Kai Tiaki NURSING NEW ZEALAND

October 2020 vol 26 no 9

# Young nurse of the year: Kelly Talbot

- AGM and conference reports
- Caring for people with Parkinson's
- PPE training vital for safe use
- Profiles of new board members

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THIS ISSUE provides coverage of NZNO's virtual conference and annual general meeting, and profiles the new president, vice-president and three new board members. There are articles on initiatives to boost the Māori nursing workforce, caring for those with Parkinson's disease and the safe and effective use of personal protective equipment. There's also a viewpoint on the health implications of climate change.

*Kai Tiaki Nursing New Zealand* is the official journal of the New Zealand Nurses' Organisation, Tōpūtanga Tapuhi Kaitiaki o Aotearoa. Views expressed are not necessarily those of NZNO. *Kai Tiaki Nursing New Zealand*, under a variety of titles, has been published continuously since 1908.

*Kai Tiaki Nursing New Zealand* is a peer-reviewed journal. All clinical practice articles are independently reviewed by expert nurses/researchers (see below). It is indexed in the *Cumulative Index to Nursing and Allied Health Literature* and *International Nursing Index*.



**Kai Tiaki** is the Māori term for carer or guardian and has always been incorporated in the title of the magazine.

**Co-editors:**
Teresa O'Connor, Anne Manchester and Mary Longmore.

**Practice article review process:**
Clinical practice, education and research articles are critiqued for publication in *Kai Tiaki Nursing New Zealand* by nurses/educators/researchers with expertise in the subject area of the article, and by the co-editors.

# This issue . . .



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# Why nurses need to be politically engaged

By Jill Clendon

Nursing in Aotearoa is considered a profession, characterised by a set of responsibilities and accountabilities that we sign up to when we make our annual declaration to the Nursing Council as competent to practise. Each of the four domains of competence a registered or enrolled nurse is required to meet are related to the professional practice of nursing: professional responsibility, management or provision of nursing care, interpersonal relationships, and interprofessional health care and quality improvement.[1,2]

Being a member of a profession requires us to behave in a way that upholds the values and education of that profession. Being professional means we behave as a professional: we take responsibility for our own learning and development; we act as a role model for others; we support the provision of services that improve or protect health; we base our practice on the best available evidence; and we lead professionally by connecting with and supporting our professional bodies and organisations, supporting those who lead our profession, taking time to develop ourselves to lead strategically and developing others to lead strategically.[3]

Being professional does not preclude us from being political. In fact, being political is a key element of being a member of a profession. In the case of nursing, every time we advocate for a patient, whānau or community to receive care, we are behaving politically. We do this nearly every single day in our work – and though we may not see this as political, it is.

To do this well, we need to be "politically savvy". There are five simple actions we can take to build the political savvy required to drive our professional agenda and advocate for patients, communities and populations, whether at the individual level or through exercising our right to vote.

- First, we need to know who to talk to when advocating for care, or for our profession, by identifying who will be able to influence and make the change you need. This is called "standing on the balcony".[4]
- Second, we need to have "presence" to get our message across. Having presence is a way of carrying yourself – sending signals that you are an authority.[4,5] Again, we do this every day by knowing what our patient, community or population group need, and backing that up with clear evidence and rationale.
- Third, we need to be "authentic". This is about being open, honest, trustworthy and having good intentions. Step back, read the environment, ask people questions, see where they sit on an issue, and then build your case, advocate your views or state your recommendations. You are in a position of strength if you hear others out first and then, based on their concerns, advocate your views.
- Fourth, be empathetic and connected. Be attentive to others and adapt your language to your audience. Ask insightful questions, give the big picture, avoid irrelevant details, listen attentively and give others credit where it is due.
- Finally, have clarity. This means being decisive in the way you say things and get to your point. It's the ability to explain your views in a way that makes others want to join your proposed course of action. Own your message and use the active voice when speaking. Simply saying: "I think we should do this for the following reasons . . ." is very powerful.

Being politically savvy is a tool we can use to promote our professional agenda, whether advocating for better patient care, supporting your professional organisation, getting in behind your leaders or by exercising your right to vote.

**Own your message and use the active voice when speaking. Simply saying: 'I think we should do this for the following reasons . . .' is very powerful.**

NZNO recently held a by-election for a new president, vice-president and three board directors. Only 6.32 per cent of members voted. This does not demonstrate either professional support for the organisation that represents you or political savvy in identifying who can advocate for change on your behalf.

We have a professional responsibility to engage in the political because this is how we will achieve change. With the national election coming up, I hope all of you will use some political savvy to get engaged and vote. •

*NB. This editorial draws on a presentation I made at the NZNO conference in 2019.*

**Jill Clendon, RN, PhD,** is the associate director of nursing and operations manager for ambulatory care at the Nelson Marlborough District Health Board. She is aso an adjunct professor and teaching fellow at Victoria University of Welington.

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1) Nursing Council of New Zealand. (2007). *Competencies for registered nurses.* Wellington: Author.
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# Tell us what you think

## Lack of equity in health becoming increasingly obvious

IN MY role as a chronic kidney disease (CKD) nurse coordinator (pre-dialysis education/vascular access) I consider myself to be really good at my job.

However, I can't hide my annoyance at the lack of equity in health that is becoming more and more obvious to me. I hate to think I have been oblivious to this in the past, but I really must have been. I have always been frustrated at the poor outcomes we have for young men, and particularly our Māori clients, in dialysis/kidney disease. Well, Māori in general, when I think about it.

So, as a middle-aged (ageist speak that!) white woman I have to admit that, no matter how respectful and culturally sensitive I try to be, there are just some things that would have a better outcome with a Māori liaison nurse to work/walk beside me. This has worked well in haematology and got me thinking about having the same service for those with kidney disease.

I started investigating. I looked at the *Whakamaua Māori Health Action Plan 2020-2025* and it was saying all the right things. It had some nice opening messages from Associate Health Minister Peeni Henare and director general of health Ashley Bloomfield about *"ongoing engagement with participation by whānau, hapu, iwi and Māori communities"*.

That's great, I think. It shouldn't be a problem to get the service needed to help Māori through the very difficult journey of kidney failure. So I keep turning the pages and what do I find? There had been *He Korowai Oranga: Māori Health Strategy 2002, Whakataka: Māori Health Action Plan 2002-2005, Whakataka Tuarua: Māori Health Action Plan 2006-2011, He Korowai Oranga: Māori Strategy 2014* and now the new plan.

So what happened with all the other action plans and strategies? Why has Māori health not improved or, if it has, nowhere near enough? Why is there still inequity and such poor outcomes?

I rang the Māori Health Service at Canterbury District Health Board (CDHB), only to be told it was for inpatients. What's more, they only have five Māori health workers for the whole hospital. Well that's great for inpatients, but if they aren't inpatients, then what? How do we get the partnership talked about in Te Tiriti o Waitangi, to somehow resolve some of the inequities we have in our service?

Next step is to see if we can create a new position, but with the $16.5 million cuts to nursing in the CDHB, I don't see how that is going to work. (Abridged)

Karyn Marshall, RN
*Christchurch*

### Email your letter to:

**coeditors@nzno.org.nz**

We reserve the right to edit letters for sense and length. Shorter letters (under 400 words) are preferred. Please include address, nursing qualifications and phone number.

## 'Aromatherapy training available'

AN AROMATHERAPY training school has contacted us to complain about a comment in the article, Aromatherapy use in palliative care, (*Kai Tiaki Nursing New Zealand*, August 2020, p34-35). The school has interpreted this comment slightly differently to our intention.

In the article, we stated there were limited training opportunities for nurses to study aromatherapy in New Zealand and such training was not regulated. Our intention was to highlight the lack of any current New Zealand Qualifications Authority-approved standard of training in aromatherapy.

However, at least one provider is accredited to provide training to international standards. It is recommended that registered nurses undertake their own due diligence in seeking training in this area.

Our original comment is still valid, as there are limited opportunities for nurses and training isn't regulated, but we are happy to provide this further clarification.

Wendy Maddocks and Kate Reid,
*Christchurch*

## Gifts from Florence Nightingale on display

DURING HERITAGE Week in Christchurch, a gift from Florence Nightingale will be on display at the Nurses' Memorial Chapel.

**The instruments in descending order: a palette knife/ tongue depressor; a probe; and a metal catheter.**

Mary Ann Vousden trained at St Thomas's Hospital in London and came to Christchurch in 1890. Before she left, Florence Nightingale gave her the instruments (above).

The display will run daily from Friday, October 30 to Tuesday, November 3, 2020, from 11am to 3pm, at the Nurses' Memorial Chapel at Christchurch Hospital. There is more information about the chapel, its nursing heritage and the *Marquette* nurses on our website: www.cnmc.org.nz/.

Nanette Ainge, RN (retired)
*Christchurch*

## How times have changed . . .

RECENTLY, I came across a 2012 issue of *Kai Tiaki Nursing New Zealand*. Ah, the memories, as I flipped through the pages. In the July 2012 edition was a letter I'd written, *Time for action against apathy*.

As I read, I realised we have made little progress. A quote from my 2012 letter: *"We have all read about the short staffing and unsafe working environment at Auckland DHB. Why aren't the mighty NZNO lawyers brandishing our MECA and demanding it be honoured? If this cannot happen, then what is the MECA's use and the hard work involved in creating it? It is a legally binding contract, not a suggestion booklet."*

It's now 2020 and unsafe staffing is still happening, but now it's nationwide.

Another quote from that letter: *"An immediate and independent questionnaire should be sent to all NZNO members to determine why voting turnouts are so low – not just for the constitution but all voting. We need to know why people aren't voting and what can be done to improve the percentages. With an improved response rate, we will have greater confidence to back NZNO when the next MECA is being negotiated."*

There's been some progress. We have had a questionnaire and there is a drive to increase membership participation, but the budget to do so, I suspect, is nothing like the $1.4 million spent on travel last year. Voting turnout remains low and members are moving to other unions.

Another quote from the 2012 letter: *"International Nurses Day? Not a single token of appreciation. We used to get something little, eg a pen."* In 2020, the International *Year* of the Nurse and Midwife, we get COVID-19. Also, still no pen.

In the 2012 edition, following the letters pages, was the column *(A) Musing on Nursing* by Chris Cottingham. He was a brilliant writer. Please bring him back. His observations were on point and rang true to many of us. He provided colour and pizzazz. Why did his columns stop?

And lastly, at the back, our guilty pleasure – the disciplinary notices. We would wonder: What nurse is in trouble this time? Do we know them? Why have these gone as well? Please restore Chris Cottingham and the disciplinary notices.

May I ask what progress have we made? Is 2020 *really* the year of the nurse and midwife? What does the future hold for nursing and NZNO? Instead of words – we want action. (Abridged)

Alana Whiting, RN
*New Plymouth*

*The co-editors reply: We agree Chris Cottingham was a brilliant satirical writer. The decision to end his column was made by mutual agreement between Chris and the co-editors.*

*The Health Practitioners Disciplinary Tribunal (HPDT) no longer makes an order for publication in* Kai Tiaki Nursing New Zealand. *The orders are on the HPDT website (www.hpdt.oprg.nz) and provide a good summary of each decision. The Nursing Council now links to those summaries in its newsletter.*

## Keeping hope alive

IT IS seven years this month since Islamic State operatives kidnapped New Zealand registered nurse (RN) Louisa Akavi and her Syrian colleagues.

Her whereabouts is unknown. Hopes of bringing her home safely have dwindled, particularly in the last 18 months.

I didn't know Louisa, but I have friends and colleagues who have memories of their connections with her. I read of Louisa's life as a Red Cross nurse in Jill Caughley's 2000 Victoria University of Wellington nursing history thesis. What struck me was her ability to work creatively, her courage, her compassion and her humility. Without doubt, a hero.

It seems to me that now is a good time to reflect on RN Louisa Akavi's life and what she has meant to so many. We do not know whether she is dead or alive. Remembering her is a way of honouring her and keeping hope alive.

Joy Bickley Asher, RN, RM, PhD,
*Wellington*

## New public health data base available for members

THE NZNO library has recently added *ProQuest Public Health* to its databases available to members. It is the ideal starting point for public health information and research. It delivers core public health literature, with centralised access to more than 800 publications, with over 500 in full-text. *ProQuest Public Health* covers a wide variety of disciplines ranging from social sciences and biological sciences to business.

Members can access current newspaper articles to uncover the latest breaking news pertaining to public health, such as pandemics and disaster preparedness. In addition, thousands of full-text dissertations offer in-depth scholarly insights into important topics such as biostatistics, environmental health sciences, epidemiology, health services administration, international public health, maternal and child health, and occupational safety and health. https://www.nzno.org.nz/resources/library/online_databases

## Notice to members

WE HAVE included the 2020 *NZNO Guidelines for Patients' Responsibilities* on the inside of the back cover of this issue.

It has been placed there due to the thicker paper, so members can more easily use the copy of the guidelines to good effect at their workplaces.

NZNO staff have been developing these guidelines since 2014. A series of articles in *Kai Tiaki Nursing New Zealand* by professional nursing adviser Anne Brinkman explain their purpose and development further:

*Balancing rights with responsibilities*, October 2014, 38-39.

*Realising patient responsibilities,* February 2017, 34.

*Focus on patient responsibilities,* February 2020, 28-29.

We hope the guidelines are useful to patients, whānau and staff, in working towards partnership and improved health outcomes.

# Young Rotorua nurse receives NZNO award

KELLY TALBOT, a 29-year-old clinical nurse specialist at Rotorua's Southern Cross Hospital and student nurse educator (SNE) at Toi Ohomai Institute of Technology, is NZNO's 2020 Young Nurse of the Year. She was one of five nominations. The award was initiated by NZNO in 2014 to recognise younger nurses showing dedication and leadership skills.

Receiving the award at the end of NZNO's AGM last month, Talbot said she was "shocked about this. It's just absolutely crazy and very unexpected. I feel very honoured to be the recipient of this award".

She told *Kai Tiaki Nursing New Zealand* that receiving the award was a "nice booster", coming as it did near the end of "quite a challenging year".

Talbot began nursing in 2014 and has been working in the pre-admission clinic at Southern Cross Hospital for the last three years. When working at the medical unit at Rotorua Hospital, she served as an NZNO delegate and took a strong leadership stance on a number of workplace issues, including bullying, encouraging others to celebrate Pink Shirt Day on her ward every year.

She is also a much respected preceptor for student nurses, becoming an SNE at the local polytechnic in 2018. This sees her teaching some clinical skills during nursing laboratories at the polytechnic and preceptoring more than 20 student nurses each year.

"I am working full time now, but fortunately my manager allows me to work flexibly when I have students to mentor. Having these two strings to my bow helps me maintain interest and freshness in both fields."

## Remembering tough times

It was also not so long ago that Talbot was a student herself. "I became a teenage mother and remember all too well trying to juggle my daughter, work and study. Times were tough and I love that now, as an SNE, I have the opportunity to support and mentor students while on their clinical placements. I like to find out the personal circumstances of each of the students. Each one will need different kinds of support, depending on their life circumstances.

**Kelly Talbot – NZNO's 2020 Young Nurse of the Year**

"It's great that I can help build on their clinical knowledge with my teaching, seeing their confidence grow and being there to support them when they feel like giving up."

Although not Māori herself, Talbot has always had close contact with Māori, growing up with Māori friends and having a Māori partner. This helps her understand the Māori students and many Māori patients she comes into contact with.

"At Southern Cross Hospital, the numbers of private and public patients are fairly evenly split, as we have six contracts with neighbouring district health boards [DHBs]. Working in the pre-admission clinic means having the very first interaction with patients at the hospital and having the luxury of being able to sit down with them for a whole hour. During this time, I can help them navigate their hospital journeys, plan their appointments, educate them about different anaesthetic options and solve any transport issues they might have. I can relate to many of these issues, as I can remember not having a car or not being able to afford the gas for the car. It's also very important any cultural considerations are met, like patients having their own room so whānau can visit or stay with them overnight."

Talbot was praised by her nominators for her strong leadership and interpersonal skills, and ability to incorporate the four articles of the Treaty of Waitangi into all aspects of her practice. A number of students she has mentored also noted her dedication to helping them succeed in their placements by sharing her clinical knowledge generously.

Talbot plans to keep developing the pre-admission clinic, so patient outcomes continue to improve. She'd also like to do an education paper to enhance her teaching skills.

She will use the prize money to help fund her last postgraduate paper for her masters, a research literature review, which she hopes to complete next April. "I have studied every year but one since I graduated. This means I don't have much of a social life but I am determined to get to the end."

The 2020 Young Nurse of the Year judging panel consisted of representatives from the award's sponsor All District Health Boards, NZNO and the Nursing Education and Research Foundation, alongside 2018 joint winners Aroha Ruha-Hiraka and Annie Stevenson.

## Other award winners

Four other awards were presented at the AGM. The first ever nurse practitioner (NP) at Wairau Hospital's emergency department, Mike McNabb, received the service to NZNO award. McNabb has served on the NZNO delegates committee for the Nelson Marlborough DHB since 2016, and has been a member of both the college of critical care nurses and the college of emergency nurses since 2012.

Also receiving service to NZNO awards were chair of the college of gerontology Bridget Richards, who delivers NP services to older adults across the Waikato; and former chair of the women's health college, Ann Simmonds, who, since retirement, has been working as a frontline screener for COVID-19 in Nelson.

The only winner of the services to nursing and midwifery award went to longstanding member and delegate for the Greater Auckland Region Bronwyn Kavalinovich, who is team leader in the obstetric operating theatre at North Shore Hospital. •

# Nursing leadership positions under threat

NURSING LEADERSHIP positions at a number of district health boards (DHBs) are under threat. In a major structural change across all hospital services, Waikato DHB is proposing to cut clinical nurse director positions. The chief nursing officer (CNO) and director of nursing (DoN) positions at Capital and Coast DHB and Hutt Valley DHB respectively are being combined into one CNO role; and the DoN at Taranaki DHB has recently resigned after being in the role little over a year. Canterbury DHB's long-serving executive director of nursing Mary Gordon left the DHB last month because of its "dysfunctional and divisive governance team".

## 'Emerging trend'

NZNO acting associate professional services manager Kate Weston said there appeared to be an emerging trend in the sector to dismantle, diminish or degrade senior nursing leadership positions.

"It seems as though some DHBs are starting to implement the recommendations of the health and disability system review [*the Simpson Report*] by stealth. The review recommends cutting the number of DHBs. But there must be no reduction in strong, visible nursing leadership at a local level," she said.

Waikato DHB's proposal for change removes seven clinical nurse director and nurse director (ND) roles and creates three ND roles. The new roles are at a higher level of decision-making within the DHB, which, according to NZNO, is an improvement. But NZNO organiser Jenny Chapman said there was frustration that clinical leadership roles were being reduced, with unrealistic workloads for the new roles. A submission from NZNO said nurses in the new ND roles could not be strategically focused or innovative "due to the enormity of the roles".

NZNO is also concerned at reporting lines for the NDs, which have no link to the current director of nursing and midwifery (DONM) structure.

As a result of the submissions on the entire proposal, Chapman said it would be revised and there would be further consultation before any final decisions. "We are pleased the DHB appears to be listening to staff's concerns."

The two top nursing roles at CCDHB and HVDHB had been combined into one large role, while the two chief medical officer roles had been retained, NZNO professional nursing adviser (PNA) Suzanne Rolls said. "Yet nursing is the biggest workforce and the single CNO role will be across primary care, aged care, mental health and hospital services. It is a significant role and will be inadequately resourced. In the first international Year of the Nurse and Midwife, this is a real blow to nursing visibility and respect for the profession."

NZNO had objected to the proposal, could not understand the rationale for it and was unsure of the appointment process, Rolls said. The person appointed would struggle to provide strategic leadership because of the enormity of the role and this would ultimately impact on the development of nurses and nursing.

PNA Wendy Blair said in the six years she had been involved with Taranaki DHB, there had been no stability in the DoN role, with three DoNs in that time.

Weston said there was a gulf between the rhetoric about nursing's contribution to health care, particularly its response to COVID-19, and the reality of nursing's power and influence within the sector.

Ministry of Health CNO Margareth Broodkoorn said she had been made aware of proposed changes at Waikato, Capital & Coast, Hutt Valley and Taranaki DHBs.

The health and safety of patients was a priority for DHBs "and current systems and standards will remain in place, ensuring patient care remains uninterrupted during any recruitment process".

During her remaining time as CNO – she leaves early next year – she would "continue to liaise with my DHB colleagues and be available to offer any advice when requested". •

# DHB MECA bargaining 'on track'

NEGOTIATIONS FOR the NZNO/district health board multi-employer collective agreement (MECA) – NZNO's biggest in terms of membes covered – are on track, according to acting industrial services manager Glenda Alexander. "Given the coverage of the MECA, the number of claims and given everything we've had to contend with this year with COVID-19 pandemic lockdowns, we are on track to get the solutions members want."

After two days of negotiations late last month, small joint subcommittees are now working on developing wording and solutions for a range of claims, eg professional development and clinical supervision. NZNO organiser Ron Angel, who is working alongside lead advocate David Wait, said the aim of the subcommittees was to ensure consistency of practice across DHBs.

## 'Good spirit' at negotiations

There had been agreement in principle on a number of technical claims, eg including legislative changes that occured during the term of the agreement and tidying up the wording of some clauses, Angel said. The negotiations were being carried out in a good spirit. "There have been pretty frank and open discussions."

According to the member update issued after last month's negotiations, there had been "robust discussions" on members' three most significant claims, ie pay, safe staffing and sick leave. But no decisions had yet been reached.

Another day of negotiations was scheduled for October 14, which was to consider the information gathered by the subcommittees, with more negotiations scheduled for mid-November, Angel said. •

# PHC nurses vote for more strike action

NURSES COVERED by the primary health care multi-employer collective agreement (PHC MECA) have voted overwhelmingly in favour of more strike action in pursuit of pay parity. At 34 stopwork meetings around the country earlier this month, a resolution for more strike action, if no additional funding for pay parity with district health board (DHB) colleagues was forthcoming by October 14, passed easily.


**PHC nurses have voted to strike for longer than last month's eight-hour strike in support of pay parity.**

Nurses are wanting to strike for more than the eight hours they did on September 3. The four options considered at the stopwork meetings were: another eight-hour strike; two eight-hour strikes; one 24-hour strike; and two 24-hour strikes. While still adding up nurses' responses at press time, PHC industrial adviser Chris Wilson said the trend was for at least a 24-hour strike.

The vote for further strike action comes after a meeting between employers', Ministry of Health and DHB representatives on September 24. A statement issued afterwards said primary care nurses were seen "as a priority workforce for progressing pay parity. Meeting attendees have agreed to work together on this issue, with an initial focus on the primary care MECA".

But little progress was evident at last-minute negotiations on September 28, when employers had no additional money to put on the table for pay parity.

New Zealand Medical Association (NZMA) chair Kate Baddock said the association was frustrated at the lack of progress. "This is a significant issue and it is taking a long time to gain pay parity for what the ministry and DHBs agree is a priority workforce. It feels like lip service to primary care and its nurses. The funding should already be there."

Wilson, who has been involved in the PHC sector for more than 30 years, said she had never before witnessed the current level of frustration and anger among nurses. "This latest fight for pay parity has been going on for two years now. We accepted a one-year MECA in 2018 in the hope additional funding would be forthcoming for this MECA. NZMA and NZNO representatives met then Health Minister David Clark in September last year and presented him with detailed evidence of the extent of the pay gap and its implications for the sector. There has been no shortage of information backing up our case for pay parity," she said. "Nurses are not going to be fobbed off."

She pointed to the support from employers, including NZMA, Green Cross, GenPro and GPNZ, for pay parity, which NZMA estimates would cost $15 million.

Baddock said it was "understandable" nurses were contemplating further strike action as there had been no resolution to date. "We are hopeful there will be resolution, however we'd like that time frame to be sooner rather than later."

Wilson said nurses were leaving the sector for jobs in DHBs. "An extra 10.5 per cent [the current pay gap between experienced PHC and DHB nurses] in a pay packet is a lot of money in a household." Baddock said recruitment was where "the challenge remains".

NZNO has also written an open letter to Prime Minister Jacinda Ardern calling for her intervention to secure pay parity. The letter asks her to "urgently resolve" the issue, to acknowledge the value of PHC nurses' work and to "show you want them to continue to use their expertise in keeping us healthy". •

# Primary health care professionals to be honoured

NURSE PRACTITIONER of the year and practice nurse of the year are just two categories open to nurses in the 2020/2021 Primary Healthcare Awards/ He Tohu Mauri Ora.

The awards are sponsored by The Health Media Ltd and the Pharmacy Guild and there are more than 20 award categories. Nurses working in secondary care on integrated projects with primary care could enter the primary and secondary integration award. Other awards open to nurses include excellence in information technology, aged or youth care, patient safety and mental health.

The focus of the 2021 awards is on achieving equity. "COVID-19 has well and truly exposed the equity issues the primary care sector has been grappling with," The Health Media managing editor Barbara Fountain said. "It's a call for each of us to move away from the status quo and become agents of change. That's what the awards are about – honouring people and projects that are helping move primary care forward."

**Winner of the nurse practitioner of the year award at the 2019/2020 awards, Jackie Clapperton, who is both an NP and intensive care paramedic in Gisborne.**

Nominations for the awards can be made at nzphawards.co.nz/enter and have to be in by November 15. Finalists will be announced on April 1 next year, and the winners will be announced at a gala dinner in Auckland on May 15. •

# Acute mental health units being upgraded

A NEW SIX-bed inpatient mental health facility at Wellington Hospital will be ready in 2021, the Ministry of Health (MoH) has confirmed.

The hospital's 30-bed Te Whare o Matairangi mental health inpatient unit was one of two named in August by chief ombudsman Peter Boshier as breaching the United Nations' convention against torture "and other cruel, inhuman or degrading treatment" for its use of seclusion rooms to home patients.

The other was Waitakere Hospital, where a patient was being housed long-term in the intensive care unit.

NZNO mental health nurses' section chair Helen Garrick has said its concerns about acute mental health bed shortages were "ignored" in the Government's mental health services inquiry and in its 2019 report, *Ha Ara Oranga*. (See last month's issue, p10.)

Nurses were often blamed when things went wrong and faced ethical dilemmas when faced with decisions about patient admissions and discharges, she said.

A spokesman for Health Minister Chris Hipkins said the Government had announced some $330 million worth of investments in new and upgraded mental health facilities. But it was not yet clear how many more beds would result, as designs were still being finalised.

"Over time, as we roll out the new, free mental health support at a community/primary care level, we would hope to see more people get early intervention to help prevent small issues from becoming big problems," the spokesman said.

Other upgrades or replacements of facilities in the planning and design stages include the Henry Rongomau Bennett Centre in Hamilton, Hillmorton campus in Christchurch, and hospitals in Palmerston North, Hauora Tairāwhiti Gisborne, Tauranga, Whakatāne, Hutt Valley and Taranaki. Final bed numbers at most of these facilities were still to be confirmed. •

## New senior policy analyst for NZNO

NZNO's NEW senior policy analyst is Lucia Bercinskas (below). She fills the role left vacant after the resignation of Jill Wilkinson in February.

Bercinskas' previous role was head of quality for the Royal New Zealand College of General Practitioners. She has also worked at the Ministry of Health as senior policy analyst/senior adviser for the cardiovascular disease, diabetes and long-term conditions team in the sector capability and (innovation) implementation business unit.

Other roles include senior policy analyst for BreastScreen Aotearoa; co-ordinator vision and hearing screening programme and well child projects for the Wellington Regional Public Health Service; lecturer/module co-ordinator for the department of health studies at the Central Institute of Technology, Upper Hutt; and principal nurse at Wakefield Hospital in Wellington. She began working for NZNO earlier this month. •

# 'Inequity is deep-seated in our society'

MUCH WORK needs to be done to address big issues such as the privilege Pākehā receive in their health care and the under-privilege of Māori, accessibility of services, the importance of wairuatanga in health care, and empowerment of Māori to make decisions about their own health.

These are some of the main conclusions from a new report on cultural safety and health equity for Māori, as delivered by doctors and based on the experiences of Māori patients. It was released last month by the Medical Council, in partnership with Te Ohu Rata O Aotearoa (Te ORA).

Te Ora chair, professor David Tipene-Leach, says improving equity of health outcomes in Aotearoa requires that the health system and its doctors acknowledge that racism exists and that current inequities are not acceptable.

"Colonisation and systemic racism have had a significant effect on health outcomes. Inequity is deep-seated in our society, it is complex and it can impact on patient engagement in their health care and the choices they make," he said.

The report also outlines the effect of "cultural loading" on Māori doctors – the often unrecognised additional cultural demands placed on them on top of their day-to-day clinical work – on the responsibilities they hold for their own whānau, hapū or iwi or advisory roles in the wider community. Medical Council chair Curtis Walker says the council is working on ways to offer greater support for Māori doctors during training and to keep them in practice.

"We need to make sure we are working in true partnership with Māori, to be bold enough to make large scale change and work together to aim for a just society that is equitable and fair, and leads to better health outcomes for our people," Walker said.

The report highlights disparities between health outcomes for Māori and non-Māori. Non-Māori were hospitalised 42 per cent less than Māori over a 10-year period, with an even greater inequity in hospitalisation for congestive heart failure, asthma, cellulitis and diabetes.

On average, the death rate for non-Māori within 30 days of major surgery was 40 per cent lower than for Māori during the 10-year time period. Non-Māori died five times less frequently than Māori from diabetes, and less than half as frequently from both circulatory and respiratory conditions. •

# Former NZNO head remembered

FORMER NATIONAL director/chief executive of NZNO Brenda Wilson died peacefully at her home in Invercargill last month, aged 83. She had been diagnosed with Parkinson's disease three years ago.

Wilson held NZNO's top job for six years, from late 1994 to December 2000. She took on the role two years after the amalgamation of NZNA and the NZNU, and oversaw a number of key financial and structural changes during that time.

The mid-1990s onwards was a stressful time for nursing due to the Employment Contracts Act and the competitive health model placed on NZNO and its members. "The casualisation of the nursing workforce, part-time jobs, constant restructuring and cuts to nursing jobs were done deliberately to create a nursing shortage and destroy nursing. This was to create a market for a new generic health worker," she told *Kai Tiaki Nursing New Zealand* in her final interview in December 2000.

Steering NZNO through these National Government years was hard, she said, with Health Ministers Jenny Shipley and Wyatt Creech mostly refusing to

meet NZNO. "The ministers could choose to ignore what nurses said, even though we were the largest body representing nurses."

Wilson saw a huge scope for nurses in primary health care. She also campaigned hard for nurses to be seen as "leaders in health". She took a strong stand on behalf of NZNO members against some of the 1998 Ministerial Taskforce on Nursing's recommendations, a move which did not endear her to some nursing leaders.

Wilson trained as a nurse and midwife in England, and arrived in New Zealand in 1967 to join her sister Jean, also a nurse, accompanied by her young son Joseph. She worked as a midwife in Canterbury for a number of years, eventually becoming second assistant matron at Burwood Hospital, then chief nurse of the Canterbury Area Health Board.

Former NZNO professional services manager Susanne Trim worked with her at Christchurch Hospital and NZNO, and describes her as "an emancipatory and truly inspirational leader dedicated to developing nursing to its full potential".

Before joining NZNO, Wilson was executive director of the Asthma Foundation for five years. She received the New Zealand Order of Merit for services to nursing in 2000.

After leaving NZNO, she and her partner, former NZNO president Judi Mulholland, moved to just north of Whanganui to a lifestyle block. They had many adventures travelling around New Zealand in a house truck Wilson had designed and had numerous overseas trips. Wilson owned and managed the Catlins Holiday Park, turning it into an international destination, before the couple finally settled in Invercargill.

Wilson is survived by her life partner Jude, son Joseph, three grandchildren and one great-grandchild. •

# Army nurse honoured for work in Iraq

A NURSE experienced in neonatal and practice nursing has recently been recognised by the New Zealand Defence Force (NZDF) for her work with coalition forces in Iraq in 2018.

Bronwyn Flewellen, who graduated from the then Christchurch Polytechnic Institute of Technology in 2012, has been a member of the regular defence force since 2016. She served in Iraq as a senior nursing officer responsible for providing health support to 3500 coalition forces and, in emergency cases, to civilians within Camp Taji.

Captain Flewellen was presented with a Defence Meritorious Service Medal in Wellington. Her citation praised her leadership skills during her pre-deployment training and when she was appointed second-in-charge of the Anzac Health Company.

While in Iraq, she created a clinical skills development programme for all

**Chief of Defence Force Air Marshall Kevin Short presents Captain Bronwyn Flewellen with her meritorious service medal.**

coalition clinicians and helped set up a number of public health initiatives.

"The medical personnel participating in the programme had varying levels of training and not all of them spoke English or spoke it as their first language," Flewellen said.

"We practised with simulated casualties to learn each other's scope of practice and how we would work as a team if a multiple casualty event occurred.

"The second area, which I set up with an Australian nursing colleague, was around public health and the sharing of health intelligence. With so many nations providing individualised health care, public health concerns were getting missed. We needed to know if there were outbreaks of communicable diseases, particularly gastro-type illnesses. We established fortnightly meetings with a representative from each nation's health team, which resulted in swift action when problems arose."

Flewellen, who is based at Linton Military Camp, said she was delighted to have been honoured for this work. "To have had the opportunity to enhance nursing care to our deployed forces and to enhance relationships with our coalition nations was a privilege. I'm also proud to represent the Royal New Zealand Nursing Corps." •

# PPE, nurses' role in pandemic dominate virtual conference

**The COVID-19 response and nurses' role in it and personal protective equipment (PPE) supply problems were key topics at the NZNO virtual conference *Community wellbeing in Aotearoa Nursing 2020 and beyond* on September 16.**

**About 170 registered for the online conference, and the annual general meeting (AGM) the following day, with connections to the live stream peaking at about 82.**

**Chief executive Memo Musa said it was impossible to know how many viewed the live stream, as behind every connection could be several participants.**

**Initial feedback was positive, despite some technical hitches early on in the conference, and also in the AGM voting processes. However, disruptions were minor overall, and the format successfully provided opportunities for questions and answers.**

**"Having speakers talk about COVID-19 national responses and review made it even more relevant," Musa said.**

**Conference coverage runs from p10-14, followed by three pages of AGM coverage. Some conference coverage has been held over until next month. Reporting by Mary Longmore and Teresa O'Connor.**

# COVID-19 elimination strategy wins praise

University of Otago Professor of Public Health Michael Baker praised the effectiveness of New Zealand's elimination approach to COVID-19 – and public health nurses.

New Zealand's elimination strategy, and how to sustain it, had drawn huge global interest, he said.

Baker said he realised in January COVID-19 would be a serious global pandemic. But after hearing late February the virus had been stopped "in its tracks" in Wuhan, Baker said he knew it could be "contained and eliminated".

With its early March establishment in New Zealand, it became evident a lockdown was needed. New Zealand's strategy changed from trying to flatten the curve, to elimination. An elimination strategy had been successful in parts of Asia such as mainland China and Taiwan, and involved excluding cases at the border, managing community cases by testing, tracing and isolation or quarantine, and reducing transmission through masks, distancing and travel restrictions.

New Zealand had one of the most "stringent" lockdowns of any country, with two months of constraints in total. Adapted from Singapore, the lockdown levels had worked extremely well and been "a triumph of risk communication". Testing capacity in the current surge had reached 25,000 daily, "a real tribute to the laboratory scientists," Baker said.

As a result of its elimination strategy, New Zealand had achieved "by far" the lowest COVID-19 mortality rate of Organisation for Economic Cooperation and Development (OECD) countries.

Economically, New Zealand appeared to "bounce back" very rapidly from the first outbreak. "The hope is that by testing and tracing, keeping limitations, mask-wearing . . . we hope to minimise the impact."

## Drop in deaths

The elimination strategy also saw a five per cent drop in overall deaths, which – if the trend continued - would mean 1500 fewer deaths by the end of the year, including winter ailments such as influenza. Anticipated negative impacts such as increased suicide had not eventuated to date, he said.

Response to the latest surge has been more rapid and targeted, with high levels of testing and tracing, alert levels specific to outbreak areas and mass masking, which was intended to reduce the length of lockdowns. "Hopefully that's the way of the future – we can identify and stamp out outbreaks very quickly, and at the same time reduce the chance of having them."

In an article written with colleagues for *The Conversation* blog (www.theconversation.com), Baker suggests improving New Zealand's public health infrastructure with a high-level COVID-19 science council and a public health agency. More public health nurses, training and career paths to make this "critical branch" of the workforce attractive were also needed.

The elimination of other infectious diseases such as pandemic influenza, HIV, tuberculosis and hepatitis C was "conceivable" in the future, with methods now available due to COVID-19.

Another big lesson for him was that "effective science and good political leadership is really a vital resource for a country", he said. Assessing risk and acting decisively was important, and for other public crises, as well as considering equity and partnership with affected communities, as could be seen in Auckland currently.

Taking an elimination approach benefited a country's health and economy and was the "least bad" choice, he said.

This experience was also an opportunity for a "broad reset", with more focus on managing global health threats such as climate change. "Climate change will not only be a more severe threat, but is also one locked in for generations, as you can't take that CO2 out of the atmosphere once it's been put in there. So it will have long-term consequences so we need to act now and we need to listen to the scientists."

Responding to a question about COVID-19 infection among health workers, Baker said it was "absolutely critical" to protect their health, as well as other frontline staff such as hospital cleaners and bus drivers. "Effective PPE is a matter of life and death for some people." •

# 'Serious questions' over PPE supply

**There were weaknesses in PPE stock management with some of it expired and a lack of knowledge about how much was available.**

Controller and auditor-general John Ryan said the Office of the Auditor-General (OAG) decided to investigate the Ministry of Health (MoH)'s management of personal protective equipment (PPE) in June, as there were "serious questions" over its supply.

"In times of crisis, there must be absolute public confidence in the systems there to protect them," Ryan said. As the COVID-19 pandemic accelerated, there were "a variety of stories" circulating about availability of PPE, from a range of essential workers and organisations.

Despite being in the middle of lockdown, Ryan said it felt "important for us to get involved" and release its findings quickly. The OAG worked with five district health boards (DHBs) and the MoH, which were "extremely open" to an independent viewpoint, he said.

Reviewers found the MoH did have a plan for DHBs' response to a pandemic and a national reserve of PPE, but both were several years old. COVID-19 has been the "first real test" and the plans did not prove adequate, Ryan said.

Some were out of date and hadn't been checked, there was "misalignment" between the DHB and MoH plans, and assumptions around procurement and distribution of PPE, which proved unworkable. "We felt there were roles and responsibilities which were not clear enough for people to be able to stand up and operate quickly in that situation," Ryan said. "It's one thing to put a plan in place, it's another to make sure . . . they operate."

A national response was needed, but DHBs were procuring PPE by themselves or regionally. Suppliers were getting multiple orders from DHBs and didn't know how to prioritise them. All the while, clinical guidelines were changing, he said. The MoH centralised its procurement by mid-March. While it should have happened sooner, it ended up "reasonably effective".

There were "weaknesses" in stock management, with expired PPE and lack of knowledge about how much PPE was available across DHBs.

Clinical guidance, too, was fast-changing and confusing, he said. Comments from director-general of health Ashley Bloomfield on March 31 that people not only needed to "be safe and to feel safe" but follow clinical guidance, caused confusion. "I think that was probably a difficult message to understand clearly."

The OAG made 10 recommendations, including regular MoH reviews of DHB emergency plans, guidance on who is responsible for procuring and distributing PPE, review of PPE clinical guidelines and their communication; and clarity on roles for maintaining PPE reserves. The MoH had accepted all 10 and he was confident they would be adopted. "We'll be keeping watch", Ryan said. •

# Full inquiry into pandemic response overdue

A full inquiry into New Zealand's response to COVID-19 should have begun "weeks ago", to better prepare the country for future pandemics, McGuiness Institute founder Wendy McGuiness told the conference.

"I think we have been very lucky, this could have been so terrible . . . but we're all looking to the honey pot and thinking this is all behind us," she said. But there would be other pandemics in future. "We've got to get together to redesign the new system for the next one."

McGuiness wants a royal commission of inquiry into New Zealand's response, covering logistics, communication and lockdown timings, as well as personal protective equipment (PPE) supply – "everything".

In April-May, the institute partnered with NZNO to survey almost 600 members' experiences with PPE. The survey found accessing PPE was a problem across district health boards (DHBs) and in the community, as well as DHB confusion over who was responsible for PPE.

Its 13 recommendations included an inquiry into what went wrong, updated pandemic planning for the Ministry of Health and regular PPE audits. McGuiness also believed individual COVID-19 positive cases should be studied to improve patient care and the health system.

"We are dealing with an incredibly tricky and difficult and sticky virus," which had caught New Zealand "off-guard".

Yet coronaviruses – which infect animals and humans – were identified in animals before the 1960s and in people in the 1960s, with different varieties emerging in the 2000s, "so that gives you 60 years of an emerging new 'kid on the block'."

While she was "delighted" with the auditor-general's review of PPE supply, which aligned with the NZNO survey, she wanted to see an inquiry into the full COVID-19 response.

The McGuiness Institute (previously the Sustainable Futures Institute) was established in 2004 by Wendy McGuiness to contribute to New Zealand's long-term future. •


**International Council of Nurses chief executive Howard Catton: Infections among health-care workers could reach 2.5 million.**

# Pandemic

COVID-19 has shown the world the reality of modern-day nursing, says the chief executive of the International Council of Nurses (ICN), Howard Catton.

"Yes, people around the world are seeing caring, but they are also seeing courage, complexity, leadership. And they are getting the value of investing in the health systems . . . they are seeing how intimately related health care is to our economic wellbeing," he said in a pre-recorded presentation to the conference.

While nobody wanted the pandemic, it had created an opportunity for nursing to be seen in a different way, for nursing to take a more prominent role in how health systems were organised, in how nurses led health-care delivery and in how nursing workforces were valued.

The pandemic had highlighted the true value of nursing work to people, societies and economies. Catton acknowledged that "gender issues run deep" in

# Global nursing report refers to

COVID-19 had brought the "critical importance of nursing into sharp focus", outgoing chief nursing officer (CNO) Margareth Broodkoorn told the conference.

Acknowledging those at the front-line and the 172 health-care workers in Aotearoa who had been infected by COVID-19, she said the pandemic had highlighted vulnerable communities, including those in aged residential care, and Māori, Pacific and rural communities. She warned of the need to be mindful the response to COVID-19 did not create more inequities.

Broodkoorn's presentation focused on the first *State of the World's Nursing Report*, released in May.

Data for Aotearoa's contribution to the report had been gathered from national health workforce accounts, the Nursing Council, the Ministries of Health and Education, employers and professional associations. Nurses made up 68 per cent of New Zealand's health workforce and midwives 3.3 per cent, with internationally qualified nurses (IQNs) comprising 27.2 per cent of the nursing workforce. The nursing workforce had topped 60,000 in March.

# highlights 'true value' of nursing

nursing and the profession was economically undervalued. "But COVID-19 is exposing that and providing an opportunity to change that mindset. We are not a cost; we are an investment."

ICN would continue to be at the forefront of arguing for the world's nurses to have a pay rise that was "a fundamental reset in how we value nurses and nursing work", he said.

Catton said from the beginning of the pandemic, ICN had followed its spread around the world and had shared the learning and experiences of nurses. In May, it issued a 12-point plan, prioritising the needs of nurses in the pandemic. The plan had guided ICN's work with national nursing organisations.

Catton referred to infections among health-care workers (HCWs) around the world, which he estimated could reach 2.5 million. ICN estimated that HCWs comprised around eight per cent of all COVID-19 infections globally. He estimated the number of nurses who die could surpass "the grim milestone of 1000". The failure to collect data on HCW infection and death rates in a systematic and co-ordinated way globally was a scandal, he said.

From the start of the pandemic, it had been clear there were problems with the supply of personal protective equipment (PPE). "Supply was either inadequate, it was not distributed properly or the quality of PPE was a problem and we were hearing reports of infections among HCWs."

Failure to provide adequate PPE had been a "contributary factor" in the deaths of HCWs. These were estimated at 3000 in July, a likely underestimation, Catton said.

**Failure to provide adequate PPE had been a 'contributary factor' in the deaths of health-care workers.**

The ICN had highlighted attacks on HCWs, which were fed by ignorance. Catton said all governments should be taking a zero tolerance approach to such attacks. ICN and the World Health Organization (WHO), believe HCWs should be prioritised when a safe and effective vaccine is developed.

Catton referred to the shortage of nurses worldwide which the first State of the World's Nursing report, released in May this year, estimated at six million by 2030. He also referred to the inequity of the shortage – low to middle-income countries would be short 5.3 million nurses.

Looking forward, Catton said arguably the biggest threat the planet faced was climate change. Climate-induced disasters were having a profound impact on people and health systems. Nursing needed a clear view and voice on what it wanted future health systems to look like. They needed to include sustainability, a far greater role for advanced nursing practice and nurse-led services and more prominent nursing leadership.

Referring to the first Global Year of the Nurse and Midwife, Catton said while it was a celebration of the anniversary of Florence Nightingale's birth, he felt there wasn't enough talk about the founder of ICN, Ethel Bedford Fenwick, who stated: "By union alone can the necessary strength be found."

Catton said union, co-operation and solidarity were "integral to dealing with the reality we face. We see nationalism in many countries, but as a profession and as professional associations, we have a very strong, legitimate and powerful voice to call for multilateralism and solidarity for our world and for our future". •

# 'ethical utilisation' of IQNs

Broodkoorn outlined five major implications of the report for New Zealand:

- that nursing workforce policy aligns to the United Nations' sustainable development goals, universal health coverage and quality care;
- that detailed and transparent nursing workforce data is collected and analysed – it is incomplete in New Zealand;
- that more is invested in the domestic production of nurses; and
- that accountable leadership in nursing education, employment, regulation and policy is advanced.

Broodkoorn referred to an academic paper examining the report that had pointed out it was silent on the international indigenous workforce.

The report referred to the ethical utilisation of IQNs, who, she said, "contributed fantastically" to our health-care system. But New Zealand was drawing on other countries' nursing workforces. At international hui, global nursing leaders had told her those nurses were needed at home.

Future policy challenges in New Zealand included recruitment and retention, safe staffing, mental wellbeing and enabling regulatory and legislative systems.

The nursing workforce would keep pace

Margareth Broodkoorn

with population growth over the next years if entry and exit patterns continued. The New Zealand nursing workforce had increased by 10 per cent between 2017-2020. But COVID-19 has had an impact on recruitment, with some practice settings and regions showing a decline in the ratio of nurses per population.

Factors influencing the demand and supply or nurses included global labour markets, models of care, wage settlements and changing immigration settings.

Referring to New Zealand, Broodkoorn said there had been good investment in nursing and she cited the safer staffing accord, more mental health nurses, investment in enrolled nurses and nurse practitioners and the advanced choice of employment programme. She was aiming to achieve "one national, coherent nursing workforce strategy" this year but COVID-19 had delayed that work.

While there had been investment in nursing, there was "still some way to go" but Broodkoorn was confident things "were in good hands".

Responding to a question, she said strategies were being considered to address the pay gap between Māori and iwi provider nurses and their district health board counterparts. She acknowledged NZNO's and kaiwhakahaere Kerri Nuku's work on the issue. "This is a very important question and we haven't had an outcome. We have continued to look at opportunities to address this issue with the Māori health directorate and our Māori health workforce team colleagues. Something needs to change in that space. Work is happening to get to a point where it is addressed."

Broodkoorn said there may be a delay in achieving 100 per cent employment for all new graduates but directors of nursing were working on strategies to ensure full employment of new graduates. In response to a question, she said she "wouldn't disagree" with free nursing education, given the looming shortfall of nurses. "It would be a dream to achieve for me. I'll put the idea forward to the Ministry of Education whānau."

Broodkoorn leaves the ministry at the end of the year to return home to take up the role of chief executive of Hokianga Hauora. It had been an "absolute pleasure" to be the CNO. •

# Cannabis 'a health issue'

AUCKLAND GP Graham Gulbransen has treated 1500 patients at his medical cannabis service in Henderson – New Zealand's first – since opening in 2018.

Patients generally came after standard treatments had failed, mostly for chronic pain (45 per cent), such as fibromyalgia and osteoarthritis, he told conference. Another 20 per cent came for emotional distress, such as anxiety, depression and insomnia. Another 17 per cent were cancer patients and 16 per cent had neurological conditions such as Parkinson's disease, seizures or multiple sclerosis (MS). It was particularly effective for migraines, said Gulbransen, also an addiction specialist. Autistic spectrum disorders, chronic fatigue, Tourette's syndrome and pre-menstrual tension could also be helped.

"Thousands" of cannabis strains had various levels of the active compounds tetrahydrocannabinol (THC) and cannabidiol (CBD). THC was a "euphoriant" but had therapeutic qualities such as pain relief, anti-nausea, sedation and muscle relaxant. CBD had pain relief, relaxant, anti-psychotic and anti-convulsant qualities. A balance of the two worked well.

About half his patients didn't return – he suspected many accessed cheaper cannabis illegally – but a quarter of those who did reported "very good" or "excellent" results.

Sativex is the only medicinal cannabis brand containing more than two per cent THC currently approved by the Ministry of Health (MoH) for prescription, having been through clinical trials for MS. With balanced amounts of THC and CBD, it cost about $900 for a three-month supply of spray. Any doctor could prescribe Sativex or a CBD product to any patient for any condition. But only specialists could prescribe cannabis products with more than two per cent THC, he said.

Voting to support the legalisation of recreational cannabis in this month's referendum would allow people over 20 to buy clearly labelled cannabis products in shops, instead of $200 million being spent annually on cannabis-related police prosecutions, he said.

"It's really saying that, as health professionals, we think cannabis is a health issue, rather than a legal issue." •

## Time for nurses to 'stamp their mark'

NOW WAS the time for nurses to "stamp their mark, understand their value and ensure they worked in solidarity", kaiwhakahaere Kerri Nuku said in her concluding remarks to conference.

The supply of nurses must be developed and wherever nurses worked, they should not marginalised. There should be no pay differentials, whether nurses chose to work with Māori and iwi providers, in primary health care (PHC) or aged care. "Nurses must be recognised for the skills and professionalism they bring to the health sector. We should never lose the art of nursing and the science," she said.

Recapping the conference theme, Nuku said COVID-19 had been a real test of Aotearoa New Zealand's planning and preparedness. She referred to the inconsistent messages from the Ministry of Health about personal protective equipment – supply, distribution, access and its use. The virus had placed "extraordinary pressure" on an already stretched health system. NZNO supported the call for a royal inquiry, which must include the Health and Safety at Work Act.

She referred to the future nursing workforce, the need to mobilise a PHC/community workforce and that students must take an active role in decreasing health disparities. She stressed the importance of community development and whānau ora approaches, and of ensuring diverse and vulnerable populations were not missed in preparations for the future. •

# New president calls for unity

The need for unity and respect was the clear message of newly-elected NZNO president Heather Symes at NZNO's annual general meeting (AGM) on September 17.

"There is no room on this board for insults or putting people down or working against each other – we are going to work in union," Symes told just over 100 NZNO members, staff and representatives on the organisation's first AGM held via Zoom.

As the country's biggest health union, NZNO must speak with "one voice", said Symes, a forensic mental health nurse based in Canterbury. "We have to work together. We're on the same journey. We're all going in the same direction. We all have the same aims."

Symes promised to be an honest and collaborative leader, and only communicate via official NZNO channels – "I'm not a keyboard warrior".

"We're going to work in harmony, we have a lot of mahi to do and we're going forward as a group, as a union."

She was "thrilled" to be working with vice-president Tracey Morgan (see p44), whom Symes had met at her first NZNO board meeting in 2009. Morgan, and many other Te Rūnanga members seemed "shy" back then, Symes said. "But I'm glad to say they have found their voice and are not afraid to speak out now."

All NZNO members had the right to use their democratic voice, she added, thanking those who voted. Just 6.32 per cent (3185) of NZNO's 50,418 eligible members voted in the by-election to replace former president Grant Brookes, who resigned in April. Of those, 2140 voted for Symes and 974 for the other presidential candidate, Canterbury nurse manager Brenda Close. Three Auckland nurses, Geraldine Kirkwood, Noleen Dayal and Diane McCulloch, were elected to fill the three vacancies left when Katrina Hopkinson, Anne Daniels and Sela Ikavuka resigned in April.

Symes said she hoped to reach as many members as possible during her year in office, and acknowledged Te Tiriti o Waitangi as New Zealand's founding document.

**Heather Symes: 'We are going to work in harmony.'**

Te Rūnanga's Midlands representative Tracey Morgan, who took up the vice-president's role unopposed, agreed. "We are moving forward, we are on a journey together." Both are only in the roles until September 2021, having filled vacancies left by two resignations during a three-year term. Morgan said both she and kaiwhakahaere Kerri Nuku had endured "ridicule" and nasty remarks on social media, but she wanted to stand up and be "freed to care, proud to nurse".

Kaiwhakahaere Kerri Nuku said Aotearoa and NZNO had been through a difficult year. But there were opportunities for "moving past the raruraru [commotion] that we've had and we've got right now". NZNO's whakapapa had seen members rise up and confront challenges "head on". From "maintaining the voice of nurses and, back then, midwives," to developing the supply of students, NZNO "also gave us a place to stand." Nuku said. "The important part of this is solidarity. Staying together, working things out together."

Chief executive Memo Musa said it been a "challenging" year but there had been much good work done by nurses and NZNO to support members and strengthen relationships. Investment was needed to grow the public health nursing workforce, the system's "backbone".

While membership had dropped by 0.9 per cent over the year to 51,634, the trajectory still pointed to growth. NZNO was "lucky" compared to other unions, many of which were seeing a decrease or "stunted" growth, he said. College and section membership also remained strong, and was seeing some growth.

NZNO had ended the financial year with a net deficit of just over $570,000 after adjustment, mainly due to the drop in its investment portfolio in the final quarter largely due to COVID-19. Financial reserves remained "healthy".

Musa said: "We are one profession with many different roles and many different voices. Each voice is important. We are a collective and together we can continue to make a massive influence." •

## Fuller account of 2019 AGM sought

MEMBER GROUPS were given a second opportunity to raise issues over the 2019 AGM minutes, after technical challenges prevented discussions when the minutes were earlier accepted. Te Tai Tonga/Southern regional council chair Linda Smillie said the 2019 minutes were only a summary, rather than a "full account" of the event and its discussions. It was the history of NZNO to learn from and "own" and should be available to members.

Chief executive Memo Musa said generally minutes were only a summary of AGM decisions rather than capturing the "full body" of discussions. He could not release the 2019 AGM recording due to privacy concerns. However, NZNO would release the draft 2020 minutes as early as possible and consider including a fuller summary in future, Musa said. •

# Te poari 'distracted' from goals for Māori

TE POARI would prefer to focus on building flourishing Māori communities for a just and healthy society, ensuring Māori had a voice.

However, its efforts were being "distracted" by the need to defend what it had, kaiwhakahaere Kerri Nuku told the NZNO AGM. Predominantly female, nurses knew what it was like not to be listened to or have others define their needs. "We know what it's like to have our mana diminished by a sexist system that devalues us and what we do."

The same thing was happening at Toputanga Tapuhi Kaitiaki o Aotearoa, with the foundation of its bicultural relationship being "sharply attacked," she said. "Our elders fought to have Te Rūnanga established and pushed even harder to ensure that we have a governance structure where equity shares power."

Kerri Nuku

Te Rūnanga had been accused of being "hungry for power and resources", she said, which was "just untrue".

There were no Māori-specific roles or funding for Māori-centred projects. "There is no real action plan to tackle the 25 per cent pay gap between Māori and iwi providers and DHBs that is informed by the Rūnanga".

## Bicultural relationship

"We do not have unfettered powers or funds," she said. "I am personally saddened by the repeated personal attacks on Māori and the fabric of our bicultural relationship. The insinuations and accusations are designed to take away our voice and our presence and replace it with fear, disappointment, pain, loss and hate."

Te Tiriti expert and constitutional lawyer Moana Jackson has said Te Tiriti-compliant organisations required good faith, compromise and a reasonable balancing of interests. "But we know at the end of the day that equity does not look like anyone other than us to define what we need to do and how we need to operate."

This did not mean Te Rūnanga wanted to impose its needs onto the rest of NZNO, but it was currently facing a threat to autonomy over its own matters.

There were many shared aspirations on the pathway forward – raising a healthy society, advancing the profession of nursing and ensuring "us and our colleagues get the pay and conditions we deserve".

To ensure change, Māori must be persistent to bring about structural and legislative change and to ensure a presence and voice. Te Rūnanga members had provided evidence for the Kaupapa Māori services inquiry, Wai 2575, and Te Rūnanga was involved with the legal challenge against Oranga Tamariki and the mana wahine Waitangi Tribunal inquiry "to name a few".

Nuku shared an excerpt from American poet and activist Maya Angelou's poem, *Still I Rise:*

*Out of the huts of history's shame*
*I rise*
*Up from a past that's rooted in pain*
*I rise*
*I'm a black ocean, leaping and wide,*
*Welling and swelling I bear in the tide.*
*Leaving behind nights of terror and fear*
*I rise*
*Into a daybreak that's wondrously clear*
*I rise*
*Bringing the gifts that my ancestors gave,*
*I am the dream and the hope of the slave.*
*I rise*
*I rise*
*I rise.*

## Anti-violence in strategic plan

NZNO WILL restore mention of its work on violence and aggression against nurses to its strategic plan 2021-25, at members' request during the AGM.

College of emergency nurses New Zealand (CENNZ) chair Sandy Richardson told the AGM it was "really disappointing to see it had been left out".

She was backed by the cancer nurses college, enrolled nurses section and other representatives.

"It's a little disturbing to see that violence and aggression isn't considered at that highest level, because I think it really does need to be acknowledged at that point," Richardson said.

Chief executive Memo Musa acknowledged it was "an important piece of work", included in an earlier draft but removed during board decision-making. It was part of NZNO's work plan. Given the strength of opinion, he was prepared, with the board's approval, to return it. Richardson thanked him for the "responsiveness".

Te Tai Tonga/Southern regional chair Linda Smillie said ensuring NZNO was an "effective and sustainable organisation" should be the plan's first pillar, as "without this the other pillars cannot be attained". Musa agreed, subject to the board's approval.

On that basis, the strategic plan was accepted by 93 per cent of voting members.

The strategy focuses on three pillars: Ensuring an effective, sustainable and bicultural NZNO; a skilled, strong workforce; and influencing improved health outcomes.

On the health workforce, NZNO will work to increase the number of Māori and Pacific nurses, ensure they get a fair deal, and safe and fair working conditions for all members.

On health outcomes, NZNO plans to lobby for a well-funded health system with equity of access and culturally appropriate services that reduce health disparities. •

# Constitution to undergo independent review

A FULL and independent review of the NZNO constitution will go ahead after all 10 constitutional and policy remits were passed at this year's online annual general meeting (AGM), heralding a raft of changes within NZNO's governance and management.

Overall, 3185 votes were received – 6.32 per cent of NZNO's 50,418 eligible membership – chief executive Memo Musa told the AGM.

A non-nurse can now be employed as NZNO's chief executive. While a nurse may still be the preferred option, the board should be able to draw on the "widest range of potential candidates", according to its rationale. This was agreed to by 2096 to 832 votes received, a 66 per cent majority.

An independent professional director can be appointed to the NZNO board, to "provide expertise in specific areas that may be of benefit to the BOD (board of directors) and organisational functioning". This was agreed by 77 per cent of voting members – 2464.

An independent evaluation of NZNO's safe staffing strategies must also be carried out, including care capacity demand management (CCDM), with options for other approaches including nurse to patient ratios to be considered. Opinion had remained divided on the benefits of CCDM and with the agreed date for its full implementation approaching on June 30, 2021, it was "timely" to review its outcomes, according to the NZNO board rationale. This passed by 2738 votes to 148, an 87 per cent majority.

A joint policy remit from the mental health nurses' section and college of cancer nurses for the constitution to be "independently reviewed in its entirety" by an external constitutional expert was accepted by 85 per cent of voting members – 2694 out of 3185 votes received. Any proposed changes would then be subject to the one-member-one-vote process at next year's AGM.

The current constitution's requirements had led to division within NZNO over the past year, the member groups said in their rationale. For example, two special general meetings (SGMs) over the former president were linked to the constitution. "We believe accountability will be better achieved by an external, independent review which identifies the obstacles to an effective organisation which may be embedded within a constitution."

They wanted any recommended changes to "support the practice of leaders and members, to enhance the mana of our members and organisation. This requires an examination of how democratic processes for individual members can work within a bicultural partnership".

It was essential any review was not "limited in its scope", as had been proposed by the board. The reviewer should have strong knowledge of constitutional law and bicultural partnerships.

The board had developed its own terms of reference (TOR) for a constitutional review, excluding any changes which would alter the bicultural partnership (unless ratified by Te Rūnanga) and NZNO's vision, mission and name.

However, as members had voted to accept the joint policy remit, the board's TOR were superseded, chief executive Memo Musa advised members at the AGM. The board was responsible for implementing the review as per the joint policy remit.

Members also agreed to several constitutional amendments to ensure remits which compromised Te Rūnanga or its constitution Ngā Ture would not be subject to the one-member, one-vote process. This was agreed by 2314 to 572 votes, a 73 per cent majority.

In another change, board candidates, including president, vice-president, kaiwhakahaere and tumu whakarae, no longer need to be endorsed by their regional council, te poari or national college or section to stand. Instead, their involvement in NZNO activities must merely be confirmed. The intent was to encourage members to be active, rather than needing endorsement.

Musa told *Kai Tiaki Nursing New Zealand* the board would be discussing the planned constitutional review and other remit decisions at its next meeting, likely to be held late October or early November. Voting online during the AGM eventually went smoothly, after glitches were sorted out, Musa said. •

# NZNO goes into deficit due to less revenue and more spending

NZNO RECEIVED $500,000 less membership revenue over 2019/20, as NZNO membership growth did not meet projections, NZNO corporate services manager David Woltman told the annual general meeting.

NZNO ended the financial year with an after-tax deficit of $842,000. That was the result of $700,000 less revenue and $480,000 more spending across a range of areas including consultancy, legal fees, staffing, travel and member insurance. Further investment gains adjusted the net deficit to $571,000.

A board overspend of $119,000 related mostly to legal fees of $130,000. The kaiwhakahaere budget overspend of $47,000 related to annual leave buyout and travel internationally and locally (including the United Nations forum on indigenous issues in New York and a Global Nurses' United meeting in the Dominican Republic, also attended by the former president). A membership committee overspend of $7000 related to travel.

Overall members' funds dropped to $12.6 million, a $570,000 drop. Colleges and sections funds remained stable at $1.692 million, a slight increase. The board's hardship fund established in 2018 sat at $103,000. NZNO's investment portfolio ended the year up $229,000 despite an earlier economic downturn.

Consultancy fees of $349,372 – nearly $100,000 over budget – included a strategic plan review ($16,000); district health board multi-employer collective agreement ($25,000); board elections ($42,000); digital membership database ($50,000), among other things, Woltman said in response to a member query. •


**Lorraine Hetaraka, with daughter Matariki, a first-year nursing student at Te Whare Wānanga o Awanuiārangi, and mokopuna Isla Waiāhorangi.**

# 'Growing the workforce takes time, resources'

**The new Māori co-leader of National Nursing Leaders outlines the range of initiatives that are helping lift the number of Māori in the nursing workforce.**

By co-editor Mary Longmore

Racism and discrimination in all its forms must be addressed before the Māori nursing workforce can grow and flourish, says the new co-leader of the National Nurse Leaders (NNL) group, Lorraine Hetaraka (Ngāti Kahu, Tapuika, Ngāti Pikiao, Ngāti Ranginui, Ngāi Te Rangi).

"Until there is a significant, conscious cultural and social shift across the whole system, the numbers are unlikely to change," she said.

Chief executive of Te Arawa Whānau Ora – a collective of whānau ora providers in the Te Arawa/Bay of Plenty region – Hetaraka was appointed in June to co-chair the high-level strategic leadership group, alongside College of Nurses Aotearoa executive director Jenny Carryer.

Workforce statistics from the Nursing Council show the number of nurses identifying as Māori rose from 4357 in 2018/19 to 4541 in 2019/20. But the workforce grew too, meaning Māori nurses remained about 7.5 per cent of the overall nursing workforce of 61,165. The national Māori population is around 16.5 per cent.

Until wider systemic issues were addressed, the Māori workforce was unlikely to grow significantly, Hetaraka said. Those included all forms of racism and discrimination, the need for equal power and influence and access to resources.

The health and disability system panel report *Pūrongo Whakamutunga*, the Waitangi Tribunal Hauora report on stage one of the health services and outcomes kaupapa inquiry (Wai275) and the Ministry of Health (MoH)'s *Whakamaua: Māori health action plan 2020-2025*, had all emphasised these, Hetaraka said.

Data from health consultancy TAS, which manages the advanced choice of employment process, showed limited growth in the number of Māori nurses coming through the nurse-entry-into-practice and a slight increase in nurse-entry-to-specialist-practice over the past four years. Nor had there been much growth in Māori taking up clinical leadership roles, such as charge nurses, nurse educators, directors of nursing or in governance, "so, there is much work to be done", Hetaraka said. That included recruiting more Māori into primary care. "Our role as nurses is to critique the system that reproduces inequitable outcomes and ensure we get more Māori nurse leaders into positions of influence."

However, several initiatives "pepper-potted" across the sector could start to bear fruit in three to five years, she suggested. (See box p19.)

**MĀORI NURSE EDUCATION:** An encouraging area was the growth of kaupapa Māori nursing programmes.

The Manukau Institute of Technology (MIT) this year launched a bachelor of nursing Māori (BNM), Te Tohu Paetahi Tikanga Rangatira ā Tapuhi. Whitireia New Zealand in Porirua has offered a BNM since 2009 and Te Whare Wānanga o Awanuiārangi in Whakatāne offers Te Ōhanga Mataora, a bachelor of health sciences Māori nursing. "So there are three schools of nursing which are supporting te kaupapa Māori and encouraging Māori to graduate, which I think are enablers for Māori going into nursing."

Such programmes validate a Māori world view as the norm, and tended to be more supportive of "second-chance or adult learners", often Māori or Pacific, with other commitments – to whānau, hapū and iwi – or work.

They often took a holistic approach to learning, considering the social determinants of health and wellbeing.

Having a lecturer working with kaupapa Māori methodology was "really important, especially for undergraduates", Hetaraka said. Face-to-face learning and extra support with things like transport or finances could make a huge difference to Māori, for whom a "one-size-fits-all" approach was not ap-

propriate, given the history of Aotearoa. "Colonisation has led to wider intergenerational impacts, including Māori being not well-resourced."

Her daughter, Matariki, is a nursing student at Awanuiārangi, where many lecturers are Māori and cultural safety, tikanga and te reo Māori are embedded across the programme, rather than in separate papers – an approach that would work well in all nursing schools, she believed. "Matariki will come out with dual competencies, meaning she will come out as an excellent nurse but also culturally safe. This speaks to the value these students add to the system."

Such programmes brought to life te Tiriti as a "lived partnership", she said.

Awanuiārangi, along with Toi Ohomai and NorthTec in Northland, were also beginning to produce high numbers of Māori nursing graduates, she said.

**MĀORI HEALTH ACTION PLAN**: The Māori health workforce is one of eight priorities identified in *Whakamaua, the Māori health action plan*, launched this year.

It is underpinned by the MoH's new Te Tiriti o Waitangi position statement, which emphasises the importance of fulfilling the special relationship between Māori and the Crown under te Tiriti. It "sets the direction" for the next five years, and draws on the voices of Māori and the stage one report of te Tiriti o Waitangi claim Wai 2575 health services and outcomes kaupapa inquiry.

Hetaraka said the NNL group would be discussing how to contribute to *Whakamaua*, which she hoped would address "key issues that impact Māori at every point of the health and disability system".

Put together, said Hetaraka, "we have a lot of different initiatives occurring across the ground". But there was no quick fix. "Growing the workforce takes time and resources, for a targeted approach where we critique, monitor and hold the system to account."

Meanwhile, NNL's role was to monitor the data, ensure equity policies were embedded across district health boards, including recruitment, and work with the new Māori health strategy. "Our chief focus is to look at *Whakamaua* and how nursing contributes to this."

Nurses could be so powerful in lobbying for change, Hetaraka said. "As the largest single profession in the country, we have an opportunity to influence those key eight areas [in *Whakamaua*] and improve equity across the whole workforce."

**PRIMARY HEALTH CARE:** There was also work to be done in boosting the Māori workforce in primary health and aged residential care (ARC), Hetaraka said. "Prevention is where we can really contribute." She wants to see more Māori nurse graduates, prescribers and nurse practitioners in primary health care.

During the COVID-19 lockdown, iwi provider Māori nurses stepped up, they were first responders, taking care of their koeke (elders) in the community. "That ability to rapidly respond, manaaki, and reach out to support their community, is a real strength for Māori.

"Māori nurses were caretakers for the whānau and hapū across the country." Their efforts saw a significant increase in 'flu vaccinations and COVID testing, and strengthened engagement with whānau. "We were able to identify whānau in need of support and visit them, ensuring they had access to essential supplies, and providing reassurance to whānau with long-term conditions. That was wider than health, that was about whānau ora."

**NATIONAL NURSING LEADERS GROUP**: The co-leadership model came as NNL adopted a bicultural structure "to ensure there is a strong focus in the current Government on partnership, equity and te Tiriti," said Hetaraka. She is also the College of Nurses Aotearoa co-chair; a Health Workforce advisory board ministerial appointed member and programme sponsor (chair) of Ngā Manukura o Āpōpō, the national leadership programme to grow the Māori nursing and midwifery workforce.

NNL is a collaborative forum of nursing leaders from across the sector who provide a nursing perspective to the MoH and health decision-makers.

As well as exchanging ideas, its members had the potential for significant influence, Hetaraka said. "It's a strategic group that's able to prioritise where we should be sharpening the pencil for nurses across the country."

Its Māori caucus includes Tōputanga Tapuhi Kaitiaki o Aotearoa NZNO kaiwhakahaere Kerri Nuku; Te Ao Maramatanga New Zealand College of Mental Health Nurses kaiwhakahaere Chrissie Kake; Te Kaunihera o Ngā Nehi Māori, National Council of Māori Nurses' tumuaki Donna Foxall and tumuaki tuarua Jo Marino; Whārangi Ruamano, nurse education in the tertiary sector, Mereana Rapata-Hanning and MoH senior adviser Ramai Lord. •

## Initiatives to boost Māori workforce

- TE ARA Oranga is an MIT-Counties Manukau pilot project to support 500 Māori and Pacific school leavers into health careers by 2025. It supports Māori and Pacific students through their studies and into work with mentoring, coaching and personalised support. "The reality is Auckland is the largest epicentre for nurse graduates, so it's good to see there are initiatives to feed more Māori and Pacific into the workforce."
- KIA ORA Hauora *Supporting Māori into health* is another collaboration between the MoH and DHBs to grow the number of Māori working in the health and disability sector. An online "hub" provides tools, resources and networks.
- A RANGE of hauora Māori scholarships are available through the MoH for Māori studying health sciences and new graduates.
- NGĀ MANUKURA o Āpōpō is a MoH training programme to grow Māori leaders in nursing and midwifery.
- A NEW nurse practitioner (NP) training programme at the University of Auckland will focus more on attracting Māori and Pacific nurses from 2021.
- TE KAUNIHERA, the National Council of Māori Nurses, runs an annual Māori student nurses hui, which was a great opportunity for Māori tuakana and teina to come together. "Mentoring from and accessing experienced Māori leaders is really important," Hekarata said.

# Nursing people with Parkinson's disease

**Many challenges confront a nurse working with people with Parkinson's disease. This is due to the nature of the disease, with symptoms and progression varying widely.**

By Claire Fisher

Parkinson's New Zealand is a charitable trust employing more than 20 Parkinson's nurses throughout the country. They provide support, education and information to people with Parkinson's and Parkinsonism conditions, including their family, carers and health professionals.

Parkinson's disease (PD) is named after English doctor James Parkinson, who first wrote about this condition in *An Essay on the Shaking Palsy* in 1817. Most people, when you say the words PD, think of the shaking, a resting tremor. Although this is synonymous with Parkinson's, the disease is actually much more than shaking.

I started my nursing career many years ago at a regional neurology unit at Charing Cross Hospital in central London. How well I remember counting out those little light dapple-blue Sinemet tablets. After two years in different neurology units, my work took a different direction for some time. However, it was a move to New Zealand that led me back to where I started – my passion, neurology – in particular nursing people with Parkinson's (PWP).

According to Parkinson's UK, *"Parkinson's is the fastest growing neurological condition in the world, and currently there is no cure."*[1]

A study in New Zealand by senior research fellow Toni Pitcher and data scientist Daniel Myall from the University of Otago's Brain Research Institute in Christchurch, shows the incidence of Parkinson's is gradually increasing, from an estimated 7300 in 2006 to 10,700 in 2017.[2] The researchers predict the number of PWP in New Zealand will increase in the next 25 years to 17,500 by 2035, and grow to 24,000 by 2068.[2] There is ongoing research and several hypotheses as to why Pākehā – New Zealand Europeans – have the highest incidence, followed by the Asian, Pacific and Māori populations.[3] Māori rates are the lowest among all ethnic groups.[3]

**Claire Fisher discusses the importance of exercise alongside medication with client Graeme Blackburn.**

PD is a chronic progressive neurodegenerative condition caused by insufficient amounts of the chemical dopamine. Dopamine allows for fast, efficient, well-coordinated movements. PD has both motor and non-motor symptoms. It is more common in older people and in men than women.

The Parkinson's Foundation states: *"More than 10 million people worldwide are living with PD . . . Men are 1.5 times more likely to have PD than women."*[4]

PD often takes many years to develop and has little effect on life expectancy. Different people will experience a different number and combination of symptoms, which affect all aspects of daily life.[5] It is relatively common, with approximately one in 500 people having the condition.[4] It is believed one per cent of people above the age of 60 have Parkinson's. It does not directly cause morbidity. However, associated complications, such as falls and pneumonia, are often associated with death.[5]

There are four main symptoms of Parkinson's: tremor, bradykinesia, postural instability and rigidity. However, there are many other symptoms too – loss of smell (often an early sign), impaired posture and balance (PWP often present with the classical stoop), and loss of automatic movements, such as blinking, smiling or moving of arms. PWP can experience speech and swallowing changes, and writing can become very small.

The non-motor symptoms can be particularly debilitating. These can include fatigue, mood disorders (depression and anxiety), constipation, sleep and urinary problems, orthostatic hypotension, weight loss, problems with vision, cognitive changes, hallucinations, delusions and pain.[6] With so many variable

symptoms, it is an extremely individual disease which can be incredibly challenging to manage. No two people present in exactly the same way with symptoms or disease progression.

Treatment focuses on managing symptoms. Levodopa, which was developed back in the 1960s, is still considered the gold standard for treatment of Parkinsonian symptoms. Other medications include dopamine agonists, monoamine oxidase-B (MAO-B) inhibitors, amantadine and anticholinergics. It is very common for PWP to take a number of these throughout the day. Timing of medication is crucial to provide the greatest benefit.[7]

## Surgical option

Deep brain stimulation is a surgical option used to treat PD when medication is no longer controlling symptoms. It uses mild electrical pulses through planting electrodes in the brain. These stimulate precisely targeted areas to treat PD symptoms. Although reversible, deep brain stimulation is not a cure and not suitable for everyone. It is usually most effective at improving tremors, slowness of movement and stiffness of joints. In New Zealand, it is carried out on fewer than 20 patients a year.

In most cases, the cause of Parkinson's is idiopathic (unknown). Most research points to a number of combined factors. It is believed there is a strong genetic element in about 30 per cent of cases,

**There is ongoing research and several hypotheses as to why Pākehā – New Zealand Europeans – have the highest incidence of PD.**

but not all who carry these genetic mutations will get PD. Researchers believe other factors, such as environment and age (the biggest risk factor), all have a combined effect on whether the disease develops.[8]

Recent research suggests that vigorous exercise has a neuroprotective effect in PD. Exercising helps PWP use the dopamine they have more efficiently and can slow disease progression. No drugs to date have been proven to have this effect. Everyone with Parkinson's should exercise and research supports a variety of exercises, such as walking, boxing and dancing.[9]

## Nurses a valuable resource

Parkinson's New Zealand's team of nurses across the country support people in our communities. Parkinson's nurses visit clients in their own homes, providing individualised advice through personal assessment. PWP are best seen in their own home environment, as they are frequently frail, and the severity of their symptoms fluctuates and changes rapidly during the course of the day. This can make attending appointments off-putting and difficult for them.

PWP are at high risk of hospital admission, but by regular contact with their clients, Parkinson's nurses are able to identify risks and intervene early to prevent these crisis admissions. A multidisciplinary approach is needed to manage a PWP effectively.[10]

The work of Parkinson's nurses is extensive. They support the client, their family and carers by giving information and support to an agreed plan that promotes best health and lifestyle. They also work closely with GPs, specialists and other health-care professionals. They advise, liaise and make referrals to services such as speech and language therapy, physiotherapy and occupational therapy and act as a resource for health-care professionals, providing education sessions as needed.

Parkinson's New Zealand nurses are there for the wellbeing of the person living with Parkinson's, providing professional support, information and advocacy. They work across the country and are a valuable resource, not only for their clients, but for all health-care professionals, who are helping navigate someone on their Parkinson's journey.

I am passionate about my role and the great Parkinson's nursing team I am fortunate to work with. Since I began writing this article, our world has changed immensely. The COVID-19 lockdown temporarily stopped face-to-face Parkinson's nurse home visits. Spreading globally, COVID-19 is a new viral illness and, as a result, we don't yet have accurate information about what its impact might be on those with PD.

## COVID-19 poses greater risk

Although the Ministry of Health has not as yet specified that PWP and Parkinsonism conditions are a high-risk group, the National Health Service in the United Kingdom has identified PWP as being at greater risk of severe morbidity or mortality should they get COVID-19. This is due to the numerous implications for PWP that coronavirus poses.[11] This sentiment is shared by a variety of Parkinson's leaders across the world.[12]

During these challenging times, our nurses remain committed to staying in touch with people who need our care more than ever. Whether by email, phone or video link, Parkinson's nurses are continuing to provide support and advice to our clients, families and carers. •

**Claire Fisher, RN,** is the team leader for clinical services at Parkinson's New Zealand (www.parkinsons.org.nz).

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# Nurses are crucial in the fight

**Nurses understand the impact of the environment on individual and population health. That understanding is crucial to ensuring health justice in interventions to mitigate climate change.**

By Michael Brenndorfer

As nurses, in our multifarious settings, we observe daily how the environment affects the health of those we care for and support. Throughout the year, we observe the ebbs and flows associated with seasonal changes, and the positive and negative ways these contribute to health outcomes. We see the impacts on health of poor housing, stressful family dynamics and workplaces, communities with limited healthy food options and of institutional racism and marginalisation.

## Nurses at the frontline

Similarly, as nurses, we continue to be at the frontline, observing the negative impacts of climate change on the health and wellbeing of our communities. The scientific evidence on the matter is clear – climate change is happening and it will have significant impacts on health in an inequitable way.[1] But we can do things to mitigate climate change, and many of these will have benefits for the health of our populations.

The impacts of climate change are very broad and, consequently, so are its impacts on health. In Aotearoa New Zealand climate change will lead to rising average temperatures, greater frequency of unpredictable weather patterns, with extreme rainfall events. We can expect wetter weather in the west, with likely drier weather and potential droughts in the east and north.[1] These predicted climate impacts, both local and global, will disrupt food production leading to food insecurity issues, while flooding will increase the potential for contamination of our water and food supplies.[1]

An increase in temperature of around two degrees is sufficient to allow mosquito varieties associated with vector-borne diseases to become established here, potentially leading to the transmission of illnesses such as dengue fever.[1]

Michael Brenndorfer

In the *Youth 19* survey young people revealed concerns about the negative impact of climate change on their mental health.[2] Anecdotally, in my role as a youth health nurse, young people frequently highlight the existential fears of climate change when discussing their own anxiety and depression symptoms. Previous research shows a clear association between the experience of extreme weather events and mental health issues.[3]

Increases in temperature and dampness will exacerbate asthma associated with sub-standard housing, an issue which already means Aotearoa New Zealand has high rates of, and inequities in asthma and respiratory illness.[4]

Health inequities arise from systemic forces and involuntary exposures, which create differences in health outcomes between different population groups. Climate change as a global health issue acts as an "involuntary exposure" which compounds and exacerbates existing inequities.[5] This means low to middle-income countries experience greater impacts and more major disruptions from climate change than high-income countries. Climate change refugees are an anticipated consequence of this situation. This is particularly so for our Pacific neighbours who are acutely vulnerable to rising sea levels.

In Aotearoa New Zealand the health impacts of climate change are magnified by the social determinants of health, exacerbating existing inequities.[1] Those already experiencing inequitable health outcomes associated with age, structural racism, disability status, location and socioeconomic status will be harder hit by the health impacts of climate change.

Māori and Pacific populations, who already experience a disproportionate burden of health conditions, will experience greater impacts of climate change. Increased risks of infectious diseases, respiratory illnesses due to substandard housing, mental health issues and food insecurity already disproportionately affect Māori. Their impact will be increased through the effects of climate change.[1]

The good news is that we can do things to mitigate climate change, and many of these will have benefits for population health and on health inequities. Reducing carbon emissions will also have positive impacts on health outcomes.

Interventions to increase active transportation in Aotearoa New Zealand have been shown to significantly improve health outcomes, reduce risks of injury and accidental death, and reduce carbon emissions. An analysis of investment into active transport infrastructure in New Plymouth and Napier saw an increase in non-motorised trips of 30 per cent, and a reduction of carbon dioxide emissions of 1149 tonnes annually.[6] At the same time, the health benefits of increased active transport contributed to a reduction in diabetes, depression, cardiovas-

**. . . we can also work to put health equity at the centre of climate change interventions by calling for ones with a focus on health justice.**

# against climate change

## What is OraTaiao?

ORATAIAO: The New Zealand Climate and Health Council is made up of more than 700 health professionals concerned with:

- The negative impacts of climate change on health, wellbeing, and fairness;
- The gains to health, wellbeing, and fairness that are possible through strong, health-centred climate action;
- Highlighting the impacts of climate change on those who already experience disadvantage or ill-health (ie equity impacts);
- Reducing the health sector's contribution to climate change.

In addition to individual members, we have the backing of 18 of New Zealand's leading health professional organisations, including NZNO, for our Health Professionals Joint Call to Action on Climate Change and Health. Together, these organisations represent tens of thousands of New Zealand's health professional workforce.

As an organisational member of the board of the Global Climate & Health Alliance, we are part of a worldwide movement of health professionals and organisations urgently focusing on the health challenges of climate change and the health opportunities of climate action.

We honour Māori aspirations, are committed to the principles of Te Tiriti o Waitangi and strive towards the elimination of health inequities between Māori and other New Zealanders. We are guided in our practice by the concepts of kaitiakitanga, kotahitanga, manaakitanga and whakatipuranga.

If you are keen to become more active please contact us at www.orataiao.org.nz

cular disease, respiratory illnesses, and injuries, becasue of safer walking and cycling infrastructure. This resulted in a reduction of disability-adjusted life years (DALYs) of 34.5.[6]

### Reducing carbon emissions

Improvements to housing and rental standards can help reduce carbon emissions with co-benefits for health. With increased energy demands, it is anticipated that, unless housing standards change, they will contribute to an increase in carbon emissions from energy production of 35 per cent within the next 10 years, through non-renewable, fossil fuel energy sources.[7] However, through requirements to insulate houses, have energy-efficient heating options, ventilation and other improvements, household energy consumption can be greatly reduced, while simultaneously reducing negative health outcomes. This will see improvements in rates of asthma exacerbations and other respiratory illnesses associated with cold, damp housing.

Food production and consumption is another area where action can reduce carbon emissions with co-benefits for health. A movement towards whole plant foods has the potential to reduce carbon emissions associated with diet by up to 42 per cent, with a consequential positive impact on health. This has been estimated to result in improvements of 1-1.5 million QALYs in Aotearoa New Zealand.[8]

Animal agriculture results in higher levels of carbon emissions than plant-based agriculture. And the consumption of a diet high in processed animal fats is associated with increased risk of dietary-related health issues, such as cardiovascular disease, some cancers and diabetes. Analysis of the benefits of such a dietary shift also showed a significantly greater positive impact on health outcomes for Māori.[8]

Since the foundation of the profession, nurses have been important change agents, tasked with addressing environmental impacts on the health of those we care for. Specifically, Florence Nightingale emphasised the role of nurses in ensuring an environment conducive to healing.[9] While Nightingale could not have imagined climate change or its environmental impacts, nurses should be expected to remain as change agents. The impacts of climate change on the populations we care for should be a catalyst for action to mitigate climate change.

From our unique perspective as nurses, we can also work to put health equity at the centre of climate change interventions by calling for those with a focus on health justice. This can be as simple as raising awareness of the impacts of climate change on health when discussing the issue with friends and family. We can also identify and address how our health care systems and services contribute to carbon emissions and unsustainable clinical practices. Acknowledging the impacts of our individual and collective actions on planetary and population health is an important extension of our roles as nurses, as conceptualised by holistic nursing philosophies. It is right that nurses are at the forefront of calls for action on climate change.

### Overcoming powerlessness

I am the NZNO representative member on the executive committee of *OraTaiao: the New Zealand Climate and Health Council* (see box at right), one of two registered nurses on the board. I would like to extend an invitation to nursing and midwifery colleagues to support the work the council does in placing health justice at the centre of climate change interventions. Becoming a council member and supporting the council's work is one way to overcome the sense of powerlessness when faced with such a massive issue as climate change. •

* *References for this article are on p45.*

**Michael Brenndorfer, RN, BHSc, MHPrac(nsg),** is a youth health nurse and nurse educator for school-based health services in West Auckland.

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**Astrocytes, shown in this 3D illustration, are brain glial cells which connect neuronal cells to blood vessels. They are the most common cells in the brain and are now the target of new research on Parkinson's disease.**

# New thinking on Parkinson's disease

**Research into the function of astrocyte cells in the brain provides a potential new avenue for Parkinson's disease therapy.**

By Georgina Casey

The major signs and symptoms of Parkinson's Disease (PD) – such as rigidity, resting tremor and bradykinesia – have long been attributed to the accumulation of abnormal proteins (Lewy bodies) in dopaminergic neurons in the brain's basal ganglia. These eventually lead to the death of the neurons. The non-motor effects of PD – dementia, depression, sleep disorders etc – occur as damage spreads to other neurons.

But the actual causes of PD – what triggers the process that leads to the death of these neurons – are unknown. For many years, the focus of research was on the neurons themselves, but more and more, researchers are looking at the other cells in the brain for answers to the puzzle of neurological diseases.

While genetics plays a small role in the development of PD, age is the greatest risk factor. Environmental factors, including pesticides and toxins, also increase risk,[1] but we do not understand why some people are more susceptible than others given the same risk exposure. And, while PD is unique among neurodegenerative diseases in having effective therapies for symptom control, there is no cure or therapies that delay its progression.[2]

## Lewy bodies

Abnormal processing of the protein alpha-synuclein has been shown in the neurons affected by PD, leading to its accumulation (as Lewy bodies) and spread to other regions of the brain.[2] Interestingly, the original sites of this abnormal protein activity are thought to be the olfactory bulbs and gut enteric nerves – the very earliest features of PD are anosmia and constipation.[2] Lewy bodies contribute to, and/or may be caused by, mitochondrial dysfunction in affected cells. In turn, abnormal mitochondria increase oxidative stress in the cell, damaging structures and affecting function.

Oxidative damage and the presence of Lewy bodies trigger inflammatory responses in the brain that further damage the cells and may increase Lewy body formation. Thus, a cycle of abnormal alpha-synuclein, cellular damage and neuroinflammation is generated and spreads to critical regions of the brain.[2]

A team of researchers has now identified that similar processes may be occurring in some of the supporting (glial) cells of the brain. Astrocytes are the commonest cell type in the brain and were thought, until recently, to act only as supporting cells for neurons – ensuring a constant energy supply and maintaining the blood-brain barrier.[3] But they also regulate synapse formation and elimination, and play key roles in regulating neuroinflammation and protecting against oxidative stress.[3] Astrocytes also exchange mitochondria with neurons in response to cell damage or stress.[4]

Conventional thinking in PD states that astrocytes scavenge abnormal alpha-synuclein deposits as they develop in the neurons until they eventually become overwhelmed, at which time Lewy bodies start to form.[4]

However, a recent study has shown that astrocytes have increased production of alpha-synuclein in people affected by PD and that these cells are much more responsive to inflammatory triggers than non-PD astrocytes. The mitochondria of affected astrocytes are also abnormal.[5] Thus, astrocytes show similar pathological changes in PD as the affected neurons and may present a target for future therapies. •


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# Using PPE correctly and safely

**Unless health-care workers are fully trained in the best use of personal protective equipment, they risk being infected with COVID-19 and other pandemic and epidemic viruses.**

By Alex Pajel

Many human viral diseases result from a zoonotic event (transfered from an animal). Some of these diseases have affected millions of people around the world, and some have resulted in high rates of morbidity/mortality in humans.

Zoonotic outbreaks over the last two decades include severe acute respiratory syndrome (SARS-CoV) in 2002, MERS-CoV in 2012, Ebola virus in 2014 and, in December 2019, a world outbreak of a novel coronavirus (SARS-CoV-2). This initially emerged in a wholesale seafood market in Wuhan, China, with bats the likely original hosts and pangolins as potential intermediate hosts.[1]

SARS-CoV-2 is the etiologic agent of coronavirus disease 2019 (COVID-19), which causes severe respiratory illness in humans. Based on current evidence, it is transmitted through close contact and droplets, as previously seen in SARS-CoV and MERS-CoV. Airborne transmission may also occur during aerosol-generating procedures. It was recognised as a pandemic by the World Health Organization (WHO) in March 2020 and has had considerable global economic and health impacts.[2,3] This pandemic has also highlighted the vulnerability of health-care workers to respiratory infections.

A major challenge in every pandemic is the effective protection of health-care workers as they are at risk of infection themselves. Health-care workers use personal protective equipment (PPE) to protect themselves from droplets from coughs, sneezes or other body fluids from infected patients and contaminated surfaces that might infect them. Recommendations for the use of PPE to protect against SARS-CoV-2 exposure by health-care workers were recently published by the WHO and the United States Centers for Disease Control and Prevention (CDC). There are questions regarding the effectiveness of PPE as an infection control strategy to protect health-care workers during the COVID-19 pandemic and other epidemics. Does it lead to an increased, rather than decreased, risk of infection among health-care workers if proper selection, fit, sequence for donning and doffing or adequate training is not implemented? This includes correct and consistent use, disposal, disinfection and maintenance.

## Risks to health-care workers

Health-care workers are at the front-line in every pandemic and epidemic outbreak. Their constant exposure to infected patients and contaminated surfaces can put them at risk of acquiring the infection. One study showed that procedures capable of generating aerosols have been associated with increased risk of virus transmission to health-care workers.[4]

During the 2002-2003 SARS epidemic, approximately 1725 front-line health-care workers were infected. During the COVID-19 pandemic, it was estimated that from December 2019 to February 2020, 1716 Chinese health-care workers were infected by COVID-19 and five died.[5,6] In Lombardy, Italy, the number of positive health-care workers was 10,627, with 34 deaths to date. Deaths among health-care workers in the United Kingdom (UK) were seven as of April 2020.[7] During the Ebola virus outbreak in West Africa in early 2013 to 2016, a high proportion of infections were among health-care workers.[8,9]

Infection among health-care workers during the aforementioned pandemics and epidemics were attributed to PPE shortages, incorrect PPE, inconsistent use of PPE, inadequate fit testing, insufficient training with donning and doffing, suboptimal hand hygiene before and after contact with patients, and protocol failure.[6-10]

Specific requirements for health-care workers' protection are advisable to ensure the functioning of the health-care system. Understanding the transmission risk is particularly important for guiding evidence-based protective measures in health-care settings.[11]

## Knowledge and practice gaps

PPE use is aimed at preventing transmission of these viruses from patients to health-care workers and vice versa, particularly when no effective treatment or prophylaxis is available. PPE includes gloves, surgical face masks, goggles or face shields and isolation gowns, as well as N95 respirators for aerosol-generating procedures.[12]

During a pandemic and epidemic, cor-

rect PPE use is crucial. As health-care workers frequently need to use several types of PPE, issues arise regarding the integration and interface of these items to ensure they provide the best protection and that contamination is avoided.[13] Findings from the literature have shown that even the best-designed and engineered PPE will not protect health-care workers if it is not selected appropriately, is unreliable or unusable due to incorrect fit, inconsistent use and training in the proper sequence for donning and doffing, and disposal or maintenance is insufficient.[7,8,9,15]

A number of randomised control trials and studies show that inconsistent use of PPE, insufficient training and inadequate fit of masks can put health-care workers at risk of infection such as COVID-19 and other viruses. In a randomised control trial, health-care workers who wore surgical masks or N95s throughout their work shift were significantly protected against nonspecific respiratory infection, compared to those who did not. However, assessment of clinical outcomes was self-reported and prone to bias, as the intervention cannot be masked.[15]

## Dangers of insufficient training

Evidence from a cohort study conducted among health-care workers in Hong Kong and Toronto showed that insufficient training in and inconsistent wearing of either a surgical mask or an N95 was associated with developing SARS when compared with sufficient training and consistent use.[10] The efficacy of respiratory protection in preventing respiratory infection among health-care workers may easily be lost, if compliance is poor or insufficient training is provided. Other studies have shown that inadequate fit of masks could compromise respiratory protection and impair vision, due to masks moving on the face. Continuously touching the mask, even with gloved hands to adjust it, can result in self-inoculation when the health-care worker inadvertently touches their face, eyes, nose or mouth. Some volunteers wore glasses which steamed up, showing further evidence of poorly-fitted masks.[8,13]

Recent studies, simulations and reviews have examined the dangers to health-care workers during PPE removal. This is when the risk of contamination is highest. Researchers found that the sequence of PPE removal, complication or error in doffing, protocol failure, hand-hygiene compliance, problems with protection, comfort and function were significant factors in contamination of health-care workers. An observational study performed in 11 hospitals in Canada found that only half the health-care workers removed their PPE in the correct sequence and hand hygiene was not routinely performed after PPE removal, thereby creating opportunities for self-contamination.[14] In a UK study in 2018, researchers saw that the health-care workers were frequently contaminated, either through a protocol failure of the PPE ensemble itself, complication or errors in doffing.[8]

A recent experimental simulation of intubation was conducted by researchers using fluorescent-simulated body fluid. This demonstrated contamination of the air in the breathing zone of participants and on the gloves, gowns (torso and cuffs) and face shields of participants.[16] Another study evaluated seven PPE ensembles designed for use for highly infectious diseases using a human factors lens. This found problems with protection, comfort, function during simulated care activities and doffing, which is similar to a 2020 Cochrane systematic review.[17] The review found there was low to very-low certainty evidence that covering more parts of the body led to better protection. Also, this usually comes at the cost of more difficult donning or doffing and less user comfort, and may therefore even lead to an increased risk of contamination when health-care workers remove it.[18]

PHOTO: DEMKO DE WAAL,NP/AFP

**The provision of PPE has limited benefit and is only one strategy within a hierarchy of infection prevention and control measures.**

Overall, the knowledge and practice gaps in the effective use of PPE shown in different studies, simulations, randomised trials and reviews strongly demonstrated that PPE may cause more harm than good and may contribute to an increased risk of having COVID-19 infection and other respiratory infections among health-care workers.

The proper use of PPE by health-care workers is vital in protecting them from biological hazards such as COVID-19 and other viruses. Fundamental is the selection of the correct PPE for each setting and context.[12,19,20] The Health and Safety at Work Act 2015 legislates that an employer will provide suitable PPE for an employee in their work. The employee must also receive adequate education and training.[21] The Ministry of Health, in line with the WHO guidelines, recommends the consistent use of PPE during exposure to biological hazards, the correct sequence of donning and doffing, performing hand hygiene after removal of any element of PPE and proper maintenance, disinfection or disposal of PPE.[12,19]

One of the critical features in helping achieve consistency in wearing PPE may be the comfort and proper fit of the equipment itself.[13] Multiple respirators should be available, because it is unlikely one model or size will fit all employees. Filtering facepiece respirators, including N95s, rely on having a good seal with the wearer's face. Therefore, a face fit test and pre-use seal check or fit check should be carried out in compliance with the NZ Standard AS/

NZS 1715:2009 to ensure the respiratory protective equipment can protect the wearer against biological hazards. This is supported by several studies.[10,19,22] For correct donning and doffing procedures, CDC guidance provides a useful protocol.[23] A one-step glove and gown removal, and hand hygiene after PPE removal can reduce contamination or self-inoculation.[18]

Increased compliance and reducing errors can be achieved by having detailed policies and protocols, personal supervision, spoken instructions during doffing, face-to-face education and training in PPE use rather than folder-based training, checklists, audits of performance, providing feedback and allowing sufficient time for donning and doffing.[9,18]

## Buddy system for instruction

A lesson the UK military learned from deployment on Operation Gritrock during the Ebola virus epidemic was to have a donning and doffing supervisor. When this was not possible, a buddy-buddy system was used. This can reduce self-infection/cross-contamination and provides automaticity of safe and efficient donning and doffing of PPE among health-care workers.[7] Qualitative feedback supported having a buddy present to instruct during doffing. This helped ensure fatigued staff followed the correct doffing procedure, bringing a personal approach rather than relying on instruction cards, ensuring protocol compliance or necessary intervention was followed, controlling the pace and providing calm reassurance. Ideally, the buddy should be an observer and instructor, but should not physically assist in doffing, to reduce the number of workers at risk of contamination.[8,9]

In occupational health, the hierarchy of controls is best practice. This means that measures with a general effect, such as control of exposure, should have priority over more individual control measures such as PPE. The provision of PPE is only one strategy within a hierarchy of infection prevention and control (IPC) measures.[8,19, 21,24] It should be used in combination with effective administrative and engineering controls, as described in the WHO's IPC measures for epidemic and pandemic acute respiratory infections in health care.[12]

## Conclusion

Health-care workers are at the front line during pandemics and epidemics, exposed to biological hazards that put them at risk of infection. To prevent acquiring infections such as COVID-19, the use of PPE remains critical.

Knowledge and practice gaps may exist in the effective use of PPE that can pose an increased risk of infection among health-care workers. Adequate education and training are vital to prevent compromising the efficacy of PPE or indeed self-contamination while incorrectly doffing it. In addition, the use of PPE in conjunction with other IPC measures among the hierarchy of controls is considered best practice where practicable.

Further systematic studies for effective use of PPE, focusing on optimal types of PPE against transmissible viruses, reengineering PPE, strategies for minimising transmission during the doffing process, and the disease transmission of viruses, especially COVID-19, are needed to ensure health-care workers' safety. •

*This article has been reviewed by Tauranga Hospital IPC clinical nurse specialist Robyn Boyne and the co-editors.*

**Alex Pajel, RN, BN,** is an occupational health nurse at OK Health Services/Habit Health in Christchurch. This article is based on a 2020 assignment for a postgraduate certificate in occupational health and safety at Otago University.

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# Looking beyond COVID-19

**While management of COVID-19 has captured a good deal of attention this election campaign, it is important to consider other concerns that have been around for a lot longer.**

By Matt Roskruge

Who would have thought, as we entered election year 2020, that the world was about to be so profoundly disrupted? The COVID-19 pandemic has dominated public discourse, and acute health, economic and social issues have captured the public psyche.

These urgent concerns have pervaded all parts of society, so it is no surprise, then, that this general election is being framed as the "COVID-election", with political parties jostling to be seen as the best crisis-managers and most "trustworthy hands". This has led to a focus on short-term issues of border management and health and socio-economic concerns. While both important and necessary, is this distracting from a much-needed discourse on the structural issues of our society?

**. . . while the acute response to COVID-19 is important, it appears to have overshadowed debate on the long-standing social and structural issues that have plagued Aotearoa New Zealand . . .**

COVID-19 is a genuinely scary pandemic that leaves us with few, if any, good options. Global and national responses have varied, but each has come with massive socio-economic consequences, and often severe health implications as well. Aotearoa New Zealand chose an elimination strategy with strict border controls, but any other response was judged to come with intolerable health costs and no guarantee of economic gains.

While we've headed down a good path, it has consequences and our politicians must take the lead in mitigating and managing these consequences. With this in mind, the election should address how borders, health, debt and the economy will all be managed.

It is important to keep one eye on the pandemic. However, what is worrying is that the acute response to COVID-19 appears to have overshadowed debate on the long-standing social and structural issues that have plagued Aotearoa New Zealand. These issues have cost lives and compromised wellbeing in excess of what COVID-19 has, or was likely to cause.

These structural issues can vary widely – from structural racism and discrimination we see in things like gender and ethnicity pay gaps, to aspects of Aotearoa New Zealand's public systems which, through underfunding or mismanagement, are now in a position where they are unable to deliver sufficiently on their roles to meet the needs of the public. Simply put, structural issues arise where, due to their design, our institutions, be they tangible, eg the health and education systems, or intangible, eg social and cultural norms, create negative outcomes for some or all of society.

Unfortunately, portions of Aotearoa New Zealand have been in chronic crisis for decades, in part because of these structural issues. While some require a collective socio-cultural response, and others arise through economic resourcing and ideology, all can benefit from political intervention. It's surprising then, that across multiple parties and leaders, politicians have shown a baffling inability or unwillingness to manage these slow-moving crises that require coordination, planning and funding that spans political cycles.

Public infrastructure is, perhaps, the clearest example of where structural issues have arisen through the political equivalent of "passing the buck". Public infrastructure includes our transportation network (which has achieved some development, mostly through strong lobbying), but also less visible networks like water and waste networks. Importantly, it also includes public services such as hospitals and schools. Infrastructure is a difficult issue for governments, particularly those with short political cycles like our own. Public appetite for debt or taxation is low, the costs of infrastructure investment are high and often the benefits are only observed well into the future.

## Lack of health infrastructure

We see this lack of infrastructure investment very clearly in the health sector. Many of our hospitals and public facilities are under severe capacity constraints, while lack of investment and renewal have resulted in buildings that are neither fit for purpose nor enabling of the best standard of care. What is perverse is often this older infrastructure is more expensive to operate and maintain than renewed infrastructure would be, placing further strain on the health budget. As some astute health professionals have observed, the poor state of much of our health infrastructure means Aotearoa New Zealand often struggles with annual flu seasons, let alone something as severe and resource-intensive as COVID-19.

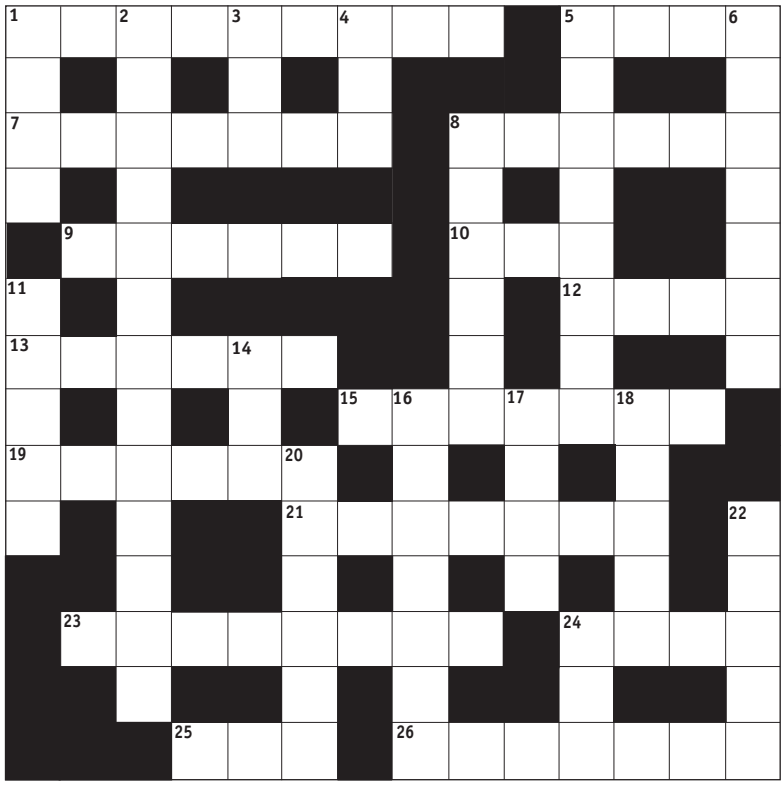
The 2020 election should be the "COVID-19 election", and we should be judging our politicians on their ability to manage their way through this acute crisis. But that doesn't absolve our political classes from thinking about managing the chronic structural issues which continue to challenge our socio-economic development.

If COVID-19 has shown us anything, it is the value of long-term planning and good quality social services in addressing the most unexpected of events. •

**Matt Roskruge, PhD, Te Ātiawa, Ngāti Tama,** is the co-director of Te Au Rangahau and a senior lecturer, School of Economics and Finance, Massey Business School, Massey University.

## crossWORD

Completing this will be easier if you have read our September issue. Answers in November.



**ACROSS**

1) Talks between two parties with impartial third party.
5) Increase in size.
7) Hormone that helps process glucose.
8) Luxury dish of fish roe.
9) What lies ahead.
10) Neither one __ the other.
12) 12 hours from midnight.
13) Stops ship from drifting.
15) Looked up to.
19) A mark of shame/ disgrace.
21) Blustering fool.
23) Endurance, without negativity.
24) These are sought at an auction.
25) Small domesticated carnivore.
26) Nervous strain.

**DOWN**

1) Mutilate.
2) Not working properly.
3) Get sick.
4) Charged atomic particle.
5) Boss at Reserve Bank.
6) An alert to danger.
8) Type of contraception.
11) Untrue.
14) Unit of electrical resistance.
16) Budget shortfall.
17) It smooths clothes.
18) Boredom.
20) Not present.
22) Beast of the American plains.
24) Carries passengers.

**September answers. ACROSS:** 1. Quarantine. 7. Foxtrot. 8. Diesel. 11. Death. 14. Oasis. 15. Buyers. 18. Karma. 19. Bedside. 20. Sire. 22. Fearless. 25. Sketch. 26. Wisdom. 27. Peace. **DOWN:** 2. Anxiety. 3. Air. 4. Nod. 5. Resign. 6. Below. 9. Iris. 10. Distress. 12. Hospice. 13. Ebb. 16. Endorsed. 17. Emu. 18. Karakia. 19. Bee. 21. Echos. 22. Flaw. 23. Sip. 24. Stye.

## wiseWORDS

> “Sometimes, I am also identified as a civil rights leader or a human rights activist. I would also like to be thought of as a complex, three-dimensional, flesh-and-blood human being with a rich storehouse of experiences, much like everyone else, yet unique in my own way, much like everyone else.”

***– Coretta Scott King (1927-2006), United States author and civil rights activist, wife of Martin Luther King Jr***

## it’s cool to kōrero

HAERE MAI and welcome to the October column. Kiore is the name of the Polynesian or Pacific rat, which came to these shores in the waka of migrating Māori. Kiore were an important food source for Māori and their pelts were used for cloaks. They are now officially regarded as pests, but are of cultural and spiritual importance to some iwi.

Kiore are present in many other Māori words, eg Matukiore (rat island) in Hokianga; the star cluster Kiore; and the carving/tattoo patterns kiri-kiore (rat skin) and Pū-kiore (rat's nest).

### Kupu hou

New word

- **Kiore** – pronounced *“ki-(as in key)-o-(as in aww)-rre-(as in red)”*
- **Kei roto i te rua o te whenua te kiore e noho ana.**

The kiore lives in a burrow in the ground.

### Rerenga kōrero

Phrases

Te Wiki o Te Reo Māori (Māori Language Week) aims to encourage use of te reo. For people just starting on this journey, here are some basic phrases you can use with anyone, anywhere.

- **Kei te pēhea koe?**
  How are you?
- **Kei te pai.**
  Good.
- **A koe?**
  And you?
- **Kei te harikoa au.**
  I'm happy.
- **Kei te maremare au.**
  I've got a bit of a cold.
- **Ka kite anō.**
  See you later.

*E mihi ana ki a Titihuia Pakeho and Keelan Ransfield; e mihi ana ki te* Māori at Work, *by Scotty Morrison, and https://teara.govt.nz*

# The fight for justice and freedom continues

**The legacy of Martin Luther King's fight for jobs, freedom and equality lives on in contemporary struggles.**

By kaiwhakahaere Kerri Nuku

At the opening of the famous August 28, 1963, March on Washington for Freedom and Jobs at Lincoln Memorial Park, civil rights activist Martin Luther King Jr said: *"I am happy to join with you today in what will go down in history as the greatest demonstration for freedom in the history of our nation . . ."*

He fought for jobs and freedom and called for economic rights and an end to racism in the United States (US). His most iconic freedom speech was *I have a dream* – its most powerful lines resonate with, and are the guiding principles for all civil rights activists. *"I have a dream that one day this nation will rise up and live out the true meaning of its creed: 'We hold these truths to be self-evident, that all men are created equal' . . ."*

**Martin Luther King's Jr 1963 March on Washington for Freedom and Jobs attracted a quarter of a million people.**

## Amplifying the voice of nurses

In September, I was part of a panel discussion on the impact of COVID-19 internationally for the National Nurses United (NNU). The NNU is the largest organisation of registered nurses in the US, representing close to 185,000 members across the country. Its focus is to amplify the voice of direct-care nurses and patients into policy. The president, Bonnie Castillo, powerful in her opening address, articulated the issues of racism, xenophobia and nationalism as the NNU's biggest battle, alongside COVID-19. The political voice and the mobilisation of their nurses was truly inspirational – the legacy of Martin Luther King Jr still evident in the fight together, as all of these nurses believed in this dream for their nation.

Our NZNO vision is to be *Freed to Care and Proud to Nurse*. We have much to be proud of and, during the recent pandemic challenges, nurses on the frontline, in aged care, palliative care, community, primary and secondary care, rose up, despite already being under-resourced, short-staffed and tired. Forever a dependable workforce, despite that lack of support, we pushed through because we are committed to caring for our communities.

However, our fight for freedom, nursing presence and voice is far from over. Our collective worth, power and solidarity must be united as we fight for professional rights, working conditions and equal pay. We are united in our struggles but this requires us to believe our dream for freedom to care is possible. Unfortunately, what seems to be happening among some of our members is a divisive undercurrent designed to erode and try to undermine the mana of our organisation.

**Unfortunately, what seems to be happening among some of our members is a divisive undercurrent designed to erode and try to undermine the mana of our organisation.**

In te poari's opinion, over the last few months on social media and in *Kai Tiaki Nursing New Zealand* there has been a relentless focus on NZNO's bicultural framework and attempts to undermine it. Te poari also believes the journal has, as a result of unconscious bias and racism, advocated for western models of leadership and portrayed Māori leadership in a negative light. Te poari feels the results of this unconscious bias and racism are now forever documented in our history.

It seems that freedom for Te Rūnanga is somehow conditional and not available to us without a struggle. Minority voices seem set to undermine and destroy our right to freedom and we must stand together to stop this.

Equal rights and justice in our own country are under threat, as our voice and presence is constantly being undermined. I understand for many it is distressing to stand by and be a spectator to the never-ending attacks, based largely on our whakapapa.

## Persistence and presence

I have been encouraged by the fight from Bonnie Castillo and NNU and expressed our international solidarity. Their persistence and presence does not waver, standing up for jobs, economic rights and an end to racism as we fight for freedom.

We will be judged by history and our actions. I invite us all to join in solidarity and kotahitanga and fight for our freedom and equal rights. •

Siupolu Tavui: Most people are grateful for a chance to talk things through.
PHOTO: AUCKLAND REGIONAL PUBLIC HEALTH SERVICE

# Pacific nurses make 'huge difference'

**A Counties Manukau nurse has loved working with Pacific families affected by COVID-19.**

By co-editor Mary Longmore

Siupolu Tavui had been working as a nurse co-ordinator at a Counties Manukau Health orthopaedic ward when she was called onto the Auckland Regional Public Health Service (ARPHS) team in June. Having identified Auckland's Pacific communities as potentially vulnerable to any COVID-19 surge, ARPHS was rapidly trying to build a Pacific response team – seconding as many Pacific and health staff from Auckland's district health boards and primary health organisations as possible.

With a long-time interest in public health, Tavui was drawn to the year-long contract for an operations manager at ARPHS's COVID-19 response. "When you have an opportunity like that, you have the chance – you have nothing to lose," she said. But, after years in hospitals, "it was like coming to a foreign country".

Nonetheless, Tavui loved it. "The best description I've heard is that in hospitals you see the individual and in public health you attend to the population."

The team was still building its Pacific capacity, when an Auckland family tested positive on August 11, signalling the presence of COVID-19 within the community.

Being a Pacific nurse made a huge difference to the success of the response. "If you are Pacific, then you understand that several families live under one roof, and the spirituality of the family and importance of being together," Tavui said. "Some of us live it, so who better to understand it and ask those questions than the Pacific team?"

Households might include several couples and relatives, and Pacific nurses were better able to find out how many people lived there and how to isolate them.

"Even better" are those nurses who can speak the same language. "They can say 'talofa' or whatever language, and that can be enough to relax people."

Having that connection helped with planning and communicating. "It's all to do with planning what is going to happen. Just being told they are [COVID-19] positive is a lot of personal burden, also on the families and the community. The conversations can be challenging, so it's really important to make that connection," Tavui said.

"How do you explain to a family with eight children that they may be best in separate hostel rooms at a quarantine facility for two weeks, rather than altogether at home?"

But the cultural connection "doesn't take away the frustration and worry" of families, who continue to feel there is a stigma to contracting the virus – despite director-general of health Ashley Bloomfield's message that the virus is the problem, not people, she said.

Mostly, however, people were grateful and appreciative of the chance to talk everything through.

With the crisis response settling down, Pacific nurses are returning to their former roles and just six remain. But the ARPHS team is following through with fixed-term recruitment of more Pacific nurses for its "base" team to manage COVID-19 and other communicable diseases that might impact heavily on Pacific communities in the future – as measles did last year. "It's all COVID right now, but this will help our public health in general, particularly in vulnerable Pacific communities," Tavui said.

For the Pacific response team, "the complexities of what they're dealing with can be overwhelming, especially for the younger nurses". So they have a talanoa – chat – every week.

"We can catch up and share our stories, that's the importance of it." Their shared "weird" Pacific sense of humour also helped, she added.

"I'm very passionate about making a difference and the place to make a difference is here in public health, because if we do this really well, it might reflect in the hospital admissions." •

# Bidding farewell to NZNO after 30 years

**A retiring lead organiser reflects on her time with NZNA/NZNO.**

By co-editor Teresa O'Connor

Careers can be shaped by the strangest of events. For long-serving NZNO organiser Lyn Olsthoorn, the first steps in that career began when she attended a delegates' meeting at Horowhenua Hospital to discuss roster problems. There she encountered a group of senior nurses knitting.

"It was quite a moment when I saw what the activists were doing. I thought 'this is not really for me' – I'd never knitted in my life. I realised no-one really cared about the rosters so I decided to ring an [NZNA] organiser."

The organiser promptly told her she should become a delegate and it was that decision that paved the way for her organising career. Olsthoorn had trained at Wellington Hospital, graduating in 1974. "I can't honestly say I always wanted to be a nurse but I'm very glad I did because I've had a wonderful career."

After working in a surgical ward at Wellington Hospital for three years and some "OE", she moved with her husband to Levin. While a delegate at Horowhenua Hospital, she took part in the first national nursing strike. Members picketed outside Labour MP Judy Keall's office – "I loved every minute on the picket line".

## Sole organiser role

She subsequently became chair of the regional council and, in 1990, the organiser who had first encouraged her to become a delegate encouraged her to take a job as an organiser in the about-to-be-opened Palmerston North office. She became the sole organiser covering Whanganui, Manawatu and Hawkes Bay. Two days' orientation in Wellington saw her meet another new organiser, Glenda Alexander. "We went out for lunch and were a little late back. The educator told us if we were not going to take the job seriously we would not survive at NZNA." Thirty years on, the educator's prediction has been proved spectacularly wrong.

She remembers the '90s as the era of the Employment Contracts Act (ECA) – the end of national awards and the growth of individual employment agreements; the jobs of senior nurses, including up to assistant matrons, "going down the gurgler"; closures of rural hospitals and a never-ending procession of management-of-change processes.

**Lyn Olsthoorn in 1974 and 2020.**

The '90s politicised many nurses, with . With the 1993 amalgamation of NZNA and the NZNU to form NZNO, Olsthoorn was joined by an organiser from NZNU, Denise Stevens, and in 1994 by Craig Walsham. That was the beginning of continued expansion of NZNO's membership and staff numbers. There are now 12 people, including six organisers and a lead organiser, in the Palmerston North office.

The following decade saw a Labour-led Government replace the ECA with the Employment Relations Act. This enabled the rebuilding of national coverage of public sector nurses, through the development of regional multi-employer collective agreements (MECAs). Olsthoorn's responsibility was to bring together contracts from multiple sites, including seven DHBs. Twelve collective contracts were consolidated into the Lower North Island MECA. In 2004, all regional MECAs were brought together into the inaugural national MECA.

Continued underfunding of health, and job and service cuts have been a feature of her work over the last decade.

Despite the relentless and, at times, unappreciated nature of the organiser role, Olsthoorn has loved its variety, the chance to learn something every day and the joy of seeing members make a difference. "I have got enormous job satisfaction from seeing the difference the union makes and how members can make a difference. And, more latterly, I've loved mentoring new organisers."

But there have been dark sides to the role. "I've witnessed some very difficult situations, where people have lost their jobs through no fault of their own. I've seen horizontal violence destroy people. Sadly it has always been a part of the nursing workforce but now another site has opened up – social media. Keyboard warriors attack colleagues without having any idea of, or care about the consequences. Horizontal violence still occurs in the workplace, but is more overt and there are systems in place to deal with it. Its transference to social media is frightening and Nursing Council must have a role in monitoring it."

A situation that will always haunt her is when some caregivers asked for her help. "I met them at the back door of the rest home. They opened a rubbish bin filled with urine-soaked newspapers – incontinent residents had newspapers instead of linen. We challenged the employer, who eventually closed the rest home."

Olsthoorn would like NZNO to refocus on organising, which she believes will, in turn, rekindle greater member activism. "The belief that organising is our reason for being seems to have been diluted."

While a little anxious about retirement initially, she is now looking forward to a different kind of life. "I know it will take some time to adjust. I'll miss the people contact and the day-to-day challenges but they will be replaced by other interests."

Those other interests include her passion for roses, piano and saxophone lessons, refugee resettlement and – most importantly and COVID-19 permitting – spending more time with her Australian and European-based grandchildren. •

# A chequered journey into nursing

**Finding her way into nursing has been a lifesaver for one young nurse. She wishes it hadn't taken her so long.**

Natalie Kerr believes her life experience has prepared her well for a career in nursing.

By co-editor Anne Manchester

After leaving school and home at the age of 14 and living a rather rebellious life trying many different jobs and meeting people from many walks of life, Natalie Kerr has finally found her calling. Nursing has given her a purpose, she says. She only wishes she had found it sooner.

Kerr completed a one-year health science foundation course in 2016 at Whitireia New Zealand in Porirua before beginning her nursing studies. She was 26 by the time she began her nursing degree, sitting exams for the very first time in her life.

When her husband-to-be, a "military man", was transferred to Auckland, Kerr went with him, continuing her degree at the Auckland University of Technology (AUT). This meant adding six months extra study to the three-year programme after completing year-one at Whitireia. During the extra six months, she also completed some paramedical papers.

Making the transition to AUT was hard, Kerr said. "There I was one of 150 students, most of them younger than me. I found the atmosphere in the big lecture theatres very formal after the friendly environment of Whitireia where there were fewer than 80 students in each intake. Emphasis at Whitireia was on hands-on learning, with lots of clinical labs and placements. We all felt very well cared for."

Although Kerr completed her nursing degree three months ago, she did not apply for a position on the Advanced Choice of Employment (ACE) programme this year, as she and her fiancé are being re-posted to Wellington. She intends applying to ACE in November, in the hope of securing a new graduate position in early 2021. Meanwhile, now she's familiar with the university system, she has started a couple of postgraduate papers for a master of health science. "I don't want to stagnate in the interim."

Her long-term goal is to become a nurse specialist or nurse practitioner.

Since leaving school, Kerr has tried her hand at many jobs. Her two-year stint in Melbourne working part-time as a manager of a bar gave her lots of experience in how to handle drunk patrons. This has stood her in good stead for the two student placements she has had in emergency departments (EDs) where, at weekends in particular, having to deal with drunks is par for the course.

She has also worked at Outward Bound as an enrolment co-ordinator, as a hospital assistant at Bowen Hospital in Wellington, as an administrator at a mechanics business, and has two children, now aged seven and eight. While she has lived in Auckland, the children have been with their father and stepmother in Wellington, a situation, Kerr says, they have adapted to well.

"As a young mother, I did not cope well. But their father and step-mum are wonderful parents who have given them a very stable home. People stand in judgement of me sometimes for not having my kids with me. This can be hard to cope with but we all choose our own pathways – mine is a strong one for me."

## A career for life

Kerr is convinced nursing will be her career for life. "This is the first thing I have ever stuck to. I know I want to be a nurse, not a doctor. Nursing is very hands-on, while doctors have rather fleeting relationships with patients. I like supporting people when they are at their most vulnerable. I also like the sisterhood of nursing. You have to work on your own a lot, but you also feel supported by the nursing team around you."

Kerr's poem *20.48* is the first she has ever written. She wrote it after a lecturer encouraged his students to be creative in their responses during their final paper. The poem describes some of the events at an Auckland hospital ED one evening,

principally the experience of trying to help resuscitate a dying man, and comfort his grieving wife.

## Part of a real scenario

Kerr had some resuscitation experience through the two paramedical papers she completed in 2018, but this was the first time she had been invited to be part of a real scenario. It was spending time with his wife that made the event so memorable.

"She had decided to drive her husband to the hospital rather than call an ambulance. The journey took half an hour."

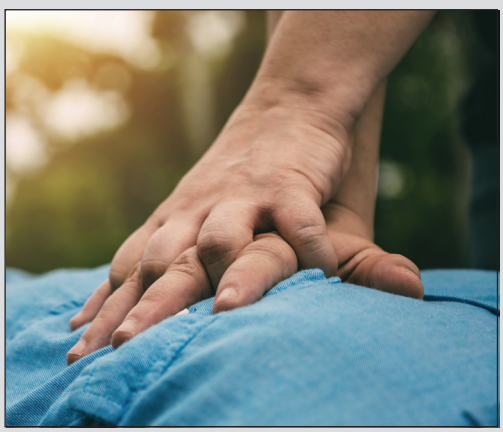
Kerr had been sitting with the wife in the resus bay before she was invited to continue with CPR. "I could hear his wife talking to him, begging him to come back to her. After my work, the time of death was called. Then I had to go back out to ED and continue helping other patients, none of whom had any idea what I had just been through."

Despite the rawness of it all, Kerr loves working in ED." I like the busyness, the quick turnover of patients before they are either discharged or sent to the wards. I feel I have the skills to look after intoxicated people and those with mental health issues. I did one of my placements at Paremoremo Prison. My life experience helped me there too – I certainly wasn't scared of any of the facial tattoes I encountered."

Kerr knows her life experience has made her resilient. Just as well, she says, as being the partner of a military man means you have to cope being on your own for long periods of time when they are posted away, either within New Zealand or overseas. •

### *20.48*

Coming to the end of shift.
Feet hurting.
Tired.
Hungry.
Lacking empathy for patient trying to get my number.
Take me seriously.
I am not cute.
Standing behind triage.
Split chocolate with preceptor.
Lady runs in.
Help.
**HELP.**
. . . help me?
Runs back out.
Male nurse runs out.
Runs in.
Grabs wheelchair without stopping.
Emergency bell.
Man purple.
Frothing.
Blue.
Frantic wife.
Resus bay one.
Too many people.
Get wife chair.
Sit on ground beside her.
Just me and her amongst chaos.
Chaos.
She reasons with me.
*I tried to get here as fast as I could.*
*No time to call ambulance.*
*F**k, f**k, f**k! This isn't happening . . . is it?*
I comfort.
I need to be honest.
Prepare her.



They are currently doing CPR.
*Will they do everything they can?*
*He's an old man they won't care.*
They will and are doing everything they can.
I explain what we can see.
The equipment that I know.
Ambulatory bag.
Defib.
Ultrasound.
Wife grabs my hand.
She can't bear to look.
But does.
Pushes my hand away.
Why is it just me alone with her?
Preceptor comes over.
I stand.
*Would you like to do CPR?*
*Are you confident?*
Yes.
***Yes.***

Can't leave wife alone.
Support worker joins.
I leave.
Excited.
Waiting behind nurse.
My turn.
Nil emotions.
Focused.
Feel rib crack.
Wife led in.
*Come on … Wake up.*
*Come back to me.*
Life.
Love.
Raw essence of both.
**20.48.**
Time of death.
Everyone stands back.
Eyes bulging.
Lips blue.
Unrecognisable.
Silence.
Wife cries out.
I picture my mother crying.
Breathe.
Not your place to shed tears.
Leave resus.
Check on patient.
Complains about waiting.
Tries to get number again.
No idea.
What I have just witnessed.
Debrief.
Receive praise.
Proud.
Guilty.
Shift end.

# Paving the way to pay equity

**Reaching an enduring pay equity settlement for the country's nurses is neither straightforward nor speedy. Rather, it's like navigating a tortuous and unknown route, to a long-desired destination.**

By co-editor Teresa O'Connor and acting industrial services manager Glenda Alexander

The undervaluation of nursing work is centuries long – a very chronic long-term condition (LTC). And, as with all LTCs, there is no quick cure.

It's worth remembering, as we clamour for a pay equity settlement and complain about the length of time it's taking, that nursing was born of two misogynist power structures – the military and the church – and has been shaped by those forces.

It's worth remembering that in the July 1909 editorial of *Kai Tiaki,* its founder and editor Hester Maclean wrote: *"We must . . . guard against any element of trades unionism creeping in among us. A nurse must be a woman, working, not in the first place for the sake of money making but for the good of her fellow creatures . . ."*

It's worth remembering the strict social and cultural mores that oppressed women, controlled their fertility, restricted their freedoms and dictated their destinies throughout the last century. Think student nurses corralled into nurses' homes with strict rules controlling their behaviour and freedoms. Think a nurse having to quit the profession if she chose to get married. Think women doing the same job as men getting paid less and that the Equal Pay Act 1972 only pertained to the public service.

**And any government-funded settlement with such major fiscal implications must be scrutinised every step of the way.**

And it's worth remembering that even though nurses make up 68 per cent of the health workforce today, their power within the sector is not commensurate with those numbers for a vast range of reasons related to gender, power and what's valued in our society.

The current average gender pay gap stands at 10 per cent, rising to 21.5 per cent and 17.9 per cent for Pacific and Māori women respectively.

So against this background, it's a little unrealistic to think pay equity is going to be achieved in a two-year time frame.

Along with the historical context, there is also the contemporary reality of achieving a robust pay equity deal for professions with a plethora of roles and specialties. And any government-funded settlement with such major fiscal implications must be scrutinised every step of the way. The process is being overseen by the State Services Governance Group and is neither simple nor straightforward.

A pay equity deal, backdated to December 31, 2019, was secured through the 2018 NZNO/district health board multi-employer collective agreement (MECA) negotiations. That meant NZNO did not have to pursue a formal claim for pay equity. Securing the deal was just the first step in a complex, multi-layered process.

Since the journey began, those working on behalf of members have conducted more than 200 interviews with nurses and midwives to gauge the range and responsibilities of all the roles included in the two professions. These interviews were then summarised into "role profiles" – a full description of all that each role entailed. The summaries were then validated.

The next step was identifying male comparator occupations. Approval from both those doing the work and their employers had to be sought, so the men could be interviewed to establish the extent of the range and responsibilities of these occupations. And, as with the nurse and midwife interviews, they had to be summarised into role profiles.

The next phase was to use a pay equity assessment tool to determine whether the nurse/midwifery roles and the male comparator roles were, in fact, comparable. The tool assesses 12 factors in three categories: skills; responsibilities; and conditions and demands of both the nursing/midwifery and male comparator jobs. What is being assessed at this point is whether the work of the comparator is actually comparable to the work of nurses/midwives.

This process is then double-checked, using another pay equity tool. A remuneration expert is now examining the total remuneration both the nurse/midwife roles and the comparator roles receive to assess what the pay gap is and whether it is due to gender.

## How to close the gap

Once this work is completed, all involved will know whether nursing and midwifery work has been undervalued and by how much. Then negotiating how that pay gap will be closed can begin.

A multidisciplinary team of NZNO, Public Service Association, Midwifery Employment Relations Advisory Service staff and delegates, and employer representatives, has been involved in this work. Many have had to be released from their day jobs and have had to undergo specialist training to do the work. There is no lack of commitment or determination to achieve pay equity on the part of those involved. But throw in a global pandemic, a two-month national lockdown and regional lockdowns, and it is hardly surprising we are not there yet.

But we will get there. Nurses and midwives will, for the first time in their history, be paid what they are worth. And hopefully that will mean more people will want to become nurses and midwives, enhancing both the quality of care and the quality of their working lives.

So, let's celebrate the fact we can and will achieve genuine pay equity – remembering good things take time – and let's give a huge shout out to those who have worked so hard to get it for us. •

# Providing safe virtual health care

**Nurses must be fully aware of how to maintain patient safety and confidentiality when providing health care via a virtual platform.**

By professional nursing adviser Catherine Lambe

Necessity is said to be the mother of invention. This certainly proved to be the case when many health professionals had to change the way they worked at short notice, in response to the COVID-19 global pandemic.

Services that had previously been face to face had to be offered differently to minimise the risk of transmission of COVID-19. For many, this required a change to telehealth, which led to an increase in online or phone consultations. Some found this was an effective way to provide health services, and have reported that a number of clients have asked for this service to continue. It reduced the time and cost of attending appointments, including travel time. Telehealth can also help those living in isolated areas receive timely health care.

**However, often lessons learned during challenging times pave the way for new and innovative ways of working.**

The underlying principle in deciding whether telehealth is appropriate is whether the care delivered will be of the same standard as if it were delivered face to face. An important factor to consider is whether an assessment is able to be completed to a professional standard.[1]

Nursing assessments rely on a range of technical skills, communication and intuition, all of which can be compromised when not performed face to face. Therefore, nurses need to think critically about whether it is safe and appropriate to use telehealth in any given situation.

Telehealth includes not only the delivery of virtual consultations, but also the transfer of medical information, eg blood sugar readings via digital images, and the delivery of health information and education. So the technology used must have the capability to transmit high-quality images.

So what are nurses' responsibilities when providing telehealth services?

Before any consultation begins, the nurse must obtain the patient's consent and advise them of any risks of telehealth.

If a nurse is recording the patient consultation, they must make sure the patient is aware of that. They must also ensure the recording is kept on a password-protected device. The patient's identity must be confirmed at the start of the consultation.

Nurses remain accountable under the Nursing Council's Code of Conduct when using telehealth.[2]

Patient privacy is a key concern and the technology must be capable of ensursing this is maintained. And nurses must be aware that some vulnerable people, such as youth, those in harmful relationships and those with disabilities, may be unable to speak out about a lack of privacy during a telehealth consultation.

Rule 2 of the Health Information Privacy Code (HIPC) requires clinicians to collect health information directly from the individual wherever possible, and to try to ensure the individual has authorised the collection of that information.[3]

Responsibilities regarding documenting care are as those for face-to-face consultations. Processes should be in place to ensure the continuity of the patient record. This may include a method for uploading any images used to inform decisions to the patient's clinical record.

Rule 6 of the HIPC requires clinicians to make a patient's health information available to the patient, if they request it. Therefore, the nurse should ensure any recordings of information can either be stored on the patient's record, or there is a process in place to document the recording accurately.[3] In addition, if a nurse receives patient reports from telehealth providers and has concerns about the standards of care, they must inform the provider of their concerns.

While savings due to reduced travel costs are a positive factor of telehealth, unexpected costs, such as the cost of sending prescriptions directly to pharmacies, should be made clear to patients.

## Employers' responsibilities

Employers also have responsibilities when implementing telehealth services. These include having policies and procedures in place to support safe practice and this way of working, regular training, performance monitoring, and competency assessment and quality improvement processes. With a sudden change from face-to-face to online working, the design of workspaces and the time spent at workstations must be managed, so clinicians' health and wellbeing are protected.

Ideally, any change in the way health services are provided or health professionals work, should be planned and coordinated. But, as COVID-19 has made abundantly clear, that is not always possible. However, often lessons learned during challenging times pave the way for new and innovative ways of working.

Organisations and individual clinicians must ensure they consider all aspects of telehealth provision and keep the wellbeing and rights of the patient top of mind. •

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# Summit brings nursing leaders together

A DIVERSE range of speakers at the New Zealand Nursing Leaders' Summit discussed the role of whānau in patient recovery, equity in health care and how nurses can transform primary health care and tackle inequity. The summit, held virtually on September 2-3, drew 160 participants.


Elizabeth Berryman


Jill Clendon


Margaret Southwick

Nurse practitioner-turned-doctor Elizabeth Berryman described how witnessing high levels of bullying at medical school and in the health sector led her to develop the "chnnl" app five years ago. The app prompts junior doctors and nurse graduates to share their feelings with employers, anonymously. Berryman described it as a "safe space" between staff and employers, from which reports and trends of wellbeing can be measured.

Health and disability system review panel member Margaret Southwick challenged nurse leaders to come together across sectors to influence health care in Aotearoa. She called on NZNO to facilitate more opportunities for nurses to network, even if in a virtual space.

A highlight of the summit was Royal Melbourne Hospital (RMH) director of nursing Denise Heinjus speaking about Victoria's COVID-19 experience. There were several parallels with the New Zealand experience in aged residential care (ARC), which suggested our approach of "going hard and going early" with lockdown may have been highly effective in limited COVID-19's spread.

## No room for complacency

However, Melbourne's experiences remind us we cannot afford to be complacent. The second wave has had a serious impact in Victoria, especially in ARC facilities and in high-density and socially and economically disadvantaged areas. A video performance of Bruno Mars' *You can count on me* by the RMH Scrub Choir brought many to tears (https://youtu.be/TVveBTTCZdo).

MidCentral District Health Board (DHB) clinical project manager Denise White spoke about the Mahi-Tahi programme, which aimed to improve patient care through greater whānau engagement and support.

MidCentral DHB had changed its visiting hours and signage and provided free parking, meals and sleep facilities to encourage whānau support for patients. Whānau had the right – not duty, which remained with the nurse – to be involved in patients' personal cares, should they wish. Whānau were acknowledged as different to "visitors" as being an integral part of the patient's life, White said. A patient determined their own whānau, which was not limited to biological relatives.

White said encouraging whānau support was a cost-effective way to improve patient outcomes, as the comfort and emotional support aided recovery.

Nursing Council legal adviser Nick Davies discussed the case of the Taranaki nurse whose registration was cancelled in an interim decision by the Health Practitioners Disciplinary Tribunal (HPDT) in late July, over racist comments she made on a Facebook page last May. His message was about the importance of zero tolerance for racism. There is clearly an opportunity for NZNO to provide further education in this space.

Jill Clendon, Nelson Marlborough District Health Board's associate director of nursing and an adjunct professor at Victoria University of Wellington, talked about unconscious and systemic bias – how to recognise and overcome both, for better patient outcomes.

Systemic biases were barriers maintained by institutions, while unconscious biases were upheld by individuals. But both resulted in inequities, she said.

Unconscious bias was an automatic way of thinking about those who differed from ourselves, and could hinder objective decision-making, she said. Strategies such as analysing the biased thought before speaking – a "self-check" – and getting to know a range of different people to avoid perpetuating biased behaviour, could address people's bias.Systemic bias persisted today due to unconscious bias, Clendon said.

Māori reported high levels of discrimination within the health system; and women were more likely to be assessed as stressed or anxious than unwell – even if they had a cardiac condition.

Clendon challenged nurses to consider how to mitigate the impact of unconscious bias in the workplace and in health outcomes.

University of Auckland senior nursing lecturer Sue Adams suggested the medical model of primary health care (PHC) was no longer fit for purpose. Smaller GP practices were being subsumed into larger entities, often with a focus on profit, and nurses were well-placed to lead change and provide holistic health services.

## PHC nurses 'make a difference'

Nurses in PHC also had a "fabulous opportunity" to make a difference to health inequities, by meeting the community's need with nurse-led multi-disciplinary teams which promoted well-being. "Nurse-led clinics and advanced practice is a very real option to achieve true universal health coverage". Adams also urged nurses to be more politically active, to influence change.

Institute of Strategic Leadership chief executive John Wadsworth spoke about the importance of leadership in an uncertain world. He suggested leaders should show compassion, to build trust with staff. But leaders needed to prioritise their own well-being, to be able to support others. Protecting down-time and role-modelling this to staff gave them permission to do the same.

*Report by acting associate professional services manager Kate Weston with co-editor Mary Longmore*

# College wants more ICU nurses qualified

THE COLLEGE of critical care nurses wants more support for nurses in New Zealand intensive care units (ICUs) to become fully qualified.

Chair Steve Kirby (right) said he estimated fewer than 40 per cent of nurses working in ICUs in New Zealand were fully qualified. This is despite the College of Intensive Care Medicine (CICM) of Australia and New Zealand guidelines which recommend at least 50 per cent of ICU nurses hold a post-registration intensive care qualification.

**Steve Kirby – postgraduate education difficult to access.**

"It's been an ongoing issue for 15-20 years, when the first set of guidelines came out that every ICU should have a minimum of 50 per cent qualified nurses, and preferably 75 per cent," Kirby said. "In New Zealand, most ICUs have, at best, is 40 per cent."

Gaining a post-graduate qualification was time-consuming – taking a year to complete part-time – expensive and difficult to access, he said. It was offered by three universities in New Zealand – Auckland, Victoria (biennially) and Otago – and by some district health boards (DHBs).

Nor was the content consistent or transferable, which needed to change, Kirby said.

"It's time-consuming, difficult to access because of the funding and a lack of consistency in the type of courses and hesitancy across ICUs to recognise each other's training."

The college wanted an agreed set of knowledge, skills and competencies across all training providers, whether tertiary institutes or DHBs, and "far greater collaboration" to allow nurse qualifications to be recognised across all ICUs.

In-house training was preferable, as it allowed technical skills to be learned at the bedside rather than in a classroom, and was also easier for rural hospitals, Kirby said. But an agreed qualification could be a combination of ICU hands-on, online and/or classroom learning, he said. "We want quality and transferability. If they do it in one part of the country, it should be recognised in another."

The college had been discussing the plan with the chief nurse, and was keen to build momentum to see an agreed qualification within the next one to two years.

"Our vision is to set up a working group to ensure each of the courses meet the standards required, so it's completely transparent," Kirby said.

## Recognition of work

"It's pressing for us because it's the recognition of the work and time and effort our nurses are putting into ICUs now." While it would not impact on salary, which was governed through NZNO's multi-employer collective agreement steps, having recognised qualifications would support ICU nurses' career progression into more senior roles.

COVID-19 had highlighted the problem, but it was not a new one. "It's been drive by the current climate but simmering away as an unmet need for a long time and it's about time we started to sort it out."

The college was in the process of updating its 2014 critical care nurse staffing standards for "safe, quality, patient-focused care" in line with the CICM and international recommendations. •

**Anne-Maree Wagg**

**Brent Doncliff**

# IPC nurse takes up membership role

ANNE-MAREE WAGG, from the infection, prevention and control nurses' college, will join Brent Doncliff as a college and section representative on NZNO's membership committee. The committee's role is to bring members' perspective to the NZNO board, and undertake projects on behalf of the board.

The committee is comprised of:

* One representative elected from each regional council;
* Two representatives from the National Student Unit;
* Two representatives from national colleges and sections;
* The president and vice president.

We usually meet face-to-face at least twice a year, as well as through video or tele-conferences at least monthly.

Members provide an "environmental scan" from the group they represent – basically a report of any matters of concern or national interest to nurses, such as violence against nurses and health workers, multi-employer collective agreement updates or requests for consultation. •

*– Brent Doncliff, NZNO membership committee college & section representative (mental health nurses section)*

# **Aged care:** Pay parity with DHBs

ACHIEVING OR maintaining pay parity with district health board (DHB) staff is a key claim across all NZNO's current round of negotiations with major aged-care chains. Negotiations with Bupa, Oceania, Heritage LifeCare and Radius are underway, and negotiations with Summerset begin next month.

## Funding increase

Aged-care industrial adviser Lesley Harry said the sector had received a three per cent funding increase this year. NZNO expected this would be passed on to staff, along with any pay increase secured in the current DHB multi-employer collective agreement negotiations.

Other claims across all providers include improved sick leave and a payment to health-care assistants (HCAs). Harry said the care and support workers equal pay settlement did not provide for a pay increase this year. "These workers deserve some recognition this year, particularly because of the impact of COVID-19 on their workload and their lives."

**Aged-care industrial adviser Lesley Harry**

NZNO, through bargaining, is also reviewing how the care and support workers settlement is working.

"We have heard of some instances where there have been barriers to caregivers being able to move up the pay scale, which is based on achieving qualifications. We want to find out if this is the case," Harry said.

The care and support workers settlement, which provided a major boost to HCAs' hourly rates, also introduced a four-step pay scale, with progression based on gaining qualifications.

NZNO Bupa advocate Lynda Boyd said there had been three lots of negotiations so far, with more scheduled in the coming month. One of the sticking points was addressing the low pay rates of household staff, who were members of E tū. •

# CTU rates political parties on work policies

THE GREEN Party has emerged on top in a Council of Trade Unions' (CTU) assessment of the five major political parties' industrial relations policies.

The five parties – Labour, National, Green, ACT and New Zealand First (NZF) – were rated on the CTU's six priority areas to improve the lives of working people:

- safer sick leave
- fair pay agreements
- four weeks' minimum redundancy
- better health and safety at work
- stronger public services
- living wages for all

CTU president Richard Wagstaff said the parties' answers were marked on whether they would take action for working people, and each had been given a grade based on that assessment. The Green Party achieved A+, Labour A, NZF B+, National E and ACT F.

The Greens and Labour are both committed to increasing minimum sick leave entitlements from five to 10 days a year, while NZF and National were unsure. The Greens, Labour and NZF would remove the six-month stand down period for sick leave when starting a new job, while National would not.

The Greens, Labour and NZF all support legislation to introduce fair pay agreements (FPAs), while National opposes them, claiming they would have a negative impact on business and jobs.

The Greens would improve minimum redundancy entitlements, NZF was unsure and National would not. Labour did not answer the quesiton directly but said it was adopting a "tripartite approach" on future work issues, "including how people transition through the labour market in times of change".

NZF and the Greens would increase funding to WorkSafe and the Greens and Labour would ensure funding for health and safety (H&S) worker representatives in all workplaces. National was unsure about increasing funding to WorkSafe and Labour pointed to its $57 million investment in WorkSafe over four years. All these four parties supported changing the Health and Safety at Work Act (HSWA) 2015 to better protect workers' mental health and all supported a review of the act.

These four parties all supported more investment in public services, with the Greens wanting "stable funding" for the community sector, particularly for services provided by Māori.

National wants "sensible and restrained" public spending, but would not introduce austerity measures.

Labour, the Greens and NZF supported a living wage for all, while National did not.

**CTU president Richard Wagstaff**

ACT did not respond to the CTU survey but sent links to relevant policies. From reviewing these policies, the CTU said ACT was opposed to increasing sick leave, to FPAs, better redundancy entitlements and the living wage for all.

ACT claims the HSWA is "weighted against small business employers".

It would freeze the current minimum wage for three years and re-introduce 90-day trial periods for all new hires.

In terms of increasing investment in public services, ACT said it would cut "wasteful spending of more than $7.6 billion", introduce tax cuts of $3.1 billion and reduce the 30 per cent tax rate to 17.5 per cent.

Wagstaff encouraged people, when voting, to think about what work should look like in the future. •

# Primary health care: CA for Access nurses?

SENIOR, REGISTERED and enrolled nurses working for community health provider Access Healthcare were voting on whether to ratify an inaugural collective agreement (CA) as *Kai Tiaki Nursing New Zealand* went to press.

The proposed deal delivers pay parity with district health board nurses; establishes salary scales and translation onto, and progression through them; increases sick leave; and provides for professional development (PD) leave. If ratified, the term of the CA would be from January 2020 to January 2022.

**The Access Healthcare bargaining team delegates, from left: Christchurch RN Julia Spencer, Kāpiti EN Linda Lonsdale and Hawke's Bay clinical team leader Emma Holland.**

## Pay scales

The proposed CA creates a four-step EN pay scale, starting at $23.38 an hour; then $24.68/hr and $26.63/hr, with the step-4 rate of $27.43/hr.

The registered nurse (RN) pay scale has six steps, with the sixth being a merit step with a pay rate of $37.23/hr. The starting rate is $25.98/hr, then $28.12/hr, $29.87/hr, $31.56/hr, with $35.07 for step 5.

The pay rates in the three-step senior nurse pay scale are $79,760, $81,322 and $85,375. Senior nurses will be appointed to a step with no automatic progression.

If the proposed CA is ratified, a merit working party will be established by July next year to develop merit criteria for step 6 of the RN pay scale.

Full-time employees will be eligible for 16 hours of PD leave a year, pro-rated to no less than eight hours a year for part-time employees. After six months' continuous employment, a full-time employee will be entitled to six working days paid sick leave for the subsequent year.

NZNO advocate Danielle Davies said the bargaining team was pleased with the offer. Ratification meetings held nationally finished on October 8. •

## Negotiations for hospices get underway

TWO DAYS of negotiations for the national hospice multi-employer collective agreement (MECA) were due to be held in Wellington earlier this month.

Claims include parity in pay and a range of other conditions with district health board collegues; an increase in study days and in professional development and recognition programme allowances; and improvements to leave entitlements. Removal of individual hospice exemptions from the MECA was another significant claim, NZNO advocate Lynley Mulrine said.

The previous MECA expired on August 31 and covered 520 members in 19 hospices.

NZNO's negotiating team is Mulrine, Nelson-based organiser Daniel Marshall, and delegates Julie Fletcher (Harbour Hospice, Auckland), Nicki Twigge (Waipuna Hospice, Auckland), Rachel Clarke (Arohanui Hospice, Palmerston North) and Shelley Bignell, (Te Omanga Hospice, Lower Hutt). •

## Mediation with Family Planning

NZNO AND Family Planning were to attend mediation earlier this month after members rejected a proposed settlement. The deal would have delivered a 2.75 per cent pay increase backdated to April 1, 2020, for nurses and health promoters. Medical receptionists would have got a 3.75 per cent increase, also backdated to April 1. Other aspects of the deal included five weeks' annual leave after six years' service.

NZNO advocate Chris Wilson said members had decisively rejected the proposed deal. "Both parties agreed to go to mediation. Clearly, underfunding is the barrier to getting a deal members will accept. We hope that the Government's commitment to pay equity in primary health care may provide an opportunity to find a way forward." •

## Negotiations at Boulcott Hospital

A SECOND day of negotiations for NZNO members working at Lower Hutt's Boulcott Hospital is scheduled for later this month. Organiser Penny Clark said there were 59 members at the hospital and their major claim was for pay parity with district health board colleagues.

Boulcott is a private 29-bed surgical hospital operated by Healthcare Australia, that country's third largest private hospital operator. •

# Virtual delegate training continues



**NZNO's educator team, from left: Angelique Walker, who covers the Central region, John Howell, who covers the Southern region and Rob George, who covers the Northern region,**

COVID-19 HAS forced changes to how NZNO conducts its delegate training.

A delegate education review had revealed that members/delegates wanted a "blended" approach to their training – both face-to-face and online. The COVID-19 lockown and social distancing requirements focused our energies on that virtual delivery in an immediate and constructive way. Given these uncertain times and the fact we don't know when there might be another disruption to "business as usual", it makes sense to keep developing our online education, alongside face-to-face delivery.

After the initial set up and development costs, online training is more cost effective than face-to-face delivery as there are no associated travel or accommodation costs. We haven't yet come across a member without internet access and some kind of device, so the accessibility factor has enormous potential. Members based in areas far from NZNO offices, who may have struggled in the past to access face-to-face education, can easily access sessions online.

**Members who are based in areas far from NZNO offices, who may have struggled in the past to access face-to-face education, can easily access sessions online.**

It's still early days regarding member engagement – it's hard to know if a member is having a "lightbulb moment" when you are looking at them down a screen! However, we hope the increased accessibility for more of our members leads to more engagement with NZNO in general.

We would like to stress to our members and their employers that access to union education is a legal right for all union members, not just delegates. This legal right is enshrined in employment relations education leave (EREL). Like other unions, NZNO prioritises delegates for EREL training. However, we would encourage members with a desire to learn more about NZNO, and unions in general, to contact us, as there may be an opportunity to join our introductory Foundations training course.

Some members who come to training are new to NZNO and are unaware of our structure and what the role of the delegate entails and lack an awareness about unions in general. We have recently launched an online pre-training course for members to complete before attending our face-to-face Foundations seminar. The course gives them a fuller understanding of the role of a delegate and how NZNO fits together. Having this knowledge before attending the face-to-face seminar means everyone is on a more level playing field, so we can maximise our time together.

Another benefit of online courses is members can use any electronic device to access and complete them in their own time and revisit the course as many times as they choose.

We are currently developing more generalised member courses, along with specific bargaining courses, which will be accessible through the NZNO website. When a delegate or member has completed a course, this is recorded on our database, so we know who has completed what courses.

It is hard to beat face-to-face delivery of training – just being in the same location together, sharing our stories, our challenges (and kai!), and collectively finding solutions to our workplace issues. But with smaller groups, it is possible to get good interaction and engagement via Zoom. Once members understand they're expected to contribute, rather than passively watch, things can get reasonably lively! Also, the "breakout room function" in Zoom is the virtual 21st century version of the "discuss in small groups". These break-out rooms have been successful in encouraging quieter members to open up a little. While it is still relatively early days in our delivery of online education, so far the feedback has been positive.

For ourselves, it is a buzz to learn a new skill. Delivering training via Zoom in some ways feels like "starting over" as an educator and that's an exciting process. Face-to-face training with a good supplementary dose of online delivery certainly keeps the job interesting.

Face-to-face training will remain our "bread and butter" for training delivery nationwide. But we are in the process of supplementing this with shorter online modules on specific union-related topics. These will range from the Health and Safety at Work Act 2015 to understanding the bargaining and disciplinary processes. •

*Report by educators John Howell, Angelique Walker and Rob George*

# COVID-19 lockdown helps finances

THE COVID-19 lockdown has had a beneficial effect on NZNO's finances. Corporate services manager David Woltman told the board the financial result for the 10 months to May 31, 2020, was a pre-tax surplus of $365,000, compared to the budgeted pre-tax deficit of $163,000. The alert level-4 lockdown was the main factor in this result, with lower travel costs, lower staff leave and lower spending on meetings.

Year-to-date revenues to May 31, 2020, were down $123,000, due mainly to delays in holding college and section conferences because of the lockdown.

Expenditure was mostly below budget, again largely due to the COVID-19 pandemic. Travel and accommodation expenses were down $203,000, general expenses were down $121,000 and colleges and sections conference expenses were down $119,000.

Expenditure increased in two main areas: staff costs were up $73,000 due to leave deferrals during lockdown and the employment of temporary staff until positions could be filled; and vehicle expenses were up on budget by $28,000 because of a delay in returning leased vehicles. •

# Membership diversity

NZNO's MEMBERSHIP is increasingly diverse. Ethnicity figures presented to the board meeting show that at May 31, 2020, New Zealand European members made up 56.1 per cent of membership (n=28,604); Filipino members made up 9.3 per cent (n=4738); Indian members, 8.9 per cent (n=4548); and Māori members 7.5 per cent (n=3815).

Pacific members make up 2.8 per cent of NZNO's total membership, with Samoan members making up 1.1 per cent (n=570); Tongan members 0.7 per cent (n=348); Fijian members 0.5 per cent (n-247); Cook Island members 0.3 per cent (n=133); and Niuean members 0.2 per cent (n=82). Twelve NZNO members are from Tokelau. •

# New members join board this month


**NZNO board members, from left: Simon Auty, Anamaria Watene, Margaret Hand, Titihuia Pakeho, kaiwhakahaere Kerri Nuku and Andrew Cunningham. They will be joined by newly-elected president Heather Symes and vice-president Tracey Morgan, and three new board members, Noleen Dayal, Geraldine Kirkwood and Diane McCulloch, at the October meeting.**

# Learning from COVID-19 response

THE MINISTRY of Health is collating lessons from the COVID-19 responses around the country and was to report back to the tripartite Health Sector Relationship Agreement (HSRA) forum last month. Chief executive Memo Musa updated the board on its request to the then Minister of Health David Clark in June for a national review of COVID-19 planning and response, which included NZNO. At the time, the minister said considering COVID-19 alert levels remained in place, the most prudent immediate focus was to respond to the Auditor General's review on the management of personal protective equipment (PPE). If NZNO had concerns that were not included in that review, then it should raise them with the ministry.

The HSRA forum, made up of representatives from the ministry, district health boards and the Council of Trade Unions' (CTU) combined health unions, has met twice since June to discuss the issue. It agreed to collate the lessons from the COVID-19 response to inform improvements to pandemic responses, including the supply of PPE. The information gathered would also contribute to any decision on the merits of a national COVID-19 review.

In his report to the board, Musa said once this information had been gathered and reported back to the HSRA forum, the CTU/combined health unions would consider their next steps. •

# Māori wellbeing model being developed

WORK IS underway to develop a Māori model of wellbeing for NZNO. In his report to the August board of directors' meeting, chief executive Memo Musa said the project had been initiated some time ago. Its aim is for NZNO to be more responsive to Māori members by developing a model which incorporates Māori models of organising into a Māori model of wellbeing. Te poari has provided feedback to the project lead, Manny Downs. A draft model is to be presented to December's board meeting. •

*The articles on this page have been written from the minutes of the August board of directors meeting.*

# Who are NZNO's new board members?

NEW VICE-PRESIDENT Tracey Morgan (Ngāti Raukawa, Ahūriri) started her health journey in 1994 as a Plunket kaiāwhina in Putaruru. After eight years in this role, she relocated to Hawke's Bay. Unable to transfer as a Plunket kaiawhina, she worked three months in a rest home and hospital before deciding to do her nursing training at the Eastern Institute of Technology in Hawke's Bay. She graduated in 2005.

New vice-president Tracey Morgan (left) with new president Heather Symes. (For more on Symes, see p15.)

## Making a difference

Accepted on a new graduate programme in three different places, she chose orthopaedics, "but community nursing and Māori health have always been my passion. I simply want to make a small difference helping our people".

For the last year, Morgan has been the practice nurse manager for a medical centre in Rotorua.

"Nursing always has its challenges, some positive, some negative. I love the mission statement 'freed to care and proud to nurse'. People are at the centre of our work – he tāngata, he tāngata, he tāngata. I love being at the frontline – empowering, encouraging and educating our patients to achieve better health, whatever their situation."

Morgan first became aware of NZNO and Te Rūnanga (TR) in 2007 when Midlands TR representative Ngaitia Nagel invited her to a TR meeting. "A month later I attended my first NZNO annual general meeting [AGM], which got me interested to learn more about NZNO."

Shortly after the AGM, Nagel resigned and Morgan, as proxy, stepped into the position. "I feel I have grown and learnt so much from this organisation, which makes me proud to be a nurse."

Morgan also served as tumu whakarae of te poari in 2016, but resigned after a year due to leadership demands at her then workplace Te Manu Toroa Kaupapa Māori Health Services in Tauranga. Four years later, she decided to stand for vice-president "to be a voice for our members. It is not about what I want to achieve, but what we all achieve together as members in a bicultural partnership. We are in this journey together – *He waka eke noa*". •

# EN promises to bring passion and energy

WAITAKERE HOSPITAL enrolled nurse (EN) Noleen Dayal promises to bring "lots of passion, new energy and a fresh face to the board".

She graduated from Unitec in 2014 with a diploma in enrolled nursing, having initially studied engineering in Fiji before immigrating to New Zealand in 2008.

It was the loss of her paternal grandmother in 2012, and not being able to stand by her side and hold her hand, that led her into nursing. "The phrase 'I did not choose nursing, nursing chose me' stands true for me. I had two young kids back then (four and two, now 11 and nine) and enrolled nursing seemed to be the right stepping stone for me."

Dayal has been a delegate on her ward since 2018. Even before taking on that role, she took an active role in the nurses' strike, rallies and meetings, and "kept the fire burning within the rest of the staff members".

It is her passion for ENs and their roles in health that motivated her to stand for the board. "I would like to work towards implementing an education system that allows ENs to bridge to a registered nurse qualification. I would also like to see a standard scope of practice for all ENs across all sectors. For example, some ENs in some district health boards [DHBs] have to get oral medications countersigned by an RN, while other DHBs do not have such policies."

She would also like to raise awareness about the EN scope of practice, and the fact they could be employed in most wards/sectors.

Violence in the workplace is another of her concerns. "I would like to know, say quarterly, how many incidents of violence have happened in each workplace, what the employer has done about this, what plans are in place etc."

To help raise awareness of domestic violence in New Zealand, Dayal is currently participating in the Mrs Universe New Zealand 2021. •

# A sense of fairness

GERALDINE KIRKWOOD has been working in New Zealand since she and her husband, also a registered nurse, arrived from the United Kingdom in 1997. She trained at Romford College of Nursing and Midwifery in Essex, graduating in 1993, and developed a background in surgical and orthopaedic nursing.

Over the last 23 years, she has worked in Auckland, Dunedin and in the private sector, and been a clinical charge nurse and a charge nurse manager at Waitakere Hospital's outpatients department for the past 15 years.

"I enjoy working with patients across our DHB and supporting my team to deliver the best care possible. I am an active member of the Greater Auckland Regional Council and am privileged to be on the national delegates committee for my DHB. I have supported members going through employment issues and have an innate sense of fairness. I have supported colleagues with COVID-related questions and stresses, and am a strong advocate for effective nursing leadership and empowering nurses to have a voice.

"I supported my DHB with our life preserving services response planning during last year's industrial action and with our local COVID-19 response this year."

It was her passion for fair employment practices and collectivity that made her decide to stand for the board.

Openness and honesty are the qualities she believes board members most need. "We need to remember who we are representing and why they chose us for these voluntary roles." •

# 'Being in the crow's nest'

DIANE MCCULLOCH has been a clinical nurse specialist in emergency care at Waitakere Hospital since 2009. She trained in South Africa in 1976 but did not nurse when her children were young.

On arriving in New Zealand, she had to retrain due to the long gap in her practice. She began her retraining at the Auckland University of Technology in 2000, and later completed a master of health science. She is a strong advocate for advanced nursing practice.

She enjoys her current role because "it gives me the opportunity of meeting people with different backgrounds from all walks of life. I am able to optimise patient care by working with nursing staff".

She got involved with NZNO and decided to stand for the board "to be able to use NZNO strength to have a voice in the workplace. I am passionate about giving workers the power to negotiate for more favourable working conditions through collective bargaining, and being able to communicate with members".

She brings to her new role "dedication, leadership, and sound decision making". She sees herself "as being in the crow's nest, scanning the horizon for signs of storms or rainbows in nursing – in New Zealand and around the world".

She is a member of NZNO's College of Emergency Nurses, of its Advanced Emergency Nurses Network and of the Auckland Nurses' Education and Research Trust (ANERT) and Pollard Fund. •

## Nurses crucial in fight against climate change, p22-23 – references


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# Classified advertising



## Reunion

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## COVID-19: impact on nurse wellbeing

**We are a group of researchers and RNs who are trying hard to go behind headlines and hearsay to better understand the experiences of nurses working on the frontline during COVID-19. You can tell us what is *really* happening for you on the ground in one of two ways:**

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If you would be interested in taking part in an interview, or have any questions at all, please contact the one of the two researchers below:

A.Prof Margaret Brunton (Massey) (09) 414-0800, ext. 43312
email: M.A.Brunton@massey.ac.nz

Dr Catherine Cook (AUT) (09) 921-9999 ext. 6651
email: catherine.cook@aut.ac.nz

- As RNs, we would love to hear from **ALL** of you about your experience of the health workplace at this critical time. We believe no-one else can give us the insights you can into what is working well, or what could perhaps be working better.
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- We would be very happy to provide further information or to answer any of your questions about the research.

*This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application NOR 20/22. If you have any concerns about the conduct of this research, please contact* ***Dr Fiona Te Momo****, Chair, Massey University Human Ethics Committee: Northern*
*Telephone 09 414 0800 x 43347, email* ***humanethicsnorth@massey.ac.nz***

NEW ZEALAND NURSES ORGANISATION | TŌPŪTANGA TAPUHI KAITIAKI O AOTEAROA

# Nau mai haere mai - Welcome
# The 2020 NZNO Guidelines for Patients' Responsibilities

Our staff are committed to working in **partnership with you** to achieve **your best possible health outcomes**. The following responsibilities are to assist you and our staff in achieving this partnership:

## Communicate Well

1. *It helps us to help you if you are **open and frank** in providing information to us about your health, your current medications and treatments, and your previous medical and surgical history.*
2. *We are committed to working together with you to develop a **care plan** that supports you and your health needs. If you are unable to follow through with the plan, let us know so we can adapt your plan and support you effectively.*
3. *Feel encouraged to ask for **clarification** of anything you need to know or do not understand regarding your health and/or your current treatment plan.*
4. *If you need **cultural support or translation services**, please let us know. It is important that you are/feel supported to make informed choices.*

## Respect others

5. *We respect your **privacy** and we expect that you regard the privacy of other patients/visitors and their whānau in the same way.*
6. *Treating others with **courtesy** is important, respecting their culture and beliefs.*
7. *Please use **social media responsibly**. Don't take and/or share photos of staff and/or other patients. Don't share identifying information about others, without their express, written permission.*

## Be considerate

8. *Please engage with others, including staff, respectfully. You can expect that our staff will treat you with respect. Any form of **abuse or violence** cannot be tolerated.*
9. *Please cooperate with the **reasonable directions of the staff** of the health care facility/organisation you are attending or that is providing your care. Staff are working to meet the needs of all patients.*
10. *Thank you for showing **consideration for other patients** with regards to your own conduct, and that of your visitors, by keeping noise levels at a minimum, and limiting the use of lighting that could disturb others.*
11. *Thank you for respecting the **Smoke-free site policy**.*
12. *Do take care of the **property of your healthcare provider**.*

## Give Feedback

13. *You are invited to inform the appropriate person and/or authority of any **recommendation and/or complaint** you wish to make*

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