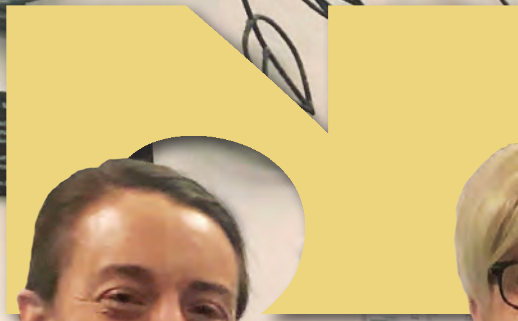

Kai Tiaki NURSING NEW ZEALAND

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- Improving health literacy

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NATIONAL OFFICE

L/3, 57 Willis St, PO Box 2128,
Wellington 6140.
Freephone 0800 28 38 48 fax (04) 382 9993,
website: www.nzno.org.nz
email: nurses@nzno.org.nz.

Memo Musa (chief executive), David Woltman (manager, corporate services), Mairi Lucas (manager, nursing & professional services), Suzanne Rolls, Anne Brinkman (professional nursing advisers), Leanne Manson (policy adviser - Māori), Heather Woods (librarian/records manager), Margaret Barnett-Davidson, Sarah Eglinton (lawyers), Rob Zorn (communications/media adviser).

REGIONAL OFFICES

WHANGAREI
Julie Governor, Odette Shaw, The Strand, Suite 1, Cameron St, PO Box 1387, Whangarei 0140. fax (09) 430 3110, Freephone 0800 28 38 48.

AUCKLAND
Andy Hipkiss (lead organiser), Carol Brown, Christine Gallagher, Fuaao Seve, Sarah Barker, Craig Muir, Christina Couling, Andy Hipkiss, Donna MacRae, Sharleen Rapoto, Phil Marshall (organisers), Rob George (educator), David Wait (industrial adviser), Kate Weston (acting associate professional services manager), Margaret Cain (competency adviser), Angela Clark, Catherine Lambe (professional nursing advisers), Sue Gasquoine (researcher/nursing policy adviser), Param Jegatheeson (lawyer), Katy Watabe (campaigns adviser).
11 Blake St., Ponsonby, Auckland, PO Box 8921, Symonds Street, Auckland 1011.
fax (09) 360 3898, Freephone 0800 28 38 48.

HAMILTON
Georgi Marchioni, Anita Leslie, Lisa Fox (organisers), Rob George (educator), Lesley Harry (industrial adviser), Annie Bradley-Ingle (professional nursing adviser), Findlay Biggs (lawyer).
Level 1, Perry House, 360 Tristram St, PO Box 1220, Hamilton 3204.
fax (07) 834 2398, Freephone 0800 28 38 48.

TAURANGA
Paul Mathews (lead organiser), Kath Erskine-Shaw, Veronica Luca, Brenda Brickland, Selina Robinson (organisers).
Ground Floor, Unit 3, 141 Cameron Road, Tauranga 3110.
PO Box 13474, Tauranga Central 3141. Freephone 0800 28 38 48

PALMERSTON NORTH/WHANGANUI/TARANAKI/HAWKES BAY
Iain Lees-Galloway (lead organiser), Donna Ryan, Stephanie Thomas, Sue Wolland, Hannah Pratt, Gail Ridgway (organisers), Wendy Blair (professional nursing adviser), Angelique Walker (educator), Manny Down (Māori cultural adviser).
Ground Floor, 328 Church Street, PO Box 1642, Palmerston North 4410.
fax (06) 355 5486, Freephone 0800 28 38 48.

WELLINGTON/WAIRARAPA
Jo Coffey, Laura Thomas, Drew Mayhem, Penny Clark (organisers).
Findex House, 57 Willis St., Wellington 6011, PO Box 2128, Wellington 6140.
fax (04) 472 4951, Freephone 0800 28 38 48.

NELSON
Denise McGurk (organiser), Jo Stokker (lead adviser, member support centre), Shannyn Hunter (call adviser, member support centre).
Ground Floor (south), Munro State Building, 190 Bridge St.
PO Box 1195, Nelson 7040. fax (03) 546 7214, Freephone 0800 28 38 48.

CHRISTCHURCH
Lynley Mulrine (acting industrial adviser), John Miller (acting lead organiser), Helen Kissell, Lynda Boyd, Danielle Davies, Tracie Palmer, Stephanie Duncan, Terri Essex (organisers), Chris Wilson (industrial adviser), Julia Anderson, Marg Bigsby (professional nursing advisers), Jinny Willis (principal researcher), Kiri Rademacher, Sophie Meares (lawyers), Christine Hickey (employment lawyer), Maree Jones (CCDM co-ordinator).
17 Washington Way, PO Box 4102, Christchurch 8011.
fax (03) 377 0338, Freephone 0800 28 38 48.

DUNEDIN
Glenda Alexander (acting manager, industrial services), Simone Montgomery, Celeste Crawford, Karyn Chalk, Colette Wright (organisers), Michelle McGrath (professional nursing adviser), John Howell (educator), Jock Lawrie (employment lawyer).
Level 10, John Wickliffe House, 265 Princes Street, PO Box 1084, Dunedin 9016.
fax (03) 477 5983. Freephone 0800 28 38 48.

REGIONAL CHAIRPERSONS

TAI TOKERAU, NORTHLAND – SACHA YOUNG
email: sachayoung@yahoo.co.nz

GREATER AUCKLAND – ESTHER LINKLATER
email: estherlinklater@hotmail.co.nz mob: 027 282 7973

MIDLANDS – DIANE DIXON
email: diane.dixon@waikatodhb.health.nz mob: 027 463 4522

BOP/TAIRAWHITI – MICHELLE FAIRBURN email: michellefairburn0@gmail.com

HAWKE'S BAY – ELIZABETH BANKS & SANDRA CORBETT (CO-CHAIRS)

CENTRAL – TRISH HURLEY email: trish.johnhurley@xtra.co.nz

GREATER WELLINGTON – REREHAU BAKKER
email: rerehau.bakker@slingshot.co.nz mob: 021 106 0582

TOP OF THE SOUTH – JOAN KNIGHT
email: joan.knight@nmhs.govt.nz mob: 027 378 7793

WEST COAST – DIANE LONGSTAFF email: diane@stimulusdesign.co.nz
mob: 027 471 8097

CANTERBURY – CHERYL HANHAM email: cahanham@gmail.com

SOUTHERN – LINDA SMILLIE email: lindasmillie1@gmail.com

TE RŪNANGA REGIONAL CONTACTS

KAIWHAKAHAERE – KERRI NUKU mob: 027 265 6064
email: kerri.nuku@nzno.org.nz

TUMU WHAKARAE – TITIHUIA PAKEHO
email: tithuia.pakeho@bopdhb.govt.nz

MIDLANDS – TRACEY MORGAN
email: traymorg6@gmail.com

CENTRAL – KELLY MCDONALD email: kelalebel@gmail.com

GREATER WELLINGTON – LIZZY KEPA-HENRY
email: lizzy.kepahenry@gmail.com

CANTERBURY – RUTH TE RANGI email: pocohontuz@gmail.com

GREATER AUCKLAND – VACANT

TE RŪNANGA TAUIRA – TRACY BLACK email: gntblack@yahoo.co.nz

TE MATAU-A-MĀUI – TINA KONIA email: tinakonia@hotmail.com

TE TAI POUTINI – VACANT

SOUTHERN/TE TAI TONGA – VACANT

TAI TOKERAU – MOANA TEIHO email: mojo.teiho48@gmail.com

BAY OF PLENTY, TAIRAWHITI – ANAMARIA WATENE
email: anamaria.watene@bopdhb.govt.nz

TOP OF THE SOUTH – VACANT

NATIONAL STUDENT UNIT CONTACTS

MIKAELA HELLIER (CHAIR)
email: mikaelahellier1717@outlook.co.nz

KIMMEL MANNING (TR TAUIRA – CHAIR)
email: kimmel.manning@gmail.com

MEMBERSHIP COMMITTEE

SANDRA CORBETT (CHAIR) email: sandra.corbett@hawkesbaydhb.govt.nz mob: 027 275 9135

ANDREA REILLY (VICE-CHAIR) email: andrea.reilly@westcoastdhb.health.nz

SECTIONS & COLLEGES Go to www.nzno.org.nz. for a list and contact details of NZNO's 20 sections and colleges - colleges and sections are listed under Groups. You can then visit the home page of each section or college and download an expression of interest form.

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OUR LAST issue for the year presents a smorgasbord of articles, with comprehensive coverage of November's Indigenous Nurses Aotearoa Conference and the South Pacific Nurses Forum, both held online this year. We publish a research article on health literacy, look at progress on developing a COVID-19 vaccine, profile some courageous nurses and list the latest acquisitions to the NZNO library. A good start to your holiday reading!

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.

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

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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.

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Correspondence:
The Co-editors
Kai Tiaki Nursing New Zealand
PO Box 2128, Wellington, 6140
ph 04 494 6386
coeditors@nzno.org.nz

Advertising queries:
Evelyn Nelson
Kai Tiaki Nursing New Zealand Advertising
PO Box 9035, Wellington, 6141
Ph 0274 476 114 /evelyn@bright.co.nz/
www.kaitiakiads.co.nz

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The president's wish list for 2021

By NZNO president Heather Symes

What a year 2020, the International Year of the Nurse and the Midwife, has been! COVID-19 lockdowns have been front and centre, primary health care (PHC) staff have had to take strike action and some health services have been cut.

Our lives have changed dramatically. We have lost friends and family members but health staff have continued to rise to the challenges. Health staff were sometimes the only ones with dying patients during the first lockdown. Their professionalism and kindness, despite risks to their own health, were outstanding.

Issues around personal protective equipment (PPE) continue, with some members experiencing distress that they still can't access PPE in a timely manner. And some providers are not coming to the table to solve the safety issues facing nurses working in quarantine/isolation facilities. Some argue the information on PPE on the Ministry of Health website is not robust enough. Fortunately, the practice of nurses being moved across sites has now stopped.

We in Aotearoa New Zealand have much to be thankful for, compared with many other countries. And the past and current governments deserve praise for their handling of this crisis, albeit with slippage regarding PPE standards, its distribution, border issues and lack of testing at times.

We have achieved a degree of safety and returned to a near normal life, although COVID-19 is not going away any time soon. My hope is that a safe, robust, reliable vaccine will be developed and available to all world citizens, not just to the wealthy and privileged. I implore the Government to ensure our quarantine facilities are safe for all returnees and staff. The International Council of Nurses has estimated 1500 health workers from 44 countries had died from COVID-19 by the end of October. We don't want any New Zealand health workers to become part of these statistics.

New Zealand remains on alert for outbreaks of COVID-19, with testing used to protect our communities. I appeal to everyone to use the tracking app, even if you are just out and about in your local community.

Unfortunately, we have also seen nursing leadership positions across the country disestablished. District health boards (DHBs) have been particularly hard hit, as they struggle to balance the books. Deficits are an all-too-common part of health service difficulties, but getting rid of nursing and other health staff is not going to save money. It's going to cost more due to lack of resources and treatments, the possibility of more serious assaults on staff, more accidents and longer times in hospital due to missed care. This is a throwback to the 1990s, when health services were managed as businesses. Many great nursing leaders had their roles disestablished, and "savings" made to DHB budgets led to needless suffering, deaths and distress for families and staff across the country.

Our lives have changed dramatically . . . but health staff have continued to rise to the challenges.

Health bosses are now planning to amalgamate DHB areas to make savings and apparently improve care for our citizens. Tinkering with services to create larger DHBs won't necessarily improve services, but may instead cause chaos and disruptions. Whether a more responsive service emerges, only time will tell.

Realising health promises

My hope is that the new Government will manage our health service properly and realise at least some of its election promises. With more adequate health funding, we would experience fewer Third World diseases, and vulnerable populations such as Māori and Pacific Islanders, who die on average 10-15 years younger than Pākehā populations, would improve their life expectancy. We would be unlikely to see women in rural areas giving birth on the sides of roads, due to not making it in time to the larger urban hospital. No matter where you lived, you would have access to robust and timely health services.

Our members are still waiting for pay parity and PHC nurses are still waiting to be paid the same as DHB staff. The DHB multi-employer collective agreement negotiations continue to grind on, with little progress so far. Iwi and Māori health providers continue to pay their nurses and health staff below DHB rates. We need to see these issues resolved with as much urgency as there was in creating "shovel ready" projects and trades funding, following the arrival of COVID-19 on our shores.

Enjoy the Christmas season and the summer holiday. Our relationships with whānau and friends are the most important aspects of our lives, so enjoy them all. For those working over the holiday season, thank you.

Thank you to NZNO staff who work hard to support members and thank you to all voluntary members, including those in governance roles, or in colleges, sections and regional councils. Our aims are the same – to achieve a fairer and just organisation for us all, and ultimately for New Zealand.

I hope 2021 will prove a better year, with those long-sought-after improved pay and conditions finally realised. •

Tell us what you think

What's the state of NZNO membership numbers?

IT WAS sad to see in October's coverage of the NZNO annual general meeting (AGM) that membership had dropped by 0.9 per cent over the 2019/20 year, to end on March 31 at 51,643. But I was struck by chief executive Memo Musa's comment about this, that "the trajectory still pointed to growth". (p15)

As a union, we have power in numbers. So a trajectory of growth would mean more union strength to deliver for each one of us, and more resources to support nursing. Sadly, however, this doesn't appear to be the case.

Just six days before the AGM, on September 11, Musa emailed members with the board by-election results. The notice stated that total membership (the number of eligible voters) was now 50,418. In other words, there had been a further 2.4 per cent drop in the five months from March 31.

The chief executive also told this year's AGM that, "*NZNO was 'lucky' compared to other unions, many of which were seeing a decrease or 'stunted' growth*". The day before these words appeared in *Kai Tiaki*, a headline on *Stuff* announced, "Covid-19 boosts NZ union membership". According to Stuff, *"Union members as a proportion of the workforce rose over the three months to June, to 19.8 per cent compared with 19.1 per cent in the December quarter 2019."*

Musa's account to the 2020 AGM had the story back to front. Over the two years from September 2018 to the 2020 board elections, while other unions have been growing, NZNO membership had dropped by 4.4 percent from 52,712 to 50,418. This is not a "trajectory of growth". NZNO members deserve the truth. And NZNO staff – whose livelihoods depend on the number of fee-paying members – are entitled to no less.

A fall of 2294 members since September 2018 is the largest numerical drop over a two-year period in NZNO's history. This is sapping our union strength and shaving approximately a million dollars off NZNO's annual income. It should be ringing alarm bells for our leaders and triggering urgent corrective action. To rebuild our organisation, we need a leadership willing to face reality and be held to account. [abridged]

Grant Brookes, RN,
Wellington

Co-editors note: The corporate services manager has advised that the actual membership growth over the long-term has exceeded the budgeted trajectory of one per cent per year. An extraordinary growth spurt at the time of the 2018 district health board pay negotiations and strikes saw membership grow 7.5 per cent over two years (March 31, 2017, to March 31, 2019) from 48,445 to 52,093. The subsequent decline to current membership of 50,530 at the end of November is viewed as a correction to that unusual growth. *See p42 for more details.*

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.

Cannabis 'not a gateway drug'

IT'S HARD to believe that voters have rejected the referendum for cannabis legalisation but unanimously voted in favour of the End of Life Choice Act.

Were the people who voted for end of life also voting against cannabis reform? Is that fair? They readily vote for ending their lives but deny the control and licensing of a product which could bring a sense of wellbeing to the younger generation, who struggle to make sense of life and find they are criminals if they are in possession of a herb.

Cannabis is not a gateway drug, the pathway to heroin or P addiction. It can be controlled and enjoyed. The people who voted against the legislation are worse than the dealers. They are happy to die yet not allow freedom of choice to the people who will be here long after they have chosen the right to die.

Dorothy Ilderton, RN,
Timaru

Survey into time pressures

I AM a New Zealand registered nurse (RN) and a PhD candidate at the University of Southampton in the United Kingdom. I am conducting an online New Zealand-based study that will explore the impact of time pressure on RN job performance.

Participants in the study will be invited to share their experiences regarding the impacts of time pressure on their full range of work practices and responsibilities. I am aiming to recruit 50 RNs who are currently working at least one clinical shift per week in a district health board (DHB) acute inpatient ward and who have at least two years' post-registration experience. I will be looking to achieve a mix of hospitals and ward types.

The study will involve the nurses completing a series of four questionnaires using an online survey tool. Each questionnaire will take up to one hour to complete. Data collection will begin in January 2021 and will run for about eight weeks.

The study is important because currently we do not have a comprehensive or coordinated picture of how time pressure affects RN job performance. This matters because when RNs are not able to perform their jobs completely and to an appropriate standard, this has been associated with negative impacts on patients' experience of nursing care, RNs' experience of work, and on organisational outcomes.

The results of the study will be used to inform a 2021 online national survey that will be administered to RNs working in DHB acute inpatient wards. If you would be interested in participating in this study or would like further information, please contact me at j.a.lawless@soton.ac.uk [abridged]

Jane Lawless, RN, PGDip, MA(Apld),
Southampton

NZNO fights parking fees

NZNO MEMBER Erin Kennedy, delegate Darren Swan and organiser Jo Coffey (above) presented a petition with nearly 1000 signatures to the Capital & Coast District Health Board (C&CDHB) in December protesting car-parking fee increases for staff.

The DHB has proposed an increase in daily staff car-parking fees from $4.50 to $7.50, and higher monthly fees, after seven years

Kennedy told the board staff already struggling to make ends meet were distressed about the proposal.

Already staff had been assaulted or threatened when walking between their car and work, and being forced to park further away would increase the danger. "Our staff work all hours of the night and day and safe, affordable parking is a necessity."

C&CDHB Chief financial officer Rosalie Percival said feedback on the proposal including the petition, was being considered.

A "proposed solution" was likely in 2021.

Staff were able to request a security escort to their cars at night, she said.

Kennedy told *Kai Tiaki Nursing New Zealand* that she felt more "hopeful" afterwards, "as some at least clearly support staff". •

Research journal out

THE EFFECT of COVID-19 on conducting research is highlighted in the 2020 issue of NZNO's research journal, *Kai Tiaki Nursing Research (KTNR)*.

In her editorial, *KTNR* editor Patricia McClunie-Trust said collecting information about the impact the pandemic has had on New Zealand's population was an important priority that nursing needed to engage with.

"Nurse researchers also need to examine and potentially embrace many of the changes that were forced on us by the pandemic," she said.

In her guest editorial, NZNO principal researcher Jinny Willis looked at the role nurses took in New Zealand's COVID-19 response.

Research articles look at issues including burnout in New Zealand nurses, use of the SOAP(IE) documentation framework, leadership walk rounds, and use of escape rooms in nursing education.

To subscribe to KTNR, email: library@nzno.org.nz. •

Fewer prof forums in 2021

THERE WILL be fewer NZNO professional forums in 2021 due to the uncertainties of COVID-19, but members will have the option of joining via Zoom, professional nursing adviser (PNA) Catherine Lambe says.

Usually NZNO holds about eight professional forums around the country, but PNAs have decided to offer just three next year – one each in Christchurch, Wellington and Auckland.

The forums, titled *Every Nurse is an Advocate – Influencing through Advocacy*, will explore advocacy through case studies and practical application at national and local level, Lambe said.

Zoom would be an option for those who could not attend in person or if restrictions on group sizes were stepped up again, she said.

While it was difficult to plan ahead due to the risk of changing levels and loss of venues to managed isolation or quarantine facilities, the PNAs felt it was important to bring nurses together after so much lost time this year.

"We know nurses love coming together to share information and network. Knowing that many would have struggled to access professional development in 2020, and also had become comfortable using Zoom, holding three events with Zoom access seemed like a great solution."

The forums will be held at the Christchurch Town Hall on February 23; Auckland's Ellerslie Convention Centre on March 2 and at Wellington's Harbourside Convention Centre on March 10.

Further details and registration will be available on the NZNO website. •

Kai Tiaki to go online

KAI TIAKI Nursing New Zealand will be available online in 2021, following a 2015 remit to offer members a choice of either a printed or electronic copy.

The digital project has gathered momentum in 2020, and the website is now at testing stage, with a plan to launch to members early next year. After that, members will have the opportunity to choose whether they would like to continue receiving their printed copies.

COVID-19 meant *Kai Tiaki* found an interim way to reach members quickly with an online flipbook in 2020. However, a fully interactive website will offer links to members as well as the ability for articles to be shared and updated. •

• *Co-editor Anne Manchester retires, see p29.*

Musa leaving NZNO for mental health role

DEPARTING NZNO chief executive Memo Musa (right) is returning to his nursing practice specialty, with a new role in the mental health and addiction sector.

Musa, who worked as a mental health nurse in the United Kingdom before taking up roles in mental health and forensic services and management in New Zealand, has accepted a chief executive role at Platform/Atamira charitable trust. The trust connects the health system with community mental health and addiction organisations. Musa said the role would keep him involved with influencing health and social policy on behalf of community organisations.

Musa came to NZNO in 2013. Since then his focus has included implementing a new constitution, NZNO's strategic and operational priorities and building relationships both inside and outside NZNO. He acknowledged the past two years had been particularly tumultuous with complex district health board pay negotiations, strikes and two "unprecedented" special general meetings.

Throughout, Musa said he had tried to focus on integrity, transparency and engaging with other nursing and union leaders. "It was important to be clear in my own mind about what was right, in order to do the right things for members." He had enjoyed working with "highly spirited" staff committed to organising, engaging and representing members across industrial and professional issues.

"NZNO is a strong organisation with more than 100 years of history and will continue being strong and to grow."

NZNO president Heather Symes said Musa had navigated NZNO through very tough times, and NZNO had been "lucky to have him so long". Musa would be drawing on his mental health nursing skills in his new role, she said. His last day is February 26, 2021. •

Chief nurse departs busy role

ONE "SILVER lining" from COVID-19 was seeing nurses step up to lead the country's response in areas such as personal protective equipment (PPE), contact-tracing and infection prevention and control (IPC), departing chief nurse Margareth Broodkoorn (above) told *Kai Tiaki Nursing New Zealand*. "Nursing has responded and our voice has been significant and held the sector in good stead."

Broodkoorn is leaving early in 2021 to take up a chief executive role at Hauora Hokianga, a Māori health provider in Northland, where she lives.

A restorative justice process for hundreds affected by surgical mesh injuries in 2019, followed by the COVID-19 pandemic, had pushed aside many of her hoped-for priorities, she said. Hearing the mesh stories was "very raw", but she was glad action was now being taken.

Broodkoorn was also "really proud" of the work being done by the National Nursing Leaders group, a strategic collective of nursing leaders of which she was a part, and which had developed a bicultural co-leadership model. "They are the pinnacle of our nursing groups and every one of those members are now bringing their Treaty partners to the table, which is really growing our Māori nursing leadership in Aotearoa."

Broodkoorn had been looking forward to 2020, as she was expecting her first grandchild and it was the International Year of the Nurse and Midwife. But "the reality soon changed – to a different place, a different space, a different world".

"It was one of the busiest and hardest times of my life," said Broodkoorn, who worked from home to resolve issues about PPE and IPC guidelines. A national nursing strategy aligning with Māori health action plan Whakamaua was almost ready. •

Meeting with minister?

NZNO LEADERS have requested a meeting with new Health Minister Andrew Little, to discuss health inequities, workforce issues, racism, safe staffing and the impacts of COVID-19.

"NZNO also looks to support the delivery of a first-rate health system where individuals, family and whānau are cared for and where every health worker is safe and receives fair pay," president Heather Symes, kaiwhakahaere Kerri Nuku and chief executive Memo Musa wrote.

NZNO supported tino rangatiratanga – Māori self-determination – as "fundamental to addressing the systemic dispossession that hinders tāngata whenua from looking after themselves on their own terms", as recommended by the Waitangi Tribunal's 2019 hauora report.

Nurses wanted pay equity across the workforce, a safe work environment and a sustainable workforce, particularly in aged and dementia care, mental health, iwi providers and primary health care.

Faster progress on implementing safe staffing system care capacity demand management was also needed. •

A PHC pay offer before Christmas?

PRIMARY HEALTH care (PHC) nurses took to the streets again last month in their first-ever 24-hour strike.

This followed an eight-hour strike two months previously, on September 3, in a campaign to achieve pay parity with nurses working for district health boards (DHBs).

A second 24-hour strike scheduled for November 23 was cancelled. This followed assurances from the Ministry of Health (MoH) and DHBs that the employers were ready to return to negotiations with an improved pay offer.

At press time, no offer had as yet been made, though it was hoped negotiations, due to resume on December 7, would prove more positive. It has been estimated that nurses need to be paid an extra 10.5 per cent to bridge the pay gap between experienced PHC and DHB nurses.

PHOTO: ANNE MANCHESTER

Primary health care nurses march through the streets of Wellington on their way to the Ministry of Health to make their demands.

"NZNO is very clear that if there is not an improved offer by December 7, we will immediately ballot for industrial action," PHC industrial adviser Chris Wilson said. "We need Government and employers to stump up with the money urgently."

The MoH has confirmed the matter is urgent for them and it was working to find a solution.

Around 3200 PHC nurses and administration staff work in about 500 general practices and medical centres throughout New Zealand. •

Nursing voice 'essential' in mesh processes

MANAWATU CONTINENCE nurse Lucy Keedle hopes to bring a nurse's "holistic" perspective to the Ministry of Health's (MoH) surgical mesh round table.

"It's nice to have that nursing voice, rather than just the medical model, to consider the holistic picture," Keedle said. That might include managing pain and continence issues alongside family and relationships. They also had to deal with "an enormous range of things, including psychosocial aspects, that are probably more the nursing field – helping to see things through a different lens", she said.

The round table provides advice to the MoH on reducing existing harm from mesh and preventing future harm. It was set up after a restorative justice process in 2019 involving more than 600 people affected by mesh injuries and a report from the chair in Restorative Justice at Victoria University of Wellington, Diana Unwin, with several recommendations.

The MoH, with the support of the Accident Compensation Corporation (ACC), has agreed to a work programme that includes establishing a register of mesh injuries and specialist multidisciplinary centres for those injured by mesh; the upskilling of surgeons in the use and removal of mesh; and a credentialing committee to recommend national standards for urogynaecology procedures.

Preventing future harm

Invercargill continence nurse Helen Peek is also involved in the MoH credentialing group to ensure practitioners are skilled in mesh surgery or removal. Both Peek and Keedle are also on the MoH mesh education group, which is focused on preventing future harm. Both nurses are on the executive committee of Continence New Zealand, and Keedle is on the executive committee of the Urological Nurses' Society.

Keedle believes a multidisciplinary approach is critical. "We, as nurses, want to be a cog in the engine, but we still need to work together with psychology, physiotherapy, family support and so on to ensure the woman at the centre of our care gets the best, most appropriate support she and her family need."

Mesh Down Under co-founder and nurse Patricia Sullivan has said that a nursing voice was "essential". "Nurses are seeing the women coming in and suffering and are dealing with the women post-op and in theatre."

On the round table, which oversees the work, Keedle joins representatives from the Royal Australian and New Zealand College of Obstetricians and Gynaecologists; the Royal Australasian College of Surgeons; the Urological Society of Australia and New Zealand; the Royal New Zealand College of General Practitioners; ACC and NZ Private Surgical Hospitals Association.

MoH chief clinical officers' manager Clare Possenniskie said nurses worked with patients considering treatment with mesh and those experiencing complications from it, so their involvement in the surgical mesh work programme was "pivotal". •

Gentle singing brings comfort

WHEN WORDS are not enough, there is always singing. This is the philosophy behind the Wellington group Whakaahuru – The Gentle Singers.

The aim of the bedside singing group is to comfort people near the end of life with gentle, soothing songs. They sing in small groups of up to four people by request, at people's bedsides, at home or in care facilities from Wellington through to Porirua and the Hutt Valley.

Chrissie Lawley after singing to a resident at Millvale House, Miramar.

"Our singing offers comfort and relaxation, a connection with community and a feeling of support that extends to family and caregivers. We're trained to be sensitive to the needs of those present, and to respond accordingly," said choir member Sue Chamberlain.

Whakaahuru singers often have a background in health. Musical adviser Chrissie Lawley nursed at Wellington Hospital for 20 years and has been a member of Whakaahuru from its beginning six years ago. She regards belonging to Whakaahuru as "an extraordinary privilege", enabling the singers to bring joy and peace to families and people receiving palliative care.

The bedside singing concept began in the United States in 2000 and has grown to become an international movement, with hundreds of groups throughout the world offering the service.

Bedside singing is available in Auckland (www.cadencesingers.org.nz), Wellington (www.whakaahuru.org.nz) and Christchurch (email: ReflectionsChristchurch@ThresholdChoir.org). Nurses who would like to let patients and their families know about bedside singing are encouraged to view the websites or email for further information. •

Infection fears at MIQs

NURSES WORKING in Auckland's managed isolation and quarantine (MIQ) facilities are being declined Christmas leave due to ongoing staff shortages, says an NZNO organiser.

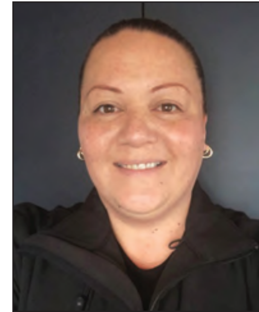
Organiser Sharleen Rapoto has been in regular contact with nursing staff at Auckland's 18 MIQ facilities, and said rostering was "atrocious", particularly heading into Christmas, as there was nobody to cover the shifts.

"Really, some people just want to have a break, but have been declined leave."

The region's district health boards (DHBs) were having enough trouble staffing their hospitals, let alone the MIQ, Rapoto told *Kai Tiaki Nursing New Zealand*.

Several nurses also had fears about infection prevention and control breaches by non-health professionals such as New Zealand Defence Force security staff. "They're leaving masks lying around, not using sanitiser – and these are the guys doing the transfers, taking luggage and escorting guests," Rapoto said.

NZNO acting associate professional services manager Kate Weston agreed it was challenging to staff Auckland's many MIQ facilities. "Pod" rostering could help. This is where teams worked in the same facility over an extended period with built-in leave, wraparound packages with professional development as well as pay incentives.



Sharleen Rapoto

NZNO also wanted to see N95 masks recommended for use in all MIQ facilities, not just those with probable or positive cases of COVID-19, Weston said.

"Why take the risk? The stakes are too high. We need to consider everyone coming into managed isolation facilities infectious, rather than not, and it's the other way around at the moment."

Ministry of Health (MoH) guidelines updated in November recommend masks be used when two-metre distancing "cannot be maintained from a confirmed or probable case of COVID-19", such as when care or checks are needed.

But NZNO wanted to treat every person in managed isolation facilities as high, rather than low risk, Weston said, citing Pakistan's cricket team, 8 members of which had so far tested positive for COVID-19 after previously testing negative.

While PPE availability and use remained a "mixed bag" across Auckland's facilities, Rapoto praised the Crowne Plaza for its on-site COVID-19 testing and N95 mask supply. •

Unsafe staffing reports

CONCERNS ABOUT safe staffing at managed isolation and quarantine (MIQ) facilities, particularly in Auckland, continue to be reported to NZNO, acting associate professional services manager Kate Weston said.

Reports included leaving a health-care assistant (HCA) responsible for a facility overnight with up to 200 guests and no registered nurse support. Other issues had been lack of back-up when guests presented with non-COVID-19 problems, including chronic health issues, Weston said.

The HCA was "absolutely exposed" if anything had gone wrong, NZNO organiser Sharleen Rapoto said.

Nurses had reported to NZNO that they were dealing with many mental health issues across MIQ facilities, including suicidal ideation and self-harming, requiring 24-hour-a-day vigilance. But it was difficult to staff the facilities in Auckland, where the district health boards were already short-staffed. "There is nobody to do it," Rapoto said.

NZNO hoped more sustainable solutions could be found to staffing MIQ facilities, "which are going to be with us well into 2021", Weston said. •

Tackling inequality to improve outcomes

TE ANIWA Sullivan began using her birth name 15 years ago. Until then, and especially during her school and nurse training days, she was known as Doey (a family nickname), Daphne or Toni. Because school teachers couldn't pronounce her name, they decided what name they would call her.

"We grew up in Wainui, a small valley near Matauri Bay in Northland," Sullivan said. "We were poor materially but rich in every other aspect of rural living. We never went hungry because there was always plenty of seafood and homemade parawa or bread. My parents spoke fluent te reo, but at that time speaking te reo at school was forbidden. Mum used to tell us stories about her mouth being washed out with a bar of soap because she was heard speaking te reo in the playground. She did not tell these stories with any bitterness. That was just the way things were.

"My siblings and I grew up understanding te reo but we weren't encouraged to speak it. Mum would tell us, '*Ahore tenei te ao Māori me mohio koe ngā mea o te Pākehā – this isn't the day of Māori. Learn the ways of the Pākehā*'."

When Sullivan was growing up, some children went to Māori schools and some to Pākehā schools. She and her siblings went to the Pākehā school. She remembers the Māori kids at the Māori school being "quite mean to us", especially when she went there to deliver some notices. "The kids would throw walnuts at me and tell me to go back to the other school. I did not volunteer to deliver notices again."

'I don't do negative' – Dargaville Health Centre registered nurse Te Aniwa Sullivan.

For Sullivan, people are either kind or not. "Skin colour or culture don't matter because we all have the potential to be kind or unkind. Sometimes Māori are worse critics towards their own."

Using her Māori name marked a turning point in her life. "I went back to the Church of Jesus Christ of Latter Day Saints in which I had been brought up, and I stopped smoking and drinking. Using my real name has helped me be in the place I need to be."

Influence of racism

Sullivan was one of four people on a panel discussing racism and its role in shaping New Zealand earlier this month as part of the Tackling Inequity to Improve Outcomes conference in Wellington. Māori clinical nurse director at Auckland and Waitemata District Health Board Dianna McGregor was also on it.

Sullivan spoke of her role at the Dargaville Medical Centre, where she has worked as a registered nurse (RN) since 1995. She described her own attitudes towards racism as: "I don't do negative and I try not to take negative experiences personally. When I joined the centre, I was the only Māori nurse. That changed four years ago. Now our frontline staff include Māori and Pasifika.

"In the past, Māori were only a small percentage of attendees. Now they are 31 per cent, with 62 per cent of our 12,000 enrolled patients being Pākehā and two per cent Pasifika. Our Māori population is becoming more interactive in their health care, but we still have a long way to go to get them to manage and understand their own health. That comes back to education. Who delivers that education is a question only Māori can answer."

Because she can whanaungatanga across Ngāpuhi, Sullivan believes she can say things quite directly to Māori patients and they don't get offended. "We laugh a lot about things," she said. "I also like to use simple language and pictures when I explain test results or disease processes to my people. Technology really helps here."

Other speakers at the two-day Tackling inequity conference were NZNO kaiwhakahaere Kerri Nuku, professor Peter Crampton from the Centre for Hauora Māori at the University of Otago, clinical director of the national Hauora Coalition Rawiri McKree, Dargaville Medical Centre RN and practice manager Judy Harris, and Dargaville GP Bev Hopkins, a fluent te reo speaker. •

Nursing medals from yesteryear

AS PART of the celebrations to mark the International Year of the Nurse and Midwife at the Whanganui District Health Board, a display of nursing medals was mounted in the cabinet in the main hospital corridor.

There were more than 40 medals from round New Zealand and several from Australia, the United Kingdom and the United States.

The medals represented more than 50 years of history – Plunket training with Sir Truby King's name on the medal, School of Advanced Nursing Studies in Wellington, a variety of NZNO badges, especially from special interest groups, as well as NZNA student nurses' badges from 1960.

"Many of the courses represented by these badges have been superseded, but it was nurses of yesteryear who raised money and worked hard, so the education of today's nurses is fit for the 21st century and beyond," said archivist and retired registered nurse Ailsa Stewart. •

NPs gifted new Māori title

History was made last month when nurse practitioners received the gift of a new name – mātanga tapuhi.

By Rhoena Davis

Tawhiti rawa i tō tatou haerenga atu te kore haere tonu – You have come too far not to go further; you have done too much, not to do more. Ta James Henare

PHOTO: NURSING COUNCIL

Nurse leaders walk onto Te Herenga Waka Marae, with registered nurse Nadine Gray carrying a photo of her mother, the late Janet Maloney-Moni.

The beginnings of mahi oranga in Aotearoa can be traced back to the delegated authority of the tohunga. These health experts practised many oranga rituals including karakia, rongoa and whānau rā, rituals handed down from tūpuna. Mahi oranga and mahi tapuhi were inherent components of Māori culture. Whānau members used a variety of medicinal and nursing skills to meet the needs of early Māori.

The first hospital in Aotearoa was established in Auckland in 1850. Hospital nurses had no official training, providing more of a cleaning and support role to doctors. In 1888, the first lectures were given to nursing students, who had to pass an exam after one year. Early nurse training was ad hoc and fostered a subservient nursing aide model. Female nurses were only allowed to nurse on female wards and men nursed on male wards.

On January 10, 1902, Ellen Dougherty from Palmerston North became the world's first state registered nurse (RN). In 1908, Akenehi Hei from Whakatōhea and Te Whānau-ā-Apanui was one of the first Māori RNs. Alongside Akenehi, we salute Mereana Tangata from Peria in Northland. Mereana, also known as Mary Ann Leonard, trained at Auckland Hospital and gained her registration in 1896.

Between 1910 and 1940, remote rural backblock nursing was introduced, the beginnings of rural nursing. Native health nurses, both Pākehā and Māori, were appointed to the Māori nursing services set up by the government in 1911.

Nursing has responded to people's need for health care throughout the generations, evolving to what it has become today. Our profession now includes nurse aides, enrolled nurses, RNs, midwives, nurse specialists and nurse practitioners (NPs).

NPs are highly-skilled, autonomous health practitioners whose academic training at clinical masters level includes advanced diagnostic reasoning, clinical and medical management, research enquiry and leadership. The role of an NP, who often works in disadvantaged or isolated rural communities, is to improve health outcomes, enable and increase access to health care and work towards reducing health inequities in the areas in which they serve.

New Zealand's first NP was Deborah Harris from the Waikato, who was endorsed by the Nursing Council in her speciality of neonatal care in 2001. Two years later, Janet Maloney-Moni was registered as the first Māori NP.

Last month, nurse leaders gathered to celebrate a special moment in nursing history at Te Herenga Waka Marae, Victoria University of Wellington – the gifting by Te Taura Whiri I Te Reo Māori, the Māori Language Commission, of a Māori name for NPs in Aotearoa – mātanga tapuhi. This translates as a nurse with expert knowledge and experience.

It was fitting that Deborah Harris's speech was a mihi aroha to the late Janet Maloney-Moni who had mentored her when the new NP role was being established. Other official speakers were Ministry of Health chief nursing officer Margareth Broodkoon, RN Nadine Gray, Maloney-Moni's daughter, former chief nurse Mark Jones, executive officer for the College of Nurses Aotearoa Jenny Carryer and Victoria University Deputy Vice-Chancellor (Māori) Rawinia Higgins. As one of the early Māori NPs, I was able to speak when the floor was opened.

It has taken 19 years to reach this nursing milestone and there are now nearly 500 NPs practising throughout the motu. As pioneers and trail blazers, we were grateful to have shared this significant moment in time. It should encourage all nurses to aspire to their true destiny, to become the best they can and to be great nurses.

Our gratitude goes to all those who have helped us along the NP pathway – our mentors including doctors, physicians, pharmacists, nurses and managers – and the many families who have been part of the journey. *Ma te Atua kei a koutou – e manaaki o tiaki i ngā wa katoa.* •

Rhoena Davis, NP, mātanga tapuhi i whānau ora, BHSc, MN (Hons), works for the Whangaroa Health Services Trust in Northland.

** Thanks also to Auckland mātanga tapuhi Michael Geraghty for additional information.*

Case points the way to the future

An historic case against a nurse who made racist comments on social media demonstrates how 'law' and 'lore' can work together.

By co-editor Anne Manchester

The decisions made at the recent Health Practitioners Disciplinary Tribunal hearing against mental health nurse Deborah Hugill were "ground-breaking", according to witness Cherene Neilson-Hornblow (Ngāpuhi me Ngāti Porou).

"This case has set a very high benchmark, setting the way forward for all organisations," Neilson-Hornblow, a forensic mental health nurse, said. "It is the first case in which the tribunal has considered the harm caused by racist comments on social media."

The hearing was held in New Plymouth over two days at the end of July. It saw Hugill, who had made racist comments on an NZNO Facebook page in May last year, lose her registration. She is unable to return to practice for two years, and has strict conditions placed on any return to practice.

A second charge related to her continuing to work as an RN in the weeks after the Nursing Council had suspended her annual practising certificate. The tribunal upheld both charges.

In her Facebook post, Hugill accused Māori nurses and management in Taranaki of being lazy, dishonest and unprofessional. Neilson-Hornblow described the comments as "very damaging".

"When I first read her posts on Facebook, I tried to stop her conversation. However she continued to slander people from Taranaki that she worked with – clients, nurses, her employers and other organisations. I made a complaint to many health organisations and the Nursing Council responded."

Neilson-Hornblow was impressed how respectfully the council's professional conduct committee lawyers followed a kaupapa Māori approach, using tauparapara, karakia and waiata. She was also impressed that Judge Maria Dew

Cherene Neilson-Hornblow

took into account the need for restorative justice, ensuring there was a way forward for the people of Taranaki, whose mana had been "trampled on" by Hugill's racist comments.

"The Nursing Council supported me, as did my husband, other whānau members and mana whenua present at the hearing," Neilson-Hornblow said. "In supporting my call for restorative justice to be returned to Taranaki, I believe the Nursing Council went above and beyond its regulations. They offered manaakitanga to me throughout the whole process."

Council's code of conduct

In reaching its decision to discipline Hugill, the tribunal pointed to principle 2 of the Nursing Council's Code of Conduct which requires nurses to respect the cultural needs and values of health consumers, with a particular focus on recognising and addressing Māori health inequalities. It also pointed to the council's social media guidelines that state that: "*Nurses are responsible for maintaining the same standards of professional behaviour in social and electronic media as they would when communicating face to face.*"

"Judge Dew provided a space for Deborah to offer restoration to the people she had offended, but it was obvious she would not take responsibility for the harm she had caused," Neilson-Hornblow said. "Judge Dew then invited me to describe how restorative justice could be achieved. I asked that mana whenua be invited to work with me, as I felt I could not reply on their behalf. When I read out the agreed statement the next day, everyone was in tears – the judge, the reporter from *Stuff*, witnesses, and Nursing Council and tribunal members. It was a moving experience.

"In my closing statement, I acknowledged the mana whenua of Taranaki who live under the raukura [the white feathers' symbol of peace], established by the 19th century prophets and passive resistance leaders Tohu Kākahi and Te Whiti o Rongomai from Parihaka.

"In the Māori world, 'takahi' means to trample on, abuse, transgress, offend, breach or infringe. Ms Hugill has trampled on the heads of our people and caused great offence to the people of this rohe. I believe a formal apology should be afforded to the Taranaki whānui, whānau, hapū and iwi. The people of Taranaki whānui have and continue to suffer from passive and overt levels of racism. Taranaki whānui believe it is time for individuals and systems to be held accountable."

In thanking the tribunal, Neilson-Hornblow also acknowledged Nursing Council members for "planting a seed of hope, manaakitanga, kaitiakitanga, tino rangatiratanga and most of all aroha".

Manu Pīwakawaka – he tohu, he tohu, ki te kotahitanga

Ka tae mai he tohu, he tohu nō runga, he manu Pīwakawaka hāmate. I te rangimārie, he tohu mōku, kia reri, ki te maumahara ki tōna wairua, ki te karakia. He tohu he tohu, ki te karakia.

Last month, a wairua whakaari lore was held at Parihaka marae Takitūtū and Toroanui. This case in lore was named Houhou i te Rongo – to make peace – by kaumātua Hokianga Tua. It was a way of bringing restoration to the people through discussion with Parihaka haukāinga.

Neilson-Hornblow was accompanied by her whānau and Nursing Council representatives – chief executive Catherine Byrne, senior legal adviser Clare Prendergast, lawyer Nick Davies and director Māori responsiveness Hikitia Ropata.

"We received a humbling, respectful pōwhiri, facilitated by Taranaki kaumātua Dr Ruakere Hond and Parihaka whānau," Neilson-Hornblow said. "Several groups shared their own tono, karakia and waiata. Nick Davies presented the facts of the case (the law), then I presented the lore. These two worldviews then united in kotahitanga. Later we presented a kete with framed manu pīwakawaka feathers as he tohu, a symbol of guidance (pictured bottom of p10)."

For Neilson-Hornblow, the gatherings were wonderful examples of bringing together taha tikanga Pākehā and taha tikanga Māori, of "law" and the "lore" becoming intertwined. Mana was restored and healing and peace achieved.

She identified a number of key highlights emerging from the case. It was:

- The first time a tribunal was conducted with a kaupapa Māori focus, led by mana whenua o Taranaki.
- The first time that restorative justice has been documented for mana whenua iwi o Taranaki.
- The first time a kaupapa Māori process benchmarked the way the and professional conduct committee operated.
- The first case concerning racist comments on social media that the Health Practitioners Disciplinary Tribunal had dealt with.

Kotahitanga through te Tiriti

"The key message for everyone is to kotahitanga and to action Te Tiriti o Waitangi now," Neilson-Hornblow said. "I would like the Crown, Minister of Health and the Ministry of Health to review the tribunal, as it made a few tikanga and kawawhakaruruhau mistakes during the hearing. Māori appointments also need to be made to the tribunal. This case highlights a way forward for all government organisations in Aotearoa New Zealand.

"Nurses need to call out racism and demand that every organisation takes responsibility and action to achieve better equitable health outcomes for Māori. Then whānau, hapū and iwi can thrive and succeed."

Neilson-Hornblow believes the case will do much to unite and enhance the mana of the Parihaka marae. She sees it as a human rights campaign worthy of United Nations attention and hopes that one day, November 5, Parihaka Day, will be recognised nationally.

"Lastly I thank each and everyone involved in this case and most importantly I acknowledge my guidance from ngā taonga tuku ihu o ngā tupuna." •

New benchmark set

By Nursing Council chief executive Catherine Byrne

Catherine Byrne

THE CANCELLATION of a nurse's registration for derogatory comments against Māori on a social media site sets a new benchmark for serious misconduct involving racism in New Zealand.

Nurses are expected to maintain the highest professional standards at all times. As with face-to-face relationships, the nurse has a responsibility to ensure their use of social media is professional and the public's trust and confidence in the nursing profession is upheld.

The nurse's actions were serious enough for a professional conduct committee, appointed by the Nursing Council, to lay charges against the nurse and for the tribunal to find that the conduct amounted to professional misconduct.

Not all complaints the Nursing Council receives about social media comments and alleged racism are within its jurisdiction to take action. However, in this case the link between the nurse's inappropriate social media postings and the risk to public safety was clear.

This case provides an evidence-based platform for change and provides health regulators with significant lessons:

- The tribunal hearing process may be alienating for Māori who participate either as a nurse under investigation or as witnesses, and the council is working to transform the process and culture for Māori.
- We have to be proactive about making space for LAW and LORE to interact together – that is what being responsive to Te Tiriti o Waitangi means.
- It has fundamentally questioned how we deliver our business services – we are making stepped changes to lift our capability and capacity to respond to Māori, we are questioning more, and are doing some things differently.
- Tribunal members may require cultural safety professional development with the need for the Crown and the Minstry of Health to review the appointments process for Māori to the tribunal and governance boards.
- The case provides insights into the harm that racism can cause and the difficulties that social media can get professionals into. We all have a collective responsibility to talk and take action about individual and systemic racism in our systems.

The council will be consulting on its code of conduct and social media guidelines in 2021 in response to this case and to other complaints it has received about nurses' communication. •

The Te Rūnanga team (from left to right): NZNO administrator Diana Geerling, Tracy Black, Anamaria Watene, Moana Teiho, tumu whakarae Titihuia Pakeho, Ruth Te Rangi, kaumātua Keelan Ransfield, Tracey Haddon, kaiwhakahaere Kerri Nuku, NZNO vice-president Tracey Morgan, Māori policy analyst Leanne Manson and Charleen Waddell.

Reflections on the Indigenous Nurses Conference

NZNO communications and media assistant Hugo Robinson attended the 2020 Indigenous Nurses Aotearoa Conference in November, and over the next five pages reflects on his impressions of the power of the kōrero.

She walks with
The power
Of thousands of years
In her cycles of blood,
And
The rhythms of her heart
She descends from the seeds
of Rangiātea

The never ending source of
who we are who we can be
Don't mess with the Māori
woman
Who stands beside you
As she walks with the power
Of thousands of years
In her blood and her bones

– Excerpt from Linda Tuhiwai Smith's poem *Don't Mess with the Māori Woman*

Mihi

Nō Airani, Ingārani, me Kōtirani ōku tūpuna. E noho ana au i te takiwā o Te Ātiawa me Ngāti Toa Rangatira. He kaitautoko whakapā o Tōpūtanga Tapuhi Kaitiaki o Aotearoa. Kō Hugo Robinson tōku ingoa.

My name is Hugo Robinson and I am the communications and media assistant at NZNO. I was honoured to attend the recent Indigenous Nurses Aotearoa Conference (INAC) and write about this experience. This article contains my reflections on the conference, and, given that I am neither Māori nor a nurse, I can only comment on things that resonated with me. However, I have tried my best to give a sense of the power of the kōrero, the context from which the speakers were coming, and the intentions with which te poari organised the conference.

Ngā mihi mahana ki ngā tāpuhi Māori o ngā mōtu me ngā kaikōrero hoki. It was a privilege to listen and I look forward to continuing to tautoko you in all ways I can. Nō reira, tēnā koutou katoa.

On November 26 and 27 Te Rūnanga o Tōpūtanga Tapuhi Kaitiaki o Aotearoa New Zealand Nurses Organisation held its first virtual INAC. After many tense, anxiety-filled months for tāpuhi Māori on the frontlines of COVID-19, as well as dealing with the ongoing issues of systemic racism and pay parity for those working for Māori and iwi providers, the conference aimed to give the space and time to re-energise the collective mauri for Te Rūnanga. These were two days filled with joy and sadness – days for reflection, remembrance and planning.

Yet, one of the big challenges in our changing world – as with the NZNO annual general meeting and conference – was the absence of the kanohi-ki-te-kanohi connections noted by many speakers. Nevertheless, it was a deeply stirring hui which, while being separated

by technology, was filled with inspiring kōrero from speakers around Aotearoa New Zealand and beyond.

The kaupapa for the year had two components: "Raising an Army of Nurses" and "Rise Up". The first – which was also the previous year's kaupapa – references Māori statesman Sir Apirana Ngata. Seeing how epidemics in earlier times devastated Māori, and the lack of state response, Ngata urged the drastic need for more Māori nurses to go out and treat their people.

It was, therefore, very fitting that the same words be carried over to this year, a year in which Māori health-care workers mobilised to fill the gaps in the Government's COVID-19 response for Māori. Their self-organisation and assertion of mana was crucial for the health of their communities.

The second component of this year's kaupapa, the call to "Rise Up", references Andra Day's inspiring song of the same name, as well as Maya Angelou's poem, "Still I Rise", the opening lines of which read:

You may write me down in history
With your bitter, twisted lies,
You may tread me in the very dirt
But still, like dust, I'll rise.

Both the poem and song were played at the beginning of each day, accompanied by karakia and photos of Māori struggles for justice through the years. These opening moments were immensely moving as they took stock of the whakapapa of struggle that Māori nurses are part of. They encapsulated the significance of the kaupapa because they conveyed just some of the tireless mahi to not just work in the system, but to actively try to change it.

In the following pages, I focus on the kōrero that I could connect with most and feel most comfortable sharing. I also want to mihi to Tracey Haddon, Sue Crengle, Dr Anne-Marie Baker and Merryn Jones, who I could not include in this piece, but whose kōrero was thought-provoking, whānau-focused and full of critical insight which I have not the experience or knowledge to discuss adequately. I hope to co-write a piece on their kōrero at a later stage.

Tina Wilson-Hall

Tina Wilson-Hall (Ngāti Tukorehe, Ngāti Raukawa, Muaupoko, Rangitāne, Ngāi Tahu), the tumu whakarae for Māori Partnerships and Capability at New Zealand Trade and Enterprise (NZTE), spoke on the impacts of the pandemic on the worlds of business and health. She drew on the whakataukī, *"Ko te pae tawhiti whaia kia tata, ko te pae tata whakamaua kia tina." Seek to bring distant horizons closer, and sustain and cherish those that have been arrived at.*

True to the whakataukī, Tina's kōrero was incredibly interesting because it brought home the interconnectedness of the global and local world and that, in spite of that, our priorities are clear. At the outset of her kōrero, she showed a slide of Tukorehe Marae. "This is my marae," she said, "and when the world changed it became apparent that this was all we really, really cared about."

She addressed some of NZTE's primary concerns about how decreased exports and tourism affected Māori. She spoke about how Aotearoa New Zealand used to send 270 flights a day filled with exports. After COVID-19 hit, that was reduced to three a day. That was why the marae was so important. It was where people mobilised to respond and support one another. And, she said, "It was so phenomenal to see what we can do when we need to."

The key takeaway for me was how deeply the economy and people's health are interconnected. Echoing many of the speakers' whakaaro, her kōrero made it clear that relying on international trade and commerce can leave communities vulnerable when that link is broken. Self-determination for tāngata whenua is therefore crucial to protect against the crises that global capitalism amplifies for already marginalised communities.

COVID-19 experiences from the indigenous view

Following Tina, was a panel on the impacts of COVID-19 on nurses in Aotearoa New Zealand and te Moananui-a-Kiwa (the Pacific). Each kaikōrero brought a unique perspective which showed how far-reaching the impacts of the virus have been, the significance of which can often get lost.

Kate Brown (Ngāiterangi) raised crucial concerns about the role of ecological

sustainability in protecting against future pandemics. This was in light of the suggestion made recently that ecological collapse is potentially linked to the spill-over of zoonotic diseases. Whether or not there is a causal link, balance must be struck and we must learn from the past and change how we do things. This is all the more pressing, Kate said, with the likelihood of recurring pandemics ahead.

Complementing Kate's kōrero nicely was that of Henri Aviga, a nurse leader based in Samoa. Henri spoke about the lessons Samoa learnt from the measles outbreak, which were then applied to keep Samoa COVID-free.

She described how a month after the first case of measles in September 2019, the Samoan government declared a state of emergency. Schools were closed, children under 17 were not allowed to be in public gatherings, self-isolation was promoted and vaccination was mandatory. Moreover, through public health education, they were able to turn around a generally distrusting public to have faith in their health-care system.

Kaumātua Keelan Ransfield officiates at the opening of the first virtual Indigenous Nurses Aotearoa Conference in November.

Following Henri, Tina Black's (Te Whānau ā Apanui) kōrero reiterated that a mana motuhake response was the only appropriate one for hapū and iwi. Self-organisation was the most important factor and her message was to "know your community and plan for them, get prepared for self-sustainability". Given the criticism Te Whānau ā Apanui received for their roadblocks initiative during the lockdown, this principle demonstrates the hypocrisy of those who called iwi roadblocks "separatism" while ignoring the fact that nobody else was coming in to help hapū and iwi prepare.

Charleen Waddell's (Rongomaiwahine, Kati Mamoe, Kai Tahu, Ngāti Kahangunu) experience similarly highlighted the need for Māori nurses to organise and be adaptable to changing circumstances. She spoke of their extraordinary team who remained in Bluff, Southland, to ensure the community was safe, enduring isolation and freezing temperatures as they set up drive-by clinics.

One thing that really stood out was how those in decision-making positions had little sense of the need for whanaungatanga to ensure that vulnerable elders were kept not just safe, but connected. "Whānau at the marae were feeling anxious, and so they got the tech in there and did karakia every night," she said. Maintaining that wairua connection is an issue we can all relate to from the rāhui period.

Kimmel Manning (Ngāi Tahu) closed with reflections on the issues facing tauira over the period. He talked about the problems with having 17 different nursing programmes being run 17 different ways. Schools rarely took into account the needs and commitments of tauira. For instance, though schools eventually moved online, there was no thought for those who did not have access to technology or who had to look after whānau.

The lack of kanohi-ki-te-kanohi time, combined with poor support, diminished their wairua and lead to a sharp increase in mental health issues showing up across the schools. On top of these stresses, next year there will now be a number of third-year students who will not meet the Nursing Council criteria if they miss even a single day on placement. "You can't get sick, and if your kids get sick, you can't look after them," Kimmel said. His talk demonstrated the urgent need for equity and accessibility in the education system.

Annette Sykes

"Te ohonga ake, the awakening. Te ohonga ake, the arising. Te ohonga ake, the realisation. Te ohonga ake, the movement. Te ohonga ake, the action, the process from passive understanding about a situation to wanting to do something about it."

This is how Tiriti and whenua activist and human rights lawyer Annette Sykes (Ngāti Pikiao) opened the second day of the conference. She implored us to rethink economic, ecological and political structures to achieve a non-colonial form of governance in which "history and wellbeing is not secured by obliterating the history and wellbeing of others".

At the outset, she pointed out how the dominant narratives around Oranga Tamariki have painted Māori nurses, midwives, and iwi leaders as barriers to effecting what the state sees as reasonable behaviour. Annette said, "I found it a racist construction . . . that denied the fundamental human rights of the nurses, the midwives . . . the survivors, the mothers, and their whānau . . ."

continues p16

Emma Espiner praises the expertise of Māori nurses who practise whakawhanaungatanga.

The power of story telling in medicine

EMMA ESPINER (Ngāti Tukorehe, Ngāti Porou) was the first speaker at the conference. She is an award-winning broadcaster and commentator who, having decided to head to medical school six years ago, will begin as a junior doctor at Middlemore Hospital next year.

Her kōrero, "The power and privilege of storytelling in medicine", drew on her experiences in medical school so far, as well as her observations of the health-care system and the stories that need to be told to change it.

How to take histories

Her opening comments, for instance, reflected on the Pākehā way that trainee doctors are taught to take histories. These, she says, are very transactional and don't allow for whakawhanaungatanga, which is crucial for whānau, not least because they rightfully distrust a system that does not look after them as well as others.

She said: "The most impactful facilitator of safety is whakawhanaungatanga", and she applauded the expertise of Māori nurses who do this. They are the bridge between whānau and the health system. And it was not until her general practice placement at Ki A Ora Ngātiwai – the iwi health provider in Whangārei – that Emma says she saw such a truly "culturally safe health service".

'The whole team was mobilised around making sure that people are well, not just being treated for being sick.'

At Ki A Ora Ngātiwai, not only was whakawhanaungatanga a priority in meeting whānau needs in a social sense, it was also crucial because it uncovered the specifics of patients' circumstances. "The whole team was mobilised around making sure that people are well, not just being treated for being sick."

Yet, despite the life-changing mahi these providers do, Emma pointed out that they also have to deal with a higher burden of compliance than non-Māori contractors. Extending this observation further, she highlighted that you can draw a direct line from racist nurses, like the one who got struck off in Taranaki, to the health system that underfunds and devalues Māori nurses and providers.

The resounding message from Emma was the necessity to have rangatiratanga over story-telling. That meant telling the story of these connections in the racist system, and calling out the different standards that Māori and iwi providers have to comply with and the racism that nurses have to deal with. And finally, too, it meant celebrating the uniqueness of Māori health practitioners, and finding strength in their own connections. •

'Race influenced who died of COVID-19'

BONNIE CASTILLO, RN, is the executive director of National Nurses United (NNU) and of the California Nurses Association/National Nurses Organising Committee (CNA/NNOC). She was named one of *Time* magazine's 100 most influential people in the world for 2020.

Bonnie's address was a chilling reminder of the dire circumstances that health-care workers in the United States (US) have had to endure under the Trump administration. She explained how this administration had refused for months to enact the Defence Production Act, which would prioritise the production and distribution of personal protective equipment (PPE) for health-care workers. She told horror stories of nurses only having one N-95 mask for up to a month and having to store this in between shifts in a paper bag. Because of this gross negligence, the US lost more

Bonnie Castillo – more than 2100 health workers lost to COVID-19 in the United States.

2100 nurses and health-care workers.

Bonnie emphasised that race heavily influenced who suffered and died with COVID-19 in the US. "With our profit-driven health system, health-care injustice and racial injustice have historically gone hand in hand," said Bonnie. Indigenous people have been 3.5 times more likely to be diagnosed with COVID-19 than white people, and in some areas black and Latinx (a gender-neutral term Bonnie used for people of Latin American descent) people have been three to four times more likely to die than white counterparts. COVID-19 also hit black and brown nurses especially hard.

She talked about an earlier report conducted by NNU that 58 per cent of the 213 nurses who had died at that point were nurses of colour, despite making up only 24 per cent of the workforce.

Bonnie says racism is a public health issue and it has taken the strength of unions, and the strength of international solidarity, to fight it. "It's a great comfort . . . knowing that to be in a pandemic that has no borders, our collective power as union nurses has no borders." I know we will continue to stand in solidarity with them. •

She also paid tribute to Jean Te Huia and Kerri Nuku for their courage in fighting the state on uplifting Māori children through public forums and the courts, despite the state's best efforts to demonise them.

Annette offered a vision for unions, and our organisation in particular, to play a central role in decolonisation. She said, "Decolonisation in Aotearoa means engaging in the perpetual hard work of maintaining relationships", of having conflict and then finding our way back to the co-existence and mutual understanding that te Tiriti envisaged.

She stressed that everyone has a role to play. The role of our members, as individuals, was to be "beautiful exemplars of humanity that [they] are, of kindness, of generosity".

Annette emphasised the core values of solidarity and collective action. She said that, although surrounded by conflict and controversy, the wave of strike action in 2018 by nurses, teachers and bus drivers, among others, lit up the public's consciousness of the issues all workers faced. Drawing on that collective strength, and the principles that health-care workers abide by, she affirmed that that same kind of action, if grounded in te Tiriti, is vital to changing the conditions for workers and tāngata whenua alike. And this starts with addressing the 25 per cent pay gap between Māori and iwi provider and DHB nurses.

Closing remarks

Though full of laughter, these were solemn days that named the deep, painful and twisted system of colonisation and the world it has produced. More than naming it, however, it was about identifying what action needs to be taken to dismantle it. Emma Espiner captured it perfectly in her closing remarks when she said: "As indigenous health practitioners, we have a lot of extra work to do. Because, well, there are obstacles right from the beginning in our path which don't exist for non-indigenous health practitioners. And because we are deeply invested in not just working in the health care system, but transforming it."

There is an increasing momentum among Māori in all areas to reject the racist structures they have to work and live in. And as Annette signalled in her kōrero, the invitation is there for all nurses and health-care workers to come together in that struggle to get back to the mutual co-existence that te Tiriti envisioned.

Mana motuhake and tino rangatiratanga are the best health strategies for Māori and all speakers emphasised that power-sharing and mutual understanding between Tiriti partners is absolutely key for a just and healthy society. This organisation is uniquely placed to be an agent for such transformation. Through solidarity, collective action and the humanity that health-care workers exemplify, we can be well on the way to building that Tiriti-based future. •

Bernard Hutchinson

Nurse understands grief

Named neonatal nurse of the year for his 'quiet' support of families, Bernard Hutchinson knows what they are going through.

By co-editor Mary Longmore

Christchurch neonatal nurse Bernard Hutchinson knows what it's like for families with babies in the neonatal unit – he and wife Gloria have been admitted there, twice, with their own premature infants.

In 1995, their second daughter, Caitlin, was born at 36 weeks. Weighing just 1600g, she died following open heart surgery in Auckland.

A couple of years later in 1997, they were in again with baby Max, born at 38 weeks, who had difficulty feeding. They eventually figured it out and their son is now a healthy young man in his early 20s. "So that gave me a bit of an insight," said Hutchinson, now Christchurch Women's Hospital (CWH) associate clinical nurse manager. "You understand why parents might get upset about certain things, what they're going through, in a way that perhaps other staff might not."

Being a bloke has rarely been a problem in his 30 years or so in the neonatal service. These days his role is a coordinating one, but in the past caring intimately for mothers, with breastfeeding support, "never felt strange", he said. "Nobody's given me a hard time and if they do, it's usually the fathers."

However, he's always been conscious of possible tension, bringing female colleagues in if he senses any. He practised a no-touch technique for mums having trouble getting their baby feeding, just talking them through it. "That worked for most of the time and if I had any difficulty, I would change tasks with another RN [registered nurse]."

Hutchinson was part of the group which established the hospital's pasteurised human milk bank in 2014 – the first in the country. He is now working through the neonatal service to attain accreditation of CWH as a baby-friendly hospital. That means no "active promotion" of baby formula, bottles and pacifiers (except for neuro-development reasons) – although, of course, for those who cannot breastfeed or choose not to, formula is provided, he said. "I have the belief that you support feeding choice and I support breastfeeding where the mother's choice is breastfeeding."

Before the establishment of the baby-friendly hospital initiative in New Zealand in 1999, it was common for sales reps to hand out free formula samples, pens and diaries to new parents in hospitals. "For vulnerable babies, particularly, or any baby, it's not necessarily the best thing for them. Of course there are mothers who can't feed for some reason or formula is their choice, and that's when we need to make sure it's done safely."

Hutchinson initially was looking for an escape from his home town of Hokitika and a career in banking when he opted for what was then called psychopaedic nursing in the '70s – caring for people with intellectual disabilities in institutions. "I just wanted to move away from the [West] Coast." After a few years working as a registered psychopaedic nurse at Christchurch's Templeton Hospital, he moved to Melbourne to pursue paediatric nursing before heading to the United Kingdom. When he and Gloria returned to New Zealand in 1990, he couldn't find work in paediatrics, so picked up a role at Burwood Hospital working with young people with disabilities. From there, he took up a neonatal role at CWH. It was a "chaotic" time for the neonatal unit, which was overcrowded and had relocated due to building and electrical issues.

But there was a "good vibe" in the busy team, and the charge nurse, Dot O'Connor, was supportive. "It grew on me, as a much smaller and really tight team."

Hutchinson has mostly stayed there ever since. Praised by outgoing Neonatal Nurses College Aotearoa chair Gina Beecroft for the "quiet" support he provides to staff and families, Hutchinson says he is "just doing his job" as a clinical coordinator. "We oversee and support. I don't see how I do that any differently.

'You just have to focus on what small thing you can do in your role in that person's life.'

"Everyone thinks about the ventilators and hi-tech stuff involved with neonatal nursing, but supporting parents to care for their own baby is the important thing," Hutchinson said. "Of course, the life-saving part is a priority but, at the end of the day, you want people to go home and enjoy their baby."

Dealing with the daily struggles of families with neonatal babies can be overwhelming, but nurses can only do so much, he said.

"As nurses we want to fix things, but you can actually help a lot by listening, supporting or giving people your time," he said. "The best way to protect yourself is not to over-commit and promise things you can't deliver. You just have to focus on what small thing you can do in your role in that person's life." •

Nurses share tales of COVID-19 at

New Zealand and Australian nurses describe the 'scary rollercoaster'

By co-editor Mary Longmore

New graduate Tina Black shared her experiences on a Māori-led COVID-19 response with the South Pacific Nurses Forum (SPNF) last month.

The biennial forum was the first to be held online, after COVID-19 prevented it being held in the host nation, Vanuatu.

Black described how one week into her new job at Te Whānau-ā-Apanui Community Health in the Bay of Plenty, New Zealand went into level-four lockdown. "I said goodbye to my husband and three children and left home to serve my people and my community."

Black said her experience felt "unique", as it was led by local iwi, in partnership with national and local Government and businesses, as well as whānau ora.

"Our community and iwi COVID-19 response were initiated and led by an indigenous approach demonstrating mana motuhake – sovereignty, autonomy and self-determination led by Māori for Māori, in alignment with the Government and Ministry of Health (MoH) guidelines."

Local tribes placed a rāhui – cultural restrictions – on the area, closing roads. Community "safe zones" were set up and social media used to communicate. Iwi were proactive in protecting a vulnerable population of more than 200 elders in the area. "The loss of them would be catastrophic for our people," Black said.

The experience highlighted for her the value of connections and support within the Māori community, as well as the health and medical teams and other local services. As a result, the impacts of COVID-19 were minimised.

She realised later how hard the separation had been, "but when you think of the bigger picture and think of the greater good, it gives you some peace in yourself that you made the right choice".

Clinical nurse director for Auckland's managed facilities, Pauline Fuimaono Sanders, also acknowledged the importance of leadership and communication in responding to COVID-19. Being familiar with the South Auckland communities during one of the clusters, was helpful when deciding where to locate testing centres and redeploying staff, she said.

Nurses dealt with stress by talking and dancing – "lots of tik-toks", she said,

COVID spotlight an 'opportunity'

HAVING A COVID-19 pandemic in the International Year of the Nurse and the Midwife had put a "dual spotlight" on nurses and midwives, and the opportunity to advance nursing and midwifery, World Health Organization (WHO) chief nursing officer Elizabeth Iro (right) told the forum.

WHO's 2020 *State of the World's Nursing* report showed much to celebrate, with growing educational opportunities for nurses, which made a difference to population health in the region, she said. But "vast inequities" remained in nurse numbers round the region. While there were 6.5 million nurses in the western Pacific, under-investment in training had contributed to a shortage of 350,000, compounding barriers to health care in remote areas, Iro said. More support was also needed to extend scope, particularly when no other health professionals were available.

The realities of nursing exposed by COVID-19 highlighted the need for a collective nursing voice. "We need to remind governments and employers that investment in nursing is not a cost. But there is a higher cost for inaction." •

Indigenous voices still sought for ICN

THE SOUTH Pacific Nurses Forum (SPNF) is to form a working group to find ways of better representing indigenous nurses on the International Council of Nurses (ICN).

NZNO kaiwhakahaere Kerri Nuku said SPNF had, in 2018, requested an indigenous nursing representative from the South Pacific region be included on Nursing Now, a global campaign to raise the profile of nursing, run by the United Kingdom-based Burdett Trust for Nursing, the World Health Organization and the ICN.

But the ICN had suggested a global indigenous representative, not just a Pacific one, Nuku said. No further communication had ensued and with the Nursing Now campaign due to wind up in 2021, the conversation was "null and void". However, the conversation between national nursing associations (NNAs), regulators and chief nurses should continue, to strengthen the voice of the Pacific region's nursing groups at a global level, she said.

At its annual general meeting at the forum, the SPNF agreed to set up a working group to pursue this.

Nuku and former NZNO president Grant Brookes have raised concerns about the "Eurocentric" nature of the Nursing Now campaign previously. •

2020 South Pacific Nurses Forum

of working in a global pandemic, in virtual regional meeting.

From left to right: Pauline Fuimaono Sanders, Tina Black and Lynda MacLean

referring to the popular dance-sharing social media site.

Australian nurses also shared their COVID-19 experiences, Alice Vafo'ou of working in an acute mental health facility in New South Wales and Lynda MacLean of working at the Royal Melbourne Hospital (RMH) and with aged residential care (ARC) homes.

A 'rollercoaster'

MacLean said COVID-19 had been a "rollercoaster – a very fast one, scary and hard to get off.

"For nurses, one of the most challenging things was how quickly we had to adapt and change to the circumstances and deliver what was required, often with very little notice."

MacLean's work included setting up screening centres within hours, and working with public housing towers swabbing thousands of residents. One tower housing more than 500 people went into sudden lockdown with nobody able to enter or leave. "That response highlighted how difficult it is to consider everything when you're moving at such a fast pace and things are changing, literally hourly."

When mistakes were made – such as failing to consider the dietary requirements of the Islamic residents of the towers – the community "stepped up and showed us how to get things done".

Melbourne was divided into four hubs to try to ensure hospitals could support the ARC homes in each. MacLean's hub had 97 private rest homes, but it was quickly obvious they were "under-prepared and under-resourced".

Lack of personal protective equipment (PPE) meant hospitals were sending packs to four or five homes every day. But as the outbreaks grew, the Victorian Government stepped in and asked hospitals to manage the ARC facilities. One home lost 80 per cent of staff to either positive COVID-19 tests, close contacts or because staff were too scared to come to work.

Private hospital staff, such as perioperative nurses, were redeployed into rest homes. "Needless to say, we were grossly unprepared for what was coming. It was an incredibly steep learning curve," she said, which highlighted the importance of communication. "We had to make a team and make it work."

NZNO kaiwhakahaere Kerri Nuku said the urgency meant "cultural norms took a second seat to the management of the pandemic".

That meant often "comforting or working alongside or being part of a bereavement when someone was dying was impossible to do". How to prepare for pandemics without compromising cultural imperatives needed to be considered, she said.

SPNF country reports can be found at: www.spnf.org.au/spnf2020.html. •

Staff at the Mangere testing station earlier this year, with Pauline Fuimaono Sanders at bottom right.

PHOTOS: MERCY SHIPS

Nursing children on the *Africa Mercy* is the highlight of Wellington nurse Robyn Ferguson's volunteer experience.

Double the healing, double the hope

The Mercy Ships charity has brought surgical care to Africa for 40 years. A new ship, to be launched next year, will more than double services, changing lives and communities.

By Sharon Walls

It was time for a new professional challenge and a different kind of experience.

As Robyn Ferguson searched for a volunteer nursing opportunity to "give back", using the skills gained over her extensive nursing career, she found Mercy Ships – the hospital ship charity providing surgical care in Africa for patients who would otherwise have little access to essential services.

The Wellingtonian was inspired by her three-month tour of duty in 2010. She is now a familiar face among the 450-strong international crew, as volunteering with Mercy Ships has become a priority she works into her annual calendar. The most recent field service in Senegal, West Africa – paused due to COVID-19 – was Ferguson's ninth time volunteering on board the *Africa Mercy*.

The hospital ship has five operating theatres, 80 ward beds, intensive care, and all the required auxiliary services to treat patients in the specialties provided – ophthalmic, maxillofacial, paediatric orthopaedic, women's health, burns and plastic reconstruction, and paediatric general surgery. Other services include mental and oral health, palliative care, and Ponseti treatment for babies born with clubfoot.

For ten months at a time, the self-contained floating hospital provides free care in low-income countries where health-care resources are usually inaccessible and unaffordable. "The long queues of people at the Mercy Ships health screenings show how desperate people are for treatment; many have walked for days to get to one of our clinics," Ferguson explained.

One of the unique aspects of the Mercy Ships wards is the level of interaction between the patients – people who were strangers before admission. "Patients support each other and follow cues from others who have been in the ward longer. It is very community-based. In western countries, people want privacy from others and would not think of asking another patient what to do, or they would not want to be seen to interfere.

"As patients don't speak English, we have ward translators, but they are not medically-trained. I have been known to resort to making up my own sign language to show patients what needs to be done. When caring for obstetric fistula patients who needed perineal/catheter care, I had the habit of indicating time for this treatment by saying and acting 'wash'. One day a patient asked for Mama WashWash, which apparently was me!"

The Mercy Ships hospital processes were familiar to Ferguson from the beginning. "There are nurses from across the globe with different nursing backgrounds and styles, so on-board care pathways guide our day-to-day care for different specialties, similar to pathways used at home. There are policies and procedures to follow like hand hygiene, infection control and intravenous therapy, all in line with my nursing experience.

"The equipment is similar. I was surprised to see more blood pressure machines on the ward of 20 patients than we had on the ward of 30 I had left in New Zealand."

The most surprising aspect of nursing on board for Ferguson was how easily the patients accept the foreign health professionals. "They come into an unfamiliar environment, not speaking or understanding the language, and not knowing what the outcome of their surgery will be. After seeing other patients' reactions, they are encouraged. They relax and settle in, letting us hold their hands and accepting hugs. They sing and dance and laugh.

"One day I gave a hug to a lady who was crying. When she settled, the patient in the next bed put her arms out for a hug too. Then I had to give a hug to all the ladies in the ward. This became a part of my working day."

Robyn Ferguson mentors Elyse, a ward assistant from Madagascar.

Mentoring and teaching

With an emphasis on mentoring and teaching, Mercy Ships leans on the experience of professionals like Ferguson to strengthen the health-care capacity of the host nation. "If we were doing surgery without mentoring, teaching and training, then change won't happen," she said. "We help the local nurses, doctors and technicians learn new skills. We provide protocols like the World Health Organization safe surgery checklist, demonstrate the importance of hand hygiene and teach specific surgical techniques. Local colleagues teach this to others, improving on what they are already doing."

While patients experience physical healing through the surgeries they receive, they often find much more. For many, access to surgery means finding hope again. Patients frequently report that the level of personal and unconditional care provided by the Mercy Ships nurses is a deeply meaningful boost to their holistic recovery. Mothers and fathers are able to return to work and provide for their families. Children can go to school. Community relationships are restored

"I love Africa, the people, community spirit, the sights and sounds, the chaos and the acceptance. I make friends in each of the countries Mercy Ships visit, and they stay with me always," Ferguson said.

According to the Lancet Commission on Global Surgery, inadequate access to surgery kills 16 million people annually, more deaths than malaria, HIV, and tuberculosis combined.

Global Mercy to be launched

As the global backlog of surgical care has escalated during COVID-19, there has never been a more urgent time for Mercy Ships to double its services for people who live in low-income countries in Africa. The deployment of a new Mercy Ship *Global Mercy* next year will more than double the surgical care the not-for-profit can provide to people with little other access to the essential services they require.

The new Mercy Ship is close to completion and will be on the water in 2021. The *Global Mercy* will have state-of-the-art technology and instrumentation, six operating theatres and 199 hospital beds.

Health-care mentoring and developing capacity in host nations is a critical part of all Mercy Ships programmes and to facilitate this, *Global Mercy* will have a training centre that includes a simulation lab, virtual reality stations, and the latest teaching equipment.

It is a very big ship and, for the volunteers, an experience potentially like no other. The new ship will be powered by 600 crew members from across the globe, and there will be ample accommodation to make nurses, surgeons, maritime crew, cooks, teachers, electricians, technicians and all our other essential people feel at home.

Over the next 50 years, it is estimated that more than 150,000 people's lives will be changed on board the *Global Mercy* through surgery alone, with countless more lives helped by the ship's medical training and infrastructure programmes. In close collaboration with host nations in Africa, the *Global Mercy*, together with the *Africa Mercy*, will more than double the charity's work.

A video about the Mercy Ships' response to global surgical need can be seen at https://vimeo.com/215942979

For more information about volunteer opportunities for paediatric, theatre, wound care and other nurse specialists, go to www.mercyships.org.nz/nurses-all-aboard/ •

Sharon Walls is communications manager for Mercy Ships NZ

PHOTO: ADOBE STOCK

Health literacy can improve inequities

Improving health literacy can help bridge health inequities, and also improve the care palliative services provide to Māori whānau.

By Deborah Crossan

The World Health Organization defines health literacy as *". . . the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health"*.[1] Health literacy is more than the ability to understand a pamphlet or to attend an appointment. It empowers a person to be proactive in looking after their health, with the ability to take action and make well-informed decisions.[1,2]

In an increasingly hectic health-care environment, where many options are available to the health-care consumer, they need to have the ability to understand health information to make informed decisions.[3] The internet and media add to the complexity of information for people to consider, and there is increased expectation for patients to participate in decision-making about their health.[3]

An example of the impact of health literacy is failure to understand instructions, such as how to take a medication effectively, which can lead to hospitalisation or death.[4] Therefore, limited health literacy is a determinant in outcomes such as increased hospitalisation, inadequate management of chronic conditions, increased mortality, increased health risk-taking, and inequalities in disease outcomes.[4,5] Effective health literacy interventions can help reduce health inequalities and health costs and improve health outcomes.[4]

Studies in the United States show around half its population lacks abilities in numeracy, reading and writing – skills required for effective navigation of the health system. People from lower socioeconomic groups and minorities were over-represented among those with inadequate literacy skills.[6]

Studies done in Aotearoa/New Zealand report poor health literacy skills in the majority of New Zealanders. Māori had the lowest health literacy skills, which is very likely to have a negative impact on their health.[7] Research has found 75 per cent of Māori women and 80 per cent of Māori men have poor health literacy skills.[8] Worldwide, those most at risk of inadequate health literacy skills are racial minorities, older people, unemployed people, prisoners, immigrants, people with chronic mental or physical conditions and people living in poverty.[6]

However, poor health literacy does not just affect the above groups – any patient, no matter their level of literacy and understanding, can find it challenging to understand or communicate if they are in pain or emotional distress.[3]

Empowering the individual

Health literacy is a tool that empowers the individual to make decisions for their health and can be achieved with effective communication and provision of information and education.[2] Therefore, health literacy is partly about how effectively health-care professionals communicate health messages. Effective communication results in higher patient satisfaction, compliance with treatment,

reduced costs, better health outcomes, and fewer claims of malpractice.[10]

Given the impact health literacy has on the health system, a large amount of research and resources about it are available worldwide, including on the New Zealand Ministry of Health website.[11] A range of tests is available to assess patients' health literary skills; however, people with low literacy could find this humiliating. Instead, asking a single question such as "how confident are you filling out medical forms by yourself?" could be considered.[3] Health-care professionals should also look out for "red flags", such as people finding excuses why they cannot fill in a form, asking others to read written materials out loud, and identifying pills by colour and shape rather than reading the label.[3]

The best way to establish if the patient understands the message given is to use the "teach-back" and the "show-me" techniques.[10] Rather than simply asking if the patient understands, the clinician can take responsibility for getting the message across by saying they want to make sure they have explained things well and could the patient please tell them, for example, how they would take this medication.[3] The show-me technique is similar, with the patient showing how they do something, eg measuring liquid medication.[10]

It is important to build a rapport with the patient, by showing empathy and being genuinely interested.[3] A patient will be more relaxed and receptive to absorb and share information if they feel valued and heard.[3] Likewise, a sense of humanity can be expressed in the tone of a brochure or in phone conversations. Similarly, the environment of a care facility affects health literacy. A building that feels inviting, is clutter-free and is easy to navigate, will affect the patient's experience.[3]

Health-care professionals should also pay attention to the speed at which they speak, and remember to pause and give the patient their undivided attention.[3] Ways to improve the older population's health literacy include providing a quiet, well-lit environment with large easy-to-read signs, to speak clearly and slowly, to have written information in plain language and large font, and encourage them to ask questions and take a support person to the appointment.[3] Overall, the health professional needs to invite questions by asking, for example, what the person's questions are, instead of asking if they have any questions.[3]

Design of brochures

Another aspect of health literacy involves design of health brochures. The best way to find out if a brochure fits its purpose is to get it tested first by the intended users.[3] The design of the brochure is important – it should be easy to read and use plain language.[3] There is a lot of help available for developing health education resources, including a plain language thesaurus.[12,13]

The Ministry of Health has a strong interest in improving health literacy to improve health outcomes and reduce health costs.[14] It complies with legitimate requirements, such as the Code of Health and Disability Services Consumers' Rights – especially the right to effective communication and the right to be fully informed – and to the Treaty of Waitangi.[15,16] In recognising the treaty, district health boards are required to address Māori health and improve disparities.[16]

Due to the Crown's failure to honour the treaty in the years following its signing, Māori suffered a vast loss of land and loss of equity.[16] Colonisation not only brought land loss, but also new diseases, and loss of culture, language and identity; lack of social and economic autonomy led to loss of self-determination.[18,19]

Although brochures written in te reo Māori were welcomed, participants stressed that not all Māori speak te reo and they must not be excluded.

Māori scholar Graham Hingangaroa Smith asserts that colonisation has not magically disappeared, with economic exploitation and cultural oppression shaping new forms of colonisation.[21]

To this day, Māori experience large disparities, not just in health but in the justice system, economy, housing, and education.[20] Māori are likely to die younger than non-Māori, having higher mortality and morbidity in cardiovascular disease, most cancers, diabetes and rheumatic fever.[20] And despite decades of cultural safety training in the health workforce, more needs to be done to decolonise and stop existing racism in the health system.[22] Continuing inequities in health outcomes for Māori are proof the system is not working for them.[20,22]

The western concept of individualism often conflicts with Māori values such as whanaungatanga (sense of family connection).[21] Western medicine also tends to concentrate on the physical aspects of the individual, while Māori usually conceptualise health more holistically.[17]

Indigenous health models such as Te Whare Tapa Whā,[17] Te Pae Mahutonga and Te Kapunga Putohe are valuable resources to help health-care professionals work in partnership with Māori.[23,24] Health workers who embrace the opportunity to learn about Māori values and customs can use this knowledge when working with any patient and their families.[16]

The Hospice New Zealand Standards for Palliative Care aim to align with the principles of the treaty, collaborating with Māori to provide the best care for Māori.[25] Despite nationwide efforts to meet Māori needs, there is still low uptake of palliative care services by Māori.[26] The New Zealand Palliative Care Strategy found a lack of awareness among Māori about palliative care and no indigenous palliative care providers.[27]

The author works as a community palliative care nurse in a district health board (DHB) region where 25 per cent of the population identify as Māori. In the Eastern Bay of Plenty, Māori make up some 40 per cent of the population. Few other statistics are available for the eastern area, despite its contrast to the western district.[28,29] In the hospice's 2019 statistics, 35 per cent of the patients identified as Māori.[30]

Iwi in this area have been working to develop and empower their people. Te Whare Wānanga o Awanuiārangi is providing tertiary education focused on building excellent bicultural skills.[21] Ngāi Tūhoe have been proactive in self-governing, including funding their own

medical centres.[31] These are important changes, given the whole district's Māori population has a mortality rate 2.3 times higher than non-Māori and an estimated avoidable mortality 2.8 times higher than non-Māori. The same statistics reveal that 87 per cent of regional stroke patients are Māori, and if aged 25 or older, Māori are 80 per cent more likely to be admitted with circulatory system diseases. According to a 2016 health profile of Māori in the Bay of Plenty DHB region, Māori are also more likely to be raised in low-income households, are more often cold, and more often postpone doctor's visits and skip vegetables and fruit, to reduce costs. Their access to a motor vehicle is less, as is access to telecommunication: they have comparatively less telephone access and 35 per cent have no internet.[28]

In recent years, several surveys have been undertaken in Aotearoa/New Zealand to get a better understanding of barriers Māori experience in accessing palliative care in terms of health literacy. One study used focus groups with kaumātua and whānau to analyse brochures provided by palliative care services, and to expose cultural and comprehension issues within.[26] Some of the brochures were found to use Māori symbols or words regarded as inappropriate and at times even offensive, and some showed a lack of understanding of Māori cultural values.

Positive messages

The participants welcomed Māori-themed brochures that had positive messages, showing the health provider was interested in learning about their cultural and spiritual needs. Although brochures written in te reo Māori were welcomed, participants stressed that not all Māori speak te reo and they must not be excluded. The kaumātua and whānau favoured a bilingual brochure that used Māori communication protocols and emphasised treaty principles and partnership. Some participants found the text in some brochures too long or cluttered with too many medical terms.

Although the kaumātua preferred kanohi-ki-te-kanohi (face-to-face) interactions, they agreed brochures had a place in conveying information.[26] This kaumātua-led group developed three Māori communication models specific to palliative care.[32]

Another survey of Māori on palliative care and health literacy highlighted the effect that shock and grief had on people's ability to understand information given by health-care professionals and what was happening to their loved one.[8] This study confirmed that the emotional nature of palliative care, coupled with high physical needs, affected health literacy. Additionally, the issue of late referrals to palliative care and vague communication about the patient's prognosis led to confusion and missed opportunities to build relationships with the palliative care provider, and less time to make necessary arrangements. Health-care professionals also found late referrals stressful.

This research discovered strategies that have been used by Māori and palliative care staff to overcome some of these challenges. These included:

- Clinicians being aware of the importance of building relationships before addressing clinical matters.
- Whānau keeping helpful information to pass onto others in a similar situation, or keeping all health-related information in one folder to aid communication with health staff.
- The internet was found to be a helpful resource for whānau, including looking up unknown words.
- Effective, open and honest communication and plain speech were key for patients' and whānau's satisfaction with the service.
- Also important was the use of a "communication book", though there was some confusion about how to use it, due to lack of explanation.

Participants gave some negative feedback on written resources. Formal language with lack of friendly tone, unfamiliar vocabulary, lack of line spacing and lengthy texts made some resources difficult to understand.

Consent to care forms were seen as particularly hard to understand and there was feedback on the large amount of information handed out at the entry to the palliative care service. There was doubt that the information was read by a majority. Interestingly, the effectiveness of this written information was directly linked to the quality of relationship whānau had with the provider.[8,19]

As a result of the combined findings of these two studies,[8,26] the Ministry of Health published a document on palliative care and Māori from a health literacy perspective.[33] One recommendation was for palliative-care organisations to provide electronic resources under guidance, while ensuring such resources would not increase inequalities.

Recommendations

Recommendations from the kaumātua-led group were firstly to improve organisational and health professionals' knowledge and application of cultural health literacy. They also wanted cultural and clinical supervision for health staff, and designing of effective brochures. They further recommended measures to increase Māori awareness of palliative services, ideally with input from local iwi in hosting events that provide information about palliative care kanohi-ki-te-kanohi.[32] There is a consensus amongst participants of various studies that local iwi feedback should be sought before the distribution of brochures.[8,19,26,32]

Health literacy is an important determinant in health outcomes such as hospitalisation, mortality rates, health costs and empowerment of the individual. Studies on Māori patients and whānau experiences in terms of palliative care and health literacy provide health professionals and policy writers with valuable information for transformation of this field. Health literacy plays an important part in increasing equity, including in the context of palliative care. •

* *References for this article are on p43.*

* *Acknowledgement: This article is adapted from an assignment written for an "education for clinical practice" course, taught by Louise Carrucan-Wood, professional teaching fellow in the School of Nursing, University of Auckland.*

Deborah Crossan, RN, PGCert(hlthsci pall care), PGDip(hlthsci adv nurs) is a palliative care nurse at Hospice Eastern Bay of Plenty, Whakatane.

COVID vaccines need ultra-cold cold chain

PHOTO: ADOBE STOCK

Two new COVID-19 vaccines have had promising early results, but their extreme cold chain requirements are a major challenge.

By Georgina Casey

In November 2020, pharmaceutical companies Pfizer and BioNTech announced promising early results for their vaccine against SARS-CoV-2 (COVID-19). This mRNA vaccine was found to have 90 per cent efficacy in phase 3 human trials on nearly 44,000 volunteers.[1] This means that for every 10 people administered the vaccine, one went on to develop COVID-19, a far better result than earlier expectations of a COVID-19 vaccine where 50 per cent efficacy was being considered acceptable.[1]

Interim results

However, there remain a number of important issues to be addressed before this Pfizer vaccine, and a similar one in development by Moderna Inc, can enter clinical use. The results announced in November were interim – the study itself will not be completed until a set number of participants have developed COVID-19 after being administered the vaccine and until all participants have been followed for at least two months to detect any adverse effects of the vaccine itself and to discover the duration of protection.[1] Due to the urgent nature of the pandemic, this follow-up time is much shorter than usual.[2] It was also noted in earlier phase 1 and 2 trials that the vaccine was less effective in older adults (65 to 85 years) although phase 3 trials are showing equal effectiveness in this age group.[3]

RNA vaccine technology is untried in humans prior to COVID-19. Older vaccine technologies inject either inactivated or reconstructed particles from the infectious pathogen. In this new method, the body is injected with a sequence of messenger RNA that encodes for a viral protein. The strand of mRNA enters cells and triggers the manufacture of the viral protein, which is then released into the tissues, or inserted onto the surface of the cell.[2]

This then triggers the body's immune system to manufacture antibodies against the "foreign" protein, generating an immune memory that quickly reactivates should the person encounter the actual virus in the future – much in the same way as traditional vaccines. The body breaks down the mRNA within hours of the injection, necessitating a minimum of two injections.[2]

A key advantage of mRNA vaccine technology is the ability to rapidly produce the correct RNA sequence for a pathogen – allowing laboratories to produce a variety of vaccines in quick order. This may be an important mechanism if the SARS-CoV-2 virus is able to mutate rapidly – especially its spike protein, which is a key element of the infectious strategy of the virus. Also, these vaccines do not need to be "grown up" in eggs or other cells so, in theory, are easy to produce rapidly and at scale.[2]

The major challenge for mRNA vaccines is the cold chain requirements. They must be stored between -20°C (Moderna) and -70°C (Pfizer) making distribution in developing nations, especially those with tropical climates, almost impossible. Less than 10 per cent of countries meet the World Health Organization recommendations for effective vaccine management practices currently,[4] where cold chain requirements for most vaccines vary between +2°C and +8°C.[5]

These extreme cold chain requirements, combined with lack of manufacturing and distribution resources and health-care personnel, and a degree of vaccine scepticism/hesitancy in the population may delay effective worldwide protection against COVID-19.

Another issue is that most vaccines prevent disease, but not infection. By suppressing COVID-19 disease but not limiting SRAS-CoV-2 infection rates, those for whom the vaccine is less effective (eg older adults) or those who are unable or refuse to be vaccinated could be more at risk when transmission mitigating behaviours become less common among the vaccinated.[6] •

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The changing nature of

This second article of a two-part analysis looks at advertising in the second 50 years of *Kai Tiaki Nursing New Zealand's* existence and how the nature of that advertising changed, compared to the first 50 years.

By Wendy Maddocks

The second part of this article examines advertising to nurses in *Kai Tiaki* from 1959 to 2009. Part one of the analysis explored the first 50 years of the journal from 1908-1958 through a social constructionist lens. Through this lens, it was apparent there were two themes of how nurses were portrayed in that date range: the nurse as a wellbeing advocate (1908-1928), and the nurse as servant of the state (1929-1958). (See *Kai Tiaki Nursing New Zealand,* November 2020, p23-25.)

The full methodology was described in part one, where advertising to nurses was categorised initially under four headings: patient benefits, nurse benefits, academic activities and lifestyle items.

For this second part of the analysis, job advertisements have been included. As with part one, these different areas will be analysed alongside key social events of the day. This part of the analysis was limited to the final year of each decade (1959, 1969, 1979, 1989, 1999, and 2009), due to the larger number of journals printed each year (up to 12) and the similarity of content across each decade.

A total of 72 issues were individually analysed. A further randomly selected 20 issues after 1959 were checked to ensure there were no major changes which may have been missed by limiting the analysis to one year of each decade. All journals reviewed appeared complete and were examined in print form.

As with the earlier analysis, each selected issue was analysed for the percentage of pages devoted to advertising; any special features of a particular issue; and the number of individual adverts under each classification.

Wendy Maddocks

Results

By the 1950s, the journal had undergone significant changes in both style, print, the use of colour and content. By 1959, placement of advertising included inside front and back covers and the journal was a larger format. Each issue also included significantly more job advertising than the previous 50 years, reaching almost two thirds of the total adverts by 1969. This was clearly at the cost of patient and nurse adverts, which had all but disappeared by 1979. By 2009, most of the adverts were now for jobs.

• Nursing as a lifestyle (1950s and 1960s)

The 1950s was a prosperous time for the country, with the population reaching two million. The baby boom was underway, with almost 400,000 births. New Zealanders had fought in the Korean War and Mt Everest had been conquered by Edmund Hillary, (later Sir Edmund Hillary). The first "supermarket" (Foodtown) opened in 1958 in South Auckland.[1]

It is immediately obvious, when comparing these later journals with those of the previous 50 years, that nursing was also undergoing a transformation. Nurses emerged from the previous "servant of the state" persona to being an aspirational lifestyle consumer who clearly had a life outside nursing. Along with more adverts for makeup, flying featured prominently, with adverts of scantily-clad nurses in exotic locations surrounded by men. An advert of a very long stockinged leg in a very short skirt featured prominently through the 1960s and large full-page adverts for tampons alluded to a lifestyle of being free to do what you wanted after your shift ended.

In the July 1969 issue, there was an advert targeting overweight nurses, promoting weight loss supplements, presumably to fit into the bikinis portrayed in the holiday adverts. It was also possible to hire a television for those leisure hours once television broadcasting began in June 1961.[2]

Technology related to patient care was on the increase, with adverts for disposable bedpans and the use of computer technology to manage patient information was reported in the March 1969 issue. In September of 1969, the profession changed forever with the registration of the first male nurses. Initially, while male nurses did not feature in any advertising, a male nurse was featured on the cover of the November 1969 issue.

The glossy look and feel of the journal, combined with the increased lifestyle and job adverts of the 1950s and 1960s, suggested nursing was a desirable career with many options both in New Zealand and overseas (mainly Australia and the United Kingdom).

• Nurses as political beings (1970-1980s)

The journals produced through the 1970s were vastly different to the previous almost glamorous publications of the 1950s-1960s. A new editor had a vision that the journal was all about the professionalisation of nurses and for

advertising in *Kai Tiaki*

the members of the union. The almost frivolous looking journals of the preceding two decades were replaced with a dry style of writing and most of the journals were devoted to meeting notes, political remits and the like. The back pages had gone from being a place to put key lifestyle adverts for nurses, to a place to put lists of union meetings.

Professionally, nursing was coming of age, with the start of the first comprehensive training programmes based

An advertisement from the March 1969 issue.

in polytechnics (now tertiary education institutes) not hospitals, in the early '70s. This huge change in the education of nurses followed on from the *Carpenter Report* published in 1971, cited in a review of nurse education.[3]

Politically, nursing also had a voice with the beginning of nurse-led protests for better conditions reported on in September 1979.

Cross-cultural care was discussed, including how to apply this within a Samoan context in a New Zealand hospital.[4] By the end of the '70s, the population of Pacific people in New Zealand was around four per cent.[5]

Academic and lifestyle advertising remained constant with previous decades; however, by 1979 there was no advertising of things to improve patient outcomes and nothing to enhance clinical practice. It was all about jobs (71 per cent) and unionism.

One bright note was evident in that New Zealand nurses could now work in the United States, with Las Vegas being promoted as a possible working destination.

By 1989, the tone and feel of the journal had softened slightly and included some of the hefty health-care issues affecting the country. Protests continued for better pay and conditions, with strikes occurring. There were concerted efforts to unite the two nursing unions to ensure a stronger political voice.

The Cartwright Report (1988) had been published. The report was of a commission of inquiry into how women with cervical cancer had been treated at National Women's Hospital, which had been the subject of a book, *The Unfortunate Experiment*. *The Cartwright Report* changed the way informed consent was obtained for all patient care.[6]

AIDS was now rearing its head in New Zealand and universal precautions for infection control were introduced against a backdrop of severe health cuts. New Zealand had its first recorded death of a patient due to AIDS in 1983;[7] however records of such deaths didn't begin until 1985.[8] The Homosexual Law Reform Bill was passed in 1986. It allowed for consensual homosexual sex over the age of 16.[9]

By the end of the 1980s, if a nurse wanted to get away from the poorly funded, overworked New Zealand health-care system, then working in Saudi Arabia and the United States were lucrative options, with adverts offering paid flights and accommodation. Job advertising was now almost 80 per cent of the advertising.

The occasional advert for patient-centred items, mainly related to wound care, reappeared. As in the 1970s, there was no advertising of items specifically for the benefit of nurses in their working day. It was either jobs (79 per cent), leisure (10.8 per cent) or a smattering of education (7.37 per cent) or patient benefits (8.06 per cent). Some issues did not contain any advertising apart from jobs. As an example of consumer spending expectations, an entry-level new car was advertised in September 1989 for $16,000, which seems excessive given the salary range of registered nurses was $12-$16,000.

• Nurses as independent beings (1990s-2009)

Analysis of the final 20 years in the 100-year review showed nurses having many career options. They were often pictured working in civilian clothing, providing care or advice. By 2006, 50 per cent of nurses worked in hospital settings, compared to 80 per cent in 1986. By 2008, the average age of registered nurses had increased to over 45 for more than half of the workforce.[10]

The comprehensive education model was now well established, and had undergone a review, with nurses now being trained to degree level and a number of universities offering nursing degrees,

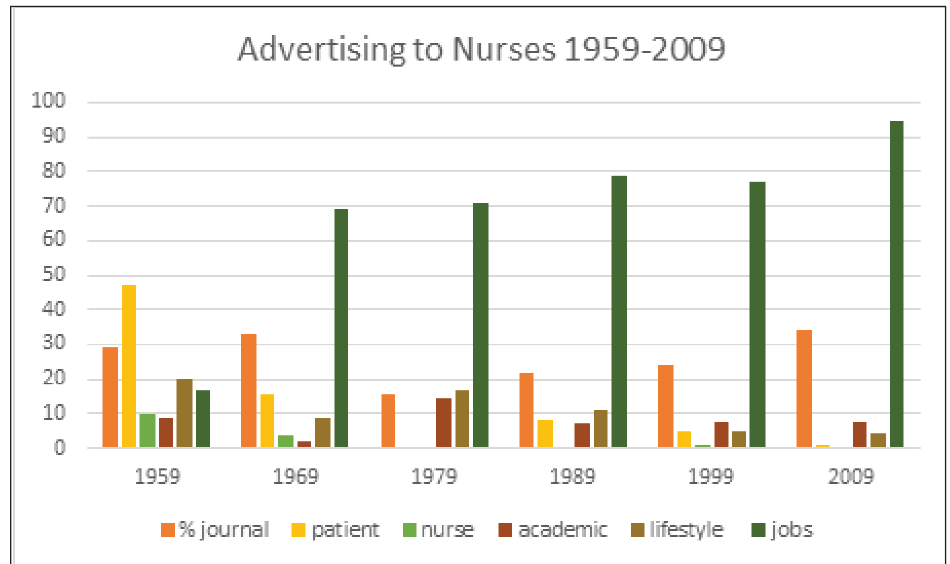
along with polytechnics/institutes of education.

The most pressing issue at the end of the millennium was the potential impact of the "Y2k bug", which had the potential to disrupt all services. For example, Gisborne Hospital was preparing for a potential onslaught of people travelling there to see in the new millennium by committing suicide.[11]

By 2009, job advertising constituted the vast bulk of adverts at 94 per cent, with all advertising taking up more than 30 per cent of the journal.

By 2009, while the focus of the journal was still as a union voice for its members, there were adverts for nurses departing for brighter climates, eg the emergence of locum work in Australia.

It was also evident at this time that New Zealand had a significant immigrant nursing population who had different issues to locally-trained nurses. This was also mentioned in the report that noted that since 2004, internationally-qualified nurses (IQNs) outnumbered New Zealand new graduate nurses.[12] In various issues in 2009 there were adverts and articles targeting IQNs, such as how to send money home and how to adapt to a New Zealand way of life. One article looked at ways to recruit and support these nurses in New Zealand.[12]



Conclusion

This analysis of advertising to nurses in New Zealand over 100 years covered the inception of *Kai Tiaki* in 1908, through its various iterations until 2009. By using a social constructionist lens, advertising has been placed in the context of the social events of the time. Through this approach, it is possible to see how the perception of nurses as consumers has changed over time. There was huge growth in job advertising after World War II (WWII), reaching almost 100 per cent of the journal's advertising content by 2009. This growth corresponded with a decline in adverts targeting patient benefits, which peaked in the pre-WWII period at more than 70 per cent of advertising space, gradually declining to virtually nil by the 1990s.

Lifestyle advertising was fairly consistent across the decades, with a peak of just over 20 per cent in the 1958 decade, which paralleled the high economic growth New Zealand was experiencing at the time.

Advertising of items for the benefit of the nurse were reasonably prominent in the early decades, but by 1979 they had disappeared altogether.

Advertisers clearly see nurses as a worthy advertising audience, given the space devoted to advertising over the 100 years.

This analysis has shown that, as nursing has evolved over the century, so too has the type of advertising. Every issue analysed had some advertising, even during the bleakest economic times. The total space allocated to advertising ranged from the lowest at less than 10 per cent in 1915 to the highest at more than 34 per cent in 2009. •

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Wendy Maddocks, RN, DHlthSc, BA, MA, is a lecturer in the School of Health Sciences at the University of Canterbury.

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A *Kai Tiaki* journey reaches its end

Co-editor Anne Manchester riffles through 25 years of highlights, before closing the *Kai Tiaki* keyboard for the last time.

By co-editor Anne Manchester

Deciding when to retire has been a difficult decision, made much harder by the arrival of COVID-19, having to work from home for weeks and all the extra work covering the pandemic and nurses' experiences of it.

Kai Tiaki Nursing New Zealand has been my working life for the past quarter of a century. I came to the job with little knowledge of nursing and health – it's been a fascinating journey and I've learned so much.

One of the great pleasures of being part of the co-editing team has been its collegiality. For the first 16 years, I worked exclusively with Teresa O'Connor, then Kathy Stodart joined the team, and in 2015, Mary Longmore, all of us juggling various combinations of part-time hours, and within a non-hierarchical structure.

As I tidy my desk and log out for the last time, I do so realising that the team and readers are entering a new era. Although a flipbook, online version of *Kai Tiaki* is now available through ISSUU, a superior digital platform is being developed, to be trialled over the coming months. How much choice readers will get as to whether they continue to receive printed copies or whether online will be the direction taken for all remains to be seen. Finances will no doubt play a crucial role in these decisions.

When Teresa and I were the only co-editors, it was inevitable we would develop a strong bond. We often joked, especially at staff conferences, that we shared a brain, as we seemed to know exactly what the other might say or be thinking at any one time.

There have been many professional and personal highlights over the past 25 years. It is perhaps foolish to single out any, but I will take the risk. Touring parts of Northland with the late Noeline Warmington, then Te Rūnanga chair; profiling migrant nurses; covering a myriad of nursing conferences including South Pacific Nurses fora and the International Council of Nurses 25th quadrennial congress in Melbourne in 2013; working on our 2008 centennial issue marking 100 years of continuous publication of the journal; and getting to know cultural safety pioneer Irihapeti Ramsden, who advised us on our special cultural safety issue in February 2001.

International presentations

Teresa and I have also co-presented at international nursing editors' conferences, the most notable in Padua, Italy, in 2008. Here, we received a standing ovation – perhaps as much for the style of our address as for its content. Our topic was an analysis of the deep divisions among the nursing community of New Zealand following our publication in 2006 of *Who Cares,* a photographic essay on aged care. For some people, the 39 black and white photos by Alan Knowles, of residents and their carers, exploited the elderly. Photos of frail and sometimes naked bodies were being used for cynical political and union ends. For others, including Teresa and myself of course, the photos highlighted the intimate relationships between carers and residents, whom they treat and love like members of their own family.

The photo essay and resulting furore have been the most demanding event during my 25-plus years with *Kai Tiaki Nursing New Zealand*. It is also one that brought a great deal of pride and professional satisfaction.

Teresa and I worked on another photo essay a few years later, to mark NZNO's centennial in 2009. More than 100 photos were submitted from a range of practice areas. The winning shot by Pamela Hill showed a district nurse bathing the feet of a South Auckland man in his home in Otara.

Outside of work, theatre is one of my great passions. I managed to harness my acting skills when Teresa and I proposed that NZNO make an educational DVD showing how prejudice and unsafe attitudes can play out in the workplace. Teresa and I wrote the six scenarios for this resource – *Harmless nursing chat or alienating attitudes?* – and donned blue nursing uniforms. Another staff member, Liz Robinson, made up the cast of three. The scenarios, which primarily explore racist and homophobic attitudes and how to confront them, have proved an effective teaching tool, and were made to mark 20 years since cultural safety was included in nursing and midwifery education.

I shall miss the community of work – karakia and waiata to start the day, the shared morning teas, doing the five-minute quiz over coffee, celebrating milestones in the lives of colleagues. But I leave with gratitude – for the opportunity to hone my writing, editing and page design skills, and to enter in such depth the worlds of nursing and health. Interviewing nurses the length and breadth of the country has been a privilege and has helped me appreciate that the very best nurses are the finest and most inspiring people you could ever wish to meet. •

District nurse captures King Country images

IT WAS only a few years ago that neonatal nurse Sara McIntyre began to see herself as a photographer.

McIntyre did take photos of newborns and their parents on occasions when working for 16 years in Wellington Hospital's neonatal unit – often parents or the nurse educator would ask her to – but it wasn't until she moved to Kākahi in the King Country in 2010 that her interest really began to flourish.

Kākahi is where she had often holidayed as a child with her parents – celebrated New Zealand artist Peter McIntyre and her mother Patti. They owned land there and McIntyre decided to move into an old house on part of it.

Initially she worked as a district nurse based at Taumarunui Hospital – the first time she had worked with adults and not in a hospital ward. Being able to treat people in their own homes helped her form close bonds with the people of the area, most of them living in isolated communities, some an hour's drive from the hospital.

"I began taking photos of the people I knew well, going back after appointments to capture the essence of them and their surroundings. My brother persuaded me to share the photos on Instagram. Auckland gallery owner Anna Miles invited me to exhibit more than 50 of the photos in 2016. This then led to my recently published book, *Observations of a Rural Nurse*." (See picture opposite page.)

Many of the people of Kākahi feature in the book, just as they did in paintings by her father, who published them in a book called *Kākahi New Zealand* in 1973.

"I am of this place too – I am not an outsider looking in," McIntyre said. "Many scenes are from my own home, and show the changing seasons and light, and many of the people are my long-time friends."

McIntyre gave up nursing two years ago, principally to give her time to finish, then promote the book. She was also finding the workload increasingly demanding, with her casual hours doubling in the time she was there.

Observations of a Rural Nurse, published by Massey University Press in hard cover, has been described as "a magnificent tribute to small town Aotearoa". When *Kai Tiaki Nursing New Zealand* spoke to McIntyre, she was nearing the end of a month-long trip in the South Island, speaking to different groups about the book.

"People from small towns really relate to it," she said. "It reminds them of their own childhood and is a picture of an older New Zealand that is fast disappearing. For others, it's an eye-opener, capturing a part of the country that has largely been forgotten. Nurses seem to like it particularly." •

Stories from a nurse/midwife in times of crisis

NEW ZEALAND nurse and midwife Barbara Walker has spent most of her working life among some of the world's most challenging and heart-breaking situations.

This year she published her book, *Purple Hands*, which records stories from a 21-year-long career working overseas in times of crisis. It also records her faith and call to become a missionary nurse.

Hers has been an illustrious career. As well as been honoured with a Queen's Service Order in 2000 for her work overseas, Walker gained a master of science in medical anthropology in 1995 from Brunel University in London. Back in New Zealand, further study led to her being ordained as an Anglican priest and becoming a hospital chaplain – all these achievements while struggling with the challenges of dyslexia.

Most of Walker's assignments have been with World Vision and some as a nurse and midwife with mission hospitals – camps in Thailand overflowing with Cambodian refugees, midwifery and nursing in Somalia in 1980 (she is pictured above in Las Dhure Camp with her first delivery) as civil war swept the country, Ethiopia during the 1984 famine, HIV/AIDs work in Zambia and Tanzania in the early '90s, to name just a few.

"Over the years, I have been interviewed by many news organisations, both here and overseas. I have also kept diaries, letters and scrapbooks, so I had plenty of material to draw on. Reliving some of the appalling situations I have been part of often brought me to tears, but the experience has also been cathartic and healing."

Walker describes the book as a tribute to the "amazing national staff" she has worked with around the world, including traditional birth attendants, local doctors and nurses, and interpreters. "These people welcomed me and allowed me to work in partnership with them. They taught me so much."

Walker finally returned to New Zealand in 1996 following a death threat in Mozambique. She was physically and emotionally exhausted, suffering from unrecognised post-traumatic stress disorder. Returning to nursing was not easy, though she did work in Northland for three years as the first community health manager for Hauora Hokianga.

Her current role as lead chaplain at Hawke's Bay Hospital is "the icing on the cake", she says. "Nothing in my career has ever been wasted – now it's all come together."

Purple Hands can be ordered from Walker at revbjwalker@xtra.co.nz or from publisher Philip Garside at bookspgpl@gmail.com. A copy can also be borrowed from the NZNO library. •

Author interviews by co-editor Anne Manchester

Erihi in her kākahu and standing in front of her memorial wall. "Getting to photograph Erihi Adams in her home at Ngakonui took some time. I was unsure about asking her. I knew her reply would be either a firm yes or no. She was delighted, it turned out . . ." – Sara McIntyre.

Recent acquisitions to the NZNO library

By Heather Woods
NZNO librarian and records manager

The following is a selection of books on a range of topics that have been added to the NZNO library over the past two years, some of them new and others new to the library.

These can be borrowed from the library by using the NZNO library enquiry form on the library's web-page. The loan period is four weeks, and all books are couriered to you, so please provide your street address when requesting items. We also ask that you bear the cost of couriering the books back to us.

• Century of service: A history of the Irish Nurses' and Midwives' Organisation, 1919-2019

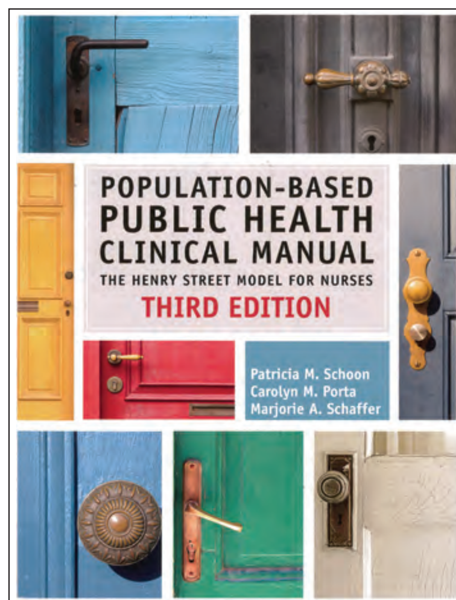
Loughrey, M. (2019). Irish Academic Press, 382pp.
BACKGROUNDS the social and economic conditions that gave rise to the INMO. It details the organisation's changes over a century and describes the services it provides to members by means of interviews with union leaders and members.

• Communication in palliative nursing: The COMFORT model

Wittenberg, E., Goldsmith, J. V., Ragan, S. L., & Parnell, T. A. (2020). Oxford University Press, 308pp.
OUTLINES the components of the COMFORT model of palliative care communication: C – Connect, O – Options, M – Making Meaning, F – Family Caregivers, O – Openings, R – Relating, T – Team. Teaches nurses to consider a universal model of communication that aligns with the holistic nature of palliative care.

• Community Health and Wellness: Principles of primary health care 6th edition

Clendon, J. & Munns, A. (2019). Elsevier Australia, 325pp.
FOCUSES on the foundational principles of primary health care, taking a socio-ecological approach to the health of individuals and populations in their personal, family and community environments. Incorporates contemporary research in community health and wellness from Australia, New Zealand and the global community.



• Death and dying in New Zealand

Johnson, E. (2018). Freerange Press, 159pp.
NEW Zealand's diverse and ageing population, advances in technology and medical care, and the social, economic and environmental challenges facing New Zealand society, make this collection of essays on death and dying a stimulus for discussion about how to plan for death as individuals and as a society.

• Emergency Nursing: 5-Tier Triage Protocols

Briggs, J. K. & Grossman, V. A. (2020). Springer Publishing Company, 305pp.
DELIVERS essential knowledge for accurate decision-making in emergency triage situations. Addresses adult and paediatric conditions in alphabetical order to facilitate rapid acuity level assessment and their nursing responses.

• Essentials of Nursing Informatics

Saba, V. K. & McCormick, K. A. (2015). McGraw-Hill, 886pp.
ELUCIDATES the role of informatics in every aspect of the nursing profession.

• Ethics at the End of Life: New issues and arguments

Davis, J. K. (2017). Routledge, 254pp.
PRESENTS 14 essays that focus on recent thinking in the field, initiating issues and lines of arguments that have not been explored previously, while orienting readers to established questions and positions in end-of-life ethics.

• Final choice: End-of-life Suffering: Is Assisted Dying the Answer?

Trayes, C. (2020). C&T Media, 276pp.
INTERVIEWS lawyers, doctors, ethicists, clerics and terminally-ill patients for their views on legislation to legalise assisted dying.

• Health of the People

Skegg, D. (2019). Bridget Williams Books Ltd., 144pp.
ARGUES that the Havelock North drinking water contamination in 2016 that caused widespread community infection signals an underlying failure of public health policy in New Zealand.

• Intergenerational Wellbeing and Public Policy: An integrated environmental, social, and economic framework

Karacaoglu, G., Krawczyk, J. B. & King, A. (2019). Springer Nature, 247pp.
FORMULATES an integrated framework for public policy through investigations in four domains: a formal stylised model; a policy-informing simulation model; the implications of introducing fundamental uncertainty into the framework and a viability theory.

• Leininger's Transcultural Nursing: Concepts, Theories, Research & Practice

McFarland, M. R. & Wehbe-Alamah, H.(2018). McGraw-Hill Education, 466pp.

INTEGRATES cultural values and beliefs into an individualised plan of culturally-appropriate, client-focused care. Presents a comparative perspective on western and non-western cultural care in Kenya, South-east Asia, Haiti, Syria and Taiwan, with insights into rural vs urban cultures in the United States.

• Maea te Toi Ora: Māori Health Transformations

Kingi, T. K., Durie, M., Elder, H., Tapsell, R., Lawrence, M., & Bennett, S. (2018). Huia Publishers, 333pp.

EXPLORES the relationship between Māori culture and Māori mental health. Discusses aspects of Māori health and the importance of culture to diagnosis, patient history, understanding causes, treatment and assessment of outcomes. Reviews current research into, and knowledge about health and culture, while providing case studies from working with Māori to restore well-being.

• Measuring Capacity to Care Using Nursing Data

Hovenga, E. J. S. & Lowe, C. (2020). Academic Press, 476pp.

PRESENTS evidence-based solutions to safe staffing principles and health delivery strategies. Teaches how to use informatics to collect, share, link and process data to meet health service demands. Includes measurement of nursing care demand and nursing models of care.

• Medical Cannabis: A brief guide for New Zealanders

Holt, S. & Dalton, E. (2019). Potton & Burton, 133pp.

TAKES an overview of its history and summarises the latest research into potential benefits and risks of using cannabis as a medicine.

• National Code of Practice for Managing Nurses' Fatigue and Shift Work in District Health Board Hospitals: Safer Nursing 24/7

Massey University, Sleep/Wake Research Centre. (2019). 63pp.

PROVIDES a ground-breaking approach to addressing the challenges of shift work, long hours and the fatigue they generate, which are inevitable but must be better managed in 24/7 nursing services. It merges the latest science and safety management practice with extensive nursing sector expertise and experience and is endorsed by WorkSafe, NZNO and the Council of Trade Unions.

• No Shortcuts: Organizing for Power in the New Gilded Age

McAlevey, J. F. (2016). Oxford University Press, 253pp.

EXAMINES cases from labour unions and social movements to argue that the social movements of previous eras gained power from mass organising. Concludes that progressive movements need strong unions.

• One Hundred Years of Purpose: Hospital for Infectious Diseases

Milne, K. (2019). Society for the Prevention of Cruelty to Animals, 22pp.

RECOUNTS the design, construction, and varied uses of the Wellington Hospital for Infectious Diseases, now the Wellington SPCA, built to treat influenza patients during the epidemic and later TB patients when it became the Fever Hospital. Backgrounds the training received by Wellington Polytechnic nurses during the 1970s when it was known as the Chest Hospital and profiles several nurses.

• Population-Based Public Health Clinical Manual: The Henry Street Model for Nurses

Schoon, P., Porta, C. M. & Schaffer, M. A. (2019). Sigma Theta Tau International, 337pp.

FOCUSES on the development of evidence-based public health nursing practice in diverse settings. Builds on the Henry Street Consortium framework of 12 competencies for population-based, entry-level public health nursing.

• Rising from the Rubble: A Health System's Extraordinary Response to the Canterbury Earthquakes

Ardagh, M. & Deely, J. (2018). Canterbury University Press, 302pp.

RECOUNTS how the Canterbury health system managed to maintain and rebuild essential health services following the 2011 earthquakes, based on first-hand interviews.

• Spirit of Māori leadership

Katene, S. (2013). Huia Publishers, 237pp.

DISCUSSES different styles and models of Māori leadership, identifying the qualities and approaches of Māori leaders. Describes six criteria to guide nascent leaders.

• Stories of Resilience in Nursing: Tales from the Frontline of Nursing

Traynor, M. (2020). Routledge, 107pp.

USES narratives to explore the concepts of resilience and identity through stories told by or about nurses. Includes contributions from mental health nurses, a former nurse, student nurses, a migrant nurse and a whistle-blowing nurse. Concludes each chapter with material to promote reflection, discussion and further reading.

• Tooth and Veil: The Life and Times of the New Zealand Dental Nurse

O'Hare, N. (2018). Massey University Press, 256pp.

BACKGROUNDS the post-World War I formation of the School Dental Service and details nurses' experiences on the front line of dental health. Reveals what their experiences imply about New Zealand society's attitudes to women, work and children's health at the time. •

AMONG the many services the NZNO library offers members is online access to articles from *Kai Tiaki Nursing New Zealand* from 2003 onwards. These can be accessed, as can a variety of member-only databases, via the online databases page on the library webpage.
Go to: https://www.nzno.org.nz/
Click: 'Login' at the top of the page
Go to: www.nzno.org.nz/resources/library/online_databases
Contact your library:
Website: http://www.nzno.org.nz/resources/library
Phone: 04 494 8230
Email: library@nzno.org.nz

Filipino nurse Aloha Sison came to New Zealand six years ago and is on the path to become a nurse practitioner. She urges other internationally-qualified nurses to overcome language and confidence barriers and aim high.

By co-editor Mary Longmore

IQN on NP path in gerontology

Aloha Sison "fell in love" with aged care nursing in New Zealand, despite rest homes being an unfamiliar concept to the Filipino immigrant.

"It's quite a cultural difference. At home, people drop their work to look after their relatives."

But after emigrating in 2014, and taking a nursing job at a small rest home in Athenree, Bay of Plenty, Sison found she loved it. "I felt really passionate about it and fell in love with gerontology."

She is now a gerontology clinical nurse specialist at Waikato District Health Board (WDHB), working in partnership with registered nurses in the region's more than 50 aged residential care (ARC) facilities, particularly those working with high and complex needs residents.

"I provide clinical mentoring and support for ARC nurses and collaborate with them to enhance patient safety and quality of care for our older adult population," Sison said. "It is also vital that we cultivate a good multidisciplinary team working in the sector."

'Not to audit, but to help'

Sison says her role is to grow and enhance the workforce to help older people live well, age well and enjoy respectful care towards the end of their lives. "Not to audit, but to help", said Sison, who will only get involved if invited.

She had just taken up the role fulltime in January this year, not long before COVID-19 broke out. Hamilton rest home Atawhai Assisi became a cluster, with 15 cases among residents, staff and others linked to the facility.

At Kingswood rest home in Morrinsville, Sison stepped in to help after a dementia unit visitor during the second lockdown tested positive. The home had applied the "bubble" principle, providing accommodation and even buying food so staff didn't have to go to the supermarket.

While it was a stressful time, nurses "stepped up" amid worries about lack of personal protective equipment (PPE), staffing and stringent new infection, prevention and control measures. She noticed rest-home care often became more person-centred during COVID-19, as staff had to focus on the individual and pick up the roles of families unable to visit.

"We adapted and we thrived through the new norm."

As an internationally-qualified nurse (IQN), Sison said she had to overcome "many obstacles". One was the language barrier. "It's not easy to speak up and you can get shy and intimidated" when English is a second language, she said. "It's tempting to keep quiet and not risk making a fool out of yourself."

Compared to her homeland, where medical hierarchies remain entrenched, nurses advocate for their patients in New Zealand. "Here, nurses have a voice, each person is respected in their discipline and specialty."

The WDHB and Office of the Chief Nurse are supporting Sison to complete her masters and become a nurse practitioner (NP), part of a new joint initiative to grow the number of highly skilled gerontology nurses in the region.

The "pipeline" approach to growing skilled gerontology nurses was part of the WDHB's strategy for older people *He Korowai Oranga o Ngā Kaumātua – a cloak of wellbeing for older people* – released this year. It intends to build a resource of NPs across the Waikato who will work closely with older people with high and complex needs, at home or in care, and support other health professionals to do so.

'Here, nurses have a voice, each person is respected in their discipline and specialty.'

This year, Sison also joined the college of gerontology nursing committee. "I believe in their vision in continuing to raise the profile of gerontology nursing in New Zealand. I am excited to contribute in the future projects of the college to promote optimum outcomes for the older adult population." •

How to retain IQNs

If internationally-qualified nurses are successfully integrated into the work environment, they experience greater job satisfaction and will have better retention rates.

By Monina Hernandez

Working in the New Zealand health-care system presents multiple challenges for internationally qualified nurses (IQNs). How they transition into new working environments will affect how well they adapt and whether they continue working in this country.

Approximately three out of 10 or 28.7 per cent of 57,833 practising nurses in New Zealand are IQNs and they are represented in all health-care areas in the country.[1] As of March 2019, the main ethnic groups IQNs identified with were Filipino (33 per cent), other European (31 per cent) and Indian (21 per cent). IQNs are younger than most nurses in the workforce, with 48 per cent under the age of 40 (compared to 34 per cent for New Zealand-qualified nurses), while male IQNs comprise 53 per cent of all practising male nurses in New Zealand.[2]

IQNs are immersed in social, educational, cultural, historical, economic and political influences that all affect the way they transition to their new working environment.[3] The benefits of IQN knowledge, skills and work background can be enhanced if they are integrated successfully into these new environments.

The design of transitioning programmes varies throughout the world, though the challenges IQNs face are universal. Six broad categories of transitional challenges have been identified, namely:

- Language and communication, ie getting used to idioms, acronyms and abbreviations. Unfamiliarity with local accents, language nuances and the socio-cultural context make this even harder.[4,5,9]
- Cultural displacement and adjustment: this is about cultural uprooting, the perception of "not belonging" and interpersonal conflicts due to differences in cultural values, norms and expectations.[5,8,9]
- Professional challenges include pre- and post-registration issues and socio-cultural differences in the health-care environment.[7] Added to this are differences in nursing practice, including role and expectations, scope of practice, professional autonomy, health-care technology and organisational structure.[4,5,8,9]
- Marginalisation, discrimination and racism: this is about race, gender and cultural bias, including stereotyping and injustices such as bullying.[5,8,9]
- Physical challenges include separation from family and culture, and adapting to New Zealand's physical environment and cooler climate.[7]
- Social challenges focus on socio-cultural differences, relationships and how social networks are used in coping.[7]

If IQNs are to stay in New Zealand, they must be successfully integrated. Successful integration has been shown to correlate with job satisfaction[6] and job satisfaction is closely related to turnover intentions.[10]

The four adjustment phases identified in literature – acquaintance, indignation, conflict resolution and integration – can be used by organisations to offer various types of support to IQNs. Successful implementation of an integration programme aligned with these phases fosters IQN retention.[11]

Navigating multiple worlds

IQNs should be viewed, not just as able-bodied workers, but as human beings who are grounded in a socioecological system that influences every aspect of their being. They navigate multiple worlds – the home and the new country, internal struggles and external interactions, the self and interrelationships. This navigation takes place within the context of socioecological influences that affect how they live in a new country and work in a new health-care system. Those who struggle need to be supported and those who simply tread water need to be understood. •

Monina Hernandez, MN(Hons), PGDipSc, PGCertTch, BSN, RN, RM, is president of the Filipino Nurses Association of New Zealand and an infection prevention and control clinical nurse specialist at the managed isolation and quarantine facilities, Northern Managed Facilities. She is also a lecturer and doctoral student at Massey University and a member of the Nursing Council. This article is informed by her doctoral work.

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Implementing the End of Life Choice Act:

Support for members

Sophie Meares

Leanne Manson

Sue Gasquoine

By NZNO medico-legal lawyer Sophie Meares, nursing policy adviser/researcher Sue Gasquoine and policy analyst Māori Leanne Manson

Now the referendum on the End of Life Choice Act 2019 (EOLCA) has passed, patients who meet all the criteria specified in the act will be able to request assisted dying from November 5, 2021.

Eligible patients must be aged 18 or over, a citizen or permanent resident of New Zealand, suffer from a terminal illness likely to end their life within six months, have significant and ongoing decline in physical capability, experience unbearable suffering that cannot be eased, and be able to make an informed decision about assisted dying.

NZNO will be developing clear guidelines to ensure members are prepared for the practical implementation of the EOLCA processes.

Nursing voice

Policy adviser Māori, Leanne Manson, says it is critical NZNO and the nursing voice are represented in all discussion and decision-making, and particularly on the Support and Consultation for End of Life in New Zealand (SCENZ) Group. Members of this group are appointed by the director-general of health to oversee a list of medical and health practitioners willing to provide end-of-life care. SCENZ members will also be advising on medical and legal procedures carried out under the EOLCA in relation to the administration of medicine.

We expect to be part of this leadership group, with a representative who ensures an equitable, culturally safe and tikanga Māori approach to end-of-life care is prioritised.

With nearly 200 nurse practitioners (NPs) – who are eligible to provide end-of-life care – belonging to NZNO, it is important our voice is heard.

This follows NZNO's active and successful advocacy in the formation of the bill as it went through the parliamentary process over the last few years. We successfully lobbied to include NPs among those able to provide care for people who choose to use the act to end their life. Kaiwhakahaere Kerri Nuku will continue to be NZNO's representative on this kaupapa.

We are now establishing a relationship with and consulting with the Ministry of Health's regulatory assurance team, which is responsibe for implementing the EOLCA.

NZNO can see several scenarios where the EOLCA is not sufficiently clear as to how the nurse/health practitioner could or should act, eg how nurses can safely talk to patients who raise the possibility of seeking an assisted death. Or, how a nurse should respond if they believe a patient is experiencing improper pressure to have an assisted death.

We propose to consult widely and bring together expertise from within NZNO and externally to ensure our members have access to guidelines and other resources to clarify their rights and obligations under the EOLCA.

These are a few issues we expect members may need support on:

- Conscientious objection: Things to consider when deciding if you might have a conscientious objection, and how to act if you do.
- Concepts in the EOLCA such as patient eligibility and competence.
- Advocating to prevent inequities in the application of the EOLCA.
- Meeting cultural expectations of patients and their whānau where these are inconsistent with, or not provided for by, EOLCA processes.
- How the EOLCA interacts with your scope of practice, professional obligations and patient rights.
- Identifying when a patient is being improperly pressured to choose assisted dying, and what to do about it.
- What to do when a patient requests assisted dying, including procedural requirements such as forms, documentation, deferment and reporting.
- Potential nurse/health-care assistant involvement in arranging and advising on assisted dying.
- Suggestions on how to navigate conversations with the patient and their whānau about assisted dying.
- Advice a nurse can offer and conversations a nurse is able to have with patients and their whānau about the EOLCA.
- Nurse practitioner obligations to prescribe and administer the medication for assisted dying.

As the regulatory assurance team prepares guidance and processes, we will seek members' input so we can ensure that resources developed by us, or with NZNO input, are complete, accurate and practical as we learn about and implement the EOLCA.

Successful implementation of the EOLCA will depend on all these issues being addressed, as well as others likely to emerge over the next 12 months as implementation proceeds. •

It's time to jump in the pool

NZNO needs its members to be involved in its campaigns. Sitting passively on the side-lines, waiting for things to happen, is not what democracy is about.

By organiser Stephanie Thomas

We stand on the brink of a new year – a good time to assess the challenges ahead. Not only are there huge issues we need to address globally – climate change for instance – but there are issues much closer to home that affect us in our working lives.

How much value is placed on our work, for example, in the profession that most of you reading this article have chosen as your work/life path?

Here in Aotearoa New Zealand we've just been through an amazing election process for a new government. We now have one with a clear majority. I believe we have that because people mobilised themselves. We got involved in campaigns, whether that was about COVID-19, housing, health, marijuana or euthanasia. Then we voted.

For lasting change to occur, we need to be engaged, and involved in local and national issues. We need to step up and many of us do, which is fantastic! Ka pai and kia kaha to you.

It takes more than just ticking a box sometimes to show your support for change to occur. Sometimes it is best to go to a meeting and to speak up. Sometimes that might mean stepping out of our comfort zones and holding a picket sign outside the office of your employer or going on a hikoi.

Our ancestors, many of our mothers, aunts, sisters, grandmothers and great grandmothers, stood up and got involved to ensure women in generations to come had the right to vote. Thank goodness for their foresight, courage and commitment to women's suffrage.

Life is busy. We have commitments, we have whānau, all priorities for us. So often we women put everything else ahead of ourselves but, as our forebears did, we need to make our mahi a priority, for the sake of our daughters' futures. As nurses we also tend to put others before ourselves. Prioritise yourself and your colleagues too.

Leadership seen in deeds

The important values of societies and cultures are captured in proverbs or sayings, such as *"Actions speak louder than words"* or *"Mā te mahi e kitea ai he rangatira, ehara mā te kōrero"* (leadership is seen in deeds, not just in words).

Nobody joins an organisation, no matter what kind, to be a passive participant. Nothing happens that way. Alternatively, things might happen and we end up being unhappy about the result and expressing our disappointment. The question is, what did we do to bring that change about?

Nobody joins their local swimming club without jumping in the pool. What would be the point of standing on the pool edge watching? It's the same with being part of NZNO. Not only are we a professional body, we are a trade union and in 2021, we need our members to get involved and not sit on the side-lines, waiting for things to happen to us.

There is a lot more to democracy than casting a vote once every three years. Political action in parliament responds to public opinion. It's the job of politicians to represent our views. Taking action helps guide the Government as it develops policies and laws that affect us. If we don't give direction, we can't complain if things don't go the way we hoped.

As the Māori proverb suggests, we should not just sit back and wait for our political leaders to tell us what to do. Taking action in our workplaces is an important way to maintain the integrity of the whole democratic and political process. By taking action in our own lives, at home and at work and in our communities, we become leaders and role models ourselves, on behalf of our whānau, our workmates, and future generations.

Our ancestors who fought for women's suffrage stepped up, against the huge social pressures of their times, when a woman's place was in the home, and politics was left to men. They stepped right outside their comfort zone. Through their courage and strength, they created great opportunities for us. We owe it to them not to waste their legacy.

One of the hardest things about taking action is planning and strategising. But that is where we develop a shared vision for the future and create possibilities. The exchange of ideas is a creative, imaginative process, and as you put forward your own ideas, you get to know others and form strong friendships – one of the benefits of being in a union.

Nobody joins an organisation, no matter what kind, to be a passive participant. Nothing happens that way.

There are so many campaigns that need you right now – In Safe Hands, the primary health-care multi-employer collective agreement (MECA), the care capacity demand management programme, the district health board MECA. We need members to get involved and support these campaigns. Come, jump in the pool, the water is warm! •

Emergency nurses shown appreciation

Rotorua emergency department (ED) nurses and Christchurch ED nurse Keziah Jones with gift packs

FOR MANY of us, there is a sense that the sooner 2020 is over and done with, the better.

Perhaps it is appropriate that it was the International Year of the Nurse. We might have hoped for fewer challenges, but with challenges come opportunties. It has been a time of transitions, of new ways of looking at the world and understanding the role of nurses.

For emergency nurses, challenges have included the need to respond to the COVID-19 pandemic – designing and adapting new pathways to manage patient flow, re-visiting the use of personal protective equipment (PPE), constantly changing protocols and policies, and staying aware of the changing knowledge about the disease itself.

The college of emergency nurses (CENNZ) has tried to support members with online forums to share information and different approaches and their effectiveness.

However, the issues facing emergency nurses are greater than those arising from the pandemic. Violence and aggression remain major concerns. We have made written and oral submissions to Parliament's Justice Committee, worked with the NZNO addressing violence and aggression against nurses group and managed to include the problem in NZNO's strategic plan.

We need all sections and colleges to actively encourage nurses to report any instance of aggression, whether verbal or physical, as we seek a safe workplace.

Crowding continues to be a problem, as hospitals try to address the cancellation of elective surgery and acute problems from delays seeking help.

As we are all aware, the issue of crowding is not specific to emergency departments (EDs), but hospital-wide, and needs a systems-based response. The evidence is clear that no single action can effectively address patient flow. Meanwhile, many EDs are being seriously impacted by patient backlogs with ambulances unable to unload at times. Collaboration is continuing between CENNZ and the Australasian College of Emergency Medicine to address this.

This year we celebrated International Day of the Emergency Nurse on October 14 with more aplomb than usual. Using money saved from lost travel, conference and education opportunities due to COVID-19, we sent a gift box to every ED nurse in New Zealand, to show our appreciation for their hard work in a difficult time. This made for a great chance to celebrate and share with each other the value of being an emergency nurse. •

Report by CENNZ chair Sandra Richardson

Nurses learn how to keep bullying at bay

ABOUT 30 nurses discussed bullying and different communication styles at an NZNO forum on navigating workplace relationships in Hamilton last month.

According to WorkSafe, bullying is repeated and unreasonable behaviour directed towards a worker or group that can lead to physical or psychological harm. It is not one-off instances of rudeness, unreasonable behaviour, tactlessness or a difference in opinion. Nor is it constructive feedback, high performance expectations, warnings or discipline in line with workplace policy.

Bullying tactics can range from the very subtle – such as eye-rolling - to very obvious, such as physical and verbal abuse.

Poor communication styles, too, can lead to perceptions of bullying and cause harm.

Individuals, teams and managers all have responsibilities for managing and preventing bullying. Workplaces need clear standards of safe behaviour, modelled by managers who are prepared to act on complaints. A truly safe workplace ensures bullying at any level is removed or stopped from becoming part of a workplace culture in the first place.

Though serious, the topic was well-received with strong participation from nurses. Much of the discussion was drawn from work done by NZNO Organiser Deb Chappell and Massey University researcher Kate Blackwell.

We finished the evening on a more positive note, learning about pre-cognitive communication.

A TED (technology, entertainment & design) presentation by New Zealand lawyer Amy Scott described her "dots" communication tool, which suggests four styles: Organised (yellow), sensitive (blue), direct (red) and ideas (purple).

The aim was to identify our own and others' predominant communication styles, to quickly get on the same wavelength. •

Report by NZNO professional nursing adviser Annette Bradley-Ingle, who presented at the forum.

Enrolled nurses & nurse practitioners step into primary mental health care

ENROLLED NURSES (ENs) and nurse practitioners (NPs) are to play a key role in expanding community mental health and addiction services, under a new University of Auckland (UoA)–led primary health initiative.

In July, the university was awarded a $9.2 million four-year contract by the Ministry of Health (MoH) to improve access to mental health and addiction support nationally, particularly for Māori, Pacific and rural populations.

UoA senior nursing lecturer Sue Adams said the funding would support up to 40 ENs and 18 NPs to work in primary mental health and addiction (MHA) services around the country. "We know that 20 to 30 per cent of any GP waiting room has people with MHA issues, and rarely do we adequately assess them and offer support."

Few ENs worked in primary health care, where better access was needed to mental health support, yet they could help patients in many ways, Adams said.

"The expectation is that ENs would contribute to the assessment of MHA issues, referring to another practitioner as required, provide brief interventions for mild to moderate issues, and act as a navigator to connect and support people utilising community resources."

ENs would be expected to take the Te Ao Māramatanga New Zealand College of Mental Health Nurses 45-hour mental health credentialing programme designed for primary health care, Adams said.

Sue Adams (left) and Robyn Hewlett

NZNO's enrolled nurse section (ENS) chair Robyn Hewlett the committee was "really excited" and keen to support the initiative. More ENs were working in MHA services at district health boards and could play a useful role in primary mental health care also.

The EN-NP initiative falls within an $18.6 million MoH contract with the university to lead an expanded NP training and placement programme for 50 trainees annually, with a focus on Māori and Pacific, from 2021. This was an increase to the pilot which offered 20 trainee places.

UoA is partnering with University of Otago, Victoria University of Wellington, Northland's Mahitahi Hauora primary health entity, Auckland's Fono Pacific service, Te Ao Māramatanga, Te Rau Ora Māori wellbeing organisation and Nurse Practitioners New Zealand on the NP work. The university was also in talks with EN diploma providers, Adams said. She hoped to see nurses in primary mental health roles from early next year.

EN vaccinators

ENs working towards becoming authorised vaccinators were meeting resistance in some workplaces, Hewlett said.

Since COVID-19, the MoH has expanded access to vaccinator training to allow faster immunisation, particularly for influenza.

A free influenza, MMR (measles-mumps-rubella) and pandemic vaccinator course is now available to any health-care professional with an annual practising certificate,

The Immunisation Advisory Centre would contact ENs awaiting peer assessment to support them, Hewlett said.

It was hoped ENs would be part of the COVID-19 vaccination teams, when a vaccine became available.

Changes to EN scope?

A meeting with the Nursing Council to make the EN scope of practice more collaborative was hoped for early next year, Hewlett said.

The need to practice under direction and delegation of colleagues was considered the most restrictive aspect of ENs' scope, according to nearly 68 per cent of ENs surveyed by NZNO last year.

The ENS hoped to meet the Nursing Council about reviewing the scope early next year.

The ENS planned to hold its 2021 conference in Dunedin on May 18-20, after its 2020 conference was cancelled. •

Nurse leaders share tips on avoiding burnout

THE NURSING leadership section, tapuhi mana whakatipu, gleaned tips on avoiding burnout at its annual general meeting on November 5, held via Zoom.

Registered nurse and author, Anne Evans-Murray discussed ways to build resilience amid difficult times and how to recognise burnout.

Adult educator Linda Hutchings talked about how our attitudes influence the behaviours of those around us and the five different "languages" of love and appreciation – words, acts, gifts, time or touch.

She challenged us to ask whether the five people we spend the most time with pull us up or down? Daily gratitude should be a way of life and emotions are contagious, she said, emphasising the importance of time to reflect.

With the cancellation of our 2020 conference, we look forward to seeing members in Whanganui on November 4-5, 2021.

Report by nursing leadership section chair Debbie O'Donoghue and NZNO professional nursing adviser Wendy Blair. •

Trauma nurses ambitious for future

THE CHRISTCHURCH mosque shootings in March 2019 and the Whakaari/White Island eruption in December required trauma responses on a scale and type not previously required in this country. The trauma nursing workforce was critical to the response to both these events.

Trauma nurses work in all acute hospitals across New Zealand. On a day-to-day basis, the trauma nurse is a key part of the trauma patient's journey, providing care for the approximately 2400 people who suffer major trauma each year on our roads, or from falls, assaults and other causes. Major trauma is associated with around a 10 per cent mortality rate and for those that survive, many have serious disability requiring long-term rehabilitation. There is a disproportionate burden of trauma on Māori, while the financial and societal cost is significant for everyone.

The National Trauma Network was established as a contemporary system of care in New Zealand to improve outcomes for those who with serious injuries. Historically, we have seen unwarranted variations in care, and adverse outcomes such as high mortality rates. Trauma nurses, along with their trauma colleagues, are credited with the improving performance measures we are now seeing. The mortality rate is reducing, and most processes of care are improving. We have set up a population-based trauma registry, a formal system of care, and approximately 30 trauma nurses with dedicated time in each acute hospital.

But what is a trauma nurse? Until recently, we had no common view, so a working group of trauma nurses, representing small and large hospitals, set out to define the core components of the role and articulate the ambitious vision for the workforce over the next five years.

Four core functions of the trauma nurse role were identified:

- **Data collection** on all patients who meet the threshold for inclusion to the major trauma registry. This registry is the foundation for data-driven quality improvements in trauma and the unique injury coding allows us to benchmark nationally and internationally.
- **Case management**: Trauma patients often require complex, coordinated care through their hospital stay. Case management is an excellent approach to ensuring they receive optimal care of their physical, social, cultural and mental health issues.
- **Quality improvement**: An effective system is one where improvement is done at all levels of service. This year, 20 nurses and allied health staff will begin quality improvement facilitator training to strengthen our national focus on critical haemorrhage, serious traumatic brain injury and rehabilitation.
- **Education** of patients, their whānau, other staff, and the community. Serious injury can have a profound effect on the individual and their community, and education plays an important role in supporting optimal recovery.

The trauma nurse professional development framework

Our goal is for all trauma nurses to have these core functions included in their role. How this is done will differ between small and large hospitals, but we understand that implanting this approach will result in better outcomes for our patients.

Hospital executives who make investment decisions and allocate hospital resources would be interested in the tangible benefits of the trauma nurse role. There is good evidence linking trauma nurses and reduced bed days, reduced acute unplanned readmission, reduced complication rates, improved referral and patient management pathways, and improved patient satisfaction.

Nationally, there have been significant improvements in the capacity and capability of the trauma nursing workforce. Many trauma nurses have completed or are undertaking a clinical masters, with potential to become nurse practitioners.

However, there are a small number of hospitals where the role is seriously under-resourced for the caseload. The health sector tends to drive high performers the hardest, and this is true in these hospitals. A trauma system is just that: a system; and if one part is stretched beyond reasonable capacity, it has an impact across the whole system.

Notwithstanding these challenges, the commitment of trauma nurses is demonstrated by a culture of professionalism and continuing education to improve patient care. This means we are in a much better position now to provide optimal care of the injured person.

We are ambitious to increase the trauma nursing workforce, and with support from ACC, nurses receive financial assistance to train, attend conferences, and continue professional development. We would like to see at least one specialist trauma nurse practitioner in each region's tertiary centres over the next few years. We would like to see more Māori nurses identify trauma nursing as a specialty.

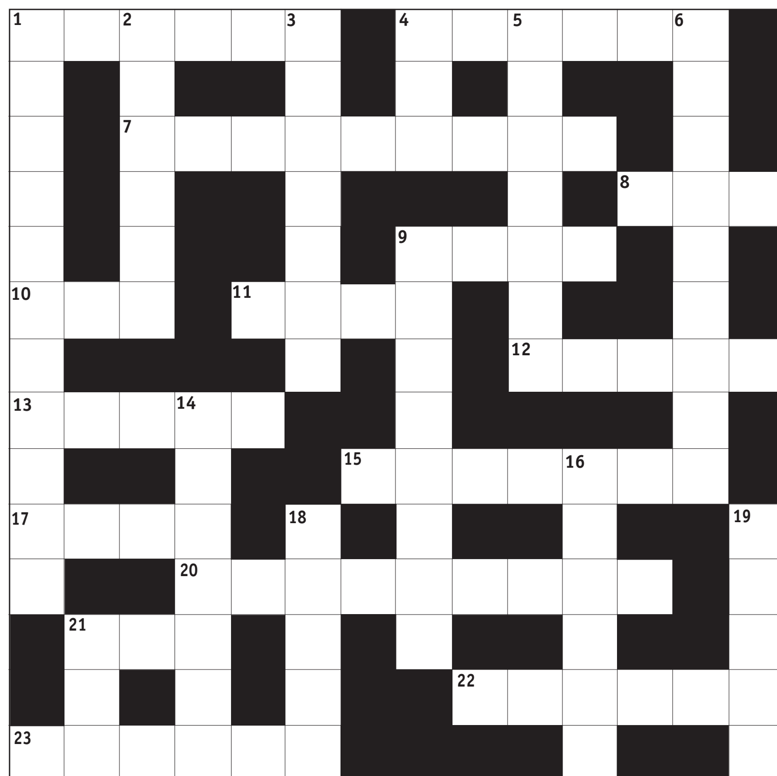
It's an exciting time to be a trauma nurse in New Zealand, and to be part of a nationwide effort to develop a world-leading trauma system.

More detail on the professional development framework for trauma nursing can be found at www.majortrauma.nz/assets/Publication-Resources/In-hospital/Trauma-nursing-professional-development-30-May-2019.pdf while the www.majortrauma.nz website has more information on the National Trauma Network. •

Report by Siobhan Isles, RN, MSc, national programme manager, National Trauma Network

crossWORD

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



ACROSS

1) Insight often gained through age, experience.
4) Animal/human with no skin pigment.
7) Tool used in CCDM to assess staffing needs.
8) Shakespeare play, Much __ About Nothing.
9) Create using wool and needles.
10) Anger.
11) Elderly woman, female elder (Māori).
12) Thin straps used to guide horse.
13) Ground-up meat.
15) Exhaustion.
17) One of a pair.
20) De-escalation tool of last resort in mental health.
21) End life.
22) Brags.
23) Online patient access to general practice.

DOWN

1) Isolated Hutt suburb, original home of former All Blacks captain Tana Umaga.
2) Sew up wound.
3) The least amount necessary.
4) Curved line.
5) Something that blocks the way.
6) Compliance.
9) Elder (Māori).
14) Give permission.
16) Worldwide.
18) Sever frown.
19) Alloy of zinc and copper.
21) Performing pair.

November answers. ACROSS: 1. Student. 4. Crumbs. 7. Vulnerable. 9. Lie. 13. Contaminate. 15. Bronchi. 17. Saline. 19. Wairua. 21. Sofa. 23. Strike. 24. Kiore. 25. Age. 26. Horizontal. **DOWN:** 1. Skill. 2. Uncle. 3. Neuron. 5. Rare. 6. Bulb. 7. Enema. 10. Ivory. 11. Mahi. 12. Delegate. 13. Cannabis. 14. Mask. 16. Horse. 18. Lesbian. 20. Aioli. 21. Stag.

wiseWORDS

“Nothing in life is to be feared; it is only to be understood. Now is the time to understand more, so that we may fear less.”

Marie Curie (1867-1934), Polish scientist who won the Nobel Prize twice, in physics and chemistry, for her pioneering work on radiation

it's cool to kōrero

HAERE MAI and welcome to the December/January issue. 2020 has been a tough year but some things in the natural world can give us perspective. A year is a tiny blip in the lifespan of the magnificent kauri.

Tāne Mahuta (lord of the forest) is Aotearoa's largest kauri, and is estimated to be 1500 years old. It is named after Tane, the god of the forest. Tāne was the son of Ranginui, the sky father, and Papatūānuku, the earth mother. He separated his parents' marital embrace and clothed his mother's body with trees and plants. The trees and birds of the forest are known as Tāne's children.

Māori have used kauri timber for waka, and kauri gum as a firestarter and tattoo pigment.

Kupu hou

New word

- **Kauri** – *pronounced "coh-rrree"*
- **Ko te rākau nui i Aotearoa, ko Tāne Mahuta. Ko te nuingā o ngā mita, rima tekau ma tahi.**

Tāne Mahuta is the largest kauri in Aotearoa. It is 51 metres tall.

Rerenga kōrero

Phrases

- **Kua uaua tēnei tau, rua mano rua tekau.**
2020 has been a tough year.
- **Kei te ngenge ahau.**
I am tired.
- **Ka pirangi hararei ahau.**
I want to have a holiday.

Whakataukī

Proverb

- **He waka eke noa.**
We are all in this together.

E mihi ana ki a Titihuia Pakeho and Keelan Ransfield.

Members to be part of constitutional review

REPRESENTATIVES FROM the mental health nursing section and cancer nurses college will be invited to be involved in the review of NZNO's constitution, it was agreed at November's NZNO board meeting.

The section and college jointly put up the policy remit for a full independent review of the constitution at this year's annual general meeting (AGM), where it was passed.

At its November 3 meeting, the board agreed their representatives should be involved in the review.

Independent reviewer

Chief executive Memo Musa said the board needed to decide on the criteria for the review, as well as a process for finding an independent reviewer, as required by the remit.

He suggested possible reviewers have a constitutional law background, te Tiriti o Waitangi knowledge and be from a union background, and who can relate to members.

Kaiwhakahaere Kerri Nuku said tikanga knowledge was also needed.

Musa also recommended a panel of NZNO member representatives be appointed, for the reviewer/s to consult with.

The review needed to be ready by July 2021, when AGM papers were sent to member groups. The remit had called for it to be ready to vote on in the 2021 AGM, Musa said.

The board agreed that Musa draft the scope of the review; discuss the draft scope with the president, kaiwhakahaere, tumu whakarae and vice-president; contact a range of constitutional lawyers and prepare a draft paper for the December board meeting.

The constitutional review had been added to the board's work plan from December 2020 on. •

Safe staffing review

Work has begun to scope a review of NZNO's safe staffing strategies, another remit passed at this year's AGM.

The remit called for an independent evaluation of NZNO's safe staffing strategies, including care capacity demand management, with options for other approaches including nurse-to-patient ratios to be considered.

Musa said a meeting had been held to prepare a draft scope for the review, after which independent reviewers would be appointed.

Timelines were tight and "ambitious", with a report expected for the 2021 AGM. Musa said it might end up being an "interim" report rather than a complete evaluation. The inclusion of an equity lens would be part of the scope, he said. •

Membership rise predicted

NZNO MEMBERSHIP in the first four months of this financial year has seen a net decrease of 2.3 per cent, corporate services manager David Woltman told the board.

Between March 31 and July 31, membership dropped 1212 from 51,643 to 50,431, a similar trajectory as this time last year although at a lower level, Woltman said in his report.

Membership was expected to recover as the district health board multi-employer collective agreement bargaining (DHB MECA) progressed, bringing more benefits to members. The loss had mostly been registered nurses and students.

Woltman said budgeted membership income for the year to date was down $71,000, with a drop of $213,000 expected for the full year to March 31, 2021, due to membership numbers being lower than budgeted for.

However, over the past six years to March 31, 2020, membership growth of eight per cent had outperformed the budgeted growth of one per cent per year, even with the recent drop since the last DHB MECA round in 2018.

That equated to nearly 2100 more members than budgeted for. The budgeted growth had been for 49,546 but had reached 51,643, he said.

Membership fees were the major source of income for NZNO, contributing 93 per cent, he noted.

COVID-19 savings

NZNO had a pre-tax surplus of $182,000 surplus in the four months to July 2020, which was $715,000 more than budgeted. This was mainly due to COVID-19 lockdown causing the cancellations of travel for member-related events and conferences, Woltman said in his report. •

See membership fee table p42.

The reports on these two pages have been written from reports and minutes taken at the November 2020 board of directors meeting.

NZNO braces for revamp

NZNO WILL need to "punch way above its weight" to support nurses through a period of change, when the Government begins a health restructure, chief executive Memo Musa told the board.

The possible reduction of district health boards from 20 to eight, the establishment of a new Māori health authority and Health New Zealand – the entity leading the restructure – amid other changes, would mean significant work for NZNO, he said.

He was also concerned about the impact on members working for community organisations such as iwi, primary health or aged residential care providers, likely to be significantly more affected than district health boards.

Musa said the election result was significant for NZNO, given how much Labour had not been able do in the previous coalition Government. •

Māori model of organising and wellbeing in pipeline

A DRAFT Māori model of wellbeing and organising, *He Tāngata Ara Poutama*, has been presented to te poari after six months of work by NZNO Māori cultural adviser Manny Downs.

Manager nursing and professional services Mairi Lucas told the board the model depicted a stairway, with each step representing excellence, skill, knowledge, achievement and understanding – all integral to wellbeing.

Chief executive Memo Musa advised the board the most important work from the model would be around training and supporting staff as they worked with Māori members in their workplaces.

The board also discussed the development of an equity tool/lens.

Musa said he had previously sought guidance as he was not aware of a framework that would apply in a union. After speaking to colleagues about a bicultural perspective, he believed the work had to start afresh.

Until a framework was developed, he expected that questions be asked on a daily basis about reducing inequalities.

Equity definition

Lucas was working to pull the Ministry of Health's equity definition into a framework, Musa said. After that, he expected the policy team would work out guidance on how to use it within the organisation.

Kaiwhakahaere Kerri Nuku said the New Zealand Medical Association had done extensive work on their cultural safety and competence framework and equity lens.

It was hoped the NZNO framework would be ready for the December meeting. •

$5000 for Lebanon's nurses

NZNO's BOARD has agreed to donate $5000 to the International Council of Nurses (ICN) disaster fund, to support the Order of Nurses in Lebanon, following the catastrophic explosion in August this year.

The ICN asked all national nursing associations for support following the August 4 explosion, in which more than 250 people died and 5000 were injured after ammonium nitrate stored at the Beirut port exploded.

The board agreed with NZNO president Heather Symes' proposal to donate $5000. The money will come from NZNO's annual disaster budget of $35,000. •

Health literacy can improve inequities, p22-24 – references

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NZNO subscriptions 2021

In November 2020 the board of directors considered a proposal from chief executive Memo Musa to increase membership fees. A range of options were provided in the proposal.

The board considered a number of matters including increased parking costs being put onto nurses, the current economically depressed environment and nurses working in their retirement years.

The board noted that indemnity insurance was essential for nurses and discussed the impact of fee increases on operational work. It noted the impact COVID-19 has had, including the change in the nature of work and the positive impact on NZNO's budget, specifically savings in travel costs.

The board sought to keep increases low, and approved the proposed fee increases ranging from less than one dollar for students, to an additional $10.80 per year for registered nurses (RNs) – equivalent to the cost of two cups of coffee. Caregivers, health-care assistants (HCAs) and aides will face an additional $6.48 per year and the enrolled nurse (EN) category will go up by $8.64. Reduced fee categories increased by $2-$3 per year.

The board has added the nurse practitioner (NP) role to the fee table in the same category as RNs.

Over the last year, the board applied a differential approach in recognition of low-income workers.

The board adopted the same approach as in the previous year (2020/21) and approved a fee increase of one per cent for low-income earners. This includes all reduced fee categories, including for caregivers, HCAs, aides, Karitane nurses, clerical, non-clerical support workers and all other workers who have income less than $26,000 gross per annum. It excludes NPs, RNs, registered midwives and ENs.

The board approved an increase of 1.9 percent for all other member fee categories.

The board retained the free fee for students in their first year of study in the bachelor of nursing, midwifery or EN programmes.

Fee increases are effective from 1 April 2021.

David Woltman, manager corporate services

MEMBERSHIP FEE EFFECTIVE FROM 1 APRIL 2021						
	Annual	**Half Yearly**	**Quarterly**	**Monthly (20th)**	**Twice Monthly (14th & 28th)**	**Fortnightly**
Nurse Practitioners, Registered Nurses and Midwives, Health Professionals New Zealand members not affiliated to their professional bodies and not mentioned elsewhere	**$574.56**	**$287.28**	**$143.64**	**$47.88**	**$23.94**	**$22.10**
Enrolled nurses, Registered Obstetric Nurses and College of Midwives members, Health Professionals New Zealand members with affiliations to their own professional bodies	**$458.88**	**$229.44**	**$114.72**	**$38.24**	**$19.12**	**$17.65**
Caregivers, Health-care Assistants, Aides, Karitane nurses, Clerical, Non-Clerical Support workers and all other Support workers	**$342.72**	**$171.36**	**$85.68**	**$28.56**	**$14.28**	**$13.18**
REDUCED FEE CATEGORIES						
Caregivers, Health-care Assistants, Aides, Karitane Nurses, Clerical, Non-Clerical Support Workers and all other Support workers who have declared their income to be less than **$26,000 gross per annum. DOES NOT INCLUDE RNs/RMs & ENs.**	**$266.88**	**$133.44**	**$66.72**	**$22.24**	**$11.12**	**$10.26**
Low income earners (if approved by NZNO), members who have declared their income less than **$19,000 gross per annum. DOES NOT INCLUDE RNs/RMs & ENs.**	**$213.60**	**$106.80**	**$53.40**	**$17.80**	**$8.90**	**$8.21**
Reduced fee earners (if approved by NZNO), those on parental and full-time postgraduate study leave, members not in nursing practice/unwaged, Enrolled Bridging Students working part-time, members of another union affiliated to CTU.	**$213.60**	**$106.80**	**$53.40**	**$17.80**	**$8.90**	**$8.21**

Students in their first year of study in the BN, midwifery or enrolled nurse programme	**Free**
Students in their first year of study in the BN, midwifery or enrolled nurse programme who wish to receive their own copy of *Kai Tiaki Nursing New Zealand*	**$45.66**
Students of nursing, midwifery or enrolled nursing in second, third and subsequent years of study and those retired from nursing but wishing to retain membership	**$47.29**
Students of nursing, midwifery or enrolled nursing in second, third and subsequent years of study and those retired from nursing but wishing to retain membership with their own copy of *Kai Tiaki Nursing New Zealand*	**$92.95**

***REDUCED FEES: At AGM in September 2009 a remit was passed excluding RNs/RMs and ENs from the REDUCED FEE subsidy.**
A new reduced fee rate for those earning less than $26,000 gross per annum was introduced. See rate chart above.
Members earning less than $19,000 gross per annum qualify for the low income subsidy.
A declaration of income needs to be made each year of membership.
The board of directors has set criteria for special consideration of a reduced fee option for RNs and ENs. Details on www.nzno.org.nz

Kai Tiaki NURSING NEW ZEALAND

writing guidelines

Guidelines for writing articles for *Kai Tiaki Nursing New Zealand*

We welcome articles on subjects relevant to nurses and nursing, midwives and midwifery. These guidelines are designed to help you write an article which is accurate, clear, easily read and interesting.

The main reason you want an article published in *Kai Tiaki Nursing New Zealand* is so other nurses/midwives will read it and hopefully learn something valuable. Therefore the subject must interest nurses/midwives and be written in a way that will appeal to them.

The essence of good writing is simple, effective communication – a good story well told. Even the most complicated nursing/midwifery care scenario, theory of nursing/midwifery practice or research study can presented in a straightforward, logical fashion.

This list should help you construct an article that will be read, understood and appreciated.

• **Always remember who your reader is.** Your readers are nurses/midwives, so what you write must be relevant to and understood by nurses/midwives. The focus of your article must be what the nurse/midwife does, how the nurse/midwife behaves, what affects the nurse/midwife. If you are writing about a new technique in your practice area, explain how it changes nursing/midwifery practice and its advantages and disadvantages to the nurse/midwife and patient/client. If you are discussing a theory of nursing/midwifery practice, link this to concrete examples of working nurses/midwives.

• **Avoid using big words, complicated sentences and technical jargon.** They don't make you smarter or your article better. Writing clearly and plainly is your goal. Widely used nursing/midwifery terms are acceptable, but avoid overly technical jargon. American writer, editor and teacher William Zinsser stresses the need for simplicity in writing: *"We are a society strangling in unnecessary words, circular constructions, pompous frills and meaningless jargon."*[1]

• **These questions will help you pull together all the relevant information needed for your article: Who? What? Why? When? Where? How?** Don't assume all other nurses/midwives know the ins and outs of your particular area of practice. If you are unsure about how to express a particular idea or technique, think how you would explain it to a student nurse/midwife.

• **Maximum length is 2500 words,** which, with illustrations, fills three pages of *Kai Tiaki Nursing New Zealand.* Longer articles need to be discussed with the co-editors.

• **References should be presented in the APA style.** Some examples:

Articles:

Sampson, M. (2013). Seeking consistency when managing patients' pain. *Kai Tiaki Nursing New Zealand; 19*(5), 26-28.

Bryant R. (2012). Nurses addressing access disparities in primary health care. *International Nursing Review; 59*(152). doi:10.1111/j.14667657.2012.01003.x

Books:

O'Connor, M. E. (2010). *Freed to Care, Proud to Nurse: 100 years of the New Zealand Nurses Organisation*. Wellington: Steele Roberts.

Websites:

Ministry of Health. (2010). *Cancer Control in New Zealand.* Retrieved from http://www.moh.govt.nz/cancercontrol

• **Submit your article via email** (to coeditors@nzno.org.nz). Type with double-spacing and wide margins and include your name, address, phone number/s, current position and nursing qualifications.

• **Photographs and illustrations are welcome.** They need to be high-resolution, at 300dpi, and at least 200kb or more. We prefer jpeg format; send them as attachments to an email rather than in the email itself. Cartoons and diagrams are also welcome, and we can also use black and white or colour prints.

• **Most clinical articles are reviewed** by ***Kai Tiaki Nursing New Zealand*** co-editors and two clinicians with expertise in the subject the article explores. Authors will be informed of the outcome of the review and the reasons why their article was accepted, rejected, or requires more work.

• **Contributors assign copyright to NZNO.** If an article is accepted for publication, copyright is automatically assigned to NZNO. Permission to republish material elsewhere is usually given to authors on request, but manuscripts must not be submitted simultaneously to other journals. •

Reference

1) Zinsser, W. (2001). *On Writing Well. The Classic Guide to Writing Nonfiction* (25th anniversary edition). New York: Harper Collins.

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*

Thank you for working in partnership with us.

Classified advertising

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43rd Annual Enrolled Nurse Section NZNO Conference

"The Year of the ENrolled Nurse"

18th – 20th May 2021 Glenroy Auditorium, Dunedin

Online Registration

www.nzno.org.nz/groups/colleges_sections/sections/enrolled_nurses/conferences_events

The Nursing Education and Research Foundation (NERF) has the following scholarships available:

THE NEW ZEALAND NURSING EDUCATION AND RESEARCH FOUNDATION

- Research Grant
- Short Course/Conference Attendance Grant
- Undergraduate Study Scholarship
- Postgraduate Study Grant
- Conference Organisers/Speakers Grant
- Wellington Nurses Education Trust Scholarship
- Margaret Nicholls Grant
- Effie Redwood Endowment Fund
- Catherine Logan Memorial Fund

Eligibility:

- Must be a current financial member of NZNO
- One NERF grant per year
- Grant application forms specify criteria

Applications close on 26 February 2021 at 4.00pm

Apply online:

https://www.nzno.org.nz/support/scholarships_and_grants

Questions should be directed to: **grants@nzno.org.nz**

Need information, advice, support?

Call the NZNO Member Support Centre

Monday to Friday 8am to 5pm   Phone: **0800 28 38 48**

A trained adviser will ensure you get the support and advice you need.

If you have an issue related to your employment or nursing practice including: a Police, Coroner's, Nursing Council, Disciplinary or Health and Disability Commissioner investigation, seek support from NZNO.

www.nzno.org.nz

Every person with a disability deserves a life of choice, freedom and independence.

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Reunion

The first ever reunion for the September 1982 Class of General Obstetric Nurses at the Christchurch School of Nursing is being planned for September 2021.
Location will be Christchurch.

If interested in further details please contact Jane Coster at jicoster@hotmail.com

DISCLAIMER: Recruitment Agencies: Kai Tiaki Nursing New Zealand accepts advertising from nurse recruitment agencies but cannot guarantee the quality of their service, however, we expect agencies to provide a good service and that their advertisements should not be misleading. Complaints about poor service from advertised agencies should be directed to: Co-editors, Kai Tiaki Nursing New Zealand, PO Box 2128, Wellington 6140. Ph 04 4946386. These complaints will be treated confidentially but the nature of them will be passed on to the agency concerned.

A privilege to be part of people's journeys

Pact clinicians who support people with mental health issues in prisons say their work is incredibly rewarding.

Who is Pact?

Pact is a major provider of community-based mental health services in the lower North Island, the West Coast, Otago and Southland. As part of its Improving Mental Health contract with the Department of Corrections, it employs clinicians in five lower North Island prisons. They support people with mental health and wellbeing issues like anxiety, stress, low mood, depression and sleep problems. They also help Corrections staff manage, understand and respond to issues that may have a mental health component and work closely with the Corrections health teams and case management.

At the coalface

When people see our clinicians, it is often the first time they have had help with mental health issues.

In Manawatū Prison in Palmerston North, mental health clinician Melissa Frank usually sees two men individually in the morning and two in the afternoon. She takes the trust the men place in her seriously. She says they learn how to talk to a health professional and how to be open and honest. She is gratified when they choose to keep coming back.

"I think we're very privileged to be part of their journeys."

Practical support

Melissa aims to give men practical tools they can use (she does not deal with medication). The tools can help with issues like sleep problems, adjusting to prison life and being anxious about leaving prison. They include practical help like breathing exercises and contacts in the community for those getting out. She must be creative, problem-solve and think on her feet. She helps men start expressing themselves to their loved ones, so they do not bottle up anger until they explode. Many assume that arguing with somebody or threatening violence is the way to get things done because that's all they have ever known. She helps them learn they can talk their problems out.

A unique perspective

Melissa sees a different side to the men in prison.

"You work with gang members and they're big and staunch with the other people in prison. And when they come into that little room with you, they're a different person and they talk about the love that they've lost coming in here and how they want to change and their anger issues and many other things."

Melissa says some of the people she supports see a distinction that she works for Pact and not Corrections, which helps them open up.

Professional benefits

The service comes under Pact's clinical governance structure. Clinicians are supported by a clinical lead, are part of a multi-disciplinary team and are free to use their individual professional skillset. Our current team comes from many backgrounds who all use different treatment modalities.

As well as having a competitive salary and generous annual leave, the clinicians have great opportunities for professional development with a personal training budget from Pact. They also get to work office hours with weekends and statutory holidays off.

A safe place to work

Staff safety is important in the prisons and there are numerous safety precautions in place to ensure our clinicians are always protected.

Melissa says that within the prison walls, her colleagues are her family and will protect her.

"You definitely sense that in here. It's a family environment."

Vacancies: Mental Health Clinicians at Rimutaka Prison (Upper Hutt) or Palmerston North Community Corrections

Are you an experienced mental health professional interested in a rewarding role with excellent benefits, based in Rimutaka Prison (Upper Hutt) or with Community Corrections in Palmerston North? We have one part-time and one full-time role in Rimutaka Prison and a part-time role in Palmerston North.

Please apply or find out more information at: **http://www.pactgroup.co.nz/careers-at-pact**

For more information about the role, please call Mental Health Services Manager Evelien Post on 027 343 0640 or email her at evelien.post@pactgroup.co.nz.

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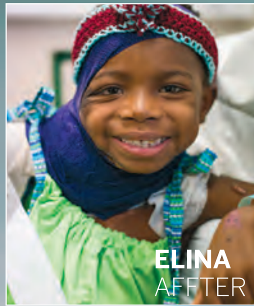

'This little girl stole our hearts. I cried when I had to say goodbye. I will miss her mimicking the nurses, her laugh as she runs down the hall, and her resilient joy. She is one of many kids and adults that impacted the hospital staff. Each have a story, and I'm honoured I played a small part.' Jeani

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Since 1978, Mercy Ships has used hospital ships to deliver transformational healthcare at no charge to the world's forgotten poor. More than 2.84 million people have directly benefited from services provided, including more than 105,500 free surgical procedures.