Kai Tiaki
NURSING
NEW ZEALAND

November 2020 vol 26 no 10

Aged care

- Fighting ageism
- The power of person-centred care
- Racism ‘hard to heal’

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OUR AGED-care issue includes articles ranging from ageism to workplace stress, the incidence of COVID-19 among health-care workers to the power of person-centred care. Other articles examine how to obtain informed consent from hearing-impaired patients, challenging unconscious bias and honouring the voices of Māori women. We publish the final in *Talking about health*, this year's professional education series.

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

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

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Teresa O'Connor, Anne Manchester
and Mary Longmore.

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

This issue . . .

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Celebrating older age diversity

By Stephen Neville

The demography of older adults living in Aotearoa largely mirrors international trends and that includes a growing ageing population.[1]

This phenomena is due to declining birth rates, longer lifespans and the last of the baby boomer generation reaching 65. Particularly noticeable is the increase in those aged 85 and over, including those living beyond 100.

Health and wellbeing innovations have resulted in more older adults living well for longer. Consequently, an ageing population is something to celebrate. Society should recognise and appreciate the knowledge, wisdom and expertise older adults bring and contribute to society. Unfortunately this is not always the case. Older adults live in an ageist world.[2]

Ageism is the purposeful, systematic stereotyping and discrimination of people based on age.[3] Ageing is no longer seen as a natural process but as a physical, social and economic problem. An example is the way the media describes increasing numbers of older people as a “grey tsunami”, as if society needs to protect itself from a fast-approaching disaster.

Nurses are in a privileged position as we work with people across the lifespan and in a variety of settings. We have some understanding of what it means to be older and the associated health and wellbeing issues this group experiences. In addition, our work frequently occurs with older people who are vulnerable.

As a nurse and social gerontologist, I am saddened to witness many instances where older people experience ageism, including from nurses. This is evident in many nursing texts which depict older adults negatively as a set of actual or potential health problems needing to be “fixed”.[4] While I do not deny the importance of providing nursing care to older adults who are unwell, I notice the lack of alternative viewpoints – instances where the positive aspects of ageing are presented within nursing education, practice and research.

Nursing must be prepared to provide nursing services that meet the needs of a very diverse group of older adults, spanning community, hospital and long-term care. Consequently, I am offering what I consider to be three important points that will help nursing address ageism. Each of these points appropriately aligns with our mandate to provide culturally safe and appropriate nursing care.

Firstly, remember older adults represent a diverse group of people with a variety of strengths and abilities. In Aotearoa, you are deemed an older adult at age 65, the age when you are eligible to receive government superannuation. Consequently, there are generational differences between a 70-year-old and a 90-year-old. Nurses need to recognise and accommodate these generational differences when providing a care service.

Focus on social aspects

Secondly, nursing should consider adding social gerontological concepts to our repertoire when engaging with older people. This would enable a focus on the social aspects of ageing, including challenging assumed assumptions and influences that affect older people’s wellbeing. These include political, economic, biological and socio-cultural factors, and may include replacing the term health with wellbeing. Wellbeing is a broader and more inclusive term that incorporates health and better reflects the realities of living as an older person, regardless of whether they live in a residential facility or in the community. This re-languaging assists with taking a strengths- rather than a deficit- and disease-focused approach when interacting with older citizens.

Finally, stop referring to older people as elderly. The language we use both shapes and reflects our values, and influences our attitudes toward older people. Media indiscriminantly refer to older people as “elderly”. Elderly is a valid term to use when refering to those older people who are frail and have been assessed as being frail, using an appropriate frailty measure. However, elderly is used indiscriminantly as an encompassing term for all older people, ie anyone 65 and over. As an editor for the *Journal of Clinical Nursing,* I have changed the authorship guidelines to ban the use of elderly and replace it with more inclusive terms.

There is no doubt nurses make a significant and ongoing contribution to the wellbeing of older people. We are important connecting points for communities and many older adults unquestioningly trust us. Therefore, it is important nurses hold true to our profession’s core values and attributes.

Older people have significant experience and wisdom that should be recognised and valued. As we engage with this group, we need to remember it is a human right that all older adults, regardless of where they live or their abilities, live in an environment that is age-inclusive rather than ageist. •

Stephen Neville, RN, PhD, is the head of department (nursing) and director of the AUT Centre for Active Ageing at the Auckland University of Technology.

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Tell us what you think

What's really happening at acute mental health unit?

WE WRITE in response to an article about our service in last month's issue of *Kai Tiaki Nursing New Zealand*. Under the headline, "Acute mental health units being upgraded" (p8), it was reported that, "A new six-bed inpatient mental health facility at Wellington Hospital will be ready in 2021".

Unfortunately, there is nothing in that statement that is true.

As a standard topic for media sensationalism, mental health services in Wellington sadly suffer from inaccurate reporting on a regular basis. So we would like to take this opportunity to inform fellow health professionals, in this privileged professional forum, about what is really happening at Te Whare o Matairangi.

Kai Tiaki New Zealand was correct to report that our 30-bed mental health inpatient unit was one of those named in August by chief ombudsman Peter Boshier as breaching the United Nations' Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment, for our use of seclusion rooms to home patients.[1]

And as *Stuff* has reported, staff had been raising these issues with senior management long before the Chief Ombudsman's visit. In February this year, for instance, we put them in writing in a collective letter to the chief executive and board of Capital & Coast District Health Board and the general manager of the mental health, addictions and intellectual disabilities (MHAID) directorate.[2]

Our letter expressed our concerns as health professionals at the use of inappropriate rooms in our seclusion area to house patients, as well as many other concerns over the safety of staff and patients.

Although this work has been led by the mental health union, the Public Service Association, we are collaborating closely with NZNO and we are receiving support from the Association of Salaried Medical Specialists.

In recent meetings with the MHAID directorate leadership team, we have been encouraged by their willingness to acknowledge, and act upon our concerns. We have also met with officials at the Ministry of Health.

Although the solutions under discussion do not include a new six-bed inpatient mental health facility at Wellington Hospital, we are hopeful that our collective action and union solidarity will yield results that address our concerns and those of Chief Ombudsman Peter Boshier.

Ian Monzari, PSA delegate,
Grant Brookes, RN,
Wellington Hospital

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The co-editors reply: We apologise for the error in our report last month about mental health unit upgrades.
Six new units for the highest needs intellectual disability and mental health patients at Capital & Coast District Health Board will in fact be attached to the current forensic intellectual disability facility at the Rātonga-Rua o Porirua mental health campus in Keneperu, not Wellington Hospital, as reported. Completion is scheduled for 2021.
An updated news story is on p8.

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.

PN school of nursing history

I AM planning on writing a comprehensive history of the Palmerston North Hospital school of nursing, which was one of the very last schools to offer hospital-based training since opening in 1895. It was initially set up to offer training for qualified nurses.

I have set up a Facebook page for graduates to connect and share information and photos. I am keen to connect with as many people as possible who may have stories to share, archival material or other interesting information.

The Facebook page is called "Palmerston North Hospital School of Nursing History Book".

People are welcome to follow the page and comment through there or email me directly wendymaddocks.nz@gmail.com

Wendy Maddocks, RN, BA, PGDipN, MA,
lecturer, School of Health Sciences,
University of Canterbury

Bullying at work study

WE ARE a team of researchers from Massey University exploring the role of mentoring in nurses' experiences of workplace bullying.

If, in the past five years, you have experienced (been a victim or witness to) or were at risk of experiencing workplace bullying AND you have had someone who you would call a mentor (formal or informal), we would like to invite you to participate in a confidential phone interview with us. We would like to hear from currently practising registered or enrolled nurses.

For more information about the study, you can email Dr Vasudha Rao at V.Rao@massey.ac.nz.

To participate in a confidential phone interview (up to an hour in length), please contact Caroline Lockhart at C.Lockhart1@massey.ac.nz. Thank you for your support of this important research.

Vasudha Rao (project lead), Kate Blackwood, Caroline Lockhart
Massey University, Palmerston North

The kaiwhakahaere comments

By Kerri Nuku

THE HARM caused by racism and discrimination can never be justified and is hard to heal.

In July this year, a Taranaki nurse had her registration cancelled, with the condition that she may not reapply for it for two years. Should she want to reapply, she would have to undertake study relating to cultural competence and a Nursing Council-approved code of conduct and ethics course. There would also be supervision requirements for a year. She was ordered to pay 15 per cent of the costs of the Health Practitioners Disciplinary Tribunal hearing.

The tribunal found her posts on an NZNO Facebook page in May last year to be "highly offensive and inappropriate". It went as far as to say "*her post makes racist generalisations about Māori nurses and offensive and derogatory generalisations about other nurses and the two key nursing organisations that represent nurses. Despite her attempts to justify her comments as being based on 'her experience', this cannot excuse racist generalisations."* Another factor that contributed to the cancellation of her registration was the fact she decided to keep working even after she was suspended, which, the tribunal said, amounted to malpractice.

I commend the tribunal for the decision, for recognising racism and finally drawing a line in the sand and proactively setting some level of expectations. Despite the fact that whakaruruhau and cultural safety have been part of nursing education for the past two decades, cultural safety standards have never been treated or viewed as having the same level of importance as clinical standards.

One of the architects of Kawa Whakaruruhau, Irihapeti Ramsden, recognised that cultural safety is based in attitudinal change. Health professionals work with people whose life experiences and cultures differ from their own. If they are not open-minded and non-judgmental towards other cultures, the care they offer and the wellbeing of their patients will be compromised.

Cultural safety is about the non-violation of all of those attitudes, values and actions which underpin the obligations inherent in Te Tiriti o Waitangi and the practice of tino rangatiratanga. Irihapeti believed that institutional and individual racism persistently violated this taonga and contravened Te Tiriti o Waitangi.

Racism is not acceptable, despite the fact our educational institutions and health policies underpinning nursing practice are inherently racist. If we want to change behaviour, we must address the cellular level of systemic policies to enable attitudinal change.

How have we changed our level of surveillance and monitoring to detect these behaviours? Can we take comfort as Māori that this tribunal hearing was an isolated case? Can we accept that there is a space such as social media that undermines others, that disempowers fellow nurses? There is little comfort in the outcome of this hearing. Disciplining one nurse does not change the system that perpetuates these behaviours.

Kerri Nuku

According to the tribunal, the fact the nurse had named workplaces, departments and one manager made her conduct even more serious. It stated that the Facebook posts were *"highly offensive and damaged the mana of Māori nurses and patients in Taranaki"*. Where among the penalties imposed by the tribunal is the restoration of mana to Māori nurses, whānau, hapū, iwi and the wider nursing community? And what restoration and support has been given to the person(s) who made the complaint?

Where have we strengthened the obligations that cultural safety is equally important to any other clinical competence and not just "a nice to have"? How are competency standards going to be monitored and reported in the future? I question the current standards within the health sector and the tools used by health regulatory authorities to eradicate racism. Disciplinary measures are often seen as a chance for a nurse to learn and reflect on their behaviours or actions that have caused harm or offence. But this is only one small step in the more radical measures needed to change deeply embedded systems. •

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How will end-of-life law affect nurses?

NZNO WILL start drawing up guidelines for nurses over the next 12 months on how to work within the new end-of-life law next year.

In last month's referendum, 65 per cent voted in favour of the End of Life Choice Act, which will come into effect in November 2021.

NZNO policy adviser Sue Gasquoine said now the act would become law, NZNO would be launching a research project among members, subject to ethics approval, on what clinical practice support nurses in Aotearoa New Zealand needed when nursing people at the end of life.

The research findings would inform a member survey, the responses to which would then form the basis of a national nursing framework.

"A valid framework for Aotearoa New Zealand would need to support nurses working in 'mainstream' end-of-life care and practising te ao Māori," Gasquoine said.

NZNO had not taken a position on end-of-life legislation, but would support its members to work within the law. That ncluded opting out of providing end-of-life care, which was provided for in the act, Gasquoine said.

"NZNO's stance on the bill, and now the act, is that while there are members representing the full spectrum of views on end-of-life choice, the concern is to support members to work within the law as they care for patients and their whānau who are making choices about end of life."

Following NZNO submissions in 2018, nurse practitioners were included among health practitioners who would provide care for people who choose to use the act to end their life, Gasquoine said.

NZNO hoped to lead or collaborate with organisations such as the Ministry of Health, Nursing Council, College of Nurses Aotearoa and medical colleges to develop guidelines for practitioners. It was also important to brief incoming Minister of Health Andrew Little on the need for nursing input as the Government prepared to implement the act over the next 12 months, she said.

NZNO acting associate professional services manager Kate Weston said nurses must "absolutely" be represented on the Support and Consultation for End of Life in New Zealand (SCENZ) group. SCENZ will keep records of health professionals willing to participate in assisted dying, maintain standards of care, and provide legal, medical and practical advice to health professionals.

"Some may be prescribing, but for most it will be in providing the actual care and we must have a voice in what this looks like," Weston said.

Results of cannabis referendum

With cannabis referendum results appearing to reject change, pending special votes, Gasquoine said there was disappointment over losing a potential opportunity to control and license cannabis products, potency and sales.

"The overall aim of reducing use and harm and the significant inequity that sees young Māori with criminal offences rather than addiction treatment options, are less likely to be realised now that cannabis use remains a criminal justice issue rather than becoming a health issue," she said. •

NZNO welcomes mesh review

NZNO WOMEN'S health college chair Denise Braid is welcoming the Accident Compensation Corporation (ACC) decision to review all declined injury claims related to surgical mesh since 2005.

"These women have suffered enormous stress and pain. The acknowledgement of this by implementing a review will go some way to address this," Braid said.

ACC announced in October its new guidelines would consider the latest medical understanding of mesh injuries when reviewing claims.

An estimated 377 mesh-related claims had been turned down over the past 15 years by ACC, Mesh Down Under (MDU) co-founder Patricia Sullivan said.

Sullivan said she was "cautiously optimistic" and hoped it would allow people injured by mesh to access help they "so desperately" needed.

Sullivan was pleased research by herself, Massey University nursing professor Annette Huntington and nursing student Emma Bramwell, *The Loss of a Life Well Lived,* in 2019 had informed ACC's new guidelines.

Sullivan urged anyone harmed by mesh who had been declined, or not put a treatment claim in, to do so now.

ACC's decision followed a Ministry of Health-led restorative justice process last year involving more than 600 people injured or affected by mesh. Sullivan said MDU would wait to see how many old and new claims were accepted before deciding if the process had been successful. •

Indigenous Nurses' hui

THE 2020 Indigenous Nurses' Aotearoa conference this year will be held on Friday November 27 and hui ā-tau (annual general meeting) on November 28. Both are virtual events, being held online via Zoom. Registration for Te Rūnanga members, to the hui, *Raising an Army of Māori Nurses – Rise Up*, is free, and can be done via the NZNO website. For more details contact hui@nzno.org.nz. •

Plan for more strike action finalised

NZNO ISSUED a strike notice late last month covering some 3200 primary health care (PHC) nurses and receptionist/administration staff across more than 500 practices and accident/medical centres nationwide.

The first 24-hour strike was due to be held on November 9, with a further 24-hour strike scheduled to take place on November 23.

PHC members voted overwhelmingly in favour of the strikes – "a clear indication of their frustration, anger and disappointment, and of how tired they are of being constantly undervalued after 10 months of fruitless negotiations", said PHC industrial adviser Chris Wilson.

This follows two national rounds of stop work meetings and a one-day strike on September 3.

"Despite assurances from the Ministry of Health, district health board [DHB] representatives and employers in September that there is finally a commitment to pay parity with staff employed in DHBs, there has been no tangible progress to enable a return to the negotiating table, so the strike notice has been served," Wilson said.

"It is very disappointing we have to take this step. Funders and the Government must join with the employers of this workforce and act with urgency to appropriately value their primary health care workforce and halt the staff recruitment and retention issues plaguing the sector."

At the end of October, the Minister of Health had encouraged NZNO members to continue using the Employment Relations Authority to help progress a settlement, Wilson said, "but we have already been to mediation with no progress because the Government will not address the funding issue at the heart of the problem. Our members are now feeling more fobbed off and angrier than ever".

Wilson said it was unfathomable that strike action should be required, with significant disruptions to services in the community, when all these PHC nurses and staff wanted was to be paid the same.

"They are not asking more than what is just – equal pay for work of equal value. We call on new Health Minister Andrew Little to find a solution. NZNO is willing to meet at any time to resolve this impasse."

At press time, a national plan for activities on November 9 was being confirmed. This would include national rallies and gatherings from midday and a march to the Ministry of Health in Wellington. Strike notices for the 24-hour strike on November 23 were also served early this month. •

NZNO ready to meet new Health Minister

NZNO LEADERS say they are looking forward to working with the new Minister of Health Andrew Little as soon as possible.

Kaiwhakahaere Kerri Nuku said Little and NZNO shared similar philosophies of kotahitanga – collectivism – and an interest in equitable outcomes. "We look forward to meeting him at his earliest convenience to progress Wai 2575 [Waitangi Tribunal claim into health services] and pay parity for Māori nurses."

President Heather Symes said she hoped the new minister would get up to speed quickly with NZNO's nursing manifesto, which outlined its priorities. After years of underfunding and a global pandemic, there were many challenges, she said.

"Investment to build up the capacity and capability of our health services is ever more urgent if we are to make significant improvements which affect working conditions of our members and the health and wellbeing of people of Aotearoa, New Zealand."

NZNO's key manifesto challenges were around supporting the health sector's recovery from the COVID-19 pandemic and reducing inequitable access to health care.

NZNO also welcomed Peeni Henare as Associate Minister of Health (Māori health), Chris Hipkins as Minister for COVID-19 response and Ayesha Verrall as Associate Minister of Health. •

MECA claims underway

NZNO's DISTRICT health board multi-employer collective agreement (DHB MECA) bargaining team is now waiting on information from the DHBs themselves in order to progress their claims.

"Quite a few of our claims need back-up information," explained DHB industrial adviser and lead advocate David Wait. "Take the claim around sick leave. Members tell us that 10 days' sick leave is simply not enough and has never been enough, if they are truly to be able to protect both their own and their patients' health. We are now waiting on the DHBs to provide us with sick leave data, so we can firm up this claim."

The election and establishment of a new government had also caused a hiatus in the negotiations, Wait said.

"We know that some of our claims will require increased funding from government in order for them to be met. We anticipate more progress will soon be made, now the new government is in place."

Having a negotiating team of 12 – twice as many as the team for DHB MECA negotiations in 2018 – was proving very effective, Wait said. "Having a more representative team was a recommendation from the Wilson report into the 2018 negotiations. This means most DHBs now have a representative delegate on the team. This has been the best decision ever. "

One member of the team had stepped down recently, due to an employment change. A delegate from Northland DHB, Jill Mortimer, had been nominated to fill the vacancy Her nomination was now out for member endorsement. The next negotiations are due to be held on November 18/19 in Wellington. •

‘Never felt so professionally compromised’

A NURSE working in an Auckland COVID-19 isolation facility says she has “never felt so professionally compromised”.

She is one of 22 nurses contacted by NZNO organiser Sharleen Rapoto, after NZNO was alerted to unsafe staffing and burnout problems across Auckland’s 18 isolation and quarantine facilities.

Rapoto said nurses reported ratios as poor as three registered nurses (RNs) and one health-care assistant (HCA) caring for more than 400 “guests” at one facility. That made it impossible to check guests twice daily, as protocols required, or adequately screen for COVID-19, Rapoto said. “Who knows what everyone’s got? Staff tell us the ratio is just impossible,” she said. “The risk is incredible.”

Other issues included pay and rostering. There were delays of up to four weeks, incorrect payments and agreed “incentive payments” not coming through. There was also a lack of support for nurses renewing their professional development and recognition programmes, resulting in loss of pay, Rapoto said.

Rostering problems

Rosters were not being posted 28 days in advance, members were being rostered on days they weren’t available and shortages meant staff were picking up extra workloads. Some of the placements had no time frame and temporary work had, in some cases, become permanent with no consultation. Staff were given split days off instead of two consecutive days.

Several had resigned, public health nurses usually working 9-5pm had been rostered on night shifts and agency nurses were given preferential rostering, Rapoto said.

There were also issues with employment agreements, which had not always been provided or were rushed through.

NZNO industrial adviser David Wait wrote to Counties Manukau District Health Board (DHB) on October 30, warning the “serious unresolved issues” in the managed isolation and quarantine facilities suggested the DHB was failing to meet its obligations under the NZNO DHB multi-employer collective agreement.

Payroll ‘being fixed’

Counties Manukau DHB had since taken steps to fix its payroll issues. It was giving assurances to NZNO members about their hours and engaging with NZNO over the unsafe staffing concerns, Wait said. “However, we need urgent action over promises,” he said. “Until these issues are resolved, finding sufficient staff will be especially challenging and the threat to New Zealanders remains very real.”

NZNO was working closely with other Council of Trade Unions-affiliated unions and the Ministry of Business, Innovation and Enterprise to develop a work participation agreement, for all workers in managed isolation or quarantine facilities across New Zealand. •

Wellington mental health staff ‘burning out’

NZNO IS working with the Public Service Association (PSA) over staff and patient safety concerns at Wellington Hospital’s mental health and addictions service, Te Whare o Matairangi (TWM).

NZNO organiser Drew Mayhem said staff at the 30-bed unit were extremely fatigued and experiencing burnout, with high turnover and potential risk to patients.

“They can’t recruit staff, they can’t retain staff, they can’t train staff, so staff are burning out for that reason.”

The problems prompted both unions to write to Mental Health, Addictions and Intellectual Disability Service (MHAIDS) general manager Nigel Fairley in February over loss of staff, unsafe staffing, sexual assault, overcrowding and the use of seclusion rooms to house patients. The problems were at “crisis point”, the letter warned.

They were highlighted again in March after a visit by ombudsman Peter Boshier, who said TWM’s use of seclusion rooms to home patients was a breach of the United Nations’ convention against torture “and other cruel, inhuman or degrading treatment”.

PSA delegate Ian Monzari said in a letter to *Kai Tiaki Nursing New Zealand*, union representatives were “encouraged by [management’s] willingness to acknowledge, and act upon, our concerns. . .” at a subseqent meeting in September.

Fairley said Capital & Coast District Health Board leadership had been “actively working in partnership with staff” over the past eight months to address concerns and was committed to working with staff and union partners to improve outcomes for staff and clients.

Despite COVID-19 disruptions, Fairley said progress had been made to:

- Employ a new health and safety business partner experienced in nursing care quality.
- Engage security staff to provide a sense of security of staff and clients.
- Implement a de-escalation communication tool *Safe Practice, Effective Communication* training schedule.
- Progress safer staffing levels where up to 16 staff work across a shift including registered nurses and mental health support workers.
- Progress safe staffing tool Trendcare.
- Use more suitable furnishings for seclusion rooms.

Mayhem said the problem was complicated, with mental health staff torn between their duty of care and lack of beds, as well as admissions being determined by off-site management, rather than by nurses’ professional judgement on-site. There was also a shortage of mental health nurses, he said.

Both the PSA and NZNO represent mental health nurses. •

Volunteer of the year

THE 2020 Health Volunteer of the Year is Patricia (Patu) Sigley, nominated by Kororareka Marae Society. She also received the Māori health volunteer award.

The annual awards began in 2013, with the Minister of Health announcing awards in nine different categories.

According to Ministry of Health information, Sigley worked as a nurse in small, isolated rural Māori communities, mainly in the Mid North, Bay of Islands, from 1966 until she retired five years ago. She also spent a large part of her non-work time volunteering, a practice she has continued in her retirement. Her colleagues describe her as a person who is “always on voluntary duty”, and an inspiration.

Sigley’s diverse volunteering activities include:

- helping establish and run hauora clinics in Russell, for both the people of Russell and the surrounding communities of Waikare, Rawhiti, Ngaiotonga and Okiato, including marae-based eye and podiatry clinics and sessions on health and wellbeing;
- volunteering for the Kawakawa rural ambulance service for 30 years;
- assisting people with everyday tasks, such as shopping and cleaning up, as well as holding someone’s hand during sad times;
- assisting kuia and kaumātua into pensioner housing;
- helping people transition from prison to community living;
- making people aware of the COVID-19 testing available and how to access it;
- helping distribute food parcels to families and whānau during COVID-19 and being available 24/7 to take their calls; and
- coordinating and supporting communities and medical practitioners with flu injections and COVID-19 testing in Kororareka/Russell.


Patricia (Patu) Sigley

Sigley said she felt very honoured to receive the awards. She credits nursing for giving her “so many opportunities and challenges in life”, and looks back on her nine years nursing at Ngawha Prison in Northland as a highlight. “I was a diabetes nurse educator so worked closely with prisoners with diabetes. I also enjoyed being an NZNO delegate.” •

Ara midwifery lecturer wins Ilam

ARA INSTITUTE of Technology midwifery lecturer Sarah Pallett has begun her new career as a Labour MP, representing the Ilam electorate. She won the seat resoundingly, ousting National MP and deputy leader Gerry Brownlee, who had held the seat since its creation in 1996.

On election night, she said she was “absolutely blown away” to have won the seat. “I think it shows that Ilam was ready for a new MP.”

Pallet’s experience as a midwife includes working both at Christchurch Women’s Hospital and as a rural midwife. At the time of her election, she was in her third term as president of the union Ara Academic Staff of Canterbury. She also co-founded and chairs the Canterbury Women’s Branch of the Labour Party, and is co-chair of the Labour Women’s Council, which represents all woman members of the Labour Party.

Her profile says “she has a strong sense of social justice, and is dedicated to ensuring that everyone has the same opportunities, irrespective of their gender, ethnicity or background”. •

Next year’s IND theme announced

THE INTERNATIONAL Council of Nurses (ICN) has announced the theme for International Nurses Day (IND) 2021. Following on from previous years, the overarching theme for IND is Nurses: A Voice to Lead. The sub-theme for 2021 is A Vision for Future Healthcare.

“This global COVID-19 pandemic has shown the world the important role that nurses play in keeping people healthy across the lifespan,” said ICN president Annette Kennedy. “While there has been significant disruption to health care, there has also been significant innovation that has improved access to care. In 2021, we will focus on the changes to, and innovations in, nursing and how this will ultimately shape the future of health care.”

NURSES
A VOICE TO LEAD
A VISION FOR FUTURE HEALTHCARE

ICN chief executive Howard Catton added, “The pandemic has exposed the weaknesses in our health systems and the enormous pressures our nurses are working under, as well as shining a light on their incredible commitment and courage. What the pandemic has also done is given us the opportunity to call for a reset and the opportunity to explore new models of care where nurses are at the centre of our health systems. We can only achieve this vision of future health care by generating new policies that pave the way for this sea-change and that is another key area IND2021 will seek to focus on.”

Nurses are invited to share their stories in the form of a case study to be a part of IND2021. Submissions and any questions should be sent to indstories@icn.ch. Previous case studies and IND resources can be found at www.icnvoicetolead.com •

New president wants unity and solidarity

By co-editor Teresa O'Connor

NZNO's new president has a range of skills to help her achieve what she wants to in the year ahead.

NZNO's newly-elected president Heather Symes brings a range of attributes to her new role. She has an outsider's perspective (she was born in Ireland); the mental health nurse's kit of practice skills; experience working with some of the most marginalised members of our society; a forthright manner; and an enduring belief in the importance of nurses' political action.

She believes all will stand her in good stead "directing the waka", along with kaiwhakahaere Kerri Nuku.

Symes left Ireland to train as a nurse in London in the mid '80s – "there was nothing in Ireland for us then". She completed her general training at the Whittington Hospital in north London and then embarked on her mental health nurse training at Middlesex University and Muswell Hill, a large London psychiatric hospital.

Once graduated, she worked in a large methadone clinic, and a needle exchange complex in central London. "Anyone could come in off the street. The emphasis was on harm minimisation and it was a one-stop shop. It provided a huge range of services – from a GP once a week, to drop-in sessions every afternoon; from education on how to inject safely to accompanying clients to appointments with social welfare agencies. It was a very ethnically diverse community, with people from around the world. Working there was a real eye opener for me." What she learnt there has informed her practice ever since.

Travelling was always on the cards and when a friend bailed on a joint adventure, she applied for the one-year working holiday visas to New Zealand for Republic of Ireland citizens – there were just 50 each year. She was successful and came to New Zealand in the mid-90s, "zig-zagging" her way around the country, enjoying the people and a nomadic lifestyle. She stayed in Christchurch and got a job on Hillmorton's acute wards. When the year was up, she returned home but, on touching down in London, she realised she wanted to return to New Zealand. "It was a great place. I felt comfortable there. I liked the people and I liked the fact there was no emphasis on religion or ethnicity."

She spent time in Ireland sorting out documentation before returning to Christchurch in 1996 and mental health nursing at Hillmorton, where she has continued to work in a range of settings for the last 24 years. She has taken a year's leave of absence from her role as a mental health nurse with the community forensic team to take up the NZNO presidency.

Symes ran for the presidency because "it was a good opportunity to get to the top table to make a few changes. I want to work collaboratively and to get on with the job of helping govern the organisation". She is clear her role is governance, not operations and management – "that's up to NZNO staff. We could do nothing without our staff".

The new board is "hugely diverse" with Māori and Pākehā, women and men, an enrolled nurse, nurses from the public and private sectors, and members of different ages. "It's a really good team and we are all there for the right reasons – the good of the members and the betterment of the organisation."

Symes is focused on moving forward together, after recent disunity in board ranks. "That was before my time. All I know is that from now on, we will be a board of unity and solidarity and will be doing our best for the organisation."

Her skills as a mental health nurse will stand her in good stead in the role, she believes. "I'm a good negotiator. I'm not afraid to front up to people. I'm good at calming situations down and finding a resolution through consensus and compromise."

'How many nurses have visited their MP and talked about our issues?' – Heather Symes

She says she's on a steep learning curve. "There's a lot I can learn about financial management and IT." She enjoyed the board's Institute of Directors' governance training last month.

Symes sees NZNO's bicultural relationship as working in collaboration with Nuku and always considering the articles of te Tiriti o Waitangi in discussions and decisions. "The treaty is one of the most important documents in this country; it's our founding document. It affects all our lives and we must always bear it in mind."

She believes there are some parallels between the Irish and Māori experiences of colonisation, land confiscation and suppression of language. "New Zealand is extremely lucky to have the treaty."

'Stronger union focus'

Some issues she'd like to promote while president include a stronger union focus for NZNO and more political activism by nurses – "how many nurses have visited their MP and talked about our issues?" A more just society has been a long-held goal and she is keen to promote equity of access to health services and treatment for Māori and other vulnerable populations. "On average, Māori die 10 years earlier than non-Māori. Why is that ok?"

So, it will be a busy year – her term ends in September 2021. She hopes by the end of that year, NZNO "will be in a better place than it has been over the last year. If we lose our members, we lose everything". •

Compassion fatigue takes its toll

Finding strategies to cope with workplace stress and burnout is important as the effects of COVID-19 continue to be felt in aged care.

By Natalie Seymour

Why do we all feel so tired? The reason is simple – COVID-19 has had a profound impact on nurses and care staff working in older persons' care.

Providing care to one of our most vulnerable populations has always been a privilege, amid a complex and challenging environment. Staff build close working relationships with their patients or residents and their families. These relationships can become emotionally taxing.

Add in a COVID-19 pandemic and it's all hands on deck, among radically changing policies and clinical care requirements – all of which must be communicated with residents, families and staff, and adopted into daily practice,

In the absence of visitors, staff also stepped up to become pseudo families. Already working in a sector with inadequate resources, nurses and other staff had to increase their care and support with even less backup in a fast-changing environment. At times, this resulted in compassion fatigue.

No group or region spared

It's now eight months down the track from the first COVID-19 outbreak and things are returning to our new normal. Compassion fatigue has become a term used daily and the impacts of the pandemic are being felt far and wide. It has not spared any particular group, facility or region as we all come to terms with how our sector has changed.

Natalie Seymour

The most important step is to assess the stressors in your life, both at work and at home.

The experience of COVID-19 has led to increasingly trusting relationships between staff, residents and their loved ones. However, the compassion fatigue manifesting in aged care has resulted in higher than usual sick leave, high staff turnover, burnout, job dissatisfaction and increased use of occupational counselling programmes.

When a phenomenon like a pandemic occurs, we see a higher level of resilience being adopted by those doing the caring as a means of self-protection. While this can help carers protect themselves, it also risks an erosion of compassion.

For nurses providing aged care, leading teams and supporting other disciplines, it is important that compassion fatigue symptoms are recognised, acknowledged and addressed.[1] Signs can vary between individuals and can include cognitive, emotional, spiritual, interpersonal and behavioural manifestations. These can be demonstrated in various ways – staff having a decreased level of concern about patients or residents, loss of or reduced empathy, physical, emotional and spiritual exhaustion, dissatisfaction with their role or job or even considering leaving the profession entirely. It's okay not to be feeling okay.

Nurses and other professions caring for older people, especially as they age themselves, tend to feel deep empathy and sympathy when residents experience loss, loneliness, illness and trauma. Nurses have an ingrained desire to remove the cause and to bring healing to those who are suffering.

As a profession, we are having to adjust how we take stock of our own emotions, so we can recognise our triggers. We talk about the importance of self-care, but have not always been so good at implementing it into our daily work and home lives. Identifying our own triggers and finding strategies will help us support our colleagues to do the same.

The most important step is to assess the stressors in your life, both at work and at home. Acknowledge the skills of your colleagues and delegate tasks accordingly and appropriately to create a better balance for both yourself and your colleagues. Allow yourself to rebalance your work life and make sure you have time to yourself during your day. The more that colleagues and managers understand our specific concerns at work and at home, the sooner and better they are placed to support us with those concerns. •

Natalie Seymour, RN, BN, is service manager at Nurse Maude Memorial Hospital in Christchurch. She was appointed chair of NZNO's college of gerontology nursing last month.

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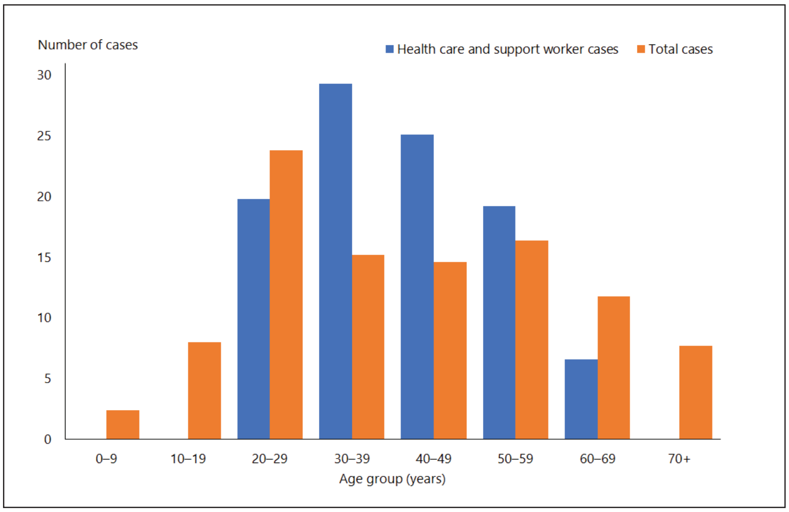
Aged residential care workers hit hard by COVID-19

A new Ministry of Health report has highlighted the incidence of COVID-19 among health-care workers and the need for a nationally consistent approach to managing pandemics in the aged residential care sector.

By co-editor Anne Manchester



Percentage of health-care worker cases of COVID-19 in Aotearoa New Zealand by age, compared with the percentage of total cases until June 12, 2020.[1]

During the first four months of the COVID-19 pandemic in New Zealand, there were 167 cases among health-care and support workers – 11 per cent of the 1504 total.

According to a Ministry of Health (MoH) report, 96 health-care and support workers with COVID-19 were likely to have been infected in the workplace. This represents 6.4 per cent of total cases.[1] Nine of the workers were hospitalised, with two needing intensive care. All recovered and there were no deaths.

More health-care assistants (HCAs)/caregivers in aged residential care (ARC) were affected, compared with other health-care and support worker groups. The majority of cases were part of a cluster, with very few instances of transmission in community health-care settings.

The report defines "health-care and support workers" as HCAs and caregivers, nurses, community support workers, doctors, allied health professionals (such as occupational therapists), and administration staff who work in a health-care setting such as ARC or a hospital. It also includes staff such as kitchen staff or security personnel who work in a health-care setting.

The first case of COVID-19 in a health care or support worker was reported on March 17, 2020. Of the 167 health workers diagnosed with COVID-19, 73 (43.7 per cent) were HCAs, caregivers or support workers, 49 (29.3 per cent) nurses, 16 (9.6 per cent) allied health professionals, 11 (6.6 per cent) administration staff, nine (5.4 per cent) doctors and nine in other occupations such as cleaners, students or catering staff.

Of the 167 cases, 60 (35.9 per cent) were found to have been infected outside the workplace (primarily transmission within their household or imported from overseas). For 11 cases (6.6 per cent), the source was unidentified but thought unlikely to be the workplace.

Workplace infections

Of the 96 health-care and support workers (57.5 per cent) who were likely to have been infected in the workplace, 42 people (25.1 per cent) were likely to have been infected by a patient, resident or client, and 32 people (19.2 per cent) were found to have been infected by another health-care worker.

The age of infected health-care and support workers ranged from 20 to 69, with a mean age of 41. Around half the cases were European, 4.8 per cent Māori, 9.6 per cent Pacific peoples and 35.3 per cent Asian.

Of the cases, 132 (79 per cent) were linked to a cluster, compared with 46 per cent of all cases. While this includes clusters unrelated to health-care settings, three major clusters in ARC facilities accounted for nearly half (49 per cent) of all cases in health-care and support workers.

The district health board (DHB) areas with the largest number of cases were Canterbury (48), Waitematā (37), Waikato (21) and Auckland (18). The higher numbers of cases in these regions reflect clusters in these areas.

Of the 96 health-care and support workers who were infected in the workplace, 60 (62.5 per cent) worked in ARC, 26 (27 per cent) worked in a hospital and 10 (10.4 per cent) worked in the community.

The majority (76.7 per cent) of health-care workers in ARC were health-care assistants/caregivers and 20 per cent were nurses. In the hospital setting, the highest proportion of infections was among nursing staff (76.7 per cent) and HCAs/caregivers made up only 11.5 per cent of cases.

According to the report, the length of time spent with COVID-19 positive patients or residents is a factor in the risk of a worker being infected with COVID-19.

Seven of the 10 hospital-based nurses who were diagnosed with COVID-19 were caring for residents transferred from ARC, as was the one HCA in a hospital setting.

It is likely that 32 workers with COVID-19 were infected by another worker in the workplace. All but one of these cases were linked to a cluster and the majority were in the ARC setting.

Of the 167 health-care and support workers who had COVID-19, 50 were likely to have infected one or more people, either at home or in the workplace.

The report highlights the importance of protecting workers, particularly nurses and HCAs/caregivers working in ARC, as the country continues to respond to the virus.

NZNO's acting associate professional services manager, Kate Weston, said it was disappointing but not surprising that most of the health-care workers diagnosed with COVID-19 worked in ARC.

"Aged residential care is often short staffed on a good day, and it was really, really stretched during COVID-19. Staff were telling us they didn't have enough time to take a break, or access the correct personal protective equipment with the right visors or masks, and donning and doffing was a problem."

Weston believes the whole country owes these workers a vote of thanks for the work they did, especially considering that the long-term effects of having the virus are still unknown.

The MoH is now implementing an action plan to address the recommendations made in the ARC cluster report.[2] A cross-sector, multidisciplinary working group, with representatives from ARC, DHBs, public health units and unions, has been formed to develop a nationally-consistent approach to managing pandemics in ARC.

Weston would like to see a full review of the COVID-19 response. •

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'A long and painful journey to recovery'

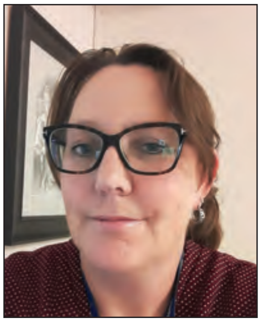
RECOVERING FROM COVID-19 has been a long and painful physical and emotional journey for Waikato rest home clinical nurse leader Donna Glossop (right).

Glossop was one of two registered nurses (RNs) at the Atawhai Assisi Home and Hospital in Hamilton to contract the virus in March. Three caregivers and three residents also contracted it, with 15 cases eventually linked to this first Waikato cluster.

Glossop is unsure how the virus first entered the 86-bed facility, though it may have been through the daughter of a resident visiting from Australia.

When a resident tested positive for the virus, 27 staff were sent home, tested and required to stand down for 14 days. At that point, Assisi lost 40 per cent of its staff, with a core group working extra hours and a number of volunteers stepping in to ensure residents were cared for safely. All residents had to stay in their rooms and eat meals alone for their own safety.

Glossop had six weeks off work. Although becoming "very sick", she did not need to be hospitalised. "When I first went to my doctor, he thought I had some kind of virus and just needed to rest. But I kept on getting worse. My body ached all over, I had a sore throat, a terrible cough, was suffering extreme fatigue and shortness of breath. Even getting to the toilet became a struggle – I had to stop for a rest on the way."



Glossop stayed locked in her room most of the time, even for her birthday. This was despite being a single mother and having a daughter with a baby living in the house. None of the family could leave the house, and they struggled to get their groceries and shopping delivered. "The kids were worried I would die."

When the drains blocked, Glossop could not even find a plumber willing to come to the house due to fear of contracting the virus. One of her friends had to ring the COVID-19 helpline in Wellington and a contractor was eventually found.

"I felt like a leper. Having the virus had a huge impact on me and my family, and created a lot of anxiety for all of us. The pain in my hips was excruciating – I would say my symptoms were 100 times worse than ordinary 'flu. I am very grateful for the daily phone calls I received from the public health nurse. She was so compassionate and understanding."

Glossop was impressed how well Assisi managed to contain the virus. "A district health board response team provided guidance on infection prevention and control, outbreak management and the use of personal protective equipment [PPE]. The home also brought in eight caravans and campervans to house staff onsite, as some were unable to continue living in shared accommodation or with vulnerable family members. Every staff member put on and removed PPE when entering and exiting residents' rooms. The cleaning routine was intense and continuous.

"A lot of people died during this lockdown period. We allowed family to visit their loved ones, but only in full PPE."

Glossop is grateful the home is now back to running normally, with visitors welcomed and activities restarted. She is still suffering from fatigue and doesn't feel as "bouncy" as she used to feel, but is confident she will gradually get her full strength back. •

The power of older person-centred care

By co-editor Mary Longmore

COVID-19 has provided a great opportunity to "reset" aged care and create a culture where older people can "flourish", said person-centred care expert and nursing professor at Edinburgh's Queen Margaret University, Brendon McCormack.

"We have a great opportunity to really think about the reality we want to create as we move forward," McCormack told the NZNO college of gerontology nursing at their virtual symposium in October, via video. "And actually it may not be just tweaking what we had before, but actually building a new model of older people nursing, which embraces the creativity and the energy that we bring to it as older people nurses and help us to enable everybody to flourish in their lives."

Person-centred practice was becoming a "truly global movement", he said, informing health strategies and systems worldwide, including the World Health Organization and Institute for Health care Improvement.

At its heart, the practice was based on the notion of "personhood", defined by different states of "being" (Figure 1). It is underpinned by the idea all people are equal and need to flourish – a concept originally from Aristotle. McCormack quoted the Greek philosopher saying: *"If I am not flourishing, I am languishing and languishing is a state worse than death."*

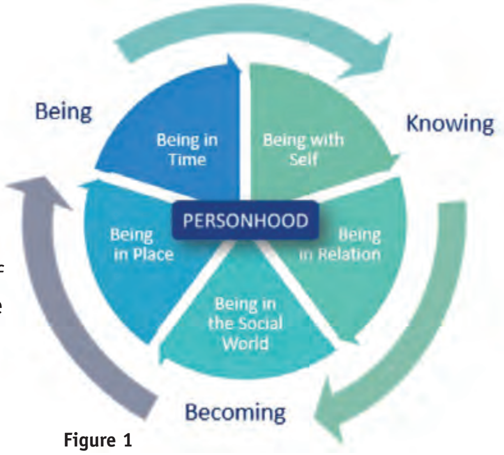


Figure 1

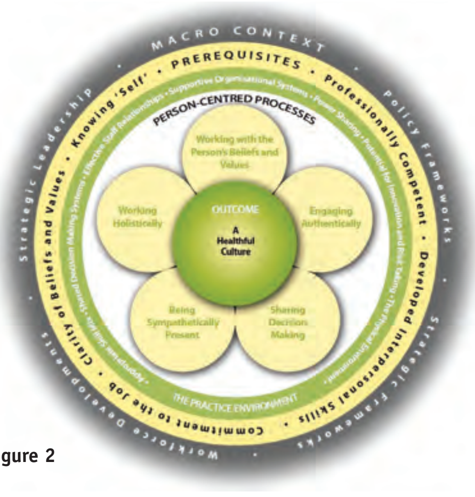


Figure 2

A person-centred approach considered the needs, culture and values of the person being cared for, but was more broadly based around relationships – with patients, residents, colleagues, managers, leaders and beyond.

This reflected the importance of flourishing for staff also, McCormack said.

"When we flourish, we are at our best, we are giving our best and we are able to give and receive loving kindness, that is we are able to connect with others in a loving way."

Danish philosopher Knud Ejler Loegstrup argued it was through our attitude to each other that we helped shape each others' worlds – and this was particularly true for nurses, whose "core function" was to help others flourish, McCormack said.

"As nurses, it's really important to think about that power that we have, particularly when working with older and perhaps vulnerable older people, he said."We can make their world big or small; it can be drab or bright and rich. . . threatening or secure".

A person-centred care practice framework (Figure 2) developed by McCormack and Tanya McCance, of Ulster University in Northern Ireland, provides a guide for curricula, strategies, policy and research in more than 29 countries. It suggests five qualities needed for person-centred practice are: knowing "self"; clarity of beliefs and values; professional competence; interpersonal skills and commitment to the job – the idea of being "present" at work and "bringing all of myself to the situation", McCormack said.

Brendon McCormack

However, the care setting must also be supportive of person-centred values, with shared power and decision-making, strong relationships, good skill mixes and potential for innovation.

COVID-19

Social distancing and the use of things like masks had made it harder to maintain connection with residents, McCormack said. However, there had also been some "beautiful" practices emerging, such as rainbow boxes with comforting items, comfort pebbles and other "creative ways of being present", McCormack said – including multi-media and the use of virtual reality, particularly in dementia and end-of-life care.

Massachusetts organisational developer Otto Scharmer has talked about COVID-19 being an opportunity to "pause, reset and step up".

McCormack, too, believed COVID-19 was an opportunity to look at aged care. "We do have a choice here. We can freeze and just wait for it all to return to some kind of normal. Or we can look at what choices we have. How do we create a world that's more compassionate and more person-centred, that enables us all to flourish?"

Carers had described person-centred care as the chance to leave a mark, or "imprint". "As a nurse, the thing I want to do most is to leave an imprint on the people I connect with and something that makes them feel they've had a good experience."

Rules vs patterns

But no matter how person-centred a practitioner was, it wouldn't work without a supportive environment.

McCormack believed aged care needed to move away from a "rule-bound" culture and look at "patterns" in care homes. "They exist in the energy that we share, through the unspoken practice we all engage in, but they generally always shape the day-to-day world we create in rest homes."

There were seven typical patterns residents engaged in:

- The dining experience
- Entering and leaving
- Getting up and settling down
- Social milieu
- Personal care
- Private, secret spaces
- Dying and death

Knowing these areas allowed the opportunity to create a "flourishing" culture, focused on creating positive patterns in the home.

Staff also needed to ensure positive patterns in their teams, with power-sharing and building nurturing relationships and positive ways to deal with conflict.

McCormack said it was important for gerontology nurses to be flexible – "having that fleetness of foot" – to work with older people, particularly those with dementia. "We have to travel through time all the time if we want to be person-centred with them". Find out more at:

www.placestoflourish.org •

College wants to attract more nurses into aged care

The NZNO college of gerontology nursing is working with the Waikato Institute of Technology (Wintec) to bring a more person-centred approach to aged residential care (ARC) in New Zealand.

Outgoing chair Bridget Richards said lower pay and lack of support were key reasons why nurses left aged care.

"We currently find that those who come to work in aged care will stay for only a year or so, with the aim of moving to the district health board [DHB]."

The college wanted to look at how to make ARC more attractive to nurses – and potential residents – and was partnering with Wintec's "Design Factory" team to find innovative solutions, Richards told *Kai Tiaki Nursing New Zealand*.

The NZNO college of gerontology nursing, with outgoing chair Bridget Richards (front left).

The Design Factory New Zealand brings together Wintec students and teachers and industry and community leaders to solve problems. It is one of 31 global design hubs, originating at Finland's Aalto University.

Researchers, social worker Anneke Driessen and registered nurse Shareen Hanif, both masters of professional practice students at Wintec, updated the college in October on the project: *How might we provide expert care to an ageing and changing population in Aotearoa, New Zealand*?

They said by 2050, 25 per cent of New Zealand's population would be over 65, and would require a "responsive, innovative, person-centred approach to thrive".

Barriers to thriving included loneliness, isolation, lack of support, fear of ageing and moving into a rest home. Not a single person interviewed by researchers wanted to go into ARC, Driessen and Hanif said.

These insights helped define the needs of older people (connection and support; a multi-disciplinary approach; a desire to stay in their homes and communities; better communication and improving "antiquated" technology).

Resulting ideas to make ARC more person-centred included a wellbeing book and a wellness expo – both "well-received", they said.

Their interviews also found nurses generally viewed working in ARC as a "stepping stone" to other work and not an attractive place to work, with too much responsibility and not enough multi-disciplinary support. Staff felt overworked and undervalued.

The next phase would focus on ARC staff needs.

Richards expected the findings to have national, and potentially global significance, for transforming ARC. •

Report by NZNO college of gerontology nursing committee member Morag MacKenzie and co-editor Mary Longmore

Teaching palliative care skills

As our population ages, the need for palliative care will increase. Greater clarity around undergraduate palliative and end-of-life care curriculum content is needed to prepare the future health workforce.

By Lis Heath, Richard Egan, Jean Ross, Ella Iosua, Robert Walker and Rod MacLeod

Advances in the management of chronic diseases, combined with an ageing population, have resulted in a rising prevalence of people with life-limiting conditions and multi-morbidities, with a corresponding increase in demand for palliative care. This trend reflects global challenges in health care and an urgent need for workforce development to meet the future needs of the population and ensure access to high-quality primary palliative care across all health-care settings.

Future projections for palliative care show the number of deaths in New Zealand is expected to rise steadily over the next 50 years, increasing by 83 per cent – from 30,300 in 2016 to 55,500 by 2068. This is reflected in a 92 per cent increase in the numbers of people needing palliative care, up from 24,400 in 2016 to 46,700 by 2068. This increase is due to the ageing population and will be felt in all health-care settings.[1] This is supported by a study at Auckland City Hospital in 2013, which showed 20 per cent of inpatients met the criteria for palliative care. The majority were over 70 and two thirds died within six months of admission.[2]

Education fundamental

The National Health Needs Assessment for Palliative Care estimates 80 per cent of these people will be cared for by primary (non-specialist) palliative care providers, and describes education as fundamental to ensuring the health workforce is prepared to care for these patients and their family/whānau.[3] Nurses are at the frontline of patient care and will therefore feel the full force of this increase, including new graduates who have the least amount of training and experience.

PHOTO: CREATIVE COMMONS

Many nurses do not feel well prepared to provide palliative and end-of-life care and find it stressful and emotionally distressing.

International research reports that many nurses do not feel well prepared to provide palliative and end-of-life care and find it stressful and emotionally distressing, which may be reflected in the care they provide.[4,5] Personal attitudes and beliefs may also influence nurses' willingness to care for people at the end of life,[6] although education is effective in addressing these issues.[7,8] Little is known about how registered nurses (RNs) in New Zealand learn to care for patients who are dying. Our research attempts to shed light on this issue.

Palliative and end-of-life care is recognised as an important component of undergraduate education among health-care professions.

Internationally, palliative and end-of-life care (PEOLC) is recognised as an important component of undergraduate education among health-care professions.[9.10] However, it has been under-represented in undergraduate curricula until relatively recently.[7,11] In fact, a recent article in *The Lancet* highlights this issue, stating the health-care workforce would have been better prepared for the COVID-19 pandemic if the long-standing recommendation to include palliative care in pre-registration training had been heeded.[12]

Fortunately, this is beginning to change, as many countries now include PEOLC in their undergraduate teaching. This has been driven by recommendations from governments and professional bodies in response to forecasts of overwhelming need. However, PEOLC still remains optional in most areas. National online programmes are available for nurses in Australia (*Palliative Care for Undergraduates* www.pcc4U.org) and the United States (*End-of-Life-Nursing Education Consortium* www.aacnnursing.org). In Europe, 43 per cent of countries include palliative care in undergraduate nursing curricula, including France, Austria and Poland where PEOLC teaching is mandatory.[13]

In New Zealand, the Ministry of Health (MoH) identified the need for workforce development in the *Palliative Care Strategy*.[14] This recommended the Nursing Council provide guidelines for the minimum palliative care content at undergraduate level. However, a 2008 survey of New Zealand undergraduate nursing programmes (in which six schools – 37.5 per cent – responded) found no identifiable modules in palliative care, but rather an integrated approach to teaching. This made it difficult to determine what was covered, and reflected a lack of visibility, and inconsistency between programmes.[15]

More recently, the MoH *Palliative Care Action Plan* prioritised the need to improve access to primary palliative care by *"supporting work to modify undergraduate education and training to provide the minimum knowledge and skills related to primary palliative care"*.[16] This statement provides a clear mandate for the council to introduce competencies to guide curriculum development. Without such competencies, teaching about PEOLC will remain optional and risk being squeezed out in favour of other topics, leaving graduates unprepared and without the necessary skills to care for these people and their family/whānau.

Survey of nursing schools

It is against this background that a national online survey of nursing schools was undertaken in 2019 as the first phase of a doctoral research project. This was approved by the University of Otago Human Ethics Committee. The aim of the survey was to obtain information about how PEOLC is taught and assessed in undergraduate nursing programmes in New Zealand. The results will be used to identify strengths, barriers and opportunities for PEOLC curriculum development.

Preliminary results indicate that PEOLC is taught in all programmes that responded (76 per cent, n=13). Teaching was mostly in an integrated manner, but with wide variability in curriculum time, methods and content, and an overall lack of assessment in PEOLC. Pressure on curriculum time and lack of clinical placements were identified as barriers to development.

Much depends on the availability of a "palliative care champion" to advocate for, and coordinate teaching in each school. This may reflect the absence of any specific requirements from the Nursing Council to include PEOLC in undergraduate curriculum content for RNs, although it may be inferred, depending on interpretation.[17]

Interestingly, however, the council does include questions that relate broadly to PEOLC concepts in State final examinations.[18] Overall, there is a need for greater clarity around the minimum PEOLC content required for undergraduate nursing education to secure the necessary support for curriculum development and prepare graduates to meet the palliative care needs of the population in the future.

Next phases of the research

The next two phases of this research explore graduates' exposure to PEOLC-related activities in clinical practice, as well as their self-efficacy and attitudes towards providing this care. This included the factors that influenced their development of self-efficacy in PEOLC during their undergraduate training. The full results from the survey of nursing schools, and the subsequent phases of this research will be reported at a later date. •

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Robert Walker is a professor in the Department of Medicine, University of Otago.
Rod MacLeod is a Hospice New Zealand clinical adviser.

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Ensuring informed consent for

By Elizabeth Henning, Jessica Wu, Georgia Battin, Kris Munar, Chloe Oh and Emma Stevenson

There are a range of ways nurses can ensure they obtain informed consent from hearing-impaired patients.

PHOTO: GOOGLE IMAGES

'To relay information to deaf patients, we used visual cues and writing on paper.'

Health-care professionals use the process of informed consent to communicate the risks and benefits of procedures to patients. However, barriers may hinder patients' understanding and prevent them from making informed decisions. During a student clinical placement, we witnessed the impact a hearing impairment had on gaining informed consent. This article explores, from a student nurse perspective, the challenges of gaining informed consent and offers possible solutions to ensure patients have the opportunity to make educated decisions.

Clinical scenario: *Mrs J, a 35-year-old woman, was admitted to the ward for a nephrostomy procedure. She was registered as deaf following meningitis as a child. Mrs J's hearing impairment caused challenges in obtaining a health history and informed consent for this procedure. An interpreter could not be present at all times, making gaining consent from Mrs J before providing nursing care problematic. Indeed, the student nurse observed registered nurses provide care to Mrs J without obtaining consent.*

We asked the following questions:

1) How is patient safety affected by a hearing impairment?
2) Which patient rights are at risk?
3) What competencies and codes are breached when nurses do not obtain informed consent?
4) How can nurses prioritise informed consent when they have a high patient load?

▶Patient safety: Patient safety is paramount, and obtaining informed consent is considered a patient safety issue.[1] Patient safety is defined as the prevention of errors and adverse effects related to patient care.[2] Impaired hearing can affect the gaining of informed consent. If the patient inadvertently mishears information, this could consequently threaten patient safety on several levels. On one occasion, the student nurse observed Mrs J receiving nephrostomy wound care from the registered nurse who had not obtained consent. This interaction caused the student nurse to question if informed consent was obtained when health-care professionals were providing care to hearing-impaired patients.

Scholars have identified that deaf and hard-of-hearing individuals tend to sign consent forms without being fully informed.[3] They can also be at risk of misdiagnosis or mistreatment due to incomplete or incorrectly obtained medical history. Unnecessary lab tests and dissatisfaction with health-care services are also common in the deaf community, and deaf patients have a harder time booking appointments and understanding health-care advice.[4] A lack of effective informed consent can, therefore, lead to poorer health outcomes.

▶Patient rights: Health-care professionals have a moral and legal obligation to obtain informed consent to maintain patient rights.[5] If a patient is asked to make health-care decisions without full access to the relevant information, their rights are being breached, and care becomes unethical. NZNO's *Code of Ethics*[6] and the *Code of Health and Disability [HDC] Services Consumers' Rights*[7] describe what patients are entitled to during hospitalisation. The HDC code's fifth to seventh rights encapsulate a patient's right to informed consent.

The right to be fully informed, treated with respect and other principles in NZNO's code are breached when provisions are not made to ensure a patient has understood information provided. It is important to understand that a hearing impairment does not affect a person's ability to reason and make informed decisions.[7]

▶Competencies and codes: Nurses spend more time with their patients than do other members of the health-care team, and nurses are accountable for obtaining informed consent before beginning nursing interventions.[7] Without informed consent, nurses breach

hearing-impaired patients

the Nursing Council's competencies for nurses.[8] Competency 3.1 states health consumers must have an adequate explanation of the proposed treatment options, and competency 3.2 states nurses must respect health consumers' rights to participate in decision making.[8] In the absence of informed consent, both of these competencies are breached. Moreover, competency 3.5 outlines that, where a patient is not competent to make an informed decision, the nurse must take reasonable steps to ensure the care is in the best interests of the patient.

Breaching these competencies means nurses have not worked with their patients to enable them to make informed decisions and give informed consent.[9] Without obtaining informed consent, the Health Practitioners Competence Assurance Act 2003 is also breached, with serious implications for both the patient and the nurse involved.

▶Prioritising nursing tasks: For patients to be fully informed before giving consent, the nurse must be able to communicate effectively. Nurses must be thoroughly involved in the informed consent process and advocate for their patients. This may prove especially difficult in busy clinical environments. Increased workload, high stress levels and time constraints reduce a nurse's capacity to communicate effectively with patients.[10] Indeed, nursing shortages compound this problem.[11] Therefore, these potential barriers to gaining informed consent must be mitigated by health-care professionals to improve their delivery of care.

The National Institute of Health, based in the United States, offers guidelines and procedures that can improve communication between the hearing-impaired patient and the nurse.[12]

Even if consent is given, the HDC code will be breached if the patient misunderstood and/or was not fully informed.[13] Without proper procedures to help hearing-impaired patients, gaining consent will be challenging, which risks patient safety and breaches relevant codes.

The COVID-19 pandemic has put unprecedented pressure on health-care systems all around the world.[14] In light of this, finding effective ways to communicate relevant information to patients has never been more important. In many situations, health-care professionals must wear personal protective equipment, including a face mask.[14] This poses a barrier to lip reading. To combat this, clear face masks are used for the deaf and hard of hearing.

The importance of hand hygiene is also highlighted. Posters, sign language and simple images function to remind deaf patients to wash their hands regularly.

PHOTO: GOOGLE IMAGES

Clear face masks can help nurses' communication with the deaf and hard of hearing.

Recommendations

Allowing a hearing-impaired patient to choose their preferred communication method (sign language, visual prompts or lip-reading), will foster a positive nurse-patient relationship.[15] The body language of the nurse, including eye contact and appropriate nodding, is crucial in building rapport with the patient. Without this, hearing-impaired patients are more likely to feel anxious during their hospitalisation.[16] The nursing workforce should be better educated about communicating with hearing-impaired patients to provide quality care. Visual cues, such as simple diagrams, provide a platform for hearing-impaired patients to give informed consent. The general emphasis, when providing care to hearing-impaired patients, is the importance of gaining informed consent throughout their care. The gold standard for communicating important clinical information to the hearing impaired is to use an interpreter.[17] It may also be useful for the nurse to regularly check if the patient has understood the information.

During clinical placements, nursing students observe a range of approaches to gaining informed consent. Working with patients with various levels of hearing impairment increased our awareness of the importance of effective communication. To relay information to deaf patients, we used visual cues and writing on paper. As students, we have a responsibility to advocate for our patients and develop nursing practice which prioritises patient safety.

Conclusion

New Zealand policies and codes clearly outline the role of the nurse and how to prioritise informed consent. Alternative ways of communication and thus ensuring patient safety are emphasised. Various recommendations aid in breaking down barriers associated with informed consent, including visual prompts, lip reading and increased awareness about communication with the hearing-impaired. Implementing these methods will improve nursing practice by advocating for and protecting all patients, regardless of their capacity to make informed decisions. •

** References for this article are on p5.*

Elizabeth Henning, Jessica Wu, Georgia Battin, Kris Munar, Chloe Oh, Emma Stevenson and **Kim Ward** are second-year nursing students at the University of Auckland. They wrote this article as part of an assignment, working with their lecturer Kim Ward.

PHOTOS: ADOBE STOCK

Talking about health:

Experiences with the general practice team and support for self-management

The fifth and final of a series of professional education articles based on the *Talking about Health* study looks at the relationships between people with long-term conditions and general practice nurses and doctors.

By Claire Budge and Melanie Taylor

This article focuses on the *Talking about Health: Long Term Conditions* study[1] participants' experiences of general practice consultations.

The aims are to explore:

- Which doctors and nurses in the general practice team (GPT) are involved in their long-term condition (LTC) care.
- How people rated their experiences with the doctors and nurses working as part of the GPT.
- How people rated the overall LTC care and support received from the GPT.
- The relationship between ratings of general practice experiences and GPT support and their self-rated health and wellbeing.
- Whether people feel they know more about their health and make better choices when they have seen a doctor or nurse at their general practice.
- What people would like to change about their general practice consultations.

Most of the analyses are based on the 2016 (year 1) data, but the question regarding changes to consultations was asked in year 3, so the final aim is addressed using the 2018 data.

Specialist LTC nurses

IN THE MidCentral region, specialist community-based nurses are employed by practices or by the primary health organisation (THINK Hauora) to work alongside general practice teams in providing support for people with long-term conditions. They are known as community clinical nurses for long-term conditions (CCN-LTCs). •

Measurement

To find out which primary-care practitioners were involved in our participants' care, we provided a list comprising general practitioner (GP), practice nurse (PN), community clinical nurse for long-term conditions (CCN-LTC) and specialist nurse or nurse practitioner (SN/NP). Participants were asked to tick all that they had seen during the last year. Consultation experiences were rated separately for GPs and nurses (if they saw more than one, they were asked to rate the one seen most often), using the same set of 14 questions based on the New Zealand version of the United Kingdom General Practice Assessment Questionnaire[2] for each.

The question stem was: "When you see the doctor/nurse at your general practice, how good are they at . . ." Each item represented a different aspect of the consultation, such as "listening to what you have to say" and "spending enough time with you", and was rated using a six-point scale ranging from "very poor" (1) to "excellent" (6). Overall support received from the GPT for management of LTCs was rated on an 11-point scale from 0 ("not at all good") to 10 ("extremely good"). Two statements were provided to assess whether people felt they had benefitted from their GPT consultations: "When I have seen a doctor or a nurse at my general practice, I feel I know more about my health"; and "When I have seen a doctor or a nurse at my general practice, I feel I can make better choices". These statements were accompanied by the responses "strongly disagree" (coded as 1), "disagree" (2), "agree" (3) and "strongly agree" (4). General health (GH: single item with poor/fair/good/very good/excellent response options), physical health (PH: four-item scale) and mental health (MH: four-item scale) were measured using the PROMIS Global SF.[3] The effect of LTC/s on quality of life was measured with a single question rated on a scale from 0 ("no effect") to 10 ("very large effect").

Results

The doctors and nurses involved in LTC care
Participants were asked about which doctors and nurses at their general practice had been involved in their LTC care during the last year (N=554). Almost all (96.8 per cent) had seen a GP and most (72.9 per cent) had seen a PN. A CCN-LTC had been seen by 29.6

Table 1. Top and bottom scoring items, based on mean ratings of GPs

	When you see the DOCTOR at your general practice, how good are they at . . .	Mean	Excellent/ very good (%)	Poor/ very poor (%)
TOP	• Making you feel comfortable about your physical examination	4.9	67.1	2.0
	• Knowing about your medical history and current treatment	4.9	67.7	3.4
	• Introducing themselves and asking you to introduce yourself	4.8	66.9	4.7
	• Listening to what you have to say	4.8	65.2	4.0
	• Explaining your problems or any treatment you need in a way you can understand	4.8	65.4	3.9
BOTTOM	• Spending enough time with you	4.5	56.0	6.7
	• Involving family/whānau/fanau in decisions about your care	4.5	55.4	11.6
	• Knowing about you as a person, not just a patient	4.4	53.2	10.7
	• Learning about and helping with your social support needs	4.2	44.7	12.4

Table 2. Top and bottom scoring items, based on mean ratings of nurses

	When you see the NURSE at your general practice, how good are they at . . .	Mean	Excellent/ very good (%)	Poor/ very poor (%)
TOP	• Making you feel comfortable about your physical examination	4.9	69.6	1.5
	• Listening to what you have to say	4.9	69.1	1.3
	• Asking fully about your symptoms and how you are feeling	4.9	68.0	1.9
	• Introducing themselves and asking you to introduce yourself	4.9	68.5	2.7
BOTTOM	• Involving family/whānau/fanau in decisions about your care	4.5	58.1	9.4
	• Knowing about you as a person, not just a patient	4.5	55.5	8.7
	• Learning about and helping with your social support needs	4.4	51.2	9.2

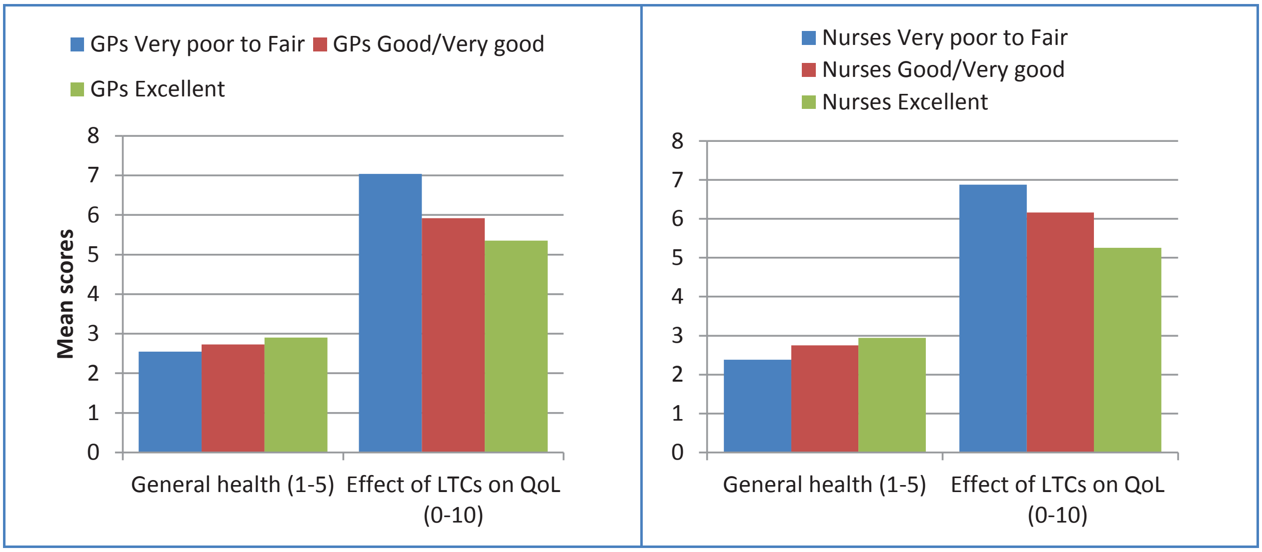

Figure 2: Mean scores on general health and effect of LTC on quality of life according to ratings of experiences with GPs and nurses

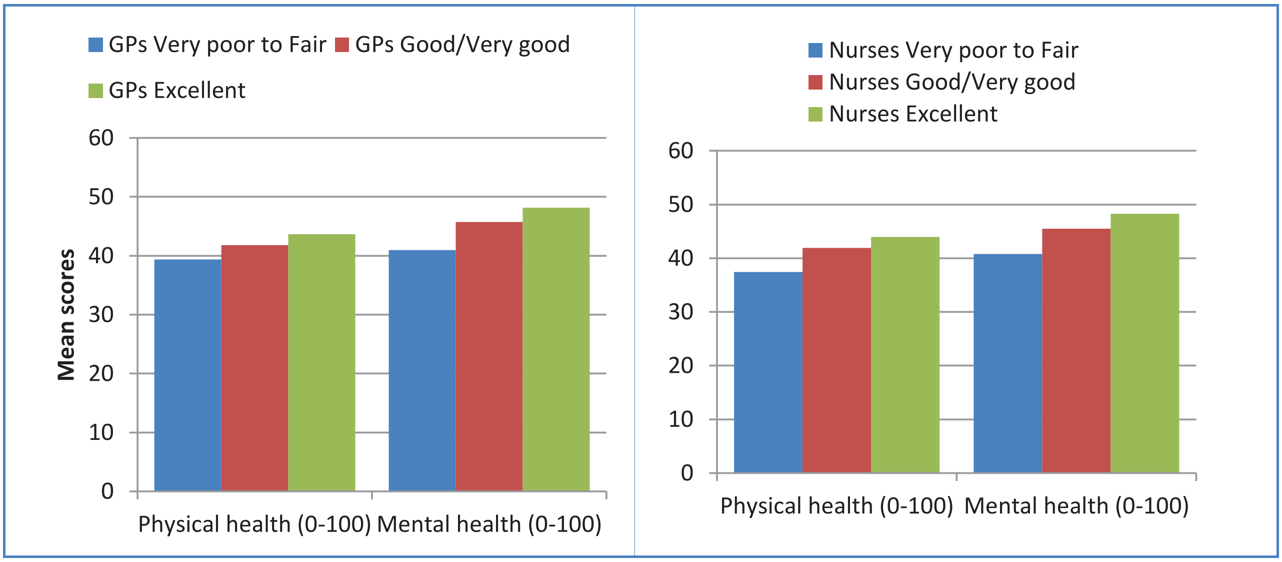

Figure 3: Mean scores on physical and mental health according to ratings of experiences with GPs and nurses

per cent and an SN or NP by 29.1 per cent. Eighty nine people (16.1 per cent) said they had seen only one type of practitioner at their general practice during the last year; 72 (13.0 per cent) had seen just a GP, eight (1.4 per cent) an SN or NP, five (0.9 per cent) a PN and four (0.7 per cent) a CCN-LTC. The majority of participants had seen at least two practitioners, the most common combination being GP and PN (40.1 per cent).

Ratings of experiences with doctors and nurses

Table 1 (see p21) displays the top and bottom-scoring items, based on mean ratings of GPs. It also shows the percentage of participants rating each as excellent or very good and poor or very poor.

The same results, but this time in relation to nurses seen in general practice, are presented in Table 2 (p21).

There are obvious similarities in the top and bottom items for doctors and nurses, with making people feel comfortable during physical examinations and listening to people featuring in the top for both GPs and nurses. Knowing the patient, embracing an holistic view of health, and cultural needs being met were all rated relatively low for both disciplines. However, the observation that "asking fully about symptoms" appears in the top three for nurses, not doctors, and "spending enough time" appears in the bottom three for doctors, but not nurses, may reflect appointment systems enabling nurses to spend more time with patients than doctors, thus encouraging more in-depth discussion of issues. Interestingly, involving family/whānau/fanau in care decisions was considered to be "not applicable" by more than half of the participants.

GP experience (GPE) and nurse experience (NE) scales were formed by averag-

Key points

- Almost everyone had seen a GP during the previous year and almost four-fifths had seen a practice nurse. Around a third had seen a specialist nurse or nurse practitioner at the practice and a third had seen a community clinical nurse (CCN-LTC).
- Consultation experiences were rated as good to very good overall. However, a quarter of the respondents rated their interactions with their GP, and a fifth their interactions with nurses, as less than good (very poor, poor or fair).
- Aspects of the consultation said to be done best were things that are integral to all types of consultations. Some of the aspects most relevant to people with LTCs – such as knowing the patient as a person, spending enough time, learning about broader social needs, and including whānau in decision-making – were considered to be less well done.
- A number of participants, Māori as well as non-Māori, noted that having their whānau included was not relevant.
- Overall LTC-related care and support from the GPT was rated as 7.9 out of 10 on average.
- Higher ratings of consultation experiences with doctors and nurses and higher ratings of support from the GPT were associated with better self-rated general, physical and mental health, and with LTCs having less impact on quality of life.
- Desirable changes to general practice consultation included more personalised care and respect, quicker access, lower costs, better follow up, more time and continuity of care.

ing the item scores. If participants had answered 12 or more of the 14 questions, they were included; if not, they were discarded from the calculation. GPE scores ranged from 1.4 to 6, with an overall mean of 4.7, and NE scores ranged from 1 to 6, with a mean of 4.8. Nearly half the sample rated their interactions with general practitioners and nurses at the general practice as very good to excellent on average. However a quarter of the respondents rated their interactions with their GP, and a fifth rated their interactions with nurses, as less than good (ie very poor, poor or fair).

Ratings of care and support for LTC management from the GPT

The overall ratings of care and support for managing LTCs received from doctors and nurses at the general practice (N=542) ranged from 0 to 10, with a mean of 7.9, a median of 8 and a mode of 9. Half of the participants rated the LTC support they receive to be a 9, or a 10 out of 10, and 14.2 per cent rated it as 5 or less.

Relationships between general practice experience and support and self-rated health and well-being

The mean GP experience (GPE) and nurse experience (NE) scores were re-coded into three groups, based on the following scores (category labels): 1 to 2.9 (very poor/poor/fair); 3 to 4.9 (good/very good); and 5 to 6 (excellent). Mean scores on general health, physical health, mental health and the effect of LTCs on quality of life were calculated and compared for the three groups. As can be seen in Figures 2 and 3, on average as the ratings of doctor and nurse experiences increased, so did ratings of general, physical and mental health. Higher general practice experience scores were also associated with LTCs having less of an impact on quality of life.

GPT support scores were similarly used to divide

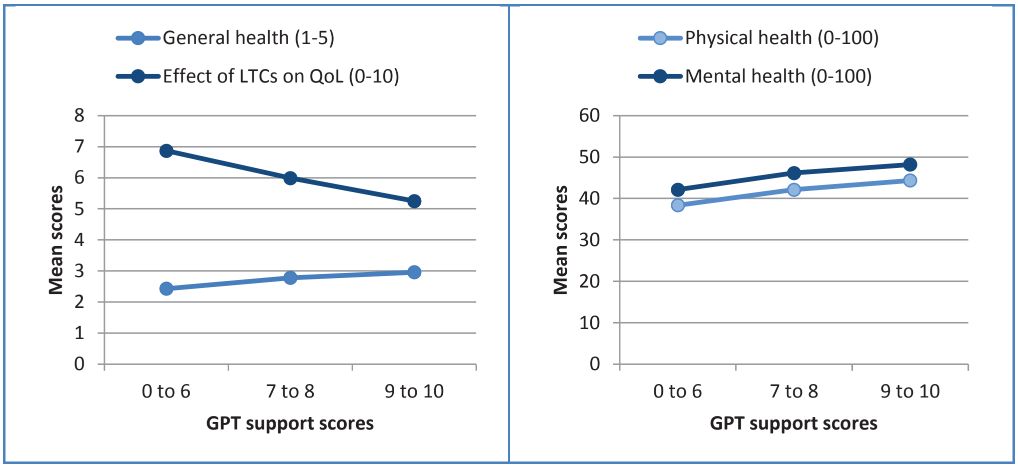

Figure 4: Mean scores on health and effect of LTCs on quality of life according to ratings of support from the general practice team.

the participants into three groups; scores of 0 to 6, 7 to 8 and 9 to 10. Comparing mean scores on health and the effect of LTCs on quality of life across these three groups (Figure 4) demonstrates that those reporting a higher level of support had better self-reported health on all three measures and indicated their LTCs were having less impact on their quality of life.

Knowledge and choices after GPT consultations

Most people agreed that they knew more about their health after seeing a doctor or nurse at their general practice (71.8 per cent), with 12.2 per cent agreeing strongly. However, 14.5 per cent disagreed and 1.5 per cent disagreed strongly. Similarly, the largest group (67.7 per cent) agreed they could make better choices following a consultation, 14.1 per cent agreed strongly, 16.2 per cent disagreed and 1.9 per cent disagreed strongly. Scores on these two questions were moderately positively correlated with GPT support scores (r=.52 and r=.37 respectively), suggesting that people who agreed that they knew more, or that they could make better choices following a consultation, also felt better supported to manage their LTCs.

We looked at the group of people who had disagreed or disagreed strongly with both statements (n=57), and compared them to those who had agreed or agreed strongly with both statements (n=397). Those who disagreed were generally younger, less likely to have a care plan, to have more LTCs on average and have less income than those who agreed.

Changes wanted in consultations

In 2018, we added a question at the end of the GPT ratings to ask what, if anything, participants would change about their consultations with doctors/nurses at the general practice. This open-response format question generated a broad range of answers. Of the 174 respondents, 50 (28.7 per cent) indicated the question was not applicable, that they were unsure of what they would change, or said they were happy with the service provided. The other responses were grouped according to content, and the main themes were (with comments from participants):

- **Personalised care and respect:** Participants expected to be treated well in the consultation. They expected practitioners to have a pleasant approach, and to feel concern and interest and allow them to express their own thoughts and ideas. They also wanted to be shown respect, to be heard and accepted (not judged).

> "Doctor listening to me, not looking at the computer. Telling me to come back next week if I still have a problem instead of addressing it at the time. Not prepared to discuss more than one problem."

- **Access:** Many participants said the waiting time for getting an appointment was too long, many having to wait for weeks rather than days. This was particularly problematic when they wanted to see their own GP.

> "Often hard to get an appointment with my GP as the practice is very large and very busy."

- **Cost:** The cost of general practice consultations, repeat prescriptions and collecting medicines was frequently raised.

> "Not everything is about money, they will charge you for everything they can, you cannot see the emergency doctor without going to the nurse first and they charge you for both."

- **Time:** People identified the busyness of general practice as a problem. Some people felt "rushed" and others felt like a "nuisance". More allocated time per consult was requested, as 15 minutes was not perceived to be enough to meet the needs of people with LTCs.

> "Stop making me feel like I'm taking up their time and then wanting me out even though I haven't been there for the allotted time."

- **Care continuity:** Participants wanted consistency of care and having their own GP or nurse for the consultation was very important. Extended waiting times often meant that patients had to see other practitioners or locums.

> "Being able to make appointment with original (normal) doctor and not seeing any doctors that are free at the time."

- **Follow up** was important, as it showed participants that practitioners cared about their progress.

> "Follow up after certain time frame from the visit, just to check that you may (or may not) be improving."

Discussion

It is clear from these results that most of the Talking About Health participants had received care from both GPs and practice nurses at their general practice, and about a third had seen one or more specialist nurses or a nurse practitioner (including CCN-LTCs). Clearly more people are now receiving care and support for their LTCs from nurses, rather than GP alone. This reflects the purposeful change introduced in our region a decade ago, with nurses promoted as being best placed to provide effective LTC care and self management support.

Although a large number of people were satisfied with their experiences, many good suggestions for consultation changes were offered. Many wanted a system that was more responsive to their needs as a person with at least one LTC. This included care continuity, reduced waiting times (both for an appointment and in the waiting room), more personalised support and lower costs. A recent survey of experiences with New Zealand health services found one in five of the 72,000 participants avoided a general practice appointment and one in five of the Māori/Pasifika respondents chose not to collect a medicine due to cost. Cost was more of a challenge for younger people and those with LTCs.[4]

In the Talking About Health study, experiences people had with doctors and nurses in general practice were considered to be good overall, and more positive experiences were associated with better self-reported health and LTCs having less impact on quality of life. However the experiences rated least well were those of particular relevance

Practice points

- EXPERIENCES WITH doctors and nurses were rated positively overall, but those rated least positively were things that were of particular relevance to an LTC population and consequently identify areas for improvement.
- HAVING A better understanding of what people are dealing with, in the context of their conditions and social situations, can enable practitioners and support people to know how they can best provide self-management support. Involving whānau and friends in consultations and care decisions can facilitate better use of self-management resources by patients. Therefore they should be actively encouraged to bring along a support person (who may well be waiting in the car) to be part of the consultation. This provides an opportunity to gain their input, educate and inform supporters and enhance the quality of support.
- LACK OF time during the consultation is always going to be an issue for LTC patients, as most are on medications, requiring repeat prescriptions and follow up, and most have more than one condition, adding to management complexity. Perhaps patients could be taught to prepare for appointments, bringing a prioritised list of what they want to talk about and the confidence to ask important questions. Others have cultural requirements that may be better met by another practitioner such as an iwi or Māori provider. Thinking about the person in their entirety, and, therefore, who would be more likely to have the most time to support them and their whānau with their LTC management, is central to good care.
- TAKING A "what matters most" approach,[6] asking people what is important to them during the consultation, would address a number of our participants' concerns. This would enable care to be personalised and respectful, and would increase practitioners' understanding of individuals' challenges. If you ask what is most important at any one time, the answer may surprise you, as it might not relate to their diabetes or respiratory health but might be concerns about caregiving, mobility or loneliness. All of which could be addressed.

Could more people be encouraged to sign up to the portal so they can contact their provider by email or see their reports and recent results?

- IN LIGHT of the changes to mode of consultation encouraged by the COVID-19 situation, it is timely to consider what changes could be implemented into the new "business as usual" model for people living with LTCs. For example, could we increase the number of those with a care/action plan? Could more people be encouraged to sign up to the portal so they can contact their provider by email or see their reports and recent results? How could you change the way **you** do things to provide better self-management support for people with LTCs?

to people with LTCs who generally need more time, to be known as a person, have their social/living situation taken into account during consultations and have whānau included in care decisions. These are key components of holistic care and most could be addressed through a longer consultation and by providing ongoing self-management support. Using a "what matters most approach" in care discussions would be a great start to learning more about the individual and their life context.

LTCs consume 59 per cent of publically funded health expenditure and 13 per cent is due to multi-morbidity (the amount spent over and above the costs associated with specific conditions).[5] Therefore reviewing the processes used to deliver LTC care and self-management support is essential – especially within general practice, the patient's health-care home. For people to be good self-managers, they need to feel informed and have the knowledge, skills and confidence to care for themselves and to work in partnership with their health-care team to improve their LTC management. •

Claire Budge, PhD, is a health researcher for THINK Hauora. Since completing her PhD in psychology in 1996, she has conducted a wide range of health-related research projects, more recently on self-management issues for people with LTCs. **Melanie Taylor, RN, BASocSci, MN,** is a nurse adviser, long-term conditions, for THINK Hauora. For the last 13 years she has focused on improving LTC management in primary care, with a particular interest in health redesign, self-management and health literacy.

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He'd always wanted to pursue the medical field but was unsure of which direction to take, so he utilised the Incubator Programme at the Southern District Health Board, in year 13 at Northern Southland College.

Designed to foster student passion for careers in health through mentoring, Dylan was able to experience a broad spectrum of healthcare through the programme and said "it was from that day on I knew my heart was in nursing".

During his three years of study at SIT, Dylan-Tane said the tutors are extremely supportive, and there was a real feel of the 'Southland family vibe'.

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Whilst he's currently working in Critical Care, managing acutely unwell and deteriorating patients, Dylan-Tane isn't resting on his laurels, he's now completing postgraduate studies, to achieve the role of Nurse Practitioner.

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Advertising in *Kai Tiaki*

This is the first of a two-part analysis looking at how advertising in *Kai Tiaki Nursing New Zealand* has changed in the decades since its inception in 1908, and some of the historical factors behind the changes.

By Wendy Maddocks

The Kai Tiaki Nursing Journal, established in 1908 by Hester MacLean (later Matron-in-Chief), has long been a way for nurses to communicate professionally.[1]

Over the years the journal has had a variety of names: *Kai Tiaki The Journal of the Nurses of New Zealand* (1908-1930);[2] *New Zealand Nursing Journal (Kai Tiaki)* (1930-1994); and *Kai Tiaki Nursing New Zealand* (1994 to present)[3].

Media images have prevailed of nurses as *"young, eager to please, and without the appearance of wisdom"*;[4] or as angels of mercy or heroines or as overly sexualised.[5] This analysis of how advertisers promoted their products to nurses through the pages of the journal provides an insight into the issues nurses faced between 1908 and 2009.

The social constructionist perspective places this advertising against a backdrop of some key national events, thus challenging conventional perspectives[6] and appreciating the progressive nature of social problems over time through a different lens.[7] Part one analyses the first 50 years from 1908-1958 and part two analyses 1959-2009. (Part two will be published in the December/January issue – Ed.)

Method (part one): Each issue from January 1, 1908, to November 1, 1947, was thematically analysed in either digital or print form.[2] And each issue in 1958 – the journal's golden jubilee year – was analysed. The total number of issues analysed was 259.

Two themes emerged: the nurse as a wellbeing advocate (1908-1928) and the nurse as servant of the state (1929-1958). Total number of pages; percentage of pages devoted to advertising; special features; and the number of individual adverts under each classification were all counted, cross checked and collated on an Excel spreadsheet under the following categories:

- **Patient benefits:** eg, devices and supplements
- **Nurse benefits:** eg, uniforms and self-care items
- **Academic activities:** eg, textbooks and courses
- **Lifestyle items:** eg, leisure activities and non-nursing clothing

The tiny number of job adverts and professional notices scattered throughout each journal – estimated at less than one per cent of each issue – were excluded.

Results

Advertising was present from the first issue. However, the placement, look and feel of these advertisements changed through the years. Product or location photographs were used from January 1914, and photographs of people appeared in January 1921. An image of a cherubic-looking child was repeated through many issues.

• The nurse as wellbeing advocate (1908-1928)

Until 1918, advertising took up 16-18.5 per cent of the total journal, with most (75 per cent) focused on patient wellbeing. Key nursing issues in the first decade of the journal included a proposal to form a trained nurses association (1908), the first registration of two Māori nurses in 1910 who went to work in the "Native Health Department", and a small pox outbreak (1913). While this outbreak, introduced by a Mormon missionary, killed 55 Māori,[8] it only rated a short comment in the journal: *"Small pox is among the native race. It is not of a severe type . . ."*[9]

January, 1921 KAI TIAKI iii

The KEYSTONE
OF FAMILY
HAPPINESS

"Baby is ever so bright, for mother is eating

Doctors
Cream o'Groats

I get some too, and everyone is happy."

Doctors Cream o'Groats is packed in useful lever top tins. Guaranteed the purest Oat Preparation obtainable anywhere.

DOCTORS
CREAM O' GROATS
A Delicious Food for Mothers, Children and Invalids.

30 Labels win a SILVER SPOON for Baby-use later or Mother-use now

PREPARED BY
FLEMING & COMPANY LTD.
In their High-grade Cereal Mills, GORE, N.Z.

Nothing but first quality Oats are used to make this superior food, and the price is only **1/4** per tin or **1/-** per packet.

'Adverts placed nurses at the centre of infant nutrition decisions and convalescence supplements.'

In the editorial in the same issue, concern was expressed at the lack of preparedness of nurses for a war or pestilence, with disease the war nurses were fighting. The editor suggested setting up an Army reserve unit to solve the problem of contagious diseases. Given the COVID-19 pandemic more than 100 years later, this is still highly relevant. Despite this concern, no adverts mentioned disinfection or ways to minimise disease transmission.

Adverts placed nurses at the centre of infant nutrition decisions and convalescence supplements. Bonny babies and happy patients apparently derived their health from "winecarnis", a meat and wine broth, or a petroleum-based emulsion used in Britain and *"all British colonies"* for *"consumption, diarrhoea and wasting disease"*.[10]

Nurses influenced the purchase of

down through the decades

medical supplies and drugs as these items were heavily advertised. Some adverts had an education role – one warned of the dreaded “milk clot” which formed in an infant’s stomach if they were not fed the correct milk.[11]

Against this rather benevolent view of child wellbeing there was a high-profile gruesome event in 1923 – the hanging of baby farmer Daniel Cooper.[12] However, the editorial following this national event was devoted to the inappropriate use of the word “nurse” by other professions, rather than social issues such as unwanted pregnancies.[13]

The pre-WW1 (1908-1913) period had very few adverts (7.7 per cent) for ways nurses could improve their work life. One advert for a nurse’s “chatelaine” or leather pouch, *“fitted with the best British made instruments”*[14] stood out as being of its time.

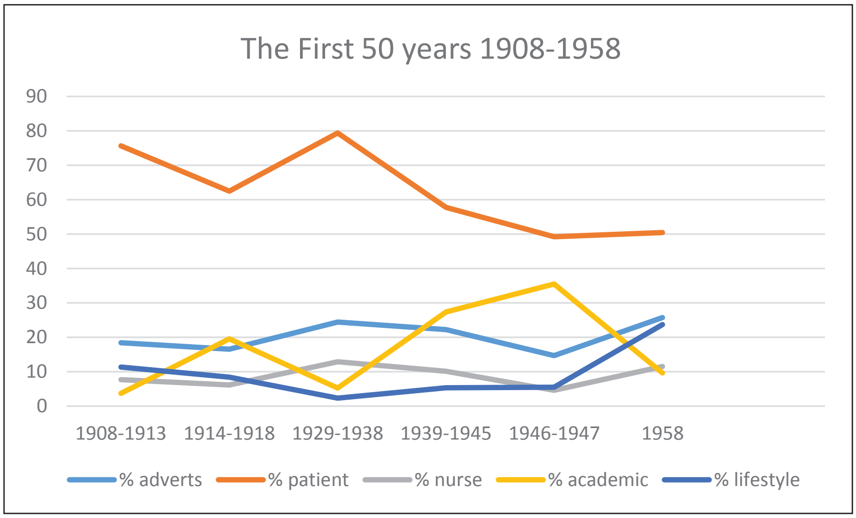
During WW1 (1914-1918), patient-related adverts dropped to 59.3 per cent, with a rise in adverts aimed at nurses’ benefits at 27.4 per cent. This was possibly due to an increased social appreciation of the value of nurses during wartime. One 1916 issue contained an advertisement targeting *“run down nurses”* and another noting ample supplies of French and Spanish wines, champagnes and *“invalids port”*.

Clinical education and state exam preparation featured in each issue, with conditions such as sepsis, consumption, scarlet fever, and neurasthenia examined. In 1909, *“kataphoresis”* was presented as a new treatment for medicine delivery, with the use of electricity for muscular and rheumatic complaints. Pre-WW1 academic/educational advertising was minimal (3.71 per cent) and only slightly increased during WW1 (5.21 per cent). It peaked in 1916 at 9.28 per cent, but had dropped to zero by 1918.

Women’s rights

Increasing political awareness and women’s rights became apparent during this time, including suffrage, fulfilment outside of marriage and advancement of education.[16] This new social freedom and a life away from nursing is hinted at, with lifestyle adverts increasing to about 11-12 per cent of all adverts. Items such as a grand piano, a double bed, the previously mentioned alcohol[15] and non-work clothing featured.

However, by the start of the Great Depression in 1929, the lack of discretionary funds also seemed to have an impact on the adverts for nurses, with only 2.3 per cent lifestyle advertising in the ensuing decade. Some issues actually contained no adverts at all, suggesting times were hard for all, including the advertisers.



An ongoing concern around WW1 was the lack of a coordinated nursing war effort or recruitment. As Matron-in-Chief, Maclean asked interested nurses to write to her directly, rather than “bother” the Ministry of Defence. There was concern that soldiers were suffering because of the lack of New Zealand nurses to care for them. Preventable deaths occurred from pneumonia, as Arab nurses did not *“nurse after sun down, and the critical time [for pneumonia] is after sunset”*.[17] Of note, St John and the Red Cross were working independently of the Government sending nurses to war. While a salary of one pound a week and board was recommended, *“it was considered . . . that patriotism should lead a nurse to accept little or no salary”*.[18]

Subtle patriotic propaganda in adverts was used, such as one featuring a photo of a soldier on a horse in the desert. The advert offered a discount on dental work to nurses; however no mention of the war or soldiers was made.[19]

By October 1918, adverts for patient benefits had decreased by 20 per cent and those for nurse benefits had increased threefold, alongside an increase in articles about treating war injuries. Sadly, the journal also highlights the situation post-WW1 for New Zealand nurses who were demobilised from the Queen Alexandra Reserves and the Army Territorial Service. They received a small gratuity, which was half the amount the regular force nurses received, and were abandoned in London with no lodgings or opportunities to find work. This was in stark contrast to their British counterparts, who received generous paid leave of up to two months, with secure work and accommodation.[20]

The influenza pandemic

The influenza pandemic (1918-1919) was not mentioned in any advertising. However, an editorial comment noted the number of doctors and nurses who succumbed, and the schoolchildren caring for the sick. This six-week outbreak killed 9000 New Zealanders, more Māori succumbing at seven times the rate of non-Māori. Exact numbers for Māori cannot be confirmed, however, as the 1916 census did not accurately reflect Māori population at the time, due to the boycott of the census by Waikato Māori.[21]

Some adverts seemed quite frivolous during this time, such as one in January 1919 advertising hair treatments of "singeing", "staining", as well as "non-rustable corsets".

• The nurse as a servant of the state (1929-1958)

This period heralded significant sociological, cultural and health-care milestones in New Zealand society. The start of the Great Depression in 1929 led to poverty, hardship and high infant mortality rates of four to five per cent. By 1932, unemployed people were rioting[22] and the Government recognised that children's health needed improving.[23] Children were dying in infancy from diphtheria, polio and gastroenteritis.[24] Children's health camps were established, building on the work of Plunket, founded in 1907, and, from 1929, they were funded partially by health stamps. The first health stamp was printed in 1929 to *"help stamp out tuberculosis"*. This first stamp had an image of a newly graduated nurse and the purpose was to raise money for children's health camps.[25] The November 1929 issue was devoted to tuberculosis, with three articles, along with a discussion on public health work.

Not all was grim however, as by 1934 adverts for holidays and textbooks appeared for the first time.

When war was declared in September 1939,[26] nurses needed permission to travel, due to a considerable nursing shortage. St John and the Red Cross set up voluntary nursing aid (VAD) training, coordinated by the Nursing Council, which had been established in 1938. Some of these nurses and VADs went on to work for the Armed Forces.[27]

The establishment of the Māori Women's Welfare League in 1951, aimed to address disparities in health care, which were beginning to be recognised, such as immunisation rates, tuberculosis and family planning.[28]

The most significant medical event at the end of this era was the first open heart surgery, performed on September 3, 1958 at Green Lane Hospital.[29]

Articles over this time focused on nurses being public servants, reaching out into their communities and working with schools to improve the health of the nation.

The image of the benevolent nurse providing advice on products such as wound care items or infant formula increased during the Depression and pre-WW2 years, with 79.4 per cent of adverts related to patient benefits. Academic and lifestyle advertising combined was less than eight per cent, with some editions having no adverts in either category.

In contrast to the years before 1929, advertising for nurse benefits decreased to an average of 12.9 per cent, with the lowest level of 5.68 percent in 1934.

During WW2 (1939-1945), patient-centred adverts reduced by 20 per cent to 57.85 per cent and academic advertising increased from virtually zero to an average of 27 per cent. While lifestyle advertising remained low – at between one to eight per cent of the total adverts – there was a significant increase to 11 per cent of total adverts in 1942. This was due to adverts encouraging nurses to make war savings or buy war bonds. Nurses could also send away for product samples to recommend to patients.

The first advert for makeup was seen in 1930, also the year the journal became bimonthly. By 1935, adverts for glamourous high-heeled shoes and golf shoes appeared and then in 1936 dancing shoes were advertised.

Despite the measles epidemic of 1938, which claimed the lives of 212 Māori and 163 Europeans,[30] no content reflected this. It seemed that by 1938, New Zealand was breathing a sigh of relief that the threat of war was over and life was continuing as normal. This absence of discussion on the growing political crisis in Europe continued right up to the August 1939 issue, published just before WW2 was declared. However, by the following issue, articles advised on how to sign up for service and how to practise preparing for an air raid, and gave information about London and the role of casualty clearing.

From 1940, nurses could work as occupational health nurses, possibly to help manage the large numbers of women employed in factories for the war effort.

In the immediate post-war period – 1946-1947 – the total space given to adverts had dropped significantly, with most issues containing three to four pages of adverts, compared to 10 to 12 pages previously, The journal was also smaller, at around 24 pages, possibly because it was now published monthly. Patient-related adverts still accounted for just over a half of all adverts at 50.44 per cent, compared to the peak of the interwar/depression areas of 79.38 per cent. Educational advertising had increased to 35 per cent, compared to a low of five per cent during the depression years.

By 1957, the journal had become more glossy and was back to being published bimonthly, apart from the golden jubilee issues in 1958.

In 1958, advertising accounted for 25 per cent of the journal, with over half still devoted to patient benefits. Job adverts were prominent at almost 10 per cent, with most of those being for agency positions in the United Kingdom. Lifestyle adverts accounting for just over 20 per cent, with ads for flying holidays and typewriters now included.

Conclusion

Over the 50 years of this analysis, the trend was away from patient-centred advertising towards increased education and lifestyle advertising. The total proportion of advertising remained fairly constant, even though the number of pages and issues published changed. The two key increases over this time were in academic/educational advertising during the two world wars and a reduction in advertising content directed at patient needs. By 1958, advertising in the journal was less about patients and more about nurses' professional and lifestyle needs. •

• *Acknowledgement: I am grateful for the voluntary assistance provided by history graduate Nyle Maddocks-Hubbard, who helped with the collection and cross-checking of data in both electronic and print format.*

* *References for this article are on p5.*

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Ageist rhetoric 'pervasive'

An independent human rights expert visited New Zealand in March this year. Her recently released report contains recommendations to ensure older people's human rights are met.

By co-editor Teresa O'Connor

Ageist rhetoric, portraying older people as a burden, is pervasive in New Zealand and contributes to negative attitudes toward ageing and older people, according to an independent human rights expert.

Rosa Kornfeld-Matte, from the United Nations' Human Rights Council, visited in March this year to identify best practice and gaps in implementing existing laws and policies promoting and protecting older people's human rights. She recently presented her report to the council.

New Zealand was undergoing significant age-structural changes, with the over-65 population projected to reach one million by 2027. The numbers aged 85 and over doubled between 1996 and 2019 to more than 88,000. These major changes necessitated a "major shift in mindset" to ensure older people's human rights were protected and their concern prioritised, the report said. "Older persons are potentially at risk from ageist attitudes, employment discrimination, lower income, material hardship, poor health, abuse and neglect, isolation and loneliness."

New Zealand has no dedicated law protecting older people, according to the report. Kornfeld-Matte recommended the establishment of an independent commissioner for older persons within the Human Rights Commission.

Age discrimination is prohibited by law but was common in the workplace. Legislation was not sufficient to change employers' behaviour and "may lead to more subtle and covert ways of discriminating", the report said. But because age discrimination was outlawed, 24 per cent of those aged over 65 – or six per cent of the total workforce – were in paid work.

Chair of NZNO's college of gerontology nursing Natalie Seymour said ageism appeared to be more prevalent in larger cities than in rural New Zealand. "This could be attributed to a lower work pool in smaller, rural communities," she said. The older populations were also not ones to "complain or make a fuss". This meant what was known about age discrimination was underreported, not reflecting the true extent of the problem.

Kornfeld-Matte had also received reports of age discrimination when seeking mortgages or insurance. "Moreover certain communities . . . such as Māori and Pasifika peoples and refugees and migrants continue to face structural inequalities and discrimination, which are exacerbated in old age."

> **. . . Māori and Pasifika peoples and refugees and migrants continue to face structural inequalities and discrimination, which are exacerbated in old age.**

Reports of abuse and neglect of older people were increasing, with older Māori experiencing greater levels of abuse than older non-Māori. The continued prevalence of abuse required further "measures and mechanisms" to detect, report and prevent all forms of abuse in all care settings, institutional and domestic.

Commenting on these findings, Seymour said that despite the Family Violence Act coming into full effect last year, "there are concerns at the very low levels of reporting and the high rate of recidivism, particularly among Māori communities". There was also a correlation between elder abuse and a dementia diagnosis, she said.

While praising New Zealand's "unqualified universal superannuation", Kornfeld-Matte noted that the basic pension remained very close to the poverty threshold. Around 60 per cent of singles and 40 per cent of couples had little or no additional income apart from superannuation "which makes them very vulnerable to any changes in policy or economic circumstances", the report said.

The provision of affordable and habitable homes remained a challenge and Māori and Pasifika were overrepresented in rental and crowded housing. "With the ongoing changes of tenure patterns, the number of older people facing material and economic hardship and poverty will increase and many of them will live in rented housing," the report stated. About five per cent of the older population lived in retirement villages and about one third of them were run by five big operators. Kornfel-Matte said legislation regulating these villages needed to ensure they adopted an "age-sensitive approach, enabling older persons to make informed decisions as to whether or not to enter into contractual agreements".

Old-age care services, whether home based or in rest homes and hospitals, as well as social, disability and mental services and respite care, were "insufficient and underfunded". Carers needed to be better paid and the demand for care professionals was expected to increase by at least 50 per cent by 2026. Between 12,000 and 20,000 more people would need aged residential care by 2026, the report predicted.

There was no data on the numbers of people with dementia, with estimates ranging from 50,000 to 70,000. She recommended strategic policy on Alzheimer's disease and other cognitive, mental and chronic health conditions.

She would also like to see the Government increase its investment in geriatric medicine and she stressed the need to ensure all patients received quality palliative care. •

Honouring the voices of Māori women

The story of Te Rūnanga O Aotearoa is part of the ongoing growth of the voice of wāhine Maori.

By Tracy Haddon

In honouring the voices of Māori women, of Māori tapuhi (nurses), ka maumahara tātou, we remember. We descend from atua wāhine Papatūānuku, Hine Ahuone, Hine Titama, Hine te Iwaiwa. The strength of women is gifted to us by our tūpuna to nurture, support, to transfer knowledge, and to provide manaakitanga (caring attitude), aroha (compassion), ukaipotanga (nurturing) to our whakapapa (genealogy), our whānau (family), our hāpu (sub-tribe), and to our iwi (tribe).

Māori women have always stood on the marae as leaders – the first to lead whānau onto the marae, the first voice heard at pōwhiri. We stand as equals to men. One gender does not outshadow the other. In western societies, the male gender stood dominant, and with colonisation, women's voices were silenced. These types of belief systems marginalised Māori women. In te ao Māori, there is duality – one cannot exist without the other. With every atua wāhine (female Māori god) there is an atua tāne (male Māori god), ira wāhine, ira tāne (the divine feminine, the divine masculine).

Our women have always stood as rangatira, and signed Te Tiriti o Waitangi in 1840. In 1893, New Zealand women became the first in the world who had the right to vote. Meri Te Tai Mangakahia led the voting rights for Māori women, to participate in governance and to have the same rights as non-Māori women.[1] However, this was not the case in nursing. The Nurses Act 1901 silenced Māori women's voices, even though women's rights were extended to include voting and standing for school boards or educational facilities.[2]

Mana undervalued

The Tōhunga Suppression Act 1907[3] and the Quackery Prevention Act 1908[4] stopped Māori practising rongoā and treating whānau; these acts assimilated and colonised indigenous wellbeing systems. Being wāhine, Māori and nurses meant being overshadowed by medical dominance. This created power differences and deleted traditional health practices. It was said at the time that the Nursing Council was using this process for "weeding out the unfit".[5] This led to Māori women not registering as nurses under their Māori names, again undervaluing the mana of wāhine Māori.

Institutional discrimination is deeply embedded in nursing, due to policies and the elevation of Florence Nightingale. This has oppressed Māori nurses, and is ingrained in the Aotearoa nursing culture in ways that "unfairly restrict the opportunities" of Māori and privilege other groups, who are racialised as superior in social systems of oppression.[6]

Māori nursing leaders faced assimilation, with policies that would not allow them to be Māori or to speak te reo – women had to use non-Māori names to become registered nurses. The earliest identified Māori nurse to register, in 1896, was Marion (Mereana) Hattaway (née Marion Tangata, and sometimes anglicised to Marion/Marianne/Mary Ann Leonard), from Peria in the Far North.[7] Ākenehi Hei was the first nurse to register under her Māori name, in 1908.[5,8] In 1920, the first chief nurse, Hester Maclean, was appointed;[9] 99 years later, in 2019, Margareth Broodkoorn, the first chief nurse who identified as Māori, was appointed to the position.[10]

The New Zealand Nurses Union (NZNU) first established Te Rūnanga o Aotearoa, because the union had a higher proportion of Māori members than the New

Hineraumoa Te Apatu was one of the founders of Te Rūnanga in 1990. A caregiver at Presbyterian Support Services at the time, she was identified by NZNU organisers as a woman of mana and courage.

Zealand Nurses Association (NZNA). Tino rangatiratanga, self-determination within the union, was now deemed essential. During an industrial dispute between NZNU and Presbyterian Support Services in Hamilton in 1990, a caregiver involved in the action, Hineraumoa Te Apatu, was identified by the organisers as someone with mana and courage. Supported by these organisers, she and others set up Te Rūnanga, with Rhoda Waitere chairing the first meeting.

At Te Puea Marae in Mangere, Māori Queen Dame Te Atairangikaahu gave it her blessing, and Te Rūnanga was officially inaugurated in 1990. Dot Stitchbury, interim chair, and kaumātua John Ahu were involved at the outset. Nora Rameka, of the Council of Trade Unions, gave support as part of her broader role to help unions establish Māori structures. Te Rūnanga was then officially endorsed by the NZNU committee of management.

PHOTO: NZ HERALD

Māori Queen Dame Te Atairangikaahu gave her blessing to Te Rūnanga at its official inauguration at Te Puea Marae in Mangere.

Te Rūnanga o Aotearoa was launched in 1990, with its first tōhu (emblem) launched in August 1999. On April 1, 1993, NZNA and NZNU merged to become NZNO.[11] As Te Rūnanga membership grew, so did its ability to lead NZNO in things Māori. They identified the need to have a new tōhu that represented who they were and their place within NZNO. In 2007, nearly 17 years later, Te Rūnanga was "allowed" a tōhu that recognised their cultural identity as Māori within NZNO.[12] It takes the form of a stylised rākau (tree), representing strength and growth.

In September 2019, elections for the NZNO board saw Anamaria Watene and Margaret Hand voted on as directors. They stood side by side, as Māori women nursing leaders, with kaiwhakahaere Kerri Nuku and tumu whakarae Titihuia Pakeho. With the resignation of the president, vice-president and three directors earlier this year, a by-election resulted in a board where the majority of seats were held by Māori women. This is the first time this has happened since NZNO was established in 1993, and is a first in more than 100 years of nursing and unions in this country.

In September 2020, at the first NZNO annual general meeting held as a webinar, Tracey Morgan took up her newly elected position as NZNO vice-president. Three out of the four elected leadership positions at NZNO are now held by Māori wāhine, and there is a total of five Māori women on the board in governance and leadership positions.

There is clear evidence in the Government's health and disability review that Māori nurses are key to the changes the review proposes. The review identified the need to increase the number of Māori and Pacific people in clinical, non-clinical and governance roles at all levels of the health system. This should be supported by system-wide workforce planning, modelling and investment, and the provision of pay equity.[13] Māori nurses will hold the Crown to account for the failings in the health system revealed in the findings from the WAI 2575 claim, and the Government must partner with Māori nurses to ensure the needed changes are made.

Female Māori nurse leaders are not just fighting for pay equity and pay parity for Māori women. They are also advocating for male Māori nurses. The voice is a collective voice, not that of an individual. Māori women who are nurses have had to stand in the political arena and advocate for whānau. Māori nursing leaders advocate daily on behalf of nurses and whānau. Advocating ensures systems and processes held by professional bodies such as NZNO, the Nursing Council, and the International Council of Nurses hear the voices of not only Māori women but that of indigenous nurses. •

Tracy Haddon (Ngāpuhi hapū Ngāti Whārara, Ngai Tū, Ngati Ue, Ngāti Pākau), RN, BN, PGDipHSM, PGDipQualSys, is te Kounga me te Kaiwhakahaere Ratonga Māori, the quality and service improvement manager Māori at Pae Ora Paiaka Whaiora Hauora Māori, the Māori Health Directorate, MidCentral District Health Board. She is also the proxy for Te Rūnanga Central Regions, and te rōpu kaiarahi, Māori adviser to the Nursing Education and Research Foundation.

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PHOTO: ADOBE STOCK

Talking about unconscious bias

It is possible to challenge our own biases and assumptions, and train ourselves to focus on the individual in front of us.

By Jill Clendon

Bias, unconscious bias, systemic bias and institutional racism all affect our ability to create a health environment that addresses inequities in health. But what are these things and how do they prevent us from making objective decisions?

Bias, commonly unconscious or implicit, occurs automatically as the brain makes rapid judgments about people and situations based on the person's own background, experiences and environment.[1] Unconscious bias has been recognised in cognitive science and social psychology for many years and reflects deeply held stereotypes associated with different social categories (such as age, gender, ethnicity, socio-economic status or religion).[2,3] Our perceptions cause responses that we are consciously unaware of. As a result, we are likely to favour groups we perceive as similar to our own group and display discrimination against groups that are dissimilar, without being aware of it.[4] Whether we like it or not, we tend to like people who look like us, think like us and come from backgrounds like our own.

Brain filters information

When we make implicit associations, it is often the more primitive parts of our brain that are activated.[5] Our brains constantly filter huge amounts of information, prioritising, categorising and summarising our surroundings. While this served us well hundreds of thousands of years ago when our daily choices were frequently life or death decisions, today our unconscious biases can lead us astray. Unconscious biases can prevent individuals from making objective decisions and cause us to miss good ideas, ignore an individual's potential, and create a less than ideal work experience for colleagues.[5] They can also create problems in health, directly resulting in systemic bias and institutional racism which in turn cause health-care disparities and inequitable outcomes.[3,4,6,7]

Systemic bias has been present in our health system since we had one. It persists today, due to unconscious bias. In health, when our institutions create barriers to health care for a certain group or groups, this is systemic bias and ultimately creates inequities in health outcomes for that group. It is important to remember that institutions are held together by policies written by people who originally held conscious biases and now hold innate unconscious biases, creating organisational structures that perpetuate systemic bias and racism. This is manifest in a multitude of ways, not least in the unequal health outcomes we see between Māori and non-Māori in Aotearoa.

> **Unconscious biases can prevent individuals from making objective decisions and cause us to miss good ideas (and) ignore an individual's potential . . .**

Impact on Māori

There are a number of clear examples of the impact of unconscious and systemic bias on Māori over many years: Maori men are less likely to receive medical intervention for cardiac disease than non-Māori men;[8] Māori women are less likely to receive epidural pain relief during child birth than non-Māori women;[9] Māori have a significantly poorer bowel cancer survival rate than non-Māori;[10] Pākehā doctors spent 17 per cent less time interviewing Māori than patients from other ethnic groups;[11] Māori are less likely to receive sudden unexplained infant death (SUDI) prevention information from their Well Child health provider than other ethnic groups;[12] and systemic bias is present in the holding, monitoring and funding of contracts for Māori public health providers.[13]

If we look beyond New Zealand, there are further examples of the impact of unconscious bias on health outcomes. A systematic review of implicit bias in health-care professionals found evidence of unconscious or implicit bias in 35 of 42 articles, and all of the studies that investigated correlations found a significant positive relationship between level of implicit bias and lower quality care.[3]

Simple steps

The news is not all bad though. Google found that staff who undertook unconscious bias training were more aware of the impact of bias, both immediately after and a month after training, compared to those who had no training. And in the first instance, there are even some simple steps we can take individually to address our own biases.

Acknowledging that unconscious bias exists is an important first step to overcoming it. Nobody wants to believe they are part of the problem. Kate Wilkinson and Anna Kirkwood, who run workplace diversity workshops in New Zealand, provide a useful staged approach to addressing unconscious bias.[14] This approach requires you to recognise stereotypical thoughts as they occur, and discount them. Instead of relying on assumptions, you train yourself to focus on the individual as your primary source of information.

Wilkinson and Kirkwood apply their staged approach to a scenario: You're sitting in the hospital waiting room, waiting for the doctor. A women in scrubs walks in and a voice in your head pipes up with a "harmless" thought . . . "oh, here's the nurse"; that's Stage 1 – the thought. At pretty much the same moment, you voice your thought to your partner sitting next to you; that's Stage 2 – the statement. It turns out she is actually the doctor, but because of your initial assumption, you can't help but take her advice a little less seriously and are more inclined to seek a second opinion; and that's Stage 3 – the action. We can run a similar scenario with nurse practitioners vs doctors, Māori vs non-Māori, black vs white, hijab-wearing Muslim vs non hijab-wearing Muslim, tattoos vs no tattoos, short skirt vs trousers, young vs old, obese vs non-obese; gay vs straight; the list goes on.

The end goal is stopping at stage 1. When that initial thought comes into your head, the trick is to leave it there. Wilkinson and Kirkwood give us some sage advice: don't voice the thought, accept it, sit with it for a moment, then promptly discard it into the gutter.[14] Overcoming unconscious bias isn't easy. It's a lifelong process that requires time and attention. It is almost impossible to rewire your brain so that the thoughts never come into your head again – remember we are fighting thousands of years of neuro-programming here.

. . . systemic bias is present in the holding, monitoring and funding of contracts for Māori public health providers.

Some more tips from Wilkinson and Kirkwood to stop at Stage one: firstly, watch your language; avoid using ableist, homophobic, gendered, racist or ageist words. When we can monitor our own language, stopping at Stage 1 will start to come naturally. Secondly, wait for the slow brain; try to lengthen the time between Stage 1 (thinking) and Stage 2 (saying) the thought. The extra split second will give you time to use your logical slow brain to analyse your thought, check whether it is biased and then decide whether to move forward to Stage 2. Thirdly, get to know different people; people close to us are most often the same as us – try expanding your friend circle beyond what and who you know.[14]

There are a plethora of opportunities to address unconscious and systemic bias in ourselves and in our workplaces. As nurses, we need to firstly work on ourselves and ensure we understand and recognise our own biases. From here we can lead by example and create inclusive workplaces that are safe for people from all walks of life. Concurrently we can support our own organisations to take steps to identify bias within our health care provision, whether this is systemic or individually driven.

This is powerful stuff and if we get it right, the benefits are immense. Not only will we have a staff that are diverse and happy in their work, we will have created an environment in which all people can rightfully feel they belong and will get the health care they need. •

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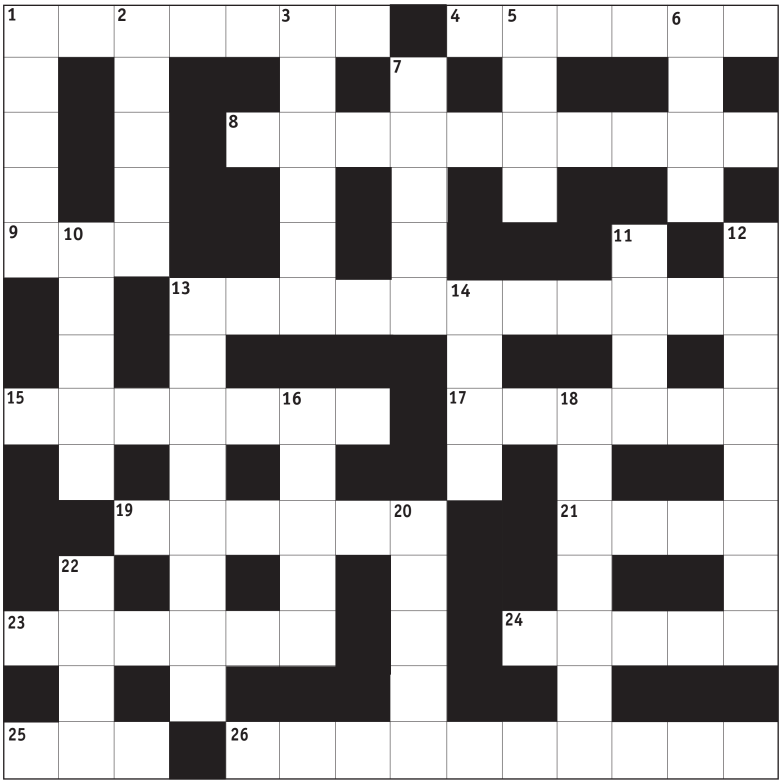
crossWORD

Completing this will be easier if you have read our October issue. Answers in December.



ACROSS

1) Undergraduate.

4) What's left on plate after cake is eaten.

8) Fragile, exposed.

9) Untruth.

13) Infect.

15) Major air pathways in lungs.

17) Salt solution.

19) Spirit (Māori)

21) Living room seating.

23) Withdraw labour.

24) Polynesian rat (Māori)

25) Life, in years

26) Lying flat

DOWN

1) Ability, knowledge.

2) Male relative.

3) Nerve cell.

4) Charged atomic particle.

5) Uncommon.

6) Spring flowers grow from this.

7) Procedure to clean out bowel.

10) Made from animal tusks.

11) Work (Māori)

12) Shopfloor union rep.

13) Drug, subject of recent referendum

14) Material covering nose and mouth

16) Animal: *Equus caballus*

18) Gay woman

20) Garlic mayonnaise

22) Male deer

October answers. ACROSS: 1. Mediation. 5. Grow. 7. Insulin. 8. Caviar. 9. Future. 10. Nor. 12. Noon. 13. Anchor. 15. Admired. 19. Stigma. 21. Buffoon. 23. Patience. 24. Bids. 25. Cat. 26. Tension. **DOWN:** 1. Maim. 2. Dysfunctional. 3. Ail. 4. Ion. 5. Governor. 6. Warning. 8. Condom. 11. False. 14. Ohm. 16. Deficit. 17. Iron. 18. Ennui. 20. Absent. 22. Bison. 24. Bus.

wiseWORDS

> “When I was younger, I could remember anything, whether it had happened or not; but my faculties are decaying now and soon I shall be so I cannot remember any but the things that never happened.”

Mark Twain (1835-1910), American writer and humourist

it’s cool to kōrero

HAERE MAI and welcome to the November column. The tōtara holds pride of place as one of the great trees of Tāne, the god of the forest. It is a huge tree that can grow for hundreds of years.

Tōtara timber is hard with a straight grain and has always been prized by Māori for carving, for building waka and houses and making tools. Its thick bark was used for roofs and to make food/water containers.

Kupu hou

New word

- **Tōtara** – pronounced “tore-tah-rrrah”
- **Te waka he mea whakairo mai i te tōtara.**
The waka is carved from tōtara.

Whakataukī

Proverb

- **Kua hinga te tōtara o te waonui a Tāne.**

The tōtara in the great forest of Tāne has fallen. (This saying is used when a chief or other important person dies.)

Rerenga kōrero

Phrases

This issue focuses on aged care. Here are some relevant phrases:

- **Ko te whare kaumātua ahau e mahi ana.**
I work in aged care.
- **Kei te kāinga i ōku mātua ahau e tiaki, e manaaki, e awhi ana.**
I care for my elders at home.
- **He pai ake ngā kōrero i ōku kaumātua.**
My kaumātua have great stories to tell.
- **Kei te hiahia koe ngā kāri e purei ana?**
Do you want to play cards?
- **Ko tēnei te wā mō ōu rongoā.**
Time for your meds.

E mihi ana ki a Titihuia Pakeho and Keelan Ransfield.

The challenges IQNs face

Internationally qualified nurses face many challenges when they begin nursing in New Zealand. But there are also opportunities. A research study is looking at both.

By Dana Taylor

According to NZNO, internationally qualified nurses (IQNs) are valued as capable and competent participants in the New Zealand nursing workforce.[1]

IQNs come to New Zealand with professional experience in their home countries, yet they must cope with transforming their communication style to integrate into the workplace culture here.[2] This is an issue because IQNs' difficulties assimilating at work and becoming members of a nursing team, may challenge their pre-existing identity as experienced health-care workers.

I am currently researching IQNs' communication experiences and their professional identity and am seeking more research participants. The aim of the research is to develop relevant and applied knowledge of how migrant nurses' professional identity is transformed through the experience of working in another country. The research aims to benefit IQNs and health-care providers in primary, hospital, and aged care settings.

IQNs in the workforce here seek to gain their peers' acceptance and recognition.

From my research so far, several themes are emerging. One of the strongest is that IQNs are eager to participate fully in the nursing community despite experiencing difficulties in communication. In this article, I share some of the experiences of three research participants – Lilly, Mons, and Carmel.* These include stories of challenging workplace interactions, such as bullying and misunderstanding, and positive workplace experiences, including leadership opportunities and team membership, as they participants integrate into New Zealand nursing.


Dana Taylor

Widespread discrimination against IQNs is detrimental to nurses' professional identity and wellbeing.[3]

IQNs are often more susceptible than New Zealand-trained nurses to workplace harassment and inequality.[4] Carmel's story of workplace bullying reflects such harassment: *"When I was starting, I thought I just keep it to myself. Because [colleagues] will sometimes mock you. 'Is she really an RN?' 'Does she really know what she's doing?' I think what I learned on that experience is to speak up for myself. Tell them that I'm doing the right thing. Yes, and to ask that [bullying] co-worker, 'Why did you do that?'"*

Communication breakdowns can result in IQNs encountering challenging workplace interactions.[2] Carmel noted that language differences meant that sometimes she could not understand colleagues' requests. However, she has developed communication strategies to respond appropriately: *"I understand English, but sometimes the accent is different. Sometimes I need to ask them what they mean. And then if I don't understand, I will just [ask], 'Please repeat it.' And 'I'm going to repeat what you said.' I don't care if they get annoyed, but I need to be correct."*

IQNs in the workforce here seek to gain their peers' acceptance and recognition.[5] Lilly, a nurse with management responsibilities, is interested in developing team members' professional skills: *"At the moment I am clinical lead. So, my plan is to go higher and higher – maybe clinical manager, or any other, like, educator, or clinical educator, instructor."*

Carmel, too, explained the need for IQNs to learn how to be optimistic and assertive when building rapport with colleagues, for the long-term benefit of staff and patients.[6]

According to Carmel, *"There are also kind, supportive co-workers. And everybody's different. Be positive. And also have confidence in yourself."*

Research into IQNs' experiences acculturating to the New Zealand workforce found that, after a period of transition, migrant nurses worked effectively with peers and managers.[2] Mons acknowledged the backing of her IQN colleagues: *"[We] have been close enough to be able to support each other very strongly in our individual roles. United we stand. It sometimes takes a hard experience to pull through. To get that common ground. Because I said to her, 'What hasn't killed us yet is only going to make us stronger'."*

These three IQNs' demonstration of proactive communication and self-confidence in creating collegial relationships reflects NZNO's vision for nurses to *"work respectfully with colleagues to best meet patient needs"*.[7]

IQN participants in my study have so far shared stories of challenging and positive workplace interactions, which support research findings that IQNs' collegial conversations impact on their (trans)formation of professional identity.[8]

In line with other research[9], my research so far may have constructive outcomes for their career pathways and health-care facilities' operations. •

** Pseudonymns have been used to protect participants' confidentiality.*

** References for this article are on p4.*

Dana Taylor is head of academic assurance and a lecturer at tertiary provider IPU New Zealand in Palmerston North. Her PhD research (in applied linguistics) is through the College of Humanities and Social Sciences at Massey University, Palmerston North. For further information on the research, or to become a research participant, please contact: danataylorphdproject@gmail.com

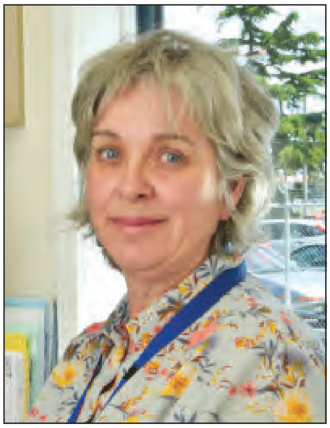
Coverage of NZNO's virtual conference in September concludes this month with three articles, all with a strong focus on how to meet the health needs of Māori. Reporting by co-editors Mary Longmore, Teresa O'Connor and Anne Manchester.

Organ donation a key issue for Māori

A transplant hui held earlier this year enabled Māori to hear stories of organ donation and to share open conversations about the process.

Renal transplant co-ordinator at Hawke's Bay District Health Board Merryn Jones (right) said she was motivated to organise the hui because of the particular issues Māori faced regarding kidney donation, including unmet need and very low transplant rates. In 2017, there were 187 kidney transplants in New Zealand, with 23 Māori recipients – 12 per cent of the total. Of those 23, 17 received a kidney from the donor list and six received a kidney from a living donor.

The hui had a tikanga focus, was nine months in the planning and, because of appalling weather on the day, was attended by 80 people, rather than the 100 who had registered. Speakers included a nephrologist who gave the context for a transplant, and a pain and palliatve care specialist, who talked about the difficult conversations with whānau at the bedside. A mother told of her decision to donate her son's organs and Jones said there wasn't a "dry eye in the house" at the end of the presentation.



A small survey of 52 health professionals working in the Hawke's Bay Regional Hospital intensive care unit found only four to five per cent were comfortable talking with Māori whānau about organ donation.

Another speaker talked of receiving a kidney from a deceased donor in 2011 and how his seven brothers had all died of unmanaged co-morbidities in their 40s and 50s.

A researcher from the Eastern Institute of Technology spoke of his research into indigenous perspectives on kidney transplantation.

Many of those at the hui disliked the term "deceased organ donation" and suggested alternatives such as gifting, recycling or rekindling. They wanted expressions to convey the sense that gifted kidney was a taonga. Others spoke of the journey involved in donating a kidney to a family member. A nurse practitioner talked about the care and support for patients post-transplant, the lifestyle changes people faced, and the need for a high fluid intake, to be sun smart and to take medications twice daily.

Jones said the hui had generated great discussion about organ transplants and there had been tears and laughter as people shared their stories in a safe environment.

"This project was significant on many levels. It was the first such hui in Aotearoa for Māori health-care providers and influencers. It raised awareness of an issue that disproportionately affects Māori, and upskilled those who attended to better support our patients on their difficult journey to transplant conversations." •

Porirua public health nurse works at

'My clients are your patients," said public health nurse Lizzy Kepa-Henry in her address to the conference. "But I am only one person working across two Work and Income [WINZ] sites in Porirua and Naenae, and one of only three registered nurses working in WINZ sites nationally."

In an address titled *Cultivating community wellbeing at the flax roots of vulnerable and diverse communities,* Kepa-Henry painted a grim picture of the realities of life for those having to survive on benefits. "In February 2020, there were 300,000 people on benefits nationally, with the Ministry of Social Development expecting this figure to rise by January next year to 495,000," she said.

Kepa-Henry described four case studies, using the names Somebody, Anybody, Who Cares and Nobody, to highlight the disparities in access to health services, to transport, to housing and to education.

Somebody, she said, had had a stroke and was discharged from hospital wheelchair-bound due to obesity. There was no wheelchair access into the house nor into the bathroom. Carer input was less than an hour a day, with no occupational therapy or physiotherapy input on the discharge plan. Somebody had to move to other accommodation, with the rent rising from $110 to $540 a week in private accommodation.

Anybody sought help from emergency mental health services. After waiting two days for a reply, his phone then

Lizzy Kepa-Henry

'Listening more important than telling'

Walking "beside" Māori whānau and communities is critically important, Māori health leaders say. And nurses are well-placed to "get alongside" to support them.

According to a service manager at Māori public health Hāpai Te Hauora, Fay Selby-Law, nurses have a "huge" role in preventing sudden unexplained death in infancy (SUDI). But listening was more important than delivering a message.

"It's more about listening than telling, to get alongside whānau, and nurses are well-placed to do that," said Selby-Law, who coordinates Te Hāpai Hauora's national SUDI prevention service.

The service offered wahakura – woven flax bassinets – to whānau for safer co-sleeping, as well as a whare where mothers could talk and even make their own wahakura.

The service also worked to encourage breastfeeding, immunisation, gentle handling of pepe, as well addressing smoking and bed-sharing – the two biggest risk factors for SUDI, Selby-Law said.

It was important for health workers to listen to whānau about their goals. "I hope you as nurses continue to grow and learn, that you are happy to share our message and that you are there for our people."

Fay Selby-Law

Chief executive of Te Tihi o Ruahine (an alliance of central Māori health providers) Materoa Mar also emphasised the importance of working alongside whānau, rather than "imposing" ideas.

"Communities have their own dreams and aspirations for what they want to achieve over time," Mar said. While agencies often had good ideas, they generally were developed away from the communities where whānau lived. It was "crucial" to engage with those living in the communities, "who obviously have the best insight" into finding solutions and identifying aspirations.

Any approach should be "walking alongside, seeking knowledge and contributing to what already exists, as opposed to imposing what our idea might be".

There were also great opportunities to honour te Tiriti in such collaborations, she said. "This is the opportunity to set our sails, to look where we are heading, far to the horizons, to be bold and courageous and undertake the change required."

Kuini Daniels of the Ngāti Hine Health Trust's Paparata Outreach, a mobile clinic in Te Tai Tokerau with a kaupapa Māori approach, said the service aimed to break barriers for "high-risk" whānau, by bringing resources to them. The service involved nurses, doctors and dietitians, as well as rongoā medicine practitioners, which could be "very meaningful" for many Māori.

Closing inequity gaps

"COVID-19 opened our eyes to the impact on people with long-term conditions" and Ngāti Hine wanted to focus on closing the inequity gaps for Māori.

The whānau ora approach used innovative and collective means, including social and mental health services in response to high suicide rates. Trialling new initiatives such as shared medical appointments and free prescriptions were two examples of successful projects Daniels would like to see extended.

She also hoped to see more resources for outreach clinics, including podiatry and mental health training, more staff and upskilling of nurses to become nurse practitioners. •

the 'flax roots' to cultivate wellbeing

broke and on day four, he was told he had missed his appointment and could not be seen. After an elevation of his mood, in which he threatened violence to get the help he needed, he was arrested, then released on bail with electronic monitoring, and trespassed from the emergency health centre. Eventually he was prescribed twice-daily medications, but he had no car and faced travel costs of $32 per day.

Who Cares had been unable to fill his prescription. The medication cost was $85 and Who Cares only had $65 left after paying his rent. He had no car, was not on a bus route and it was the middle of winter. "Why was there no follow-up on this client?" Kepa-Henry asked. Who Cares had a third stroke and was now being cared for full-time by his mother, who had had to give up her business to do so.

Nobody had failed numerous job interview medicals and had not seen a GP for a decade. He was unwell and illiterate, and had chronic abscesses on his face and upper body. After considerable advocacy by Kepa-Henry, he was eventually seen by a doctor.

"My clients don't have a standing place," she said. "They live in rented, often short-term accommodation and long for a 'forever home'. They live and survive day to day – this is their normal reality, yet they do not see themselves as vulnerable or diverse."

Kepa-Henry described her role as invisible. She called on nurses throughout New Zealand to strengthen their professional relationships and join with her in responding to clients like Somebody, Nobody, Who Cares and Anybody, "treating and caring for them with respect. *He waka eke noa – we are all in this together*". •

Youth and school nurses come together

AFTER A year of restrictions, more than 120 school and youth nurses, counsellors and other health professionals came together at the inaugural school and youth nurse symposium *Where Nursing and Youth unite – connect, collaborate & coordinate,* held in September at Hamilton's Rototuna High School.

Waikato clinical nurse specialist Katy Cryer, who organised the conference, said it was a "much-needed" opportunity for professional development and connection for nurses from around the country. School nurses often worked in isolation, and it was hoped that an annual event would bring them together, encouraging more collaboration, Cryer said.

The programme was designed in response to a survey of nurses, and included sessions on assessment skills, mental health resilience, rainbow youth, sexual health, best practice, medicine management and practical skills from a range of experts, including Waikato nurse practitioner Lynette Baines, psychologist Bridget Jelley and Hamilton Sexual Health director Jane Morgan.

The one-day event, which allowed virtual attendance for those still under travel restrictions, replaced the two-day conference originally planned.

Pinnacle Midland Health Network supported 27 of its nurses to attend the symposium.

Director of mobile nursing service, Your Health New Zealand, Nicky Sayers – a co-organiser – said demand had been high for the event, the first of its kind here. A full school and youth health nursing conference, A Seat at the Table: Working Together for Youth Health, was planned for next October in Hamilton. We invite potential sponsors, speakers and delegates to save the date and follow on:

www.facebook.com/nursesandyouthunite. •

Report by Waikato emergency nurse Katy Cryer

Neonatal nurses share learning

THE NEONATAL nurses' college Aotearoa (NNCA) ran a day of workshops in October for nurse practitioners and those on the pathway, nurse managers, leaders and those who collect the data for the Australia and New Zealand neonatal network (ANZNN).

Next year, NNCA will add an educators' forum, as these national networking events are great for shared learning.

The workshop, held a day before the NNCA symposium *Go with the flo – challenges and changes in neonatal nursing today* in Christchurch, was the first opportunity for many to come together since COVID-19 arrived.

Neuroscience educator Nathan Wallis spoke about the importance of a consistent dyadic (pair) relationship – connection with the one important person – for infant brain development, reminding us that the first 1000 days set in place the foundations of healthy brain growth and relationship development for a lifetime.

University of Auckland psychology professor Nathan Consedine talked about sustaining compassion in health care, and the contribution of working environments to practitioners' compassion "fatigue".

Counsellor and former addict Peter Thorburn shared valuable insights on methamphetamine use in Aotearoa and what might alert a nurse or midwife to methamphetamine use within a family they're working with.

Other topics included how human milk banks kept supplies to infants needing support during the COVID-19 lockdown. •

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

'Quiet' neonatal nurse makes a difference

LONG-TIME Christchurch Women's Hospital nurse Bernard Hutchinson has been awarded neonatal nurse of the year by the neonatal nurses college Aotearoa (NNCA) for his quiet "behind-the-scenes" work to make a difference.

"Bernard quietly goes about his work, always trying to make things better for those needing neonatal care or working in neonatal care," outgoing chair Gina Beecroft told the NNCA symposium. "He is always available to support and soothe (both staff and parents!)".

Neonatal nurse of the year Bernard Hutchinson with Tina Saltmarsh of Fisher & Paykel (award supporter.)

'He is always available to support and soothe'

Hutchinson helped establish the hospital's human milk bank, set up parent support groups and has represented the college on Baby Friendly Aotearoa, which supports breastfeeding, Beecroft said.

Now an associate clinical nurse manager, Hutchinson is overseeing the neonatal service's baby-friendly hospital initiative.

"He is always watching and supporting the three key components in NICU [neonatal intensive care unit] – parent, nurse or baby," Beecroft said. "You never ever feel unsupported or indeed you are never unsupported as either a staff member or parent or baby when he is about." •

NZNO on ARC pandemic plan

NZNO HAS asked the Ministry of Health (MoH) to better consider Māori and unions in its pandemic response policy for aged residential care (ARC).

The policy is being drafted following a review of the ARC sector's response to COVID-19, after five clusters were linked to rest homes. A key recommendation was for a national outbreak management policy.

Its stated intention is to provide nationally consistent guidance on how the ARC sector works together to prepare for, prevent and manage transmissible disease outbreaks.

It is based around six principles: achieving Māori health equity; achieving health equity; wellbeing of ARC residents; wellbeing of ARC staff; collaboration and communication; and preparedness.

NZNO policy analyst Māori Leanne Manson said more work was needed to ensure culturally safe care for Māori residents and whānau in an outbreak.

A kaumātua and Māori wardens must be available to residents, as part of ARC's relationship with tāngata whenua, she said.

NZNO professional nursing adviser Marg Bigsby said the plan needed more detail to ensure the right staff, skills and experience would be in the right place at the right time. It also needed to highlight the importance of providers engaging with union representatives during a pandemic, she said.

More details were needed on how to prepare for a pandemic and the impact on staff of things like pandemic training, Bigsby said.

College of gerontology nursing member Bridget Richards said the impact of extra training, particularly on small providers with few staff, needed to be considered.

Bigsby and Richards are part of the MoH ARC pandemic working group, which is currently developing an ARC pandemic response workbook, hopefully by the end of the year, Richards said. •

ARC nurses seek feedback

THE COLLEGE of gerontology nursing is seeking feedback, as it updates its knowledge and skills framework (KSF) to better support aged-care nurses' professional development.

Committee member Morag MacKenzie said a KSF was important to maintain a well-trained gerontology nursing workforce. It promoted best practice, and underpinned the college vision of a "visible and valued" workforce.

To update its six-year-old KSF, the college has drawn on a Canadian-United States model called the "geriatric 5Ms" to describe the core competencies needed, adapting it for New Zealand.

It comprised:

- **Matters most:** What matters most to the individual and their health goals.
- **Mind**: Mental wellness and managing depression, delirum and dementia.
- **Mobility**: Key to independence and support may be needed.
- **Medications**: Poly-pharmacy, deprescribing, managing adverse reactions and best practice for older people.
- **Multi-complexity**: Supporting people to manage their own health, particularly for those with complex needs.

Details are available on the college's NZNO website. MacKenzie, who is a senior health and social practice academic at Waikato Institute of Technology, said the college was keen to hear members' thoughts. •

Gerontology nurse given honour

LONG-TIME nurse and active NZNO member, Otago's Margaret Stevenson (above) has been inducted onto the NZNO college of gerontology nursing's honour roll, for her years of local and national contribution to aged care.

After 20 years of hospital nursing, Stevenson moved into aged residential care (ARC) in 2003, becoming a dementia unit manager at the Birchleigh residential centre in 2007. In her 10 years there, Stevenson was pivotal in bringing about a multitude of improvements for the residents before retiring in 2017.

She fought hard for optimum staff ratios and was also involved in piloting the interRai assessment programme, her enthusiasm for it rubbing off on to others, including me. To this day, I remain a keen user of the tool.

A long-time NZNO member, in 2003 she also joined the Otago branch of NZNO's then-gerontology section.

Over the years Stevenson has been a mentor to many, including me. Her wisdom and knowledge have been valued and appreciated by those across a wide spectrum of life and she has been a valuable contributor to gerontology within New Zealand. •

Report by NZNO college of gerontology nursing secretary Gayleen Watkins

The struggle for pay parity in PHC

By co-editor Teresa O'Connor and industrial adviser Chris Wilson

Despite prolonged and concerted efforts, pay parity for primary health care nurses has yet to be achieved.

Pay parity for primary health care (PHC) nurses has proved an elusive goal. And PHC nurses and medical receptionists are getting tired of waiting. They have voted overwhelmingly in favour of two 24-hour strikes this month – the first on November 9, followed by another on November 23. This action follows their inaugural eight-hour strike on September 3.

A combination of factors is behind the historic industrial action. PHC nurses' sense of injustice – an experienced PHC nurse is paid 10.6 per cent less ($7600 a year) than a district health board (DHB) nurse with the same experience and qualifications. A feeling they have been fobbed off for too long – the latest push for pay parity has been going on for the last two years. Before 2018, PHC pay rates had been within cooee of DHB pay rates, but the last DHB multi-employer collective agreement (MECA) widened the gap considerably. A sense their work is undervalued and misunderstood – the skills required to work in PHC, with presentations covering the whole gamut of health care, are no less valuable than those required in the DHB sector. And a certain cynicism at the gap between the rhetoric about nurses' great work during the continuing COVID-19 pandemic and the reality of the growing pay gap. As one PHC nurse said: "Clapping hands and words of thanks don't pay the bills".

Seeking resolution

NZNO members have done everything in their power to achieve pay parity without striking – agreeing to a one-year PHC MECA for 2018/19 in the hope extra government funding would be forthcoming. Preparing a paper with the New Zealand Medical Association (NZMA), which represents the vast bulk of PHC employers, detailing the case for pay parity. Meeting the then Health Minister David Clark with NZMA representatives to press their case. Continuing negotiations with NZMA in good faith, despite the lack of additional funding. Seeking support from the chief nursing officer Margareth Broodkoorn and director general of health Ashley Bloomfield. Attending last-minute mediation before the September 3 strike. Writing a pre-election open letter to Prime Minister Jacinda Ardern calling for her support.

PHC nurses are wanting the answer to this question.

And in their battle for pay parity, PHC nurses are in the rare situation of being supported by their employers. Employers' support is driven by two factors. The first is the need to recruit and retain PHC nurses. In an NZNO survey of PHC nurses early this year, 70 per cent of respondents said they were contemplating leaving the sector for higher pay elsewhere. NZNO is now hearing of employers advertising for nurses and getting few, if any, responses. The second is by employers' own campaign for sustainable general practice. They believe more government funding is needed for both capitation and co-payments.

The cost of pay parity for PHC nurses is estimated at around $15 million. The current Health and Education Minister, Chris Hipkins, found additional money earlier this year to boost the pay of early childhood education teachers to solve that sector's recruitment and retention issues. These teachers, on the whole, work for private providers. The same lifeline has not been extended to PHC nurses or their employers, who face the very same issue. The fact that PHC negotiations are underway and are in the private sector seem to be the excuse for government inaction, despite the precedent that was set here.

PHC nurses' hopes were lifted following a meeting between employers and Ministry of Health and DHB representatives in September. A statement following that meeting, acknowledged that pay parity needed to occur across the PHC sector, with the initial focus on the PHC MECA. But in a letter to NZNO late last month, Hipkins seemed to be resiling from that. He said it was not appropriate for him *"to comment on or intervene in this bargaining"*.[1] But former Health Minister David Clark stumped up $38 million to get a DHB MECA across the line in 2018.

Pay parity for all nurses

It is not right that one group of nurses is forced to take strike action in an attempt to get the same pay as another group of nurses. All nurses, regardless of where they work or who they work for, should get the same pay.

If this situation is not resolved, there will be an exodus of nurses from PHC. And that will have an escalating impact on secondary health services, as many of those unable to access PHC will end up in hospitals with entirely preventable health conditions. •

Reference

1) Office of the Minister of Health. (2020). Letter to NZNO industrial adviser Chris Wilson.

By professional nursing adviser
Anne Brinkman

All adverse events must be reported

Reporting of adverse events in all health-care settings must be comprehensive and transparent. Health professionals have a role to play in advocating for robust patient safety systems.

Incident reporting has many facets. I remember a registered nurse (RN) telling me she had left a private hospital because of the bullying behaviour of one of the surgeons. The nurse had taken her concerns to the hospital manager who told her there was nothing they could do about it because "the surgeon brought in the patients [to the facility]".[1] The power imbalance was overwhelming for this nurse.

Were there implications for patient safety in this scenario? Possibly. There certainly were for staff safety. The nurse didn't feel supported by the management – or her peers – who did not want to get involved. She left knowing she had at least informed the hospital's management about the surgeon's behaviours. The hospital lost an experienced nurse through unsatisfactory processes.

Health professionals must be equipped and encouraged to learn from adverse events, but the current system appears to encourage under-reporting.

Incident reporting is an accepted, but inconsistently applied, record of things that went wrong, or might have gone wrong, in the public health system. The Health Quality & Safety Commission (HQSC) is charged with the national reporting of adverse events in the health sector.

Of the nearly 190,000 discharges in private surgical hospitals in 2017/18, New Zealand Private Sector Hospitals Association (NZPSHA) members reported 91 adverse events.[2] In comparison, in the country's 20 district health boards (DHBs), there were 891,837 inpatient discharges for the 2017/18 year,[3] with 631 adverse events reported – an average of 30 events per DHB.[4] Only 31 of that total were "health-care associated infections".[4]

How effective is the HQSC's adverse events reporting? In 2017/18, only one adverse event was reported from the primary health care sector. The HQSC notes the need to *"actively engage with the aged residential care (ARC) and primary care sectors to improve reporting and management of adverse events in these areas."*[4]

It is worth noting adverse events in ARC were either not reported or were grouped within the nine events in the "other providers" category in this same report.[4]

Commenting on the above data, the HQSC writes that the DHB numbers are *"well below the total that could be expected"* indicating that *"providers are only identifying and reporting a small percentage of adverse events that actually occur"*.[4]

Surgical site infections (SSEs) are very costly and can often be prevented. The HQSC's surgical site infection improvement programme reports that, from October to December 2017, DHBs performed 2717 hip and knee arthroplasty procedures. Thirty-five SSIs were reported, a rate of 1.3 percent.[5]

The SSII programme began in 2012. It only covers the DHBs, not private surgical hospitals, yet is designed to help prevent *"emotional and financial stress, serious illness, consequences for patients, as well as health services"* caused by SSIs.[6] Why are private hospital patients not entitled to the same level and quality of reporting?

Reporting is voluntary

The public may well ask why the reporting of adverse events and SSIs is voluntary. Former HSQC chair Alan Merry states that *"it is important that health-care providers enable a just culture where staff can report patient harm, confident that the response will be to focus on learning rather than attributing blame"*.[4]

Shouldn't the Ministry of Health require a much more focused approach to these ongoing national issues, rather than accepting the under-reporting of adverse events? Adverse events are, after all, primary indicators of inadequcies in health care.

This weak data should prompt health professionals to lobby the Government to make transparent, comprehensive reporting of adverse events a priority for the HQSC.

Little progress

A 2010 review on the HQSC's website shows how little progress has been made in achieving a nationally consistent approach to incident reporting. That review speaks to a 2007 DHB project that was unable to meet the overall project goal *"to achieve a nationally consistent approach to incident management across all health and disability services in New Zealand"*.[7] Thirteen years later this goal has yet to be achieved.

Also on the HQSC website is a 2016 literature review of international patient safety reporting.[8] It is wide-reaching and provides easily understood details for best-practice for both local and national systems.

Health professionals must be equipped and encouraged to learn from adverse events, but the current system appears to encourage under-reporting.

Health information systems must be put in place to support patient safety reporting systems.[9] As health professionals, we owe it to patients and their whanau to learn from our collective mistakes and advocate for more robust patient safety systems. •

** References for this article are on p5.*

CCDM: Huge progress at one DHB

MORE THAN 100 additional full-time equivalent (FTE) nursing, midwifery and caregiver positions have been approved at Capital & Coast District Health Board (CCDHB) for the 2020/21 year, following implementation of the care capacity demand management (CCDM) programme over the past two years. The additional positions will be a mix of registered nurses, registered midwives, enrolled nurses and health-care assistants, and is the result of FTE calculations in 15 inpatient areas.

"This is a major milestone to result from the CCDM programme at CCDHB," said programme manager Emma Williams (right). "We've built a robust and sustainable programme. All of the FTEs have been approved and we are currently recruiting as part of a staged implementation through to March next year.

"There are some great career opportunities for nurses and midwives, particularly for new graduates. CCDHB is also seeing some applications from New Zealand-trained nurses returning from overseas. Recruitment is well underway with 20.5 FTE already appointed."

A further five FTE calculations have been undertaken and will be included in the 2021/22 budget, Williams said. This includes staffing for two mental health, addictions and intellectual disability service (MHAIDS) wards. "Following implementation of TrendCare into the remaining nine MHAIDS units, their FTE calculation process can be progressed," she said. "Seven general wards are also being supported to achieve the required TrendCare accuracy and compliance, and will be assessed again next month."

Williams said the staff increases signal the move to acuity-based staffing for CCDHB. The FTE will be in addition to the Ministry of Health and DHB hotspot FTE allocation that has been appointed to over the last 18 months in response to the data.

"The key has been an active partnership between the organisation, safe staffing unit and unions. Good relationships, trust and respect, with a clear focus on patient and staff safety, have been crucial. Accurate data collection from TrendCare and the core data have helped identify model of care changes and the roster model needed. The CCDM programme has kept up its momentum and proved it is a robust and sustainable process," she said.

Support for other DHBs

Meanwhile, NZNO is continuing its efforts to help DHBs comply with their obligation to fully implement CCDM by June next year. The healthy workplaces agreement monitoring group met last month to discuss goals and the approach for achieving this. Draft terms of reference have now been circulated. •

NZNO organiser gains Labour seat

NZNO HAS lost one of its Christchurch-based organisers, while Banks Peninsula has gained a new MP.

Tracey McLellan won the electorate seat last month, with a more than 11,000 majority over her nearest rival, National Party candidate Catherine Chu.

She has worked for NZNO since 2015, covering mainly primary health care sites and the whole of South Canterbury, including the district health board. She stepped down from the role in July this year, with her work picked up by Christchurch Hospital delegate Stephanie Duncan on a fixed-term contract.

McLellan said she was "very excited" to be part of the Labour Party resurgence, but realised she had "big shoes to fill", taking over the seat from long-serving MP Ruth Dyson.

Before joining NZNO, McLellan had worked at the University of Canterbury as a research scientist, specialising in sports injuries and concussion. She became acting Labour Party president last year following Nigel Haworth's resignation.

Former Labour MP Iain Lees-Galloway rejoined NZNO at the end of last month as the Central Region lead organiser. His temporary, fixed-term contract runs to the end of March next year. He replaces Lyn Olsthoorn, who retired from NZNO last month. Galloway was MP for the Palmerston North electorate from 2008 until July this year, and has previously worked for NZNO as an organiser and campaign and media adviser.

Other former staff to have joined NZNO after political careers include industrial services manager Laila Harré and lead organiser Carol Beaumont. "In the time they worked for us, they all gave us the benefit of their experience, which has been valuable to our work," said industrial services manager Glenda Alexander. "We expect Iain will also have a lot to share with us." Former NZNO organiser Sue Moroney served as a Labour List MP from 2005 to 2017.

New Banks Peninsula electorate MP Tracey McLellan

Two staff members leaving NZNO at the end of this month are Auckland organiser Sue Sharpe and Nelson organiser Daniel Marshall. Marshall will be joining the Public Service Association organising team in Nelson in January. •

Aged care: Heritage achieves settlements

UNION MEMBERS working at Heritage Lifecare have endorsed their 2020 wage offer, with 90 per cent of members supporting it. A priority for the negotiating team was to ensure union members received the district health board (DHB) aged-care funding increase of three per cent for 2020.

Service workers: A three per cent increase, backdated to July 1, 2020, and an increase to a minimum rate of $20.40 on April 1, 2021, has been awarded to all service workers. These include all kitchen workers, cleaners, laundry workers and maintenance workers. Increases for this group were a priority for the union team as they negotiated with Heritage on the 2020 DHB funding increase. We are delighted our colleagues are able to move off their previous low/minimum wages.

While we think it is good that we have been able to negotiate a minimum Heritage rate that is ahead of the minimum wage, we will continue to work on making sure there is a wage progression process in a collective agreement (CA), as there will be for all other workers at Heritage.

Enrolled nurses: The new EN scale is based on length of service, with a third step available by appointment and with interRAI training. Step one, up to three years' service, is now $27 per hour. An EN with more than three years' service will now be paid $28 an hour. Pay increases are backdated to July 1, 2020.

Registered nurses: The ability to recruit and retain nurses (particularly RNs) is a significant issue in the aged-care sector. This has meant that the wage scale we have been able to negotiate with Heritage has targeted increases towards RNs. The new hourly rates range from $30 an hour for a first-year RN who is interRAI trained and has a first aid certificate, up to $38 for an RN with more than six years' service and by invitation only. Wage increases for 2020 will be based on service with Heritage Lifecare and any immediate employer predecessor.

NZNO will continue working towards settling a Heritage collective agreement (CA). We will be working with RN union members in the coming months to make sure the progression through the pay scale is achievable.

Pay equity: The union negotiating team advocated strongly for an increase for those covered by the pay equity workers' settlement in 2020. Heritage was not willing to offer any pay increases for this group of workers this year. We believe this is unfair given the incredible work all aged-care workers have done in 2020. Focus for those workers covered by pay equity will move to making sure that union members are supported to gain health and wellbeing qualifications so they are able to move up the pay scale (the current top rate is $25.50 and will be $27 in July 2021); and continuing to work on getting a Heritage CA in place so we can achieve improvements to other conditions (eg weekend rates and overtime).

We will be surveying union members later this month to find out what their priorities are for securing a CA. •

Report by NZNO organiser Christina Couling

Negotiations at CHT Healthcare continue

NEGOTIATIONS FOR a collective agreement at CHT Healthcare Trust sites are continuing, with the main sticking point gaining movement on our sick leave claim.

CHT Healthcare is a regional aged-care chain based primarily in Auckland and with facilities in the Waikato and Bay of Plenty regions. We have a multi-union collective agreement (MUCA) in place here, covering approximately 250 union members. We have had two days of negotiations recently, but were unfortunately not able to settle a proposed CA. We have claimed 15 days' sick leave, beginning from an employee's appointment, but this is proving hard to get agreement on.

NZNO delegates on the negotiating team are (left to right) health-care assistants Barbara Too Too, Veniana Rabo and Mata Ariki, and registered nurses Robin Moll and Therese Tating.

Our members at CHT have dealt first-hand with COVID-19 this year – St Margaret's Hospital and Rest Home in Te Atatū is a CHT site and was one of five coronavirus clusters in aged care earlier this year. Four residents died and seven staff were infected, with a further 11 probable cases. Members have been well supported by the employer, with paid leave being provided when staff are required to self-isolate. In some instances, CHT has also paid for accommodation in order to support staff to continue working when they have vulnerable family members at home. We appreciate CHT's commitment on these issues and are hopeful this compassionate approach leads to some movement on our sick leave claim and the settlement of a positive CA this year.

Report back meetings will be held across CHT facilities later this month/early December to discuss how we can work collectively to progress our claims. •

Report by organiser Christina Couling

Kai Tiaki NURSING NEW ZEALAND

writing guidelines

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

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

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

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

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

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

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

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

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

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

Articles:

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

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

Books:

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

Websites:

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

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

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

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

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

Reference

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

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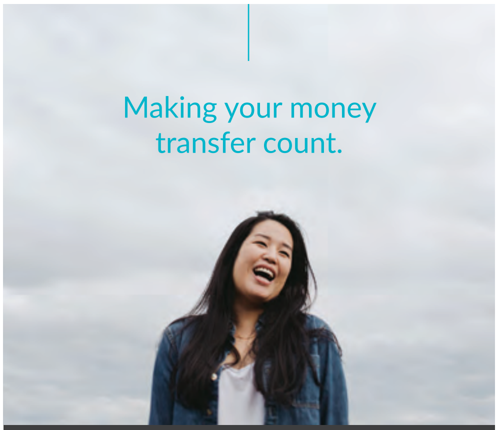

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