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

SUMMER 2023

He Ako Hiringa
Nurse Prescriber
Immunisations
Ascribe App
Reflection article

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

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Summer 2023

In this issue…

Chair's Report

Tracey Morgan
Chair

As we draw to a close for another year and head into the festive activities, I would like to take this time to thank the Executive Committee and members for the ever ongoing work you have all given to ensure we are all heading in the same direction. Thank you to NZNO staff who continually support our Primary Health. And of course, all our members who continue to work tirelessly for the good of all our patients/clients/whaimua/members.

It is only fitting we wrap the year and reflect back on the year that was:

- **Constitution Review**: This piece of work within NZNO has been worked on and another discussion on where this sits currently will be provided again for the next phase of completion.
- **General Practitioner Leadership Forum:** In collaboration with Royal College of GPs, Hauora Taiwhenua, GenPro, PMANZ, GPNZ and CPHCN NZNO letters have been sent to Minister Verall addressing the pay parity gap and the need for 95% parity.
- **School Based Immunisation Programme Survey (SBIP)**: A Survey was sent out to look at the Immunisation within the schools.
- **Medsafe:** Regulatory guidance on Controlled Drug Classification.
- **Advanced Diabetes Management Course:** This course run by NZSSD and University of Waikato
- **Pharmac:** Continually promoting and updating changes within their Sector which is always reassuring and helping us all stay current within our Practice.
- **HPV:** This Self Swab self screening test rolled out in September 2023 to ensure the delivery of a clinically safe, ethical and equitable HPV Primary Screening Programme, has received positive feedback with some minor obstacles continuing to be ironed out.

At a face-to-face meeting with the National Executive Committee and Interim National Chief Nurse Emma Hickson, Emma stated "now is the time for Nurses to stand even stronger and ensure our voice is heard". Chief Nurse for Te Aka Whaiora Nadine Gray reiterated Primary Health Care is in a prime position for making strong leaders and change for Nurses. The time is now, and we must always remember if we are not on the menu we are not at the table. As per Maranga Mai Campaign 'every nurse everywhere'.

The members of National Executive Committee represent the College members on many external working groups and at times members are called upon to represent as well. These representatives act in the best interest of NZCPHCN and communicate back to the Committee as required; provide reports as identified by NZCPHCN Chair of participation and progress; provide overview of external

groups represented. As well as the Executive Committee the sub–Committees PPC and Logic continue to work hard to ensure members voices are being heard and addressed.

PAY PARITY

As most will be aware there has been lots of ongoing discussion pertaining to Pay Parity.

As a part of the General Practitioners Leadership Forum collaboratively we are working to address this with the Minister and letters have been sent pertaining to these requests addressing the inequities faced with in Primary Health. For General Practices they primarily were Primary Care but with the wider community it is Primary Health Care.

GPLF (General Practitioners Leadership Forum)

Current discussions and areas of advocacy that we are working on together are pay equity for primary care nurses, contracted provider representation at contract negotiations, and review of capitation funding. NZNO is leading the work on pay equity for nursing, and we are following up on the timing of the meeting on the capitation review.

Further progress was made in establishing and agreeing a mechanism to all Contracted Providers to select their own agents at PSAAP. We're continuing to work together towards this, with the aim of reconvening PSAAP. We anticipate that the next steps will be completed over the coming weeks and will announce the position then. Any future contract negotiating process needs to have the same rights and responsibilities for all parties and if we can get this right now it will stand us in good stead for the future.

Abbe Anderson, Head of Commissioning at Te Whatu Ora, and Andy Inder who is working on the primary care data set met with GPLF. We spoke about the 'survival' rather than sustainability of general practice, the expected reach of the rural telehealth service, the role out of comprehensive care teams, and integration between community and hospital services. We also touched on urgent care services and the struggles in this area as well, recognising that they are very different across the motu.

The GP Leaders Forum continues to work together to advance health services delivered by general practice in the community.

I want to take this time to send a huge thank you to the Executive Committee and NZNO staff throughout this year for their support.

Meri Kirihimete me te Tau Hou

Nga Mihi

Tracey Morgan
Chair

Editors Report

Yvonne Little
Editor

Welcome to the Summer Edition of LOGIC. Well at least it is supposed to be Summer, but I think we are all starting to wonder if it is actually going to arrive, what with the never-ending rain and now snow forecast – those of us with Scottish or English Heritage could be forgiven for thinking we had done some time travel back to where our ancestors came from.

Well, here we are, another year coming to an end, and I don't suspect that there will be too many of us who will be glad to see the back of 2023 with all the events that have been occurring: weather related events such as flooding and let's not forget Cyclone Gabrielle who dropped in and caused (and is still causing) headaches in certain regions of Aotearoa. Our thoughts go out to those still being affected and wish them a much-improved year in 2024.

You will have seen in the Chair's Report about what has been happening around pay parity – yet again another never-ending saga – but we need to be strong and stand together to make sure that ALL nurses get a fair deal, not just some.

We have had some changes in the cervical screening arena, and this has been a moving feast with a lot of work done by some very experienced and dedicated team members on the National Cervical Screening Advisory and Action Group (NCSPAAG) and the National Screening Unit (NSU). I have had the privilege of being the college representative on the NCSPAAG for several years now and this past 12 months has been the most intense with so many changes being made and trying to ensure that wāhine are at the front of these changes. We are still trying to get free screening for ALL, (like breast screening and bowel screening) but this may still take some time (getting money from the government is always fun).

We have heard many positive experiences around the new self-test but there are still some things being worked out – as with all new ventures, not everything goes smoothly. Please feel free to contact me if you have issues around the new programme as I am one of the voices for Primary Health Care on this group, we also have General Practitioners and our lovely Support to Screening colleagues.

As Editor of LOGIC, I would value any articles around the rollout and how things are going around the Motu to be published in our journal in the New Year.

Whilst the launches done in September went well, in the background we needed to revisit some issues around the guidelines. The members of the NCSPAAG went onto some smaller and more specific groups to help with streamlining and improving: The Notifications Strategy Group and The Clinical Guidelines Group, this latter group have worked to improve an updated document which will come out with more concise algorithms (rather than those large and confusing ones we are currently looking at) to make life easier for clinicians. The plan is to have the guidelines as an online document with links, therefore making it a smaller document to read but giving access to the information links if further information is needed.

Add to the above changes we have had a change in government, let us hope that the hard mahi we have put in to make changes happen do not get disrupted by this change in government.

I would like to say a big Thank You to the NZCPCHN team for all the hard work done over the past year, many of us have had personal and whanau related issues to deal with but have managed to soldier on and keep the College going. We value our members and want to be able to provide you with the support and education you need.

We have had some resignations due to the above issues, but we have also welcomed on board some new members which is fantastic. If anyone is interested in finding out more about what being on the any of the NZCPHCN college committees entails, then please contact one of the members (my email address and that of the publisher are provided here in the journal) but you can also contact us through our website or our Facebook page.

This issue is slightly smaller than our previous ones but that is due to the fact that Christmas is approaching rather quickly, and we need to get the journal out to you before NZNO close for the holidays and our administrator Sally Chapman goes on her well-deserved break.

In closing, I just want to wish everyone a safe and happy holiday season and I hope that many of you get some time off to spend with family and friends. To those who have to work over the holiday season I hope it is not too stressful. But either way I hope you get time to read some interesting and thought provoking articles we have for you in this issue.

We will be back in 2024, with some fantastic articles, I am sure. Also, please see the Save the Date Flyer for our AGM in March 2024, I will be putting updates on our Facebook page once we have secured our speaker and also the link for the AGM – we need as many of our members to join us, online if you cannot be present in Christchurch so that we have a quorum to be able to pass any remits or changes needed. But we would also like to see as many of you as possible that can make it to the meeting, we would like to network with you, our members.

Registered Nurse Prescribing in Community Health (RNPCH).

Marianne Grant. National Educator. Whānau Āwhina Plunket

Where are we now with Registered Nurse Prescribing in Community Health ?

This group of Registered Nurse prescribers have been in existence since 2019 – with 331 RNPCH registered with the Nursing Council (NCNZ) in June 2023, representative of 18.5% of nurses with prescribing rights in NZ. This compares with 214 RNPCH at the same time period in 2022 (NCNZ,2023a). Currently, this is the fastest growing group of nurse prescribers. Overall, 2.5% of all nurses with an APC have prescribing rights at the end of June 2023.
Recent consultation around this programme has seen some wording changes to the defined population and seven amendments to the Medicines list. A number of medicines were added, conditions and changed (NCNC, 2023b).

Who are RNPCH?
They are registered nurses practising in community health settings, who have completed a work-based education programme, successfully applied for prescribing authority for a limited number of medicines for minor ailments and illnesses in normally healthy people without significant comorbidities. Community health settings are schools, general practice, public health, well-child services, Maori and Pacific Health providers, services for youth, family planning, sexual health, district nursing, walk in clinics and other outpatient and home-based services.
The medicines they can prescribe from is a subset of the medicine list for approved RN Designated prescribers in Primary Health and Speciality Teams (NCNZ, 2023c) relevant to their practice setting. They use decision support tools, current best practice guidelines, and support from colleagues. The health conditions for this type of prescribing include common skin conditions such as simple eczema, impetigo, fungal infections and parasites, common aches and pain, ear infections, sore throats and rheumatic fever prophylaxis and ongoing treatment, common forms of contraception and the treatment of common sexually transmitted infections, urinary tract infections and constipation (NCNZ, 2023c).

What are the opportunities for RNPCH?
Currently community health services are experiencing increased demand, alongside a shortage of General Practitioners (GP's) which is impacting timely access to Primary Health Care (PHC), medication and treatment for people in need (Jeffreys, et al., 2022). Early access to PHC services is becoming a nationwide issue, with those living in high deprivation areas, ethnic minority and rural communities most impacted (EHINZ, 2022; Irurzun-Lopez et al., 2021). It is reported in the Growing Up in NZ Study that 4.7% of children aged 24-54 months experienced barriers to seeing a GP in the year to 24 months and 5.5% in the year to 54 months (Jeffreys, et al., 2022). At each age group the barriers to accessibly primary health care was more prevalent amongst Māori and Pacific compared to NZ European children.
The most common reason barrier to seeing a GP / nurse is the time taken to get an

appointment or care - 11.5% - 14% for adults and 7.6% for children. Approximately 10.7% of adults reported not seeing a GP due to cost, in the 12 months prior to the NZ Health Survey 2022 (HQSC,2022; Jatrana & Crampton, 2011; MOH,2022). For Maori the percentage wanting health care and unable to access is higher – 27%, for adults aged 15-44 years – 29% (HQSC,2022). More prescribers working in the community increases access and gives whānau more immediate access to needed medication, especially with current climate of New Zealanders unable to access primary health care in a timely manner [1].

Prescribing data

While nurse prescriptions only make up 3% of those issued in primary health care in 2020, the number of nurse prescriptions has increased by 68% in 2021(Stoddard, 2022). Twenty one percent of nurse prescriptions were for Māori, compared to 15% of those written by GPs; 30% of nurse prescriptions were written for people living in areas of high deprivation compared to 24% for GPs (Stoddard, 2022). An RN prescribing evaluation indicated that more patients were getting quick access to medications, which improved equity and improved health outcomes (McGinty et al., 2020; Stoddard, 2022).

Pathway to RNPCH

RNs must meet prerequisites , complete an education programme, and then apply to NZNC for Recertification as a RNPCH. The pathway consists of:

- A minimum of three years' clinical experience with at least one year in the area of practice they will be prescribing in .
- Completed a Nursing Council approved recertification programme for registered nurse prescribing in community health.
- Completed a period of supervised practice with a designated authorised prescriber (a medical practitioner or nurse practitioner) as part of the recertification programme.
- A limited list of medicines from which they can prescribe within their competence and area of practice, ongoing competence requirements for prescribing.
-

There are seven education programmes across New Zealand for RNPCH: Auckland Metro Region, Family Planning, Midlands Collaborative, MidCentral, Hawkes Bay, a combined Capital & Coast, Hutt Valley & Wairarapa DHB areas, and South Island Alliance. An RN prescribing RNPCH evaluation indicated that more patients were getting quick access to medications, which improved equity and improved health outcomes (McGinty et al., 2020; Stoddard, 2022).

Entry requirements for educational programme

- Minimum of 3 years clinical experience with at least 1 year in

[1] https://www.nzdoctor.co.nz/article/undoctored/access-family-doctor-services-reducing, https://www.stuff.co.nz/national/health/300755643/a-million-kiwis-each-year-are-struggling-to-see-their-doctor--ive-yet-to-meet-mine,https://www.nzherald.co.nz/nz/gp-crisis-about-half-nzs-clinics-not-taking-new-patients/JL26GBOIJOK5ULVMVSAJPGLATU/

area of practice they will be prescribing in
- Current APC
- Compliance with Standing Order requirements/ current use of Standing Orders / demonstration of assessment using best practice guidelines.
- Nurse is not subject to current performance review and management
- Current or / Assessed PDRP or employers own credentialing programme or equivalent
- Support from employer organisation

(The above are overall requirements – others may be present as per individual programme providers)

Educational Programme includes:

- Ko Awatea Online Modules
- Group learning sessions – These will vary according to provider e.g., virtual or face to face
- Clinical Practice component- Clinical supervision by **authorised prescriber (GP or NP)-** minimum of 12 hours (to include a Clinical learning log - learning needs and resources log, case review discussion log detailing assessment & prescribing decisions & covering clinical supervision sessions – minimum of 10 -12 case review discussions
- Two case studies demonstrating a cultural approach including Māori/Pasifika models of care, using assessment & diagnostic reasoning, clinical decision support tools, outlining a plan of care and treatment and evaluation with patient and whānau)
- Submission of portfolio to Programme for review and recommendation for recertification as Designated RNCPH
- Mentor is recommended.
- **Recertification should be completed within one year of commencement of course**

Ongoing requirements

- Minimum of 20 hours Prescribing Professional Development out of 60 hours over 3 yrs
- Prescribing practice – letter from Prescribing supervisor to confirm that have completed 40 days of Rx practice every year and maintained rx competence

Conclusion

Current inequities in the provision of primary health care in Aotearoa New Zealand offer continued opportunities for RNs to engage in the Registered Nurse Prescribing in Community Health pathway. Seven providers are offering the programme that leads to recertification as a RNPCH, ranging from one to three courses per year. Combined with a commitment from RNs this will contribute to removing barriers to timely access to care and treatment and increase health outcomes for a portion of our population currently missing out.

For more on RNPCH see this link: Nursing Council of New Zealand: Registered Nurse Prescribing in Community Health

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New resources

Menopause resource hub

Looking for information on menopause management? You can find it in our menopause resource hub.

We've linked resources from multiple providers into one place so it's easy for you to find what you need, including:

- clinical education resources
- guides, flowcharts and check sheets
- websites and papers
- national strategy and international position statements
- patient resources.

Go to tinyurl.com/menopause-hub to explore the hub

Eradicating Hepatitis C

Chronic hepatitis C is the leading indication for liver transplantation in Aotearoa and is responsible for more than 200 deaths annually, all of them preventable with earlier diagnosis and treatment.

Infection with hepatitis C often goes unnoticed with symptoms not appearing until serious liver damage occurs, often 20 or 30 years after the initial infection.

A short course of oral antivirals can cure hepatitis C, but the challenge lies in overcoming stigma and identifying those with chronic infection so they can be treated.

Go to tinyurl.com/HepC-eradication to learn more

Cold Chain – a key link in patient safety

By Jude Young – Immunisation Education Facilitator – Immunisation Advisory Centre (IMAC)

Cold chain continues to, and will always, be a vital link for vaccine validity and therefore the safety of our patients, yet it is often an area that is treated as an afterthought. However, not maintaining effective cold chain processes and practices can potentially lead to compromising your patients' health status.

The definition of cold chain is the process that ensures vaccines are continuously stored within their required temperature range from the place of manufacture to the point of administration (ie, your patient). Most vaccines at the provider level are stored in the +2°C to +8°C range.

All vaccinators have a professional responsibility to ensure the vaccines they are giving have been stored correctly and safely.
The essential components all vaccination providers must ensure are in place are:

- A designated cold chain lead (usually an authorised vaccinator or doctor) and at least one backup person.
- An up-to-date cold chain policy specific to YOUR clinic/service including what to do in the event of a cold chain breach. It should be detailed enough that anyone in the service can refer to it and follow what to do and when.
- ALL staff should be orientated to the cold chain for your service and have read, understood and signed your cold chain policy.
- A pharmaceutical fridge is used to store medicines and vaccines only (NO food or specimens).
- The fridge should be positioned in such a way that the door closes automatically.
- It needs to be connected to an independent power point that:
    - is power surge protected
    - has a notice which clearly states, 'Do not turn off or disconnect this refrigerator'.
    - has the power plug taped over to prevent accidental removal/dislodgement.
- **Two** types of monitoring systems are required - a digital temperature monitoring display (usually inbuilt on the fridge) and a second separate continuous data logging system (this can be datalogger or cloud-based).
- Daily min-max temperature readings must be taken (usually first thing in the morning BEFORE any vaccines are given) and documented on the temperature chart.
- Weekly downloads of the continuous monitoring data are needed to compare and look for any anomalies or identify any areas of concern.
- Co-ordinate with your stock management process, ensuring that the fridge is not overstocked (a

max of 6 weeks' supply and consider seasonal variation – eg, influenza vaccine stock).

- Vaccines are kept in their original packaging (to protect from light and thermal assault), boxes are stacked in columns (not blocks) away from the sides, back and floor of the fridge to allow optimum air circulation.
- It is important to rotate stock and check expiry dates, so those vaccines closest to expiry are used first.
- All vaccine boxes should be marked with date of arrival at the provider; and
- Always remove expired stock and return for destruction.

Despite the New Zealand *National Standards for Vaccine Storage and Transportation for Immunisation Providers 2017* being in place for many years and providing clear requirements for vaccine providers, we continue to see cold chain issues. While some are of course unavoidable (such as power cuts, weather events, fridge failure), others
are due to the above essential policies and procedures not
being in place and/or followed.

If there is a cold chain problem, refer to your policy on what to do and the steps to take. If your vaccines have been exposed to temperatures outside the +2°C to +8°C range, **QUARANTINE THE VACCINES at +2°C to +8°C until you can get advice from your immunisation/cold chain coordinator. Don't discard them without advice.**

When you have new staff or equipment, it is important to revisit your cold chain set-up and check in with all staff to safeguard your vaccines. A team meeting is an excellent opportunity to do this so

Cold chain breach: An event that has led to vaccines being stored or transported in temperatures outside the required +2°C to +8°C range, without compromising the potency or stability of the vaccines.
Cold chain excursion: An event that has led to the vaccines being stored or transported in temperatures outside the required +2°C to +8°C range and, as a result, vaccines are compromised and need to be returned for destruction.
Cold chain failure: An event in which vaccines involved in a cold chain excursion are administered to patients.

everyone in the practice knows their role, whether a nurse, doctor, or receptionist. Talk through issues such as what to do if the fridge alarms, where things are kept (like the chilly bin and ice packs in case of a power failure), and who will do the daily and weekly temperature checks while others are on leave. There is an excellent video on IMAC's website that covers all the key points that you can use as a discussion tool (https://www.immune.org.nz/vaccines/cold-chain).

If in doubt, please call your immunisation coordinator or refer to our IMAC website (https://www.immune.org.nz/vaccines/cold-chain) or ring our 0800 clinical support team (0800 466 863) who can provide some basic cold chain advice.

Remember, cold chain is a 'team sport' in which we all have a part to play, whether your position is on the field (authorised vaccinator, cold chain lead) or supporting from the sidelines (doctor, receptionist) to ensure the safe delivery of vaccines to our patients.

Reflection:

Marianne Grant

Reflection from the Child Population Health (NZCYES) Meeting, as part of the Paediatric Society of New Zealand 74th Annual Meeting on 7/11/2023 attended by a small group of interested Clinicians and researchers from across NZ. The meeting was convened by the Director of NCYES, Dr Mavis Duncanson.

The opening address was delivered online from the new Mana Mokopuna (Children & Young Peoples Commission), Chief Children's Commissioner Dr Clare Achmad – congratulating on the conference and setting out some of the direction of her role (having been only in the role six days) and engagement with the NZ Paediatric Society. Of note some of the factors that she seeks to attend to include the effects of housing, health , racism, discrimination and poverty for mokopuna and their whānau in Aotearoa New Zealand. For more see - https://www.manamokopuna.org.nz

Topics for the meeting included:

An update on the NZ Child & Youth Epidemiology Service – based at Otago University. NZCYES are known for a range of reports that they generate annually around child and youth health, often highlighting disparities in health outcomes and inequities in service provision. https://www.otago.ac.nz/nzcyes. The most recent reports published consider Children and young people with chronic health conditions in Aotearoa (2022). This 2022 report focuses on children and young people with long-term health conditions. Some of these conditions are present at birth, and others develop during childhood and adolescence. Once diagnosed, the conditions may be ongoing, long term, or recurrent. Children with these conditions usually require lifelong health care and may experience limitations in day-to-day activities and interrupted education. In addition, management of the conditions can impact on whānau wellbeing**.** These conditions are: Cystic fibrosis, Diabetes, Cerebral palsy, Epilepsy, Bronchiectasis (non-cystic fibrosis) and Inflammatory bowel disease. The Reports are available for NZ overall as well as discrete regions and areas. The presentation of some of the aspects of this report sparked a range of

comments, questions which indicates possibly some of the stories, as well as different systems and processes behind the numbers across the different Te Whatu Ora hospitals and outpatients' services.

Development of an Interactive Data Platform at NZCYES. The service is moving away from annual reports to more client requirements, issue specific data and local trends. Most of the data they work with is from Statistics NZ, NMDS, MOH and PMS. The platform is planned to be functional in 2024. Watch this space!

Northern Region - use of data at a local level. This group of clinicians and researchers are looking at the effects of the longer periods of 'lockdowns' experienced in the Northern region on children and youth. The data has shown a range of themes – mental health distress, missing in- person school, learning stress, loneliness – missing friends, missing parent engagement (parents busy working from home), as well as access to oral health, immunisation, health & development screening . Post a literature review and further data analysis , there is a " Road Map for Recovery "with a range of priority areas including:

1. Increasing access to primary mental health care in education setting
2. Consider health issues for young people in alternate education setting or not engaged in education or work – what are the barriers to access?
3. Improve primary health care utilisation – keep young people engaged thru adolescence.
4. Oral health improvement is part of the Northern Region Oral Healht Action Plan
5. Immunisation – Covered in the Northern Region Immunisation Action Plan

The group are keeping children and young people "on the agenda" linked across the Northern Region with the Northern Region Well Being Plan and viewing success with ongoing data analysis

The new structure and role of the **National Mortality Review Committee** was presented by Liza Edmonds Chair of the Committee formed in July 2023. Changes have been made across the current mortality review committees to one overall committee with subject matter experts. In Liza's words "is the current system meeting whanau needs, seeking preventable mortality when – 50 % of Maori are dying prematurely ? A number of recommendations are being made but only 50% of these are taken up – change is required for long term health and well-being." The subject matter expert workstreams are – child & youth mortality review (28 days to 24 years), perinatal and maternal mortality review, family violence death review, perioperative mortality review and suicide mortality. For more on this please see https://www.hqsc.govt.nz/our-work/mortality-review-committees/

It was a privilege to attend this meeting and be able to hear and feel the passion in the room for the work that is happening in this space. With the data analysis on one hand and the reality on the other for the clinicians – what underlies the data – is the data helpful and what does the data mean in practice? Some of the system and process differences are possibly not captured – with an overwhelming need to get the interpretation right or consider what versions of interpretations there may be?

The effects of the SARS-CoV-2 are ongoing in many ways. For those of working in child and youth health and primary health care we are to be cognisant of this group over this time and be aware of the possible effects , as well as ensuring continued engagement in their health and well-being journey. For under-fives – have you been seen face to face for your Well Child Tamariki Ora visits, B4 School Check, immunisations up to date, attended an Oral Health Clinic (free until 18 years)? For older children and youth – are they engaged in an educational journey, engaged in primary health care, enquired about mental health and wellbeing ?
I look forward to seeing recommendations and change that arise from the National Mortality Review Committee alongside the continued subject matter areas – of interest being child and youth 'space'.
If you are interested in Child and Youth Health, bookmark the Paediatric Society website with the forthcoming 2024 Annual Meeting information due to appear. https://www.paediatrics.org.nz/about/annual-meeting

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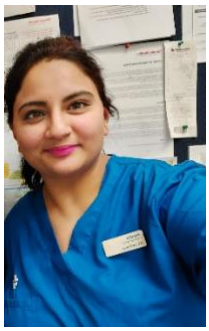
Reflection



Asmita Dinani, Registered Nurse, White Cross Glenfield

Asmita Dinani was able to attend a 3-day Diabetes and CVD course funded by her PHO Total Healthcare & hosted by Comprehensive Healthcare PHO.

What I learned:

- The pathophysiology, epidemiology, and classifications of diabetes
- Assessing a person with newly diagnosed diabetes - signs and symptoms of T1DM and T2DM including diabetic ketosis, once diagnosed the follow-up care required including referrals- i.e., retinal screening, blood tests, foot checks, and podiatry. If the patient is identified as high risk, BP, psychology, dietician, Green Rx, DSME referrals, medications education, Hypoglycaemia education, education on the use of insulin, the insulin pen and needles including self-administration, diet and lifestyle advice.
- Ongoing management 3-6 monthly: Laboratory tests including - diabetes profile, lipids, Serum Creatinine, Urine ACR, ECG, check BP, and steps as mentioned in the above points.
- Criteria for when specialist input is required.
- Understanding biochemistry results- following up on the results and interpretation
- Hypoglycaemia and sick day management
- We covered online modules on the 2nd day of study – self-monitoring Blood Sugar Levels, Sedentary behaviour, assessing cardiovascular risk + management (and interpretation of this),

Hypertension, and understanding ECGs.

- Microvascular and macrovascular complications of Diabetes
- Diabetes distress - for all patients with diabetes, how to help them live well with diabetes.
- Nutrition – Diet, what to eat and how much to eat- portion sizes, micro and macronutrients.
- DSME, CVD, and Diabetes checks and discuss Live the Life exercise.
- Atrial fibrillation and other cardiac conditions + ECG's

How this learning has influenced your practice :

- Throughout this three-day course, I have gained a lot of knowledge about Diabetes/CVD, CVD risk, patient screening, and referral pathways to further services that help manage the patient's long-term conditions. Through this education, I am supporting the clinical team in my practice as their resource person to go to if anyone has new questions on referral pathways or patients newly diagnosed with Diabetes. I am currently precepting a pre-reg Nursing student and have helped her understand long-term conditions.

What teaching or quality improvements have I made as a result of this learning?

- Consultation with patients newly diagnosed with diabetes.
- Full assessments for Diabetes and CVD
- Diet and lifestyle advice to patients
- Education to patients with elevated CVD Risk
- Screening and referrals for further management
- Education and coaching fellow nurses and student nurses

APP Review: Ascribe

Yvonne Little, Nurse Practitioner, LOGIC Editor

This little App is going to be a nurse's best friend. It was designed by Chris Aldridge a cardiac nurse practitioner (NP) and is free to download so you can use as your learning diary, that way you never forget what you have done. It provides an at hand way of documenting your Professional Development Hours at the time you are doing it, rather than waiting till you get home to put it down in some form and hope to be able to find it when you need to provide it for your APC.

He has made it for both iPhone and Android devices, which is super helpful as we know everyone uses a different type of device. And you can use it from both Google Play or Apple App stores depending on your preference.

To make life even easier, each version has what has been called its Easter Egg, or extra feature: The Android version has a CPD expense-tracking module whilst the Apple version has a sync to iCloud thus allowing use across multiple devices.

I recently downloaded this App myself and have found it extremely easy to use. If I had to recommend one App it would be this one. Easy to use, easy to keep track of your PD hours right at your fingertips whilst you are doing those said hours.

Planning PD for 2024?

Check out these four conferences related to the child and family context, particularly relevant for WCTO nursing and other PHC nurses working in the early years.

Investigate if your employer or Te Whatu Ora have a professional development fund you can tap into that could support you to attend in person, or if available, virtually.

The Australasian Injury Prevention Network (AIPN) 15th Australasian Injury Prevention and Safety Promotion Conference

"Weaving knowledges for injury prevention and safety promotion; creating a new way together"

11th-13th March 2024
Rotorua
New Zealand
https://www.aipn.com.au/conference

The Cairns institute, Early Years Conference

"It takes a village to raise a family"

16th – 17th May 2024
Cairns
Australia
https://www.earlyyearsconference.com.au/

Australian Institute of Family Studies

"Families Thriving?"

11th – 14th June 2024
Melbourne
Australia
https://www.aifsconference.com.au/event/66ecfefe-cb8b-4426-b995-9e5c27ec8f9c/websitePage:bc00fac0-3641-4302-ba9b-06d689951de6

Maternal Child and Family Nurses (MCaFNA)

"Driving Change for Better Outcomes"

29th – 31st August 2024
Brisbane
Australia

https://web.cvent.com/event/a37278df-4898-4d3e-932b-4ed29cd60c0e/summary

New Zealand College of Primary Health Care Nurses NZNO

NEW ZEALAND NURSES ORGANISATION
TŌPŪTANGA TAPUHI
KAITIAKI O AOTEAROA

SAVE THE DATE

THURSDAY 14TH MARCH 2024
6PM TO 7PM
AGM AND GUEST SPEAKER

CHRISTCHURCH NZNO ROOMS

ZOOM LINK WILL BE AVAILABLE

THEME:
PRIMARY HEALTH CARE NURSING MOVING FORWARD

A brief glimpse at Nurse-Led clinics and gender affirming healthcare in the community

By Michael Brenndorfer Nurse Practitioner

The following is adapted from a presentation delivered at the recent combined Australian Professional Association for Trans Health and Professional Association for Transgender Health Aotearoa conference, held in Melbourne, Australia, from the 2nd to the 4th of November 2023.

Nurse-led clinics are an under-utilised model of care which has significant potential for delivering positive and holistic health outcomes. They allow for a fuller manifestation of nursing paradigms of healthcare to thrive unhindered by more rigid bio-medical models of care, and as such offer a clear opportunity to observe the impacts of the bio-psycho-social approach of nursing. Transgender healthcare is an area of health which has experienced a recent process of de-pathologisation of transgender and gender diverse clients, a journey which has resulted in an area of healthcare that is very well suited for delivery to nurse-led models of care. By looking at a case study of gender affirming healthcare in a nurse-led youth health service we'll provide a brief insight into both this area of health care and this model of care.

There isn't a completely agreed upon definition in the literature on what makes up a nurse-led clinic, but there are few vaguely agreed characteristics that are present.

The first is nursing leadership practically implemented within the clinic, ensuring that a nursing paradigm of healthcare forms the foundation of the model of care within the service. This pulls the focus away from medical diagnoses and interventions, to a more holistic approach incorporating nursing diagnoses and interventions alongside medical ones. Nurses also practice with varying degrees of autonomy and supervision within nurse-led clinics, often dependent on the experience and qualification level of the nurse and the nature of the area of practice. This autonomy and scope obviously has different manifestations for nurse practitioner-led clinics, but nurse-led clinics do not require nurse practitioner leadership to operate. Often nurse-led clinics also focus on the management of long-term health issues, or health promotion work such as sexual and reproductive health clinics. In my previous nursing roles I ran nurse-led clinics within a primary care setting which including asthma clinics, diabetes clinics, and healthy lifestyle clinics, which while included supporting clients with the self-management of their medication, in collaboration with a GP, also involved support with the psychological and social impacts their health issues had on their life, and the formulation of non-medical interventions to support their journey of wellness.

The benefits of nurse-led clinics are many. In terms of gender affirming healthcare, nurse-led clinics provide a model of care which is inherently holistic and bio-psycho-social, an approach that fits very well alongside the move to de-pathologise

gender affirming healthcare, as we move away from viewing gender diversity as a disorder requiring a formal diagnosis in order to receive desired health care interventions. This approach fits well with the approach of encouraging wellness and fullness of human experience, through nursing interventions that sit alongside client goals of social aspects of their gender expression, identity and experience, such as navigating school, work, or family dynamics for example. Nurse-led clinics also can increase the accessibility of trans-inclusive health care services, by moving services into communities, alongside existing health care centres, and away from centralised, specialist clinics, with often long wait times, and occasionally long transport journeys. Previous surveys of trans and gender diverse community members showed that access to inclusive healthcare remains a consistent barrier. Fortunately, or unfortunately, nurse-led clinics are often considered a cost saving measure, deliver quality, accessible, and acceptable healthcare for a lower cost than specialist or medical-led approaches.

I work through the Youth Health Hub, a nurse-led youth health service based across West Auckland and the North Shore, which provides Primary Health Care level support in a youth developed-informed approach. As part of this our service has been providing gender affirming healthcare for over 15 years. We sit under a Māori health non-profit NGO which is currently funded through Te Aka Whai Ora. At the time of presenting this, our staff included four nurse practitioners and three registered nurses working across our two clinics. We are also well connected to local school-based health clinics and provide a primary mental health service with free counselling provided to young people in our area aged 12 to 24 years. We are well connected to a range of community, youth development, and healthcare services and organisations across the city.

The Youth Health Hub has long been the first point of contact for young people and their families when seeking gender affirming care locally. Initial appointments with the nurses are generally set for one hour, regardless of the presenting concern, and includes the use of the HEeADSSS framework to guide rapport building. When young people present initially requesting gender affirming hormone therapy access this initial assessment includes clarification of their journey thus far, their gender identity and pronouns, and the goals they have in mind that have led to their seeking gender affirming medical interventions. As part of this support is provided as needed around increasing family understanding of their child's gender identity, guidance around navigating gender dysphoria (the unease that arises from the incongruence between ones gender identity and their gender assigned at birth), support in accessing resources such as chest binders to reduce any discomfort or dysphoria transgender men experience in terms of their chests in public, and guiding of decision making around fertility preservation, to highlight a few.

For those under 18 years of age, once their goals regarding the desired outcomes of gender affirming hormone therapies are clear a referral is often made to the specialist youth health physician service, who are funded to initiate hormone therapy as well as provide psychological readiness assessments as part of the general assessment process. Throughout this journey young people remain connected to the nurse-led service for ongoing supports, and when initiated on hormone therapies or puberty suppression medication they are also able to access the

administration of these by the nurses in the clinic, providing an opportunity for regular check ins on their broader psycho-social health and wellbeing as well. For those over 18 often hormone therapy is able to be initiated by the nurse practitioners, working in partnership with the registered nurses to provide a holistic, fully in-house support. The close support and clinical liaison connection with specialist physicians is often utilised when questions or issues arise outside of the scope of the registered nurses and nurse practitioners; reaching out for expert advice should be standard practice for all health professionals, and it is certainly a component of nurse-led clinics without compromising the nurse-led paradigm.

The feedback from the local trans and gender diverse community is generally very positive. Local NGOs supporting LGBTQIA+ youth have stated that the Youth Health Hub is their service of preference for referring young people seeking support around their gender identity. The Google reviews for our service including multiple five star reviews from transgender young people. And other direct, formally received feedback as referred to this service as the "only place where I have felt safe, understood, and where I have not had to tirelessly advocate for my needs in order to receive basic care".

While nurse-led clinics offer a wide range of opportunities for our community-based healthcare in Aotearoa New Zealand, we do have several limitations which restrict their implementation. Generally, nurse-led clinics require dedicated, highly experienced clinical nursing staff who are able to operate at high levels of autonomy. Unfortunately, the nature of our Primary Health Care system underpays nurses and fails to adequately recognize the contribution of Primary Health Care nurse specialists within most primary care clinic settings, so retaining and recruiting expert nurses for nurse-led services can be a challenge when more competitive pay is often available elsewhere. Existing Primary Health Care funding streams in general fail to consider nurse-led services within the community overall, which impedes clinics from even considering them as options, while funding streams continue to be tied to bio-medical-centric models of care. There is much need for ongoing advocacy in this work.

This is a very brief glimpse at two very dense concepts of healthcare: nurse-led clinics, and gender affirming care, and much more could easily be said about both to provide a better understanding of them. But generally, nurse-led clinics offer an effective approach to increased accessibility and acceptability of holistic health care. Existing services could better utilise the full scope of nurses, first by understanding the potential this holistic paradigm and scope offers and unshackle nurses from the limitations of bio-medical dominated paradigms of Primary Health Care. There is substantial room for nursing leadership to expand and grow to improve overall provision of holistic health care in our communities, and gender affirming care offers one clear example of where beneficial changes can be made.