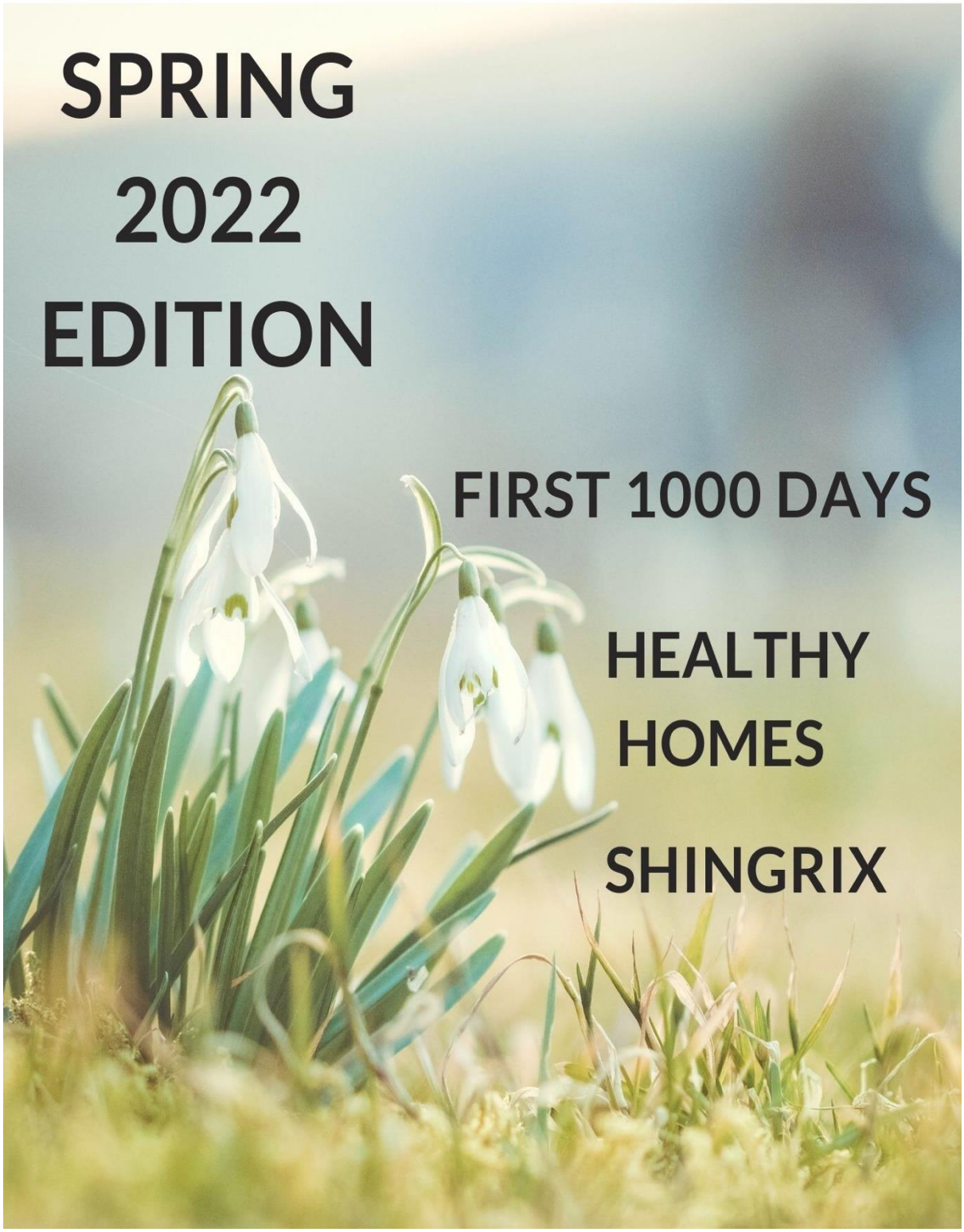
LOGIC

LINKING OPPORTUNITIES GENERATING INTER-PROFESSIONAL COLLABORATION

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



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Spring 2022

In this issue…

Chairs Report

Tracey Morgan
Interim Chair

Tēnā koutou katoa,

I would like to begin by taking this opportunity to reflect on the past year. I would like to acknowledge the ongoing work that every one of you have produced over this tumultuous period of Covid and the continual ongoing Nursing crisis that we continue to battle through. With the current change to our New Zealand Health System and the introduction of Te Whatu Ora and Te Aka Whai Ora it is our resilience that continues the journey we all embark o take this on as we try to pave through this new pathway.

I would like to take this opportunity to thank Jill Clendon for the commitment and dedication she has provided to Primary Health. She is currently taking a well-earned break so wish her all the very best. I would like to thank the Executive committee, the Professional Practice and LOGIC committees, for your continued commitment and strategic leadership and dedication you have all put in throughout these challenges.

I would also like to take this time to acknowledge Fiona Murray our secretary who will be standing down. Thank you, Fiona, for the support and ongoing emails, communication and work you have provided to both Jill and myself and our committee. In this very short time working alongside you have been very supportive on top of your already busy workload so thank you.

Primary Health have had another successful year and continue to produce information to our members so that we are all kept informed. Some highlights of mention:

Equity Grant: The Executive Committee are proud to present the Oritetanga Pounamu Equity Grant of $2500 this year. The Committee thank Charleen Waddell for her input of drafting this new grant on behalf of the team and we were all excited to reward this to the successful recipient at our Christchurch Forum. This grant looks at diversity to Māori, Pacific Island, vulnerable and disabled communities with Te Tiriti o Waitangi embedded in the criteria.

General Practitioners Leadership Forum: This Conference was held in Christchurch. Some key themes shown throughout this conference was top priority accessing Primary Health Services, change is occurring in absence of consumer voice, how can we be involved in locality if we are not at the table, locality strategy, locality not well defined in Pae Ora. Grow capacity and capability. Just as the Nursing workforce shortage, a shortage of GPs in Aotearoa is evident. Have met face to face with this forum twice in 2022 and will continue relationship alongside NZNO Staff.

CEO/NZNO Staff: The Executive Committee had the opportunity to meet face to face with Paul Coulter who is the new CEO for NZNO. A question put to the Committee is “how do we know we are successful”. The Committee were able to

articulate the work of the College. The CEO will continue to have this ongoing relationship with the College. He provided insight of Maranga Mai Campaign which is the vehicle moving forward for NZNO.

I would also like to thank Cathy Leigh and Angela Clarke for their continued ongoing support to the College and providing all the relevant information necessary to all for discussion or dissemination where required. A special thanks also to our Administrator Sally Chapman for providing all information that the Committee require and the ongoing support to us all.

Logic and other Committees: Primary Health continues to work tirelessly ensuring communication and information is provided to all Sections. A huge thank you all for the extra voluntary time you all give. The College is always looking at every avenue to improve where required. It is the behind scenes and work that are things unnoticed that provide the greatest successes and impact.

Symposium: In the tumultuous times Primary Health successfully held a Symposium in 2021 in conjunction with College of Nurses. The next Symposium is scheduled to be held in Rotorua in March 2023

Health Select Committee: A letter of support was sent from Primary Health to Health Select Committee for Cure our Ovarian Cancer which was acknowledged by Jane Ludeman

Although I have only come on since June 2022 I look forward to the AGM and meeting everyone face to face and the ongoing relationship, we all will all embark on over the next twelve months

Editors Report

Yvonne Little

Welcome to the Spring issue of LOGIC. Firstly, I need to apologise for its late publication but as you are all well aware COVID-19 is still doing the rounds and we have had some delays in getting articles due to either illness or increased workloads. Having said that I am sure you will enjoy what we have managed to put in this issue.

Rest assured our Summer issue will be out in time for the Christmas break.

They do say "parting is such sweet sorrow" and this is the case for the college as we said farewell at our recent AGM/Forum on the 13th of October in Christchurch to our fantastic secretary for the past four years, Fiona Murray. Fiona has completed her two terms and now is going on to give her valuable time and caring to herself and her family and we wish her well for the future. Hopefully, one day we may see her back on one of our committees.
In her place we now have Rachael Maheno, you can find out more about her in the new committee member section and on the webpage.

At the AGM we also had some other committee member changes: Erica Donovan has now moved from LOGIC to the PPC, and Katie Inker has moved from the PPC to LOGIC. We welcomed to the

LOGIC committee Elle Moloney and confirmed all other positions as they were currently standing.

As mentioned before, we held our AGM/Forum at the Christchurch NZNO rooms on the 13th of October. It was a bit disappointing that more members didn't join us via the ZOOM link (albeit we did have some technical difficulties at the beginning) to listen to our fantastic and energising speaker Suli Tuitaupe speaking on "Working in partnership with Pasifika individuals, families and their communities: A nursing perspective". Anyone who has heard Suli speak will know how passionate he is about his role in health care and his communities.

At this forum we were able to present our two inaugural awards to very deserving recipients:
The Oritetanga Pounamu (Equity) Grant Award was presented by Charleen Waddell to Cathy Fraser-Reading who joined us via ZOOM, for the project she is leading in her area, Cathy will provide us with an article about her project in the future. Tracey Morgan will present the certificate to her in person, and we will have a photo and short piece to go with this in our Summer issue.

I was extremely pleased to be able to present (albeit slightly emotionally) the Leadership (Haututanga) and Innovation (Tangongitanga) Award to our departing secretary Fiona Murray. She had two nominations come in for this award, one from her colleagues at Waitemata and one from us her college committee colleagues. Fiona will be providing us with a small article for our Summer issue of LOGIC about receiving this award.
So, whilst these are annual awards, I would like to suggest everyone starts thinking of colleagues they could nominate for these awards in 2023.

In this and following issues of LOGIC you will find "save the date" reminders for upcoming events. Please mark these in your calendars.

A reminder here to check out our college website and Facebook page which we are now working hard to keep current. We can post more frequently on these sites about events and information around ongoing educational opportunities and updates.
I will sign off now with my usual reminders, if you or someone you know are interested in joining our committees, please make contact as we still have vacancies to fill and we would like to continue to future-proof the college committees.

Likewise, if you or someone you know would like to provide us with an article for LOGIC in 2023, please contact me at: logiceditorcphcn@gmail.com and I can forward to one of the LOGIC committee team to follow up with you. Please see our annual planner attached below, you can write on any subject you like, it does not have to be one of the themed headings at the top. As you will see we have many nursing areas listed and updates about what is happening in your area is always welcome and may help people in other regions who have similar issues but have not yet found solutions.

Nga Mihi

AUTUMN 2023	WINTER 2023	SPRING 2023	SUMMER 2023
EDITOR: Yvonne FEATURE TOPICS	EDITOR: Yvonne FEATURE TOPICS	EDITOR: Yvonne FEATURE TOPICS	EDITOR: Yvonne FEATURE TOPICS
Diversity and understanding all groups in society	**Healthy Homes**	**Polypharmacy (The spring clean out)**	**Reconnecting and recharging**
Respiratory	**Mental Wellness**	**Peer Supervision/Support**	**Safety**
Leadership	**Leadership**	**Leadership**	**Leadership**
REGULAR TOPICS	REGULAR TOPICS	REGULAR TOPICS	REGULAR TOPICS
Well Child	Well Child	Well Child	Well Child
Apps	Apps	Apps	Apps
Mental Health	Mental Health	Mental Health	Mental Health
Diabetes	Diabetes	Diabetes	Diabetes
School Nurse Section	School Nurse Section	School Nurse Section	School Nurse Section
District Nurse Section	District Nurse Section	District Nurse Section	District Nurse Section
PHO Nurse Section	PHO Nurse Section	PHO Nurse Section	PHO Nurse Section
Public Health Nurse Section	Public Health Nurse Section	Public Health Nurse Section	Public Health Nurse Section
New Graduate Section	New Graduate Section	New Graduate Section	New Graduate Section
Child Youth Section	Child Youth Section	Child Youth Section	Child Youth Section
Aged Care Section	Aged Care Section	Aged Care Section	Aged Care Section
Palliative Care Section	Palliative Care Section	Palliative Care Section	Palliative Care Section
Ostomy Nurse	Ostomy Nurse	Ostomy Nurse	Ostomy Nurse
Nurse Prescriber	Nurse Prescriber	Nurse Prescriber	Nurse Prescriber
Youth NP/NP Section	Youth NP/NP Section	Youth NP/NP Section	Youth NP/NP Section
Prison Nurses	Prison Nurses	Prison Nurses	Prison Nurses
Enrolled Nurses	Enrolled Nurses	Enrolled Nurses	Enrolled Nurses
Pacific Health	Pacific Health	Pacific Health	Pacific Health

Education	**Education**	**Education**	**Education**
Cultural – related to feature topic	Cultural – related to feature topic	Cultural – related to feature topic	Cultural – related to feature topic
Professional Practice Update	Professional Practice Update	Professional Practice Update	Professional Practice Update
Reflection	Reflection	Reflection	Reflection
Rural Muster	Rural Muster	Rural Muster	Rural Muster
Pharmaceutical Update	Pharmaceutical Update	Pharmaceutical Update	Pharmaceutical Update
Regional Forum Reports	Regional Forum Reports	Regional Forum Reports	Regional Forum Reports
National Delegates Report	National Delegates Report	National Delegates Report	National Delegates Report
NZNO Professional News	NZNO Professional News	NZNO Professional News	NZNO Professional News
NZNO Library	NZNO Library	NZNO Library	NZNO Library
Immunisation Update	**Immunisation Update**	**Immunisation Update**	**Immunisation Update**
Symposium/Conference/Regional Activities	**Symposium/Conference/Regional Activities**	**Symposium/Conference/Regional Activities**	**Symposium/Conference/ Regional Activities**

Your NZCPHCN Committee Members:

Photo taken at NZNO rooms, Christchurch, October 2022.

Front Row: Charleen Waddell (Executive), Tracey Morgan (Executive), Katie Inker (LOGIC), Shell Piercy (PPC), Yvonne Little (LOGIC), Erica Donovan (PPC)

Back Row: Michael Brenndorfer (LOGIC), Nicola Thompson (EXECUTIVE), Melanie Terry (PPC), Jeanette Banks (PPC), Bridget Wild (PPC), Cathy Leigh (NZNO, PNA), Missy Brett (EXECUTIVE)

Missing from the photo are Lee-Anne Tait (LOGIC); Jess Beauchamp (LOGIC); Nicky Cooper (LOGIC), Rachael Maheno (incoming secretary), Fiona Murray (outgoing secretary), Elle Moloney (LOGIC)

New Committee Members:

Rachael Maheno (Incoming Secretary)

Ko Maungahaumia tōku maunga
Ko Mangatu toku awa
Ko Mattatua toku waka
Ko Mangatu me Te Wainui oku marae
Ko Ngaariki Kaiputahi, Tuhoe, Ngati Porou, Kati Mamoe, Kai Tahu, Waitaha oku iwi

Ko Racheal tōku ingoa

I have worked full time in various nursing positions across primary and secondary care. I have a background in Mental Health Nursing; Māori Health Nursing at the former Southerndhb, Whanau Ora Nurse a Māori Health provider and most recently my current mahi is at Wellsouth PHO as an Outreach Nurse.

I am passionate about the health and wellbeing of all people in general with a focus on Equity and improving health outcomes particularly for Māori. To support and help those in need to access timely, equitable access to care.

LOGIC COMMITTEE welcomes Elle Moloney to the group – her photo and bio will be in the SUMMER Edition of LOGJC.

Lee-Anne Tait
Nurse Prescriber - Te Whare Ora O Eketāhuna – Eketāhuna Health Centre

Supporting Patient health - The Healthy Homes Standards and Nationwide Healthy Homes Initiative

All across Aotearoa we are aware of people living in below standard housing. This is a surprising statement considering 'The Residential Tenancies' (healthy homes standards) came into force 1st of July 2019, in order to support tenants to live in healthy homes which comply with these standards and avoid the related health disparities which come from inadequate housing.

These standards are now almost 3 years old, and tenants/ landlords should be starting to see some improvements in the standard of housing within our communities. In some rental properties in Eketahuna we are still awaiting further improvements- however by 2024 all landlords must comply with these standards- and this is a health and psychosocial blessing for tenants.

This article is designed to briefly explain these standards and also what you can do to help tenants if you are aware that the property, they are living in falls short of them.

I had such a case 3 years ago just as these standards came into force with a young pregnant mother and her partner moving into a rental property in Eketahuna which they had seen briefly and were desperate to move into as they were homeless, only to move in and find it had limited heating, a hole in the fireplace, damp and black mould, no extractors and widespread leaky windows and doors. With the help of photographs taken on her first two weeks in this rental property and the ongoing help of a key Healthy Homes Initiative (HHI) support worker, (see further into article for explanation) the couple managed to be relocated to a warmer healthier home in Masterton before the child was born. Furthermore, over the following year they managed to take this landlord to court and win their case. This would not have come about had we not had insight into the healthy home's standards or the help of a key HHI worker.

The legislation within the healthy homes standards is long and wordy but there are simple formations of this document available online that you can download to help your patients more aware of what is ok (compliant) and what is not acceptable (noncompliant) going forwards.

The basic overview of the legislation refers for the need to address adequate heating, ventilation and moisture ingress and drainage standards within all rental properties.

Heating

The main living room of the rental property must have a fixed heating device that can heat the room to at least 18°C. The new regulations clarify the requirements for heating devices – some will not meet the requirements under the heating standard as they are inefficient, unaffordable, or unhealthy. A heating assessment tool became available in July this year, which assists with determining the heating capacity required for individual rooms.

Heating standard

Landlords must provide one or more fixed heaters that can directly heat the main living room. The heater(s) must be acceptable types and must meet the minimum heating capacity required for your main living room.

Insulation

The minimum level of ceiling and underfloor insulation must either meet the 2008 Building Code, or (for existing ceiling insulation) have a minimum thickness of 120mm and be in reasonable condition with no dampness, damage, or displacement. The new regulations also specify where insulation exemption applies.

Insulation standard

Ceiling and underfloor insulation has been compulsory in all rental homes since 1 July 2019. The healthy homes insulation standard builds on the current regulations and some existing insulation will need to be topped up or replaced.

Ventilation
Ventilation must include openable windows in each habitable space. The windows must comprise at least 5% of the floor area of that space. An appropriately sized extraction fan or cooker /range hood must be installed in rooms with indoor cooktop and also a fan in rooms with a bath or shower.

Ventilation standard

Rental homes must have openable windows in the living room, dining room, kitchen, and bedrooms. Kitchens and bathrooms must have extractor fans.

Moisture ingress and drainage
The standards reinforce existing law that says landlords must have adequate ingress and drainage and guttering. If a rental property has an enclosed subfloor space, it must have an on-ground moisture barrier, which will stop moisture rising into the home.

Moisture ingress and drainage standard

Rental properties must have efficient drainage for the removal of storm water, surface water and ground water. Rental properties with an enclosed sub-floor space must have a ground moisture barrier.

Draught stopping
Any gaps or holes in walls, ceilings, windows, floors, and doors that cause unreasonable draughts must be blocked/ sealed. This includes all unused open fireplaces and chimneys.

Draught stopping standard

Landlords must make sure the property doesn't have unreasonable gaps or holes in walls, ceilings, windows, skylights, floors, and doors which cause noticeable draughts. All unused open fireplaces must be closed off or their chimneys must be blocked to prevent draughts.

If you are aware of tenants struggling with landlords or living in non-complaint housing and in need of support, you can refer them for help through the **Healthy Homes Initiative**.

The Healthy Homes Initiative (HHI) It was set up in 2013, designed to support warm dry and healthy homes. Initially the program was targeted towards those on low income, living in crowded homes particularly concentrating on areas with a high incidence of rheumatic fever and ethnic disparity with Māori and Pacific families being overrepresented.

Over the next 3 years the breadth of the service expanded and by 2016 went on to cover 11 DHB's and worked with a wider scope, addressing the needs of low income families, pregnant tenants and those with children under five, especially those who had been hospitalised with preventable illness such as respiratory or skin conditions. In 2021, it was announced by MOH the whole country would be supported by HHI, by July 2022. 30million dollars has been set aside for use over a four-year period, for nationwide coverage.

The MOH HHI's website states:

"The HHIs identify eligible families, working with them to carry out a comprehensive housing assessment and complete an individualised action plan to create a warmer, drier, healthier home.

The HHIs then help families to get the interventions they need to create a better living environment, especially for their children. Interventions given to these families include help with accessing insulation, curtains, beds, bedding, minor repairs, floor coverings, ventilation, heating sources, Full and Correct Entitlement assessments through Work and Income, support with power bills, and finding alternative accommodation as needed.

The Ministry has a selection of resources and tips available on this website for creating and maintaining warm, healthy homes.

Key facts about the HHI

- To date, over 24,000 children have been referred to the programme
- Over 74,000 interventions (such as curtains and draft stopping) have been delivered
- 75 percent of referrals to the HHI have been either Māori or Pacific people
- An outcome evaluation showed us that for every 10 children referred to the HHI, there is estimated to be one fewer hospitalisation, six fewer GP visits and six fewer filled prescriptions over the following 12 months."

So please be aware of the standards and HHI and refer onwards where necessary in order to help your patients live in healthier homes and hopefully have healthier lives.

https://www.legislation.govt.nz/regulation/public/2019/0088/latest/whole.html

https://www.hud.govt.nz/assets/Residential-Housing/Healthy-Rental-Homes/Healthy-Homes-Standards/Healthy-Homes-Standards-factsheet-June-2020.pdf

https://www.tenancy.govt.nz/healthy-homes/https://www.health.govt.nz/our-work/preventative-health-wellness/healthy-homes-initiative

PREVENTION IS BETTER THAN CURE.

By: Suzie King – Clinical Nurse Specialist Youth Health – Te Whatu Ora Health New Zealand Counties Manukau – KidzFirst Community

According to the World Health Organisation (2018), the social determinants of health are the non-medical considerations that impact health outcomes. This includes housing, essential

services and the environment. The New Zealand 2018 census showed that people from Māori and Pacific descent are more likely to be living in cold damp housing. New Zealand's North Island has higher rates of Māori and Pacifica living in these conditions when compared to the South Island (Stats NZ 2020). The highest rate for Māori was in the Northland district and for Pacific people it was in the Auckland region. Cold, damp housing including mould and poor indoor air conditions leads to poor respiratory health and the potential development of Rheumatic Fever (Stats NZ, 2020). The Ministry of Health (2021) also concludes that in combination overcrowding, low socioeconomic status, barriers in accessing primary care, and untreated Group Streptococcus A throat infections are key factors in the development of Rheumatic Fever amongst Māori and Pacific ethnic groups.

The highest rates of Rheumatic Fever occur in Māori and Pacific young people between the ages of 5 and 19 years (Ministry of Health, 2021). To decrease the consequences of Rheumatic Fever the Ministry of Health rolled out the Rheumatic Fever sore throat swabbing programme in schools in 2011. Although this programme ceased in 2017, the Ministry of Health continues this work in Te Whatu Ora Health New Zealand Counties Manukau, to reduce the incidence of Rheumatic Fever (Ministry of Health, 2021).

In my previous role I worked as a youth health nurse for 15 years, in a school that was part of the sore throat swabbing programme, and this health service currently continues. Working within a Ministry of Health funded school, nurses have contractual obligations to fulfil Year 9 health assessments and undertaking swabbing and treatment of students with sore throats. Parents and caregivers are informed of these health services in the school's enrolment pack and may choose to opt out.

The psychosocial component of the health assessments involves asking questions about home, education, activities, drugs and alcohol, sexuality, safety, and suicidality (HEADSSS) (Goldenring and Rosen, 2004). It is during this health assessment we enquire about the young person's home to establish if home is damp, cold, and overcrowded, as well as exploring safety in the home context. Questions within the health assessment include but are not limited to, who do you live with? What do you use to heat the home? Do you have window coverings such as curtains or blinds? Do you sleep in your own bed or share your bed? Is there any mould on the walls, ceilings or around the windows? Where are your clothes dried? These questions guide the school nurse to establish if the student lives in a healthy, safe living environment. Nurses offer relevant services as required, such as the Healthy Homes Initiatives.

The Healthy Homes Initiatives was initially created to provide dry, warm, and healthier homes in areas where there were high rates of Rheumatic Fever and overcrowding. This has expanded to include low-income families with children 0-5 years who have been in hospital with household related conditions, families with children 0-5 years with a minimum of two or more social economic risk factors and anyone who is pregnant. It is currently offered to all households in Aotearoa. Interventions offered within the Healthy Homes Initiatives include assistance with

access to home insulation, window, and floor coverings, beds including linen, ventilation, heating options, power subsidies and if appropriate relocating to alternative accommodation (Te Whatu Ora Health New Zealand, 2022). After discussion with the students and obtaining parent/caregiver's permission a Healthy Homes initiatives referral is completed. The students are also informed of the services available at school and that there is drop-in clinics for any health-related concerns including assessment and treatment for sore throats.

All school nurses must complete the relevant training to acquire the skills to assess sore throats, take swabs, retrieve laboratory results, and offer treatment. School nurses work under Standing Orders supported by the Nurse Practitioner, or school doctor, or are Registered Nurse Prescribers in Community Health. This enables nurses to expedite treatment for common uncomplicated infections including students who have a positive Group A Streptococcus bacterial infection.

The school nurse conducts a thorough clinical assessment and consults with the young person and their caregiver regarding treatment and follow up. The nurse offers an intramuscular Benzyl Penicillin injection as a single dose, or a course of oral antibiotics for ten days following the Heart Foundation (2019) Group A Streptococcal Sore Throat Management Guideline: 2019 Update. Nurses then follow up with adherence checks regularly to ensure treatment has been completed. In addition, the school nurse will inform the students usual doctor that treatment for a Group A Streptococcus bacteria positive throat swab has been given.

Nurses working in schools have broad roles and responsibilities and provide comprehensive health services. We are in the perfect position to help reduce inequities and offer better, sooner, more convenient health care to meet the needs of our students leading to optimal health outcomes. The services offered by school nurses helps enhance the physical, social, and mental health of young people. A large part of the school nurse's role is health education and promotion which helps foster lifelong learning and the development of healthy behaviours for our rangitahi. Ultimately, leading to preventable long term health related conditions that may impact their lives.

Reference List

Goldenring, J.M, and Rosen, D.S (2004). Getting into adolescent heads: an essential update. *Contemporary Pediatrics* 21(1),64-90

Heart Foundation (2019) Group A Streptococcal Sore Throat Management Guideline: 2019 Update.

https://www.heartfoundation.org.nz/resources/acute-rheumatic-fever-and-rheumatic-heart-disease-guideline

Ministry of Health (22 November 2021) New Zealand Guidelines for Rheumatic Fever, https://www.health.govt.nz/our-work/diseases-and-conditions/rheumatic-fever

Ministry of Health (01 August 2022) Reducing rheumatic fever, https://www.health.govt.nz/our-work/diseases-and-conditions/rheumatic-fever/reducing-rheumatic-fever

Stats NZ (19 May 2020), More than 2 in5 Māori and Pacific people live in a damp house-corrected

https://www.stats.govt.nz/news/more-than-2-in-5-maori-and-pacific-people-live-in-a-damp-house-corrected

Te Whatu Ora Health New Zealand (13 September 2022)Healthy Homes Initiative Healthy Homes Initiative – http://www.tewhatuora.govt.nz/keeping-well/healthy-homes-inititive

World Health Organisation (2022), Social Determinants of Health, https://www.who.int/health-topics/social-determinants-of-health

Shingles and Shingrix® - the new recombinant Zoster vaccine in New Zealand

Kate Marshall
IMAC Immunisation Educator
Southern

Review of shingles (Herpes zoster)

As many primary health nurses would agree, an episode of shingles (herpes zoster) is an illness that you wouldn't wish on your worst enemy. Caused by reactivation of the varicella-zoster virus in individuals who have previously had chickenpox, shingles presents as a painful, unilateral (one side of the body) vesicular rash, along the dermatome of the spinal or cranial nerve pathway where the virus lay dormant. Like in chickenpox, the blisters in the rash crust over and heal over the course of several days to weeks.

For around 10 - 18% of affected people, shingles can cause chronic nerve damage resulting in ongoing burning nerve pain, tingling or numbness, a condition termed postherpetic neuralgia (PHN) (CDC, 2019). The risk of PHN increases with age and can be debilitating, especially in older adults. If you're unfortunate enough to get shingles in the eye, it can cause complications like ulceration, glaucoma and even blindness. Shingles is notoriously difficult to treat as the window for antiviral medication is short, and many people may brush off the prodromal symptoms (headache, fatigue and fever) as cold or flu symptoms, leaving it too late when seeking help from their primary care provider.

The incidence of shingles increases with age, with a lifetime risk of about 1 in 3, and for those aged over 85 years, the risk is 1 in 2 (MOH, 2020). Shingles more commonly affects people aged from 50 years (risk increases with age), people who are immunocompromised and disproportionately affects more females than males (Cadogen et al. 2022). Bhavsar et al (2022) found that within the 6 months post COVID-19 infection, people aged ≥ 50 years old had a 15% higher risk of developing shingles, and 21% higher risk if they'd been hospitalised with COVID-19, so you may see more of this disease in the coming months.

It's important to know that a person cannot spread shingles to another person, however the virus is transmissible (via the contact with the blister fluid) to people who aren't immune to chickenpox (i.e. have not had the varicella vaccine or caught chickenpox) (CDC, 2020).

Since 2017 we have had the live attenuated zoster vaccine Zostavax® on the National Immunisation Schedule. Whilst offering some protection for our older population, as a live vaccine it is contraindicated for severely immunocompromised or pregnant people, so its use was limited for those at higher risk of shingles at a younger age. It also doesn't offer long lasting protection (decline in efficacy within 5 years) and although much better than placebo (or crossing your fingers), it only reduces the burden of shingles by 61% in all adults aged over 60 years, with decreasing effectiveness with age (MOH, 2020).

From 1st August 2022, Zostavax® was phased out and replaced by a newly funded non-live zoster vaccine called Shingrix®.

What is Shingrix®?

Shingrix® is made by GlaxoSmithKline and is a highly effective, non-live adjuvanted recombinant subunit vaccine. The primary course consists of two doses of 0.5mL given 2-6 months apart. No booster doses are suggested currently.

The vaccine contains the recombinant Varicella Zoster Virus (VZV) glycoprotein E and an adjuvant plus excipients. The AS01B adjuvant contains fractions extracted from the bark of the Chilean soapwood tree *Quillaja saponaria* (QS-21) and monophosphoryl lipid A (MPL) derived from *Salmonella minnesota* (see NZ data sheet https://www.medsafe.govt.nz/profs/datasheet/s/shingrixinj.pdf). The adjuvant components help the vaccine to induce a robust immune response against the VZV glycoprotein E.

Efficacy

In pooled results from two placebo-controlled, randomised phase 3 clinical trials (ZOE-50 and ZOE-70), vaccine efficacy against shingles was found to be 91% for all ages ≥ 50 years, and ongoing protection was maintained at 84% for at least 7 years (Boutry et al. 2021). Importantly with Shingrix® there is no loss in efficacy in older adults (i.e. >70 years) and the vaccine efficacy protecting against postherpetic neuralgia was 88.8% (Cunningham et al, 2016).

Safety and side effects

Shingrix® is contraindicated in anyone with a history of severe allergic reaction to a previous dose of Shingrix® or to a component of the vaccine. The vaccine should be deferred if a person is acutely unwell or has a fever >38°C, and due to a limited knowledge of interactions, spacing of 3 days after another adjuvanted vaccine is given (e.g. Nuvaxovid or Fluad Quad) is recommended. There is a lack of data for Shingrix® in pregnancy, so please contact IMAC on 0800 IMMUNE (466 863) to discuss if indicated.

The vaccine has a good safety profile as demonstrated in the clinical trial studies and real-world reports (Fiore et al, 2021). Common local adverse reactions for people 50 years and older after having Shingrix® included pain (78.0%), redness (38.1%), and swelling (25.9%); and common general reactions included myalgia (44.7%), fatigue (44.5%), headache (37.7%), shivering (26.8%), fever (20.5%), and gastrointestinal symptoms (17.3%) (GSK, 2022). The usual length of time experiencing these side effects lasted between 2-3 days.

Funding and eligibility

It is funded only for people aged 65 years (i.e. for the 12 months following the 65th birthday). It is available for private purchase and approved for use from the age of 50 years, and from 18 years for those at increased risk of shingles (e.g. due to immunocompromise). Propharma is supplying the funded supply whereas privately funded Shingrix® can be ordered from HCL, however it is an expensive vaccine, so make sure your clients know it is a two-dose course before ordering.

It is recommended to wait 12 months following a shingles episode or being previously vaccinated with Zostavax® before having Shingrix®, though this can be shortened to 3 months if at high risk (e.g. severely immunocompromised) or ideally given prior to planned immunosuppressive therapy.

Preparation and administration

Shingrix® comes with two vials that you need to mix to reconstitute (see Appendix A7.2.2 in the Immunisation Handbook to refresh on how to reconstitute vaccines where the diluent is in a vial). It is administered IM into the deltoid.

IMAC resources and further information

Before giving your first Shingrix® vaccine, please see IMAC's resources including:

1. "Quick Answers – Recombinant Zoster Vaccine rZV Shingrix" resource (https://www.immune.org.nz/sites/default/files/resources/Written%20Resources/Quick%20Answers%20-%20Recombinant%20Zoster%20Vaccine%2C%20rZV%20Shingrix%20v2.pdf)
2. Shingrix info page https://www.immune.org.nz/vaccines/available-vaccines/shingrix
3. Pre-vaccination screening tool https://www.immune.org.nz/sites/default/files/resources/Written%20Resources/Pre-vaccination%20screening%20tool%20general%20including%20live%20vaccines%20%E2%80%93%20health%20professional%202021%20Final.pdf

We recommend referring to the Data Safety sheet (GSK, 2022) and the Immunisation Handbook (MOH, 2020) before administering a new vaccine so you know it is safe for your client. If you have any clinical queries around Shingrix® please contact our friendly advisors on 0800 IMMUNE (466 863).

References

Bhavsar, A., Lonnet, G., Wang, C., et al. (2022). Increased Risk of Herpes Zoster in Adults ≥50 Years Old Diagnosed With COVID-19 in the United States, *Open Forum Infectious Diseases*, Volume 9, Issue 5, May 2022, ofac118, https://doi.org/10.1093/ofid/ofac118

Boutry, C., Hastie, A., Diez-Domingo, J., et al. (2021). The adjuvanted recombinant zoster vaccine confers long-term protection against herpes zoster: Interim results of an extension study of the pivotal phase III clinical trials (ZOE-50 and ZOE-70). Clinical Infectious Diseases, 2021.

Cadogan, S. L., Mindell, J. S., Breuer, J., Hayward, A., & Warren-Gash, C. (2022). Prevalence of and factors associated with herpes zoster in England: a cross-sectional analysis of the Health Survey for England. *BMC infectious diseases*, *22*(1), 513

https://doi.org/10.1186/s12879-022-07479-z

CDC. (2020). *Shingles (Herpes zoster) Clinical Overview*. Centers for Disease Control and Prevention. https://www.cdc.gov/shingles/hcp/clinical-overview.html

Cunningham, A., Lal, H., Kovac, M et al. (2016). Efficacy of the herpes zoster subunit vaccine in adults 70 years of age or older. New England Journal of Medicine, 2016. 375(11): p. 1019-32.

Fiore, J., Co-van der Mee, M. M., Maldonado, A., Glasser, L., & Watson, P. (2021). Safety and reactogenicity of the adjuvanted recombinant zoster vaccine: experience from clinical trials and post-marketing surveillance. *Therapeutic advances in vaccines and immunotherapy*, *9*, 25151355211057479. https://doi.org/10.1177/25151355211057479

GSK. (2022). SHINGRIX New Zealand Data Sheet. GlaskoSmithKline. https://www.medsafe.govt.nz/profs/datasheet/s/shingrixinj.pdf

Ministry of Health. (2020). *Immunisation Handbook 2020*. Wellington: Ministry of Health.

Cancer Society Supportive Care Services

By Hiliary Graham-Smith – Supportive Care Contractor – Waikato/Bay of Plenty Cancer Society

The Cancer Society delivers valued and key support for people experiencing cancer and their whānau across Aotearoa. This article is an introduction to our supportive care service. It describes what we currently offer and makes mention of our new Model of Care where we hope to grow and expand our service by collaborating with other providers to enable equity of access and consistency in availability of services.

New Zealand has a growing and aging population and a consequence of that is an increase in the incidence of cancer. In addition, thanks to improvements in treatment, people are living longer with and beyond cancer. Each year, approximately 25,000 people are diagnosed with cancer in Aotearoa and almost 3,000 of those are Māori, who are twenty percent more likely to develop cancer and twice as likely to die from cancer (The State of Cancer in New Zealand 2020, p6). The number of new cancer diagnoses in New Zealand is expected to double by 2040 (MoH, 2019). While this places significant demand on cancer services across the continuum – diagnostic, surgical, radiation, chemotherapy, it also impacts those services outside of what is traditionally seen as treatment i.e., community based supportive care.

The Cancer Society supportive care service provides navigation, advocacy and practical support to people who are diagnosed with cancer and their whānau. The Cancer Society has identified this service as a unique point of difference from other cancer services in Aotearoa as it covers all cancers, and access to various types of support is available from the start of the journey with cancer, through diagnosis and treatment and on into survivorship.

The components of care the Cancer Society provides align well with evidence of what effective support should include. The evidence points to a range of components that make up effective support including financial support and emotional support, as well as support with relationships, self-worth, fatigue, coping skills and psychosocial issues.

Our experienced health professionals including registered nurses, social workers and counsellors / psychologists make up the supportive care teams who will meet with those experiencing cancer either face to face or via Zoom.

They support individuals experiencing cancer and their whānau by

- creating opportunities to discuss each person's situation and that of their whānau, as they face a period of change and uncertainty
- providing information/education, support and guidance on things like medication side effects and impacts, and assistance with communicating with the others involved in their care.
- walking alongside the whole whānau in providing time to listen and to ensure they have the things they need in their kete to enable them to harness their own strengths and resources
- assisting clients to navigate their cancer experience by working with other providers to make the journey as smooth as possible
- convening support groups where people can talk about their journey, learn from others on a similar path and find comfort in what can sometimes feel like a lonely space

At a practical level we offer: (these are not all available everywhere at this stage)

- counselling,
- transportation,
- accommodation while undergoing treatment away from home,
- information and guidance on where to get access to other forms of practical support
- meals and
- massage therapy.

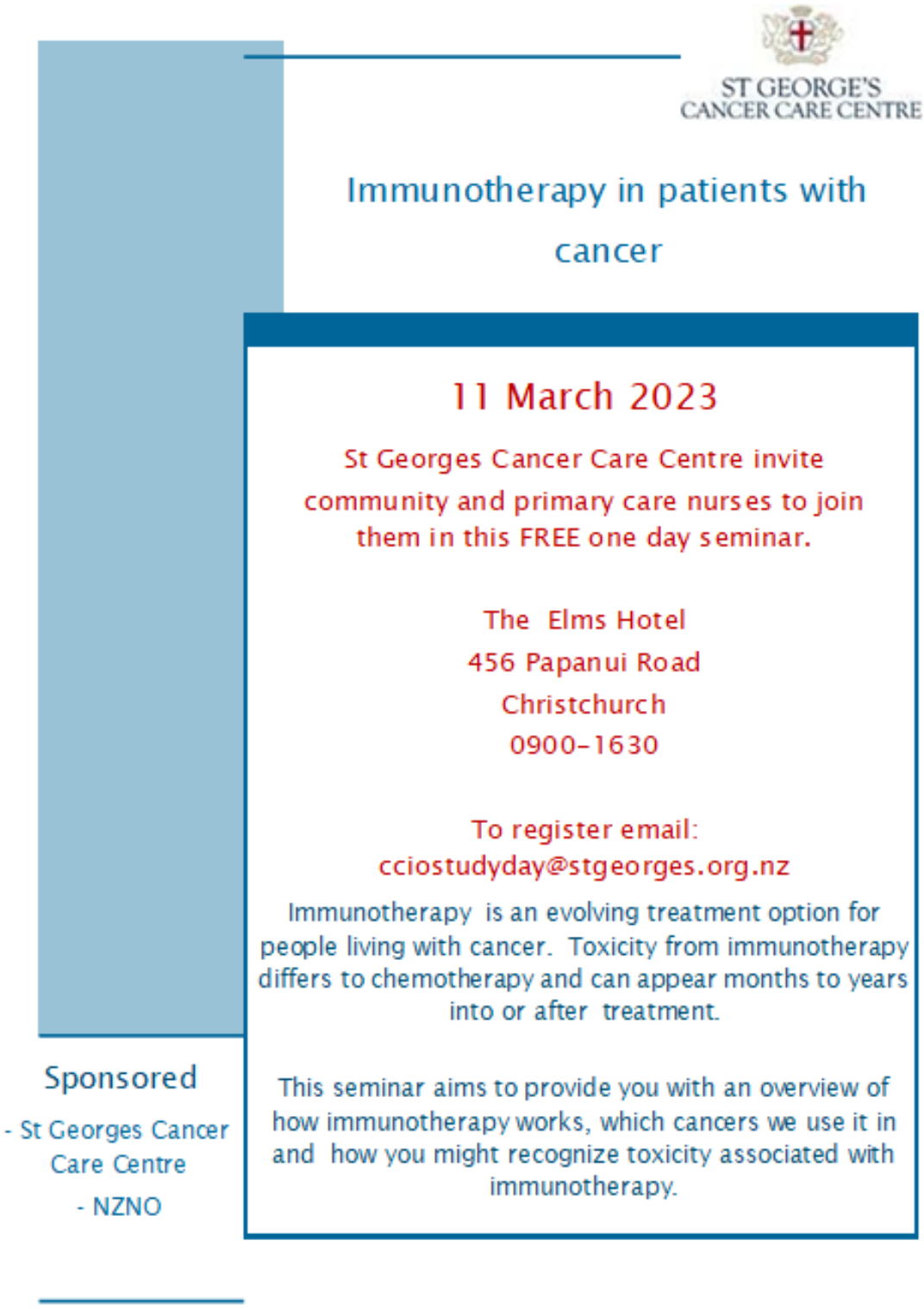
We are well supported by an amazing, trained volunteer workforce in delivering some of these forms of support.

The Cancer Society has recently undertaken research into how we might grow the reach of our supportive care services and in doing that achieve more equitable availability and access. At present not all services are available everywhere, so we are working on identifying the services that are most valued by our clients and developing a new Model of Care that offers multiple entry points, choices to support self-care and offerings that support the whole whānau. We also want to partner with a range of providers, in particular Māori/Iwi and Pasifika service providers to ensure clients have access to the most appropriate care for them.

We are not quite there yet so more of that story in the next article.

In the interim, if you have a patient you think could benefit from our supportive care service give us a call on our **Cancer Information Helpline 0800 226 237**

SAVE THE DATE: IMMUNOTHERAPY AND CANCER



Nicky Cooper RN/MN
Public Health Nurse/Hauora
Tūmatanui Nēhi – First 1000 days Practitioner & Hepatitis C Community Services

Hei Pa Harakeke – Te Whatu Ora - Nelson Marlborough

Supporting families to give babies the best start to life

Hei pa Harakeke is a programme designed to support pēpi, and their whānau, in the first 1000 days of their life (from conception through the first few years of life). The focus of the support is based on building **strong infant-parent relationships**.

Stepped care model

The Hei Pa Harakeke rōpū is made up of kaimahi from multiple organisations across Te Tauihu. Using a stepped care model as the foundation, support is individualised to meet the needs of pēpi and their whānau. The support centers on **therapeutic intervention** for the **parent-infant relationship**. Each multi-disciplinary team (MDT) meet fortnightly to contribute their knowledge and care to the support for each whānau.

Connected professional network

A strength of the Hei Pa Harakeke is the connections and mātauranga of the professional network. Practitioners receive information and professional development in this area.

Why is the parent-infant relationship so important?

About Infant Mental Health

Brain architecture is built on the foundation established in infancy. Early experiences provide the blueprints for later relationships. Timely detection of infant mental health issues and effective early intervention can greatly improve a child's life trajectory by impacting development, relationships, mental health, and general health.

The key factor in the emotional wellbeing of an infant/pēpi aged 0 to 2 years is the presence of a stable, attuned primary caregiver (usually a parent). Absence of or disruption to this primary relationship is a common cause of infant mental health difficulties, which need to be considered in the context of the infant-caregiver dyad, and the wellbeing of the whole whānau. The infant is primed from birth to form relationships and will be actively using strategies to do so.

The parent may present with concerns about unsettled, distressed or abnormal infant behaviours, developmental concerns, or their own mental health worries. Without treatment, a high proportion of mental health disorders in

infancy and the pre-school years persist into childhood, adolescence, and adulthood.

Who is eligible?

The Hei Pa Harakeke service is for any hapū wāhine or whānau with tamariki who are in their first 1000 days of life (from conception to two years old) who will benefit from therapeutic support with their parent-infant relationship.

The current locality areas have been rolled out in the Motueka, Wairau and Victory regions of Nelson/Tasman. Whānau must consent to be being part of this rōpū.

Whānau who typically benefit from the rōpū meet the following criteria:

- The mental health of the infant is compromised or at risk of being compromised;
- The presentation is severe and/or complex in nature, with the infant and their family experiencing an accumulation of risk factors and associated distress;
- The parent-infant relationship is disrupted or at risk of being disrupted, placing the social, emotional and other developmental wellbeing of the infant at risk;
- The infant resides in one of the three locality areas and lives for the majority of the time with their primary caregiver who has capacity to, and will, engage in the intervention

How they refer

Practitioners who have access to ERMS can refer by completing the referral form or by emailing the Locality Care Coordinator with the referral information (Name of parent(/s), name of pēpi, NHI and reason for referral).

Hei Pa Harakeke Team

Early Intervention Public Health Nurses

Early Intervention Public Health Nurses deliver a therapeutic parent-infant relationship service. They also have a key focus on the teaching of our workforce, including professional groups and whānau, through facilitation of both formal and informal learning opportunities

Locality Care Coordinators

Locality Care Coordinators (LCCs) facilitate the MDTs and ensure that information is followed up upon to ensure strong coordinated care. LCCs can also organise and facilitate individual MDTs for whānau outside the Hei Pa Harakeke rōpū.

Community Wrap-around Services

Community services such as Family Start and Whānau Āwhina Plunket provide wrap-around support and parenting help for whānau.

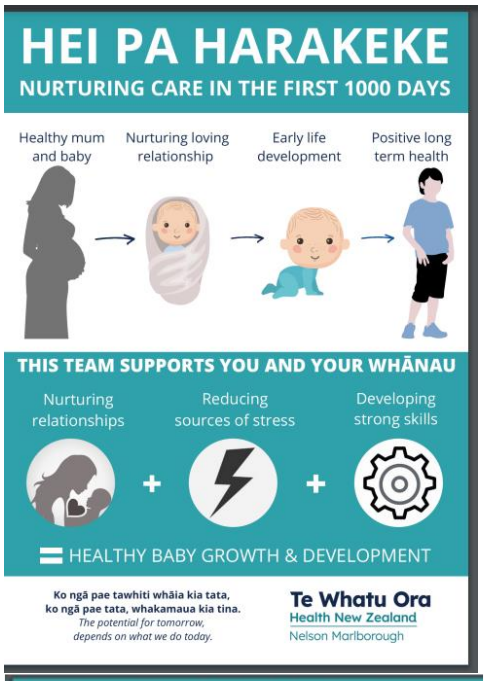
Kaupapa Māori Services

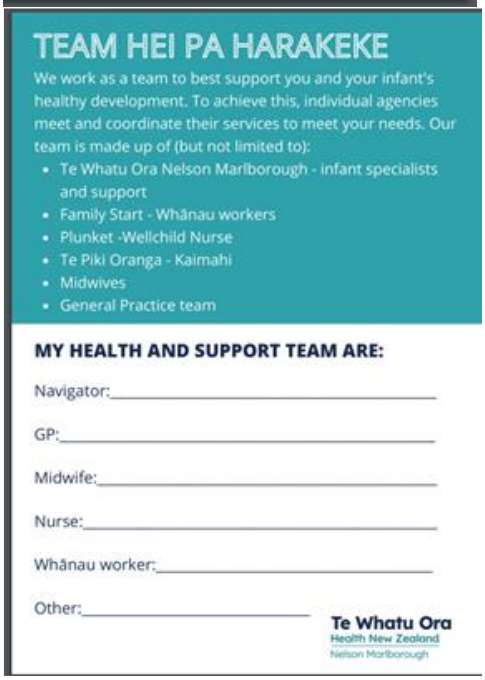
Kaupapa Māori services, such as Te Piki Oranga, Te Korowai Trust and Maataa Waka provide holistic support to whānau.

iCAMHS

Medical professionals

Medical professionals such as General Practitioners (GPs), Paediatricians and Midwives.





Rural Muster

By Katie Inker – Nurse Practitioner (First published in New Zealand Doctor and reprinted here with permission)

Should I stay or should I go?

That is the question that many a rural person seriously has to consider if their health begins to fail them. And, if your entire life has been lived in a rural space where you feel connected in body, mind and spirit to the land and community around you, then why should the tortuous dilemma of whether to stay put in the place you love, or leave in the hope of surrounding yourself with better, faster health service, even have to occur? In my opinion, for those who live and love their rural lives, relocation to an urban setting can impede mental wellness.

Why would this be? To many, rural living conjures up a slower paced, quality of life image, a sense of community, closeness to fresh air and nature, co-operation, higher degrees of self-management and reciprocity. When compared to urban living, perceptions seem to allude to increased density, pace, anonymity, and individualism instead. Whilst both pros and cons could be gleaned from either perspective, the struggle for a rural person with physical health issues becomes a nightmare reality once a health lens is introduced.

If a “move to a town” or city IS actioned for the purpose of receiving better, faster assistance for physical health issue(s), the contrast from one loved, known, familiar lifestyle to another unfamiliar one brings a “culture shock” that cannot be prepared for. Culture shock that creates stress, anxiety, depression, loneliness, fear, even regret. A downward, spiraling decline of mindset that invariably aggravates any physical health issue and in addition, worsens mental health. Many of us have witnessed an elderly person decline once their loved and known home space has been forfeited.

Perhaps, healthcare should work towards keeping rural patients in their own homes and communities to keep their mental, and therefore physical health intact.

World Health Organisation (WHO) suggests that three major factors influence health care in rural settings. The first is communication – rural voices certainly need advocates, a familiar, trusted someone they can rely on to join their complicated health care dots and navigate them to the correct spaces. Trust is a valued aspect of rural nursing. Increasing telehealth does not always suit rural communities who have scrapped their landlines and have cellphones with capped data, poor Wi-Fi reception and work schedules that do not always fit with conventional 9- 5 town services etcetera.

The second factor WHO suggests impedes rural health and communities is “goods and service delivery.” With healthcare currently so siloed, rural patients often receive invites for multiple, individual appointments with multiple individual practitioners which of course, is not favourable if you happen to live rurally.

For example, it may require multiple trips to town if you were a female with an injured knee, who also required a cervical smear, who happened to have diabetes and asthma with a wound on your leg. Topped off with a required Nurse Practitioner or GP review plus or minus a Specialist and perhaps collecting monthly medications from a pharmacy and then maybe a quick trip to the physio for that knee. Not considering monitoring blood tests/blood pressure/cardiovascular reviews etcetera. Easy to see when the weather is bad and fuel costs are high, with perhaps only one vehicle per household, that siloed healthcare suddenly becomes too difficult to manage. Easy to understand when considering current service delivery, why rural patients with increasing health issues become forced to consider upheaving and relocating to urban environments.

WHO’s third influencing factor that restricts rural health, is stated to be workforce. Our current global pandemic has of course amplified gaps in workforce and pushed services to breaking point. It must be difficult from a business model lens to provide service to just one rural person/whānau within a given time period, when five or six town visits may occur within the same time frame. Having said that, town services are struggling too and cannot even deliver urban service locally without disruption and continual rejigging. So, to disrupt and uplift an entire life and relocate to an urban setting merely in the hope that improved access and service may be at your fingertips is an illusion in our current environment.

It seems that the grass is not greener, that considering relocating to an urban setting may not in fact be the answer for physical

ailments that require attention. Certainly, if one's mental health is to remain a priority.

A potential solution would be increased funding from Government to support nurses, nurse practitioners and innovative service delivery that is multidisciplinary and accessible. Continued attempts by government to address WHO's communication, goods and service delivery, and workforce issues recommendations is vital. A review of overseas models shows that where communities can be trained/supported/paid to care for their own people, then relocation and leaving behind everything that a rural person loves, never has to become a consideration. How perfect would it be for rural persons to receive health care in the place that keeps them well, in the place they love best.

Climate Change

By: Michael Brenndorfer – Youth Health Nurse Specialist/Nurse Practitioner Intern – Te Puna Manawa HealthWEST (First published in New Zealand Doctor and reprinted here with permission)

Despite the ongoing response to the global health crisis that is the COVID-19 pandemic climate change remains the greatest threat to human health (WHO, 2021). Within the next ten years we will likely see an additional 250,000 deaths per year as a consequence of climate change related health issues. Even right now we are seeing the health impacts of climate change in our communities, as increasingly frequent severe weather patterns result in tornadoes, disruptions to our food production, worsening of mouldy and unhealthy housing, and increasing mental health distress of young people. Change is required at every level of human society in order to mitigate further carbon emissions and to adapt to the degree of global warming that is already inevitable.

Our health care systems must be part of this response to adaptation and mitigation, as we prepare to respond to climate change-related health issues to increase, and as we redesign, rethink, and reprioritise our health care delivery to reduce the carbon emissions our industry contributes to. Primary health care has the potential to play a vitally important role in this, as the prioritisation of primary health care can reduce the overall carbon emissions of the rest of the health care system.

The nature of secondary and tertiary health care services inherently results in significant carbon emissions and contributions to climate change. This occurs for multiple reasons.

Nearly two-thirds of the carbon emissions produced by District Health Boards (DHBs) are a result of energy usage, including coal burning at two DHBs in particular, specifically for the temperature control of large hospitals and buildings (Geesink, 2021). Along with this is the significant climate impact of medical gasses used for

anaesthesia and pain management, including nitrous oxide, which are hard to avoid when surgical interventions are required. Consumables used throughout secondary and tertiary services are perhaps the most significant factors in terms of climate change contribution, due both to the carbon emissions associated with the production of single-use, plastic-wrapped items, but also the transport of this goods from their overseas points of production (Lomax, 2021). A well-funded and designed primary health care system, delivered with an equity focus, could assist the tertiary and secondary services in reducing their carbon emissions through preventative measures that reduce need for increased hospital energy consumption and single-use consumables.

The centralisation of specialist services contributes to patient transportation needs that not only acts as a significant barrier to accessing essential health care services, but also results in avoidable carbon emissions produced by private motor vehicles (Geesink, 2021). Previous studies have indicated that specialist services provided within community-based primary care centres reduced wait times and produced higher patient satisfaction when compared to centralised specialist services visits (van Hoof et al., 2019). By providing specialist-level support within primary health care services that are located directly within the communities that patients live in avoidable carbon emissions from unnecessary patient travel can be avoided while producing better clinical outcomes.

As the health impacts of climate change become more evident it will be increasingly vital for primary health care clinicians to add their voice to the calls for a health-focused approach to mitigation and adaptation. We add the valuable perspective of observing the health impacts of climate change first hand throughout our clinical work, and as highly respected members of our communities we hold positions of potentially significant influence when we chose to utilise it. In so doing we can also add weight to our advocacy for a better funded primary health care system by identifying the important role our work will play in reducing the carbon emissions produced across the health sector and the additional work we face as we support our communities in managing the negative health impacts of climate change. Through health education we can also support communities in adapting healthy, climate friendly lifestyle changes, such as increasing active transport where possible and moving towards more plant-based, heart health diets that are coincidentally lower in their carbon foot prints. Primary health care plays an important role in responding to climate change, and it is important that we recognise that and ensure the government also acknowledges this contribution.

A conversation with Anne Hodren WCTO Nurse and Doctoral student about her work and Doctoral research

By Jess Beauchamp – Plunket Whānau āwhina

Anne Hodren – WCTO Nurse

***Jess* (LOGIC):** Hello Anne! Thank you for giving us this time for a chat about your study. I am really interested in it and thought LOGIC readers would be too. First though, tell me about you.

Anne: I am a registered nurse and have been working in community child health practice for 30 plus years. I am a mum of two adult children, a partner and dog mum of two. I have a significant passion for infant and maternal mental health, relational practice, and the nurses place in that relationship.

Tell me about your 30 plus years in nursing, has that all been in primary care?

Anne: I started as a new graduate in paediatrics in Lower Hutt Hospital, then in neonates in Christchurch. I did a bit of adult nursing but decided that working in community child health was my passion. I saw an ad in Kaitiaki for WCTO training, so I took that up and have been working in this scope ever since.

Now 30 years on, with a wealth of knowledge and experience in WCTO nursing, what has evolved to be your particular area of interest?

Anne: Relationships, the whānau and their child's relationship and the relationship between the nurse and the whanau. And wondering about the effectiveness of our relationships?

What do you think sparked your interest in relationships?

Anne: Around 2015 in my role as an Educator in Plunket, I heard a Clinical Psychologist talk about the parent child relationship and the lifelong impact of secure and insecure attachment. She talked about enhancing the capacity of whānau to notice what is happening in their relationship with their child. She talked about secure relationships and attunement with their child including rupture and repair moments. This led me to not to just wonder about the whānau child relationship but also the nurses' relationships with whānau including what we notice when the relationship is not attuned and if and how we repair this.

Fascinating and complex! And foundational for any person working with families and children. You already have a master's degree so what made you want to do your Doctorate?

Anne: I had an opportunity to do the FAN (Facilitated Attuned Interactions) training. This is a relational model that is a reflective model to support the nurse to be attuned to where the client is and also to be attuned to herself. This training made me

think how we could be more whānau lead rather than nurse lead in our WCTO visits. The FAN has the capacity to do that. I wanted to look at the FAN model in depth in my research but because the model is only just beginning to be shared in New Zealand that would be tricky.

So, I decided to explore community child health nurses' relationship with whānau particularly if the nurse is in a stressed state or walks into a stressed environment. The first wedge of the FAN (it has five) is for the nurse. It focuses on the need for the nurse to calm themselves as a critical part of the engagement. There is growing research on neuroscience, stress, and mindfulness in capacity to calm. But there is very little research on nurses' ability to regulate ourselves especially when working with parents who are stressed and dysregulated themselves.

Sounds like a very integrated approach to nursing practice. Maybe we have not been strong in that way previously?

Anne: The study is a qualitative exploration of community child health nurses' capacity for self-regulation and being in relationship with whānau in a stressful situation. The key is not about bringing stress into the relationship as there will be stress for the nurse, she might be busy, have just had a difficult conversation prior, but it is about being in the moment with that whanau stress. It might be perceived stress, the nurses stress in the moment or, stress for the whanau. My interest is the nurses stress, how does it impact in that environment, at that moment and from the nurse's perspective.

Anne's actual project title: Self-regulation and attunement in times of stress: A qualitative exploration of child health nurses experience and perspective of stress, self-regulation, and attunement with whānau.

I'm using Sally Thorns interpretive description as my methodology. Interpretive description comes from a nursing philosophical basis, to wonder what is happening and then, rather than coming from a theoretical model or preconceived theory, this methodology acknowledges the messiness of nursing and the complexity and the researchers positioning.

My research is in two parts. First part is a questionnaire with two simple vignettes to read and explore what the nurse might notice about themselves, about the family and the child in that situation. They are simple stories to reflect on.

The second part is a one-on-one interview, but participants can do just do the first part or opt to do both

Noticing comes into clinical judgement nursing models like Tanner. I'm wondering has much been done about this topic.

Anne: None in New Zealand and that is why I'm interested. There is a little internationally and in New Zealand with midwives, A and E and with psychologists. A bit done with nurses and their own experience of Adverse Childhood experiences (ACEs). But none on the topic I'm exploring for community child health nursing. Nobody has studied what happens to the nurse and whānau in a stressful situation, the nurse's capacity to

notice and the impacts on the infant parent relationship.

Are you exploring from the whānau perspective as well?

Anne: No. My research focus is completely on the nurse in that stressed situation and what the nurse notices about themselves and how they feel that impacts on the relationship

Run us through a typical study day for you so that we can understand what it is like to do a Doctorate and work full time

Anne: I'm a great procrastinator! I have big study hiatus's, things happen like my daughter's wedding, and Covid. And there is no study in those times.

For me I need to have dedicated time and knuckle down. Also, to be flexible to glitches in the process like changes in my proposal and needing three attempts with my ethics application.

I'm learning to go with the flow. Accepting the process will not be perfect. Rupture and repair, ups and downs. I have a couple of close student colleagues and two great supervisors. I try to use everything that AUT offers to motivate me and guide my way. People study in different ways, so not to be competitive with others process or progress.

As a doctoral student I must be in practice, so working as a National Educator for Plunket is an essential part of my process. I tend to be an evening and weekend studier so as not to disrupt work, but they can clash if I have to do extra for work, but I have to put boundaries on both.

Having the end goal in mind helps me stay focused and not overwhelmed. Right now, I'm working on my methodology chapter cos If I thought about the whole thing I'd freak out! I need to compartmentalise and go step by step. And I'm learning to celebrate the steps and small achievements. If I stopped now and didn't complete, I would have learnt so much anyway. Sometimes that is what motivates me to keep going, the next discovery (hopefully not the next hurdle)!

Thanks Anne and when do you hope to complete?

Anne: by the end of 2023. That is three and a half years in total. Got a bit of an extension cos of Covid.

Ok last questions. What has really challenged you about your study? Just choose one thing!

Anne: The hiccoughs along the way. I thought the process would be more linear, having to go back to ethics, and the process around that put in delays. And getting participants, you hope everyone will be as passionate about your study as you are and really want to help but that has been a bit of a struggle. It seems to have taken a long time to get to the doing/interviewing part, which I think could be the most exciting bit, talking with nurses and hearing their stories. Then the interpretive analysis will be exciting. I know it will be messy and challenging as I work through making meaning of what nurses have shared.

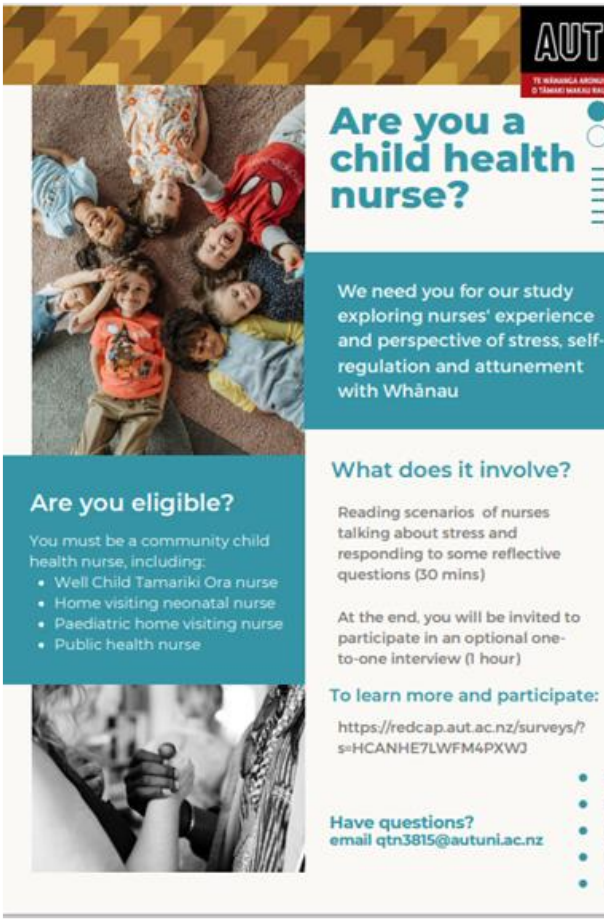
What has been a joy about your research so far?

Anne: My study timing has coincided with the explosion in neuroscience, and the application of that knowledge to nursing practice is mind blowingly exciting.

Last question Anne. Where are you currently in your Doctoral study process and how can we help?

Anne: Getting nurse participants! I need about 30 for the questions and around 12 for the interview. If you want to know more, please have a look at my study flyer and click on the study information link. The first part, the vignettes take about 20-30 mins. When they are completed, there is an opportunity to do the one-on-one interview. I would really appreciate more participants who are community child health nurses to take part.

Jess: Thank you Anne and very best wishes. Please come back to us with an update, though no doubt we will hear you at a conference, in a podcast, or on the radio in the future!



ACC changes – Maternal Birth Injuries

The following links have been provided by Diana Macdonald, Health Partner ACC. These are a good resource to have on hand. We were fortunate to have her present to our committees at our October meeting.

https://www.acc.co.nz/for-providers/maternal-birth-injuries/

https://www.acc.co.nz/for-providers/maternal-birth-injuries/specific-changes-for-providers/

https://www.acc.co.nz/for-providers/maternal-birth-injuries/how-to-provide-maternal-birth-injury-services/

https://www.acc.co.nz/im-injured/what-we-cover/cover-for-maternal-birth-injuries/