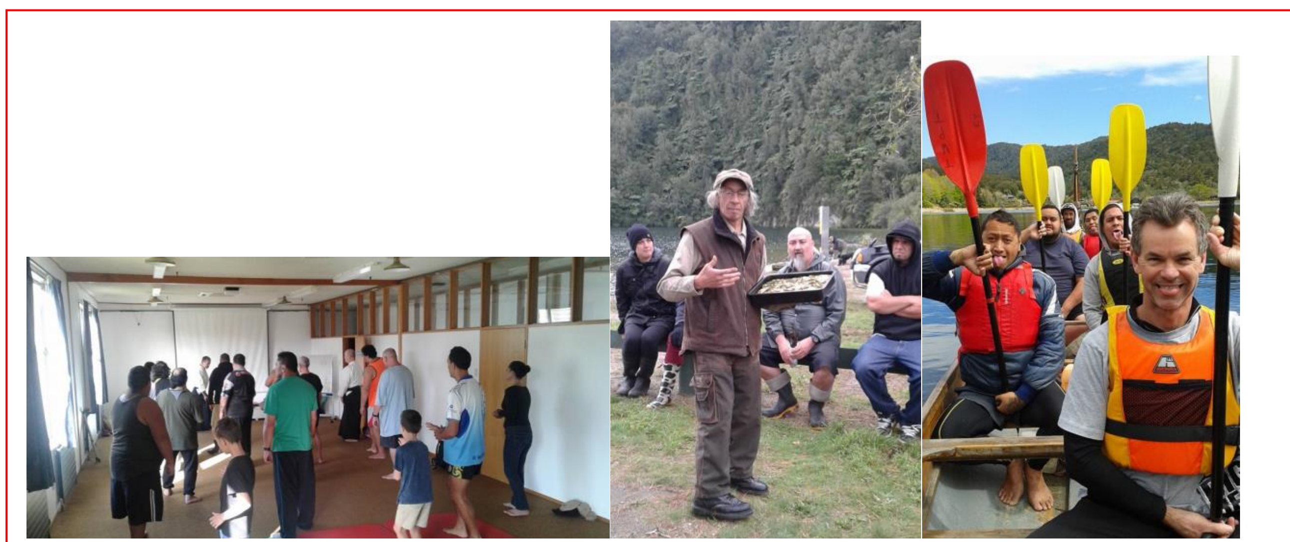
Tāne Takitu Ake is a Kaupapa Māori program for Māori men facilitated by men. Those targeted for the program are men whom have children in their care while diagnosed with health related issues like;

diabetes, or with social or mental health issues.

The goal of the Tāne Takitu Ake programme is to engage Māori men through a facilitated program outside of contemporary health centre environments such as health centres. This innovative 10-week programme uses a diversity of environments to deliver healthy behaviour change education.

The program has 3 stages: Tāne Whakapiripiri; relates to the formation of the group, Tāne Te Waiora; relates to the physical connections and Tāne Tokorangi; relates to the sustainable change. Within each stage is a mixture of cultural and clinical workshops. The reliance on community support networks and selected guest speakers ensures a unique balance of practicable tools the men can use, combined with science of behaviour change. The program is very interactive (good for men) and outcome based. Each Tāne is assessed for motivation and is assisted with setting goals. The strength of the program lies in using outdoor environments to create honest conversation with out judgement. The men find empowerment and identity in the program which leads to an openness in learning healthy behaviours which is supported by whakawhanaungatangai (comradeship) within the group. As facilitators we do not give hand outs but we will give a hand up. The goal is for less dependence on the health facilities and more reliance on themselves especially with one another using a formula in group dynamics to achieve this.

Learning the Te Whare Tapa Whare model and applying these principles to real life, Tāne make the connection between physical, mental, social and spiritual wellness, in other words a holistic approach to wellbeing



Interventions:

Noho Marae (cultural traditions), native kai gathering, waka, gym exercise program, nutritional workshops, Aikido, mental health education, cultural identity are other activities are used on the program. These activities are designed to open their minds on understanding what holistic health means. For example the waka tete gives the analogy of good health. When the men are paddling together, they can feel how smooth the journey is, items that slow them down, like smoking, are tossed over as they were back in the day.

Research Topic:

This research study is an 'Exploration of environment in a health education program'. Using a focus group interview approach, the dictation is then thematically analysed to provide an insight into the thoughts of participant's on the program.

Application to nursing:

For community nursing having men engaged positively in their health, is the ultimate challenge. Our goal is to have a program structure that is replicated in other areas of need without reinventing the wheel. The health system is under pressure to curb the tide of diabetes, cancer, asthma etc these conditions are often made worse through their social situations. Therefore we need innovation and experimentation to drive solutions to these health issues. The aim of Tāne Takitu Ake is to have sustainable change with men that will influence their Whanau and therefore evolve into a community change to improve health and wellbeing for everyone.

We have found that while on the program the men's health literacy is increased immensely. For example, the Tāne will relate to high cholesterol with poor life expectancy and now understands fully the impact nutrition and exercise can have on their cholesterol levels. This shows the message delivery has had an effect by using cultural analogies. Often we hear from the men, that the same message has been delivered in a clinical setting but with limited success. The men show a real keenness to apply their new gained knowledge.

Results/Findings:

Better relationships within the whanau, improved biomarkers, increased nutritional and cultural literacy, commitment to learned behaviours eg exercise, eating, awareness of spiritual importance to health, are some of the outcomes achieved. Non-Māori men have been put through the program with similar results.

Conclusion:

Blending the old ways with the new, proves vital for increasing 'at risk' men's health literacy while at the same time changing behaviours that will have an intergenerational effect. If we get it right for Māori we get it right for everyone. Taking nursing outside the consultation room is an alternative to making a difference to this cohort.

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Preserving a therapeutic relationship with parents who decline childhood vaccinations: a literature review.

Jacquie Westenra, RN, PGDip(Nursing)

The purpose of this review was to investigate how nurses' attitudes, behavior, knowledge and communication skills can influence parents' vaccine decision making and the nurse-parent relationship. The objective of this article is to discuss key strategies in communication which may enhance nursing care, nurse-parent relationships and nurse job satisfaction. The author works as a Practice Nurse in a General Practice.

Abstract

Parents who decline or refuse to have their children vaccinated may challenge healthcare providers (nurses and doctors) vaccine knowledge, professional obligation, ethical stance, communication skills and confidence. This review of articles aims to recognize and discuss further the challenges doctors and nurses encounter when working with parents and offer suggestions in effective communication strategies. Furthermore this review highlights the importance of preserving the relationship between healthcare providers and parents, regardless of their differing perspectives on vaccination. It is evident that in order to have effective conversations and maintain a trusting therapeutic relationship with parents, healthcare providers need to be knowledgeable and have effective communication skills in order listen to parents' concerns and provide accurate vaccination information. This paper also presents some ethical issues of vaccination refusal/decline and illustrates the importance of healthcare providers understanding the complexity of parents' vaccination decision making.

The published literature focuses mainly on doctors' experiences with very few articles specific to nurses and parental decline/refusal of childhood vaccination. 'Healthcare provider' is used throughout this paper which includes nurses and doctors. Although this review identified there is a lack of literature specific to nurses, issues discussed in the articles are extremely relevant to nurses who work in primary care.

Key words: vaccination decline/refusal/hesitancy, vaccination ethics, vaccine communication/decision making, therapeutic relationship, parent/child, healthcare providers/doctors/nurses.

Introduction

It is well established that vaccination is integral in the prevention of death or serious illness caused by vaccine preventable diseases (Diekema, 2005; Dube, Gagnon et al., 2015; Healy, Pickering, 2011). Regardless of this consensus a certain percentage of parents do not vaccinate their children (Diekema, 2005). In New Zealand 78.8% of 6 months old children are up to date with their vaccinations and recent statistics show the decline (refusal) rate is 3.9% at 6months and 4.7% at 5 years old (Ministry of Health, 2017). Importantly, those parents who decline, delay or are hesitant to vaccinate their children are likely to have concerns about vaccination. Therefore, healthcare providers need the skills and knowledge to effectively communicate accurate information to help parents to make informed decisions (Simone, Carrillo-Santisteve et al. 2012). Parents need to trust their healthcare provider to provide accurate vaccination information (Benin, Wisler-Scher et al, 2006; Fernbach, 2011, Simone et al., 2012). However vaccination decision making is complex and parents' decisions are influenced by many different factors (Brunson, 2013; Glanz, Wagner et al. 2013; Healy, Pickering, 2011).

Healthcare providers can experience moral and ethical conflict when parents decline to vaccinate their children (Berry, Henry et al., 2017; Schwartz, Caplan, 2011; Fernbach, 2011).Consequently conflicting perspectives between healthcare providers and parents can arise and cause communication difficulties which have a negative effect on their therapeutic relationship (Berry et al., 2017; Fernbach, 2011).

Vaccine hesitancy and decline/refusal

Dube et al. (2013) propose that vaccine hesitancy of one, several or all vaccines, is on a continuum with refusal and acceptance at opposing ends. Hesitancy may not necessarily be due to a lack of understanding or trust, but reflects parents' caution and their need to be informed to make what they perceive the right decision for their child's wellbeing (McCauley, Kennedy et al. 2012). Jacobson (2010) stresses the importance of recognizing parents' the difference between hesitancy and refusal. Parents' initial reluctance to vaccinate is likely to be hesitancy rather than outright refusal. Therefore, a key message for health care providers is to encourage conversation with parents to discuss their concerns, recognizing the potential for parents' decision to change

Vaccination communication

McCauley et. al (2012) & Diekema (2005) suggest that instead of perceiving parental refusal or hesitancy as a lack of trust, healthcare providers should consider parents hesitancy as caution and a desire to be well informed in order to make decisions they believe potentially optimizes their children's health and wellbeing. In addition, parents' vaccination knowledge and beliefs are likely to be reflective of parents' health literacy and their desire to do what they perceive is best for their children. Healthcare providers should express to parents that they also consider the wellbeing of their children as paramount. This shows healthcare providers empathy, finds 'common ground' and helps develop a mutual objective with parents (Rentmeester, 2013).

In a New Zealand study, Desmond et al. (2011) found practice nurses' confidence and knowledge impacts on vaccination with lower nurse confidence reflected in lower vaccination rates. Nurses with vaccination training were more likely to be confident in their vaccine knowledge and

recommend vaccination to parents. Furthermore, higher vaccination rates occurred in practices where the nurse(s) had a greater awareness of parental vaccine hesitancy, concern or apathy. The authors concluded the nurses' confidence and positive attitude results in nurses' using effective communication and empathy, resulting in vaccination promotion (Desmond, Grant et al. 2011). Healthcare providers may have concerns around vaccine safety which is communicated to parents and as members of their community, doctors and nurses both reflect and influence public opinion and norms regarding vaccination. Accordingly, if they do not attempt to correct any misinformation, parents may interpret this lack of response as agreement (Leask et al., 2012). Healthcare providers may also be misinformed by media therefore timely release of information is needed to help healthcare providers in their own knowledge (Leask et al., 2008). Therefore education and ongoing professional development for practice nurses is crucial to the success of vaccination delivery (Desmond et. al. 2011).

Effective communication and vaccination promotion may be constrained by healthcare providers' limited time. Results from a survey by Berry et al. (2017) found doctors and nurses often feel rushed during clinics and this impaired their ability to discuss the parents' concerns. Kempe et al. (2011) also found doctors reported an increasing number of parents with vaccine concerns and identified time constraints as the greatest barrier to effective communication. According to McCauley et al. (2012) parents' predominant concern is side effects of a variety of vaccines. The authors recommend that health providers are up to date with information on each vaccine to individualize vaccine education in order to answer specific parents' concerns. It is also important to acknowledge the risks as well as benefits associated with vaccination as parents are more likely to be reassured if they feel they have been given a balanced view of both negative and positive aspects (Serpell, Green, 2006). Consequently healthcare providers who are confident in their vaccine knowledge will more likely communicate effectively in the time available.

Healthcare providers should initiate conversation with the aim to inform parents of the benefits of vaccination in contrast to the risks of vaccine adverse events. However providing information on vaccine safety to correct vaccine misinformation and promote vaccination may not necessarily be effective, the focus needs to be on effective communication which preserves trusting relationships between parents and healthcare providers (Leask et al, 2006). In fact, the assumption that parents would choose to vaccinate if provided with all the necessary information, including education on vaccine preventable diseases and the benefits/risks of vaccination is misguided (Serpell et al., 2006). In a large randomized trial by Nyhan et al. (2014), parents were educated using MMR promotion resources in an effort to negate specific anti immunization messages regarding the MMR vaccine and show the effects of measles. Interestingly, the study showed that the education methods and information used did not increase the likelihood of parents to vaccinate and those parents originally resistant to vaccination in fact had increased concerns and resulted in parents even less likely to vaccinate than prior to educational exposure. On the contrary, interviews and pictures of sick children with vaccine preventable diseases compounded parents' anxiety about vaccines (Nyhan, Reifler

et al., 2014). Perhaps this use of 'fear appeals' could help explain this finding. 'Fear appeals' described by Witte et al., (2000) should be used carefully as it can result in fear, denial and avoidance. Importantly to be effective 'fear appeals' not only need to strongly heighten audience risk perception with the high probability of contracting the disease and ensuing serious illness, but individuals must be convinced they can mitigate these risks and therefore be protected from the disease. Another reason for potential failure of 'fear appeals' as a strategy for vaccination promotion is due to the focus on the risk and impact of the disease, as opposed to vaccine risk. This is illustrated in a study by Brown et al. (2010) who found what 'vaccine acceptors' feared most was the risk of disease and what 'vaccine refusers' feared most was risk of the vaccine. Therefore information and education methods need to be individualized to the target certain audiences. For example, vaccine hesitant and resistant parents more emphasis needs to be on information about vaccines.

It is noteworthy that the study method by Nyhan et al. (2014) used information and resources released in a media format rather than delivered by individuals' family healthcare providers. It is likely this less personalized method of education influenced the outcome. This is supported by Freed et al. (2011); Leask et al. (2012) and Berry et al. (2017) who suggest that healthcare providers' communication style and relationship with parents is a crucial factor in influencing parent's decision making. Moreover, several studies confirm that parents are most likely to trust health providers to give them credible information compared to other sources (Freed, Clark et al., 2011; Healy et al., 2011; Leask et al., 2012; McCauley et al., 2012). An important finding in a study by Leask et al. (2012) was that the mothers trusted their doctors to tell them the risks of vaccination. Consequently parents who were not aware of vaccine risks and are later exposed to anti-immunization marketing felt their trust in their doctor was eroded. These mothers felt distressed and believed they were not fully informed by their doctor (Leask, Chapman et al., 2006). Parents need to trust their healthcare provider to give them the correct information, instill confidence in vaccines, and to give reassurance so to relieve anxiety (Benin et al., 2006; Freed et al., 2011; Fernbach, 2011). Conversely gaining parental trust is not automatic but requires healthcare providers to demonstrate a commitment of care to the family regardless of the (vaccination) outcome. Importantly the priority is on preserving a therapeutic relationship with the primary focus on the wellbeing of the child. Moreover trust is developed through positive interaction and empathy with parents, regardless of healthcare providers' personal feelings (Berry et al., 2017; Rentmeester, 2013). Although numerous studies show parents consider doctors to be the most trusted source of vaccine information, Freed et al. (2011) found many parents also search and trust many alternative sources of information, with differences depending on parents' gender. For example compared to fathers, mothers were more likely to be influenced by parents and media that publicized claims of children affected by vaccine adverse effects.

Vaccine communication may include healthcare provider vaccine recommendation. This strategy has been shown to be effective in increasing vaccination rates (Dube et al, 2017; Jacobson, 2010; Opel, 2013). Moreover a study by Opel et al., 2013 found a

significant percentage of hesitant parents who initially declined to vaccinate, following further recommendation by their healthcare provider decided to vaccinate. Recommendation and healthcare providers' positive attitude toward vaccination increases the likelihood of vaccination. This is supported by McCauley et al. (2012) and Kempe et al. (2011) who suggest a useful strategy is for health providers to express how they personally believe vaccination is very important in keeping children healthy by helping protect them from getting vaccine preventable diseases. In addition, health care providers who discuss their own experiences in deciding to vaccinate and subsequent vaccination of their own children proved helpful to parents in decision making.

Jacobson (2010) maintains that doctors not only need to educate parents but should also persuade them to vaccinate and that ultimately parents want a recommendation. However, if recommendation is perceived by the parent as persuasion this may end in a one-sided conversation. For example Goldstein et al. (2015) state that effective communication is a 'two-way process' involving individuals sharing thoughts and discussing information, ultimately resulting in empathy and learning. Leask et al. (2012) encourage healthcare providers to use a supportive and questioning approach which identifies parents' readiness in decision making rather than telling and directing parents.

The basis of effective communication is a trusting relationship (Bester, 2015). Many studies show that doctors and other healthcare providers are the most trusted source of vaccine information (Simone et al., 2012). Therefore doctors are in a position to successfully use a persuasive approach (Nyhan, 2014 & Serpell et al., 2006). However Leask et al. (2012) suggest a communication style where healthcare providers tell parents what to do is unhelpful in answering parents' concerns and does little to promote vaccination. An individualized approach where healthcare providers use motivational interviewing techniques which includes building a rapport and trust, listening to and answering parents' concerns, and communicating with empathy and respect is recommended. In addition Leask et al (2012) developed a framework for healthcare providers, encouraging them to assess parents' position on vaccination, identify parents' concerns and gaps in knowledge, then have a conversation based on parents' needs. In summary this facilitates parents to make an informed decision, preserves the relationship between healthcare providers and parents and furthermore provides an opportunity to develop mutual and realistic goals of care.

Parental decision making

It is important that healthcare providers understand factors and processes which influence how parents make the decision whether or not to vaccinate their children (Brunson, 2013; Glanz, Wagner et al. 2013; Healy et al., 2011). Brunson (2013) describes this is as a complex process that is affected by many socio-cultural factors such as personality, previous personal experiences and that of their peer group, friends and family and the influence of social norms. Simply, this may be described as 'what makes sense' for the individual (Ministry of Health, 2014). To help healthcare providers' empathize with parents, they need to acknowledge that parents' decisions are formulated from their personal influencing factors and health literacy therefore their interpretation

of information may differ from their own (Diekema, 2005).

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Brunson (2013) identified stages of decision making: 'pre-decision', 'awareness', 'assessing, 'choosing', 'stasis', 'reassessment and ongoing assessment'. Importantly, identifying what stage parents are in can help health providers individualize communication with parents. For example the pivotal phase, 'stasis, reassessment and ongoing assessment' may be the best time to promote vaccination to hesitant parents as there is an increased likelihood of influencing them to vaccinate (Brunson, 2013).

Furthermore, Brunson (2013) describes three groups of parents: 'acceptors', 'reliers' and 'searchers'. Individuals of each group have certain characteristics which influence where they get information, their critical analysis of its content and source, and the level of acceptance within societal norms (Brunson, 2013).

Parents' perception of the risk of their children contracting the disease, illness severity and vaccine risk can be influenced by simplistic, sensational, inaccurate and/or unscientific media stories and websites which are critical of vaccination. Conversely, communicating scientific information to parents is difficult often due to parents' health literacy and can consequently result in confusion and uncertainty (Healy et al., 2011). Therefore, health care providers' best approach is to have honest and calm discussion with parents, listening to their concerns with sensitivity and give information appropriate to the parents' needs (Fortune, Wilson, 2007).

Healthcare providers should understand that parents' perception and children's actual risk can vary. Parents' risk perception is formulated by information related to the chance of getting the disease and the potential for serious harm; in the context of each disease, its prevalence and the community rates of protection through vaccination (herd immunity). For example unvaccinated children may gain some protection from the combined effect of vaccinated individuals in the community, consequently this can influence parents risk perception.

Societal norms are key influencing factors in decision making therefore any education needs to not only to be focused toward parents but also extended family, friends and communities (Brunson, 2013). An extensive systematic literature review by Larson et al. (2012) identify that when vaccination is considered a social norm, supported by social networks and members of the community including health care providers, that this has a positive effect on vaccination rates. Healthcare provider recommendation is a strategy which can increase the likelihood of vaccination (Dube, Laberge et al, 2013; Jacobson, 2010; Opel, Bahta, 2014). Furthermore, healthcare providers act as role models to reinforce social norms. This is demonstrated in a study by Kempe et.al. (2011) who found that doctors felt that saying to parents they have vaccinated or would vaccinate their own children and sharing their experiences regarding vaccine safety was the most effective technique in promoting vaccination. An analysis of doctor/nurse and parent conversations by Opel et al. (2013) looked specifically at the type of approach healthcare providers used when talking with parents. The results supported the theory of 'social norm' as an important influencing factor. For example, when healthcare providers used language which recommended vaccination and presumed the parents would agree to go ahead to vaccinate when presenting in the clinic, then vaccination was much more likely to occur. However Leask et al. (2012) cautions

against presuming that presentation for a vaccination appointment means parents give informed consent. The healthcare provider has a responsibility to ask parents to give consent at the appointment prior to vaccination (Leask et al., 2012).

In an Australian study of mothers' attitudes regarding vaccination, Leask et al. (2006) found these mothers did consider one benefit of vaccinating their children was that it contributed to the herd immunity of the community. The authors suggested informing mothers of this benefit could help promote individual vaccination. However, regardless of societal benefit Fernbach (2011) maintains parents make decisions based on what they consider best for their children.

Therapeutic relationship with parents

Due to the complexity and evolving nature of vaccination decision making it is important parents feel comfortable to approach their healthcare provider to discuss concerns and ask questions. Healthcare providers who listen to parents concerns with empathy are more likely to preserve a therapeutic relationship with parents. Conversely preserving this relationship is paramount in order to have ongoing effective communication about vaccination (Rentmeester, 2013).

Jacobson (2010) states that “Parents are struggling to make correct decisions for their children and they depend upon their relationships with their clinicians for help with these decisions” (Jacobson, 2010; p.241).

Relationships between primary healthcare providers and parents are typically ongoing therefore there may be many opportunities to discuss vaccination (Diekema, 2005; Fortune et al., 2007). However healthcare providers may avoid conversations with parents who are resistant to vaccinate their children in order to avoid any conflict which they feel may be detrimental to their relationship with the parent and potentially inhibit future interaction (Berry et al., 2017; Fortune et al., 2007). Aside from vaccination, primary healthcare nurses have the opportunity to provide ongoing child assessment and parent education in many aspects of child health (Fernbach, 2011). Nurses may be concerned their differing perspective on vaccination may have a negative impact on their relationship and the child's on-going health care, due to parents' reluctance to present to appointments about other health concerns (Fernbach, 2011).

Feelings of frustration with parents who maintain an anti-immunization position may result in healthcare providers' behavior toward these parents becoming confrontational risking the continuation of their therapeutic relationship (Berry et al., 2017, Fortune, Wilson, 2007; Leask, Kinnersley et al., 2012; Rentmeester, 2013). A study by Leask et al. (2012) shows that although doctors and nurses were aware that arguing with parents would result in a negative outcome, they were still drawn into heated conversation. The authors concluded that doctors or nurses, who are overly determined to change the minds of parents, compromised their relationship and risked any future constructive conversation. Furthermore, confrontational conversation is often time consuming and results in no one winning. Healthcare providers' should recognize that preserving a trusting therapeutic relationship is integral in overcoming any issues (Berry et al., 2017; Healy, 2011, Leask et al., 2012, Rentmeester, 2013).

Ethical issues related to vaccination refusal/decline or delay

When parents refuse/decline or delay to have their children vaccinated, healthcare providers may experience an ethical dilemma. They have responsibility to help protect both the individual child and the community and each situation needs to be deliberated to ascertain the potential serious consequences of non-vaccination to the child and/or community (Fernbach, 2011).

Nurses aim to empower parents to make informed choices regarding childhood vaccinations (Fernbach, 2011). Paradoxically, vaccine hesitancy, delay or refusal is a likely consequence of empowering parents' involvement in vaccination decision making (Dube, et al. 2013). Healthcare providers have an obligation to respect parents' decisions. However if parents are reluctant to vaccinate, healthcare providers may find their obligation for protecting other individuals, particularly those unable to be vaccinated compromised (Berry et. al. 2017; Fernbach, 2011; Schwartz et al., 2013). Herd immunity gives some protection to individuals by reducing the prevalence and potential outbreaks of many infectious diseases in the community, however to be effective it requires a certain percentage of individuals to be vaccinated (Ministry of Health, 2014). In summery the community is reliant on individual vaccination to maintain this protection (Brunson, 2013, Fernbach, 2011).

Healthcare providers have a responsibility to ensure parents are equipped with information to enable them to make an informed decision, although communication with resistant parents may be challenging (Bester, 2015). Healthcare providers should determine parents' vaccine knowledge and whether they want any further information. Parents who refuse their children's vaccinations may not want to participate in discussion therefore healthcare providers need to respect this. Regardless, parents should be aware information is available and that healthcare providers are approachable if and when parents wish to discuss vaccination (Leask, 2008).

Conclusion

This paper draws on a review of articles related to parents who decline or refuse their children's vaccinations and identifies key issues and challenges faced by healthcare providers. Importantly, the articles discuss strategies in effective communication and acknowledge the importance of preserving therapeutic relationships with parents. It is evident that in order to have effective conversations and maintain a trusting therapeutic relationship with parents, healthcare providers need to be knowledgeable and have effective communication skills in order listen to parents' concerns and provide accurate vaccination information. This paper also presents some ethical issues of vaccination refusal and illustrates the importance of healthcare providers understanding the complexity of parents' vaccination decision making. Healthcare provider recommendation supported by vaccination considered as societal norm increases vaccination rates is emphasized within the articles. In summary, communication based on trust, empathy and mutual understanding with parents that their children's wellbeing is the focus is fundamental to preserving a therapeutic relationship.

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Research Request –
Nurses' views of Community Pharmacists

Good afternoon,

I am a researcher from the School of Management, at Massey University in Auckland, and I am working with Dr Shane Scahill and Professor Lorraine Warren on a research project exploring nurses' views of community pharmacists, with a focus on entrepreneurial behaviours. As part of this project we are speaking with representatives of nursing professional bodies and nurses, and given the crucial role of primary health care nurses in this I am writing to enquire whether it would be possible to disseminate this request for participation among members of the New Zealand College of Primary Health Care Nurses? If this is possible, I have included a short research blurb for dissemination:

Opportunity to share your views on community pharmacists and the integration amongst health care practitioners.

Dr Shane Scahill and Professor Lorraine Warren from Massey University are seeking participants for a study which aims to explore nurses' views on what being an entrepreneurial pharmacist means and how this might influence your working with them, as a result of the integration of primary health services.

For this study, we are seeking nurses, nurse managers, nurse educators, and representatives of nursing bodies, to participate in an interview about their perceptions of community pharmacists, with a focus on entrepreneurship and innovation, as well as professional integration. These interviews will last approximately 45-60 minutes, in person (if you are located within the greater Auckland region) or via phone or Skype. Your identity will be known only to the researcher and you will not be identified in any research findings.

If you would like to participate in this study, or you would like more information, please contact Natalia at N.J.D'Souza@massey.ac.nz or on 02111757444.

I have also attached an information sheet outlining the study aims and details, along with the notification of ethical approval. The interview is expected to take approximately 45 minutes to an hour, and can occur in-person (within the greater Auckland region), or via phone or Skype, at a time (and location) convenient to the respondents. Any guidance or help you could provide us with recruitment for this project would be greatly appreciated!

Warm regards,

Natalia D Souza

School of Management

Massey University, Albany

MASSEY UNIVERSITY
UNIVERSITY OF NEW ZEALAND
MASSEY BUSINESS SCHOOL

PARTICIPANT INFORMATION SHEET

Are Community Pharmacists Really Entrepreneurial? The views of Nurses!

Researchers:
I (Dr Shane Scahill) am the lead researcher of this study. Other researchers involved are Prof Lorraine Warren and Natalia D'Souza. We are a group of researchers from the School of Management, Massey Business School at Massey University.

Project Description
This research investigates the effects of recent changes in the market environment for community pharmacy service delivery. It aims to understand to what extent nurses perceive pharmacists as being entrepreneurs and innovators, and how this impacts working together and the integration of primary health care services. Practice nurses and representatives from professional nursing bodies will be interviewed in-order to gather the required data.

An Invitation
You are invited to share your views/understanding about what being an entrepreneurial pharmacist means to you and how this may influence your working with them and the integration process of primary health services. We are hoping to conduct approximately 20 interviews to generate key understandings about community pharmacists and entrepreneurship.

We would like to interview you in person, over the phone, or by Skype for about 45 minutes. If you are a nurse or a representative of a professional nursing body we will ask you questions about your perceptions of what being entrepreneurial and innovative means in the context of New Zealand Community Pharmacy, and how this might impact upon the integration and delivery of health services.

The interviews will be audio recorded, then transcribed verbatim and analysed using NVIVO qualitative data analysis software. Electronic data collected will be kept secure on a password protected computer for two years. After two years data collected in interviews will be deleted.

Information about you will remain confidential to the researchers and identifying details about you or the organisation for which you work will be removed from the transcript and any publications generated from this research. The research team will use pseudonyms and a numbering system instead of your name.

There are benefits to you participating in this study. There is a chance to share your views on the extent to which you see pharmacists as entrepreneurs and innovators, and what this means to you. As well, you will have the opportunity to discuss how this might influence teamwork and professional integration amongst health care practitioners. Similar work has recently been conducted by this team with pharmacists themselves, and it is hoped that your views will be collectively analysed and distributed with a view to improve the delivery of health services.

Participant's Rights
You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- Decline to answer any particular question;
- Withdraw from the study up until the point at which the data is being analysed and interpreted which should be approximately 2 months after your interview;
- Ask any questions about the study at any time during participation;

- Ask for the recorder to be turned off at any time during the interview;
- Provide information on the understanding that your name will not be used unless you give permission to the researcher;
- If you wish, you will be given access to a summary of the project findings when it is concluded.

If you'd like to participate in this research, please contact one of us by text or email and we will get back to you to organise a meeting. The lead researcher's details are below, along with the fellow researchers involved in this study. Please contact any of the researchers (lead or other) if you have any questions about this project.

Project Contacts

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Ethics

This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher(s) named in this document are responsible for the ethical conduct of this research.
If you have any concerns about the conduct of this research that you want to raise with someone other than the researcher(s), please contact Dr Brian Finch, Director (Research Ethics), email humanethics@massey.ac.nz

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- **'Does simulation make nursing students more confident when they start clinical placements?'**

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Diabetes in Pregnancy

Diane Selves

Lesley Maclennan

The incidence for GDM, Type 2 and Type 1 diabetes in pregnancy is rising (Ministry of Health, (MOH), 2014)(b). Diabetes in Pregnancy is associated with higher risk of serious complications and morbidity in pregnancy including macrosomia in the fetus and an increased risk of obesity and type 2 diabetes. A pregnancy complicated with diabetes requires close monitoring by a team specialised in the care of Diabetic pregnant women to minimise the risks to mum and baby ADIPS (2005).

The diabetes in pregnancy (DIP) midwives are part of the Multidisciplinary team consisting of Obstetricians, Diabetes Physicians and Dietitians collaborating to care for women with diabetes in pregnancy at Counties Manukau Health (CMH). CMH covers an area of high socio economic

My name is Diane Selves and I am a Diabetes in Pregnancy Speciality Midwife and I work in a team of 5 midwives, 2 of whom are Diabetes Midwife Specialists. I enjoy my current role which is part time and the rest of my week is taken up with my 2 young children. I have been in NZ since 2003 where I have worked in various midwifery roles within Counties Manukau DHB. I qualified as a midwife in 1996 and prior to emigrating to NZ, I worked in Edinburgh, Hampshire in England, Saudi Arabia and Alice Springs.

Lesley Maclennan is a midwife specialist in diabetes at Counties Manukau Health (CMH) Diabetes in Pregnancy Service. She started her career as a Nurse at Glasgow Royal Infirmary then training in Midwifery at Glasgow Royal Maternity Hospital in Scotland. Since her move to New Zealand in 1994, she has worked in a variety of midwifery roles at National Women's Hospital, Christchurch Women's Hospital and with the New Zealand College of Midwives. On her return to Auckland in 2007, Lesley joined the Community Midwifery team at Counties Manukau. Here she found her area of interest in working with the women with diabetes in pregnancy and has completed the 'Advanced Diabetes Nursing Practice' Masters in Nursing paper at WINTEC and continues to contribute to service development.

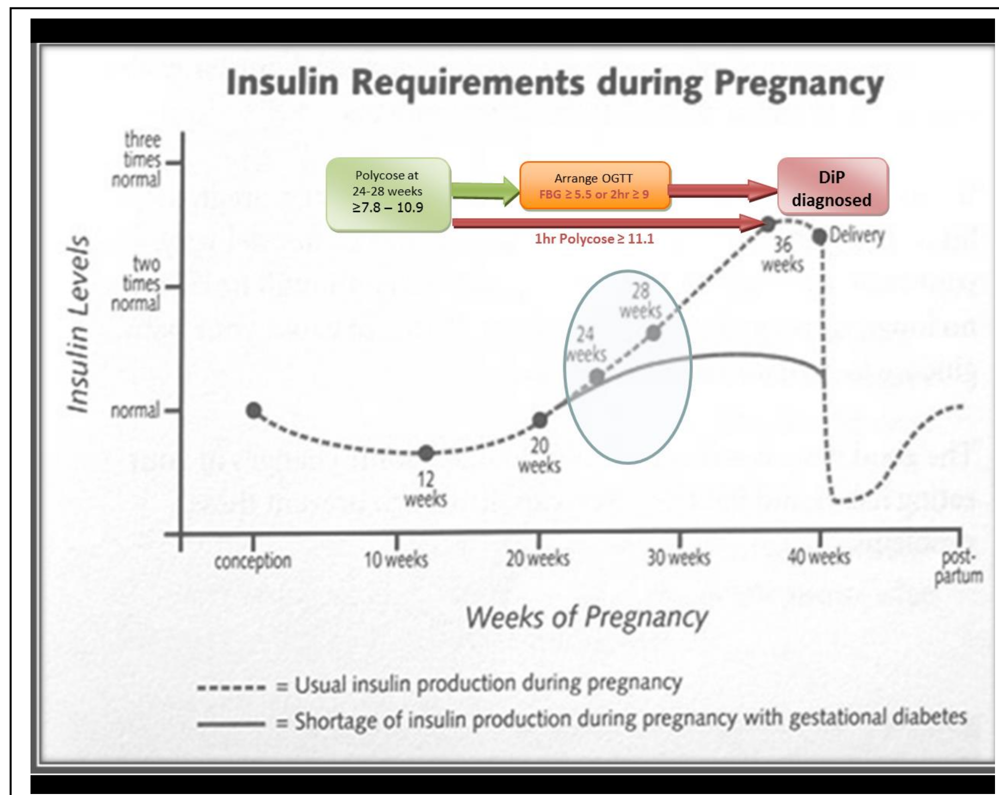
deprivation (Ekeroma et al 2014; Warin et al 2016), and women have a higher prevalence of risk factors for poorer outcomes in pregnancy (Perinatal and Maternal Mortality Review Committee, 2016). In 2016, 429 women with Gestational Diabetes (GDM), 129 Type 2 women and 14 Type 1 women were referred to our service.

The MOH (2014)(a) recommend a pathway for the screening and diagnosis of probable undiagnosed Type 2 diabetes in pregnancy and for early identification of those who may develop gestational diabetes. The aim of this guideline is to improve neonatal and maternal outcomes. This guideline recommends:

- Every pregnant woman should be offered glycated haemoglobin (HbA1c) as a routine booking blood test before 20 weeks.
  - HbA1c ≥ 50mmol/mol should be referred directly to diabetes in pregnancy service.
  - HbA1c 41-49mmol/mol should receive dietary and lifestyle advice and have an oral glucose tolerance test (OGTT) at 24-28 weeks. (*These women are at increased risk of developing GDM).*
- All other women should be offered screening for diabetes using the one hour 50g, oral glucose challenge test (polycose) at 24 weeks.

Pathophysiology of Diabetes in Pregnancy

The role of Insulin in the body is mainly related to glucose metabolism. In the 1st trimester the pregnant women without diabetes has an increased sensitivity to Insulin with lower fasting blood glucose levels and the likelihood of hypoglycaemia between meals and during sleep. In the second trimester, pregnancy hormones, human placental lactogen and prolactin are thought to cause Insulin resistance making



glucose available to the fetus for longer.

(International Diabetes Center at Park Nicollet, 2010 as cited in Marcinkevage and Narayan 2010)

Gestational Diabetes

Some women do not produce enough Insulin to counteract insulin resistance or have a degree of Insulin resistance. If maternal pancreatic Insulin response is inadequate there is increased glucogenesis (Moore, 2009). These women then develop carbohydrate intolerance in pregnancy. Women with gestational diabetes should be informed of

the risks of developing Type 2 diabetes in later life and the MOH (2014)(a) have recommended an Hba1c at 3 months postnatal to detect diabetes outside pregnancy.

Women with IGT and Type 2 diabetes who already have pathological Insulin resistance will develop raised blood glucose levels in pregnancy as insulin resistance develops. They will require additional treatment for their hyperglycaemia in pregnancy. Women with Type 1 diabetes are reliant on exogenous Insulin and the impact of pregnancy and the hormonal

influences on their diabetes is significant and the balance between avoiding hypoglycaemia and hyperglycaemia can be very challenging.

The fetus

The fetus is exposed to episodic hyperglycaemia consequently pancreatic beta cell hyperplasia and increased Insulin levels. This promotes excess nutrient storage resulting in macrosomia. The risks associated with hyperinsulinaeima and macrosomia include polycythaemia, jaundice, respiratory distress syndrome, neonatal hypoglycaemia ,birth trauma and stillbirth. Type 2 diabetes carries a much higher risk of morbidity and mortality to the fetus and NICE (2015) state that these risks increase with the length of time the woman has had diabetes.

Preconceptual care

It is recognised internationally that women with diabetes who are planning pregnancy should be informed that establishing good glycaemic control before conception and throughout pregnancy will reduce the risk of miscarriage, congenital malformations, stillbirth and neonatal death (Campbell and Nairn, 2002). The MoH (2014)(c) recommends that women with diabetes of childbearing age should be advised of optimal planning of pregnancy including preconception glycaemic control. The Best Practice Advisory Centre Best Tests Publication (2011) makes suggestions for pre pregnancy care for women with diabetes in primary care. Women planning pregnancy should be offered preconception advice before discontinuing contraception.

5mg Folic Acid should be commenced 4 weeks prior to pregnancy to reduce likelihood of Neural tube defects and Iodine 150mg once pregnant for fetal brain development. ACE inhibitors are contraindicated in pregnancy and be stopped. Women with pre-existing hypertensive disease should be switched to a safe antihypertensive therapy during the pregnancy SOMANZ (2008). Statins are also contraindicated in pregnancy ADIPS (2005).

The oral anti-diabetic medication currently recommended in pregnancy is Metformin therefore all other oral anti-diabetics should be stopped on confirmation of pregnancy (Rowan, Hague, Gao,Battin and Moore, 2008). Metformin and/or Insulin should be started for hyperglycaemia without delay when pregnancy is confirmed.

Treatment

The treatment for control of diabetes during pregnancy involves dietary and exercise lifestyle changes, daily capillary blood glucose self-monitoring and pharmacological treatment where required when capillary blood glucose (CBG) is above treatment targets despite lifestyle interventions.

The DiP service midwives provide monitoring and support to assist women in continuing improvement towards achievement of agreed glycaemic targets. As part of this supportive contact process women may require initiation and/or titration of medications prescribed for treatment of diabetes.

Treatment Targets

The evidence on treatment targets is unclear (MOH 2014)(a) and currently a large trial is being conducted in New Zealand to improve evidence for the current MoH recommended targets. There is a need to optimise glycaemic targets in order to normalise fetal growth and minimise

perinatal and later complications (Metzger 2007, Combs 2011, Herandez 2011, Rowan 2011 as cited in Crowther, 2015).

<u>Fasting and Pre-prandial capillary blood glucose upper level limit</u>

≤ 5.0 mmol/

<u>2 hours Post-prandial capillary blood glucose upper level limit</u>

≤ 6.7 mmol/L

These targets are used as a guide to treatment in CMDHB. With Type 1 diabetes in pregnancy, individual targets are set.

Hypoglycaemia

Diabetes in Pregnancy treatment objective is to achieve glycaemic control and reduce the risk of perinatal complications without serious hypoglycaemia, the major adverse effect of insulin therapy

In pregnancy a CBG level < 3.5 is classified as hypoglycaemia with GDM or Type 2 diabetics on Insulin, whereas with Type 1 diabetes treatment is required when CBG reading <4.0.

Women are supported by the DIP team throughout their pregnancies to achieve the best possible outcome for their long-term health and for the health of their babies. On diagnosis of the pregnancy the woman should be commenced on treatment if necessary and referred to local diabetes in pregnancy service as soon as possible.

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Reflecting on the journey to Registered Nurse Prescribing (RNP)

Erin Searle

Nursing has certainly changed since I trained in the early 1990s at Wellington Polytechnic. I recall being clearly informed that "nurses do not diagnose and they certainly do not prescribe". But now, with the right qualifications and training, Nurse Practitioners and Registered Nurses (RN) can do both safely. I have discovered that becoming a nurse prescriber is not for the faint of heart. It requires stamina, discipline and drive, especially if study is in addition to full-time work. The process of learning to study as an adult, sit exams and securing support and prescribing mentors has taught me to live on the edge of my comfort zone. Change and growth has been the by-product of this process.

Role

As a Clinical Nurse Specialist for diabetes, employed by a Primary Health Organisation (PHO) in Wellington, my role is autonomous. I am part of a larger team of Diabetes Nurse Specialists from primary and secondary care settings that form the Capital and Coast DHB Diabetes Care Improvement Package, Diabetes Nurse Practice Partnership (DNPP) initiative. The partnership was established to increase Primary Health Care's workforce capability to meet the needs of an increasing population with diabetes. As part of this model of care, I support six General Practices including one high need practice in the Porirua area. Prior to prescribing, medications were initiated, changed and titrated using onerous diabetes standing orders.

Post Graduate study journey

My evolving journey towards prescribing started in 2010. As a Practice Nurse employed by a high needs practice, I completed a Post Graduate Certificate from Whitireia Polytechnic in Primary Health Care Specialty Nursing. I am still aligned with that practice in my RN prescriber role and where I currently run nurse led diabetes clinics. It wasn't until 2012, once the diabetes nurse prescribing pilot was underway, that I heard about nurse prescribing and began to consider advancing my practice. I then planned the progression of my study programme with Massey University with prescribing in mind. Fortunately, RN prescribing legislation was implemented during my prescribing practicum in 2016. I completed my Masters with the new Evidenced-based Practice paper this year.

Prescribing Practicum

I decided to go down the route of completing the Prescribing Practicum paper as it fitted into my Masters programme. There was a robust process with: a practicum proposal; practice log; competency sign off; case studies; oral examination; 150

hours supervised practice and supervision with the prescribing mentor. I had the opportunity to join my secondary care colleagues who were completing a six to twelve week prescribing practicum to achieve Diabetes Nurse Prescribing (DNP). However, with imminent changes to the legislation, I wasn't sure how the timing of the DNP practicum would work with my practice being in the primary setting. I also felt that RNP, with its broader medication scope, could offer improved access to healthcare for patients as well as future proofing my career and employment opportunities within primary care. With the support of my employer, I increased the number of supervised hours with my prescribing mentor. We arranged to add long term condition clinics to the diabetes clinics, increasing contact with a range of patients. This allowed me to become more familiar with a broader range of medications related to the condition of diabetes on the RNP medication list. This arrangement was a "win-win" both for myself and the practice.

Finding a prescribing mentor

My role as a PHO nurse led to challenges securing a prescribing mentor for the prescribing practicum. I approached one of the secondary consultants but was informed that his first duty was to the registrars. Discouraged, but determined, I then approached a General Practitioner (GP) at my main high needs practice where I had been a practice nurse and was running clinics. I thought he would be the perfect mentor as he had been awarded the Queen Service Medal for his services to training GP registrars. The main challenge for him was lack of time as he was working part-time and heading towards retirement. Therefore, his initial answer was no. I felt quite despondent at this stage. Fortunately, after consideration, he said that he would support me as my prescribing mentor. Weekly formal supervision sessions were held after the working day. I felt as if I had won "My Golden Ticket" to RNP and I remain extremely grateful for this opportunity.

Application process

I submitted my RNP application in March 2017 and found the process to be user-friendly. For example, if a piece of evidence needed tweaking, there was the opportunity to do so and resubmit that piece only. I gathered together all the necessary requirements which included transcripts of the relevant papers, letters of support from both my employers and supporting practice as well as a brief CV, prescribing log and competence assessment form. The competence assessment form is extensive and was completed by the GP with some exemplars being rather brief. This individual piece of evidence did require resubmitting however, the approval process was surprisingly quick with efficient turnaround.

Requirements

I am now authorised to be a designated prescriber with one year's supervision as indicated on my Annual Practicing Certificate and need to ensure that I prescribe within scope, expertise and knowledge. With RN prescribing, there is the opportunity to challenge and grow primary and specialty nursing roles as long as support and training continues, and the scope of each role allows. RNP requires an annual competency sign off and letter of support as well as twenty continuing professional development (CPD) hours over three years. Ensuring appropriate opportunities for relevant CPD is still an evolving area for nurse prescribers. Hopefully a

structure can be developed around quality assurance for prescribing CPD for nurses.

My experience so far has been positive, and I have found that the benefits outlined in the research regarding nurse prescribing have been verified in practice. My GP colleague have been supportive and enjoyed the reduced work load and patients have enjoyed the convenience, reduced costs and improved access to regular medications (Budge & Snell, 2013; Wilkinson, Carryer & Adams, 2013). For myself I have found prescribing empowering and liberating. No standing orders and reduced paperwork to manage. My role has been broadened with increased utility and sense of purpose. There is also the opportunity to specialise in other areas in the future.

We say to patients to be their own health advocates and that no one cares about their health as much as they do. The same is true for nurses and their ability to develop their skills and career. No one is as invested as nurses are in what skills and services they can provide. Therefore, I think nurses need to be brave, be assertive and creative to drive what they want to happen.

Conclusion:

I feel like a nursing pioneer, travelling a newly carved out road in processes, scope and practice and am grateful for the tireless work of many that has led to this opportunity and feel privileged to support my nursing colleagues with their pioneering journeys as well. I would like to acknowledge the support of Massey University, my employer, HWFNZ for funding, my family and, last but not least, my prescribing mentor.

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Regional Networks

Cathy Nichols

Chair – NZCPHCN Professional Practice Committee

Are you thinking about starting a College of Primary Health Care (PHC) Nursing Regional Network group and not sure where to begin? The following are some top tips from the Chair of Wellington's very successful Regional Network Group.

Firstly, why is such a group worthy of your time and effort to organise? We think there are many reasons that might persuade you and others to run a group. The regional network meetings are a great forum to share information, meet with other nurses, and build relationships and integration across the breadth of Primary Health Care. The meetings also enable having a generally pleasant time with other health professionals and such activity is great evidence in your professional development and recognition programme portfolio.

Our advice is to start with a small group of enthusiastic nurses who will be the organising committee. Have enough people in your committee to spread the workload and keep "shoulder tapping" for new members as turnover is inevitable. Be organised at your committee meetings, have an agenda, allocate activities, and keep yourselves to time.

Decide on a broad topic, one that suits as many nurses as possible and covering the multiple facets of Primary Health Care nursing. Successful topics for us have included, renal health; drug and alcohol abuse; respiratory conditions; palliative care; advanced care planning; wound care and travel medicine.

Break the topic into two or three sections, allowing for different aspects to be explored. Having more than one speaker can be useful, giving the attendees different styles of presentations. Choose subject areas that you want to know about as a PHC nurse as other nurses are likely to find the topic interesting too. We have found that ensuring the patients' voice and the psychological impact of any situation is strongly represented in the session has been very popular. Having client case studies and reflections from practice also seems to enhance the learning. We aim to make it very clear to the speakers, who the audience are and what type of work they do. The diversity of primary health care nurses can be quite a challenge, however our speakers have always responded well and pitched the information appropriately.

Speakers can be from a variety of areas relating to the topic. For the drug abuse session we had speakers from Police

informing us about names of street drugs and drug hot spots around our city; DHB Clinical Nurse Specialist (CNS) from drug and alcohol service describing their work and referral pathways; and a volunteer from the drug and needle exchange programme complimented the session by sharing information about their resources. For the renal health session, speakers were CNSs from the renal unit, giving a brief overview of the patho-physiology of the kidneys, one with specialist interest in diabetes who described the importance of PHC nurses in recognising deteriorating e-GFR levels. We also had a presentation from the renal transplant team.

Once speakers have been confirmed to be available and willing to contribute to the session, we give them a brief guide to the detail of what focus we think their topic could have. This often takes some discussion as they know their topic best but we know the audience well and sometimes need to advise what issues wouldn't be worth covering. It is ideal to inform each speaker of the whole programme and how their session fits into it. The speakers often know each other and share presentation plans prior to the event. It is always amazing how each speaker has synergy with other presenters and one section dovetails perfectly into the next. Our speakers are incredibly generous and have never asked us to be paid for their time and effort. However, we always give a small gift as demonstration of our gratitude and follow up with an email of thanks.

When the timetable plan is finalised, advertising the event is important. A well-presented flyer with all the required details including RSVP information helps both attendees and organisers (see the example below). We have found that we can get over subscribed for our 80-seater room, however due to last minute attendee cancellations we have never had to turn anyone away. To disseminate the flyer, we e-mail it to the NZNO administrator who sends it on to local college members. We also ask the local Director of Nursing for Primary and Community to send it out through the PHC networks. As such, the flyer is received by Aged Residential Care; Non-Governmental Organisations; Iwi providers; Primary Health Organisations; General Practice; Regional Public Health; District Nurses; Tele Health Nurses; Occupational Health Nurses; Corrections; Well Child Tamariki Ora; Tertiary Education providers and their students; School based Nurses and many others.

Other organising issues to consider include:

Registrations for the study sessions are taken via a Gmail account we set up; saves clogging up personal emails and also means committee members can assess it; so spreading the load. We usually find ten people do not arrive whilst another ten just turn up. We have cancelled one session at very short notice due to an extreme weather event. Since that time, when accepting registrations we add people into a group, allowing one email to be sent to all attendees should the need arise. We also add attendees to our list of contacts; then we are able to invite them to our next study session. By doing this we are extending our reach to primary health care nurses who may not receive notifications any other way.

Provide drinks and nibbles for attendees on arrival. Many nurses, including ourselves attend straight from a full day at work. We try and offer just enough sustenance to get them through the two and a half hour session. One of our committee is amazing and happy to be in charge of this arrangement for every evening,

however it is quite a bit of work that most committees could share the load.

Ensure you have microphones if attendee numbers are large, it can be very frustrating if you are at the back of a full room and you can't hear a great speaker.

Evaluation sheets and certificates are be printed by the NZNO administrator who posts them out to organisers given sufficient time. Templates for these are on the College website.

We provide these education sessions free to all College members and we charge a small koha to non-members. Nursing students also attend for free.

The Wellington Regional Network Group organises 3-4 study sessions per year, but we would advise starting with one to see how it goes. We run our sessions in the evenings which enables a much better attendance, even though it is a long day for some. We start planning 3-4 months in advance, have a regular venue utilising our DHB contact to resource a room at no charge and we apply for funding from the College to support catering costs.

When we reflect on why we have such a successful regional forum, we suspect that firstly our committee represents the many areas of PHC practice ensuring the topics are valuable to most; the committee are enthusiastic about facilitating such a positive gathering of nurses; and finally we all get great reward from watching the networking and enjoying attendee and our own learning. We wish anyone thinking of embarking on a similar arrangement lots of luck, you will enjoy it.

Dignity in Death: RN Verification of death to reduce the wait times for verification of expected patient death in the community

Gabrielle Driscoll, Clinical Nurse Specialist (CNS) Palliative Care, Capital & Coast DHB

When a patient is identified to be in their last days or weeks of life, it is important that health professionals explore their advanced care wishes with them, including their preferred final place of care. Many patients express a strong desire to die in their own homes and supporting this is a priority of the health services involved. These patients often receive comprehensive end of life care delivered by a shared care model involving the District Nursing Service and Hospice teams working closely with the patient's General Practitioner (GP). Following the expected death of a community patient, their GP is called upon to complete a Medical Certificate Cause of Death, and a Cremation Certificate where required. There can be delays in GPs attendance to carry out this action, particularly at weekends and afterhours when the GP may not be available. The resulting delays have the potential to cause anxiety and distress to patients' whānau.

Working mostly as a Hospital Palliative Care CNS but also as a Palliative District Nurse, I have had direct experience of the delay in death certification causing whānau discomfort. Although there is no legal requirement for deaths to be verified in order for the deceased patient to be transported, some funeral directors can be reluctant to do so without this confirmation taking place. With many community patient deaths occurring out of normal working hours, district and hospice nurses are often faced with the task of trying to co-ordinate the timely transport of the deceased patient by a funeral director when their death has not yet been verified by the unavailable GP.

Following a Ministry of Health review, and publication of the guidance document *Verification of Death* (2015), Registered Nurses (RNs) are now amongst a broader group of health professionals who are also able to verify patient deaths. Our teams of nurses believe that RNs are well placed within the community to provide this last act of care. We proposed that enabling RNs to verify expected deaths within our community services would enable a more timely response to and support of after-death care processes. There was however, no local policy in place to support this practice.

With the support of a working group, I sought out the experiences of other District Health Boards within New Zealand where this activity was already taking place. Several

colleagues from other DHBs were kind enough to share their supportive documents and policies which we were able to localise to our own setting. I also undertook an audit of wait times for verification of those who had been supported with end of life care in their own homes. These audit results provided compelling evidence of significant delays. Perhaps as powerful was the finding that of these patients, 76% had at least one, if not two Registered Nurses visit their homes in the time between their death and the GP verification taking place.

I presented these findings, a draft policy and a pilot project proposal to numerous governance committees, both within our District Health Board and the local hospice. Permission has been obtained to commence a pilot project, which we will begin in the next month. All of the GP practices in the local area have received written information and a visit from a working group member to explain how the pilot project will function, and to obtain their feedback. The response from General Practice teams has been overwhelmingly positive.

A training session has been developed for district and hospice nurses, the attendance at which is voluntary. Some nurses expressed initial reluctance and concern of the responsibility of verifying a patient. However, over time this fear has been allayed by developing their knowledge of the comprehensive assessment that is undertaken to verify death, and the many clinical safeguards that will be in place. Many of our nurses now express how keen they are to support their patients' whānau through providing this service.

Supporting the nurses who are participating in the pilot project is a priority of our working group. Our guidelines highlight the RNs' right to 'opt out' of verifying any death they do not feel comfortable to carry out. We also plan to offer the nurses the opportunity to regularly debrief and reflect on the deaths they may verify, or to revisit any of the education regarding the processes.

We believe this project is significant for a number of reasons. Firstly, for the whānau of patients who receive end of life care at home and the staff that support them. This project ensures that the dignity, cultural and religious needs of the patient and their whānau are maintained. The plan also provides clinical safeguard for funeral directors when transporting deceased patients. Secondly, the project is a step in ensuring clinical policy and processes reflect and support the increasing number of advanced nursing roles being developed within our DHB. Nurse led services, including those within palliative care, require support and recognition of the enhanced RN scope of practice which enables nurses to perform such clinical tasks such as death verification.

The intention of this pilot project is to enable RN verification of death within the community setting, and to develop sound policies and process. In the future, we look forward to sharing these resources and the education packages with other District Health Boards and care providers such as Aged Residential Care to enable more whānau support to timely verification of a loved one's death.

Family violence and how we can make a difference

Tania Roberts-Thomson, Plunket Nurse Titahi Bay, Porirua, Wellington.

This article was originally written as a reflection piece following Tania's attendance at the Capital & Coast District Health Board *(CCDHB) Violence Intervention Programme (VIP) training day in August 2016.*

In 2016, the Minister of Social Development commented that new legislative reforms were designed to underpin wider work on the issues of family and sexual violence in our society. The main change required focus on early intervention and prevention.

The Plunket Society also launched a public awareness campaign in 2016 for the best start in 1000 days, highlighting the importance of a child's experiences in their first three years (Plunket, 2016). By working in partnership with parents and encouraging their participation in creating a safe and supportive environment for their children, there is an opportunity to contribute to the next generation of caring kind and secure adults.

Plunket nurses have a vital role in addressing concerns around violence in the home and are crucially placed to identify families of concern (Fanslow, Kelly, 2016). However, to do this it is important to know what to look for and how to respond when a concern is identified.

Whilst it is accepted that abuse is not limited to any one gender, religious, cultural or income group, it is also recognised that there are certain factors that increase the risk of abuse. Maori women have a higher prevalence of suffering physical or sexual abuse compared to any other ethnic group in New Zealand. Other groups which have a higher incidence of abuse include: Pacific and refugee groups and people from the LGBT community. It is important for Plunket clients from all ethnic groups to be confident they are not discriminated against and Kruger (2004) highlighted that culture is not an excuse for normalising violence,

Plunket policy is to promote a safe home for children through non-violent parenting practices and prevention of abuse and neglect (Plunket, 2016). There are clear definitions around what constitutes abuse and there is no excuse for not taking action should there be any concern for a child's well-being.

Routine enquiry at every core Well Child Tamariki Ora contact ensures families know Plunket considers family violence an important health issue whilst assuring clients they can divulge their concerns safely to Plunket staff. Working in

partnership with clients helps to establish a relationship where victims might feel empowered to reveal personal abuse or feelings of being unsafe. A significant number of victims seek help from health professionals.

As a result of attending the Capital and Coast DHB VIP training, I feel more confident to support clients should a risk be identified. I routinely screen for family violence and have had disclosures. At a disclosure, a risk assessment is made and appropriate action taken. This could be offering specialist services such as Woman's Refuge and direct referral as agreed by the client or making a Report of Concern to Oranga Tamariki. I would consult with my Plunket Clinical Leader as per Plunket policies. Part of my risk assessment would be to ascertain the safety of those involved and take emergency action as necessary. I also feel more confident to complete written reports after receiving training on appropriate wording and phraseology from the VIP course (Wilson et al, 2015).

I also appreciate how difficult it is for victims to speak out. As a result of the training, I have spoken to our volunteers about having brochure stands placed in our bathrooms at the Plunket centre, to have discreet access to safety plans and support service contact details. I now always carry support service contact details should a client require them (e.g. for Women's Refuge). I am confident to ask difficult questions should it be necessary.

Family violence is a long-standing and complex problem that affects all levels of society. It is a multifaceted issue with no easy fix but requires deliberate persistent commitment across many sectors.

After attending the VIP training, not only do I feel more aware and informed of violence related issues and support agencies, but I also feel more confident and equipped to address any related needs of my clients. The VIP Guidelines (Fanslow et al, 2016) fit with Plunket's policies and processes and have given me added confidence in writing reports of concern.

By taking a stand against family violence with our next generation, there is an opportunity to change the inter-generational transmission of violence that is prevalent in NZ society. Plunket's policy is to support families in non-violent parenting practices, providing the opportunity to turn the record around and reduce the violence trends. By intervening with children in the first 1000 days, there is a chance to raise a generation of competent, caring and positive adults.

Capital & Coast District Health Board conducts Violence Intervention Programme courses throughout the year. Primary health care nurses are offered opportunities to attend the training courses together with DHB staff. If primary health care nurses wish to attend VIP courses, feel free to contact your local DHB VIP Coordinator.

What's on top in the immunisation world?

Bernadette Heaphy

Bernadette Heaphy is a registered nurse and is the Regional Immunisation Advisor for Central Region, working for the Immunisation Advisory Centre. Bernadette has specialised in Immunisation for the last 10 years and worked with IMAC for the last 6 years and recently completed a 10 month secondment with the Ministry of Health's Immunisation Team

When posed with the question what is on top in the world of immunisation, my mind is filled with the increasing complexity and breadth of the National Immunisation Schedule (NIS). When I think back to when I started vaccinating, at the turn of the millennium, we had a NIS that included oral polio vaccine (OPV) and covered 6 weeks to 11 years. In addition, there was influenza for those age 65 years and older and those with eligible medical conditions. On the surface, it seemed so much simpler, but was it really?

Even then the NIS had its own complexities. There were significant concerns regarding the side effects from OPV, so we changed to IPV (inactivated), and switched from the more reactive whole cell pertussis to the less reactive acellular vaccine. There was no National Immunisation Register, only those old patient note cover sheets with limited documentation.

We were then faced with a set of schedule changes, August 2000, January 2001 and February 2002, with associated practice management system changes for those who were moving to computerisation.

Thankfully NIS changes now occur, for the most part, every 3 years with minor adjustments in between. 2017 has been a year of change, continuing the evolution of the NIS and for the most part it has gone well. Providers have the aim to deliver a seamless service for clients and a huge thank you is needed to all immunisation providers and all immunisation administration and coordination services. Without their commitment and energy the challenges that come with schedule changes would be overwhelming.

In 2017 two main changes occurred to the NIS. These included: the extension of Human papillomavirus vaccine (HPV) programme from 1

January 2017, and changes to the infant programme from 1 July 2017 with the introduction of varicella vaccine. There were also some changes around eligibility for vaccines for special groups.

The HPV programme was extended to include males and all those aged up to 26 years (inclusive). At the same time the HPV9 vaccine became available, initially for the school based programme, and later available to primary health care as the stocks of HPV4 were used up. These changes were met with both excitement and good old kiwi can do attitude by providers. A doubling of the work load occurred for those delivering the school based programme to Year 8 students. These nurses rose well to this opportunity to extend the programme. General practice providers have been working hard to provide opportunities for young men to receive the

vaccine for the first time and offering of the vaccine to young women who had previously not started or completed a course. Some general practices even delivered the HPV9 vaccine outside the traditional four walls of practices and took the programme to their local high schools. The practices that implemented these initiatives are to be congratulated and are great examples of providers working together to ensure better health for their populations.

The schedule changes in July 2017 resulted in the much anticipated addition of the Varicella vaccine at 15 months of age: "Four in a row" has become the mantra for nurses delivering these events. From reports, nurses not surprisingly, have continued to offer safe and effective vaccinations events for those wriggly toddlers. There were also changes to vaccine brands. In theory it should be straight forward to finish one brand of vaccine and start on the next. For three of the four changes that is essentially what happened. However, for the rotavirus vaccine change, a change in from three to two doses and a change in the cut off ages for the administration of doses increased the complexity.

The zoster vaccine to prevent shingles (herpes zoster), may be introduced in 2018 for those aged 65 years with a suggested catch up opportunity for those 66 to 80 years of age. PHARMAC consultation occurred in September/October and we await the outcome (https://www.pharmac.govt.nz/news/consultation-2017-09-15-zoster-vaccine/).
Interestingly on 20 October 2017, the Federal Drug Administration in the US advised it had licensed Shingrix, another zoster vaccine manufactured by GSK. Shingrix is not a live vaccine providing the potential for greater coverage. With the likely roll out of the currently licensed vaccine, Zostavax from 1 April 2018, it will be interesting to see when Shingrix becomes available in New Zealand.

Vaccines for individuals of special groups whose medical conditions or treatments put them at greater risk of the complications of vaccine preventable diseases, is an increasingly complex area for vaccinators in New Zealand. While special groups such as babies born to hepatitis B positive mothers, patients pre- or post-splenectomy and patient post-chemotherapy are well recognised, the breadth of patients who are now eligible for specific vaccines has widened. It is not surprising that health professionals can be confused with what to offer and who to offer to and also working through the recommended and funded and recommend but not funded options. While resources are available, getting to know how to use the PHARMAC website (https://www.pharmac.govt.nz/) search tool is invaluable when checking if a vaccine is funded.

The Immunisation Handbook includes a chapter on Immunisations for special groups and the Immunisation Advisory Centre has developed a specific fact sheet to assist providers in identifying if an individual is eligible for funded vaccines.http://www.immune.org.nz/sites/default/files/resources/Written%20Resources/ProgrammeSpecialGroups20170703V01Final.pdf. If you open this file in Internet Explorer, when you hover the mouse over a vaccine, an extra box outlining which special groups are eligible for the vaccine is viewable. There are new fact sheets available outlining vaccines and schedules for a number of the adult special groups. Do not hesitate to talk your Immunisation Coordinator or the advisors on 0800 IMMUNE if you want to check the criteria.

The final area for my "what's on top" is the vaccine cold chain. I have a special interest in this topic as I have been involved in vaccine cold chain since my first days as a practice nurse. Later, in the early days of cold chain accreditation I was an assessor. More recently I have been involved in the review of the 2012 National Guidelines for Vaccines Storage and Distribution which led to release of the Ministry of Health's (the Ministry) *National Standards for Vaccine Storage and Transportation for Immunisation Providers 2017* (the Standards).

Having worked through the process of dealing with a cold chain failure as a Regional Immunisation Advisor and while on secondment with the Ministry, I have come to a new appreciation of the impact that such an event has on all involved. No vaccinator ever starts their day planning to administer a compromised vaccine to a patient. However at times, it is easy to dismiss the process around vaccine storage and transport as being unnecessary and time consuming. The reality is that dealing with a cold chain failure is very time consuming and for the most part avoidable. Making sure that you have the correct equipment, appropriate processes and systems and that the people who are responsible for your cold chain have current knowledge will reduce the risk of a cold chain failure. A great place to look for any information regarding cold chain is the Ministry website www.health.govt.nz/coldchain and the IMAC website http://www.immune.org.nz/health-professionals/cold-chain.

So that concludes my musings on what is on top in immunisation, the schedule changes in 2017 and the potential changes in 2018, wider vaccine eligibility for special groups and vaccines storage standards. Immunisation is an ever changing, ever evolving area of health. The opportunity to go to work and say "I helped prevent cancer today", or "I helped reduce the inequities that exist in health" means, as immunisers we will never be unsatisfied. I would like to finish by recognising the hard work of the National Immunisation Register administrators who ensure that the recording of immunisation is a true and accurate record of the vaccines actually given, so much better than those paper note covers we used to rely on.

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Resources For Nurses

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Articles – Sexual Health

1. Altschuler, Joanne. Midlife and older women's experiences and advice about sex with men, risk behaviors, and HIV prevention education. Journal of Women & Aging; London Vol. 29, Iss. 1, (Jan-Feb 2017): 63-74.

This article reports on older women's experiences and advice on condom use, male-female relationships, HIV risk, and prevention education. Analysis revealed four themes: (a) Gap between condom use advice and condom use behavior; (b) invisibility with age; (c) negative expectations of men; and (d) desire for education that breaks the silence on sex.

2. Bauer, Greta R.; Giblon, Rachel; Coleman, Todd A.; Aykroyd, Gloria; Fraser, Meredith; Pugh, Daniel. Community acceptance and HIV sexual risk among gay and bisexual men in a 'typical' Canadian city. Canadian Journal of Human Sexuality. 2017, Vol. 26 Issue 1, p7-16. 10p

Included in Statistics Canada's largest geographical "peer group," London, Ontario is typical of many midsize Canadian cities. A local health forum identified community acceptance and homophobia as key factors impacting LGBTQ health; we studied these with regard to HIV-related sexual risk in gay and bisexual men. How do community norms and availability of partners shape sexual risk-taking? Are conventional "contextualized" measures of sexual risk sufficient, or do they miss important risk-mitigation strategies used within gay communities?

3. Bauer, Michael; Haesler, Emily; Fetherstonhaugh, Deirdre. Let's talk about sex: older people's views on the recognition of sexuality and sexual health in the health-care setting. Health Expectations. Dec 2016, Vol. 19 Issue 6, p1237-1250. 14p

The article offers information on a study conducted on views of older people on incorporation of sexual health care in health-care setting. Topics discussed include sexuality being important to old people with increased level of embarrassment among old generation, need of discussing issues related to sexual health with old patients and providing education for reducing discomfort of patient being important.

4. The ‘holder of secrets’: A day in the life of a sexual health nurse. Australian Nursing & Midwifery Journal. Sep 2017, 25(3), p34-34. 1p.

The article describes a typical day in the life of a sexual health nurse in Australia. Topics discussed include the author's encounter with several patients with different sexual health issues, services offered at the sexual health clinic, and details

on how the author deal with her patients.

5. Hunt, Katherine. Providing sexual and reproductive healthcare in general practice: Historically, much of the work relating to women's health in general practice fell to female GPs. Now, it is more likely to be the general practice nurse who shoulders most of the workload relating to contraception and sexual health. Practice Nurse. May 2017, 47(5), p20-25. 6p

Abstract: The article looks at essential elements of sexual and reproductive healthcare (SRH) that nurses can gain competence and confidence in. Topics include undertaking repeat contraceptive checks for women already taking oral or injectable contraception; assessing whether a woman is at risk of pregnancy; and undertaking a risk assessment to determine if a patient is at risk of a sexually transmitted infection.

6. Leichliter, Jami S.; Copen, Casey; Dittus, Patricia J. Confidentiality Issues and Use of Sexually Transmitted Disease Services Among Sexually Experienced Persons Aged 15-25 Years - United States, 2013-2015. MMWR: Morbidity & Mortality Weekly Report. 3/10/2017, 66(9), p237-241. 5p

Changes in the U.S. health care system have permitted dependent children to remain on a parent's health insurance plan until the child's 26th birthday and required coverage of certain preventive services, including some STD services, without cost sharing for most plans (1,2). Although these provisions likely facilitate access to the health care system, adolescents and young adults might not seek care or might delay seeking care for certain services because of concerns about confidentiality, including fears that their parents might find out.

7. Mellins, Claude A; Walsh, Kate; Sarvet, Aaron L; Wall, Melanie; Gilbert, Louisa; et al. Sexual assault incidents among college undergraduates: Prevalence and factors associated with risk. PLoS One; San Francisco Vol. 12, Iss. 11, (Nov 2017): e0186471

This paper focuses on student experiences of different types of sexual assault victimization, as well as sociodemographic, social, and risk environment correlates. Across types of assault and gender groups, incapacitation due to alcohol and drug use and/or other factors was the perpetration method reported most frequently (> 50%); physical force (particularly for completed penetration in women) and verbal coercion were also commonly reported.

8. Subasinghe, Asvini K; Jayasinghe, Yasmin L; Wark, John D; Gorelik, Alexandra; Garland, Suzanne M; et al. Factors associated with unwanted sexual experiences of young Australian females: an observational study. Sexual Health (Online). 14(4), Aug 2017: 383-391

Behavioural and lifestyle factors associated with childhood unwanted sexual experiences (USE) have yet to be investigated in Australian females aged less than 18 years. Approximately 37% of survivors of childhood USE reported penile-genital contact in relation to their USE. Participants who reported depression were almost four times as likely to have experienced childhood USE than those who did not report suffering from depression.

Articles - Recreational Drugs

9. Casey, Georgina Dealing with addiction. Kai Tiaki : Nursing New Zealand; Wellington Vol. 23, Iss. 8, (Sep 2017): 20-24

Stimulant drugs (eg amphetamines, cocaine) act directly on the mesolimbic system to produce their effects, but other drugs of abuse, as well as activating this pathway,

have their primary actions in other regions of the brain.911 Release of dopamine in response to a drug is used to assess the drug's risk for addiction or abuse during commercial development - rat studies are often performed to measure this.

10. Education: Crystal Methamphetamine -- ICE. Australian Nursing & Midwifery Journal. Jun 2017, Vol. 24 Issue 11, p36-37. 2p.

The article offers information about Crystal Methamphetamine (ICE). Topics covered include the reported percentage of Australia population using amphetamine or methamphetamine according to the "2013 National Drug Strategy Household Survey (NDSHS)," the different properties and functions of ICE, and the short-term effects of ICE.

11. Herbert, Annie; Gilbert, Ruth; Cottrell, David; Li, Leah. Causes of death up to 10 years after admissions to hospitals for self-inflicted, drug-related or alcohol-related, or violent injury during adolescence: a retrospective, nationwide, cohort study. The Lancet. Aug 5, 2017, 390, (10094), 577-587.

Emergency hospital admission with adversity-related injury (ie, self-inflicted, drug-related or alcohol-related, or violent injury) affects 4% of 10-19-year-olds. Their risk of death in the decade after hospital discharge is twice as high as that of adolescents admitted to hospitals for accident-related injury. We established how cause of death varied between these groups.

12. Hutson, Matthew. Last night a DJ saved my life. Psychology Today. May/Jun 2016, Vol. 49 Issue 3, p40-42. 3p

The author presents a personal narrative about his life as a troubled teenager, his depression, the impact of psychedelic drugs and raving, and his decision to change his life after listening to the trance music from a disc jockey's mix tape while driving home from a rave in Connecticut in 1996

13. McCall Jones, Christopher; Baldwin, Grant T.; Compton, Wilson M. Recent Increases in Cocaine-Related Overdose Deaths and the Role of Opioids. American Journal of Public Health. Mar 2017, Vol. 107 Issue 3, p430-432. 3p

This article examines the trends in cocaine overdose deaths and examine the role opioids play in these deaths. Opioids, primarily heroin and synthetic opioids, have been driving the recent increase in cocaine-related overdose deaths. This corresponds to the growing supply and use of heroin and illicitly manufactured fentanyl in the United States.

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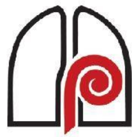

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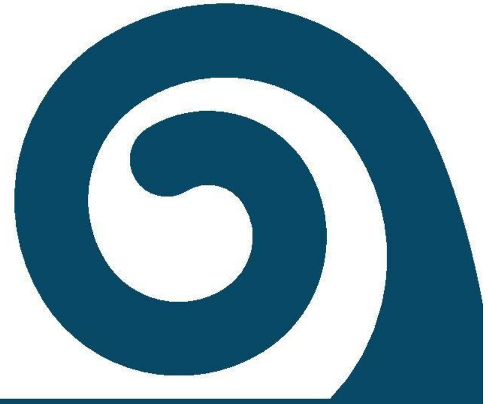

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