LOGIC
LINKING OPPORTUNITIES GENERATING INTER-PROFESSIONAL COLLABORATION
The Official Journal Of The New Zealand College Of Primary Health Care Nurses, NZNO

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

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Autumn 2022
In this issue…

Chair's report April 2022
Dr Jill Clendon

Kia ora e te whānau

When I was contemplating what to write for this edition's Chair's Report, I didn't think that what follows was going to be something I would write about. On April 10th I lost my dad following a bicycle accident. He would have been 87 in just a few weeks. He was on his way to get some groceries from the local supermarket when someone opened their car door on him. He crashed into the door and then the ground, suffering a significant head injury. I was at his side when he died 36 hours later. As you can imagine, we are all devastated. He was a wonderful man, incredibly fit and active for his age, out on his bike every day and absolutely loved life.

While this is an incredibly difficult piece to write, I want something good to come from this. I want you to go home and talk to your family, friends, and colleagues about watching for car doors while out on their bikes. Talk to your family, friends, and colleagues about always checking for bikes when opening the car door. Talk with your patients/clients about bicycle safety.

In fact, there is an approach that is taught widely in Europe and is about to be taught in the UK called the "Dutch reach". This approach encourages people to open their vehicle doors with their opposite hand. This means you must swing your body round to reach the door handle which in turn puts you in a position to be looking behind you for any passing cyclists. Maybe give it a go.

There are significantly more bicycles on our roads following the pandemic and it is an activity we should absolutely be encouraging among our patients/clients as part of a healthy lifestyle and as a means of addressing global warming. Accidents happen, but when they are preventable then we have an obligation to step up and speak out to ensure all road users are safe and that there is mutual respect between users. No-one should ever have to go through the wide-reaching trauma of road accidents. Hug your families tonight, sometimes we never know what is just around the corner.

Editors Report
Yvonne Little

Firstly, let me convey my condolences to our NZCPHCN Chair Jill Clendon for the tragic loss of her father recently, and I would also like to convey condolences to any of you whom have lost a loved one due to similar tragedies or due to have been unable to farewell your loved ones due to COVID -19 restrictions or have lost a loved one to COVID-19.

Whilst sitting down to write this editorial, I was drawn to reflect on the past couple of years and how this has changed so many lives. Not least of all you my nursing colleagues. We went from BAU (Business as usual) to HWGO (Here we go again) with yet another change to nursing at the outset of the COVID-19 outbreak. And now, we are still at the HWGO due to the emerging variants of this virus but trying to get back to BAU.

I would like to thank each and every one of you for your dedication not only to nursing but to your ongoing fortitude in the face of adversity. We have all had to deal with the conspiracy theorists and the anti-vaccinators, but we have held our heads up high and soldiered on.

Some of you may have contracted the virus yourselves, and I hope you are well on the road to recovery. Most of us know of someone who has had the virus and have been there to support them.
What I ask is that you take care of yourselves, not just your physical well-being (most of us are absolutely exhausted from the extra work) but also your mental well-being. If we don't take care of our mental well-being, then we are going to feel even more physically drained. I have included in this issue an article I did for NZ Doctor on COVID-19 Frustration and Compassion Fatigue for just this reason.

This issue took a bit to get together due to the work commitments of all the LOGIC team members, so thank you to the LOGIC committee for managing to find time to get these articles despite being overwhelmed with your BAU and COVID workloads.

I hope you, the members will enjoy reading this issue. We have many fantastic and thought-provoking articles.
We would love to hear from you if you have any suggestions for articles or would perhaps like to write an article for us or better still join one of our committees as we will have some vacancies when we come to our AGM this year as some of our dedicated team members will have fulfilled their two 2-year terms and therefore cannot continue on the committee/s.

As a suggestion, to encourage your colleagues who are not currently members of NZCPHCN maybe you could print off a copy of LOGIC and leave it in your break room for them to read and see who we are and what the college is about.

PROFESSIONAL PRACTICE COMMITTEE REPORT

PPC Committee Meeting: 02/03/22
This was our first meeting of the year, we are very excited to have Jeannette Banks join our committee, she comes with a wealth of knowledge after nursing for 40 years - 20 in PHC and 10 as Senior Nurse lead. We were sad to get the resignation from Kelly Robertson (who has offered to organise the symposium). Our symposium has been delayed until March 2023 and will be held in Rotorua.

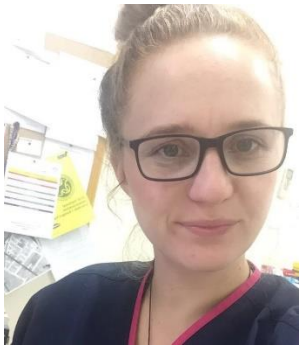
Shell Piercy gave an update on the Urgent Care Triage course she has collated, and this will be live on the ACEhub education platform in the next month. Shell has also written articles for the LOGIC and also NZ Doctor.
We are also looking at how we can get printed copies of the LOGIC out to primary health care providers and asking members to print a copy and take one to work for the coffee table. We are looking forward to when we can all meet up face to face.

Bridget Wild
Chair
Professional Practice Committee
NZCPHCN

NEW NZCPHCN COMMITTEE MEMBERS

We would like to Welcome on Board the following committee members.

EXECUTIVE COMMITTEE



Melissa (Missy) Brett – Registered Nurse

Kia ora,

I work as a rural practice nurse at Rakaia medical centre in Mid-Canterbury. I hold a post graduate diploma in rural nursing, and I am working towards a master's degree. I have been working in primary health care for 8 years. I enjoy working in primary health as it offers variation clinically and across the lifespan. I am passionate about primary health nursing and enjoy being proactive and providing holistic care to our patients. I am privileged to be part of the executive committee, where I can represent a rural and te ao Māori view, to reduce disparities and improve equity within primary health.

PROFESSIONAL PRACTICE COMMITTEE

Jeanette Banks – Registered Nurse

Jeanette has been a practice nurse in Aranui, Christchurch for the past 20+ years and has been nursing for over 40 years. She has a passion for supporting the ongoing professional development for practice nurses and is a small group leader for the education programme provided at Pegasus Health, and a member of the RNZCGP local faculty board.
In her spare time, she is a totally committed Grandma of a grand one, a Sea Shepard supporter and 100% committed to reducing waste and protecting our environment. A lover of life, family, and friends.

LOGIC COMMITTEE MEMBER

We welcome aboard our newest LOGIC committee member: Jess Beauchamp who has taken over the position vacated by Katrina Coleman who stepped down due to other commitments.

Jess Beauchamp – Registered Nurse

Ko Aoraki te maunga e rū nei taku ngākau
Aoraki is the mountain that speaks to my heart

Ko Tākapo te roto e matea nei aku māharahara
Tekapo is the lake that alleviates my worries

Nō Tamaki Makaurau ahau
I am from Auckland

E mihi ana ki ngā tohu e nehe, o Wanganui a tara e noho nei au
I recognise the ancestral and spiritual landmarks of Wellington where I live

Nō reira, tēnā koutou katoa
This is my acknowledgment to you all

Kia ora! I am a NZ registered General and Obstetric Nurse. I completed a Master of Arts (applied in nursing) in 2011 and this included a thesis on the health of refugee children post resettlement. I have worked widely in primary health care including practice nursing and in child health for an NGO in the Philippines. My work in the last two decades has latterly evolved to focus on primary health care quality improvement and professional nurse practice in Well Child Tamariki Ora (WCTO) nursing. Since February 2017 I have worked as part of an education team delivering the PGCert in Primary Health Care Specialty Nursing through Whitireia. I am a generalist as well as a specialist nurse with a deep interest in theory to practice and the art and science of nursing.

SELF - CARE

Compassion and Frustration in a COVID world

Yvonne Little (Nurse Practitioner)

This article was previously published in NZ Doctor and reprinted here with permission.

Allow me to start with a positive note: Thank you to all for the great work that you are doing especially in those areas hardest hit by COVID. In Hawkes Bay to date, we have been lucky to have few cases, but they are increasing now but still low compared to many areas.

Do you ever get the feeling that our patients think we live in some alternative universe to them? Why are they constantly confronting us in one form or another – FEAR and UNCERTAINTY!

It is understandable that there is fear, uncertainty, distrust, weariness, suspicion, and irritation in the general populace but even as healthcare individuals we have these same issues after all we are human beings not robots, albeit with the added responsibility of not only looking after ourselves and our families but also these self-same patients and their whanau.

Whilst there has always been and always will be families and society where there is some form of division for whatever reason, with COVID this has become more public than private. Fear and Uncertainty alongside Abuse and Confrontation have become more visible and more frequent. Mental Health issues are on the rise namely the increasing amount of anxiety both for our patients but also the staff in medical centres (from the receptionist on the front desk to the nurses to the doctors and on to the management teams). Life is starting to resemble a WAR but without the guns and bombs unless you count the verbal grenades that parts of our society like to throw at those of us just trying to do our job.

Where has our *Compassion* gone – for some of us it is starting to wear very thin when we are faced with this constant hostility from even a small group of people. We are becoming increasingly frustrated and irritated at constantly being questioned about *WHY* do we have to do it this way when last week we didn't? The rules are there for a reason and with the constant changing face of COVID, these rules will need tweaking frequently and we will have people questioning why. My standard answer as likely is the same for many of you is: We are following the rules and working in new and different ways to keep ourselves and our families, you (our patient) and your families and the community SAFE. For some this works, for others it never will, and I guess we just have to accept that we cannot please everyone.

We all know COVID isn't going anywhere soon despite our wishing it would, so what can we do to reclaim/reinvigorate our Compassion and reduce our Frustration?

We need to be on the lookout for stress and frequent illness where we weren't exhibiting either of these before. I believe we notice it more frequently in patients and family members than we do in ourselves or our colleagues as we see it as "normal" because of the nature of our work. As a professional group (here I speak mainly but not exclusively of medical and nursing staff) we are often loathe to admit we are not coping for appearing weak and therefore we hide it and battle on privately instead of seeking help early. Invariably, this is likely to result in burnout or breakdowns from which it is hard but not impossible to recover. So, we need to stop hiding and take action – take care of our physical and mental health which long hours and constant stress puts pressure on. Try to find the enjoyment in the things we used to enjoy instead of seeing them as just another chore that needs doing. Eat well, do some exercise, spend time with family, read a novel, do something relaxing or be outdoors whatever works for you and get enough rest/sleep which for many is hard to come by as the mind is constantly turning trying to stay ahead of the next change to our already busy lives.

I'm not sure if it is just the state of my mind of late but I noted that interestingly, one illness in the past was the Plague we got rid of that by getting rid of the RATS, but now we are using RATs to check for an illness – thankfully a different type of RAT(s).

Let's all try to reinvigorate our Compassion and look after our Health. We are not here for a long time so we need to make the best decisions and enjoy life.

LEADERSHIP

The Changing Face of Primary Health Care – Paramedics in the mix.

By Michelle Piercy

This article has been previously published in NZ Doctor and reprinted here with permission.

The health system is under the pump, it was already pressured prior to covid-19. The health work force is stretched and burning out. Hiring GPs, NPs, Nurses or locums can be challenging. It is time to look for novel solutions to maintain our health work force.

Paramedic registration has opened many doors for primary health care (PHC) and paramedics alike. This highly trained and registered group of health professionals are ready and able to pick up the slack in the work force, especially in areas of acute illness and injury within primary health care, rural PHC and urgent care.

However not all paramedics are trained for PHC work, just like not all doctors are GP's or Urgent Care Fellows, some paramedics choose to train in the intensive/ critical care pathway. However specific Extended Care Paramedic post graduate training is more often than not a PGDip as a minimum expectation, in a specific set of papers via a PHC pathway or similar. This postgraduate training is not too dissimilar to the prerequisites for nurses looking to start their Nurse Practitioner Training. Projecting into to the future there is likely to be a Paramedic Practitioner Practicum offered. Once registered as a Paramedic Practitioner, like Nurse Practitioners will allow for Autonomy of Practice.

Paramedics are not there yet though.

So, what can a paramedic do and how do they work?

Paramedics trained in the Extended Care Pathway from AUT or similar qualification from Whitireia or an overseas provider will have studied papers similar to these offered by AUT; EAL840 Critical Enquiry for Evidence Based Practice, HEAL811 Integrative Research, HEAL812 Health Professional Practice, HEAL813 Practice Reality, PARA808 Community and Remote Area Paramedicine, HEAL824 Advanced Assessment and Diagnostic Reasoning, PHMY803 Pharmacology Science and Therapeutics, RADY801 Ultrasound Imaging.

As registered health professionals' paramedics fall under the health practitioners competence assurance act which means they are assessed by their professional body (Kaunihera Manapou Paramedic Council) as fully competent in the practice of their profession. This means they need to maintain their registration and annual practising certificate yearly. Paramedics practice under a medical or nurse practitioner who will delegate an authority to practice based on the individual paramedic's education level, skills and knowledge. This should also include a competence assessment for the standing orders, procedures and guidelines that shape the scope of that paramedic. The standing orders include skills that can be performed, medications for administration and also for supply of medication under the medication practitioners supply order (MPSO).

Extended Care Paramedics working In PHC and Urgent Care can take comprehensive medical histories, perform physical exams, order and interpret basic diagnostic tests, collaborate with the members of the patient's MDT healthcare team, Diagnose injuries and

illnesses, administer and supply medications on standing orders and clinical procedures and guidelines, Document and communicate relevant patient information, refer patients on to other health care providers and provide counselling and patient education on health maintenance and disease prevention.

Could hiring an Extended Care Paramedic boost the health work force in your practice?

Useful links and references

Postgraduate Certificate in Specialty Care | Whitireia and WelTec (whitireiaweltec.ac.nz)

PCTH-Paramedics-GP-Toolkit-for-Employing-a-Paramedic-in-Primary-Care.pdf (hee.nhs.uk)

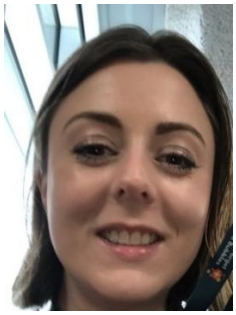
Paramedicine - Postgraduate Diploma in Health Science - AUT

Standing Order Guidelines | Ministry of Health NZ

Medicines (Standing Order) Regulations 2002 (SR 2002/373) (as at 17 August 2016) Contents – New Zealand Legislation

Home (paramediccouncil.org.nz)

APP REVIEW:



By Erica Donovan

So, this edition our app is one that is helpful for both patients and clinicians - The NZ Blood Service Donor App.

While most of you won't be giving patient's blood or blood product transfusions in Primary Care, in the wider healthcare settings administering these products can be a daily part of a nurse's job. Their app will allow you to see upcoming blood drives, book appointments and allow you to note down concerns that may mean you're stood down from donating. And for gamification, there's also merit badges to collect as you count up the donations.

As well as blood, users can also book in to donate plasma, which is widely used and can be made into 11 other products, such as immunoglobulins and clotting factors.

Demand for certain blood types fluctuates over time, but currently the service is crying out for O+ blood. It would be really great if those who have never donated check out the app or the NZ Blood Service website nzblood.co.nz

According to the Blood Service less than 3% of New Zealanders donors, and nationwide we need 4000 donations every week! As someone who has received blood products, as well as administered them, I'm grateful to each and every person who chooses to give up a bit of their time and bodily fluids for the cause.

DIABETES

Management in the Community

By Vicky McKay

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

I have great respect for primary health care nurses, with their broad knowledge and skills, and value their insight into our shared patients. They have usually known the patient and their whanau for several years (decades in some cases!).

The majority of my patients have Type 2 diabetes with an elevated HbA1c (>65 mol/mol). I enjoy working with these patients and have the luxury of time and flexibility in regard to where we meet. My appointment slots are generally 1 hour long, and can be at the general practice, at the patient's home or workplace, at our Primary Health Organisation (PHO) clinic room, or occasionally at a café.

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

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

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

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

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

for the new recently-funded/available medications.

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

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

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

Chronic Kidney Disease - It's relationship to Diabetes

By Vicky McKay

Some reflective thinking and notes taken by Vicky McKay after viewing a Webinar on CKD.

I viewed this informative webinar. I have a renal nursing background (over 10 years ago now) and am now working in a primary care practice. I am also a RN Prescriber.

This webinar is available, alongside a variety of other interesting health webinars can be viewed
on https://myhealthhub.co.nz/webinars/

Webinar "Supporting chronic kidney disease management in primary care"
March 21 2022
Presented by Dr Andrew Salmon, Consultant Nephrologist, Waitemata DHB
Hosted by My Health Hub

The points of interest for me were:
*CKD is stronger risk factor for CVD than diabetes.
*Risk factors for progressive CKD:
1) presence of albuminuria
2) uncontrolled hypertension
3) uncontrolled diabetes
*Ethnicity - Pasifika have double incidence of CKD than NZ Europeans. Māori also have a greater risk of CKD than NZ European.
* SGLT2i (empagliflozin) is more effective than ACE/ARBs in slowing CKD progression - potentially a 15 year delay in reaching ESKD. Empagliflozin is currently available under Special Authority criteria - those not meeting the criteria could self-fund (approx $85 a month - this cost could be reduced by prescribing the higher strength tablets and the patient cutting the tablets in half).
*If patient is on an SGLT2i, and eGFR declines over time to <30mL/min, don't stop the SGLT2i - refer the patient to DHB Renal Service and leave decision to nephrologist.

* ACE/ARBs - don't prescribe both classes at the same time! When treatment is initiated, expect a reduction in eGFR, then stabilisation. However, if eGFR decreases by >25%, cease the ACE/ARB.
* Lifestyle factors to slow progression:
- reduce salt intake
- maintain/reach healthy weight
- be physical active
- stop smoking
- alcohol intake within recommended limits

A useful resource for patients and healthcare professionals is Kidney Health NZ, https://www.kidney.health.nz/
Under the 'Professionals' tab, check out the 'Tools for Health Professionals' tab - it contains lots of useful information including a risk calculator, a general practice guide, and eLearning/webinar links.

PUBLIC HEALTH NURSING

Contact Tracing

By Nicky Cooper

Contact tracing, case investigation and clinical review for the covid pandemic response are all a part of the role I now do in addition to Public Health BAU. You get to speak to a lot of people, cases of covid, probable but not yet confirmed cases, those that have been exposed, those that were simply in the wrong place at the wrong time and suddenly their world came crumbling down, albeit for 7, 10 or 14 days depending on their vaccination status or type of exposure.

On one particular day, I called John (pseudo name) it was his day 14 and he was due for release the following day. He just needed a quick call for clarification purposes so I thought I'd give him a quick call then go to lunch, rookie mistake it would seem.

On this day 14, after he'd spent days speaking to a variety of public health professionals up and down the ladder of skill and station, today we just clicked.

He told me he was an alcoholic, then he cried, he said that's the first time he'd said it out loud. And then I listened, and he told me his story. He told me of the trauma in early childhood, the early relationships that never were. He told me about the choices, the regrets, the speed bumps, the forks in the road, the morning afters, the 'oh hell, I don't want to remember, so I'll have another drink'.

And I listened for near on 30, 40 minutes maybe, until when he was ready, and he finally stopped. He then apologized, and I thanked him, I thanked him for his bravery, I thanked him for his trust. I reaffirmed how it had taken great courage to have finally spoken his truth.

We then talked about how this could look going forward, he talked about being sober for 14 days already and how much better he felt already, both physically and emotionally. We made a plan, at least for today, then we, well actually he made another one going forward, I just helped him to steer his ship, when he paused looking for any insight or gems of wisdom into how to maintain his new world.

And then at the end of a very long emotional phone journey, he said goodbye. He said he was ready, he had more tools, more insight and again I sincerely thanked him and wished him well. We ended the call, I took off my headphones, closed the laptop, stepped out of the closed room and headed for lunch, and I heard "Nicky, oh there you are, can I just have a quick word"?.....

RESPIRATORY

When two progressive paths merge to improve the respiratory community's health, by prioritising supportive self-management.

By: Sue Ward and Kate Te Pou

Kate Te Pou (MN) and Sue Ward (MN) (*since this article was written they are now both new Nurse Practitioners)*

Sue Ward (MN) and Kate Te Pou (MN) were both Nurse Practitioner Interns in Hawke's Bay DHB working as part of the Respiratory team. They completed the clinical project as part of their final two papers for their MN through Massey University.
As new Nurse Practitioners they envisage focusing on broadening the scope to long term condition management, aiming to support improvement in quality of life.

Background / rationale

With one in six New Zealanders affected by a respiratory concern, the current economic health burden is estimated at seven billion dollars annually, and accounts for 10% of hospital presentations (Telfar, Barnard & Zhang, 2018, p. 18). Hospitalisation is expensive and associated with poorer respiratory health related outcomes compared to primary care proactive approaches.

The changes that have taken place in Hawkes Bay over the last five years have improved care and management of respiratory disease for whaiora (seekers of health) and whānau (family). These changes have encompassed transition of reactive management (Secondary Care) to a proactive approach in Primary Care. This fully funded initiative included formation of a practice nurse network, all of whom have advanced training in performing diagnostic testing, and guideline led management for those diagnosed with obstructive lung diseases including asthma and chronic obstructive pulmonary disease (COPD). This is now known as the respiratory programme. As a result, admissions to hospital have radically decreased; based on previous projections approximately 10,000 bed days were saved over 5 years; as a result, COPD is no longer in the top 10 reasons for admission ("Health Round Table", 2020). Although many whaiora are now experiencing less exacerbations, breathlessness symptomology remains a key area that is difficult to manage. Frequently in a busy GP practice/hospital environment, whaiora are handed medication to manage dyspnoea without further exploration of alternative strategies.

Hospital therapy for an exacerbation of chronic respiratory disease includes the proven benefits of nasal humidified flow (NHF) therapy to help manage and alleviate symptoms associated with the increased work of breathing, sputum retention and dyspnoea. Moreover, no safety concerns on its use were detected by researchers Crimi et al. (2020). Emerging research and technology advancement have enabled domiciliary NHF therapy to be available for proactive and supportive self-management alongside concurrent recommended respiratory therapy.

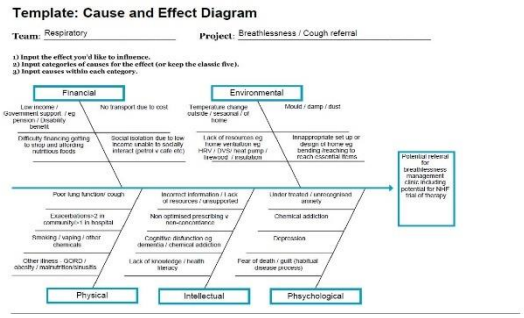
Aims / objectives

The aim of the combined clinical projects was to create a pathway for identification of those who would benefit from breathlessness management, having already been optimised using recognised global best practices; and appropriate referral into specialist nurse led respiratory clinics from both primary and secondary healthcare professionals (HCPs). Whilst treatment frequently consisted of pharmacological and non-pharmacological approaches, an identified adjunctive

treatment was use of domiciliary nasal humidified flow therapy (DNHF). Previously the expert respiratory nurses (ERN) had utilised DNHF for whaiora with dyspnoea related palliative needs, hypoxia despite long-term oxygen therapy/unable to use oxygen due to lifestyle choices, and suppurative lung disease. The treatment would be multidisciplinary, with an aspiration of improving measurable health related quality of life (HRQoL), potentially reducing hospitalisation time and rates.

A referral criteria/form was required for both areas which needed to be comprehensive, without being onerous for an HCP to complete, and adaptable into all electronic Primary Care patient management systems (PMS) used in Hawkes Bay, as well as written referral user friendly. To ensure the whaiora who are referred are appropriate for this service, this clinical project focussed on the formation of a referral form which contains information adequate for the clinic triage lead (ERN)) to decide whether to accept the referral / reject with guidance / ask for further information prior to decision making. The Plan, Do, Study, Act (PDSA) cycle was used to ensure consultation was achieved, using communication skills to provide education / information when required, and to ensure the process was accurately and adequately documented.

Fig 1: Fish diagram demonstrating referral process for respiratory whaiora.



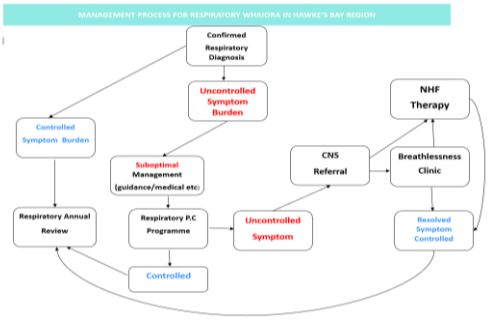
Key findings

Throughout the consultation process, feedback was consistent; although originally envisaged that GPs would be the main identifiers of whaiora who would benefit from the breathlessness clinic, the respiratory programme has changed the balance of contact in Hawke's Bay. Nurses are now leading the proactive management in primary care; with longer appointments whakawhanaungatanga has been successfully established (relationships / connections) with the whaiora and will and therefore become the main referrers.

Other findings were the need for separate referral forms for hospital and community given the different patient population and skill mix. Simultaneously this year two referral forms for complex respiratory patients into the ERN service were developed. These were the referral to the breathlessness management clinic and the DNHF therapy to support self-management of respiratory disease in the community. To streamline the process, it was identified by the ERN's that all referrals should be received via the jointly managed generic respiratory nurse email address, enabling triage and follow up review as appropriate. The other main finding was whaiora/whanau (family) voice was key in understanding the impact on HRQoL, which in turn helped to identify the most appropriate assessment tools for use in the referral process.

Recommendations

Fig 2: Management process for respiratory whaiora in Hawke's Bay region



- The referral forms become advanced forms on the patient management system in Primary Care and be attached to the printing hub in Secondary Care.
- Time allowance be put in place for education around breathlessness, encompassing the impact on the whaiora. The education should include the importance of not continually medicating, but instead co-using non-pharmacological strategies where appropriate.
- Evaluation of effectiveness of referral form and clinic to be submitted as part of a business proposal for funding, so that the clinic can be spread throughout Hawke's Bay.
- The BODE index (Cote & Celli, 2005), may be helpful for future exploration of integrating into Primary Care, however this will need careful introduction and education.
- Self-assessment scores prior to, and following the introduction of breathlessness management and DNHF are to include COPD assessment test (CAT) and the Leicester cough questionnaire (LCQ) as internationally validated tools for HRQoL assessment and monitoring.
- Further review, education and socialisation of this concept needs to continue to enable refinement and improvement of this initial referral process.

Finally, it is recommended that the DNHF treatment option be expanded into other services such as speech and language therapist to support their patient/whaiora burden of airway symptoms.

This conjoined clinical project, was undertaken by the authors to complete their Master's degree at Massey University and was presented at the National Respiratory Conference 2020. The authors are newly qualified Nurse Practitioners with a significant background in respiratory management.

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Nurse Prescribing Gazette Update

Nurse Prescribing Gazette update March 22

By Lee-Anne Tait – Nurse Prescriber

Te Whare Ora O Eketāhuna – Eketāhuna Health Centre

As a Nurse Prescriber, I was really pleased to hear of the release of the second update of the medications available within the gazette https://www.gazette.govt.nz/notice/id/2016-go5037 since from the original listings there was quite a limitation on medications available when one is working in a specialised clinical areas, as many Nurse Prescribers are.

Over recent years I have heard of the plight of many Nurse Prescribers where the lack of drugs in certain categories / speciality areas of work have caused major headaches for them – as it appears there are not logical collective drug groups despite MOH and Best Practice guidelines recommending clinical medication guidance pathways- for example with Diabetic annual reviews, Hypertension, Cardiovascular risk assessments, some of the initiation drug recommendations are not available. Over the past few years many prescribers have offered feedback and recommendations to Nursing Council for the update. On the 23rd of March 22, their long wait was over with the release of the updated Gazette, https://gazette.govt.nz/notice/id/2022-go969 and alongside it came New medicines guidance for registered nurse prescribing in primary health and specialty teams

Whilst I am delighted to see the release of the updated gazette for others, as I personally use very few of these drugs within the acute primary health care setting, it has however already been brought to my attention that within the updated Gazette, there is a bit of a mixed blessing for Nurse Prescribers working within specialist fields, when you look more carefully in relation to the areas previously mentioned above and "continuation only" drugs. On exploration of New medicines guidance for registered nurse prescribing in primary health and specialty teams, I feel the section below taken from this document (extracted completely) really informs one as to the reasoning for these decisions, as they relate entirely to ongoing clinical partnership and collaboration within primary health care teams:-

As whilst Registered nurses prescribing in primary health and specialty teams must work within a collaborative team and prescribe medicines that are relevant to their area of practice and level of competence. Members of the collaborative team have overlapping and complementary roles. Prescribing in partnership describes working in partnership both with the person, their whānau, and other health professionals to optimise health outcomes. Registered nurse prescribers have a responsibility to work collaboratively with their teams to ensure continuity of care to avoid fragmentation of care, as this is known to increase the risk of adverse medical events. In a collaborative team, registered nurse prescribers work alongside other healthcare professionals; sharing responsibility for problem-solving and making decisions to formulate and carry out plans to provide healthcare. The registered nurse prescriber

communicates prescribing decisions to other healthcare professionals caring for the same person and updates the health record in a timely manner. A key feature of a collaborative team is the shared access to information about the person they are caring for, such as diagnosis, medication history, treatment plans, test results, and progress notes. This also includes ready access to the other team members in a timely manner. This ensures that the registered nurse prescriber has direct and up-to-date access to the necessary information about a person's medical history and medicines to enable them to make informed decisions about the person's treatment and care. In a collaborative team, the registered nurse prescriber plays an active part in the decision-making process with respect to initiating or changing a person's medicine, and their decisions and recommendations directly affect the person's medicine therapy. When a registered nurse prescriber continues the treatment prescribed by another prescriber, they are still professionally accountable and responsible for the prescribing decisions they make. They must make sure the medicine and the prescription are appropriate, meets the person's needs, and allows continuity of care for them (see also Continuation prescribing), thus enabling equitable health outcomes.

I hope this extract sheds light and gives answers where needed, as this is just a small segment from a really informative accompanying document, which I have spent some time exploring and still have not completed all of the references or explored all the new drugs within it. One hopes this document will both guide and hopefully inspire many other nurses to move into further study, and into Nurse Prescribing pathways.

Furthermore, I am pleased to see with ongoing support and collaboration some Nurse Prescribers are gaining the experience, insight and confidence to go on to further study and become Nurse Practitioners. One of which has submitted an article for this Logic. Hopefully in a later edition, she will describe her journey and the transitional process she is currently going through.

In the meantime, I hope you will all go well out there in clinical practice and within your personal lives too. It feels tough at the moment- I hope it eases up soon.

Reflection:

Aiming high: postgraduate study and primary health care nursing

By: Michael Brenndorfer (BHSc MHPrac PGDipHSc) (Youth Health)) is a youth health nurse specialist and nurse practitioner intern working for Te Puna Manawa HealthWEST in Auckland.

The beginning of 2022 marks the final year of my study towards becoming a nurse practitioner. As I look forward to the challenge ahead that is the nurse practitioner internship I've been reflecting on my postgraduate journey, considering the ways my learnings have benefited the work I do in my clinic, while also acknowledging the barriers and enablers I encountered along the way. Postgraduate study is an asset for primary health care nurses in Aotearoa New Zealand. Despite the benefits there are multiple barriers which prevent nurses from engaging with this form of professional development. Some of these barriers are systemic issues in the structure of the primary health care system, which as a union and as a college we can work to address and improve.

Evidence of the impacts of postgraduate nursing study shows broad benefits. A systematic review which analysed 20 studies looking at the impacts of postgraduate study on nursing practice indicated an increased

sense of confidence in knowledge and skills, a perception of improvements in care provided, increased job satisfaction for nurses, and improved patient satisfaction (Abu-Qamar et al., 2020). Research within my own specialist area of youth health nursing indicates that secondary school students who were supported by postgraduate-trained school nurses in Aotearoa New Zealand experienced fewer mental health issues and had reductions in binge-drinking behaviour compared to support by school nurses who had only taken part in one-off training days (Denny et al., 2016). While the same research data indicated that one-off trainings still improved outcomes around suicide risk and mental health issues, there was a significantly greater effect from postgraduate study (Denny et al., 2014). From my experience, postgraduate study results in a concentrated focus on an area of learning across a full semester, resulting in a deeper impact on my clinical practice and reasoning than I gained from one-off study days, as valuable as those one-off trainings were.

Despite the apparent benefits to postgraduate study there are multiple barriers which can prevent nurses from engaging with this form of professional development. A study looking at the facilitators and barriers to nurse practitioner training showed that several structural factors in the planning and funding of primary health care prevented aspiring nurse practitioners from completing their qualifications (Adams & Carryer, 2019). These included a lack of commitment to funding advanced nursing roles in primary health care, decreased access to Health Workforce NZ funding for study, and the subsequent personal cost of postgraduate study. The Primary Health Care MECA gives evidence of this lack of consideration for advanced nursing roles within primary health care settings, as is clear by the lack of senior nurses pay scales for our area of practice being included in this collective agreement. Another study which surveyed 1244 nurses in Warsaw found that along with financial barriers being a major issue, nurses also reported a lack of support from employers and managers for pursuing postgraduate training (Kielan et al., 2018). Being aware of the barriers can help us in addressing them and improving the accessibility of valuable postgraduate study.

Developing a culture of encouragement for postgraduate study within primary health care nursing is an important way to facilitate this study. Adams and Carryer's research (2019) highlighted the value that the availability of mentors had on supporting nurse practitioners completing their studies. Mlambo et al (2021) described three components which led to a nursing culture which encouraged professional development: mentors, workplace camaraderie, and a highly functional workplace team (p. 8). Increasing the number of postgraduate-trained nurses may itself be a facilitator in changing the culture of nursing. Abu-Qamar et al (2020) point out that postgraduate learning and skills development has a ripple effect on nursing colleagues of postgraduate-trained nurses, who share their new skills and knowledge throughout their team. This ripple effect may act to encourage other nurses to pursue their own postgraduate study.

As a college and as a union we can also play a role in activating for systemic changes which encourage the advancement of nursing practice through postgraduate study. Using the standing of the College of Primary Health Care Nurses we can highlight the important value that specialist primary health care nurses can play within the primary health care system. We need to push for the recognition of the unique contribution highly skills nurses play within this practice area and ensure that primary health care nurses are encouraged to practice at the top of their scope. Alongside this, through our industrial arm, we need to push for a collective agreement which ensures the financial recognition of advanced primary health care nursing roles to ensure motivation for expanding practice rests not only on altruism. Highly skilled primary health care nurses should have the opportunities to shine and

should be paid on par with our DHB-based senior nurse colleagues.

In my journey to become a nurse practitioner I have been motivated primarily by the desire to provide the best possible care I can to the population I support. In doing so I've navigated various barriers to postgraduate training. But throughout my journey I have been encouraged by mentors and employers and have had financial support from Health Workforce NZ. Through experience I can see the significant value that postgraduate study has had on my nursing practice, and I hope to assist in removing barriers to study for others, and to help create a culture and a structure in primary health care nursing which encourages others to take up this study as well.

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WHANAU AWHINA PLUNKET

Kia ora to all LOGIC readers,

Have you ever wondered how the experiences of childhood have gone on to impact the mental health and wellbeing of women as they became mothers?

Doctor of Health Science student and Whānau Āwhina Plunket Nurse Educator, Katrina Coleman has, and she is currently doing a significant prevalence study focusing on ACEs (adverse childhood experiences) of New Zealand mothers, maternal mental health and wellbeing in the first-year post-partum. Her study is important as research shows a key predictor of health, social and educational outcomes for tamariki are the early life experiences of their mama.

She has gathered almost all her study participants (nearly 500!) but needs that last handful to support robust findings.

If you work with mothers aged 18 or over, with a baby aged under one year and who has used any kind of Plunket service (PlunketLine, WCTO nurse, Plunket group etc), please consider telling them about the study, printing out a poster for your clinic or keeping a copy of the poster on your phone

They (and you) can find out more by using a phone to scan the QR code in the poster or following the link. If a mama decides to participate there is a 10-minute online survey about adverse childhood experiences, mental health and wellbeing. At the end there are support services available to talk through any of the themes covered in the survey if needed.

The survey is available till the end of June 2022.

Katrina plans to share her literature review with us in a couple of months so watch this space for updates

Nga mihi nui

Jess Beauchamp LOGIC Editorial Group

IMMUNISATION

Measles

As Covid outbreaks continue around the world there have been impacts on the health and well-being of many people. Locally we have observed a reduction in immunisation rates for all ages across all immunisation programmes.

The 2019 Auckland Measles outbreak identified a particularly at-risk population of 15-30 year old's. This population are known

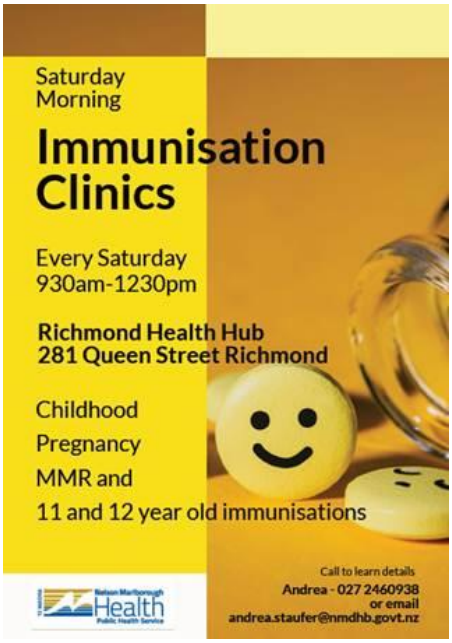
to have a lower rate of vaccination and are therefore at higher risk of catching and spreading measles. As New Zealand prepares to open the travel boarders to other countries there is increased concern regarding which diseases may come into the country. The MoH have identified that future outbreak may disproportionately impact our more vulnerable populations, in particular Māori and Pacific peoples who have lower MMR coverage rates.

This factor, along with visibly lower vaccination rates at all ages on the childhood immunisation schedule make it essential that we prioritise and increase opportunities for immunisation for all ages groups for our communities across Te Tau Ihu.

Free, out of hours Immunisation Clinics at the Richmond Health Hub have been an idea that we have been toying with for years, and now is the right time to put these into practice.
Saturday morning Immunisation Clinics (9:30-12:20pm) offer the opportunity for anyone to wishes to receive a vaccination (especially whanau that are unable to attend weekday appointments) to receive a vaccine in a safe and supported environment. Increasing access to immunisation services is one way of reducing barriers for our community in our equity focused service.

The drop-in clinic is primarily staffed by Public Health Nurses and provides the opportunity for whanau to ask questions and have in depth discussions to make an informed decision about immunisation and give informed consent.

While we continue to promote the clinics to increase vaccination uptake, we are enjoying working in a new and exciting way.



PAEDIATRIC

Pre-School Development – By Nicky Cooper

Pre-School level – Lucas aged four years (name changed to maintain confidentiality)

Observation: Before school check and four-year-old vaccines.

Lucas came to see me for his developmental screening 'Before School Check' (B4SC) and four-year-old vaccines. I had fully equipped his mother prior of what this would entail so she could emotionally prepare him. He walked into my room confidently and I asked him why he was there, "I am here for my jabs". When prompted he obligingly stepped onto the scales allowing for weight then height measurements before I left the room to prepare the vaccines.

On my return I gained his permission to show him with a pen what and where I was going to 'jab'. I re-enacted what I had scripted his mother, explaining it might hurt briefly like a 'bee-sting' demonstrating this on both limbs counting to three. I told him that as this was his last visit to my office, he would get a present. I showed him the drawer of toys instructing him to choose one and that he could open it after his 'jabs'. I asked him which side of his body he wanted me to do, "this one or that one? pointing to each of his thighs and he pointed to his right side.

When positioned appropriately on his mother's lap, holding his toy, I administered both vaccines. Firstly, his thigh, and he watched intently flinching a little, then his arm although this did upset him until the plaster was in place, and his mother helped him unwrap the toy. There he stayed on his mother's lap for a few minutes for a supportive cuddle, albeit carefully examining his new graduation trophy.

Links to Concepts:
I was not taught specific methods to minimise vaccine distress however, I developed this process from my own experience as a nurse and mother. The approach and use of "which side?" closed questioning could be perceived as 'behaviour modification', which does acquire the desired response (Martin & Pear, 2019). This of course could also be interpreted as a form of coercion; equally it could be seen through the lens of 'informed consent', when practiced in an ethical reflective manner (Brubacher et al., 2019).

From a cognitive perspective, Lucas did demonstrate some logical reasoning and self-control. Confirming this progressive shift from egocentricity to conventional logic, distinguishing between make-believe and actuality (Goldstein & Lerner, 2018). He was able to assert himself more autonomously "I am here for my jabs" and obliged us without parental scaffolding. In this instance, the introduction of role-play reduced his resistance. Whereas the use of a 'toy incentive' aligns with current research post procedurally, enabling children to gain a sense of control over their pain and distress (Ballard et al., 2017).

Mismanagement or misreading children's cues during uncomfortable situations, although not harmful may increase anxiety around medical interventions, in particular needles (Mulder et al., 2019). Anxiety can create misery for both children and parents manifesting into a lifetime of overestimating risk and underestimating their ability to cope. Orchestrating this child-focused scenario in a secure environment prepared him and set a pre-emptive tone. These early interventions may empower children to embrace challenging situations, enabling caregivers to sooth, comfort and protect, without fixing their discomfort (Ballard et al., 2017).

Stafford (2020) wrote "Providing an umbrella for our children to hide under might feel like the right move, but we have to know when to provide shelter and when to let them experience a little rain in hopes that it will prepare them for larger storms" (p. 63).

Avoidance 'feeds' anxiety, decreases confidence, accelerating uncertainty (Ballard et al., 2017). When parents/caregivers assist children to confront their fears, they learn how to understand them, whilst building and strengthening their own internal mechanisms (Obradović, 2016). Lucas understood what he needed to feel safe, his secure attachment and co-regulation with his mother was evident, he engaged fully, cooperated, and took a chance.

Co-regulation in the parent/child dyad is automatic, mutually beneficial, requires repetition and consistency to simulate self-regulation (Mulder et al., 2019). Conversely, this developmental trajectory determines firstly an understanding of themselves before they can empathise with the emotions and conduct of others. This exposure broadens their spectrum of feelings, regulating behaviour pre-emptively for emotional intelligence and executive functioning. This facilitates and strengthens children to successfully flourish and thrive in all their uniqueness, develops the 'theory of mind',

adapts self-awareness and resilience (Obradović, 2016).

Consequently, without realising it, I had inadvertently supported those skills to develop. Since infancy we had formed a robust relationship based on safety and trust. With repeated exposure over time, this had fostered self-soothing, emotional regulation, problem solving, and self-efficacy for both parents and children.

JOIN A COMMITTEE

This year we will have committee member positions become vacant at the AGM with representatives having completed the permitted two 2-year office terms.

This work is illuminating, stimulating, puzzling, and challenging at times. Being part of the NZCPHCN is an opportunity to extend your practice, contribute to nursing, and advocate for other nurses and the communities we serve. A measure of the satisfaction derived from this work is the number of representatives who have completed two terms.

Meetings in the past have been some face-to-face meetings, usually on a weekday to facilitate attendance of guest speakers and also flight availability. Meetings have been in Wellington and Christchurch. Further meetings for the Executive, Professional Practice and LOGIC committees have been evening ZOOM meetings and frequency has been dependent on the workload.

More recently, many of the meetings have been transferred to ZOOM due to COVID restrictions and workloads.

There is an expectation that there will be active participation by committee members; reading materials emailed out, responding as appropriate, participating in committee ZOOM meetings and the follow up activity required from these meetings.

You may need to consider travel time to and from the face-to-face meetings. Travel expenses – flights are paid for by the College, road travel cost is reimbursed. Lunch costs are reimbursed by the college.

It is recommended you discuss committee representation with your manager before nomination. Only members of the college are eligible to be on a committee. Nominations need to be made using the NZCPHCN nomination forms.

Forms can be found below, or you may wish to visit our website:
http://www.nzno.org.nz/groups/colleges/college_of_primary_health_care_nurses/hot_topics

If you don't have a nominator, or would like any other information, please email NZCPHCNsecretary@gmail.com

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 9th September 2022**, using one of the following:

Email: sally.chapman@nzno.org.nz 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.

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 9th September 2022,** using one of the following:

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NZNO PROFESSIONAL NEWS

Sue Gasquoine is the Nursing Policy Adviser/Researcher in the Professional Services Team. She has worked at NZNO since March 2017 and in addition to her work in the Policy and Research Team is involved in publications and supports the Nursing Education and Research Foundation (NERF) Board.

Nurturing the next generation of nurses

The Nursing Education and Research Foundation (NERF) is a registered charity that has been investing bequests and funds from donors for 50 years and distributing the income to nurses who are NZNO members to support their education – both undergraduate and postgraduate, research, innovation and events.

NZNO is represented on the NERF Board with NZNOs President and Kaiwhakahaere as co-chairs. At the Board meeting in November 2021, the three NZNO staff members (including myself) who support the Boards work were asked to develop a plan for improving NERFs online presence and accessibility to both potential applicants and donors. The NERF work I am responsible for is one of the highlights of my role as Nursing Policy Adviser and Researcher as I get to support members seeking financial assistance to complete qualifications and research, 'seed' nursing innovation, and organise events. It is the breadth of the impact on the work of scholarship recipients that I most enjoy: from the very grateful student who reported that the greatest benefit he derived from the undergraduate scholarship he received was a 'proper' pair of new shoes to wear with his uniform on clinical placement, to the nursing academic who, with support from NZNO researchers, has conducted research into the experience of Internationally qualified nurses (IQNs) as they 'settle' into professional nursing roles in Aotearoa New Zealand (Brunton, Cook, Walker, Clendon & Atefi, 2020). This NERF funded research was shared recently with the Education and Welfare Select Committee which is conducting an inquiry into migrant exploitation and to which NZNO has made a written submission. We are also supporting members to make an oral submission to the inquiry. And the ongoing Nursing Oral History Project is also funded by NERF with the most recent phase underway with researchers at Manukau Institute of Technology. http://www.nursinghistory.org.nz/index.php/An_Online_Archive_of_Nursing_Oral_Histories_in_NZ

At the time of writing, applications for the February scholarship and grant round had arrived. The number of applications, particularly for undergraduate scholarships has halved since the pre-COVID February 2020 grant round. Instead of 50 plus applications from students of undergraduate nursing programmes, there are 10! Where are all the applicants? It would be easy to pass this off as yet another impact of COVID but at a time when the nursing workforce is in the greatest need, it must be possible to effectively distribute the support available.

The paradox is that nursing has achieved a profile in recent years that only a global pandemic could generate. The pandemic response has depended in large part on nursing and nurses at a time when the workforce is experiencing unprecedented demand for its skills and knowledge. Over the last couple of years NERF has been working with some very generous donors seeking to support our profession with funding and has recently benefited from several significant bequests from retired nurses.

The critical next step is to make this funding as accessible as possible to nurses who meet the scholarship criteria, including the categories that seek applications from Māori and Pacific students and those which are offered to nurses in rural and remote areas or who are doing specific postgraduate study, for example pharmacology. Most of the scholarship applications ask for a description of practice excellence, career goals that contribute to the profession and health and wellbeing of communities, and an exploration of how the planned study or project will support equity of access for vulnerable and disenfranchised communities.

A sustainable pipeline of nurses is in everyone's interests. In Aotearoa New Zealand, in the short to medium term, that pipeline will continue to rely on being supplemented by migrant nurses. However, the last two years has taught us that we need to be more self-sufficient and develop succession planning for ourselves and our profession. Who will you recruit to the workforce as your successor? The profession needs some good news stories to counter the headlines that 'shout' burn out and stress; overload and care rationing; shortages and missed care, all of which often understate the situation on the front lines. Financial support from NERF scholarships is a good news story – please share it.

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