Kai Tiaki NURSING NEW ZEALAND

February 2021 vol 27 no 1

Batman saves the classroom!

- MIF nurses buckle under workload
- Memo Musa's farewell words
- Student leaders profiled

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ISSN 1173-2032

Vol. 27 No. 1 FEBRUARY 2021

AS USUAL, our first issue of the year has a focus on students and undergraduate education. There's a feature on Batman enlivening online education, profiles of NZNO's student leaders and an article on how COVID-19 prompted a paradigm shift in education. We talk to nurses working in managed isolation facilities and outgoing chief executive Memo Musa reflects on his time with NZNO.

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

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

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

Co-editors:
Teresa O'Connor and Mary Longmore.

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

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Need information, advice, support?
Call NZNO's Membership Support Centre: **0800-28-38-48**

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Cover: With thanks to Shelley van der Krogt and Lachy Waugh.
Photo: Caleb Finegan.
Cover design: Kathy Stodart.
Pre-press production: TBD Design.
Printers: Inkwise.

Significant stepping stones

By Rhoena Davis

"Mā mua ka kite a muri, mā muri ka ora a mua.

Those who lead give sight to those who follow, those who follow give life to those who lead."

Māori nursing began with the arrival of our waka in Aotearoa. The date of first settlement is a matter of debate, but current understanding is that the first arrivals came from East Polynesia in the late 13th century. Māori health and wellbeing practices included tohunga rituals and medicinal remedies specific to particular hapu.

Nursing history indicates the first hospital was established in Auckland in 1850. There were also informal cottage hospitals run by untrained women, some little more than domestic servants, where able-bodied patients were expected to look after the others.[1]

Nursing history reminds us of the many events that have moulded contemporary nursing. There is too much history to remember it all, so we make choices about what is worth remembering. Significant events include those that resulted in great change for large numbers of people, but significance also depends on one's perspective and purpose.

Today we can celebrate the progress of the nursing and midwifery professions and the significant contributions and events nurse leaders and nursing organisations have made and navigated during the 20th and 21st centuries. Nursing is a noble profession, constantly enlarging its body of knowledge and enhancing its education. Nursing conceptualises and focuses on the whole patient, thereby setting itself apart from other disciplines. As nurses and midwives, we must take time to look at our own philosophies and what we would like to attain as nurses, and both the obvious and subtle differences we can make.

My nursing career has been shaped by many factors. It began in 1993 in Northland. I was asked to be the Northland Polytechnic representative on NZNO's National Student Unit (NSU). It was a very challenging but interesting time: cultural safety was a topic of political interest, and concepts of health policy, such as the improvement of education and regulation, were to the fore. As a Māori nursing student, the words that ran through my head were *te ao hurihuri* – the unknown.

In 1994-95, I became chair of the NSU and lobbied for a bicultural perspective and to incorporate Tiriti o Waitangi principles within the structures and frameworks of NZNO. It was a rewarding time to part of a diverse team in strengthening Te Rūnanga (TR) and working to establish Te Rūnanga Tauira. Some highlights of that time included my NSU role, being TR vice chair and the TR representative on the board of directors (1997-2004), being an active member of the Nursing and Midwifery Advisory Committee (NMAC), the Nursing Education Research Foundation (NERF) and the editorial committee of *Kai Tiaki Nursing New Zealand*.

Presenting at the South Pacific Nurses Forum in Tonga in 2014 is a treasured highlight. My presentation, *Walking in two worlds*, conceptualised "Mana-A-Ki" (Manaaki) and advocated for Māori nursing. I received an NZNO leadership award in 2009 and was also endorsed as a nurse practitioner (NP) whānau ora that year. My career has evolved further and today I am the secretary of the Rural General Practice Network, a fellow of the College of Nurses Aotearoa (CONA), an interview panelist for the Nursing Council, a member of the Northland NP leadership group and, in that role, a mentor for aspiring NPs.

The development of my nursing career and its highlights can be attributed to the stepping stones provided by NZNO and, later, the CONA. Being part of NZNO enabled comprehensive and extensive learning. I have had a privileged nursing career, filled with great experiences and achievements. My confidence has grown, as has my awareness that greater investment in health and the variables that affect health outcomes is needed.

Nurses have opportunities to enable good health care and to make major and subtle differences to people's lives. Along your professional pathways, I implore you to have fun and find joy in what you do. Health-care coverage does not guarantee high-quality health care. Health equity – that everyone has a fair and just opportunity to be as healthy as possible – is an issue in virtually all health-care systems. But without health care, health equity is impossible to attain. As nurses, we have an important and integral part to play in ensuring health care and health equity for all – this is one of the most important differences we can make. Kia kaha e hoa ma. •

As nurses, we have an important and integral part to play in ensuring health care and health equity for all . . .

"Ehara taku toa i te toa takitahi, engari kē he toa takitini.

My success should not be bestowed onto me alone, it was not individual success but the success of a collective."

Rhoena Davis, RN, BHSc, PGDipBus, MN(hons), NP, is a community nurse practitioner at Whangaroa Health Services Trust, Kaeo, Northland.

Reference

1) HealthTimes. (2015). *History of Nursing in New Zealand*. Retrieved from https://healthtimes.com.au/hub/nursing-careers/6/guidance/nc1/history-of-nursing-in-new-zealand/515/

Tell us what you think

Registered nurses' experiences of work time pressures wanted

I WROTE to *Kai Tiaki Nursing New Zealand* in December last year (Survey into time pressures, pg 3) seeking participants for my research into the impact of time pressure on registered nurses' (RNs) job performance. I am a PhD candidate at the University of Southampton in the United Kingdom and am conducting my research via an online New Zealand-based study.

Unfortunately, the contact email in the letter was incorrect so some RNs who wanted to take part in the study may not have been able to contact me. Please try again at: J.A.Lawless@soton.ac.uk

I am still seeking study participants so would greatly appreciate hearing from interested RNs working in acute inpatient wards/units at district health boards.

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

Co-editors reply: We apologise for the incorrect email address in the letter.

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.

New education feature

Kai Tiaki Nursing New Zealand is pleased to introduce a new professional education feature for members this month. The articles, which will run every second month, will focus on promoting health equity, with a particular focus on eliminating inequities in access to medicines. They have been supplied by He Ako Hiringa, a clinical education programme for primary care clinicians. The inaugural feature runs on pp20-25 in this issue.

We would like to take this opportunity to thank our previous providers of professional development for nurses, Georgina Casey and Claire Budge and Melanie Taylor.

The co-editors

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**
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***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

New policy analyst Māori

NZNO'S NEW policy analyst Māori Belinda Tuari-Toma (Ngāti Porou) will bring another Māori lens to NZNO's policy and research work.

Tuari-Toma joined Leanne Manson as a second policy analyst Māori on the research team last month, NZNO professional services manager Mairi Lucas said.

Tuari-Toma said she would be focusing on how te ao Māori tikanga, whakapapa, matauranga (knowledge) could influence NZNO's "bicultural transformation". This would allow more scope to address equity in policy and research.

Belinda Tuari-Toma

There was a lot of pressure on Māori nurses and all Māori hauora kaimahi (health workers) to work within structures not always supportive of a te ao Māori cultural perspective, she said. Nor were obligations to Māori whānau, hapū and iwi outside the workplace often considered. "The innate role to care, protect and help never stops. Consequently, it is important to address pay inequities for those in Māori/iwi providers, in particular those working in community with high health needs," Tuari-Toma said. "Being adequately resourced at all levels, professionally, is equally important as having recognition of te ao Māori."

Her approach would be based on te ao Māori whakapapa to whakamana (empower) the mana motuhake (self-determination) of iwi, hapū and whānau, while drawing on te Tiriti o Waitangi and the obligation to tino rangatiratanga (sovereignty within the Treaty partnership).

Tuari-Toma is also a contemporary practitioner of rongoā Māori (traditional healing).

She works voluntarily for iwi collective ART (Te Atiawa, Raukawa and Ngāti Toa Rangatira). She also volunteers for Te Awakairangi Tihei Mauri Tu, which supports Māori survivors of state care, by reconnecting whānau with tikanga Māori values.

She brought experience in Māori public health, research and analysis, policy and ministerial advice, among other things, Lucas said. •

Whaea Rose mourned

TE RŪNUNGA O Tāpūtanga Tapuhi Kaitiaki o Aotearoa/NZNO is mourning the passing of Rose Pere, as a "revered tōhuna tipua and leader for the revitalisation of indigenous knowledge and life throughout the world".

Te Rūnanga tumu whakarae Titihuia Pakeho said she had informed many indigenous nurses' journey with holistic ways of looking at health. "She played a significant part in my studies as a strong Māori wahine who maintained her staunch dedication to health for our Māori people and to any kaupapa she believed in."

Rangimarie Turuki Arikirangi Rose Pere (Tūhoe, Ngāti Ruapani and Ngāti Kahungunu) died in December at the age of 83. •

PHOTO: ERICA SINCLAIR

Whaea Rose at the 2019 indigenous nurses hui

Symes resigned for family/whānau reasons

EX-NZNO PRESIDENT Heather Symes would not elaborate on her reasons for resigning as president just two months after her election, when asked by *Kai Tiaki Nursing New Zealand* this month. She restated that it was for family/whānau reasons.

She announced her resignation in December. At that time, she said her personal circumstances had changed and she believed she was not able to continue in the role. "This has not been an easy decision for me, but I have made it after much discussion with my family and whānau, who have given me their support."

Heather Symes

It had not been an easy decision "because I have enjoyed my short time as president and the opportunity it gave me to contribute to the organisation I love and value", she said.

Symes had appreciated being part of a strong board team that were working together in the right direction for NZNO. "Likewise, I have been impressed by how hard staff work for members and the expertise and experience they bring to their roles. You have good people working for you and I encourage you to give them your support."

She thanked those who had supported her as president and those who had voted for her. "I am really sorry not to be carrying on in the position, but I will remain a supportive member of NZNO and will continue to make a positive contribution wherever I can."

Her tenure as president finished on January 8. Speaking earlier this month, she said she wished both the organisation and the next president well. "I hope they enjoy it."

Symes has returned to work at forensic mental health services at Hillmorton Hospital in Christchurch.

• When *Kai Tiaki Nursing New Zealand* went to press, the board had made no decision on how the presidential vacancy would be filled. Tracey Morgan was elected unopposed as vice president in last year's board elections. •

New chief nurse seeks leadership shift

Lorraine Hetaraka with daughter Matariki, and mokopuna Isla Waiāhorangi

INCOMING CHIEF nursing officer Lorraine Hetaraka (Tapuika, Ngāti Pikiao, Ngāiterangi, Ngāti Ranginui, Ngāti Kahu) hopes to support more Māori leadership models in health and nursing organisations.

"It is timely there is a strong focus on equity in Aotearoa, and the opportunity to foster meaningful relationships underpinned by te Tiriti o Waitangi,' Hetaraka told *Kai Tiaki Nursing New Zealand*.

Hetaraka said "transformational change" needed bicultural leadership models, rather than a "lone Māori" nursing leader within a Western framework, expected to represent all Māori. Rather, te Tiriti o Waitangi principles needed to be embedded in health governance, nursing groups and regulatory authorities.

Shift in awareness

"There is a shift in awareness around doing what we have done before and expecting to get different results. We need an approach for all New Zealanders, especially those who experience inequitable outcomes," Hetaraka said. "Māori should be part of the decision-making which is really difficult to do if this is not reflected at a governance level."

Hetaraka is co-chair of the National Nurse Leaders group (NNL), which introduced a treaty relationship governance model with co-leadership last year. Nursing Executives New Zealand and the College of Nurses Aotearoahad also adopted co-leadership models. "Other organisations can influence equity through nursing by demonstrating that they're actively working towards a partnership model."

Being the country's lead nurse provides a "strong" opportunity for her to take a broad lens. "Alongside increasing the number of Māori nurses, we need to be committed to achieving equitable health outcomes for Māori and other high-needs populations," she said.

'I would like to be able to influence and create change that ensures health outcomes are equitable for all New Zealanders in Aotearoa.'

Experience across the health system allowed her to take a wide approach to challenges. "I would like to be able to influence and create change that ensures health outcomes are equitable for all New Zealanders in Aotearoa."

The national nursing strategy currently being developed by NNL was founded on the eight priority areas for action in the Ministry of Health's *Whakamaua: Māori Health Action Plan 2020-2025:*

- Māori-Crown relationships
- Nursing leadership
- Nursing workforce
- Sector development
- Cross-sector action
- Quality and safety
- Insights and evidence
- Performance and accountability

This basis would ensure nursing in Aotearoa was on track to achieving "pae ora" healthy futures for Māori and all New Zealanders, she said.

Hetaraka intended to build relationships with directors of nursing, tertiary education providers and Māori and Pacific nursing leaders around the country, as well as support nurses in aged and primary health care.

She also wanted to increase the nurse practitioner (NP) and prescriber workforce. "For me, the NP and prescriber roles are enablers to address equity issues. They're mobile, they're already in communities with the highest needs, and they're well distributed across the country."

Director-general of health Ashley Bloomfield said Hetaraka showed "outstanding leadership" and the ability to build collaborative relationships and networks in the health and social sectors.

She had a strong clinical and academic background in nursing leadership, progressing from registered nurse to leadership roles in the National Hauora Coalition, primary health organisations, Auckland District Health Board and the University of Auckland, he said.

She would be "working with us to help improve equity for Māori and health outcomes for whānau around the motu", as well as supporting the delivery of *Whakamaua*, Bloomfield said.

He thanked Pam Doole, who had been acting chief nursing officer since Margareth Broodkoorn resigned last year.

Hetaraka will leave her current role as chief executive of Te Arawa Whānau Ora – a collection of whānau ora providers in the Te Arawa/Bay of Plenty region – and take up the new role on March 15.•

Nursing workforce close to 60,000

NEW ZEALAND's nursing workforce reached close to 60,000 last year – 59,866 to be exact – according to the Nursing Council's annual report for the year ending March 31, 2020. The report, released last month, showed the nursing workforce grew by 2033, the biggest increase in the last five years.

But 4756 nurses were added to the register. Of these, more than half – 2724 – were internationally qualified registered nurses (IQNs), with 1822 New Zealand RN graduates joining the register. Enrolled nurses also boosted the register – 44 internationally qualified ENs and 166 New Zealand EN graduates.

Of the IQNs who joined the register, the majority (n=1108) were from the Philippines, followed by 923 from India, 266 from the United Kingdom, and 194 from Australia. Other source countries were the United States (53), South Africa (37), Canada (32), Ireland (29) and "other" 106. From October 2019, the council has outsourced the authentication and verification of registration documents for IQNs to an international organisation.

NZNO associate professional services manager Kate Weston said IQNs were a significant and valuable part of the workforce. "We expect to see a considerable drop in numbers joining the register in the coming 12 months because of the strict border restrictions. This is having an effect across the health sector, as demand for nurses grows and new workforces are needed to respond to COVID-19 ."

Within the total nursing workforce, 4541 or eight per cent identified as Māori, an increase from 4295 for the year ending March 31, 2019. The number of Māori new graduates was 250, compared to 237 in the previous year. Four per cent (n=2244) of the total workforce identify as Pacific, with 145 new graduates identifying as such, a drop of three on the previous year. Eighty-six nurse practitioners were endorsed in the year ending March 31, 2020, boosting the total number in practice to 459. Weston said it was pleasing to see a steady increase in the number of NPs.

Other key results from the latest annual report include:

- Twenty-five per cent (n=15,445) of the nursing workforce is involved in professional development and recognition programmes (PDRPs).

Weston said this was a disappointing uptake "considering the majority of the nursing workforce is in DHBs, primary health or aged care, where PDRP programmes are available".

- The council received 28 new notifications about the competence of nurses, representing 0.047 per cent of the total nursing workforce.
- Professional conduct committees (PCCs) investigated 23 complaints about nurses' conduct. Four nurses had charges laid with the Health Practitioners Disciplinary Tribunal (HPDT); eight received a letter of counsel; two were referred for a health review; one had condition included on their scope of practice and in eight cases, no further action was taken.
- Twenty-seven nurses had court convictions considered by PCCs; of these, 14 were for drink driving, six were for a traffic violation, one was for an assault and six were for other offences. No further action was taken in six cases; six nurses received a letter of counsel, 11 were referred for health monitoring; and three had charges laid with the HPDT.

Five nurses were prosecuted before the HPDT; of these, two had their registration cancelled, two were suspended, censured and had conditions included in their scope of practice, and one charge was not proven.

Council chief executive Catherine Byrne said the delay in releasing the latest annual report was due to the general election, which delayed the report being tabled in Parliament. The new Minister of Health, Andrew Little, also had some questions about the report which had to be answered before the report could be published. "Hopefully this year's report will be back to a more timely report." •

• The council has not yet announced the three successful candidates (from a field of 31) in last year's election of nurses to the council. Voting by the profession closed on September 4.

"We are still waiting for the minister to appoint to the elected positions. I understand we may not hear until mid-February," Byrne said. •

Filipino nurses begin study in Hawke's Bay

SIXTEEN FILIPINO-qualified nurses entered New Zealand last month after being granted a "critical purpose" exception. They are now completing a seven-week registered nurse competence training scheme for overseas-registered nurses at Eastern Institute of Technology (EIT) in Hawke's Bay. The course is also known as the competency assessment programme (CAP).

Executive director of EIT's International Centre Philippa Jones said it was a great start for the return of international students to New Zealand. "We are looking forward to welcoming the next cohort of CAP nurses next month."

Gines Cabahug

Marnie Castrence

Among the newcomers are Gines Cabahug and Marnie Castrence. Both are thrilled to start their training. Cabahug worked as an emergency department (ED) nurse for four years, before working in a medical/surgical paediatric ward. Castrence, also an ED nurse, worked in Saudi Arabia for many years before her application to come here was granted. •

Older nurses should have support to keep working

A RECENTLY-released international policy brief lays out a 10-point plan to support older nurses – those aged over 55 – to stay at work. Developed for the International Centre on Nurse Migration (ICNM) and supported by the International Council of Nurses (ICN) and CGFNS International, it is aimed at national nursing associations and others responsible for nursing workforce planning.

PHOTO: NURSING STANDARD

Older nurses should be supported to stay in the workforce.

Along with other international evidence, the brief draws on the *State of the World's Nursing (SOWN)* report.

The report, released for the 2020 International Year of the Nurse and Midwife, highlighted that one in six (17 per cent) of nurses around the world were aged 55 or over, and expected to retire within the next 10 years. It estimated 4.7 million "new" nurses would have to be educated and employed just to replace those older nurses who retire. And for every 10 "new" nurses required to address the global shortage of 5.9 million, another eight would have to be trained to replace those retiring in the next 10 years.

The policy brief, *Ageing Well? Policies to support older nurses at work*, says COVID-19 has exacerbated the worldwide nursing shortage. And older nurses were more vulnerable to COVID-19 so must be well protected in the workplace, it said.

There was a global risk some countries could meet their replacement needs by active international recruitment. "If not underpinned by an ethical approach . . . this may damage the nurse workforce capacity of some 'source' countries to meet immediate population health demands caused by COVID-19 and longer-term objectives of achieving universal health care," the brief said.

The reasons for examining the issue of older nurses in the workforce were "compelling", according to the brief's authors. Preventing, reducing or replacing the potential loss of skills and expertise was one of the main nursing workforce challenges facing many countries. Older nurses were more likely to have additional skills and advanced practice or specialist qualifications.

The brief pointed out that policy makers must be aware that their efforts to retain nurses for longer in the workforce would only be effective if they were tailored to the needs and expectations of older nurses.

The 10-point plan is:

- understand the workforce profile and employment needs of older nurses . . .;
- avoid age bias in recruitment and employment practices;
- provide flexible working opportunties that meet older nurses' requirements;
- ensure older nurses have equal access to learning and career opportunities;
- ensure occupational health and safety policies enable staff wellbeing;
- support job re-design to reduce heavy workloads and stress, and support job enrichment to optimise the contribution of older nurses;
- maintain a pay and benefits system that meets older nurses' needs and rewards experience;
- support older nurses in advanced and specialist practice, mentorship and preceptor roles;
- maintain succession planning to enable knowledge transfer and leadership development; and
- provide retirement planning options and, where appropriate, flexible pensions.

The report's authors are James Buchan of the ICNM, ICN chief executive Howard Catton and Franklin A Schaffer of CGFNS International. •

ICN congress to be virtual

THE INTERNATIONAL Council of Nurses (ICN) congress this year will be a virtual affair. With the theme, *Nursing Around the World*, it will take place virtually on November 2-4.

ICN is calling on nurses to share their ideas, research and expertise by submitting abstracts for the scientific programme.

The deadline for submission of abstracts is March 11. Details of the themes for abstracts and how to submit abstracts are available at: www.icncongress2021.org.

In a statement on the congress, ICN said it had hoped to celebrate the work of nurses and midwives internationally, during the inaugural International Year of the Nurse and Midwife last year and draw attention to often challenging conditions nurses faced.

"The arrival of the global COVID-19 pandemic emphasised, even more than our planned celebrations could have, the importance of the nursing workforce in this time of need. Nurses have been and continue to be at the centre of efforts to prevent, contain and manage this health emergency." •

'Significant' number apply for NZNO's top job

THERE HAD been "a significant number" of applications for the NZNO chief executive (CE) role, board member Simon Auty told *Kai Tiaki Nursing New Zealand*. Applications closed last month. Current CE Memo Musa announced his resignation in December, after nearly eight years in the job. He leaves on February 26.

Auty said the board's CE employment committee was "moving through the recruitment process" and hoped to appoint a new CE before Musa's last day.

(See also *Leading NZNO through turbulent times*, p14-15.) •

NZNO keen to see members vaccinated

NZNO WOULD be encouraging members to have a COVID-19 vaccination unless they had a medical reason not to, acting industrial services manager Glenda Alexander said.

Pfizer's COVID-19 vaccine was provisionally approved for use in New Zealand by Medsafe on February 3. An estimated 12,000 border and managed isolation/quarantine (MIF/MIQ) workers and their families or close contacts are first in line for the two-dose vaccination, due in March, according to the Ministry of Health (MoH).

"We don't think there will be many people who will not take up the opportunity to protect themselves and those they care for," Alexander said. "We don't have a lot of spare people if our workforce gets sick."

Overseas, the virus and new variants were running "rampant", she said. "It's not your average 'flu, it's pretty contagious and the new variants are a concern."

NZNO would likely take its lead from the MoH's COVID-19 vaccination guidelines for the health workforce – but she hoped nurses and their colleagues would not hesitate. "A well-read and informed workforce would have no problem with being vaccinated," Alexander said. "We support informed consent and support a vaccinated workforce."

PHOTO:ADOBE STOCK

Residential aged care provider, Arvida Group, on February 3 said any new staff must consent to a COVID-19 vaccination. Chief operating officer Jeremy Nicoll said he hoped this would protect the 5000 residents in its 32 facilities around the country.

Aged Care Association chief executive Simon Wallace has said he would expect all aged-care workers to be vaccinated to protect those they cared for.

Immunisation Advisory Centre (IMAC) national manager Loretta Roberts said they were ready, with preparations for a mass COVID-19 vaccination programme underway since April 2020.

An extra 2300 people were in training as vaccinators on top of an existing vaccination workforce of 5400. The new additions included retired health professionals, enrolled nurses, final-year medical, nursing and pharmacy students, dentists and physiotherapists, according to the MoH.

Now the vaccine was approved, 500 vaccinators could complete the COVID-19 training module and begin inoculating essential workers from next month, Roberts said.

More details on vaccinator training can be found at www.immune.org.nz.

Roberts urged nurses to sign up for the IMAC newsletter for up-to-date information. •

NZNO joins nurses' global call for better

CITING GROWING evidence on the risks of airborne COVID-19 infection, NZNO has joined a global call for better COVID-19 guidance and protection for nurses.

"WHO's (World Health Organization) weak guidance has left nurses, health care workers and patients unprotected, exposed and infected," Global Nurses United (GNU) said in a letter to WHO director-general Tedros Adhanom Ghebreyesus in November, 2020. "Thousands of health-care workers have died from COVID-19 around the world".

NZNO kaiwhakahaere Kerri Nuku and former president Heather Symes jointly signed the letter on behalf of NZNO, in a decision approved by the board electronically in November and ratified retrospectively at December's board meeting.

According to the GNU, recent research found tiny respiratory droplets could be transported as far as eight metres away when people breathed, talked, coughed or sneezed.[1] Studies had found infectious COVID-19 particles in the air two to five metres from infected patients[2] "providing further evidence for airborne/aerosol transmission".

Yet WHO had refused to recognise this, failing to meet its own obligations to be "guided by the best available science, evidence and technical expertise", GNU said in the letter.

Many nurses and health-care workers did not have sufficient personal protective equipment (PPE) or guidelines to care for their patients safely, leaving them exposed to infection and death.

The letter cited WHO reports that 14 per cent of COVID-19 cases worldwide were health-care workers – and in some countries as high as 35 per cent.

WHO must "immediately and fully recognise that airborne/aerosol transmission is a significant mode of transmission" and strengthen its guidelines on PPE and workplace safety to include airborne precautions when caring for suspected or confirmed COVID-19 patients. "Implementation of such precautions would have saved an untold number of lives," the letter stated.

An N95 respirator face mask, eye protection, fluid-impermeable gown and

Christchurch MIQ nurses paid less

NURSES WORKING in Auckland's managed isolation or quarantine facilities (MIF/MIQ) are getting paid higher rates than those in Canterbury, says an NZNO organiser.

Christchurch organiser Danielle Davies has told Canterbury District Health Board (CDHB) that all nurses working in MIQ facilities should be paid the same, no matter which city they were in.

NZNO delegates Mary Duggan (left) and Gemma Kelley (right) with organiser Danielle Davies.

Currently, nurses in Auckland MIQ facilities are being paid community nursing rates, which allows higher pay than the RN scale being paid by CDHB, her letter said.

Both scales are identical until steps 6 and 7, where the salary becomes higher for community nurses. The community nurse scale also has eight steps, compared to seven on the RN scale. "Most of our members employed with CDHB in MIQ are on step 6 or 7 and are thus disadvantaged being on the RN (inpatient) scale compared with Auckland DHB-based members."

The difference ranged from $1600 up to $5500 for experienced RNs.

"As all NZNO members employed by DHBs fall under the NZNO DHB MECA [multi-employer collective agreement] we are concerned by the disparities that have become apparent between the MIQ facilities."

Auckland nurses were also offered incentive payments into the thousands and extra leave, unlike those in Canterbury, Davies said. She understood the need for incentives to "entice" nurses into the MIQ workforce, but said they needed to be paid to all nurses, regardless of which MIQ they worked in.

A final disparity was the notice period, which was four weeks in Auckland and just one week in Canterbury.

NZNO wanted all its members working in MIQ facilities placed on the DHB community nursing scale, given back pay for lost income from the disparity and allowed accrued pay and leave incentives. All nurses should also have a four-week notice period.

"We appreciate that CDHB has had a very busy year and that we are now in December. However, the disparities our members are experiencing result in a real material impact, compounding as each day passes."

Acting executive director of nursing Becky Hickmott and other CDHB representatives acknowledged the disparities at a meeting with Davies and NZNO delegates on February 4. They agreed to immediately change the CDHB notice period to four weeks, Davies said.

The salary and incentive disparities would be raised with incoming chief executive Peter Bramley when he took up the role later this month, Davies said.

"We made it clear that any restitution would need to be retrospective." •

COVID-19 protection and guidance

Chair of NZNO's infection prevention and control nurses' college Carolyn Clissold

medical grade gloves should be the "absolute minimum" and full skin, hair and clothing coverage "optimal", GNU stated. PPE should always be worn when entering a COVID-19 patient's room.

GNU observed that COVID-19 was a new virus, with still many unanswered questions, meaning "the precautionary principle must govern decisions about protections.

"Instead, WHO's guidance on PPE and infection control ignored the precautionary principle, remains unprotective and continues to endanger nurses, health care workers and their patients."

GNU is a federation of nurse and health unions from 29 countries, 24 of which have signed the letter.

Infection prevention and control nurses college chair Carolyn Clissold said she felt for colleagues overseas who were facing "desperate situations".

However PPE was not the only way to protect workers – good airflow and hygiene practices, such as frequent surface cleaning and hand hygiene, were also important. "PPE is not everything," she said.

In New Zealand, the Ministry of Health, updated guidelines for workers in managed isolation/quarantine facilities in November after reviweing concerns about air transmission. It now advises using N95/P2 masks, when a two-metre distance cannot be maintained, for example when entering a guest's room. •

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Nurses buckle under 'relentless' workload

Nurses working in managed isolation and quarantine facilities are being socially ostracised, as well as dealing with suicidal and abusive guests. By co-editor Mary Longmore.

PHOTO: ADOBE STOCK

Auckland nurse Toni (not her real name) has been working in an Auckland managed isolation facility (MIF) since March 2020 and says nurses are starting to burn-out under a "relentless" workload.

"We don't stop, we are eating on the run – there are just constant jobs to attend to. People think all we are doing is temperature and health checks, but there are more than 200 of those to do every day in our hotel. Apart from that, we deal with a myriad of problems and illnesses."

An extra COVID-19 test is now required on arrival, on top of the day three and 12 nasal swab tests. This has added to the workload, which she says is also exacerbated by constantly changing rules and guidelines.

"It's really tough – we're getting really tired."

An experienced nurse who has spent many years working in remote communities overseas, Toni picked up some MIF shifts when lockdown hit. But even she – experienced in challenging environments – is considering quitting.

Nurses are regularly verbally abused, as guests "offload" their frustrations on the frontline workers – often, the only people they see. Mental health issues such as panic attacks and claustrophobia are frequent, triggered by the isolation. "People might have depression and anxiety, which is normally under control, but when they're alone in a room, and not sleeping, they can be triggered." Occasionally, there were suicidal guests, requiring extra vigilance. A widowed guest told nurses last year she no longer wished to live. Dealing with such anguish, without the ability to comfort with hugs and touch, required a lot of time and energy, as nurses tried to counsel within social distancing requirements, she says.

Toni is generally able to guide guests through breathing exercises from the doorway in her personal protective equipment (PPE), staying and talking them through their panic, anxiety or insomnia. Workers can also call in a community mental health team, when needed.

"We are doing it psychologically and emotionally tough – and who's looking after us?" Toni said. "We're looking after each other as best we can, but we are just so busy."

Moments of appreciation help – the gratitude of a family who needed to get a child to hospital quickly, or a nervous guest who appreciated how gently she was swabbed. "The good thing is we know we have helped people. We get letters and messages of gratitude – those are the things that keep us going, people thanking us."

The stigma and fear around COVID-19 contagion – usually poorly informed – meant nurses often kept to themselves after hours, fearing they might be a risk, or others' reactions.

'We get letters and messages of gratitude – those are the things that keep us going, people thanking us.'

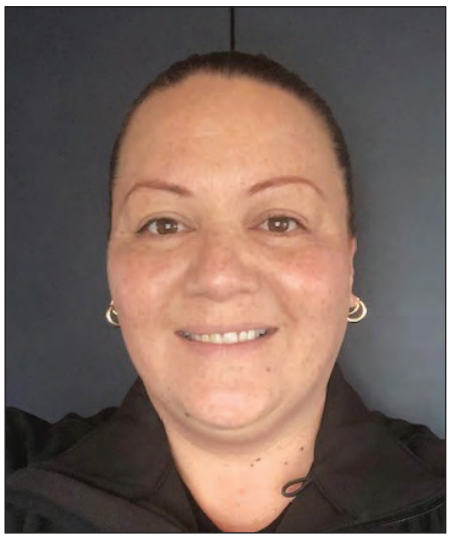
This sense of stigma had worsened lately, with new, more infectious variants spreading, Toni said.

Nonetheless, at work, the team made sure they found time to put some music on and have a sing while swabbing the guests – "that keeps us going".

Public health nurse and NZNO delegate, Carmel Farmer, who has worked in a different managed MIF in Auckland since late 2020, has also been taken aback by the prevalence of mental health issues among guests – claustrophobia, agoraphobia, food phobias and insomnia, to name a few. "I was really quite shocked to see so many young people with depression, anxiety, eating disorders and phobias like obsessive-compulsive disorder."

Such complex issues are daunting to deal with, without


Carmel Farmer


Sharleen Rapoto


Danielle Davies

knowing a person's history or being able to have in-depth consultations, and nurses were often without mental health experience. "We can't go into their rooms, we don't know their story, as there is only one of us on a shift."

Some have threatened to harm or kill themselves. "It's really scary stuff. We see five or six people with recognised mental health issues every day."

Nurses are mostly able to de-escalate situations and calm guests. However, a community team of mental health professionals is on call for all the MIF facilities, and was "fabulous" – although also pretty stretched, Farmer said.

She agreed the overall workload is "unbelievable. It's hard, very hard. We are constantly standing – it's relentless".

As well as the repeated swabbing of guests and staff, a typical day involves two nurses knocking at the rooms of up to 340 guests, stepping back to maintain a two-metre distance, verbally checking for any of the 12 COVID-19 symptoms and checking temperature. Face-to-face checks by nurses alternate with telephone calls by health-care assistants. Sometimes guests need pain relief or medication for long-term conditions, such as diabetes or hypertension.

Most – "95 per cent" – of guests are "delightful", but there are a few challenging ones, Farmer said. "Some people really appreciate us, but others not so much." Some of those are stressed, unwell – mentally or physically – or grieving for dying relatives they are trying to reach.

"They've come back because mum or dad is dying, so they're highly stressed and can be difficult to manage," she said. "They can be pretty abusive and rude."

The hardest thing for her is not being able to connect with guests in the way she does normally in the community, due to the sheer numbers.

"They never ask you your name, you don't build a relationship with them. There are not many connections made, it's just the nature of the beast. I find it a little frustrating. You feel like a servant at times."

Similarly, with constantly changing staff, she misses feeling part of a team. "You miss that human contact. You don't build rapport and connection – even with the other nurses, you don't know them, as we are moved around."

But there are also moments of connection. Those with insomnia are encouraged to ring down and talk to the night nurse, and often do so at 3am or 4am, just for a chat. "A nurse can be very kind and lovely for the people who are lonely and sad – and the night is very long for the people who are lonely and sad."

'A nurse can be very kind and lovely for the people who are lonely and sad – and the night is very long for the people who are lonely and sad.'

Farmer also got to know some guests, when she helped a new mother through breastfeeding issues and a young women with concerns for a sibling, always with a two-metre distance and PPE.

CHRISTCHURCH

NZNO Christchurch organiser Danielle Davies – who spent time working in an MIF facility last year – says there are about 66 NZNO members working in Christchurch facilities. Many are dealing with complex needs, including mental health, chronic conditions and the effects of an isolation setting.

The work is also impacting on their personal lives, with social ostracism from a fearful public. "Many have been told they're not welcome at Christmas events, school and parent events – the social impact is more than you could ever be paid for."

COVID-19's impact has caused significant upheaval in the lives of thousands of returnees going through managed isolation and quarantine, she says. While some guests have simply cut a holiday or trip short, many have lived away from New

'All they have got is us. The only people who converse with them are us. We are kind of filling a void where family should be.'

Gemma Kelley

Mary Duggan

'It's important to take the time to find out what's underlying their behaviour.'

Zealand for years and are disconnected from their home communities. For those most socially isolated, spending 14 days alone in a room can cause tremendous stress – particularly when they are having to rebuild their lives. "Nurses are charged with the difficult task of not only managing the COVID-19 testing and infection prevention and control, but also the holistic wellbeing of guests. When the stress boils over, nurses bear the brunt."

New graduate from Ara Institute of Canterbury, Gemma Kelley, and her preceptor Mary Duggan – both NZNO delegates – have been working in some of the six MIQ facilities across Christchurch for several months. Kelley is one of 12 Christchurch graduates who took up a nurse-entry-to-practice place in MIQ facilities. "I was interested – jobs were kind of scarce at the time," says Kelley, who had worked as a frontline ambulance officer for 13 years.

After a week-long orientation (which included a range of things from mental health, primary care, child and maternal health, cultural safety, Māori and Pacific health and managing sleep on shifts), she began working at the Novatel.

But, "I don't think anything can prepare you for entering that environment", Kelley said. She has now worked in three facilities, dealing with a range of illnesses, from cardiovascular to rheumatic heart disease and injuries – but found mental health issues the biggest challenge.

"It's a really mixed bag, but probably mental health and people's distress over their situation is the most prevalent thing."

People trying to reach loved ones before they died, the general effects of isolation – particularly for the young, those travelling alone or with language barriers or medical conditions – all contribute to high distress levels.

"Those are the people we try to maintain a bit more frequency of contact," Kelley said. "All they have got is us. The only people who converse with them is us. We are kind of filling a void where family should be."

When relatives die before guests can reach them, the nurses try to spend time talking to the guests and checking they are okay, she says. "It's almost as if we have to kind of meet everybody as if they have some element of distress in their lives and work together to support them."

If they need to enter the room, they must don full PPE "and that can be quite confronting" when nurses are trying to break down barriers.

She was also working at the city airport Sudima Hotel last November when an outbreak saw two nurses and several Russian and Ukrainian seamen infected. However, infection control processes had vastly improved since then, she said. N95 masks were now required for all interactions with guests, not just those with positive tests.

"I wasn't aware of how much risk I was at before – it was potentially catastrophic," Kelley said.

It is hard to face fear from the local community as a result of her work. "Our roles have meant we've become segregated in society, while we protect the wider community. At first, I felt it was quite a privilege, but now I'm aware there is an evolving stigma, and it feels like a burden."

Kelley has had flatmates move out due to perceived danger of her role and knows of others who were unable to attend Christmas festivities due to family fears.

Duggan, who returned from Queensland in August, says nurses are dealing with the "full spectrum" of health issues, including mental health and addictions. For the more complex cases, time and deeper conversations are required to understand what is going on with the guest."It's important to take the time to find out what's underlying their behaviour."

NZNO Auckland organiser Sharleen Rapoto says readily available PPE and consistent up-to-date guidelines on COVID-19 infection control are needed, particularly with the new variants. "If the communication [around guidelines] was clear to guests, that would decrease anxiety for our staff, as they're getting shot from all directions." •

Nicolette Sheridan

A career devoted to promoting equity

The head of Massey University's nursing school has had a lifelong commitment to promoting health equity.

Nicolette Sheridan, of Ngāpuhi descent, is a pioneering nursing educator. A registered nurse (RN) with a PhD and master of public health from the University of Auckland (UoA), she has more than 30 years' experience in clinical practice, education and research. She is now head of Massey University's school of nursing and director of the Centre for Nursing and Health Research.

She strongly believes the health system is a determinant of health and that nurses have a major role in creating a fairer health system. "This requires a commitment to health equity and the use of evidence to inform their actions when making decisions at all levels within the system, whether providing clinical services, developing policy or allocating resources."

She trained as an RN at Cook Hospital in Gisborne in the 1980s. Early career roles included public health nursing, occupational health nursing at an abattoir, practice nursing, district nursing visiting oncology patients at home and managing a hospital day-stay ward where patients received chemotherapy.

Before her role at Massey, Sheridan was the first associate dean (equity) in the Faculty of Medical and Health Sciences at the UoA. She held this role from 2008-2017. She won an excellence award in equity for building capacity with Māori postgraduate nursing students and a second award in 2012 for a research collaboration that put health equity on the agenda.

Sheridan is currently leading $1.3 million government-funded research into the effectiveness of primary care. The research is exploring the fact that, while general practice works well for some people, it does not work well for others, and that some ways of providing primary care are more equitable. Co-investigators are from five universities – Massey, Auckland, Otago, Cambridge in the United Kingdom and the Karolinska Institute (Sweden).

She was recently co-lead of a study, *Implementing models of primary health care for older adults with complex needs,* funded to the tune of $3 million by the Health Research Council (HRC) and the Canadian Institutes of Health Research.

The health system is a determinant of health and nurses have a major role in creating a fairer health system.

Before her role at UoA, she was head of health and social sciences at Te Tairawhiti Polytechnic for six years and completed a degree in occupational health practice from the University of Otago. She was commissioned by the then Health Funding Authority to evaluate integrated care and by South Auckland Healthcare – now Counties Manukau District Health Board (DHB) to design a research institute and clinical research centre.

Sheridan has led or been a co-investigator in more than 30 research projects. These have reported on the health-care experiences of Māori and Pacific older adults living with long term conditions, measured health equity in DHBs, tracked communication between clinicians and people newly-diagnosed with diabetes and evaluated the implementation of innovations to improve palliative care.

For a decade she was the New Zealand Qualifications Authority academic monitor for the bachelor of health sciences Māori nursing programme delivered by Te Whare Wanānga o Awanuiarāngi.

In 2000, together with UoA researcher Lorna Dyall, Sheridan won a Ministry of Health contract to deliver a pioneering postgraduate diploma in health sciences (Māori nursing) to 41 Māori nurses in "mobile disease state management". These nurses, all employed by Māori provider organisations, went on to deliver life-changing primary health care services across New Zealand.

In the last 12 months, under her leadership, Massey University has started a graduate entry-to-nursing programme, the master of clinical practice. The bachelor of nursing is delivered to 560 students on Wellington, Manawatu and Auckland campuses.

Public good and social responsibility are embedded in the school's culture. During the COVID-19 pandemic, the school was in a position to deliver, at no cost, two online critical care courses to more than 100 nurses in New Zealand and in Samoa, all supervised by critical care nurses and anaesthetists.

"As a country we have a history and culture of promoting human rights and indigenous rights. Nurses, as the largest group of health workers, can make a real difference by being culturally and clinically safe in practice, and as educators we have a responsibility to make this happen". •

** Information for this article was supplied by Massey University's public affairs and communications team, with additional information from the co-editors.*

Leading NZNO through turbulent times

Leading NZNO for the last eight years has not been an easy ride. Chief executive Memo Musa has decided it's time to move on.

By co-editor Teresa O'Connor

"It's time for someone else to do the juggling!" That's NZNO chief executive (CE) Memo Musa's sentiment as he steps down after eight years.

He says many people underestimate the complexity of NZNO – "the internal and external relationships, which bring different tensions and conflicts, both in interests and agendas".

Then there's the sheer scope of the work – industrial, professional, legal, policy, research, regulation and education. And that's not to mention an abiding commitment to equity and social justice. "It takes enormous time and effort to deal with interests of our diverse membership, the sometimes conflicting situations and demands, as well as the ongoing operational requirements," he explained. On top of that has been "the increasing and unnecessary abuse" on social media.

"Leading NZNO has become a real juggling act and it is time for someone else to do the juggling."

Despite the pressures and the governance turbulence of the last three years, Musa believes NZNO has continued to "move forward, punch above its weight on key issues and is listened to, taken seriously and respected".

'Many people underestimate the complexity of NZNO' – Memo Musa

'A nightmare to navigate'

He says the last three years of "unprecedented events and turbulence in our governance" has been a "nightmare to navigate" and undoubtedly the most difficult time of his tenure. That turbulence has included board complaint investigations, two special general meetings in 2019, the resignations of the vice-president, president and three board members in the first half of 2020 and the resignation of the next elected president late last year. And he had to decide whether to accept two member petitions arising from the turbulence – he rejected both.

All these issues took a lot of time and energy "which I would have preferred to put to more effective use elsewhere".

Despite this "negative energy", he was determined to navigate the turbulent waters. "As a leader, if you know what is right, you do the right thing, stay true to yourself and others, maintain your integrity and your moral, ethical and professional compass. Doing that gave me the resilience to work through those turbulent times. Bailing out was not an option, as during that time, NZNO continued to function well operationally. That gave me the perseverance to carry on."

As he reflects on his time as NZNO CE, Musa keeps returning to the issue of trust. "For the organisation to function effectively, it largely comes down to trust, respectful constructive relationships, team work and understanding the functions of governance and operations."

He believes the constitutional review – endorsed last year through the one-member one-vote system – will be challenging. "But I hope and believe it will bring greater transparency in governance, decision-making and member participation. And much-needed clarity between governance and operations."

The lack of trust and respect between NZNO governance and operations is not new. "It has been an ongoing hindrance and unnecessary distraction. I identified that in my first six months. Everyone worked hard to reignite trust and respectful, constructive relationships and to operate from a positive construct, rather than a negative and blaming one.

"You can have the best constitution or rules, the best governance structure founded on the premise of a bicultural partnership, the best guidelines, position statements and policy positions on various issues of importance to members, but these will not work or go far, nor will key parties take heed of them, if they are not, fundamentally, underpinned by trust and respectful relationships."

'A blaming culture'

And he sees the situation at NZNO in the context of the wider health sector. "The sector is riddled with a blaming culture. We must collectively work to change this and create a culture of accountability, not blame, and to stop the fear of retri-

bution for those who speak out."

Despite the time and energy diverted to governance issues over the last few years, Musa is pleased NZNO has remained influential at key union, health, nursing, social justice and policy tables. "NZNO is well respected. Without influence, without trusting constructive relationships, opportunities to advocate on behalf of members and the profession will be lost," he said.

"We continued to put forward strongly NZNO's perspectives on key issues in key forums. Even as COVID-19 took hold across the globe and in New Zealand through the lockdown, we were present where it mattered most, in the right forums to put members' professional and industrial issues forward."

He's always remembered the words of the president of the Canadian Federation of Nurses Unions, Linda Silas, at the 2014 NZNO conference: *"If you are not at the table, you are on the menu."* He's also found comfort in similar words from International Council of Nurses' president Annette Kennedy, who once said: *"If you are not invited to the table, take your own chair and join the table."*

NZNO 'at the table'

"In these tough governance times, the reality is NZNO has remained at the table and, where appropriate, we have taken a chair to the table, if not invited."

Musa believes NZNO's leadership and contribution in key areas has helped shape conversations. NZNO has lobbied hard for more health funding, equal pay, pay equity, safe staffing, full employment of new graduate nurses, a funded entry-to-practice programme for enrolled nurses, national nurse practitioner training, climate change and changes to employment and health and safety legislation.

"NZNO will continue to be influential where issues affect members and the profession. There have been some wins. However, due to the amount and complexity of the work, the wins quickly fade, as more issues constantly emerge, requiring our attention. This is due to a stretched and under-funded health system and a nursing workforce which is not growing fast enough to match population growth, an ageing population and increasing complexity in health needs."

Musa says it's easy to forget what has been gained and the progress made in chipping away at major issues which have been around for decades. "Not all issues can be solved instantly. We must celebrate and build on our wins, rather than saying they are not enough."

Musa praises the complex and unrelenting work of industrial and professional staff. "It's important NZNO's operational, industrial and professional advocacy is visible. We have committed staff, who go the extra mile for members and the profession as a whole, but sadly they are sometimes attacked on social media for their efforts. I back them to do the mahi and they need members' support."

Looking back, Musa has few regrets. "With the benefit of hindsight, there are some situations and things I would approach differently. As I reflect, I see NZNO's significant participation on key member matters. In our work with the Council of Trade Unions, the Nursing Council, nurse leaders, the Ministry of Health and other agencies, our relationships continue to strengthen and our input is sought. While we may not always agree, we put our viewpoint uncompromisingly on behalf of members."

'I was unable to moderate some of the abusive language on social media' – Memo Musa

But he does have one abiding regret. "I was unable to moderate some of the abusive language on social media, about the work of NZNO, its staff and governance. Some of it was directed at me personally. What I find sad is the potential damage this does to those subjected to it, and to the profession. I struggle to reconcile how someone can hide behind the keyboard and use vitriol towards their professional colleagues. I'm not sure how that contributes to constructive relationships and advancing nursing. I have learnt not to take things personally and I draw invaluable support from my network of colleagues, professional/management mentors, friends, family and my cultural background."

Cultural support

Musa hails from Zimbabwe. Part of his cultural support is a series of questions he received from elders in Zimbabwe and which he asks himself regularly: *Have you been true and honest to yourself? Have you been true and honest to others? Have you done something today which has intentionally or unintentionally hurt someone or something?* and *Are your key relationships intact?*

"My folk and mentors across the globe say that if the answer to most of these questions is 'yes', then rest and sleep with ease. However, this does not diminish the impact of the abuse or make it right."

He is looking forward to a renewed focus on mental health and addictions in his next role as CE of Platform/Atamira Trust. He hopes to return to nursing practice and education, pending agreement with the trust. "I want to get close to the reality of the policy, funding and health-system issues faced by non-governmental organisations in the mental health and addiction sectors."

Outside work, Musa's primary passion is football – he was in New Zealand's bronze-medal winning team at the World Masters Games in 2017 – and referees at top level. He also loves walking, biking – "on proper bikes, not electric ones" – cooking, reading and is a seasoned gardener. "I love gardening. We are self sufficient in most vegetables throughout the year. The best thing about gardening is that you do all the prepartory work, watch the plants grow and then harvest them. Plants do not answer back or abuse you – that's very soothing."

'Onwards and upwards'

As he hands over the juggling balls, Musa thanks NZNO's "highly spirited and committed" staff, the members he's worked with and current and former board members. "Despite the difficulties, there is only one way for NZNO – onwards and upwards. It's in good stead and can build further strength to achieve more wins for members." •

How Batman saved the classroom

Lecturer Shelley van der Krogt and admin/tech support staff member Caleb Finegan set up camera angles for the Batman classroom at the Massey University nursing school in Wellington.

The Caped Crusader brought the superpower of humour into an online nursing classroom during the COVID-19 lockdown.

By Shelley van der Krogt, Jenny K Green, Camille Manning and Marla Burrow

2020 was one of the most exceptional teaching years we have experienced. The pandemic and public health response severely disrupted all clinically-based teaching institutions around the world. Nursing schools everywhere were required to rapidly pivot their courses online to limit the disruption to teaching.

This article highlights elements that can successfully engage nursing students in online learning. There is minimal literature discussing the need for a holistic teaching design that promotes a non-threatening, learning environment and which encourages the free exchange of ideas and questions normally associated with face-to-face teaching. The online learning programme we designed at Massey University incorporates humour, game-based learning and consideration of students' wellness. We believe this will be of interest to our nursing colleagues, as well as those in other professions.

The focus of this course was health assessment and clinical decision-making. The learning objective was to equip first-year nursing students with the skills to assess each body system and make clinical decisions based on subjective and objective data.

Using humour in nursing practice can be an effective way of building connections between nurses, and with patients.

Before COVID-19, teaching students these skills relied heavily on face-to-face and hands-on interactions, with students pairing up to practise history-taking, inspection, percussion, palpation and auscultation. Social-distancing guidelines following the COVID-19 outbreaks in Aotearoa New Zealand prevented this mode of delivery. A new strategy was needed to provide interactive learning to help students develop these clinical skills.

To adapt the course for online learning, we decided one teacher would demonstrate health-assessment skills on a live model, streaming to all students via Zoom across Massey's three campuses. The teacher would both demonstrate clinical skills, and encourage online participation by the students. But we wanted to go further, by adding an element of fun. Enter Batman, stage right, to bring a playful context to our teaching.

Using humour in nursing practice can be an effective way of building connections between nurses, and with patients.[1] Some may dismiss humour as unimportant in the patient-nurse relationship, or as unprofessional.[2] However, research has shown the value of humour in encouraging communication and building relationships, especially in stressful situations.[1]

Humour can also help reduce the power imbalance between students and teachers. Laughing together provides a moment of understanding and connection between learners and teachers. During the 2020 lockdown, students were desperate to continue their education, but heightened stress levels had become a significant barrier to learning. Humour allows for cognitive reframing of stressful or uncomfortable situations, making them appear less threatening or distressing.[3] Time out from a highly stressed state can provide collective respite for students in the online classroom. Humour can create a positive learning environment, which encourages interaction.[4]

Counteracting anxiety

To make online learning about clinical assessment fun, we chose the "Caped Crusader" as our clinical model. The evolution of a Batman-inspired classroom created the opportunity to counteract potential anxiety.

Batman is a well-known character. Using his back story gave the subjective health history questions a humorous twist that resonated with the students while still conveying essential learning information. Our sessions were live-streamed to three campuses simultaneously, allowing students real-time access to see and interact with each body system's health assessment.

Choosing to have our live model wear a superhero mask provided an element of anonymity, but also a sense of mystery and connection. Students were drawn into the Batman persona and fully engaged with learning about physical health assessment skills in the online environment. Batman created a relaxed and fun learning environment, which encouraged students to ask questions and contribute to the class. The chat function within the Zoom classroom was frequently used to ask questions or make humorous comments about Batman. Two lecturers monitored this and provided ongoing, immediate feedback and answers. Occasional reminders were needed to focus students on the assessment rather than adding yet another pun about Batman movie sequels!

Observing Batman's walking co-ordination was important for his neurological assessment.

Use of touch

As well as providing a respite from COVID-19 related stressors, the Batman classroom also presented students with the opportunity to observe how both humour and touch can be incorporated into their clinical practice. Massey nursing lecturers role-modelled the use of humour in the hui process[5] which is used at the start of the online lesson, and while teaching health assessment. This validates and strengthens the use of humour as a communication tool. Seeing first-hand the teacher use humour to connect with Batman signalled to students that humour is an acceptable and valuable nursing skill. There were many moments of laughter shared between Batman and the teacher during the assessment, and this was reflected in the developing professional relationship.

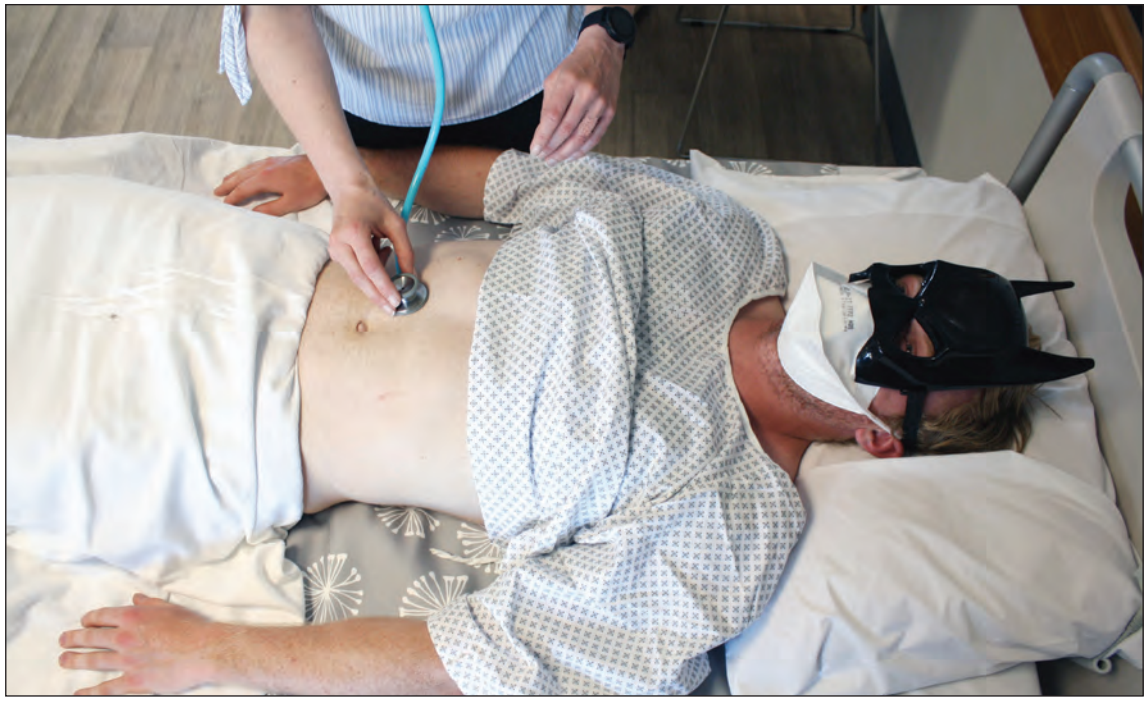
Therapeutic touch was also role-modelled, reinforcing the role it can play in maintaining psychological wellbeing.[6] During physical assessments, and at the conclusion of the interaction, touch was used to both connect to and reassure Batman. Students can often be hesitant to use touch because of concerns about the touch being seen as inappropriate.[6] By normalising and providing real-life examples of touch, students' fears can be reduced, allowing them to accept and incorporate these elements into clinical practice. This was especially relevant during a time when physical proximity and touch were discouraged and warned against in wider society under pandemic controls.

Demonstrating therapeutic touch and excellent hand hygiene in the online classroom reminded students about the importance of looking after pa-

tient wellbeing in clinical settings.

While the online classroom was fun, the enjoyment didn't stop there for those of us involved in organising this lesson. It flowed over behind the scenes. We worked in a team of six: four teachers, Batman and one admin/technical support person. Everyone contributed their expertise and shared ideas. This created a vibrant and collegial environment both in and out of the online classroom.

The division of labour to match the strength of each team member allowed some respite from the pressure COVID-19 created in the academic environment. Working to our strengths in this extraordinary time allowed a flexibility which is rarely available in academia, creating its own energy and excitement. Collaborating across three campuses helped reduce isolation and strengthened our mental wellbeing and resilience. This reduction in personal stress was evident in our relaxed delivery while teaching in this novel learning environment and enabled us to role-model calm and professional personas.



Assessment of Batman's abdominal sounds.

Our online classroom provided an anchor for both staff and student wellbeing through creation of a playful environment, which was further reinforced with inclusion of a yoga session. All lecturers took part and wore Batman-branded clothing to continue the playful theme. Staff and students practised breathing and yoga poses, which helped reduce stress both inside and outside the classroom. Staff from the student health and wellbeing service ran this session, sharing their expertise in mindfulness and yoga techniques.

The collegial relationships formed through this experience have strengthened partnerships with departments outside nursing. This interprofessional collaboration has sparked future planning to include other superheroes in the classroom. Further mindfulness sessions have been included in the curriculum for 2021, as 2020 highlighted the need to build and foster resilience.

Positive feedback

The Batman classroom was a success for both students and teachers, as demonstrated by the overwhelmingly positive feedback. In a time of global and national uncertainty, Batman provided humour and playfulness that was greatly appreciated by staff and students, helping to manage rising stress. Role-modelling the use of humour and touch while conducting a health assessment gave students the opportunity to reflect and evaluate how they might develop these skills within the restricted environment created by COVID-19.

Once students returned to the face-to-face classroom, after physical distancing restrictions were lifted, they were enthusiastic and primed to practise health assessment skills. The relationships created across campuses and interprofessionally have proven invaluable and now provide ongoing opportunities to enhance the curriculum and the wellbeing of staff and students. •

Staff involved in the Batman online classroom won the 2020 ASCILITE teaching innovation award. ASCILITE is a not-for-profit organisation promoting the use of technology to enhance tertiary education.

Shelley van der Krogt, RN, MHC, is a senior tutor at the School of Nursing, Massey University, Wellington. **Jenny K Green RN, MPhil (Nursing),** is a senior lecturer at the School of Nursing, Massey University, Albany. **Camille Manning, RN, MN,** is a professional clinician at the School of Nursing, Massey University, Manawatu. **Marla Burrow, RN, CNL (AACN), MS,** is a lecturer at the School of Nursing, Massey University, Manawatu.

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Achieving equitable access to medicines

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How to change lives:

Prescribing equity through better use of medicines

THE CALL for equity in health care is not new, but is louder now than it has ever been. The release of the Waitangi Tribunal report on primary health care, the investigation of the Health and Disability System Review Panel and a growing swathe of published research underlining inequitable health outcomes for Māori and Pacific peoples and disadvantaged populations, add to the zeitgeist.

PHARMAC Te Pātaka Whaioranga, the government health agency that decides which medicines and medical devices are funded, has added its voice, with a determination to eliminate inequity in access to medicines. A new programme – He Ako Hiringa – aims to drive that target.

An end to inequity in medicine access: it's a bold call from PHARMAC and one that requires a commitment beyond your standard government agency undertaking. The agency is focused on five key drivers – medicine availability, accessibility, affordability, acceptability and appropriateness – with the aim of changing people's lives. And those who prescribe, dispense and deliver medicines are being called to drive this change.

In *Achieving medicine access equity in Aotearoa New Zealand: Towards a theory of change,* published last year, PHARMAC lays down the gauntlet – everyone involved in health care needs to facilitate equitable access to funded medicines. It gives Māori, as Te Tiriti o Waitangi partners, highest priority in this plan for change.

"Medicine access equity means that everyone should have a fair opportunity to access funded medicines to attain their full health potential, and that no one should be disadvantaged from achieving this potential." That's the definition PHARMAC is working from.

According to the Ministry of Health in its *Health and Independence Report 2016,* when compared to other New Zealanders, *"Māori and Pacific people are two to three times more likely to die of conditions that could have been avoided if effective and timely health care had been available".*

As PHARMAC puts it: *"Treating people equally under the current system will never eliminate inequities."*

Series focuses on medicines equity

THIS YEAR, *Kai Tiaki Nursing New Zealand* will be publishing a series of articles supplied by He Ako Hiringa to support nurses' professional development.

He Ako Hiringa is a clinical education programme for primary care clinicians delivered by Matui Ltd, a joint venture between The Health Media – publisher of *New Zealand Doctor|Rata Aotearoa* and *Pharmacy Today|Kaitiaki Rongoā o te Wā* – and health data company Airmed.

The programme is funded by PHARMAC Te Pātaka Whaioranga and aims to raise awareness of health inequities and improve access to funded medicines for those who are missing out. Priority populations include Māori, Pacific peoples, rural communities, former refugees, and those living in high socioeconomic deprivation.

To have the biggest impact on patient health, He Ako Hiringa will also focus on four conditions significantly amenable to treatment with medicine. These are asthma, cardiovascular disease, diabetes and gout. Five main drivers of medicine access equity have been identified: medicine availability, accessibility, affordability, acceptability and appropriateness. Nurses can have a huge impact on these drivers.

PHARMAC's former acting medical director, Ken Clark, says health professionals have a big role to play in access to medicines in New Zealand. He hopes providing free resources and tools will promote the responsible use of pharmaceuticals and encourage more equitable access. •

At the helm of PHARMAC's commitment to equity is its manager of Access Equity, pharmacist Sandhaya (Sandy) Bhawan.

Bhawan was raised in Fiji, and was inspired to study pharmacy by an uncle who ran a pharmacy there. As a child, Bhawan recalls seeing locals knocking on her uncle's door after hours for help.

The social upheaval wrought by Fiji's 1987 coup saw her family emigrate to New Zealand. After attaining a science degree from Victoria University, Bhawan worked as a science technician before becoming the first Pacific student to finish top of the class when she graduated with a pharmacy degree with honours from the University of Otago in 1996.

It was in 2012, while working at Te Awakairangi Health Network, a primary health organisation (PHO) serving high-needs populations in the Hutt Valley, that her passion for improving access to medicine took shape.

She recalls a particular moment when she was referred a patient with diabetes who had missed several appointments. The patient was not picking up repeat prescriptions nor undertaking requested lab tests.

"When she came, I was prepared with my spiel, my agenda, a list of reasons she ought to be taking her medication, including benefits for her whānau and her quality of life.

"She stopped me and said, 'It's not that I don't want to take these medications: I just don't have the money to renew the prescriptions every three months. Isn't taking some every second or third day better than not taking it at all?' "

Bhawan says she thinks of that patient every day.

"The majority of the time, people absolutely know the reasons why medicines are prescribed and ought to be taken – it's just their social circumstances are so dire . . . health seems to be the last priority amidst other things they are facing."

Systems lie at the heart of medicines access equity, she says.

And knowing that, clinicians might be inclined to throw their hands in the air, thinking the structural challenges hamper any potential to have an impact on inequity.

But, Bhawan says, clinicians can make a big difference by partnering with NGOs and following campaigns to reduce the prevalence of targeted diseases and by using audit tools to monitor patient outcomes.

To this end, PHARMAC has contracted clinical education and data analytics company Matui to increase awareness and action on medicine access equity by providing resources to support primary health care professionals. Matui is a joint venture between health data science company Airmed and health care communications company The Health Media.

The programme, He Ako Hiringa, follows in the footsteps of work carried out by providers of CPD for health-care professionals, BPACnz, based at the University of Otago, and the Goodfellow Unit, based at the University of Auckland.

'Four conditions: gout, cardiovascular disease, diabetes and asthma, they are our biggest priorities.'

Anna Mickell, programme manager for He Ako Hiringa, highlights its goals.

"The aims of He Ako Hiringa are easy to understand. We are calling on primary care clinicians to work together and with us to deal to medicine access equity once and for all."

With a focus on conditions amenable to treatment with medicines, and patient groups who tend to experience higher levels of inequity, He Ako Hiringa aims to have the biggest impact on patient health possible.

"Four conditions, gout, cardiovascular disease, diabetes and asthma, are our biggest priorities. We know the root causes of disparities in treatment of these conditions are social and one key way we can assist in reducing these social inequities is by getting people access to medicine."

Mickell explains that while the problem is complicated, clinicians can make a difference.

"Clinicians can't fix housing, clinicians

SANDY BHAWAN

'The majority of the time, people absolutely know the reasons why medicines are prescribed and ought to be taken – it's just their social circumstances are so dire . . . '

ANNA MICKELL

'Clinicians can't fix housing, clinicians can't fix the economy . . . What clinicians can do is give patients access to medicine and help them persist with taking it.'

MARGARET HAND

'Patients will often tell you what they think you want to hear rather than what actually matters for them. They're trying to make you feel good. That's why having an honest conversation is important.'

SUE CRENGLE

'It's easy for inequities to slip into our practice without us being aware they have.'

can't fix the economy, but they can still do something meaningful. What clinicians can do is give patients access to medicine and help them persist with taking it. So let's work on that and get this right for the patients who have been left behind."

Change starts with clinicians looking at their behaviour. That is the experience of clinicians interviewed for this article – GPs, pharmacists and nurse practitioners uncovering inequity and seeking ways to improve outcomes for patients.

In Whangārei's Otangarei, a suburb where 48 per cent of homes are state houses, concern for the health of whānau was the catalyst for the small thriving community getting behind the establishment of the local health clinic.

Te Hau Āwhiowhio ō Otangarei Trust nurse practitioner Margaret Hand (Te Roroa, Ngāti Whātua) works in the nurse-led clinic with an enrolled population of 1800 predominantly Māori patients.

A common theme for many patients is wanting to live long enough to see their mokopuna (grandchildren) grow up, but sadly this is not always the case.

Lack of a living wage is one of the most inequitable factors affecting patients, Hand says.

"Try living on $40 a week. Many patients will never admit to this, but this is the reality of those living on the lowest income in New Zealand."

For Hand, access to medication means asking patients a really hard question, namely, "Can you afford to pay for your medications?"

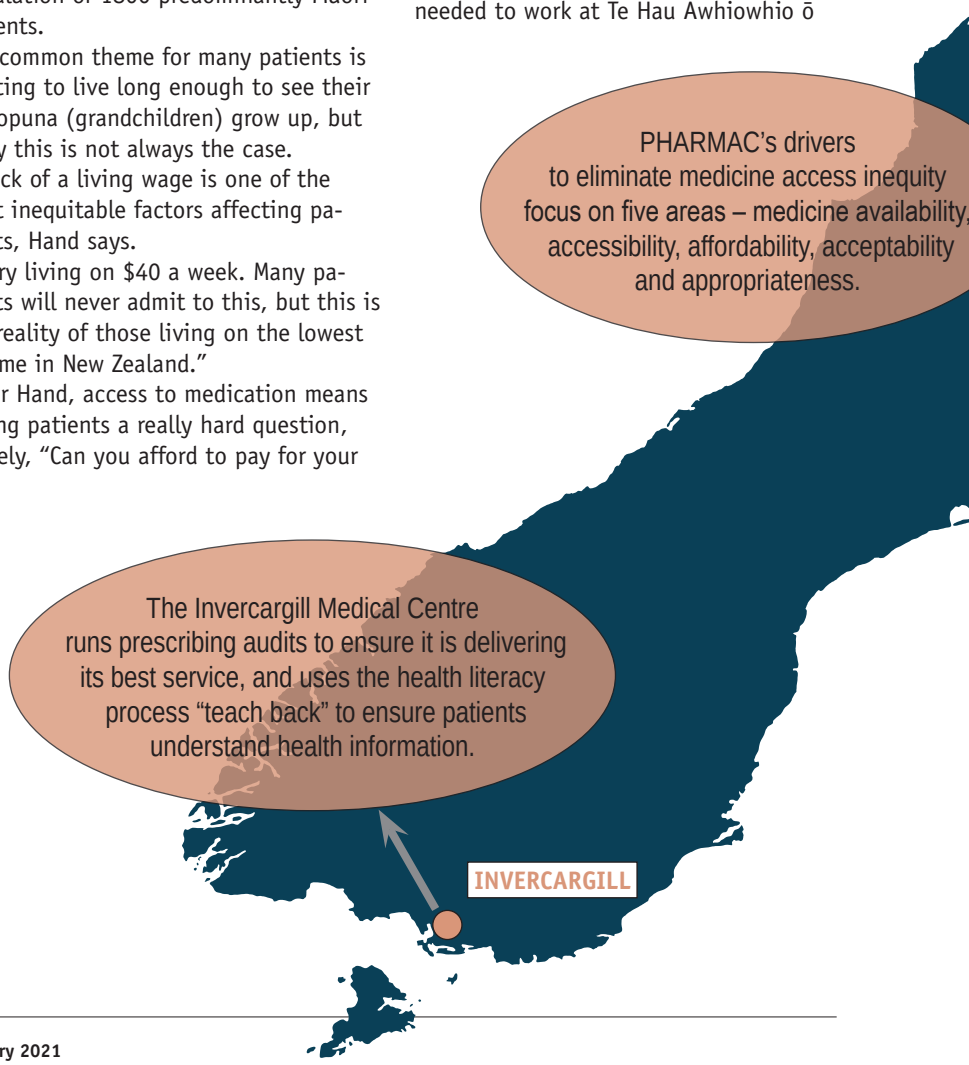
"I guess most of us think if we ask that question it will create more work and of course they will say 'no'. The answer is often 'yes, but only on pay day'. That's two days away, and I need them to start their diuretic today.

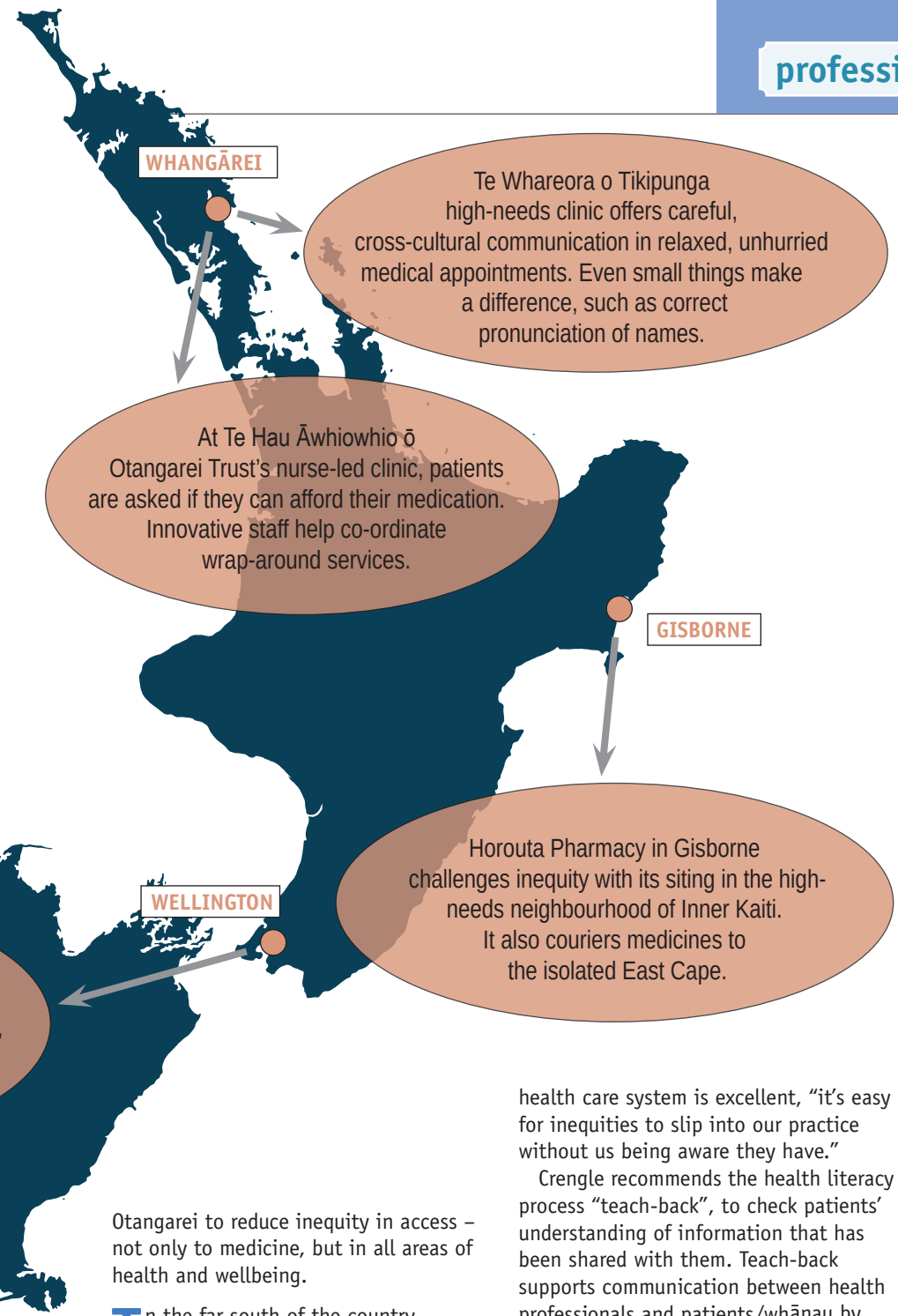
"Patients will often tell you what they think you want to hear, rather than what actually matters for them. They're trying to make you feel good. That's why having an honest conversation is important," she says.

A solution is trying to walk in the patient's shoes and coordinate wrap-around services and good communication with pharmacists, Hand says.

The use of standing orders also helps improve access to medicines. Three clinicians from the trust are involved with the multidisciplinary Northland Medicines Management Group that is developing a peer-reviewed set of standing orders.

Hand says her team is innovative and creative. These are the credentials needed to work at Te Hau Āwhiowhio ō





Otangarei to reduce inequity in access – not only to medicine, but in all areas of health and wellbeing.

In the far south of the country, University of Otago Māori health researcher and Invercargill GP Sue Crengle (Kāi Tahu, Kāti Māmoe, Waitaha) knows doctors feel uncomfortable if they think they are not delivering their best.

Running prescribing audits on their own data can help clarify how well they are doing, Crengle says.

She practises two half days per week at the Invercargill Medical Centre, a practice with a variety of ages, ethnicities and deprivation profiles among its 13,000 patients, about 2000 of them Māori.

She says while much of the primary health care system is excellent, "it's easy for inequities to slip into our practice without us being aware they have."

Crengle recommends the health literacy process "teach-back", to check patients' understanding of information that has been shared with them. Teach-back supports communication between health professionals and patients/whānau by providing an opportunity for the health professional to check how clearly they have communicated important information, and to "fill in the gaps" if needed.

"Being Māori, I've been committed to Māori health from very early on in my career," Crengle says.

"The foundations of health and well-being are unequally distributed, so we are more likely to have histories of deprivation, risky occupations – the whole gamut of social determinants of health. We also experience differences in access to and quality of care.

KEVIN PEWHAIRANGI

'Having the right conversations is essential, specifically about gout.'

ANIVA LAWRENCE

'When junior doctors are placed with us, I say you spend six years learning medical language then six years un-learning. It's important to be able to relate to all walks of life.'

IAIN BUCHANAN

'We've created an atmosphere in which we're there to help people without telling them what to do. We're helping them to make good choices.'

"If you look along a clinical pathway, for example bowel cancer, you see a similar incidence in populations, but Māori mortality is much worse. But there's not one big thing we can fix – it's a little bit of a lot of things right along the pathway."

Gisborne pharmacist Kevin Pewhairangi (Ngāti Porou, Ngāti Ira, Te Aitanga a Hauiti, Ngāti Whakaue) established Horouta Pharmacy in 2019 to challenge inequity by reducing the physical barriers to access and positioning the pharmacy in the high-needs neighbourhood of Inner Kaiti, across the river from the city centre.

"For parents pushing their babies in the pram in the rain having to get to the health centre in the city, that doesn't tell me equity. We decided it was appropriate to put a pharmacy on this side of the river."

Even though the next pharmacy might not seem too far away, at three to four kilometres, for people without cars or with illegal cars, that's not ideal, Pewhairangi says. His pharmacy also offers courier delivery up to 2.5 hours away in remote East Cape, where there are no pharmacies.

Further barriers exist within the pharmacy itself. Pewhairangi says the "four-walls, white-jacket approach" may give patients the perception that they are being talked down to. Pharmacists need to relax the environment and make themselves and their services approachable.

Having the right conversations is essential, he says, specifically about gout. PHARMAC's reporting shows gout is over-treated with anti-inflammatories and under-treated with allopurinol.[1]

Pewhairangi recommends all health practitioners undergo a Māori cultural experience to improve their understanding of te ao Māori.

Just two per cent of pharmacists are Māori and that needs to change, he says. Greater Māori representation in the health workforce would bring a better connection with Māori and whānau, greater understanding of medicines and, ultimately, improved health outcomes.

Back up north in Whangārei, Te Whareora o Tikipunga owner and GP Aniva Lawrence says her high-needs clinic does its best to reduce inequity from the moment patients step through the door.

The clinic offers careful, cross-cultural communication in relaxed, unhurried medical appointments, Lawrence says. Even small things can make a difference, for instance "if names are pronounced incorrectly patients are less likely to open up and disclose the things that are worrying them".

She draws her inspiration to improve health outcomes from her Samoan family, from the tragedy of seeing people die before they should.

"My grandmother had lung cancer caused by smoking. From an equity aspect, those things directly impact on how you view the world. Sometimes the systems are against populations, or set up to deliver in an inequitable way.

"When junior doctors are placed with us, I say you spend six years learning medical language then six years un-learning. It's important to be able to relate to all walks of life."

Te Whareora o Tikipunga has an enrolled patient population of around 4000, 78 per cent of whom are Māori. Most of the staff are also Māori or Pacific.

EVIDENCE OF INEQUITY

asthma

PHOTOS: ADOBE STOCK

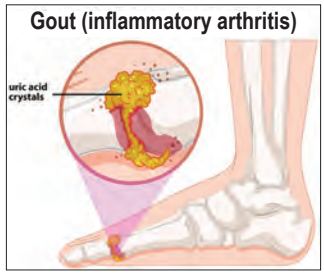
Hospital admission rates:

11.8/1000
Pacific children

8.1/1000
Māori children

4.3/1000
European/other children

gout



The prevalence of gout is

4x higher in Māori
aged 20–44 years, and

8x higher in Pacific
peoples aged 20–44 years than non-Māori, non-Pacific populations.

Māori and Pacific peoples are less likely to receive regular urate-lowering therapy than non-Māori, non-Pacific peoples.

Source: Health Quality & Safety Commission 2018

The clinic aims for patients to be able to see a regular doctor for continuity of care. Staff have weekly meetings to talk about whānau they are working with. They keep an eye on data showing people who are overdue for diabetes check-ups, provide education on the genetic factors affecting gout, provide outreach to patients who might otherwise drop off the radar, and offer advice and treatment to people with mental health challenges.

Health improvement practitioners, health coaches and social workers are all on the team and virtual consultations are on offer.

The big picture: "When people . . . feel like they have more control over their wellbeing, they're empowered to make those changes themselves," Lawrence says.

An unusual feature of the practice is a shared lunchroom with the pharmacy next door. That pharmacy is Unichem Buchanan's Kiripaka Pharmacy.

Owner and pharmacist Iain Buchanan recounts his recent experience building a relationship with a whānau whose kuia required palliative care. Good service began with stepping out from behind the pharmacy counter.

Buchanan explains that he delivered the medication following the kuia's discharge from hospital on a Friday afternoon, and spent almost an hour talking with whānau and answering their questions.

"That allowed me to understand what the whānau's requirements were," he says.

While the kuia has since passed away, the constructive relationship between whānau and pharmacist remains.

Buchanan says about his community: "We've created an atmosphere in which we're there to help people without telling them what to do. We're helping them to make good choices. It's more than simply saying, 'Here is the medication, here are the side effects.' "

His experience tells him that Māori especially appreciate relationships being formed and the clinician understanding where they are coming from.

He recommends being mindful of the role family hierarchy plays, and offering an environment in which patients don't feel they're wasting anyone's time or feel they should already know everything. He also advises clinicians to offer 0800 numbers for people who struggle to have credit on their cellphones, offer flexible pharmacy opening hours, and make the most of targeted programmes such as Gout Stop.

He delivered the medication following the kuia's discharge from hospital on a Friday afternoon, and spent almost an hour talking with whānau and answering their questions.

Buchanan is bold in his view of pharmacy's role. Boldness is also plain in the pages of PHARMAC's medicine access equity plan.

In her foreword, PHARMAC chief executive Sarah Fitt writes: "We deliberately chose to be bold, as we know that change is needed."

The agency aims to become a "tenacious influencer", nudging other decision and policy-makers in the direction of improving health equity, which is one of the Government's four priorities for health.

Fitt says: "But we can't achieve change alone – it requires committed collaboration across the whole health system." •

Interviews by Northland journalist Michael Botur

Learning to create equity – join us

ACHIEVING MEDICINE access equity in Aotearoa will be no mean feat, but clinical education and data analytics company Matui plans to encourage change with its new programme, He Ako Hiringa.

He Ako Hiringa provides free evidence-informed and data-led educational resources for primary care clinicians. The focus is on reducing medicine access inequities and on conditions amenable to treatment with medicine. Learning opportunities are provided through a variety of platforms – tailored to what works best for the clinician.

Clinicians also have access to their prescribing data through the He Ako Hiringa EPiC Dashboard – EPiC stands for Evaluating Prescribing to Inform Care. The dashboard is an interactive tool that shows comparative prescribing rates and trends, includes narratives on what's going well and provides links to further resources.

He Ako Hiringa's name highlights its educational goals. **Ako** means to learn or study, while **Hiringa** means energy, perseverance, determination, inspiration and vitality.

Find out more at www.akohiringa.co.nz •

EARN 1.5 CPD HOURS

Nurses can claim 1.5 professional development hours by

- **reading this article**
- **reading PHARMAC's document *Achieving medicine access equity in Aotearoa New Zealand: Towards a theory of change,* and**
- **watching He Ako Hiringa's video *Medicine access equity: A call to action.***

Both the video and PHARMAC report can be found at www.akohiringa.co.nz

Reference

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Full house of student leaders for 2021

After a chaotic year in 2020, the National Student Unit (NSU) once again has a full cohort of leaders.

"This year we are really looking to focus on getting into our roles and building up the unit," returning chair Mikaela Hellier (Ngâti Hine), told *Kai Tiaki Nursing New Zealand*. In 2020, "we were very limited in what we were able to do".

Not only did COVID-19 bring huge uncertainty to nursing schools nationally, but the NSU vice-chair Trudi Kent was killed in a car accident in in July.

"Amongst all the chaos, there were times I thought 'I can't do this anymore'," Hellier said.

But with the support of former Te Rûnanga Tauira (TRT) chair Tracy Black – who acted in a tuakana or mentoring, role – her co-leaders who stepped up to support NSU, and NZNO staff, Hellier kept going.

"We were the people everyone turned to for answers."

Delegation, sharing of the workload and keeping connected were vital elements.

"Communication is the biggest thing I learned to maintain. Talking every week [with co-leaders] about what we need to focus on was really important."

NZNO acting associate professional services manager Kate Weston and nursing and professional services manager Mairi Lucas also provided a huge amount of support. "One day I hope to be equally as hard-working as those two incredible women."

In her third year at Te Whare Wânanga o Awanuiârangi in Whakatâne, Hellier is interested in paediatrics but also women's health, since experiencing endometriosis, and maternal and child health. She has also found her place of calm working in high pressure environments such as intensive care or emergency nursing. "Organised chaos is where I want to be."

Returning Te Rûnanga Tauira chair Kimmel Manning, Ngâi Tahu, wants to see NZNO's student arm return as a "major political voice for nursing students in Aotearoa" this year.

"COVID-19 caused a lot of chaos in our schools of nursing, and it is imperative that we build students' capacity to participate in NZNO processes so we can have a seat at the table and speak to the issues affecting us."

That included a long-term strategic focus, and efforts to ensure all nursing schools were represented on the NSU, as well as succession planning for future leadership. "This year will be about re-establishing NSU. There are a lot of new people [student representatives] and they will need a lot of guidance."

The short-term nature of the roles, meant it had been difficult to get traction on entrenched problems such as bullying. However the NSU leadership was determined to address this in 2021, he said.

A third year student at Southern Institute of Technology (SIT), Manning chose nursing after growing up witnessing many whânau member with health issues – "physical, mental, addictions" – unable to get help.

Clockwise, from top left: NSU leaders Mikaela Hellier, Kimmel Manning, Lucinda Solomon and Jade Power.

Ko Takitimu te maunga
Ko Aparima te awa
Ko Takitimu te waka
Ko Ngâi Tahu te iwi
Ko Takutai o Te Tîtî te marae
Ko Kimmel Manning tôku ingoa

Ko wai au ko Moumoukai te maunga
Ko Takitimu te waka
ko Waikerepu te awa
ko Manutai te marae
Ko Ngâti Rakaipaaka te hapû
ko Ngâti Kahungunu te iwi
Ko Lucinda Solomon tôku ingoa

'Amongst all the chaos, there were times I thought, I can't do this anymore'.

"I remember going to these appointments and it felt like people weren't listening. I felt there was a gap that needed to be filled," he said. "And we need more diversity in nursing, and everywhere these days."

Raised between Invercargill and Brisbane, Manning's whânau was "materially" poor but valued education highly. They supported him to be the first member of his family to not only study at degree-level but to complete high school. "Whenever I have been given an opportunity, I try and see what I can learn."

For incoming NSU vice-chair Jade Power nursing "has always been my dream".

Having spent time in hospital as a young child, "nurses have always been individuals I have looked up to", she

Focus on student bullying planned

Like many others, the National Student Unit (NSU) has faced many difficult challenges and obstacles in 2020.

We had hoped to hit the ground running and achieve some of the goals set in our first meeting, particularly around growing kawa whakaruruhau – cultural safety.

Sadly, COVID-19 disrupted our hopes. Despite this, we commend our student representatives for their hard work and advocacy over the year.

We tried to respond to students' needs head-on, using Zoom to discuss issues. But when we finally were able to fly to Wellington in December to meet face to face, we accomplished so much more and collaborated seamlessly – as we had hoped to from the beginning.

At our first meeting in January this year, via Zoom, our intention to build a more solid foundation through more collaboration, became clear. We hope to keep building on this momentum, and have established a strategic and work plan to keep on track.

Bullying

Our key areas of focus include bullying, increasing our student advocacy and re-establishing relationships with other NZNO member groups.

We recognise that bullying continues to be a huge issue faced by student nurses regularly. We all want this to be resolved and see a new nursing culture evolve in which bullying plays no part.

National Student Unit (NSU) chair Mikaela Hellier (right) in 2020 with former NSU vice-chair, the late Trudi Kent.

Last year we were sad to lose one of our most bubbly and passionate student representatives.

The NSU, with the support of NZNO researchers, will also be surveying students throughout the first six months of the year about a range of topics from bullying and kawa whakaruruhau to the impact of COVID-19. Results will be shared at the heads of schools meeting in July.

We are also working on two remits. One is to restructure NSU rules and expectations, as we feel some of these are outdated and do not suit our needs.

The other aims to encourage students to retain their NZNO membership throughout their studies and careers.

Last year we were sad to lose one of our most bubbly and passionate student representatives.

We would like to acknowledge Trudi Kent for the time she shared with us. She is missed dearly by all who had the pleasure of knowing her.

We would also like to acknowledge the leaving members. At the end of last year and start of this year, we have had to say goodbye to many of our year-three students, who are now registered nurses.

We are all very proud of you for reaching registration and we wish you all the best with your careers.

This year the NSU, including Te Rûnanga Tauira (TRT), has a full team of chairs and vice chairs.

It has been a long time coming, but we all look forward to helping drive the NSU towards a successful future. •

Report by NSU/TRT leaders

'I felt like there was a gap that needed to be filled. And we need more diversity in nursing, and everywhere these days'.

said. "Being a nurse is one of the most wonderful professions in the world."

In her second year of nursing studies at Otago Polytechnic in Dunedin, Power joined NSU to support other students and nurses – and be a "friendly face" for those with concerns.

TRT vice-chair Lucinda Solomon is a third-year student at Whitireia's bachelor of nursing Mâori. Previously a beauty therapist, she was keen to get into dermatology and cosmetic medicine. But it also opened her eyes to other possibilties. "I was given the chance to be me, to be Mâori. I sit in a class of people who understand me and I don't have to hide it from anyone. They have given me strength to push myself further and not to focus on working with the skin but also working with our people."

She hoped to advocate for other students in her new role – which she says is "the best move" she's made. "Last year we got really lost and this year, I want to really push things for students." •

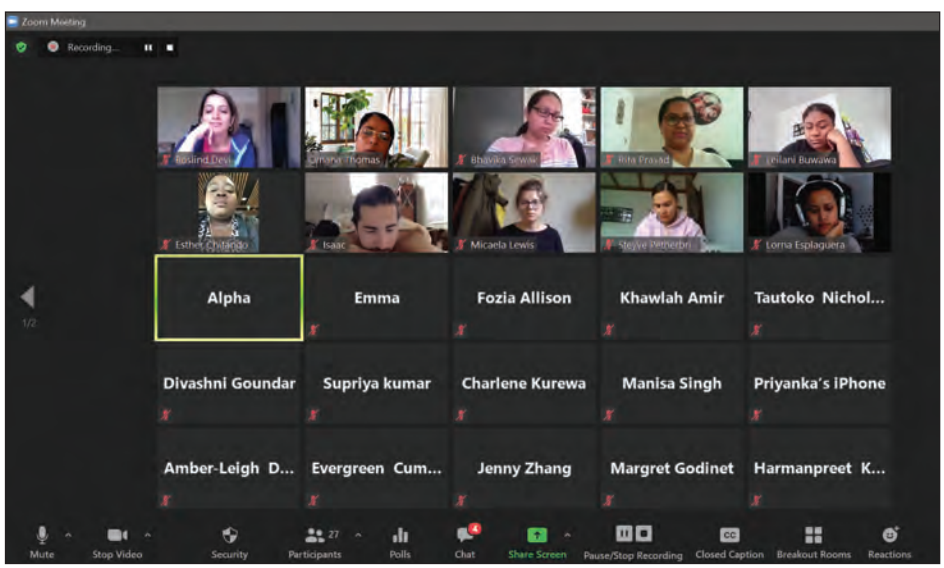
Report by co-editor Mary Longmore

The COVID-19 pandemic brought major change to how nursing education is provided. However, although remote education works well for didactic teaching, it cannot replace the hands-on experience of clinical placements.

Face-to-face learning: MIT nursing lecturer Omana Thomas (left) with students during 2020.

Pandemic brings paradigm shift

By Omana Thomas



Remote real-time learning on Zoom: Omana Thomas with a class of nursing students during lockdown.

The COVID-19 pandemic has disrupted the education of some 1.6 billion learners around the world, requiring a shift to distance learning.[1]

Data supports the use of some distance or blended education in health care.[2] Use of videoconferencing tools (such as Zoom or Teams) has allowed nursing education to continue through a fundamentally new approach – where groups of students can learn together, remotely, in real time.[3] The strengths and weakness of these novel teaching approaches in nursing education are now emerging.

Technology's effect

Technology has made possible unprecedented connections between instructors and students, and among students. Initially based on a classic distance education format, technology has enhanced equitable education[4] through an approach that has allowed students to work at their own pace, at any distance from the education provider.[5] The latest technology, which combines technology-based learning with face-to-face learning[6] has liberated education from the classically-structured classroom paradigm. Early work suggests that for many disciplines this blended teaching method may be superior to traditional face-to-face lecturing,[7] yet nursing may be an outlier in these success stories.

In recent times, nursing education programmes have been slowly transforming teaching methods by reducing the number of lectures and using technology to drive self-directed, individualised learning. The COVID-19 lockdown brought an unprecedented paradigm shift as a result of social distancing, isolation and quarantine measures. For many educational institutions, Zoom and Teams were the educational approaches which allowed learning to continue.[4,5] Lecturers had to change teaching plans, ensure students had access to technology and update all electronic resources.

At the Manukau Institute of Technology (MIT) in South Auckland, our nursing students are streamed into two groups. Challenges arose for Stream A students, who do their clinical placements earlier in the year. When the lockdown was implemented, they were removed from

clinical placements during the fifth of their seven-week clinical period. This meant they were unable to complete their learning assignments, which jeopardised their ability to demonstrate their clinical competency. However they were able to complete this work later, in one-on-one Zoom sessions with their lecturer. Stream B students continued their classroom learning via Zoom during the lockdown, and were able to do their clinical placements as normal later in the year.

The main insurmountable challenge in remotely educating nurses is the need to provide students with the hands-on, mentored experience of simply observing the actions of working nurses . . .

Learning remotely

All of these changes were unexpected for students and teachers; however, through this experience, we had some notable successes.[7] Teaching student nurses during lockdown required lecturers to quickly gain competence with new technologies and an untested route of delivery. For the didactic (teaching) component of undergraduate education, Zoom enabled and encouraged contact, greatly increasing cooperation between students and lecturers.

Breakout rooms (a feature of Zoom, allowing a meeting to break up into separate sessions) enhanced interactive learning and interested students received extra tutorials. Virtual lectures were recorded and catalogued, so students who were unable to join the online classroom still had access to the learning materials.[4] In certain situations, this platform allowed two individuals to co-teach, bringing unprecedented synergy.[2] Thus, for the didactic portion of nursing education, students kept pace with the historic learning milestones.

Challenges with remote learning

However, the move to more remote education has highlighted significant challenges that distance learning poses for nursing. Some of these challenges are easy to address, such as students lacking computer devices or having problems with internet connectivity. Other challenges, such as students experiencing a reduced attention span during online learning, compared to face-to-face sessions,[8] are hard to surmount.

The main insurmountable challenge in remotely educating nurses is the need to provide students with the hands-on, mentored experience of simply observing the actions of working nurses, such as answering call bells and interacting with patients.[9] We do not currently have an educational approach to achieve the equivalent of the hands-on practical nurse education students require and the immersion into the nursing professional culture in practice.

During the COVID-19 crisis, simulation – whether virtual or interactive – was used as the best-available option for meeting requirements for clinical-placement hours.[9]

Nursing is fundamentally a service career, involving patient care and a practice profession. Technology-focused education delivery has a place in didactic teaching in nursing education, but lacks the interpersonal interactions necessary for nurses to become competent providers of holistic patient-centred care.[10] Moving didactic teaching to a distance platform makes sense, but we cannot educate nurses to enter a practice profession without the human interaction patient-centred nursing care requires. •

Omana Thomas, RN, RM, MN, is a lecturer in the Faculty of Nursing and Health Studies, Manukau Institute of Technology, Auckland.

Simulation learning: Lecturer Omana Thomas using a manikin to guide students on how to deal with a patient with chest pain.

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Why are employers not providing a cheaper, more effective option than the N95 mask?

Which respirator offers best pandemic protection?

By Simon Auty

NZNO's board has signalled its intent that the organisation be led by the best most up-to-date science in its response to the COVID-19 pandemic. It has done so with the adoption of the Global Nurses United (GNU) statement to the World Health Organization (WHO) and the John Snow Memorandum (see p44).[1,2]

With this in mind, it's important to understand why GNU (and so NZNO) is advocating for improved personal protective equipment (PPE), including powered air-purifying respirators (PAPR), for health-care staff working in areas where there are suspected or confirmed COVID-19 positive patients. This is especially important for staff working in emergency departments (who will see emergent cases), and in managed isolation and quarantine facilities (MIF/MIQ).

Health and safety

Under the Health and Safety at Work Act, there is a hierarchy of processes to protect employees from a hazard in the workplace. This starts with eliminating the hazard. In this hierarchy, PPE is the final option, so an employer has to have exhausted other means of protecting workers from an occupational hazard. Obviously where the hazard is a virus, health-care workers must have appropriate PPE.[3]

Under law, PPE must be provided by the employer and they cannot charge you for it. You can provide your own (your employer should reimburse you for this) if it is your genuine choice and voluntary.

PPE must be:

- *"suitable for the nature of the work and any risks associated with the work"*
- *"suitable size and fit and reasonably comfortable"*
- *"compatible with any other PPE the employee is required to wear or use"*.

Employees must *"receive information and training on how to correctly use, wear and maintain it"*.

Simon Auty (above) with the PAPR kit, and (above right) modelling its use.

It must be used or worn as instructed and *"should meet any industry-specific requirements or standards"*.[4,5]

In the case of the biological hazard SARS CoV-2 virus, a variety of organisations have made recommendations that have evolved as the science has. These organisations range from WHO, the Centers for Disease Control and Prevention (CDC) in the United States, the European Union Occupational Safety and Health Authority (EU-OSHA) and New Zealand's Ministry of Health (MoH) and district health boards (DHBs).

In New Zealand, these recommendations are in the form of "guidelines" and advice, so unfortunately do not have the regulatory authority of an industry standard. Also, MoH and DHB advice hasn't changed since July 2020. The MoH is still saying that transmission *"occurs mainly through respiratory droplets generated by coughing and sneezing, and through contact with contaminated surfaces"*.[6]

In this advice, the MoH recommends following contact and droplet precautions for probable and confirmed cases of COVID-19, and airborne precautions only when an aerosol-generating procedure is to be performed. The recommended PPE for contact and airborne precautions is *"long sleeve impervious gown, gloves, eye protection and particulate respirator (N95/P2 mask)"*.[6]

This advice, published on July 3, 2020, soon became outdated by the science when the WHO taskforce on infection control technical leader Benedetta Allegranzi acknowledged the airborne route in a press conference on July 7.[7]

There is also little evidence of transmission via surface contact. Research published in September found patient

fomites and surfaces are not contaminated with viable virus.[8] The CDC now states that: "Spread from touching surfaces is not thought to be the main way the virus spreads".[9]

N95 v PAPR

According to MoH advice, an N95 respirator is recommended for aerosol-generating procedures. It is important to understand exactly what an N95 respirator is. So, what does N95 mean?

- **N:** This is the respirator rating letter class. It stands for "non-oil", meaning that if no oil-based particulates are present, then you can use the mask in the work environment. Other masks ratings are R (resistant to oil for eight hours) and P (oil proof).
- **95:** Masks ending in a 95 have a 95 per cent efficiency, meaning they screen out 95 percent of particles down to 0.3 microns in size. Masks ending in a 99 have a 99 per cent efficiency. Masks ending in 100 are 99.97 per cent efficient, which is the same standard as a HEPA (high efficiency particulate air) quality filter.
- **0.3 microns:** The masks filter out contaminants like dusts, mists and fumes. According to the CDC, the mask will prevent particles or droplets down to a size of 0.3 microns from passing through. Because of turbulent airflow through the fibres, a properly-fitted N95 respirator can filter out particulates smaller than 0.3 microns, but how effective it is at this is unknown.[10]

However, N95 respirators are made for industry, not health care, and are mainly made to fit men. So the PPE we are given to wear is designed for nine per cent of the workforce. In a 2020 study by the University of Western Australia, it was found that N95 respirators fitted 85 per cent of women and that dropped to 60 per cent for Asian women.[11,12]

PAPR sets provide integrated protection that can fit a wider range of staff, including those with a beard or glasses. Because PAPR sets have removable interchangeable filters, they can also provide a higher level of respiratory protection. Due to their reusability, PAPR sets also have significant cost and environmental benefits over disposable N95 respirators.[13,14]

Size, aerosols and transmission

The SARS CoV-2 virus is between 0.125 and 0.140 microns in size. This doesn't mean that a properly-fitting N95 respirator isn't effective at reducing the wearer's exposure. The key phrase, however, is "properly fitting". The "one-size-fits-all" approach to PPE provision means that a significant proportion of the health-care workforce will not be protected because the provided equipment does not fit. Remember the employer is obligated under law to provide properly-fitting PPE.

MoH advice on only wearing N95s during aerosol-generating procedures and social distancing is based on a fundamental misunderstanding of droplet/aerosol behaviour. Depending on airflow conditions, many particles that would be classified as "large" (diameter >5 microns) can travel much farther than the "mythical" 1-2 metres distance, within which such particles are claimed to fall to the ground. So taking this into account, even large particles can also behave like traditional "aerosols".

N95 respirators are made for industry, not health care, and are mainly made to fit men.

An article published in January 2021 in the *Journal of Hospital Infection* notes: *"Although we do not yet have genotypic evidence that inhaled virus causes COVID-19 in humans, many outbreaks are difficult to explain other than inhalation of aerosolised SARS-CoV-2"*.[15,16]

Conclusion

PAPR is not only more effective, it is cheaper and more environmentally friendly than N95 respirators.

MoH advice needs to be updated to reflect the airborne transmission of COVID-19 and the increased risks posed by the emerging variants.

WorkSafe's tool for selecting appropriate respiratory protection isn't suitable in the case of biological hazard. But if you were working in a confined space (patient room) with a fine dust that, if inhaled, could cause serious harm, then the tool says you should be wearing a breathing apparatus.[17]

The question must therefore be asked: Is it because of cost or some other reason that employers do not provide better respiratory protection, despite their legal obligation to do so? •

Simon Auty, RN, PGDip health informatics, is a theatre nurse with training in health and safety, and wears a mask every day at work. He is also a member of NZNO's board of directors.

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How well is patient-centred care applied in practice?

Patient-centred care is an ideal of nursing practice. How well is it applied in practice? A group of students share their thoughts and experiences.

By Georgia Bond, Joshua Christiaan, Michael Kessell, Maryanne Ma'asi, Sarah McCulloch, Stephanie Tea and Kylie Hodgson.

Patient-centred care (PCC), as defined by the Institute of Medicine, provides care that is responsive to, and respectful of each patient's needs, values and preferences, to ensure the individual's values guide all clinical decisions.[1] This is a crucial health-care concept as it separates disease (characterised by pathophysiological aspects, such as symptoms, diagnosis and treatment) and illness (describing the overall patient experience, including the effect on individual wellbeing, feelings, ideas and lifestyle).[2] Understanding these differences enables the health-care professional to understand the disease and work alongside patients as they experience illness, to increase patient-centred decision-making.[2]

To highlight the importance of this health-care model, this article explores cultural safety, family/patient support networks, active patient involvement and participation in care, and the nurse-patient relationship. It incorporates personal experiences from our clinical placements to demonstrate how these concepts are utilised in health care from the perspective of a student nurse. We also include practices we feel can be improved to ensure the best patient outcomes.

▶ **Cultural safety:** Cultural safety has been defined as: *"An outcome of nursing education that enables a safe, appropriate and acceptable service that has been defined by those who receive it."*[3] This encompasses, but is not limited to, differences in ethnicity, religious beliefs, sexual orientation, gender, age, socioeconomic status and disability.[4] It is enacted by the nurse, but allows the recipient of care to determine whether their care was safe.[5] Safety is a subjective term that is deliberately used to give the person receiving health care the power.[5] Cultural safety is also included in the Nursing Council's *Code of Conduct* (the code). Principle two is: *"Respect for the cultural needs and values of health consumers".*[4] Failure to fulfil this principle would breach the standards registered nurses (RN) are expected to uphold.

Cultural safety is a vital component of the undergraduate nursing curriculum and is in the forefront of many student nurses' minds during clinical placements. However, this concept was only developed in the early 1990s and therefore differences exist in its implementation.[5]

An experience recalled by a second-year student nurse demonstrates the contrast between the concept of cultural safety and its lack of implementation by some RNs. The student nurse and their assigned preceptor were undertaking the care of an elderly Indian woman who did not speak English and was reliant on her family to translate. None of the health-care staff had provided this woman or her whānau with communication resources, such as the translating service.

The student nurse was asked to assist the woman with hygiene care. The student questioned their preceptor about how they were supposed to ask permission, as the family was not present to translate. The RN dismissed the query, replying that the patient didn't care. No attempt was made to communicate with, or gain consent from the patient. When there is no attempt made to communicate, nurses can't deliver culturally competent care. Standard 2.2 of the Nursing Council's code states the nurse must: *"Assist the health consumer to gain appropriate support and representation from those who understand the health consumer's first language culture, needs, and preferences."*[4]

The preceding scenario breached this right. The care was not culturally safe and therefore not patient-centred. The link between these two concepts is mutually inclusive because it would be impossible to achieve PCC without considering what was most important to a patient.

The foundations for cultural safety are cultural awareness and cultural sensitivity. Cultural awareness is the first step in sensitising people to differences. Cultural sensitivity involves alertness to the legitimacy of difference, self-exploration, and the impact this may have on our treatment of others.[5] In our clinical experience, RNs attended frequent workshops related to clinical nursing skills. However, none we knew of were patient-centred education sessions.

▶ **Family and patient support networks:** Family and support networks are an essential aspect of PCC.[6] Families have been defined as close blood relatives, such as children, siblings or relations through marriage.[7] Close friends are also considered family to some, as support networks are individualised, depending on personal values.[7]

Nurses must respect that patients have the right to have one or more support people during their care, if they choose, except where the safety of the patient or support person may be compromised.[8]

Support networks are essential for patients, as they provide extensive informal care and are an integral part of patients' psychosocial context and family members create an environment that enhances patient safety within the hospital.[6] There is a correlation between family support in a hospital environment and good

PHOTO: GOOGLE IMAGES

Family and support networks are an essential aspect of patient-centred care.

health outcomes,[9] so it is crucial nurses promote these relationships. However, some patients may have no such support.

One student nurse experienced the use of family and support networks in the clinical setting. The student explained that, during the care of a patient, the patient's wife and daughter would always be there, attend to cares and assist in translation, as the patient spoke Tongan and could not fluently speak or understand English. The family members were active participants in this patient's care. They also supported him by attending his procedures, such as colonoscopy, as was agreed to by the staff involved. Staff greatly appreciated this family support, as it improved the patient's care and ensured his family advocated for him. This example shows how family and support networks can benefit patients in health-care settings.

A recent systematic review summarises research papers related to interventions that showed an improvement in health or wellbeing for the family as a whole.[10] It includes home-visiting services, the Whānau Ora programme, and brain injury intervention.[10] These nursing interventions were successful in improving the health of patients. The literature review stated that: *"The identified papers include some models and some tools which may be useful for consideration by services aiming to effect change at the level of the family in Counties Manukau".*[10] This research could be used in other district health boards to emphasise the importance of the family's involvement in PCC.

▶ **Patient participation:** Patient participation is a fundamental concept of PCC[11] and is reflected through patient engagement and involvement with their care and wellbeing.[12] Terms considered synonymous with participation include engagement, involvement, collaboration and cooperation.[11]

Patient participation encompasses patient involvement in informed decision-making, enabling patients to express opinions regarding various treatment alternatives and consent to health team instructions.[12] Patient participation is essential in health-care decision-making and widely regarded as significant in health-care quality, patient safety and clinical effectiveness.[13]

By respecting patient autonomy and empowering patients in their treatment, adherence to the treatment plan is promoted.[12] This enhances patient wellbeing and ensures better provision of health maintenance services. Other benefits include the promotion of patient knowledge, satisfaction, perceived quality of care and, ultimately, an improvement in their condition.[12]

However, in clinical practice, patient participation can occasionally be poor, as experienced by a second-year student nurse. Nurses planned the care for the patients at the nurses' station, based on entries and recommendations written by the medical team from the previous shift. They did this without meeting the patient or asking for patient input. There are various challenges in involving patients in their care, including patient enthusiasm, the nurse's approach and ambiguous expectations and roles.[11] The severity of the patient's condition may impede some forms of participation. The patient's inclination to be active, collaborative or passive in their patient role, in conjunction with different understandings of patient and nurse collaboration, can further hinder patient involvement. Nurses can create barriers to patient involvement, eg being task-focused, appearing busy, or making assumptions about what patients want.[11]

However, principle three of the code promotes advocacy and protection of patient wellbeing by working in partnership with the patient.[4] It highlights the significance of upholding patients' independence, perceptions and preferences.

Nurses can, therefore, facilitate patient involvement through bedside handovers. Patients prefer bedside handovers to traditional private office handovers, due to the social aspects.[14] Patients get to meet and familiarise themselves with the nurses taking care of them and are included in discussions related to their wellbeing. Assumptions and misconceptions are mitigated, as patients are present for clarification and can contribute to decision-making.

By inviting and encouraging patient input, nurses foster a genuine relationship with their patients, which further enhances patients' engagement in their care and perception of self-worth.[14] Nurses also benefit from these interactions by being able to assess the patient and assess patient participation.[11] The differing expectations of nurse-patient partnerships are thus addressed.[14]

A second-year student nurse's positive experience illustrates the use of patient participation to attain PCC. A patient was about to be discharged and told the student nurse of his apprehension about the health-care team's wish that he self-inject medication subcutaneously. The student nurse acknowledged the patient's fear and discussed alternatives and potential actions by the nurse and student

nurse to support him in managing his care, including education and supervision with his self-injections. The patient then decided to practise self-injecting medication subcutaneously under the guidance of the nurse and student nurse. Initially, he was cautious and hesitant. However, by the time the patient was ready to be discharged, his confidence had increased greatly. He was capable and competent in self-administering medication. This exemplifies how patient empowerment and wellbeing is achieved when patients collaborate and engage in their care, leading to the overall promotion of PCC.

▶ **Nurse-patient relationship:** A beneficial nurse-patient relationship plays an integral role in PCC. It is paramount that nurses and other health professionals foster trusting relationships with their patients. The code states that such relationships are built on respect, partnership and integrity.[4] From a clinical perspective, when patients trust their health-care professionals more, they are more likely to demonstrate healthy behaviours, experience fewer symptoms, and indicate a higher quality of life and satisfaction with their care.[15]

Although establishing a therapeutic relationship is considered mutually beneficial, several barriers may prevent a nurse from building such connections. Effective communication is needed to establish a trusting relationship, but language differences often prevent nurses from understanding a patient's concerns.[16] While the use of professional interpreters can improve care and communication between patient and care providers, research indicates the quality of communication between a provider and patient, even with interpreters, remains suboptimal.[17] Family members can help to an extent. However, they lack the training and understanding of medical terminology that professional interpreters have.[18]

Caring for patients for whom English is not their language can also prove a challenge, as interpreters can only be booked for a short period. Without interpreters, instructions can be misunderstood and the establishment of a trusting relationship can be hampered.

The time constraints nurses are routinely under are also a barrier to establishing patient-centred communication.[13] One study found that these time constraints led to a focus on diagnosis and treatment, potentially preventing a nurse from asking the patient to voice any concerns.[13] The same study also found that patients expected nurses to be busy. This was another barrier to communication, as patients felt reluctant to ask questions, out of respect for the nurse's time.[13]

In our clinical experience, we found nurses often tried to engage with patients regularly. The patients themselves also held a great deal of respect for the nurses and generally followed instructions. However, work overload was an obstacle to patient-centred communication in some cases. In a conversation with a student nurse, one dissatisfied patient complained of nurse negligence and a lack of involvement in her care. The student nurse who cared for her admitted the day was hectic, and work overload was a significant factor in preventing effective communication.

▶ **Practice recommendations for the nurse-patient relationship:** Solving the burden of work overload on a nurse's shift is a complicated issue, but attempts to improve work distribution may allow nurses more time to initiate conversations between patients and improve patient-centred communication. Encouraging student nurses to take more responsibility for their patients will also help them improve their time management skills. A difference in spoken language is another difficult issue to resolve. One way to address this issue is to focus on recruiting an ethnically and linguistically diverse workforce.[17] By doing this, nurses may be able to better empathise and communicate with patients who are more comfortable speaking in their home tongue, thus promoting patient-centred communication.[17]

While PCC is taught thoroughly, there are barriers to fully implementing it in the clinical environment. It is up to all nurses – students and RNs – to work towards meeting the ideal of PCC in all clinical settings. •

Georgia Bond, Joshua Christiaan, Michael Kessell, Maryanne Ma'asi, Sarah McCulloch and **Stephanie Tea** were second-year nursing students at the University of Auckland when they wrote this article, with the guidance of their lecturer **Kylie Hodgson**.

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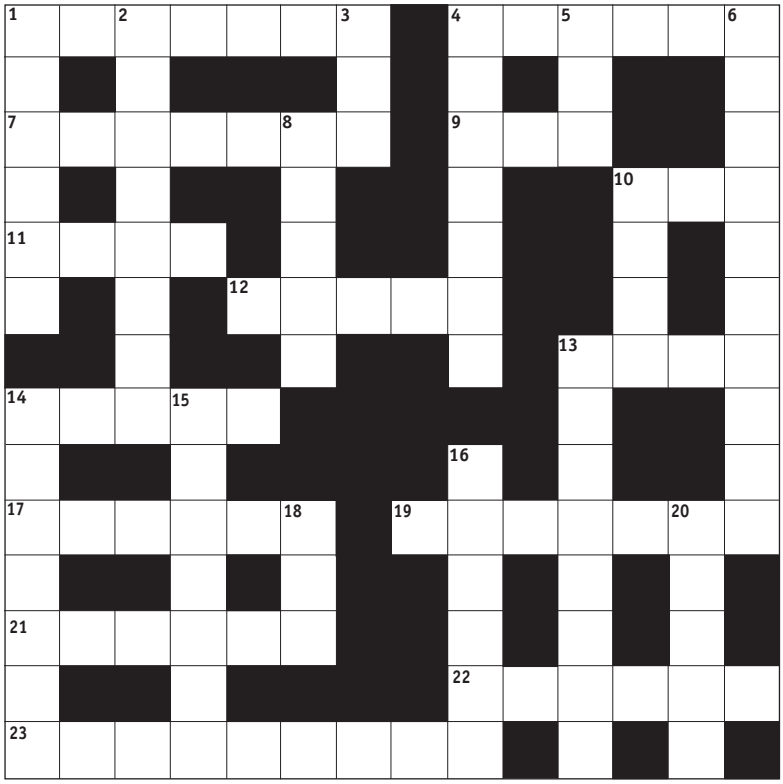
crossWORD

Completing this will be easier if you have read our Dec/Jan issue. Answers in March.



ACROSS

1) Substance providing immunity to infectious disease.
4) Causes vomiting.
7) Support (Māori).
9) A grain used in whisky.
10) Small specific program designed for mobile devices.
11) Prospect of danger.
12) Sadness about loss.
13) Pull sharply.
14) Fast and superficial.
17) Milky Way.
19) Brother or sister.
21) Arm joints.
22) Pay attention.
23) Get rid of.

DOWN

1) Participants in election.
2) Advises.
3) Conscious self.
4) Keeps ear warm.
5) Night before.
6) Contentious issue for Capital & Coast nurses.
8) The largest one is Tāne Mahuta.
10) Old land measurement.
13) Envy.
14) Cleanliness.
15) Old-fashioned cafe.
16) New health minister.
18) Affirmative reply.
20) Unclothed.

Dec/Jan answers. ACROSS: 1. Wisdom. 4. Albino. 8. Trendcare. 8. Ado. 9. Knit. 10. Ire. 11. Kuia. 12. Reins. 13. Mince. 15. Fatigue. 17. Twin. 20. Seclusion. 21. Die. 22. Boasts. 23. Portal. **DOWN:** 1. Wainuiomata. 2. Suture. 3. Minimum. 4. Arc. 5. Barrier. 6. Obedience. 9. Kaumātua. 14. Consent. 16. Global. 19. Brass. 21. Duo.

wiseWORDS

> “It is only when you have grazed on the lower slopes of your own ignorance, and begun to understand the great vistas of non-knowledge that you have, that you can claim to have been educated at all.”

Christopher Hitchens (1949-2011), British/US journalist, author and orator

it’s cool to kōrero

HAERE MAI and welcome to the first column for 2021. Kawakawa is a native shrub with large, heart-shaped leaves, and is one of the most important herbs in rongoā Māori, with many medicinal uses. Sometimes called "the pharmacy of the forest", kawakawa is anti-microbial, so useful for fighting infections, and also has properties which can help heal minor cuts, stings and rashes, and ease pain, inflammation and digestive upsets.*

In te ao Māori, kawakawa also has spiritual meaning – it is used in tapu-lifting ceremonies, and is also a symbol of death.

Kupu hou

New word

- **Kawakawa** – *pronounced "kah-wah-kah-wah""*
- **Kei roto i ngā rongoā Māori he tipu nui ā kawakawa.**

Kawakawa is an important plant in Māori medicine.

Rerenga kōrero

Phrases

This issue focuses on students and education. Here are some useful phrases:

- **Kia ora, ko Aroha tāku ingoa. He tapuhi kaitiaki tauira āhau.**

Hello, my name is Aroha.
I am a student nurse.

- **Ko taku hiahia kai tiaki au i ngā kaumātua.**

I want to work in aged care.

- **I whiwhia tāku whakamātautau.**

I passed my exams.

- **Whakamihi!**

Congratulations!

* NZNO has a position statement on use of rongoā Māori and complementary therapies in nursing practice (see tinyurl.com/oo0cz9fu).

E mihi ana ki a Titihuia Pakeho and Keelan Ransfield.

The impact of racism on

Institutional racism and unconscious bias play a significant role in the high rates of rheumatic fever among Māori.

By Men-Fang Shaio

Rheumatic fever (RF) is a disease of poverty. It is rarely seen in most developed countries but is prevalent in Māori and Pacific people in Aotearoa/New Zealand.[1] It is preventable and treatable if early diagnosis and prompt treatment are provided. Without treatment, it can permanently damage the heart valves, leading to rheumatic heart disease (RHD). A persistent threat of RF and RHD to Māori and Pacific people reflects the social deprivation and health disparities in Aotearoa/New Zealand.

RF is an inflammatory disorder due to an autoimmune response triggered by group A beta-hemolytic streptococcus (GAS) infection, which is transmitted by airborne droplets and causes pharyngitis. A sore throat is the early symptom of GAS pharyngitis and the onset of RF often occurs two to four weeks after a GAS throat infection.[2] Early and active intervention of GAS pharyngitis, with throat swabbing and appropriate antibiotic treatment, is fundamental to the primary prevention of RF.[3] RF can lead to irreparable complications, such as RHD.[4]

RF is almost eliminated in developed countries because living conditions and health services have significantly improved.[5] However, RF remains a major public health problem in developing countries[6] and is endemic here.[7]

Life expectancy shortened

Over the past decades, 95 per cent of the 150-200 patients with RF each year have been Māori and Pacific people.[8] There are 600-800 hospital admissions for RHD per year. Māori and Pacific people have five to 10 times higher mortality from RHD than non-Māori/non-Pacific. There are 150-200 premature deaths from RHD per year in New Zealand and life expectancy in people with RF is shortened by about 15 years.[9]

The geographical distribution of RF is uneven. An epidemiological study in 2014-2015 revealed a national RF incidence rate of 2.6 per 100,000.[10] RF rates were highest in Pacific people (77.3 per 100,000), followed by Māori (31.7 per 100,000), and lowest in Pākehā (0.5 per 100,000).[10]

Nearly half of the cases with first-episode RF were from the upper North Island district health boards (DHBs), with 14.9 per 100,000 in Tairawhiti DHB, followed by 7.8 per 100,000 in Northland DHB, and 7.1 per 100,000 in Counties Manukau DHB.[10]

The burden of RF and RHD in Tai Tokerau/Northland Māori is of great concern. One study revealed that in Tai Tokerau from 2002-2011, 95 per cent of patients with RF were Māori children between five and 14, with rates of 78 per 100,000 in Māori, compared to 4.6 per 100,000 in non-Māori.[11] These are almost double the rates of other epidemics in this country.[12]

Although RF has been regarded as a disease of childhood, 10 RF patients aged over 20 were reported during 2012-2017 in Tai Tokerau, indicating a possible delay in diagnosis of acute RF.[13]

RF was a threat to the entire population in the 1920s, with rates of 60-80 per 100,000 in urban, school-aged Pākehā children.[14] However, since the 1960s, rapid urbanisation of Māori and socioeconomic reforms which led to the deterioration of Māori socioeconomic status, have contributed to household crowding and poverty, and dramatically increased RF rates in Māori children.[15,16] Distribution of the Māori population changed greatly following World War II. In 1945, 26 per cent of the Māori population lived in urban areas. This had increased to 80 per cent by 1986 and 84 per cent by 2013.[17]

Since then, both Māori and Pacific people have experienced high RF rates, but Pākehā rates have remained low.[8]

There is no evidence to support a genetic link to RF in Māori, as Pākehā once experienced high rates also.[8] Research suggests RF is closely associated with the socioeconomic determinants of health.

Studies have shown that 90 per cent of patients with RF and RHD live in areas of high deprivation.[18] Studies have also found that whānau have had difficulties accessing health services for RF. Barriers included inability to get appointments with GPs or to pay for them, and/or lack of transport.[19] Inflexible delivery and a lack of appropriate follow–up care are also barriers for teenagers who leave school or lose contact with services.[19]

Rheumatic fever is a complex disease and will not be eliminated until poverty, household crowding, racism and barriers to accessing health services are addressed.

People living in the most deprived regions are 30 times more likely to be diagnosed with RF than those living in the least-deprived regions. However, both Māori and Pacific people are still more likely to suffer from RF, no matter where they live,[20] suggesting factors other than deprivation are responsible for health disparities.

Racism and discrimination are major reasons for health disparities in RF for Māori and Pacific people.[21,22] A lack of cultural safety reinforces whānau fears, vulnerability and concerns about being disrespected. Whānau can feel ignored and receive inappropriate management for RF.[19] Such negative clinical experiences in primary care services can lead to mistrust of health professionals.

Before colonisation, Aotearoa/New Zealand was almost free of epidemic diseases. European settlers brought with them new diseases, such as measles, in-

rheumatic fever rates

fluenza, RF, and venereal diseases, which threatened Māori health and ravaged Māori communities.[23,24] Māori had no immunity against these infectious diseases and Māori traditional medicine was not effective for their treatment.

Furthermore, legislation and land confiscation after the land wars resulted in rapid loss of Māori land that led to impoverishment. Māori land ownership dropped to six per cent of the total land area of Aotearoa/New Zealand by 1995.[25] The consequent malnutrition and poor housing contributed to increased mortality. The Māori population had halved to approximately 42,000 by 1895.[26] Although the Māori population has gradually recovered over time, the average life expectancy at birth in the 2010s was still seven to eight years shorter for Māori than non-Māori.[27]

Understanding New Zealand colonial history is fundamental to understanding Māori health disparities. Māori disconnection from their land, and the loss of language and cultural identity for many, have meant their economic base and social connectedness have been disrupted.[24]

Government policies of assimilation and integration further suppressed Māori language and culture. In the '60s, Māori were forced to move to urban areas looking for jobs and education.[26] Urbanisation eroded Māori tribal lifestyle and culture and this further contributed to a loss of identity.

In the '80s and '90s, during major neoliberal social and economic reforms, income inequality increased dramatically, as did health inequalities for Māori and Pacific people. Māori and Pacific children were 12-25 times more likely to be living in crowded households,[28] with Māori home ownership dropping by more than 25 per cent in Tai Tokerau between 1986 and 2013.[29] Consequently, Māori are more likely to live in poorly-insulated, overcrowded private rental accommodation.

A 2019 literature review on risk factors for RF in New Zealand evaluated the link between RF and a range of possible modifiable risk factors.[30] It also examined the potential protective effect of easy access to primary health care for RF.[30] However, it did not consider the contribution of racism and discrimination to RF health disparities.

For many Māori, western health services are not considered conducive to their health and wellbeing and when they engage with health services, many have experienced racism and discrimination.[31] Māori receive lower levels and poorer quality of health care compared to Pākehā.[32]

Institutional racism is a violation of Te Tiriti o Waitangi.[33] Unconscious bias is common, including among health professionals.[33] Racism and discrimination are at the root of health inequalities in Aotearoa/New Zealand. Health disparities need to be addressed, not only through health policies and strategies but also through changes in the health-care system and in the attitudes of some of those who work within it.

To date, no government has created a specific policy which targets RF. However, in 2011 the Government initiated the Rheumatic Fever Prevention Programme (RFPP), with three main strategies to reduce RF in 11 high-risk regions, including Tai Tokerau.[34] A target was to decrease first-episode RF hospitalisation rates by two-thirds by 2017 (from 4.0 per 100,000 in 2012 to 1.4 per 100,000 by 2017). The Ministry of Health-led programme focused on three strategies: RF advocacy, education, and awareness; school-based sore throat swabbing and expansion of sore throat clinics; and improvement in household living standards.[34]

In spite of government funding and public health initiatives, one study indicated that, between 2012-2017, RF rates of 64.5 per 100,000 remained for Northland Māori children aged 5-14 – a one fifth decrease compared to 2002-2011 rates.[13] The incidence of RF in Northland DHB has also only reduced slightly from 7.7/100,000/year to 7/100,000/year. The high rates of RF among Māori have remained at the same level as rates in developing countries.[13]

Current strategies to reduce RF emphasise the primary prevention of acute RF, with less focus on the secondary prevention of RHD. One study found that systematic screening with echocardiography had approximately 10 times higher rate of identifying RHD.[35] Echocardiography to screen for RHD provides the opportunity to initiate secondary prevention with antibiotic prophylaxis. Using portable echocardiography, researchers found one to two per cent of children in high-risk RF regions had undetected RHD.[12] Thus combining primary prevention and mobile echocardiographic examination to identify unknown RHD in the high-incidence RF populations is recommended.

Conclusion

The persistence of high rates of RF among Māori and Pacific people implies a failure of the health-care system in preventing RF. It also indicates inequality in the application of human rights and social justice. Colonisation has had a long-term detrimental impact on Māori land, culture, health and wellbeing. Deep-rooted and/or unconscious racism is still a challenge for health equity. RF is a complex disease and will not be eliminated until poverty, household crowding, racism and barriers to accessing health services are addressed. •

* *References for this article are available from the co-editors on request.*

This article has been reviewed by educators Zoe Tipa, from the Centre for Interdisciplinary Trauma Research at the Auckland University of Technology, and Johanna Rhodes, head of the School of Nursing, Southern Institute of Technology, and the co-editors.

Men-Fang Shiao, RN, BN, will begin a nurse-entry-to-specialist practice programme at Tumanako, the mental health unit at Whangarei Base Hospital, in April.

This article has been developed from an assignment he wrote as a third-year student at NorthTec.

COVID-19 fight must continue

After enjoying liberties unknown in COVID-19-wracked countries, Aotearoa New Zealand was rocked by cases in the community last month.

By acting associate professional services manager Kate Weston

As 2021 gets underway, there is a sense of uneasy calm in Aotearoa New Zealand. We are still witnessing harrowing images and stories of overwhelmed health systems overseas, as COVID-19 cases and deaths continue to rise. More virulent and transmissible strains from United Kingdom and South Africa have emerged.

Aotearoa has contained the virus, thanks to the strong initial government response and lock down. This has been maintained by the tireless work of infection prevention and control nurses, primary care nurses testing in the community, and those unsung heroes – nurses, caregivers and others – who are staffing the managed isolation and quarantine facilities (MIF/MIQ). NZNO organisers have been working hard with the nurses working in this unique and isolated situation, to ensure support, and that both professional and industrial concerns can be addressed effectively. Concerns, such as adequate personal protective equipment (PPE) and staffing, remain on the agenda in the new year.

Further precautions

We are now moving into another phase – keeping up all efforts to ensure the virus is kept out of the community and is contained at the border. With further precautions, it is hoped the virus cannot enter the country with returning residents, who are now required to have negative tests at country of origin and within a day of landing at the border. We are now also awaiting the roll-out of the vaccine.

NZNO will be working closely with the various parties planning for the largest public health vaccination programme in history, with vulnerable populations and health workers prioritised. Planning is now underway, with the Ministry of Health announcing last month that 2000-3000 new vaccinators will be required to implement the roll-out. Putting together such a workforce will be challenging, with pre-existing shortages across the health sector and the significant decrease in number of internationally qualified nurses able to enter the country. The response will need to be innovative. Nurses are highly skilled at leading such major projects – nurses implemented and delivered past programmes, such as nationwide measles and meningitis vaccination programmes.

Following media about the need for a major vaccination workforce, NZNO has been contacted by a number of members and non-members. The Nursing Council is now compiling a list of interested nurses for vaccination recruitment. The Immunisation Advisory Centre vaccinator courses will include training for COVID-19 vaccinators (www.immune.org.nz/covid-19-vaccinator-information).

Last month we heard the news the country had been dreading – a case in the community; this time a returning resident from Tai Tokerau. It is believed the woman contracted the South African strain of the virus while in a MIF, which is deeply concerning. When *Kai Tiaki Nursing New Zealand* went to press, the woman was considered recovered and all her close contacts had tested negative.

This latest case calls into question the efficacy of the length of stay in MIF/MIQ facilities and illustrates the point NZNO has been making for a considerable time – that people can be asymptomatic or mildly symptomatic, yet still have the virus. Every effort must be made to protect border workers, as they are all that stands between the border and the public health and safety of five million people.

Over the holidays, COVID-19 complacency appeared to have crept in. While travelling, I witnessed a young woman going through security at the airport complaining that it was "silly" to have to wear a mask. Surely she has seen images of the crisis all around the world but must think it cannot or will not happen here. And I have observed a number of people on Auckland public tranpsort not wearing masks.

Effective mask wearing

As health professionals, we have an obligation in this public health emergency to model good practice. This includes wearing a mask effectively when indicated, eg on public transport in Auckland and on all flights, and teaching others how to wear a mask properly. I have seen many examples of how *not* to wear a mask – with the person's nose poking out over the top and my personal favourite, wearing the mask as a chin strap, with neither mouth or nose covered.

As health professionals, we have an obligation in this public health emergency to model good practice.

The best defence for the community will not be vaccines alone – these are many months off. Our strongest defence is to protect ourselves and others, especially the most vulnerable. And ensuring the health system copes will be through good old-fashioned infection prevention and control measures – washing your hands, getting tested when you feel sick and staying home if you are sick. More contemporary public health measures – scanning wherever you visit and turning blue tooth on if you have it – are also very important.

We will get through this. We need to work together to do everything we can to avoid the crisis and relentless distress our international colleagues have seen and, a year on, are still experiencing. •

Crunch point coming

It's getting to crunch point in the NZNO/district health board multi-employer collective agreement negotiations.

By industrial adviser David Wait

The next two days of bargaining for the NZNO/district health board multi-employer collective agreement (DHB MECA), scheduled for February 16 and 17, are likely to draw the negotiations to a head.

After 15 days of negotiations, which began in June last year, we have reached agreement on a number of issues which have minimal financial cost to DHBs. The areas of agreement include improvements in rostering, particularly for those coming off night shift, to ensure they have adequate rest, and improvements to flexible working arrangements for pregnant employees and for those aged over 60. It's important to point out that while these areas have been agreed in principle, any offer by the DHBs is not finalised until they make a complete offer on all matters.

Three core claims

But we remain poles apart on our three core claims: pay, safe staffing and improved sick leave.

▶ The value of the package the DHB team is operating within is less than a two per cent increase in total, including any pay increase. And the DHB team is holding firm to its position of a flat rate increase on all steps, except for those members earning more than $100,000, who would receive no increase. This divisive move on the part of the DHBs fails to recognise those nurses working in advanced practice roles, while also failing to recognise the value of healthcare assistants (HCAs). The DHB position would see HCAs on step 1 of their pay scale earning just the minimum wage.

▶ Members' staffing claim has three components. We are seeking a commitment from DHBs to staff at safe levels, as determined by methodology from the core data set of care capacity demand management. Members also want DHBs to publicly report on staffing levels, with information available at the ward/unit level for each shift on the day, and implementation of penalty payments to members when DHBs staff below these levels. This is a mechanism to encourage DHBs to staff safely and to provide a modest recognition of the stress and strain members endure when working in environments that do not have enough staff for the work that needs to be done.

Delegates from different DHBs and practice areas 'a real asset' – David Wait

▶ The third core claim is to increase sick leave from 10 to 15 days. The rationale for this claim is that members need to be able to take time off when they, or a family member, are sick. And, because they are constantly working with sick people, members are more at risk of contracting an illness or exposing patients to risk, if members are unable to take needed sick leave. And, in the COVID-19 environment, everybody is being exhorted to stay home if they are unwell.

Despite the lack of movement from the DHB team on these three core claims, there are some positives emerging from the bargaining process. Having used the Ross Wilson review of the previous MECA bargaining as a starting point, we have run an inclusive, member-focused campaign and created a solid base for communication, particularly on two closed Facebook groups. These are focused on delegates and provide a place for discussion with and among members. We have a strong sense of unity and of purpose, both of which will be necessary to achieve a settlement members will accept.

In particular, I would like to thank and congratulate the 12 delegates on the bargaining team. Having a larger team means the delegates bring so much experience from different DHBs and from so many different practice areas, which is a real asset. We have formed a strong team.

Training sessions for delegates

Starting late last year and continuing, NZNO organisers are running training sessions for delegates on the ratification process and how delegates can play a part in that. Any ratification vote will be online. Delegates and organisers have a great deal of flexibility when setting up and running meetings, which can range from small ward/unit-based meetings to larger, more formal meetings. Because the vote is online, members won't have to attend a meeting in order to vote, although that is the best way to decide collectively on our course of action.

We have a strong sense of unity and of purpose, both of which will be necessary to achieve a settlement members will accept.

Organisers are also running meetings for delegates on contingency planning, if we find ourselves facing some form of industrial action. While we want to avoid the disruption of any industrial action, it is prudent to prepare for such an eventuality.

A full update will be sent to members following the negotiations this month and members can take part in further discussion on the closed Facebook group: NZNODHBMECA2020.www.facebook.com/groups/NZNODHBMECA2020/ •

Primary health care: Some employers reject MECA deal

MORE THAN 10 per cent of employers covered by the primary health care multi-employer collective agreement (PHC MECA) have rejected the terms of the proposed deal. And 35 employers had not ratified the deal by the time *Kai Tiaki Nursing New Zealand* went to press. Around 650 members work for the 85 employers who have rejected or not ratified the offer. But more than 67 per cent (over 400) of employers – the acceptance threshold – ratified the offer.

The PHC MECA offer – made possible by increased Ministry of Health (MoH) and district health board (DHB) funding – includes pay increases ranging from 4.5 per cent to 7.75 per cent and locks in a new registered nurse (RN) step 6. This new step will be implemented from February 1 this year and will be paid at $36.02 an hour – matching the current DHB rate. It will deliver a 7.75 per cent increase on the pay rate for step five in the current PHC MECA. Employees who have been on step 5 for a year or more at February 1 this year will move to step 6 on that date.

NZNO PHC industrial adviser Chris Wilson was disappointed in the number of employers who had either not ratified the offer or rejected it. Among those employers who rejected the offer, two main reasons had emerged, she said. One was that the MoH and DHBs had given no guarantee of future funding; the other that employers did not support the offer being restricted to NZNO members.

Members' collectivity guaranteed the improved offer – Chris Wilson

Wilson said both reasons did not stand up to scrutiny. "The ministry and DHBs have given no indication that funding will be discontinued. Discussions are continuing on the basis that the parties will get together and confirm funding in the new funding year in July. And the ministry and DHBs made the additional funding available on the basis that it would only apply to NZNO members," she explained.

She pointed out it was NZNO members who had fought long and hard to achieve the improved offer.

NZNO will now enter "serious negotiations" with the employers who have rejected or who have not ratified the offer. Because of the high number, this would take time and soak up NZNO resources. This meant the online ratification process for NZNO members would not start until late this month, she said.

If the proposed settlement is ratified by NZNO members, it will expire on August 31. Wilson said there were two further opportunities this year to improve the MECA – once the NZNO DHB MECA negotiations had been completed and once the DHB pay equity settlement was concluded, the latter expected to be mid-year.

Wilson said the additional funding to ensure an improved offer would not have been forthcoming without NZNO members' hard campaign and collectivity and without the strong support of most employers.

Details of the the pay increases are:

- RN/practice nurse/midwife scale: a 2.5 per cent increase backdated to January 6, 2020; a further two per cent increase backdated to September 1, 2020; a new step 6;
- coordinator/lead nurse/nurse team leader scale: a 2.5 per cent increase backdated to January 6, 2020; a further two per cent increase backdated to September 1, 2020; a further three per cent increase on February 1, 2021;
- enrolled nurse and medical receptionist/administration staff scales: a 2.5 per cent increase backdated to January 6, 2020; a further two per cent increase backdated to September 1, 2020. •

Bargaining underway at HCNZ/NZ Care

BARGAINING IS underway with district nursing and community care providers Healthcare New Zealand/ New Zealand Care. Two days of negotiations were held last month, with another two scheduled for later this month in Christchurch.

There are 150 members covered by the current multi-employer collective agreement (MECA). NZNO organiser Danielle Davies said pay parity with the NZNO/district health board (DHB MECA) – average salary steps lag four per cent below each comparative DHB step – was the major claim. Other claims are for increases in the vehicle reimbursement rate, penal rates and sick leave days.

Davies was pleased with the discussions on the first two days and said the three delegates had done a "stellar job" at the bargaining table. The three delegates are Hammie Jackson a registered nurse (RN) working for Healthcare Rehab in Auckland, EN Maree Vincent and RN Margaret Franks, who both work in district nursing services in Christchurch. •

Primary health care: Family Planning members to strike

NZNO MEMBERS working for Family Planning (FP) will strike for 24 hours this month, from 7am on Tuesday February 16 – the first-ever such action at FP. NZNO served the strike notice late last month.

NZNO primary health care (PHC) industrial adviser Chris Wilson said the members – there are about 100 around the country – were very determined. They rejected FP's last offer of a three per cent increase for nurses and health promoters, to be back dated to April 1, 2020, and increases ranging from 3.75 per cent to 4.7 per cent for administrative staff.

Pay parity with the NZNO/district health board multi-employer collective agreement (DHB MECA) is the central claim. But Wilson pointed out that it was a complex situation as there was no direct linkage between the DHB MECA pay scales and the pay levels of FP nurses. Adding to the complexity was the autonomy in practice and procedures enjoyed by FP nurses, who must also be registered prescribers to achieve level 3 on the FP pay scale. "FP nurses have more autonomy than most nurses working in an inpatient setting."

The increases for administrative staff did not bring them all up to the living wage, currently $22.10 an hour.

Wilson said there was "no doubt" the continued underfunding of FP had "left the organisation unable to offer the desired increase. We would like to see some strong collaboration about how to approach this in terms of the new Government".

Since the overwhelming vote in support of strike action, FP had begun some background work on where nurses' pay rates should be pitched vis a vis the DHB MECA rates, Wilson said. "This will inform any next steps."

The current FP collective agreement expired on April 1, 2020. •

Primary health care: Negotiations at NZBS

The NZBS bargaining team (from left): Christiane Friedrichs (registered nurse (RN), Auckland), Monique Russell (RN, Cambridge), Frances Franklyn (enrolled nurse, Wellington), Carol Brown (NZNO co-advocate), Beth Colmore-Williams (clinical nurse specialist, Palmerston North), Julie Waters (qualified donor technician, Auckland) and Iain Lees-Galloway (NZNO co-advocate).

NEGOTIATIONS FOR the 245 NZNO members at the New Zealand Blood Service (NZBS) got underway last month.

Claims include pay parity with the NZNO/district health board multi-employer collective agreement (DHB MECA); a top-up for members who take parental leave (DHBs currently provide a top-up for 14 weeks, ie they make up the difference between the statutory entitlement and what the member is ordinarily paid); and parity of sick leave, with the full first-year leave entitlement available on appointment rather than after six months.

Expanding CA coverage

Other claims include:

- expanding collective agreement coverage to include two nursing roles – transformation officers and donor coordinators;
- special leave when members must stay home for public health reasons, eg COVID-19;
- allowing periods of absence on parental leave to count towards long-service entitlements; and
- all members covered by the CA to be paid at least the living wage.

NZNO advocate Iain Lees-Galloway said during the first two days of negotiations the five delegates did a "superb job" of articulating the day-to-day realities members faced.

Because many of the claims are based on achieving or maintaining parity with the NZNO/DHB MECA, the progress of NZBS bargaining depends on the progress of the DHB MECA bargaining. The NZNO and NZBS teams have tentatively agreed to a further two days of bargaining in early March, after the next round of NZNO/DHB MECA bargaining.

In the meantime, NZBS has undertaken to work towards having rosters notified four weeks in advance and covering four weeks' work. The service is investigating what date that could be effective from. •

Caregivers week next month

NZNO IS to refresh its *In Safe Hands* branding and communication resources in time for caregivers week next month. Aged-care industrial adviser Lesley Harry said the week would provide an opportunity to highlight the need for mandatory staffing levels in aged residential care (ARC), including more registered and enrolled nurses to support the valuable work of caregivers.

"More caregivers are telling us they are doing more complex nursing care and that they do not feel safe working without the ready availability of an RN, but the RN may be working in another part of the facility."

NZNO's national aged-care delegates and NZNO and E tū staff will meet in April or May to plan the year's campaign activities for mandatory safe staffing levels in ARC.

Other plans for the year ahead include bargaining, with collective agreements in a number of the large ARC chains due to be renegotiated in June/July. "Our pay strategy for the sector includes the need to achieve pay parity for RNs and ENs with district health board members and also maintaining the value of the care and support workers' settlement for health-care assistants/caregivers." •

Proposed deal at CHT Healthcare Trust

MEMBERS WORKING at aged residential care provider CHT Healthcare Trust are voting this month on an offer which includes a 3.5 per cent wage increase for registered and enrolled nurses, backdated to July 1, 2020, and the inclusion of miscarriage in the bereavement leave clause. Despite the offer not meeting our ideal position on sick leave, the bargaining team was prepared to take it out to the wider membership for a vote. During the last round of report-back meetings in December, members signed an online petition to support their sick-leave claim. The bargaining team feels this collective activity helped reshape the employer offer.

Importantly, the terms of settlement provide for an increase to sick-leave entitlements once sick leave increases nationally to 10 days and this is funded through the aged-related residential care (ARRC) agreements. While this is not a guarantee of 15 days sick leave (pro-rated), the team is confident this will lead to an increase in sick leave for all members covered by the multi-union collective agreement (MUCA) in 2021. Any increase to sick leave will be done through the next negotiations.

The team believes the overall offer is positive and covers off a number of the issues raised for discussions at negotiations. Of note is the wage increase, which is in excess of the 2020 ARRC funding of three per cent. The MUCA does not cover service workers, and health-care assistants, who are covered by the equal pay settlement for care and support workers.

CHT Healthcare Trust is based primarily in Auckland, with facilities also in the Waikato and Bay of Plenty. The MUCA covers approximately 250 union members. •

Report by organiser Christina Couling

Hospice ratification meetings underway

HOSPICE RATIFICATION meetings are underway and will run from February 11-26. Negotiations for a new national hospice multi-employer collective agreement (MECA) began in September last year. Members would be voting on an offer which did not quite reach their original claim of pay parity with NZNO/district health board MECA, lead organiser Lynley Mulrine said. They had also sought rates and parity with a range of other DHB conditions.

Another key claim had been the removal of individual hospice exemptions from the current hospice MECA. The current MECA expired on August 31 and covered 520 members in 21 hospices around the country. •

Recruitment to industrial services team underway

RECRUITMENT FOR a range of permanent positions on NZNO's industrial services team (IST) is underway.

Acting IST manager Glenda Alexander (left) said 2021 would be a big year for the team. NZNO/district health board multi-employer collective (DHB MECA) agreement bargaining was still underway, the primary health care MECA ratification still had to be completed, a pay equity settlement for DHB members was yet to be finalised and pay equity for other sectors would have to be implemented. This work would be done in conjunction with all the usual bargaining, advocacy and individual case work.

Recruitment for the following positions is underway:

- an Auckland-based organiser (0.8 full-time equivalent);
- a Hamilton-based educator for the Northern region (full-time);
- a half-time industrial adviser with responsibility for private hospitals and hospices (can be based in any NZNO office); and
- a Palmerston North or Wellington-based full-time lead organiser for the Central team.

And Alexander, who has been the acting IST manager since last April, has accepted an extension in the role until the end of January 2022. An associate IST manager will also be appointed until the end of January next year. Alexander said the arrangement may change under a new chief executive, who may want to recruit a permanent IST manager and associate manager before next year. •

2021 'better' for colleges & sections

COVID-19 WAS significantly disruptive on a number of levels for the work of the NZNO colleges and sections (C&S) in 2020.

Looking back, many conferences were cancelled or postponed. We became rapidly adept at using Zoom and other technologies to remain connected. The NZNO annual general meeting (AGM) and conference were held virtually last year, as was the C&S day.

Many C&S committee members ended 2020 very tired from changes to practices and the demands arising from COVID-19. Demands on nurses in places such as aged residential care facilities has been huge, particularly through the lockdown periods. This has left less energy for usual activities, such as contributing to NZNO submissions. Many C&S symposiums and conferences had to be cancelled, and the work that went into contingency planning throughout the year was significant.

Given the many conferences that were disrupted and/or postponed, 2021 promises to be a better year with many events being rescheduled. Please keep an eye out on the calendar of events for upcoming dates and registration processes, on the NZNO website and in *Kai Tiaki Nursing New Zealand* magazine. Here are just a few of the events planned:

- On March 6, the College of Primary Health Care nurses, alongside the College of Nurses Aotearoa, is hosting a symposium in Christchurch: *'Nursing diversity brings nursing strength – a focus on primary and community nursing'*.

Kate Weston

- On March 30, the College of Critical Care Nurses is hosting a virtual education event.
- On May 18-20, the Enrolled Nurses Section is planning to hold its AGM and conference in Dunedin. The Women's Health College is also planning to hold its AGM and conference in Dunedin in May.
- On August 27, the Mental Health Nurses Section is holding a one-day forum on "mental capacity" in Dunedin.
- On August 30-September 1, the College of Air and Surface Transport nurses is holding a joint conference, 'Critical care in the air', with the Aeromedical Society of Australasia in Wellington.
- In September, the College of Child and Youth Nurses is planning to hold a symposium in Christchurch.
- On September 15-17, the Infection, Prevention and Control Nurses College is planning to hold its AGM and conference in Invercargill.
- On October 7-9, the Perioperative Nurses College is planning to hold its conference and AGM in Christchurch.
- The Cancer Nurses College is exploring the possibilities of working in with the New Zealand Society of Oncologists' conference on October 28-30 in Rotorua.
- The College of Gerontology Nursing continues to partner with postgraduate students at Waikato's Institute of Technology to explore the provision of skilled and appropriate care for older people. This project is expected to conclude later in 2021. The college's 2020 biennial conference was cancelled and its next conference is planned for some time after April 2022.

Professional forums

In February and March, the annual professional forums will be "hybrid" events, with both in-person and "virtual" participants. It is hoped that this new online option will increase the reach of the forums to those who may not otherwise be able to attend. The online education will be of the same high quality, running concurrently with the programme being received in the room – so I encourage you to register. Details can be found here: www.nzno.org.nz/support/professional_development. I hope to see you there. •

Report by acting NZNO associate professional services manager Kate Weston

Perioperative nurses hopeful for conference

WE ARE hoping it will be third time lucky as we plan for our 47th annual perioperative nurses college (PNC) conference in Christchurch this year.

The 2010/11 earthquakes were the first thing to affect our chance of hosting, then a pandemic jumped into the mix in 2020. But we won't let that stop us – we are all rebooked and confirmed for October 7–9.

After hardship and a lot of uncertainty, we are looking to provide uplifting speakers who will help you develop both personally and professionally. They include founder of the New Zealand Institute of Wellbeing and Resilience, Lucy Hone; University of Otago lecturer in physiotherapy, Helen Harcombe on musculoskeletal disorders, and sepsis survivor Korrin Barrett, sharing her experiences as a quad amputee.

Our city has been transforming since the earthquakes, so we are looking forward to showing you our "new" Christchurch. New shopping precincts, food markets, arts – come and explore, learn and have fun.

The call for abstracts is open and submissions for oral presentations are welcome before May 10. Details available at: www.perioperativeconference2021.co.nz.

The college is also setting up social media – Facebook and Instagram – accounts for members to share updates and professional development opportunities this year. •

Report by Perioperative nurses college secretary Sarah Elley

NZNO signs up to scientific approach

THE BOARD has agreed to adopt the "John Snow memorandum", a science-based response to COVID-19, as NZNO policy. The memorandum is named after an epidemiologist who traced the source of a London cholera outbreak in 1854. It was a response to a herd immunity approach suggested late last year in Great Barrington, Massachusetts, board member Simon Auty told the board.

In October 2020, the "Great Barrington declaration"[1] challenged lockdown measures, urging instead a "focused protection" approach. Easing restrictions on low-risk groups, some epidemiologists argued, would lead to herd immunity.

But an opposing group of experts launched the John Snow memorandum, warning herd immunity was a "dangerous fallacy unsupported by scientific evidence".[2] Such a strategy would result in recurring epidemics, the group of researchers wrote in an open letter to medical journal *The Lancet* in October.[2]

In New Zealand, the "COVID Plan B" group promoted a herd immunity approach. This failed to consider the "precarious state of New Zealand's healthcare system, the unique vulnerabilities of Māori and Pasifika community in New Zealand and the probability of spread from New Zealand to the Pacific Islands", Auty said in his proposal for NZNO to adopt the memorandum.

Many prominent New Zealanders in epidemiology and infection control had signed the memorandum, which aligned with NZNO's strategic plan and the national COVID-19 response strategy, Auty said. "The John Snow memorandum provides a solid scientific rationale to base any of our COVID response policies and any member advocacy on around this issue." •

References
1) Sample, I. (2020). Scientists call for herd immunity Covid strategy for young. *The Guardian*. Retrieved from www.theguardian.com/world/2020/oct/06/scientists-call-for-herd-immunity-covid-strategy-for-young.
2) Finucane, M. (2020, Boston Researchers join letter in The Lancet rejecting herd immunity strategy. *The Boston Globe*. Retrieved from www.bostonglobe.com/2020/10/14/nation/boston-researchers-join-letter-lancet-rejecting-herd-immunity-strategy.

Constitutional review planning

THE BOARD has appointed its members Diane McCulloch, Titihuia Pakeho and Andrew Cunningham to the NZNO constitutional review advisory group.

The board also agreed to invite representatives from the cancer nurses college and mental health nurses section – which jointly submitted the review remit – onto the advisory group. NZNO's membership committee and te poari would also be invited to participate.

NZNO chief executive Memo Musa shared draft terms of reference (TOR) for both the full constitutional review and a review advisory group. He advised an expressions of interest process for potential reviewers. The board should be "open-minded" in its search, rather than limiting options. Someone from a law firm may or may not have union or bicultural understanding, Musa said.

The board agreed to review both ToR but they would only be finalised with the agreement of the appointed reviewer/s, Musa said. He would ensure that the ToR would allow members to feed back. •

This page has been written from reports and minutes taken from the December 2020 board of directors meeting.

Membership 'stabilised'

NZNO MEMBERSHIP "stabilised" from mid-2020 after beginning the financial year with a decline, NZNO manager corporate services David Woltman said in his report to the board.

Speaking to the board, Woltman said the "correction" in membership numbers after an unusual peak of more 52,000 following the 2018 district health board pay negotiations had been realised.

Overall, membership dropped 2.3 per cent – 1192 - from 51,643 to 50,451 in the six months to September 30, 2020. That was a similar trajectory to the previous year, he said.

But between July and September last year, the decline steadied, he noted.

Income from membership was short $370,000 against budget, with a $713,000 shortfall forecast by the end of the financial year due to the drop off, he said.

However, a pre-tax surplus of $123,000 in the year to date was better than budgeted. Spending levels were lower, mainly due to COVID-19 travel restrictions resulting in savings on NZNO events such as college and section or regional conferences and hui-ā-tau.

Printing and stationery costs were down by $93,000 and communication and postage by $76,000, in part due to savings from an online-only *Kai Tiaki* during the lockdown.

Equity tool in pipeline

A DRAFT equity framework to guide NZNO in all its work was shared with the board by NZNO policy analyst Māori Leanne Manson and senior policy analyst Lucia Bercinskas.

Its guiding questions – How are Māori represented in NZNO? How does NZNO's culture support Māori? Who will benefit the most? What are the unintended consequences? – were intended as a starting point when designing policy, resourcing campaigns or in other NZNO work, Manson advised the board. The framework would now be shared with staff and then members for feedback, she said. Chief executive Memo Musa said it was important the framework was understood and applied by staff to ensure policies and actions resulted in equitable outcomes for members "that would in turn support equitable results for the people they work with". •

Classified advertising

IPCNC CONFERENCE | ASCOT PARK HOTEL, INVERCARGILL, NZ | 15-17 SEPT 2021

***We warmly welcome you to the Deep South** and the Infection Prevention and Control Nurses College (IPCN) Conference in 2021.*

With true Southern hospitality we will offer a relaxed interactive, dynamic conference that will both consolidate and challenge our current practices alongside exploring new theories/ developments and initiates.

Our conference theme ***"Just Bluffing It"*** refers to both our southern roots and the many metaphorical bluffs, mountains and valleys we traverse each day.

Keynote speakers – Rt Hon Jacinda Ardern, Dr Ashley Bloomfield and Dr Stephanie Dancer UK – invited. Confirmed Prof Michael Baker, University of Otago, Dr Arthur Morris, Auckland City Hospital and Ruth Barratt, Infection Prevention and Control Consultant.

We offer a relaxed, interactive, and dynamic conference that will both consolidate and challenge our current practices alongside exploring new theories/developments and initiatives.

CALL FOR ABSTACTS – NOW OPEN
The organising committee invites submissions for oral presentations and posters. Full details on the conference website – www.ipcconferencenz2021.co.nz Submissions close 3 May 2021

REGISTRATION – Online registration will open April

For further information **www.ipcconferencenz2021.co.nz** or email **joanne@conferenceteam.co.nz**

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NEW ZEALAND NURSES ORGANISATION
TŌPŪTANGA TAPUHI KAITIAKI O AOTEAROA

NOW OPEN

This grant is available to all NZNO financial members and is awarded annually.

The purpose of this fund is to provide members with assistance for professional development activities to enhance health care outcomes/provision in Aotearoa/New Zealand.

The fund is available for a variety of activities such as short courses, conferences, seminars, postgraduate and undergraduate study, workshops, books and travel. Other course related costs may be considered.

The fund is not available for any mandatory training required by an employer which is the employer's responsibility to provide or fund.

The amount of any grant is determined by the Committee and will be decided based on total fund amount available once all applications are assessed. The maximum amount available for each applicant in 2021 will be **$800.00**.

There are three categories of grants:

Category One:	**Enrolled Nurses**
Category Two:	**Registered Nurses/Midwives/ Nurse Practitioners**
Category Three:	**Student and Midwifery Students**
Category Four:	**Unregulated Members**

To apply online and for the criteria please go to: **https://www.nzno.org.nz/support/scholarships_and_grants#909**

Any questions regarding eligibility please email **grants@nzno.org.nz**

Applications close 31 March 2021

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.

NEW ZEALAND NURSES ORGANISATION | TŌPŪTANGA TAPUHI KAITIAKI O AOTEAROA

NZNO Young Nurse of the Year 2021

Nominations now open!

Purpose of award:

- To recognise and celebrate the often exemplary work of nurses in the younger age group who may still be in the early stages of their careers
- To encourage younger nurses to demonstrate their commitment to the nursing profession
- To provide an incentive for them to remain nursing in New Zealand.

Nomination criteria:

The public, colleagues or managers may nominate a young nurse for this award. Nominators are requested to specify how the nurse they are nominating demonstrates commitment and passion to nursing beyond the every day. This may include how the nurse:

- Shows compassion or courage beyond what is expected in their role as a nurse;
- Has improved care or health outcomes for their patients through their commitment to care, leadership, research or quality;
- Has overcome major challenges to deliver exceptional care.

Nominees may be registered or enrolled nurses, may be new graduates, do not have to be in paid nursing work, must be under the age of 31 as at December 31st 2021, be resident in New Zealand, and a current financial member of NZNO.

Judges will be looking for strong, detailed applications that clearly evidence the strengths and achievements of the nominee. In addition to giving evidence of how the nominee meets the nomination criteria listed above, further aspects that the judges will be considering are as follows:

- Is there a particular project that the nurse has been involved in or is it a general, all round nomination?
- In what way are any outcomes demonstrable e.g. has the nurse been accepted onto a programme by merit or have patient outcomes demonstrably improved?
- Has the nominee contributed in a special way to a community or culture that stands out?

The winner will receive a trophy and a cash prize (of which 50% must go toward further education / professional development). Up to two runners-up will receive a runner-up certificate and a book voucher to the value of $200. All nominees will receive a certificate recognising their nomination.

This is an exciting opportunity for young nurses in New Zealand and we encourage you to submit a nomination in recognition of the work of young nurses throughout the country.

Closing date for nominations: 5.00pm, June 30, 2021

Nominations to be sent to: Heather Sander **heather.sander@nzno.org.nz**

For Nomination Form and further information/criteria go to:

www.nzno.org.nz

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**

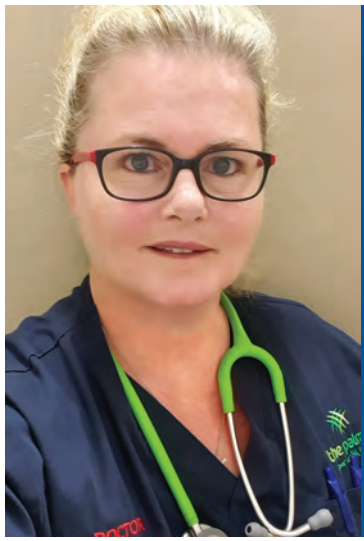
Eligibility:

- 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**



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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

NEW ZEALAND NURSES ORGANISATION | TŌPŪTANGA TAPUHI KAITIAKI O AOTEAROA

Conference and AGM

Wednesday 15 and Thursday 16 September 2021

Museum of New Zealand, Te Papa Tongarewa, Wellington

Call for remits: opens 16 March 2021
closing date 16 May 2021 at 5.00 pm

Call for Abstracts: opens February
closing date 4 June 2021 at 5.00pm

Call for Award Nominations: opens February
closing date 4 June 2021 at 5.00pm

Call for Abstracts

The call for abstracts will open in late February for the 2021 Annual Conference.

This is your opportunity to share your innovations and achievements, allowing others to learn from your developments as you will learn from theirs. NZNO's annual conference is vibrant, attracting nurses, students, educators and researchers from all health sectors across the country, creating multiple opportunities for relationship building and networking.

Share your ideas, innovations and expertise.

Closing date 4 June 2021 at 5.00pm

Full details available on the website: www.nzno.org.nz/2021conference

Conference Sponsorship

The New Zealand Nurses Organisation (NZNO) invites you to become a sponsor for our 2021 Conference being held at the Museum of New Zealand Te Papa Tongarewa on Wednesday 15th September 2021, giving you an opportunity to promote your services to nurses and health professionals.

A range of sponsorship options are available for your consideration. If you would like to consider other options to support our event, you are welcome to contact our Conference and AGM organisers Panda Events at **hello@pandaevents.co.nz**, or view the Prospectus from our homepage at **www.nzno.org.nz/2021conference**.

OUR FUTURE
The health of AOTEAROA

NZNO CONFERENCE AND AGM
15-16 September 2021
Museum of New Zealand
Te Papa Tongarewa
Wellington

CALL FOR AWARD NOMINATIONS

NZNO Award of Honour

The Award of Honour is one of NZNO's two most prestigious awards. It is awarded biennially, alternating with the other prestigious award, Te Akenehi Hei Taonga. The Award of Honour is presented to a single recipient who retains it for two years, before returning it for the next recipient.

The nominee must be a current financial NZNO member who has:

- Made a noteworthy contribution to NZNO, professionally and/or industrially, at a workplace, local, regional and /or national level;
- Promoted the work of NZNO in a significant way;
- Had a personal, positive impact on the nursing profession in New Zealand;
- Made a substantial and innovative contribution to health care in New Zealand; and
- Participated in national and/or international activities which increased the status and public recognition of the nursing profession in New Zealand.

National Awards

Nominations for *Service to NZNO* and *Service to Nursing/Midwifery* are called from NZNO Regional Councils, National Sections and Colleges, National Student Unit and Te Rūnanga.

Service to NZNO

The nominee must be an NZNO member who has a commitment to NZNO and who has made a superior contribution to the national or regional work of NZNO.

Contribution could be made in any area of NZNO activities at a national or regional level.

- Promotion of NZNO to nurses or outside groups
- National or regional committee work
- Performed additional work for the committee
- Advanced NZNO objectives or policies

Service to Nursing/Midwifery

The nominee must be an NZNO member:

a) Whose actions have made a difference to nursing or midwifery care in the region (may be in the area of practice, education, management of nursing/midwifery, research or support area such as QA, infection control, staff development), or

b) Whose actions have improved the occupational health, welfare or practice environment of nurses or midwives in New Zealand

Closing date 4 June 2021 at 5.00pm

Completed nomination forms should be forwarded to **The Returning Officer, PO Box 2128, Wellington**, or by email to **awards@nzno.org.nz** to be received before the closing date.

Application Forms and details are available on the conference website: **www.nzno.org.nz/2021conference**

CAREERS WITH PACT

Pact is a growing NGO, supporting people to lead fulfilling lives in the lower North Island, West Coast, Otago and Southland. Our investment in new services means we are looking for great people for three Wellington roles, suitable for a Mental Health Nurse, Social Worker, Clinical Psychologist, Psychotherapist, Occupational Therapist, Counsellor or Addictions Practitioner. Contact us if you would like to be among many registered health professionals that we employ.

WHY WORK FOR PACT?

- competitive, market-based remuneration packages
- personal training budget you can spend on professional development.
- five weeks' annual leave
- the opportunity to play a part in developing our services
- making a real impact in the community

CLINICAL LEAD COORDINATORS (2 full-time positions), Wellington

- **Clinical Lead Coordinator (adult): working in our Alcohol and Other Drug (AOD) Service (a live-in abstinence-based eight-week programme), plus an AOD Community Support Service**
- **Clinical Lead Coordinator (youth): working in Youth Service that provides AOD counselling, community support, group sessions and mentoring**

We are seeking: motivated and innovative registered health professionals to provide clinical oversight and coordinate our passionate teams to support people experiencing mild to moderate mental health issues and co-existing alcohol and drug related issues. You will benefit from Monday-to-Friday working hours and a personal work vehicle.

You will: make clinical recommendations; carry out risk and referral management; coordinate care and treatment plans with secondary services and other external stakeholders; have an active role in further developing services; allocate daily staffing; and provide staff supervision and performance management. The Clinical Lead Coordinator (adult) will also conduct alcohol and drug assessments and train support staff to increase their knowledge on mental health and addictions. The Clinical Lead Coordinator (youth) role will also manage a small individual caseload across Lower Hutt and Wellington.

You must: have experience in mental health and drug assessments and treatment; be passionate about providing a meaningful and supportive environment for clients to assist in gaining social, health, education, whānau, community and cultural reconnection; and have excellent communication and networking expertise, effective time-management and prioritisation skills, a full driver licence and computer skills. The ideal candidate will have previous leadership experience.

MENTAL HEALTH CLINICIAN (full-time), Wellington (Lower Hutt)

We are seeking: an enthusiastic and motivated individual to for a rewarding role in providing clinical support to people experiencing a mental health crisis who are using our mental health Crisis Respite Service in Lower Hutt. The service provides a safe and positive home environment that helps our clients maintain their independence and work towards recovery, while being supported by a team of clinicians and support workers on site.

You will: manage intakes and liaise with Hutt Valley DHB, MHAIDS and duty managers; help with client welfare; oversee the service; deal with medication management; assist with coaching and mentoring support workers by developing and improving their mental health knowledge, and work in collaboration with the Clinical Lead and Service Manager to further develop the service.

You must: have relevant clinical qualifications, registration and an annual practising certificate or be working towards this. You must be able to work flexibly because this role requires working some weekends and evenings, have a valid work visa (if applicable) that is valid for at least 12 months, a full driver licence and computer skills, and be available for an interview in Lower Hutt if successfully shortlisted. The ideal candidate will have experience with mental health disorders and understanding of behavioral difficulties; have excellent communication skills; the ability to work well within a team of professionals and work collaboratively with external stakeholders; be able to work effectively, safely and creatively with clients and their family/whānau.

To apply for these roles, go to: http://www.pactgroup.co.nz/careers-at-pact.
For more information, contact Mental Health Services Manager Evelien Post on 027 343 0640 or evelien.post@pactgroup.co.nz.