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

AUTUMN WINTER 2020 EDITION

RESPIRATORY CARE

THE FIGHT FOR A NEW CF DRUG

ADVANCED CARE PLANNING

WINNER OF NEW TO PHC AWARD

CAR SEAT SAFETY

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

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Interim Chair's Report

Jill Clendon
Interim Chairperson

Kia ora koutou. This is my first report for you in my role as interim chair of the College of Primary Health Care Nurses. Celeste is taking some time out for a little while as she focuses on her new business and an extremely demanding role responding to the COVID-19 situation. I'd like to start by thanking Celeste for all her work with the College and to acknowledge both her role with the College and her role as a leader in primary health care nursing. Celeste exemplifies everything it is to be a primary health care nurse – committed to equity, focused on providing the best possible care to clients, building her own primary health care practice, responding to requests for help no matter from whom and being ready to step up no matter what the situation. Taking the lead from Celeste, it is this commitment to primary health care nursing practice I'd like to talk to a little today.

We all come from many different backgrounds and have many different roles but we have one thing in common: we are all committed to working in and with communities to ensure they get the best possible health care. This is primary health care. It is a set of principles and an organising framework to guide nurses (and others) in facilitating socially just, equitable conditions for good health. Primary health care is more than just provision of medical or nursing care in general practice (this type of care is what we call primary care). Primary health care includes this but extends further to include the way in which we identify and address the social determinants of health as well, things such as access to food, healthy housing, healthy social and physical environments and education.

It's a big ask to think about these things in everyday practice, but in reality you are doing it every day with every assessment, every conversation, every intervention and every referral. Luckily there are six principles of primary health care that will guide us to ensure we take a truly holistic and primary health approach to care. These are:

- accessible health care (what can we do to ensure all people can access our services equitably?)
- appropriate technology (if a person doesn't have a phone, how are we going to keep in touch with them?)
- health promotion (how do we promote health and health literacy to our patient population?)
- cultural safety and cultural sensitivity (how do I make my practice safe for others who may be different from me?)
- intersectoral collaboration (how does my team work with others who also need to be involved? Do I have a

relationship with a WINZ case worker or a DHB social worker?); and

- community participation (how does my client group engage with my health care team and do we listen?).

These principles guide our practice and take us beyond being just good nurses to being great nurses and great leaders. On this note, leadership doesn't come with a title, it comes with the way we practice and the way we lead by example. COVID-19 has challenged every one of us these last few months. All of us have had to step up; you only have to read the media to see the role primary health care nurses have played and continue to play in assessment, testing, reassuring, vaccinating, supporting and facilitating. And all of that is on top of our everyday work. This is leadership by example. We should be rightly proud of our work in this space and proud to be a primary health care nurse. I'd like to thank all of you for stepping up over the past few months and I'd like to acknowledge those of you in general practice who are currently fighting for recognition of your work in line with your DHB colleagues. The College stands alongside you in your fight.

Nga mihi nui

Jill

Nicola Thompson and team – out in the community at a low-cost boarding house delivering flu vaccinations during 'lock-down'.

Editor's Report

Yvonne Little

Nurse Practitioner

Well what a roller coaster ride the world and little old New Zealand has been on since the beginning of 2020. Our lives have been turned upside down and inside out, our working conditions have changed immeasurably and adding to our changed and increased workloads, many of us have had to take on extra responsibilities at work and in our home lives.

Although many of you would have been too busy to read our Autumn issue, even if we had managed to bring it to you, it was disappointing to not be able to produce it. With everything that was happening in March, we made the decision to combine it with this our Winter issue for a couple of reasons: 1. Due to COVID-19 our article writers were heavily involved in the frontline and not able to provide their articles and 2. You, our members were also busy on the frontline and we felt would have had little if any time to sit down, relax and read it.

We have tried in this issue to cover as many non COVID- 19 articles as possible, as I am sure that living the COVID-19 life is enough at this time. I know I am getting enough of COVID-19 via television and MOH updates without adding it to our publication more than is necessary. Our acknowledgement of COVID-19 is through the Report from the Chief Nurse and our photo montage of our NZCPHCN committee members and their teams in action during this crisis. I hope you can find time to sit and enjoy the articles we have for you and maybe you would like to consider writing an article for us for one of our future issues.

It was unfortunate that we had to cancel our much-anticipated Auckland Workshop in July and now we also need to postpone the study day in Christchurch in November, with a proposed new date on March 2021 due to the reemergence of COVID19.

Finally, we can bring you the article from our 2019 winner of the Nurse New to Primary Health Care – Donna Auld, this was planned and ready to go for our Autumn issue which didn't eventuate. We are running this award again in 2020 so please nominate your colleagues, this award will still be judged and the presentation format will be advised through the college website and facebook page. Formal presentation is planned at the study day in March 2021.

We also have vacancies on our committees as members of our team come to the end of their terms, so if you are looking for a new challenge then why not come and join a dynamic team. It would be great to see our committees with as much work, ethnic background, and regional diversity as possible to ensure all our Primary Health Care Nurses are represented. We may have started out as a Practice Nurse group but we our now Primary Health Care which encompasses so many more areas of practice.

You will find the Nomination Forms for the Nurse New to PHC Award and Committee positions here in LOGIC, on our Website and on our Facebook page.

We will endeavour to continue bringing you interesting and thought-provoking articles in future LOGIC issues. We would love to hear your stories – do you have any special area of interest, do you belong to a regional meeting group, do you have a COVID-19 journey story – if so then please get in contact with us.

Thank you each and every one for your commitment to PHC nursing, especially in these recent stressful and uncertain times. I would also like to say thank you to your families as without their support we as nurses could not do our work.

Take care of yourselves, your whanau, friends, patients and colleagues, utilise the support services available and check out the App in this issue to ensure everyone's mental health and wellbeing is being cared for.

Pharmac Seminars Update

Because of COVID-19, like many education providers Pharmac are currently not holding any face to face seminars but you can keep learning with their online seminars.

The advantage of the online seminars is that you don't need to register to do them, this allows more of us to enjoy the benefits of these seminars. They can also be done in the comfort of your own home, without the need to travel and the time that this consumes out of your day.

Just subscribe to Pharmac seminar updates to stay informed.

If you haven't already signed up it is really very easy:

1. Go to Google and type in Pharmac Seminars or type into your favourite search engine: https://www.pharmac.govt.nz
2. Click on Pharmac Seminars
3. Click on subscribe to seminar updates

It literally takes less than a minute to sign up. Then you can peruse the seminars that are online and make your choice as to what you wish to look at. Unfortunately, due to COVID-19 there have been no new updates since 2019 but I am sure once things settle down we will see more updates from the Pharmac Seminar team.

Fiona Murray – from dayshift to nightshift for COVID-19 Border response at Auckland Airport

Report from the Office of the Chief Nurse

Margareth Broodkoorn (Chief Nurse) has previously given permission to utilise parts of her reports for LOGIC, in this time period when she has no doubt been extremely busy we have done the same again. This report has information gathered from the monthly reports sent out during the COVID-19 pandemic and other news from the Office of the Chief Nurse. Many of you will have seen some of this information but we feel it is still important to include in LOGIC again.

2020 Year of the Nurse and Midwife

We always knew that 2020 was going to be a big year for nursing and midwifery but no one would have anticipated the current situation. Within the realm of uncertainty there is one thing we can be certain of, and that is the important role of nurses, midwives, kaimahi and other health professionals in an event such as this.

We must not allow COVID-19 to cast a shadow on the Year of the Nurse and Midwife, in fact this extraordinary situation only highlights the pivotal and powerful contribution that our workforce can make.

Research trials

The Health Research Council (HRC) has announced funding for researchers from the Medical Research Institute of New Zealand to lead three internationally significant trials in the fight against COVID-19.

The clinical trials will provide hospitals and patients with access to the most promising COVID-19 treatments and the latest evidence on which treatments are most effective. They will assess potential therapeutic agents to fight COVID-19, including hydroxychloroquine which is one of several drugs gaining attention as a potential treatment for the virus. More information can be found on the HRC website.

Advanced Care Planning

During the COVID-19 response. it is more important than ever clinicians understand what really matters to a patient.

We encourage nurses and other health workers to connect with vulnerable patients and their whānau and talk about their priorities and preferences if their health did change and they were no longer able to speak for themselves. Document key information and shared goals of care in their medical records so this information can be easily accessed if needed.

The Health Quality & Safety Commission (HQSC) have launched the talkingCOVID webpage, which provides a toolkit to help you navigate care planning and decision-making in an empathetic and person-centric way in the current changing environment. More information about advanced care planning can be found at www.myacp.org.nz.

We cannot and should not fall into complacency mode but use this time to reflect on what has been achieved, take forward the great learnings, review what could be improved on and be prepared in the event we need to

stand up the required system and processes.

Updated PPE and IPC advice

Keep an eye on the MoH PPE in health and disability care settings page to ensure the most up to date information is being used.

Independent Review of COVID-19 Clusters in Aged Residential Care Facilities

The Ministry of Health has published the Independent Review of COVID-19 Clusters in Aged Residential Care Facilities report. The report was commissioned by the Director-General of Health in April to learn from clusters of COVID-19 in Aged Care facilities so New Zealand would be better placed to manage any further occurrences.

The report includes a number of recommendations for improvements which the Ministry will be seeking sector feedback on. Following this feedback, the approach, priorities and agreed actions can be confirmed. Both the independent reviewers and the Ministry have acknowledged the work of staff and others involved in aged residential care to protect a vulnerable group of the New Zealand population, and in preventing and managing the cluster outbreaks.

The Ministry also recognises the willingness of the sector to participate in the review and to put in place measures to limit further clusters or infections. The review examines in detail five clusters, as well as looking at a similar number of facilities which were largely unaffected.

The panel report has confirmed that the infections were introduced to the facilities by staff or visitors. ESR data shows that three facilities experienced staff cases first. The key focus of both the reviewers and the Ministry is to improve systems to prevent similar occurrences. Addressing faults in our systems reinforces the quality improvement focus used throughout health and disability services. No blame is being attributed to any staff involved.

The Ministry will be seeking feedback from aged care representatives, DHBs and PHUs on feedback on the Review recommendations over the next three weeks to inform a response and an agreed action plan for improvement.

Contact Tracing

Even at Alert Level 1, it remains important to keep a record of where we have been. We'll be interacting with more people so having a thorough record of where we've been and who we've seen will assist with rapid contact tracing if required.

We have released an update to the NZ COVID Tracer mobile app that provides new features and makes it more useful for contact tracing:

- You can now choose to receive a contact alert if you've checked into the same location at the same time as someone who has subsequently developed COVID-19.
- You can now use the app to send your digital diary to contact tracers if you are found to have COVID-19.
- To improve accessibility for blind New Zealanders and those with low vision, on supported devices the app will now vibrate your phone whenever you scan a QR code.

We're continuing to develop new features for future updates. We know Kiwis want to use the app to record their visits to friends and whānau, and we're also looking to support older phones and offer the app in languages other than English in a future update.

International Nurses Day – 12th May 2020

Well what a fantastic week of celebrations with the 12th May as a focal point of acknowledging nurses on International Nurses Day. Over 170 people listened to a wide range of speakers related to 2020 International Year of the Nurse. We started with a couple of videos from the Minister of Health and Elizabeth Iro (Chief Nurse at the WHO). We heard from three inspirational Nurse

leaders sharing their perspective of the International Nurses Day theme – Nursing the World to Health.

The National Nurse Leaders group and Chief Nursing Office also put together a short video, which can be found here: www.youtube.com/watch?v=17DejUc_l2E

Budget 2020

On Thursday 14 May Government announced Budget 2020: Rebuilding Together. Budget 2020 sees a significant additional investment in the health and wellbeing of New Zealanders to support the day-to-day operation of services delivered by a skilled workforce in our communities, hospitals and other care settings. It includes funding for mental health, disability support, pharmacies, general practice, Māori health, pacific health, maternity services, surgery, pharmaceuticals and ambulance services. Here are some of the highlights from this year's funding:

• A total $3.92 billion is allocated to District Health Boards in 2020/21 to provide additional support over the next four years, and another $125.4 million over four years to meet further cost pressures on planned care. DHBs have also had a one-off injection of $232.5 million to help them catch up planned care after COVID-19.

• Disability Support Services will get its largest-ever funding boost, with an additional $832.8 million over five years to take pressure off services and ensure access, which includes $103.7 million for the current financial year to 30 June 2020 to meet existing cost pressures.

• A further $12 million has been invested towards transforming New Zealand's disability support system to allow access to pilots around the country. Extra funding of $22.664 million over four years has also been allocated to boost home and community support carers' pay for travel to carry out their jobs, covering minimum wage pay increases.

• PHARMAC has received an additional $160 million over four years to help New Zealanders access important medicines and new treatments. The Combined Pharmaceutical Budget is managed by PHARMAC and covers DHB purchasing of medicines, vaccines, medical devices and other treatments. I am aware that while this is a significant increase in funding, not everything we might have hoped for has been funded. However, a number of areas are still under further consideration. New Zealand's need for a strong, high quality health care system had never before been so important in the face of the challenge presented by COVID-19. This Budget strongly signals that this is the time for rebuilding our health system, and the Ministry's role in supporting you is as critical as ever.

Voluntary Bonding Scheme 2020

Many of you will be familiar with the Voluntary Bonding Scheme (VBS which was set up to encourage newly qualified health professionals to work in the communities and specialties that need them most, and to retain essential health professionals throughout New Zealand. Those on the scheme receive annual payments to help repay their student loan or as top-up income. For the first time this year enrolled nurses working in aged care and mental health and addictions were included in VBS which is great news. The Ministry accepted all 418 registrations for the 2020 intake: 273 registered nurses, 14 enrolled nurses, 86 midwives, 35 general practice trainees, five sonographers, and five dentists. Of the registered and enrolled nurses, 164 are working in mental health and addictions, the highest number within in intake. 80 registrants identify as Māori while 44 identify as Pasifika, the highest numbers than in any previous intake. A big congratulations to everyone who was accepted.

COVID-19 Psychosocial and Mental Wellbeing Recovery Plan

The Ministry of Health released the Kia Kaha, Kia Māia, Kia Ora Aotearoa - COVID19 psychosocial and mental wellbeing recovery plan. This builds on the response plan previously published for COVID-19 Alert Level 4, which provided guidance to assist agencies involved in planning, coordinating and delivering psychosocial interventions and mental health and addiction services. The new plan provides a framework for collective actions to support whānau and communities to adapt and thrive next 12 to 18 months. It draws on the directions for mental wellbeing that were laid down in He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction. It is a 'living document' that the Ministry of Health will continue to review as we assess the ongoing impacts of COVID-19. To this end, we are inviting feedback on the document to help build a collective picture of how different organisations are contributing to COVID-19 recovery and to assist with shaping a further iteration of the plan, anticipated for September 2020.

Phone counselling service for frontline workers: 0800 820 080

An 0800 number has been set up to provide extra support to frontline health workers who may be experiencing distress or heightened anxiety at this challenging time. Any frontline health and support worker can call 0800 820 080 to talk with a trained and experienced mental health professional. Healthcare workers often work in extremely stressful environments, which have been heightened during COVID-19. It's important to remember that if we aren't feeling good, there are things we can do to improve our mental wellbeing. In addition to the phone counselling service, a range of information and tools are available on the Ministry of Health website. I encourage you to share this with your friends and whanau.

Āwhina app

The Ministry released a new mobile app, Āwhina, on 27 May. This app will help health workers access the information they need about COVID-19 on their mobile devices. Āwhina means health workers will be able to gain quick access to the latest information, such as case definitions, clinical care pathways and Personal Protective Equipment guidance. App users can quickly filter content so they can find what is relevant to them and can also save content in the app to give them quick access to it again later. The Ministry developed the new app with feedback from people working in the health sector, and by learning from approaches taken in other countries to get information about COVID-19 to health workers. I have downloaded the app already and am finding this really useful in getting timely updates and information, it might make my weekly letter redundant, but lets hope not!

Vaccine strategy

The development of a safe and effective vaccine is a crucial tool in the control of COVID19 worldwide. New Zealand's COVID-19 vaccine strategy aims to secure a vaccine that is safe and effective, at the earliest possible time. This will ensure New Zealand goes all out to advance discovery, development, testing and supply of a vaccine. It will enable our scientists to contribute to global research efforts and ensure New Zealand has detailed knowledge of international developments. More information on the COVID-19 vaccine strategy announced today can be found on the MBIE website.

Three nurses receive Queen's Birthday Honours

On 1 June 2020 it was so pleasing to see three nurses were appointed to The New Zealand Order of Merit: Officers (ONZM) Dr Daryle Elizabeth Anne Deering, of Christchurch, for services to

nursing, particularly mental health and addiction nursing Dr Anthony John O'Brien, of Auckland, for services to mental health nursing Members (MNZM) Jacqueline Leigh Edmond, Brooklyn, Wellington, for services to sexual and reproductive health It is wonderful to see these nurses recognised via this prestigious award for the vital work that they do. I want to pass on my congratulations, along with a big mihi, to these three nurses and the contributions they have made and will continue to make to patients, whanau and communities lives.

Emergent models of care

While being clear not to downplay the significant global and local impact of COVID-19, there have been some silver linings within the reality of the pandemic. Innovation has occurred where previously this was stifled by over-analysis and structural barriers, with more permissive opportunities and in some cases by matter of urgency and need – models of care have changed to meet the needs of the community. Community – Maori, Pacific, Rural and other communities and providers have stepped up and created innovative ideas to respond to the pandemic crisis, telehealth and remote consults burgeoned, digital technology and the development of apps have featured. Above all we have had to do things differently, and even though a lot of what was planned was not put to the test – we are in a better position for being prepared should we need to apply and stand up these plans again. As we reflect on these past twelve plus weeks, we have learnt so much, there is a lot to be thankful for here in Aotearoa, New Zealand but we are not out of the woods yet. While we have some breathing space the ability to look back over this time to assess what went well, what didn't go so well, and what we can take further; it will be important to capture all of the learnings. Please let me know if you would be willing to share any of these learning and innovation. Nursing has been at the forefront of the COVID-19 response so I am sure there will be a lot to share.

Helen Parry

Nurse New to Primary Health Care Award 2019

Donna Auld, RN, was the winner of the Nurse New to Primary Healthcare award in 2019. Donna is working in a rural practice in South Canterbury and has written this article for us.

When I was asked to write a piece for the LOGIC journal, I was concerned about choosing an appropriate topic. I have chosen to share my experience as part of small rural practice having had a recent experience with a flood within our surgery and how I have reflected on the experience.

Being the first to the scene Monday morning it was very practical response in the beginning: water off, plumber, power off and remove equipment and begin the salvage of stocks and supplies into water damaged and saved items. Our small staff rallied around all mucking in.

It was apparent early during the initial cleanup we would not be able work from our building for an unknown timeframe. We are a small rural GP practice so buildings to accommodate us are not easily found. As a team we had to brainstorm possible rooms, buildings that we would be able to operate out of, technical support and secure and maintain necessary equipment so we could perform and maintain our patient's medical needs.

After a week of operating in several different buildings with unstable internet access we secured a community space where, for the first time, all our staff would be able to work under the same roof.

As a surgery we were a tenant of this community space, but this secured us two clinical rooms and some shared reception space. During this time as a clinical group we had a meeting to highlight our need for privacy and patient protection.

When working in the public space I was acutely aware of some people feeling vulnerable and that increased my own need to instill my professional boundaries and maintain my patient's privacy. I went to great lengths to reassure patients and demonstrated our separate space, while providing continuity of care.

With rudiment computer access (very temperamental at times) and two rooms set up with minimal clinical resources (scales, assessment tools, wound care kit, cervical smear equipment, lab pottles, vials and swabs etc.) we were able to maintain our practice and provide continuity of care. We were also to continue to gather supplies daily from our surgery while maintaining our cleaning and sterilisation of equipment.

We were also able, with the help of our District Health Board, maintain our cold chain vaccination process with the loan of specific equipment, which meant continual monitoring throughout the day. A difficult task when your focus in the day is not solely vaccines.

A positive learning outcome for me personally was the ability to become familiar with the offsite data logger and its requirements

as during influenza season we do several offsite vaccinations. As a practice we were so impressed with the system we borrowed from the DHB and since have purchased our own set, which will also mean if an event like this happens again we can maintain cold chain and annually complete offsite vaccinations efficiently.

As nurses we were expected to keep a supply of basic resources, and daily anticipate certain patient procedures or assessments and provide appropriate equipment while maintaining supplies, linen etc. between two sites. Also, taking phones off after hours and re diverting them to our temporary premises and monitoring the fax machine when at surgery. This was part of my skill set learnt from my NETP year with District Nursing, preparing daily for patients on particular lists and checking nurse care plans for the right products or materials for each patient.

Our patients were amazing, tolerant, respectful and appreciative of our efforts. We constantly referred to our predicament as glamping and were encouraged by the public and staff at the facility we were working out of.

To say we became fatigued would be an understatement, but it brought us closer as a team, highlighted a lot of tasks taken for granted, and made us aware of the mindset required for an emergency response. Self-care became paramount and difficult to facilitate.

I do feel personally that as a team and individually we needed more self-care strategies in place. This could have been helped by meetings regularly and given some guidelines as to timeframes, although I believe this was very difficult to anticipate. Towards the end of the relocation most staff became unwell which I strongly related to exhaustion at the time.

Our practice is a PRIME responder practice and also have portable emergency equipment with us always which added new challenges in our temporary environment.

Having this opportunity has highlighted what is necessary in an emergency relocation and what would be a luxury. It is fair to say the longer we stayed at the temporary facility the more equipment and supplies we gathered.

In total we were 10 weeks in temporary accommodation and although not yet completely finished it is nice to be back in our surgery, with our supplies at hand, vaccine fridge, autoclave etc., all on site. It is something that I will not take for granted and have the utmost respect for those that operate in temporary sites delivering necessary medical help on a daily basis.

While reflecting on this it has given us all great insight into “disaster management” readiness and I feel I have grown in my nursing development. Reflecting on the timing of this incident we were incredibly lucky it was not in amongst a busy influenza timeframe.

Nurse New to

Primary Health Care

Proudly Sponsored by the NZ College of Primary Health Care Nurses

Purpose of the Award

This award is for a Primary Health Care Nurse with three years or less experience in primary health.

The winner of this award will be chosen by a panel from written nominations and presented at the New Zealand College of Primary Health Care Nurses AGM in Christchurch in November.

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

Nominate your Primary Health Care colleagues for their excellence and/or creativity in nursing.

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

Reason for Nomination

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

Nominee Details

Name as on NZNO membership ……

Position: .....……...

Name of organisation: .....…….....

Address of organisation: .....……..

……..

Work phone: …… Email: ……

Nominator Details

Name as on NZNO membership……..

Position…….

Name of organisation: …….

Address of organisation: …….

…….

Work phone: …… Email: …….

Nominations are to be received by

5pm Monday 28th September 2020

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

Email, fax or post all documents to:
Sally Chapman

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

DON'T BREAK THE CHAIN

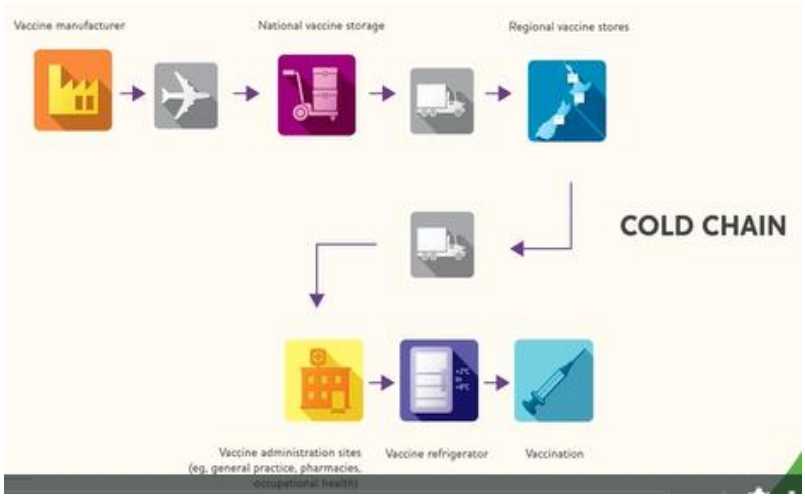
Anna is the South Island Regional Immunisation Advisor for the Immunisation Advisory Centre (IMAC) and a registered nurse.

Authors: Anna Smith with Jude Young, Maria Crawford and Shelley Kininmonth

riasouth@auckland.ac.nz

As health professionals, we know vaccines are a delicate biological substance that need to be stored and handled correctly to maintain potency. It is called the 'cold **chain'** for a reason. Each link in the chain plays a vital and equally important role. The chain has lengthened considerably, with vaccines now provided in many settings, from pharmacies and GPs, to people's homes and in the current circumstances due to Covid-19, even in car parks. Maintaining the cold chain is more important than ever.

The cold chain is the process of keeping vaccines between the temperatures of 2 and 8 degrees Celsius from the point of manufacture to the point of administration. Traditionally this has been considered the nurses' role, with one or two nurses being responsible for it within the workplace. However, with increasingly more cold chain breaches occurring due to the actions of others in the workplace, it has stressed how important it is for everyone who is part of an immunisation service provider to understand the importance of the cold chain and their role in maintaining its integrity. The following real-life example demonstrates this.



It is the middle of a busy flu season and a practice nurse has arrived at work to find the vaccine fridge sounding an alarm with a reading of 15.6°C on the fridge temperature display. The nurse responsible for managing the cold chain is not working today. No one else in the practice knows how to download the datalogger. There is a fully booked flu clinic due to start in 15 minutes. They have to quarantine the vaccines in the fridge and call in the nurse from home to download the datalogger. While waiting for the nurse to arrive, the morning flu clinic has been cancelled. Once the data logger is downloaded, the local Immunisation Coordinator is contacted. Confirmation that the vaccines are able to be used is given, with the boxes marked appropriately. Despite this, when the practice nurse informs the GP, they are instructed to throw all the vaccines out. The practice nurse does as the GP instructs.

This demonstrates a huge waste of resources and time! What lessons can we take away from this scenario to make managing the cold chain easier for everyone in this time of increased work pressure and demand for vaccines?

Administration staff are generally the first point of contact when vaccines are delivered. Their key role is to immediately notify staff members to get the vaccines into the vaccine fridge. Admin staff also need to know what to do when they hear a vaccine fridge alarming, that this needs to be investigated and to notify key staff.

All Health professionals should be able to download a datalogger. This includes health care assistants, nurses, practice managers and GPs. Every staff member needs to know the steps in managing a cold chain breach and who to contact. Everybody also needs to be aware that the local Immunisation Coordinator is the person responsible for deciding if vaccines are able to be used after exposure to temperatures outside the 2 to 8 degrees Celsius range. The Immunisation Coordinator holds important information that guides them in making this decision.

A cold chain failure occurs when a patient has received a vaccine that is no longer effective, due to an excursion from the cold chain. It can result in patients needing revaccination, which could lead to a loss in confidence in your service. It can also cause additional stress and leave a person vulnerable to disease. In addition, it can vastly increase the services workload. Cold chain excursions will also have a financial impact on both your own service and the health system. The contents of one medium sized vaccine fridge has an estimated value of $24,000 not including private purchase vaccines.

Cold chain does not just involve the fridge inside the practice. Any vaccines used offsite must also be kept within the cold chain. This means the chilly bin is also a link in the chain and must be continuously monitored to ensure the vaccines are kept between 2 and 8 degrees Celsius. Fortunately, we have the National Standards for Vaccine Storage and Transportation for Immunisation Providers 2017 (2nd edition) to guide and support us. These are available on the Ministry of Health or Immunisation Advisory Centre (IMAC) websites.

Maintaining cold chain is not a difficult process but there are some essential points that providers need to be aware of. The Immunisation Advisory Centre (IMAC) provides a free one hour online course that all members of the workplace team can access. The IMAC website, www.immune.org.nz, has a cold chain section where you will find both the National Standards and resources with essential cold chain information. This includes information on off-site vaccination as well as equipment needed. Remember your local Immunisation Coordinator is the key contact for any cold chain related issues.

At a time when the country has been uniting against Covid-19 and preparing for the influenza season, there has been a huge increase in workload whilst the health sector adapts to a new way of delivering immunisation programmes. We need to keep front and centre the importance of maintaining the cold chain and of the role we all play to ensure the links remain strong. This is a timely reminder how essential it is to work together to protect our patients from vaccine preventable diseases and preserve the stability and viability of our vaccines. Cold chain is easy to maintain if the systems and processes are in place and we all remember that we are all links in the chain.

School Nurse

Born and brought up in Nelson, Debbie did her hospital based training in Wellington and worked there another 2 years after graduating in 1978. Then she left New Zealand for a 3 year overseas adventure. On her return she worked for 11 years as an occupational health nurse and has been employed at Nelson College for the past 10 years.

No two days are the same for Debbie Baxter, school nurse at Nelson College where she cares for the health and welfare of approximately 1100 boys which includes 170 New Zealand and international boarders.

She can see 20-30 pupils per day in Winter and Summer can be just as busy due to heat and dehydration. The boys are all keen to be outdoors during breaks so accident first aid is a part of daily life. Debbie said she has got to know the A and E and orthopaedic staff very well at Nelson Hospital, just over Waimea road! Tima Health, a local general practice, provides medical services to the boarders and she said she couldn't do her job without the wonderful doctors and nurses there.

Debbie works full time 8 am – 4.00 pm at the school's 7 bed Sanitorium located in landscaped grounds. Student nurses provide cover after 4.30 pm in exchange for cheap accommodation while they study nursing at NMIT. Boarders with colds, flu and diarrhoea and vomiting are isolated there and it is a "place of safety" for the boarders but she dreads experiencing another outbreak of Norovirus which she described as the stuff of nightmares.

The school was established in 1856 and is the oldest state secondary school in New Zealand. The school's day boys reflect Nelson's general population mix of higher and lower socio-economic groups and a sizeable quota of refugees. In the two boarding houses boys come from China, Japan, Korea and Thailand and other Asian and Pacific countries as well as Germany and New Zealand. Some choose homestay arrangements and there are about 21 of these at present. Boys from the local Nelson Bays region can board to take advantage of the school's excellent sporting programme.

Debbie can deal with all sorts from head lice to concussion to ingrown toenails and everything in between. When receiving new boarders with existing health issues, she takes them to the GP for a baseline appointment in an effort to be proactive rather than reactive. It is important to keep on top of records of vaccinations and controlled drugs such as Ritalin. Issues that the boarders sometimes face include homesickness, anxiety, depression and sleeping problems so counselling and support are another part of the role.

First Aid kits for out of school visits need to be kept up to date and training provided in anaphylaxis management for the teachers.

For the last 5 years Debbie has also worked as a Supervisor at one of the hostels some evenings and weekends as well as supervising in the dining room twice a week. She works on educating students about the

importance of good diet, fluids and sleep habits.

Raising 3 sons herself, mostly alone, was good preparation for Debbie's role. She has learnt that boys are all the same. They can be good, bad and all shades in between, regardless of where they come from.

Some boarders arrive with no English at all and they all have to deal with homesickness, culture shock, strange food and the routine. Some are unable to cope and have to go home but if they stay they can become part of a surrogate 'family'. She said it is interesting to see the personality and dynamics of the boarders, some of which form firm friendships after 5 years leading to emotional departures. Debbie said: " I love this job because every day is different".

Getting appropriate professional development can be a challenge. There is a school nurses group in Auckland but travel is prohibitive. Paid on an individual contract by the school, her pay was quite poor when she started but she has fought "tooth and nail" to get parity with the NZNO DHB Meca. However, unlike the teachers she only gets paid for term time so her annualised pay packet is not that great.

Last year she developed her job description which was 'huge'. Despite the poor pay, she recommends school nursing as very rewarding and found the job fitted her well as a solo mum.

Dr Marie Burke and PN Jeanette Banks from EastCare Health in Christchurch.

Diabetes

Yvonne Little, Nurse Practitioner

Diabetes is often referred to as either a chronic or long-term condition, it does not go away but can be so well-controlled by some patients that it appears that it may have, this is what we call diabetic remission. Unfortunately, there is always the potential for it to reappear if the patient does not maintain their healthy lifestyle.

Whilst diabetes cannot be cured, it can be managed and the best person to manage it is the person who has the condition. Having said this, we all need help to manage things in our lives, we cannot do this alone and this is no different for the diabetic patient.

The age of diagnosis for Type 2 diabetes is getting younger, this was once considered an older adult disease whilst Type 1 was considered a childhood disease. These lines are becoming more blurred as time goes on. Diagnosis of Type 2 diabetes was often in those over 50 years of age, most commonly those in the 65-70 year age group but now we are seeing people in their 20's or even in their teens or younger being diagnosed with it and the increasing obesity rates are having an impact on this also.

We are only seeing the tip of the iceberg of this epidemic, there is so much more below the waterline and this is where, as Primary Health Care Nurses (PHCN) we can make the most difference.

According to the Ministry of Health (MOH) the prevalence of diabetes is three times greater in Maori and Pacific populations and also high in those from South East Asia compared to those of European descent. Of the estimated 200,000 diabetics in New Zealand, the majority of these are Type 2 and these are just the ones we know about.

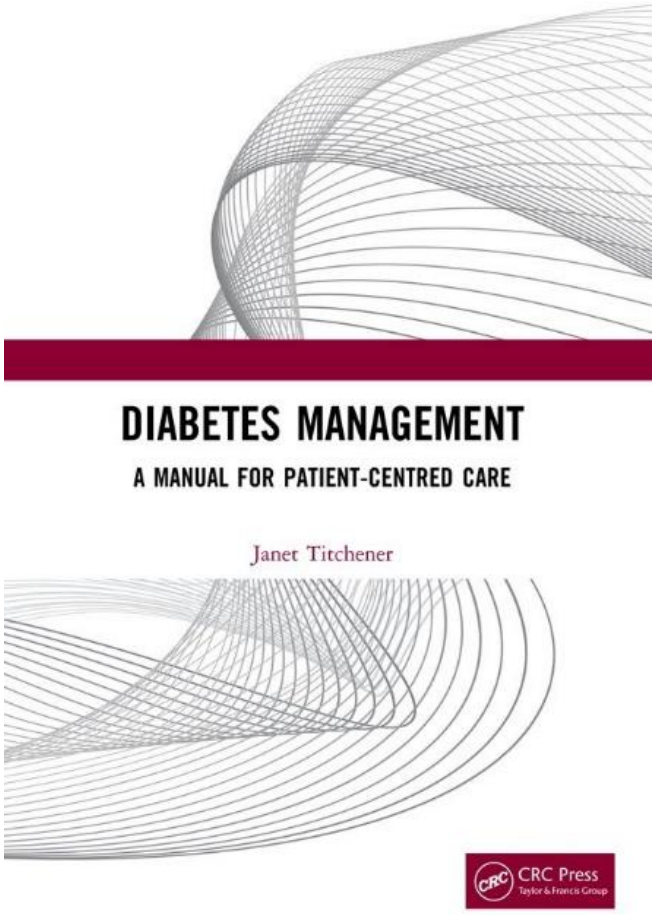
How many more undiagnosed diabetics do we have in New Zealand? That is a question that cannot be answered without further investigation and testing.

Opportunistic screening is part of our PHCN toolkit, we do it at every consultation during our workday, often subconsciously, and therefore having an understanding (no matter what level) of diabetes is essential to our caring for the population we serve. Through our training we will all have learned the pathophysiology behind diabetes, for some of us it will be recent and fresh in our minds, for others it won't.

No matter whether you're new to nursing or an "old hand" , a prescriber or non-prescriber having a good foundation in diabetes pathophysiology, medications and education tools is vital to your ability to provide your patients with support through the ever-changing reality of diabetes care. Being able to answer your patients questions with confidence gives them confidence in their own ability to self-manage their condition and this is what we want.

Obviously, prevention is better than cure for any illness or condition, but for some of us it is

inevitable that we will become ill or develop a long-term condition whether through genetics, poor lifestyle choices, simple bad luck or medication induced.



As everyone reading this will have different levels of knowledge around diabetes, I felt rather than writing an entire article myself that it would be prudent to share with you a tool from my toolkit. I have utilised a previous book by Dr Janet Titchener in my Diabetes Clinic which has made it easier for patients to understand their diabetes and how medications work. Some of you may have seen articles written by her in previous issues of LOGIC. She has just written a new book entitled *"Diabetes Management: A Manual for Patient-Centred Care".*

Janet has kindly allowed me to put the link here so that as many PHCN can access this book with such wonderful information in it to add to your own toolkits.

Diabetes is a chronic disease involving self-management by the patients. This book teaches providers the skills to Diabetes is a chronic disease involving self-management by the patients. This book teaches providers the skills to translate and transfer complex medical information to empower patients to participate in making well-informed decisions about their own care on a daily basis, as directed by the American Diabetes Association.

It provides the basic knowledge around the pathophysiology of diabetes, different management options including insulin management and calculations, information on how foods affect blood sugars and how to address cardiovascular risk factors. This book aims to change clinical outcomes through its unique presentation of information and its approach to awareness.

Key Features

- Follows a unique approach in imparting techniques that bring long-term patient behaviour changes, making the provision of chronic disease management more efficient and satisfying
- Serves to help professionals in their day-to-day patient management to achieve better outcomes
- Addresses the area of need for primary care and helps to make well-informed decisions by understanding the essential cost of care

Diabetes Management: A Manual for Patient-Centred Care, First Edition, is now available to order from www.crcpress.com, simply enter the code **SCI3P** at the checkout to receive 20% off your next purchase. If you are interested in reviewing this book please click here.

Kiwis with Cystic Fibrosis (CF) are celebrating

Erica Donovan

New Zealanders with Cystic Fibrosis (CF) and their families are celebrating with the announcement that Pharmac has started funding CF drug Kalydeco (Ivacaftor). For Invercargill man John Ward, the news that he had been approved to get the drug was a welcome surprise just before the COVID19 lockdown.

Although the medication has been available to those in areas such as the US and Australia for some time, it's been something that those on our side of the ditch have been working towards. John first heard about the medication several years ago, long before it made it to our shores. His first thought was that it sounded promising, but he had the 'disheartening' thought that it would be years before we had it in New Zealand.

"I was just wishing, hoping, praying that it came here".

Fast forward to 2018, and the grassroots campaign, Kalydeco for Kiwis was launched on Facebook by a couple called Eddie and Emma, parents of a child with CF. John acknowledges that the drug might not have been funded if it hadn't been for all their hard work, as well as families getting behind the cause. John's wife was also big part of his journey, providing Facebook updates on the campaign progress and encouraging friends and family to sign petitions.

Once the funding had come through Pharmac, the application process involved John's Doctors digging through genetic testing records from when he was first diagnosed in the 80s and proving that he had the specific genetics that the drug would be beneficial for. From there a specialist's application went through, and he had the green light.

"The first dose was crazy, you have to have a high fat meal with it…it's like a surge of energy". Some people also feel like they are purging and coughing up secretions, when first starting the drug, he adds.

However, this drug is not a cure-all, a tightly controlled regimen of medications, digestive enzymes and nebulizers continues for John. Patients also have to have regular monitoring of liver function, as liver dysfunction is one of the concerning side effects of the medication. Even gaining the medication isn't as easy as any other prescription, since it is only stocked in a small number of pharmacies. But despite all this John says he feels grateful for the benefits he has seen in the relatively short period of time he has been on it. Improvements include an increase in FEV1, weight gain and increased energy.

"The quality of life that I've already seen. There's no amount of exercise and healthy eating that could have got me there."

What is cystic fibrosis?

Cystic fibrosis is an inherited disease, caused by a fault in the CFTR gene. With the gene, both parents must have a copy in order for their children to inherit it. Those with only one copy of the gene are carriers, but do not have Cystic Fibrosis. If both parents have the gene, then there is a one in four chance this will be passed on to a child. If someone is a carrier and wants to start a family, there is availability of genetic testing to check if their partner carries the gene.

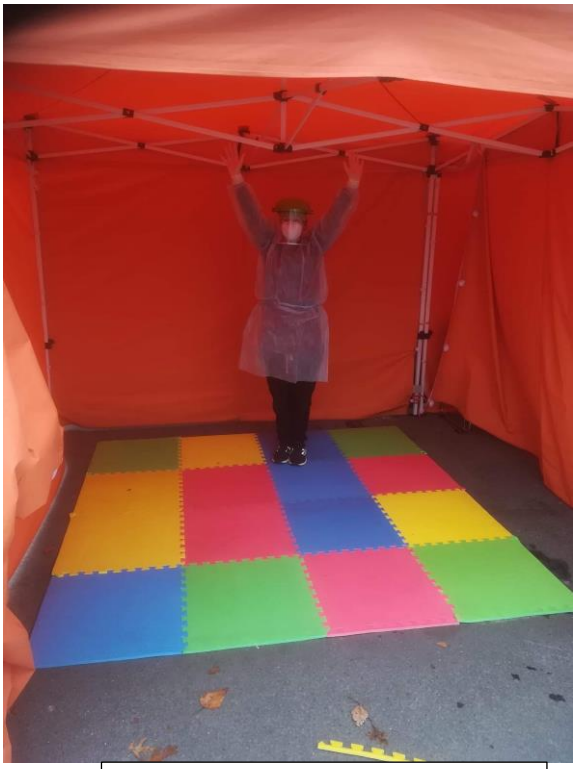
Cases are most often diagnosed in childhood, and CF is one of the things tested for when children get the Guthrie test soon after birth. Then if there are concerns from this test, there are other methods that can be used to confirm the diagnosis.

Those with CF have issues with several body systems such as the respiratory system, gastrointestinal system, and endocrine system. The lungs and pancreas are commonly affected causing altered respiratory function, difficulties in digestion and for some cystic fibrosis related diabetes.

CF is a life-long condition, that requires input from several groups, commonly including CF Clinical Nurse Specialists, Doctors, physio and other multi-disciplinary team members.

There is currently no cure, but there are several medications like Kalydeco that can be used, some patients may also be eligible for lung transplantation. Goals of therapy can include ensuring the person stays well, lung function is maintained and prevention of chest infections.

For more information check out Cystic Fibrosis New Zealand on their website.



Colder weather adaptation of CBAC from Erica Donovan

Road Safety

Yvonne Little
Nurse Practitioner

Road Safety: What is it? Why is it important? What can we as Primary Health Care Nurses (PHCN) do to help?

These are the questions I posed when starting to think about this subject. Mainly, because Road Safety means different things to us as a collective group and as individuals, our knowledge and understanding is reliant on who we are (a child; a teenager; a young adult; a middle aged [whatever that is] adult; an older adult; a parent, sibling or family member; a health professional or emergency services team member) and our life experiences.

"Across New Zealand, on average one person is killed everyday and another injured every hour" according to the Ministry of Transport (MOT). We see this regularly in our newspapers and on the news. So why do these accidents happen, who is the cause and what can we do about them?

In the material I researched only half of those killed or injured contributed to the accident therefore the other 50% of the time it was the fault of someone else. Only 30% of the time was it due to risk taking behaviours or deliberate violation of the law which means that 70% were due to simple errors of judgment which is concerning. (MOT)

Road Safety can be described as staying safe on the road, being able to get from your starting point to your destination without incident whether this be as a pedestrian, a cyclist, a passenger, or a driver. Being aware of the traffic environment including crossings, road hazards and safety measures such as seatbelts.

As to why it is important, well I'll let you answer that one but I am sure we would all come up with a similar response. These are not the scenes we want to keep on seeing.

More importantly, what can we as PHCN's do about it? From a personal standpoint you will all have had to impart your knowledge and wisdom to family/whanau and friends over the years but beyond the personal level there is also the professional level.

This is where our ever present toolkit is important, so what do we have there that can be used to educate our patients – I had not thought about this personally and when I had a look at what I had to use I found my toolkit wanting in the area of Road Safety.

But as PHCN's we are again in a prime position to educate our populations from the very young to the very old and all those in-between. This time it is not opportunistic screening but opportunistic education.

For those over 70 years of age, they need to pass a medical examination to continue to hold their drivers licence, for those younger with heavy vehicle driver licences they also need to pass a medical examination to continue to hold this class of licence. These are two groups where we can ensure that drivers on our roads are in good medical and mental health (although we cannot foretell what will happen health wise for them, at the time of examination they are deemed fit to drive). So, that is one thing we can do.

Doing a Drivers Medical Examination is not as easy as some may think – I will cover this in the next issue and at our Christchurch Workshop.

Whilst, we can discuss road safety matters with our patients after an accident, it would be better to ensure they didn't have the accident in the first place. So being able to discuss what is on offer in the community regarding Road Safety would be the ideal.

As you would expect the New Zealand Police are highly motivated in the area of Road Safety, as are NZTA, Road Safety NZ, Ministry of Transport and AA. All these groups are committed to the reduction of trauma on our roads, below is a summary of which some groups provide, and you will note there is an overlapping theme. There is no reason that we cannot forward these websites on to our patients to further the message of Road Safety.

Fundraising Institute of New Zealand (FINZ) runs a programme developed for Years 9-12 which involves practical workshops aimed at changing the way our young people think about road safety. It not only focuses on the students but also on parents and schools in conjunction with corporate partners. Providing teachers with a resource tool.

Road Safety New Zealand (RSE) provide a one-day workshop for students to improve their understanding of road safety. During the workshop they learn about habits and motivation to take action and stay safe both as passengers and drivers.

New Zealand Police provide resources and learning activities for schools and communities, parents and teachers. They are also involved with the school traffic safety teams. Partner resources include: NZTA Educational Portal; Bryan and Bobby and Bike Ready.

Here is a direct quote from the **Ministry of Transport**- Road to Zero, which I think we can all agree is very pertinent.

"Vision Zero is a world-leading approach to road safety that says:

1. No lose of life on the road is acceptable

2. Road deaths and serious injuries are preventable

3. People make mistakes and are vulnerable – we need to stop simple mistakes turning into tragedies
4. Safety should be a critical decision-making priority in our transport decisions
5. We need to focus on shared responsibility between road users and the people who design and operate our roads."

So, what can we as PHCN's do apart from educating our communities? Well, we can get our voices heard when there is any consultation about new roading and traffic safety. We need to be at the forefront to ensure that not only are people educated in Road Safety but also that the road layouts and barriers in each area are appropriate, and that we have safe speeds.

References:

Fundraising institute of New Zealand Road Safety Education: www.finz.org.nz

Road Safety Education: http://www.rse.org.nz

New Zealand Police: www.police.govt.nz

Ministry of Transport – Road to Zero: A new Road Safety Strategy for New Zealand: www.transport.govt.nz

AA: www.aa.co.nz

Erica Donovan with PPE

Child Car Restraints

Yvonne Little
Nurse Practitioner

Children are our future, so we must take care of them and keep them safe. Life is full of unexpected events, many of which we cannot avoid but when it comes to safety in the car it is imperative that as Primary Health Care Nurses (PHCN's) we ensure the safety of the babies and young children in our community. We can do this as a planned education session, or we can use an opportunistic moment to educate our parents and their young children regarding the need for child car restraints that are appropriate for the age of the child.

"Car accidents are one of the biggest dangers to New Zealand children. It's important to choose the right child restraint to keep your child safe" www.plunket.org.nz

Whilst it is illegal for any child under the age of 7 to travel in a car without an approved restraint (NZTA), it is a sad fact that many do so. Whether this is due to poor education of the parents or financial constraints is not always clear.

The driver of any vehicle is responsible for ensuring everyone is restrained in the vehicle before moving off. This includes the provision of an appropriate child restraint based on age, size and development. So, how does the average person know what is appropriate? This is where Plunket, Kidshealth, NZTA and PHCN's can help. Whilst as nurses we do not provide or fit these restraints, we can provide our parents and their whanau with the information about where to go to get the help they need.

Some simple pointers that we can provide parents with is what is the appropriate restraint, and at which point they can move their child from one restraint to the next.

Types of restraints: (plunket.org.nz; kidshealth.org.nz;nzta.govt.nz)

Rear facing child restraint is the recommendation for infants and toddlers until the age of 2.

Forward facing child-restraint: there are three different kinds

1. Convertible (can be used as either a rear-facing or forward facing)
2. Forward facing only
3. Combination of booster seat with built in harness

Booster seat: full seat is better than a simple booster cushion. This is used until they are 148cm tall which is usually around the age of 10-12.

Full booster seat vs cushion only.

Adult safety belt: the child needs to be 148cm tall and pass a 5 - step test:

1. Be able to sit right back on the seat
2. Their legs need to bend comfortably over the edge of the seat (not sticking out in front of them)
3. Shoulder belt must come over the shoulder and not across their neck
4. The lap part of the belt must sit low on top of the thighs and not across the abdomen.
5. Finally, most importantly, the child must be able to stay in this position for the whole journey.

We must remind our parents that no child seat should be placed in the front seat especially in vehicles with air bags as this will cause major injury, even death from these going off in an accident.

Child restraints will save lives BUT they need to be installed correctly, so part of our job as PHCN's is to provide parents with the information regarding trained technicians who can install these restraints. These technicians can be accessed through Plunket or the NZTA.

References:

Plunket: www.plunket.org.nz

Kidshealth: www.kidshealth.org.nz

New Zealand Transport Association: http://www.nzta.govt.nz

ADVANCE CARE PLANNING

Planning for our future healthcare

Carla Arkless

If one of your patients couldn't make their own healthcare decisions, would the treating team know how they would want to be cared for and what medical treatment they prefer to receive?

Have you had conversations with your frail, elderly or chronically ill patients about what kind of interventions they would want if they deteriorate or have a sudden event? Is this information readily available to those who may need it?

We know these are important conversations which will positively impact a person's healthcare experience. We're talking about **Advance Care Panning (ACP)**.

Here is the New Zealand definition:

ACP is a process of discussion and shared planning for future healthcare. It involves an individual, whānau and healthcare professionals.

Carla Arkless is the Advance Care Planning Facilitator for Nelson Tasman, and a lead trainer on the national Advance Care Planning Training Programme. She is also a palliative care Nurse Practitioner with experience working in aged residential care, hospice and primary care settings.

*ACP gives people the opportunity to develop and express **their** preferences for future care based on:*

- *their values, beliefs, concerns, hopes and goals*
- *a better understanding of their current and likely future health*
- *the treatment and care options available to them.*

An Advance Care Planning discussion might include a number of different topics, including: who the person would want to make decisions on their behalf if needed in the future; how involved they want their family/whānau to be in their healthcare; where they would prefer to be cared for at the end of their lives; how they would like their body cared for after death.

As more people become aware of ACP and its benefits, we are hearing about how ACP has affected individuals, their healthcare team and their outcomes.

Arthur Te Anini is a strong advocate for ACP; he participates as a consumer on the national ACP Steering Group and features in national campaigns.

Talking about his Advance Care Plan, Arthur says: It gave a clear view, not only for me, but for people around me … people afterwards … If I get to such a stage where I can't speak … there's no use sticking a tube down me … so having the Advance Care Plan was an opportunity to actually write that down. I could say to the medical team, 'no I don't want that done, please don't do that, just let me pass'".

His daughter, Tracey, comments:

"Having it written down … and knowing we can refer to it anytime as well, gives me and my brother a lot of peace of mind. We don't have to make some hard decisions …"

Individuals who have gone through the Advance Care Planning process in General Practice have said:

"Thank you so much for spending the time to listen to my story; I will be encouraging more of my friends to complete one".

"This is so important! Thank you for this opportunity. It's such a relief knowing that it's all in writing and the doctors and nurses know what I want if I get sick again."

Feedback from practice nurses include:

"It has been a great way to build rapport with patients, particularly as their wishes, ideas and thoughts are being listened to, rather than them being told how the process must go."

"Once the plan is completed and signed, there seems to be a weight that lifts off their shoulders."

"We had one lady who many clinicians were trying to get into rest home care. The patient had completed an ACP stating it was important for her to stay at home for as long as possible. Having this documented the family then arranged for a carer to keep the patient at home for as long as it was possible. This was really important for the patient and a great way to see how an ACP can communicate the patient's wishes."

So as a practice nurse, how can you get involved?

Here are some ideas:

- Have a supply of the national Advance Care Plan booklets (plan and guide) and trifold information pamphlets at your practice and consider putting them on display (order from www.myacp.org.nz).
- Look for opportunities to introduce the idea of Advance Care Planning to patients as you see them for other reasons, e.g. new patient appointments; Care Plus (or similar) appointments; wound care. Help people to see the relevance for them.
- Offer the booklet and suggest they read through it and complete as much as they would like or feel able to, preferably involving family/whānau. Make an appointment for them to return to complete the booklet with you or their GP – allow half an hour.
- At the follow up appointment, answer any questions they may have and discuss the Advance Directives with them (section 6) to ensure they have a good understanding of the medical treatment approach they are requesting in this section, and that Advance Directives are written clearly and unambiguously.
- Refer to a GP or experienced colleague if the patient needs more information about the medical options than you are able to provide.
- Do the online modules to learn more about ACP and the legalities at: www.myacp.org.nz
- Consider your own ACP so you are more prepared to talk with patients about theirs.

For more information about all things ACP, visit: www.myacp.org.nz:

- eLearning modules (select 'Training for Healthcare Staff')
- ACP resources including a downloadable pdf of the plan and guide
- Campaign posters and videos
- Online ordering of resources (they're free!) – go to 'Publications and Resources'

And more …

For further information, and to find your local ACP contact, please email: acp@hqsc.govt.nz

Bethany Simmons, District Nurse, Te Korowai Hauora o Hauraki CBAC for the Coromandel Hauraki area and Bethany

Feilding Health Care Cardiac Clinic – a specialist primary health care nursing service

Tasha Morris

In June 2017 Feilding Health Care began a specialist nurse- led cardiac clinic which focused on care closer to home. It was designed to support and develop clinicians in general practice teams to improve their knowledge and skills in managing patients with heart failure in order to provide a better experience for those living with heart failure; to enhance patient education about heart failure and related self-management; to empower the patient to manage their heart failure condition more actively with appropriate clinical support; and to support patients when their condition becomes more advanced.

A half-day clinic is held each fortnight. Appointment durations are 60 minutes for new patients and 30 minutes for follow up patients. Having longer appointment times allows time for appropriate patient education and holistic care with a specific focus on action plans, titration of good cardiac medications and support of not only the patient and their whānau but also those in the general practice team.

Originally the clinic was very specific to heart failure but has now branched out to seeing patients with a range of cardiac conditions. A range of services are provided such as patient teaching and education, fluid and heart rate management, heart failure action plans, cardiovascular risk assessment, titration of cardiac medications and consideration of intravenous diuretic therapy on-site.

This clinic is a free service for patients and has proved very popular. Clinicians can book patients directly into the cardiac appointment book and the clinic has been well utilised.

In the six months from January to July 2019 the cardiac clinic has had 56 patient contacts and 61 case reviews with only one patient not arriving for their appointment. During this same period, seven Feilding Health Care patients that were known to the clinic presented to Palmerston North Hospital and required admission; the average length of stay was five days. The New Zealand Heart Failure Registry average length of stay for the same period was between six and seven days. One of the patients, while known to the clinic, had presented following a motor vehicle accident not heart failure. Two patients died during the six month period; both were advanced heart failure patients who were known to palliative care services. It is known that heart failure has significant burden on the health system and the role of this clinic in relation to this is educate patients, whānau and practitioners to recognise the signs of change and act sooner in order to avoid admission but also recognising the complexity of the disease and admitting where appropriate and aiming for a reduced length of stay and more days at home.

The clinic has received positive feedback from patients and staff. Many of the patients are elderly

and appreciate being seen in Feilding rather than having to travel to Palmerston North. Home visits are also provided if required. Patients really appreciate having a designated contact person who is readily available to provide advice – just knowing that someone is available is very reassuring for people.

App review – Ten Percent Happier.

Erica Donovan

Up until now we've been reviewing apps that help you in the clinical realm, such as learning ECGs or care pathways for paediatrics. But in this edition we're reviewing one that can help you in your home and clinical life, and that's an app called Ten Percent, which is about mindfulness and meditation. They may seem like buzzwords, but they benefit many people, and there is established and emerging research on both topics.

With COVID19, we've been through the wringer, both at work and in our home lives. Most of us continued to work, as well as many nurses picking up extra family care responsibilities. For the first few months, there were a lot of changes around many workplaces as well. I for one found this a little unsettling to my normal routine, which is what lead me into looking into mindfulness and meditation.

I hadn't actually heard much about this app before downloading it, but I was surprised at the range of meditations and talks. I'd downloaded a few other similar apps but never found quite the right one.

Whether you're a fan of sleep meditations, or just need something to make you stop for a while, there's a lot of choose from. They also have a section called 'Coronavirus Sanity' which includes a meditation for those working in healthcare.

At the moment the company is offering full subscriptions to those working in health, education and other essential areas. The process to getting this was very quick, and there wasn't a whole lot of hoops to jump through. To access this, head to:

https://www.tenpercent.com/care

Youth Nurse Practitioners

Maria Kekus and Pat Mitchel

The health needs of young people are well researched and documented but are our primary healthcare services able to adapt to provide primary care services to young people? Health Connections is a nurse led primary care practice specifically for young people. We are proud members of Auckland PHO.

Our experience of recent decades has shown that many young people/rangatahi are either not enrolled in primary care, haven't accessed their general practice for over 3 years or choose not to attend the practice they are enrolled in. How this presents clinically is in the low rate of immunisation, high rates of sexual health, mental health and AOD issues – showing young people/ rangatahi are not good users of general practice.

In an attempt to improve outcomes, Health Connections have opened as a general practice specifically for young people/ rangatahi aged 10 to 25 years. It's not been an easy journey and it's one that's taken lots of perseverance and navigating complex systems which often work against what we know is important for young people/rangatahi.

Health Connections have delivered enhanced primary care services to the Oranga Tamariki secure residences and Alternative Education sites for the past 5 years. It was delivering episodic care that has really triggered Health Connections moving into General Practice in order to ensure a continuity of care for young people.

Our first static site opened on March 1st 2020 in Papatoetoe in the Youthline Building. This offers anonymity to young people when they attend and an environment that truly is youth focussed. From here we will offer pop up sites across the Auckland region and will soon be starting a second static site in Auckland Central.

Patricia Mitchell RN MN and Maria Kekus RN MN NP started Health Connections over 7 years ago. With over 5 decades of shared nursing experience, we felt that exploring how we could be responsible for delivering innovative nurse led services to young people was the right step. Being referred to as Nursepreneurs has been humbling and as we journey forward, it really is the passionate team that bring the great services together for those young people we serve.

Health Connections believe all young people have a right to healthcare that is wellness focussed and proactive in managing their health plans. Our model is a nurse led, innovative and designed to improve access to health care where young people live and learn and where young people/rangatahi will be at the centre of all decisions.

Our model shifts primary care to a proactive wellness focussed approach and uses technology to support the health needs of young people. Being nurse led has empowered the team to know and understand the scope of practice of all clinicians. The medical scope of our General Practitioner is dovetailed into Registered Nurses working at the top of their scope. Nurse

Practitioners hold lead clinical roles of Clinical Director and Youth Health Specialist demonstrating expert clinical leadership. Supported operationally and culturally, the clinical team focus their clinical skills as close to the young person as possible.

We know young people require a different approach which has led how our general practice operates. Our team of 15 (Nurses, Nurse Practitioner, General Practitioner, Practice Manager, Cultural Advisor, Kaumatua and Administrative team members) are scaffolded to work at the top of their scope. This ensures their clinical skills are as close to the young people as possible allowing young people to receive opportunistic healthcare. Our clinical team are skilled in vaccination, blood taking, Jadelle insertion (and removal) and work under standing orders.

To date we have received overwhelming positive feedback from young people. They show us this by turning up for their health care needs and using a token system to indicate how satisfied they are with their health consult.

How we work differently with young people is to address their presenting issue in amongst an holistic approach that is informed by what we know young people may present with. For example a young person may present with an ACC injury but during that time we will offer STI testing and treatment, contraception options, undertake a primary mental health and AOD screen and commence a youth focussed assessment that informs a shared health plan and incorporate the young person health goals.

Health Connections receives the same level of capitation from the PHO for young people/rangatahi as other primary care providers. In order to ensure services remain free we have a Givealittle page which people can donate to: https://givealittle.co.nz/cause/health-connections-youth-health-service. This is an opportunity to think differently about how we design services that remove barriers that prevent young people/ rangatahi accessing health care.

Health Connections reached the finals for Best Youth Service at the recent NZ Primary Healthcare Awards. It was an amazing opportunity to acknowledge and celebrate the work we do by serving young people in our community. In addition, Health Connections' Practice Manager was also finalist for the Best Practice Manager Award. In 2019, Health Connections also won the MOH Kōkako Immunisation Award for Service Delivery and Practice presented at IMAC's conference.

Some of the Health Connections team with the Kōkako Immunisation Award for Service Delivery and Practice.

Young people rate our service after every visit.

Using your voice and votes in September 2020

Sue Gasquoine
NZNO

It's the International Year of the Nurse and Midwife and the theme is: "Nurses: A Voice to Lead – Nursing the World to Health". How shall we celebrate? One way is to use the opportunity we have in September to vote – not just in the general election but also in the referendums.

'Nursing Matters – even more in 2020' the New Zealand Nurses Organisation (NZNO) manifesto is being finalised and will be published and distributed to members via NZNO's website in July. Please take the time to read the manifesto and familiarise yourself with those issues that as a nurse working in primary care should influence your voting decisions. We also hope it will provide a 'discussion tool' for conversations with political candidates and other voters as the 2020 general election approaches.

In addition to voting for an individual parliamentary candidate and a party, you will also have votes in two referendums. Theres a great deal to think and talk about within our profession and membership, with care recipients and their whanau as well as those seeking our votes.

The significance of the five themes NZNOs manifesto presents have been emphasied by the COVID – 19 pandemic and their relevance confirmed by the recently released report of the Health and Disability System Review (The Simpson Report).

1. <u>Achieving health equity</u> – The Waitangi Tribunal Hauora inquiry report (2019) (Wai 2575) presents compelling evidence of funding inequities, institutional racism and structural barriers that impact on the ability of whānau, hapū and iwi to access health and wellbeing services in Aotearoa New Zealand.
   Recommendations include stopping the use of the principles of the Treaty of Waitangi - partnership, protection and participation and instead using the articles of te Tiriti o Waitangi: Tino Rangatiratanga; Partnership; Active Protection; Options; and Equity.

2. <u>Health funding models</u> - Implementation of the findings of recent inquiries including the Mental Health and Addictions Inquiry, Health

and Disability System Review and the Oranga Tamariki Inquiry are not achievable without significant change to health funding models and mechanisms. Pay inequity for Māori nurses working for iwi providers is one example of how the existing funding models create an inequitable system. The NZNO Strategy for Nursing (2018) proposes an alternative care model that seeks sustainable innovation and evaluation and aligns with community need, embraces whānau ora concepts and better utilises the breadth of nurses skills.

3. Health workforce - Addressing aggression and violence in homes, communities and workplaces is an important part of achieving a safe work environment for nurses and other health workers and moving towards a sustainable workforce, particularly in aged care and mental health settings. Health workforce shortages are particularly acute in the Māori and Pacific workforce.Further risks are posed by the Review of Vocational Education (RoVE) implementation which so far ignores the significance of health related education programmes to the Institutes of Technology and Polytechnics (ITPs) in the regions.

4. Health determinants – Researchers have been establishing a strong correlation between housing availability, affordability and quality and health outcomes for decades. Measures of child poverty identify affordability of housing as the biggest factor contributing to the poverty of households in which children live. https://www.stats.govt.nz/information-releases/child-poverty-statistics-year-ended-june-2019

Researchers and public health advocates are calling for the determinants of health to include the 'commercial' determinants of health defined by Kickbusch, Allen and Franz (2016, p. 895) as 'strategies and approaches used by the private sector to promote products and choices that are derimental to health'. Profit-driven non-communicable disease triggered by obesity and alcohol and tobacco addiction disproportionately affects those on low-incomes and further entrenches poverty for children living in those communities.

5. Health related referendums

We will have a 'Yes' or 'No' vote on the End of Life Choice Act (2019) to determine if it comes into force. This Act would:

- prohibit nurses and doctors from starting conversations with patients about assisted dying,
- establish a process for patients who have been diagnosed with a terminal illness and with less than six months to live, to request an assisted death,
- allow medications to achieve an assisted death be administered orally or intravenously and by the patient themselves or by a nurse or doctor and in a place and at a time of the patients choosing,

- ensure nurses and doctors can opt out of any part of the assisted death process without penalty.

The Cannabis Legislation and Control Bill will also have a 'Yes' or 'No' vote. Controls the Bill proposes include:

- an age restriction of 20 years
- a ban on marketing and advertising
- limits on use to private homes and licensed premises and
- state control and licensing of growing (including potency) and supplying at all points.

As it is still a Bill the control measures proposed may change depending on the referendum outcome.

The website below will give more information as the September 19 vote approaches and explains what a 'Yes' and 'No' vote mean in terms of whats next with the End of Life Choice Act and the Cannabis Legislation and Control Bill.

http://www.referendums.govt.nz/

Conclusion

In this, the International Year of the Nurse and Midwife, let's use the opportunity to use our individual and collective voice and our votes to advocate for what nurses and the people, whanau and communities with whom we work need to live well.

References

Health and Disability System Review – Final Report – Pūrongo Whakamutunga (2020) Wellington: HDSR

Kickbusch, I.; Allen, L. & Franz, C. (2016) 'The commercial determinants of health' Lancet vol:4 e895-6

New Zealand Nurses Organisation (2018) Strategy for Nursing. Advancing the health of the nation. Hei oranga motuhake mō ngā whānau hapū iwi 2018-2023. Wellington

Waitangi Tribunal Report (2019) *'HAUORA Report on stage one of the health services and outcomes kaupapa inquiry.'*

Opinion Piece

Annie Tyldesley

As a member of the LOGIC editorial committee I have been supporting Donna Auld, the winner of the 2019 Nurse New to Primary Healthcare award, while she wrote her article which appears in this edition.

Donna and I worked together during her NETP year at a general practice. I was one of her preceptors. I have undertaken the Preceptor Education at my local DHB, and the update study day, but I am aware that many of my colleagues have not.

Recently, my attention was grabbed by two articles in the most recent Kai Tiaki:

The first, "Graduate's painful entry to nursing", is an account of how painfully difficult a new graduate's first year working as a registered nurse was (page 13).

The second, "Preceptorship: the neglected area", an account of research undertaken by John Withington and Peta Taylor of Ara, into preceptorship and how to make it successful (page 27).

To clarify where I come from, my nurse training started in 1979 in England. Of course, in those days, students worked on wards for long periods of time. I worked with many nurses, some of whom were not so tolerant of students and others who were supportive and even fun to work with.

On the whole, my experiences were good because there were always students and pupils (nurses undergoing Enrolled Nurse training) on all the wards and we often worked with students and pupils at different points in their training, learning from them as well as the permanent staff. Of course, it was good to be paid as well!

At that time, all those years ago, there was a call for nurse education to be less of an apprenticeship i.e. "all hands on deck", and more supernumerary and academic.

This change has happened and nurses at the end of their education meet the standards set by the Nursing Council of New Zealand and are professionally responsible and accountable for their practice.

I want to say the following:

1 I once heard from a tutor that "professionals train their own" implying that to learn to be a nurse, you must be taught by a nurse. The same would apply to a lawyer, plumber or electrician.

2 The term professional describes a standard of training and education which provides particular set of skills and knowledge that enable the person to perform their job.

3 Professionals are often held to strict codes of conduct, ethics and morals which are maintained and enforced by their own professional colleagues.

If these three points hold true, we fall short as a profession when our new colleagues are treated as poorly as the new graduate in the first article was. It makes me sad and angry – I hope I have not treated my colleagues like that.

I'm not perfect and I have had difficult relationships with colleagues over the years, and I too have found it difficult to always be supportive with those I do not get on with – students, pupils, colleagues.

I did the preceptor education so that I would have a better understanding of the modern education and training nursing students go through; to get some insight into the challenges both students and new graduate nurses face. I recommend it!

Working in an environment which enabled me to attend the education and to then implement the strategies I had learned was, of course, helpful, but even if the working environment is difficult or home life troubled, we are professionals and must be respectful of our colleagues.

Working with Donna also gave me such a great insight into the knowledge she had gained during her education. Her keenness, enthusiasm and dedication to our profession has not been dulled during that year and now, another year on, she still works in primary healthcare.

NZNO Primary Health Care Delegate Committee

Wendy King

Report from Meeting 23rd October, Wellington 2019

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

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

On the minus side; recruitment, retention and lack of relievers are issues for all primary health care sectors; as are working conditions for many. Trying to do more with the same or less; trying to do more volume and more types of services in the same facility without modification, is a common theme. Remember what primary care was like 10, 15 years ago, and now just think about all the types of things being done, needing to be done or expected to be done by PHC sector that is, the nurses.

All current PHC delegates were in attendance, although there are three sector delegate vacancies.

My initial nursing education was at Taumarunui Hospital, with post-graduate nursing and non-nursing study following. Most of my work has been with children and families; ranging from neonatal retrievals when I worked in NBU to the school MENZB immunisation programme. Work experiences include orientating, precepting, staff education, shift coordination, peer reviewer, scholarship panel member, clinical nurse leader and manager. When PDRP was implemented at Waikato DHB, I was the NZNO representative on the Implementation Subcommittee; currently I am an assessor. Alongside this, as part of my 11 years as a Nursing Officer in the Territorials I had a stint in Vanuatu with the New Zealand Defence Forces and like many nurses I have also worked in Australia.

Wendy King

RGON ADN BSocSci MPH

Public Health Nurse (15 years)

ATTENTION ALL NURSES WORKING IN PRIMARY HEALTHCARE

Seminar – "Nursing diversity brings nursing strength" -a focus on primary health care nursing"

The **NZ College of Primary Healthcare Nurses, NZNO** and the **College of Nurses Aotearoa, NZ** are combining to acknowledge the diversity in nursing within the primary health care sector by facilitating a seminar for all primary health care nurses.

This exciting seminar will provide the opportunity to celebrate the huge contribution that we, as primary health care nurses, make to the delivery of primary health care in so many ways and in a variety of roles and settings. The programme will include dynamic speakers, clinical workshops and the opportunity to network with colleagues across the primary health care sector.

Further information and an opportunity to register will be circulated within the next month.

The programme will include:

Keynote speakers – Acknowledging the diversity of nursing within primary care

Clinical and leadership workshops

A celebration of nursing roles across primary healthcare

Date – Saturday 6th March 2021

Time: 08:00 – 17:00

Where: Rydges Hotel, Christchurch

NZCPHCN National Executive Committee Nominations

NOMINATION FORM FOR NZNO's
New Zealand College of Primary Health Care Nurses (NZCPHCN),
National Executive Committee

(*Please print clearly*)

I, _____ wish to nominate

_____
(Surname) *(Given Name)*

for the position of National Executive Committee member, NZCPHCN.

Signed: _____ Date: _____

[Nominator needs to be a member of NZCPHCN]

This section to be completed by Nominee

I, _____ accept the nomination as National Executive Committee member of the NZCPHCN. *[Nominee needs to be a member of NZCPHCN]*

Address (*Personal*) Address (*Business*)

_____ _____

_____ _____

_____ _____

Ph/Fax: _____ Ph/Fax: _____

E-mail: _____ E-mail: _____

Area of current work: _____

NZNO Membership No. _____

Length of time as a member of the NZCPHCN: _____

Work experience, include level of responsibility: _____

_____

_____

Explain briefly why you think you are suitable for this position (*if relevant, include previous committee experience*) _____

_____

_____

Signature _____ Date: _____

Please attach a recent photograph, passport type or close-up preferable.

Please return the completed Nomination Form to Sally Chapman, Returning Officer by **5pm** on **Friday, 11th September 2020**, using one of the following:

Email: sally.chapman@nzno.org.nz
Fax: 04 382 9993, or
Post: New Zealand Nurses Organisation,
PO Box 2128,
Wellington 6140

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

NZCPHCN

Professional Practice

Committee

Nominations

NOMINATION FORM FOR NZNO's
New Zealand College of Primary Health Care Nurses (NZCPHCN),
Professional Practice Committee

(*Please print clearly*)

I, _____ wish to nominate

_____
(Surname) *(Given Name)*

for the position of PROFESSIONAL PRACTICE Committee member, NZCPHCN.

Signed: _____ Date: _____

[Nominator needs to be a member of NZCPHCN]

This section to be completed by Nominee

I, _____ accept the nomination as Professional Practice Committee member of the NZCPHCN. *[Nominee needs to be a member of NZCPHCN]*

Address (*Personal*) Address (*Business*)

_____ _____

_____ _____

_____ _____

Ph/Fax: _____ Ph/Fax: _____

E-mail: _____ E-mail: _____

Area of current work: _____

NZNO Membership No. _____

Length of time as member of NZCPHCN: _____

Work experience, including level of responsibility: _____

_____

_____

Explain briefly why you think you are suitable for this position (*if relevant, include previous committee experience*) _____

_____

_____

Signature _____ Date: _____

Please attach a recent photograph, passport type or close-up preferable.

Please return the completed Nomination Form to Sally Chapman, Returning Officer by **5pm** on **Friday 11th September 2020**, using one of the following:

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Fax: 04 382 9993, or
Post: New Zealand Nurses Organisation,
PO Box 2128,
Wellington 6140

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

NZCPHCN LOGIC

Committee

Nominations

NOMINATION FORM FOR NZNO's
New Zealand College of Primary Health Primary Health Care Nurses (NZCPHCN),
LOGIC Journal Committee

(*Please print clearly*)

I, _____ wish to nominate

_____
(Surname) *(Given Name)*

for the position of LOGIC Committee member, NZCPHCN.

Signed: _____ Date: _____

[Nominator needs to be a member of NZCPHCN]

This section to be completed by Nominee

I, _____ accept the nomination as LOGIC Committee member of the NZCPHCN. *[Nominee needs to be a member of NZCPHCN]*

Address (*Personal*) Address (*Business*)

_____ _____

_____ _____

_____ _____

Ph/Fax: _____ Ph/Fax: _____

E-mail: _____ E-mail: _____

Area of current work: _____

NZNO Membership No. _____

Length of time as a member of the NZCPHCN: _____

Work experience, including level of responsibility: _____

_____

_____

Explain briefly why you think you are suitable for this position (*if relevant, include previous committee experience*) _____

_____

_____

Signature _____ Date: _____

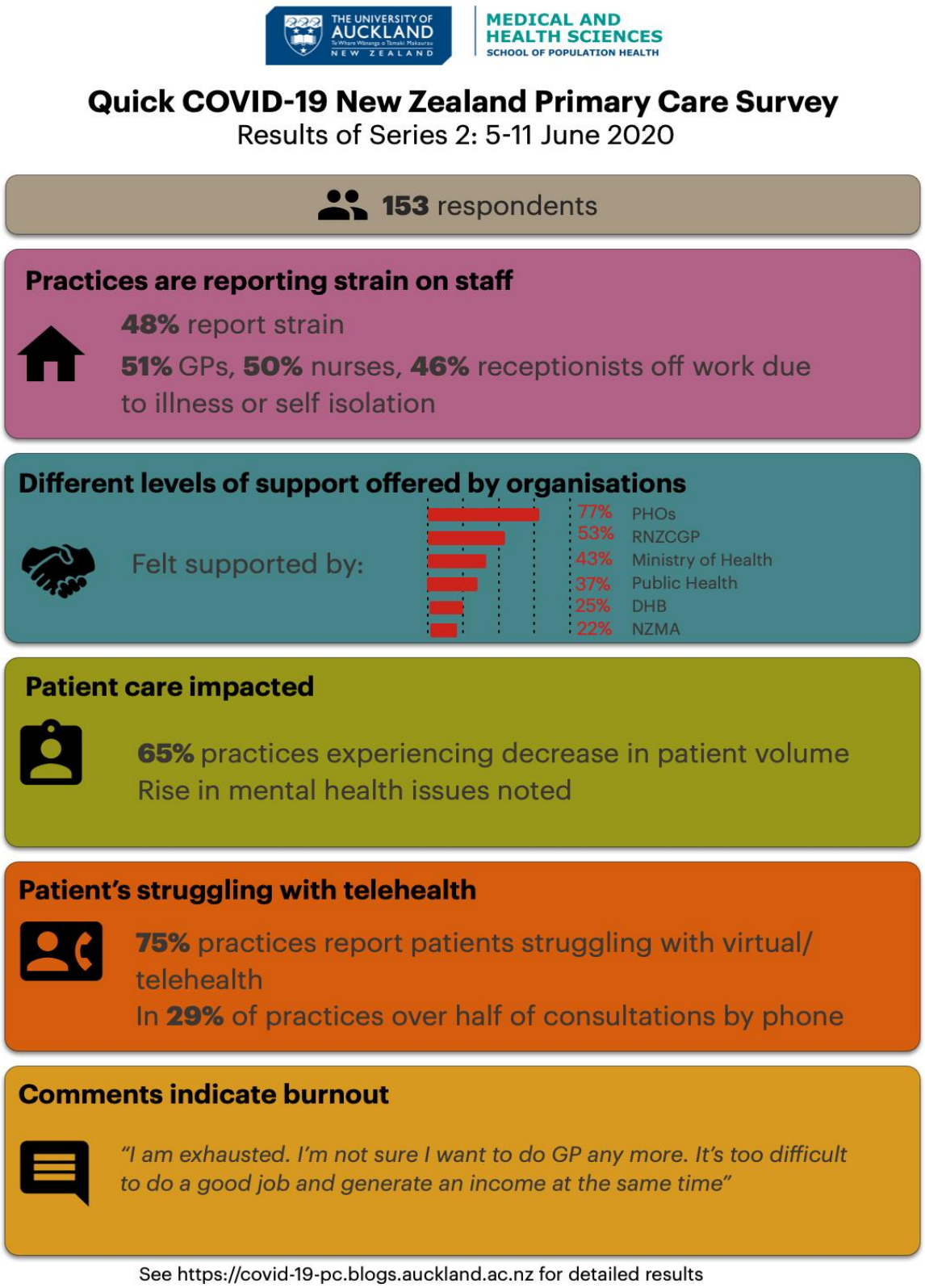
Please attach a recent photograph, passport type or close-up preferable.

Please return the completed Nomination Form to Sally Chapman, Returning Officer by **5pm** on **Friday 11th September 2020**, using one of the following:

Email: sally.chapman@nzno.org.nz
Fax: 04 382 9993, or
Post: New Zealand Nurses Organisation,
PO Box 2128,
Wellington 6140

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

COVIC19 NZ Primary Care Survey



QUICK COVID-19 NEW ZEALAND PRIMARY CARE SURVEY

Executive Summary for Series 2, 5-11 June 2020

This is the second of the national surveys of New Zealand general practice experience with COVID-19 and its aftermath. This survey was launched when NZ was in alert level 2 (moved from level 3 to level 2 on 14 May) and moved to alert level 1 on 8 June. There was still some physical distancing in place, triaging and encouragement to use virtual consultations under level 2. Under level 1 face-to-face care is not restricted except special care to be taken with people with possible COVID-19 symptoms.

Policy recommendations

Under Alert level 1, practices are mostly back to providing face-to-face care, and moving into the busy winter season. Many practices are still financially stressed, and staff morale is low, feeling that their extraordinary efforts have gone under-recognised. Support should be provided to ensure staffing or money issues do not lead to practice closures.

Future surveys will explore the post-COVID-19 consequences further - whether and how e-consultations are conducted going forward, delayed management concerns due to COVID-19, and the rise in mental health issues and social problems from unemployment in the aftermath.

Effects on patient care

65% of practices are still experiencing a large decrease in patient volume (down from 84% in S1), but others are now back to busy patient loads.

> *Not having patients waiting in the waiting room was great. As was no appt times initially. Moving back towards "normal", I am reinforced to the idea that the standard 15 min appt is a crappy way to provide good care and makes my life a misery.* [GP]

75% still report that well and chronic care visits are limited for COVID-19-related reasons (down from 84% in S1)

Practices are still conducting telehealth consultations

- 75% reported patients struggling with virtual / tele-health (internet or technical limitations) (74% in S1).
- 63% are still conducting video-consultations, but for 50% this is only a little.
- 99% are still conducting telephone consultations, with 29% over half of consultations done over the telephone. This is down from S1, when 58% of practices reported conducting over half of the consultations by phone.
- Correspondingly, 50% practices are now seeing more than half of patients face-to-face, up from 25% in S1.

Practices felt that some patients have unrealistic expectations of the care they receive, and sometimes are demanding and abusive.

- *Patient expectations have added to the stress. A large number (probably stressed themselves) have no appreciation that we are working with fast-changing and imperfect conditions and our ability to deliver care as usual (even timely flu vaccines) has been impossible through no fault of our own. This has added additional stress on the staff and the sense of injustice and frustration has taken its toll on morale.* [PM]
- *Telehealth is awful, no non verbal cues, patients talk over you (phone delay contributing but patients becoming more demanding and rude when not face to face).* [GP]

It was suggested that the media has played a part, with patients complaining about the cost of a telephone consult and refusing to pay.

> *RNZ reported on patients being charged for short phone consults in a negative way, then patients who were happy to pay started arguing about the value of a phone consult* [GP]

A rise in mental health issues and complexity of presenting conditions was also highlighted post-lockdown.

> *So much mental health work with anxiety and depression. Significantly increased complexity [GP]*

Respondents reported on the level of support they had received from various organisations

For all organisations, respondents indicated a range of responses from 'none' through to 'couldn't have done more', but the proportion of those unhappy with the support varied by organisation.

They felt most supported ('moderate' or 'couldn't have done more') by their PHOs (77%) and then the RNZCGP (53%). Less than half (43%) felt supported by the Ministry of Health, and a minority by their DHB (25%), public health (37%), or NZMA (22%).

We have felt supported quite well by our PHO and the RNZCGP have been great. But we feel let down by the government - GPs have done much of the work during this COVID situation, but we've not had much recognition, the media focus has been on the hospital doctors, and our reward for our hard work was reduced income during lockdown along with increased expenses. [GP]

However there was great praise for the teamwork and resilience of practice staff.

- *All my staff deserve giant gold stars for riding this wave, they have all shown resilience and risen to whatever has been required, sometimes with incredibly short notice* [PM]
- *This has placed significant stress on all team members - who have coped excellently* [GP]

Wishing to leave the profession and burnt-out

In this survey there are a number of GPs who are actively considering leaving the profession as a result of their COVID-19 pandemic experience. Others are feeling burnt out, taking leave for mental health reasons, or wanting a holiday which is not possible with the winter patient load.

- *Nationalised employee status with DHBs would be better. I am exhausted. I'm not sure I want to do GP any more. It's too difficult to do a good job and generate an income at the same time.* [GP]
- *Feeling ready for a break rather than a busy winter* [GP]
- *I've had 2 weeks off with relapse anxiety and clinical depression. First time in 10 yrs* [GP]
- *Half my nurses wanting to leave PHC Including myself* [PN]

Effects of COVID-19 on practice

Despite now being in Alert level 2 or 1, these affects have not changed significantly since the 1st survey (S1).

- 48% report COVID-19 is putting strain on practice (down from 60% in S1)
- In 51% of practices GPs are off work due to illness or self-isolation (50% in S1)
- In 50% of practices nurses are off work due to illness or self-isolation (60% in S1)
- In 46% of practices receptionists are off work due to illness or self-isolation (45% in S1)
- In 31% of practices staff are taking leave or being laid off (37% in S1)

Financial considerations

The lack of government financial support is still a common theme, although one practice said they had actually done well financially.

We increased revenue compared to same period last year. Our practice did very well financially. [GP]

For many others though, the lack of financial support from the government during the lockdown period was a recurring theme.

- *Having the money we were offered to support us through the huge COVID demands removed by cabinet took the wind out of my sails. At worst I did 85 hour weeks and was paid for 16 hours* [GP]
- *We were unpaid for our swabbing for more than 6 weeks. This was extremely stressful as we were the predominant practice providing swabbing in our community. This was disheartening also as our GP roles were cut back and there was a lot of uncertainty around our hours and pay* [GP]
- *We got just over 11 thousand which doesn't even cover a fortnight's wages for nurses and admin, let alone the GPs who are on guaranteed minimums and the owners pay. We couldn't apply for the wage subsidy because we were only 28% down on revenue, yet our expenses have gone through the roof* [PM]

Method On Friday 5 June, the second of the fortnightly Quick COVID-19 NZ Primary Care Survey was launched. An invitation to participate was distributed to general practice GPs, nurses and managers across the country, disseminated by the RNZCGP, GPNZ and PMAANZ. The survey closed on 11 June.

Sample There were 153 respondents: 85 GPs, 16 practice nurses [PN],and 58 practice managers [PM].

73% of practices were GP-owned; 76% had more than 3 GPs; 34% independent and part of a larger group, 7% were DHB-owned, and 14% owned by a community trust. 21% identified as rural practices, and 17% as urgent care or after-hours practice.

NZNO Library

Resources For Nurse

NZNO Library

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

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

Books available for borrowing

- Books can be borrowed by NZNO members, for a period of 4 weeks.
- All books are couriered to you, so please provide your street address when requesting items.
- The NZNO library has other titles in addition to the ones listed below, so please contact us and we will check the catalogue for you.

RESPIRATORY HEALTH

Baker, E. & Fatoye, F. (2017). Clinical and cost effectiveness of nurse-led self-management interventions for patients with copd in primary care: A systematic review. *International Journal of Nursing Studies*, *71*, 125–138. http://dx.doi.org/10.1016/j.ijnurstu.2017.03.010
Evaluates nurse-led self-management for patients with chronic obstructive pulmonary disease (COPD) in primary care.

Chambers, R., Talbot, M., Hatfield, R. (2019). Adoption of technology-enabled care for patients with respiratory conditions in primary care. *Primary Health Care*, *29*(4), 22-27.
https://doi.org/10.7748/phc.2019.e1551
Gathers comments and perspectives from hundreds of delegates at workshops on upskilling in clinical management and digital provision of care, and from general practice nurses who participated in digital-upskilling-action learning sets.

Mahoney, L. & Ross, J. (2019). Nurse learners' educational interaction with communities as 'living labs' has proven to impact positively on the sustainability of rural community health-care outcomes. *Scope (Health & Wellbeing), 4,* 88-95. https://doi.org/10.34074/scop.3004016
Provides examples of interventions and resources developed by nurse learners and their impact on health outcomes with respect to identified population groups.

McKinlay, E., McDonald, J., Darlow, B. & Perry, M. (2017). Social networks of patients with multimorbidity: A qualitative study of patients' and supporters' views. *Journal of Primary Health Care 9*(2), 153–161. https://doi.org/10.1071/HC16062
Elicits the views of New Zealanders with multi-morbidity about their social networks and the views of their nominated supporters.

McKinlay, E., Young, J. & Gray, B. (2018). General practice and patients' views of the social networks of patients with multimorbidity. *Journal of Primary Health Care*, *10*(3), 258-266. https://doi.org/10.1071/HC17050
Assesses general practice knowledge of the social networks of patients with multi-morbidity.

PAEDIATRICS

Corbett, T. & Smith, J. (2019). Supporting adolescents with type 1 diabetes during the transition from child to adult services: A literature review. *Primary Health Care, 29*(4), 28-34. http://dx.doi.org/10.7748/phc.2019.e1487
Presents examples of positive practice grounded in improved personal and service transition. Considers the problems encountered and informs professionals about gaps in practice.

Durbin, J., Baguioro, M., & Jones, D. (2018). Pediatric obesity in primary practice: A review of the literature. *Pediatric Nursing, 44*(4), 202-206. https://search.proquest.com/docview/2096475334?accountid=145528
Reviews four studies of evidence-based childhood obesity interventions, in children 8-10 years, 9-11 years, 6-11 years, and 6-18 years. Discusses the outcomes of each study in relation to physical activity and balanced meals.

Fernandez, S. (2019). Adolescent sleep: Challenges and solutions for pediatric primary care. *Pediatric Annals, 48*(8), e292-e295. https://DOI.org/10.3928/19382359-20190724-02
Examines the causes of insufficient sleep in teenagers and gives tips on how to address the morbidity associated with poor sleep in adolescents, including mood disorders such as depression and anxiety, increased obesity risk, and higher rates of drowsy driving.

Gellasch, P. (2016). Developmental screening: What every nurse practitioner needs to know. *Journal for Nurse Practitioners, 12*(8), e355-e358. http://dx.doi.org/10.1016/j.nurpra.2016.04.012
Informs nurse practitioners (NP) of the importance of employing evidence-based recommendations for developmental screening in primary care. Highlights validated developmental screening instruments.

Henry, H. (2020). Using play to educate children about asthma. *Primary Health Care, 30(2).* https://doi.org/10.7748/phc.2020.e1653
Details the author's experience of severe childhood asthma and how she has used that to create an innovative health literacy approach for primary school-aged children called BreathChamps, with the organising principles of fun and play.

ROAD SAFETY

Cook, A.C., Leung, G., & Smith, R.A. (2020). Marijuana decriminalization, medical marijuana laws, and fatal traffic crashes in US cities, 2010–2017. *American Journal of Public Health, 110*(3)*,* 363-369. https://search.proquest.com/health/docview/2371359338/fulltextPDF/8E4A9270C50C4CDFPQ/1?accountid=145528
Determines the impact of cannabis decriminalisation and medical marijuana laws (MMLs) on fatal traffic crashes in US cities. Investigates MMLs and cannabis decriminalisation in relation to fatal crashes by age and gender of driver.

Gregg, J., Miller, J., & Tennant, K.F. (2018). Nurse policy entrepreneurship in a rural community: A multiple streams framework approach. *Online Journal of Issues in Nursing, 23*(3), 1-11. https://ojin.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol-23-2018/No3-Sept-2018/Articles-Previous-Topics/Nurse-Policy-Entrepreneurship-Multiple-Streams-Approach.html
Explains the concept of policy entrepreneurship, describes the purpose of this quality-improvement project involving the reduction of motor vehicle crashes in a rural, Midwest community in the US, and discusses process considerations and project outcomes.

Iversen, C., Brostrom, A., & Ulander, M. (2018). Traffic risk work with sleepy patients: From rationality to practice. *Health, Risk & Society, 20*(1-2), 23-42. https://doi.org/10.1080/13698575.2017.1399986
Considers the relationship between risk rationality and risk practices in nurses' conversations with Obstructive Sleep Apnoea patients about traffic risks.

Workplace safety highlighted in rural and remote (2016). *Australian Nursing & Midwifery Journal, 23*(8), 9. https://search.proquest.com/docview/1768850747/47EFF38D7FCD45DDPQ/1?accountid=145528
Recounts the case of a remote area nurse killed in a road accident, to highlight the inherent safety risks faced by single practitioners in rural areas.

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