Kai Tiaki
NURSING NEW ZEALAND
March 2021
VOL 27 NO 2

IPC nurses in huge demand

The skills of infection prevention and control nurses have never been more in demand, as the COVID-19 pandemic turns a year old.

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The dedication of caregivers

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Remembering February 2011

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NEW ZEALAND NURSES ORGANISATION | TŌPŪTANGA TAPUHI KAITIAKI O AOTEAROA

NZNO Young Nurse of the Year 2021

Nominations now open!

Purpose of award:

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

Nomination criteria:

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

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

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

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

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

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

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

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

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

For Nomination Form and further information/criteria go to:

www.nzno.org.nz

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THIS ISSUE looks at the pressure infection prevention and control nurses have been under since the emergence of COVID-19, reports on the ongoing impact of the February 22, 2011, earthquake in Canterbury, examines the importance of cultural safety in disaster nursing and features interviews with two caregivers to mark Caregivers' Week later this month.

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

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

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

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

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

This issue . . .

Need information, advice, support?
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Making a difference together

By Robyn Boyne

When I began my nursing career in the mid-1970s, there was no such thing as an infection control nurse. We followed very prescribed ways of doing things without question, believing we were doing the right thing.

Some of what we did would be almost laughable today. For example, we put on a short-sleeved cloth gown when entering the room of a patient in isolation. When we left the room, we carefully removed the gown and placed it on hooks on a metal stand, ready for the next person to put on and remove in the same way. We did not use gloves for much and when we did, they were plastic and far too big for our hands. We washed our hands with soap and water, and they often became raw and sore. How times have changed. Standard precautions, the use of personal protective equipment (PPE) and the application of the five moments of hand hygiene have completely changed the way patients are cared for.

'Pandemic clock ticking'

Infection control nursing has evolved into a specialist nursing role with the emphasis now on prevention rather than control. This has become even more important as the upsurge in multi-resistant organisms and communicable diseases challenges us daily. I remember a speaker at an American infection prevention and control (IPC) conference I attended many years ago saying the pandemic clock was ticking, but we just didn't know what time it was. Well we do now! SARS-CoV-2 (aka COVID-19) has changed everything. We should have been prepared for it, but when reality hit, we found we were not.

Questions and more questions

As an IPC nurse for more than 20 years, things I thought I knew were turned on their head, as the overwhelming tide of new information, some of it contradictory, flooded in. Was COVID-19 droplet borne or was it airborne? Should we wear an N95 mask or a surgical mask, or both? Should we be using powered air respirators? Should we use face shields or should we use goggles? Should the patients be nursed in a room with negative pressure or could they be nursed in a normal room? Then there were fears about whether there was enough PPE; whether we could we pass it on to our families at home; and whether you could refuse to look after a COVID-19 positive patient. And there are so many more questions and still no clear answers to many of these questions.

What is important, however, is where information is sourced from and that the advice given is consistent. For my workplace, the Ministry of Health (MOH) became the voice of "truth" that cut through the many different opinions on how we should be doing things. While initially confusing for some, using the MOH guidance documents helped provide clarity and certainty for staff that what we were doing was current best practice.

The impacts of COVID-19 were many, particularly when hospitals were closed to visitors, and infection prevention rules meant families could not be with their loved ones even when they were dying. This particularly affected the Māori concept of whanaungatanga, in which relationships and family connections are so important. The tikanga around death and dying had to change, as families had to use telephones or online meetings instead of being there and health-care workers performed karakia instead of the usual spiritual advisers.

Not all the effects of COVID-19 were negative. The number of influenza cases dropped to almost none. This proved that, along with vaccination programmes, basic infection prevention measures, such as frequent hand hygiene, cough and sneeze etiquette, social distancing and not coming to work when sick, worked. Mask use has become part of the way things are done and I have had many staff tell me they now realise they should have been doing some of what they are doing now, all the time.

A continued emphasis on good IPC practice will help prevent many other diseases from spreading as IPC is not something we do when we are facing an imminent threat – it is part of what we should be doing all the time. In time, COVID-19 will go away but we cannot afford to be complacent – there will be something else waiting to come along.

As an IPC nurse for more than 20 years, things I thought I knew were turned on their head, as the overwhelming tide of new information, some of it contradictory, flooded in.

Finally, I want to say thank-you to all the many different health-care workers who have been, and still are, working so hard to screen for, and manage the care of suspected or known COVID-19 patients. At this time, it is those working in the managed isolation and quarantine facilities and doing the swabbing in the community that are at the forefront of efforts to keep COVID-19 out. But together, we have all made a difference. •

Robyn Boyne, RN, BN,PGDip (HlthSci) is a clinical nurse specialist in infection prevention and control at Bay of Plenty District Health Board.

NZNO launches Kai Tiaki website

KAI TIAKI Nursing New Zealand will be available digitally from this month, at www.kaitiaki.org.nz.

Co-editors Mary Longmore and Teresa O'Connor said they were excited to launch a digital option, as requested by members in 2015.

The website's simple design made it easy to access and a digital magazine allowed more timely and relevant news for nurses and health professionals, they said.

Content will be similar to the print magazine, but with links, updates and the ability for members to share articles with each other, the co-editors said.

The online *Kai Tiaki Nursing New Zealand* would remain a member-only benefit, with an initial login required. The printed cover has been redesigned slightly to align with the website.

Acting NZNO chief executive Mairi Lucas said it was exciting to see the website "go live", more than five years after members asked for a digital option at the 2015 annual general meeting.

"This has been a long time coming, and has taken a lot of work – from many staff and the web designers – but we are really pleased with the result."

The website was designed and developed by Hive. Corporate services manager David Woltman said its total cost had been in the region of $80,000.

Kai Tiaki Nursing New Zealand was first published in 1908. Since COVID-19 lockdowns in 2020, it has also been available in an online flipbook, as an interim measure. •

Kai Tiaki goes live

www.kaitiaki.org.nz

Easy to access • Links and updates • Share articles with each other

Board review recommends some radical changes

A SMALLER board of nine, an appointed chair, two appointed directors to bridge skill gaps and a half-time president and kaiwhakahaere are among the key recommendations of the NZNO governance review, completed late last year. The board should also improve its financial literacy and establish a whistleblower policy, according to the recommendations.

The board has refused to release the full review report "for reasons of professional sensitivity and confidentiality" but last month released the reviewers' 33 recommendations. The review was conducted by commercial corporate lawyer with the Tuia Group, Guy Royal (Ngāti Raukawa, Parehauraki, Ngāti Hine, Ngāpuhi), and leadership development manager at Canterbury-based company Brannigans Human Capital, Chris Bailey.

Chair of NZNO's governance committee Andrew Cunningham said previous annual governance reviews had not been released. "The purpose of this review was to help shape the upcoming constitutional review, to see if there was a better way of doing things. It was not prompted by the resignations of the president and board members last year."

The recommendations, released last month, said the capability of the chair needed to improve in three areas: board ethics, organisational culture and an effective governance culture. The board should set and role model the expected organisational culture.

An appointed chair

The review recommended the chair be an appointed position, with a three-year term and the option to re-apply for a maximum of a further two terms. Identification as Māori or having a strong grasp of Māori perspectives would be highly desirable.

The review recommended the president and kaiwhakahaere positions remain, but be reduced to half-time, with the tumu whakarae and vice president remaining in place to support them. Three positions elected from the membership would remain, with two appointed directors. Like the chair, the two appointed directors would have a three-year term with the option of a maximum of two further terms. All directors should join the New Zealand Institute of Directors (or relevant governance body) when starting on the board. To be eligible for a second term, they should complete relevant governance courses in their first term.

One-day meetings

Board meetings should also be reduced to a day. This could be achieved by clarifying the board's key decisions, aligning the agenda more closely to strategy and improving trust and capability between directors.

Under a series of recommendations on biculturalism, the review recommended the board, te poari, the kaiwhakahaere and the chief executive work in closer partnership to achieve agreed bicultural outcomes. And it recommended the board conduct a strategic wānanga "to clarify how the bicultural model enhanced NZNO's purpose and vision".

Cunningham said some recommendations had been implemented, eg governance training and improving the board's financial literacy. But because many recommendations required constitutional change, eg an independent chair and two independent directors, they would be considered in the constitutional review. The report will be given to the reviewers.

The board, staff and members all recognised the need for change and the board was committed to change, he said. It had done some things poorly, eg explaining what governance was, but had done "incredibly well" in other areas. "The board is willing to lead change where needed, is being bold and strong, is sticking together and is keeping people in the loop about what is going on. There is still work to be done – we know we can do things better. But we are really excited about the possibility of change."

The review's cost could not be released because of commercial sensitivity. •

Members petition for release of review report

A MEMBER petition for the NZNO board of directors to release the full evaluation of its performance has so far attracted 200 signatories.

One of the organisers, NZNO delegate Allister Dietschin, said a group of active NZNO members, including delegates, were behind the petition to release the full review. "It was initiated late last year by a network of active members who have been concerned about the direction of the organisation for some time," Dietschin said.

The intent was to lodge the petition with the board or chief executive when it met the required one per cent threshold – about 500 – of verified member signatures. "As a transparent, member-led organisation, we believe every member who wants to see this review, which was paid for by NZNO members' fees, should be able to access it on the website."

The board has refused to release the full report but last month released its 33 recommendations (see story at left). The petition said the decision to withhold the full review was "unacceptable".

"NZNO members are the main financial contributors to the organisation and, as such, have a right to ensure the board's performance meets national and international best-practice standards," the petition states.

Dietschin said the release of an independent review by former Council of Trade Unions' president Ross Wilson on NZNO's contentious 2017/18 district health board negotiations had led to a "much better process" this year. The hope was releasing this review would similarly provide the chance to improve NZNO governance for members, he said.

"The resignation of one chief executive, two presidents, one vice-president and three board members in one year in any other organisation would ring alarm bells that something is amiss," Dietschin said. "There seems to be no willingness to acknowledge the issues and look at how to improve the organisation, for its members." •

Offer to follow 'focused' DHB MECA negotiations

TWO SMALL teams of negotiators were exploring "ideas and options" for a new NZNO/district health board multi-employer collective agreement (DHB MECA) when *Kai Tiaki Nursing New Zealand* went to press.

The DHB team had presented an "indicative offer of settlement" late last month, but member feedback on it had been overwhelmingly negative, NZNO advocate David Wait said. The negotiating teams then decided to continue discussions about the offer over the course of a week.

Members' response 'significant'

"We are taking this as a positive sign. The DHB negotiating team understood the significance of members' reaction to the offer and wanted to talk more about ideas and options," he said.

He acknowledged the DHB team would have to find more money to come up with an offer that had any chance of ratification.

"Our view is that members' response to the serious drawbacks in the indicative offer had a strong impact on the DHB bargaining team," Wait said.

"Our bargaining team delegates read out a selection of members' responses that had been posted on Facebook. That was really powerful and brought members' voices into the negotiations. We were no longer a bargaining team of 15 but a team of 30,000," he said.

The DHB's smaller team consists of two negotiators and a director of nursing, and NZNO's team is Wait, organiser Ron Angel and three delegates.

Wait said shifting discussions to a less formal bargaining setting enabled quicker discussions. At the end of the three days of discussions between the two teams, the full teams were to return to negotiations. Any options the smaller teams came up with would be negotiated by the full bargaining team.

"I expect the DHB team to revise and firm up its offer. Whatever it is, we will take it out for members to consider," Wait said. "We will then determine our next steps."

The DHBs' indicative offer presented last month took a flat rate approach for staff on less than $100,000, while members on pay steps above $100,000 would not receive any increase to rates. •

Secondment to help with community nurse prescribing

DEPUTY CHIEF nurse at Counties Manukau District Health Board (DHB) Karyn Sangster has been seconded to the Nursing Council for 12 months to advance its nurse prescribing agenda.

Council chief executive Catherine Byrne said Sangster, who began last month, had been seconded to help implement the reviewed designated prescribing medicines list and with the establishment of community nurse prescribing. "Nurse prescribing is complex and Karyn's knowledge and expertise related to prescribing will be invaluable to the council."

The number of designated nurse prescribers continued to grow, likewise the number of community nurse prescribing programmes, Byrne said. The council had accredited two community nurse prescribing programmes, with a further three well on the way to accreditation.

She emphasised the need for consistency across the six-month prescribing programmes. Once qualified, community nurse prescribers will be able to prescribe for a normally well population with a minor health concern.

The council acknowledged Counties Manukau DHB for making Sangster's secondment possible. •

Acting chief executive appointed

NZNO's MANAGER of nursing and professional services (MNPS) Mairi Lucas (Ngāti Ranginui, Ngāti Raukawa) has been appointed acting chief executive (CE) by NZNO's board of directors, following Memo Musa's resignation last month.

Mairi Lucas

Board member Simon Auty said the board had received a "significant" number of strong applications for the CE position and wanted to take the time to find the right person. He hoped a decision on a permanent CE could be made within a few weeks.

Lucas has been MNPS since January 2019. Before that, she held senior nursing roles at Hauora Tairawhiti and the Bay of Plenty District Health Board, as well as at iwi and Māori providers.

Lucas said she would be supported in the role by an "exceptional" management team who would help ensure the organisation ran smoothly until a permanent appointment was made. Associate professional services manager Kate Weston will cover Lucas' role. •

Board still to decide how best to fill presidential vacancy

NZNO's BOARD of directors was still considering how best to fill the presidential vacancy, when *Kai Tiaki Nursing New Zealand* went to press. But a decision was imminent.

The vacancy was created when Heather Symes resigned in December last year, effective from early January this year. She resigned for family reasons.

Tracey Morgan was elected unopposed as NZNO's vice president in last year's board elections. •

Māori providers 'pivotal' in rollout

MĀORI AND iwi health providers in Northland are preparing to roll out the COVID-19 vaccine to remote and vulnerable Māori communities.

Ki A Ora Ngātiwai iwi health provider clinical manager and nurse Sharon Russell said iwi providers would play a "pivotal" role in ensuring any vaccination programme would reach those most at risk of missing out in rural Māori populations. "The Māori providers have direct, up-to-date links with those communities and will play a pivotal role in meeting those needs."

Vaccinating communities was still likely to be several weeks away, as the health workforce would need to be vaccinated first.

Managing vaccine 'complex'

Managing a cold-chain vaccine was complex and would need to be carefully managed. Russell said the Northland District Health Board (DHB) had been working closely with iwi providers on how the rollout would work when the time came, she said. "There has been really good communication between the DHB and partners in this – they have made every effort to be inclusive," Russell said.

"This is a massive undertaking for Tai Tokerau and a lot of thought has gone into how this might work and accessing communities at risk."

PHOTO: TANIA WHYTE, NORTHLAND AGE

Maureen Allan

Far North Māori provider, Whakawhiti Ora Pai, clinical manager and nurse Maureen Allan said it would be important, as part of the rollout, for whānau to have the chance to ask questions about the vaccines to help their understanding.

"Part of our strategy is to go out and talk to communities and maraes and give them that opportunity."

Māori providers had been working closely with the Northland DHB to ensure access and equity for remote Māori populations. Whakawhiti Ora Pai covered the communities of Te Hapua, Te Kao, Ngataki and Pukenui.

Immunisation Advisory Centre (IMAC) national manager Loretta Roberts said IMAC was working with Māori and iwi health providers around the country to ensure staff were confident as the rollout approached – including communication about the vaccine to address any possible hesitancy.

So far, apart from some misinformation on social media, "it seems to be okay".

Minister for the COVID-19 response Chris Hipkins has said there would be a specific vaccination rollout plan for Māori, focused on giving them confidence to receive the vaccine.

That would involve working closely with Māori health providers, he said in response to a parliamentary question by Māori Party co-leader Debbie Ngarewa-Packer. "One of the things we're very mindful of is that we need to ensure Māori feel confident in receiving the vaccine and they're more likely to feel confident . . . if they're receiving that vaccine through health providers they have an existing, trusting relationship with," the minister said.

Ngarewa-Packer has said Māori are more vulnerable to COVID-19 at earlier stages than the general population.

"History shows us that Māori have been the ones to suffer the most through pandemics in the past – we must be ahead of the curve now and ensure that doesn't happen." •

Enrolled nurses fighting to become vaccinators

NZNO's ENROLLED nurse (EN) section has taken its fight for ENs to become provisional COVID-19 vaccinators to the Minister of Health. And it seems to have worked.

In a letter to Health Minister Andrew Little, section chair Robyn Hewlett said some district health boards (DHBs) were blocking ENs from being assessed by registered nurses, even though the ENs had completed the online provisional vaccinators education programme, provided by the Immunisation Advisory Centre (IMAC). After the online programme and passing a test, participants must be assessed by their peers, and for ENs that is RNs. But in some DHBs, RNs were surprised ENs could do the programme. In its information on the online education programme, IMAC said ENs could complete it.

Hewlett said other health professionals were being assessed. This was "disappointing and frustrating" for ENs, who were a valuable resource and willing to be involved in vaccination programmes. The section wanted DHBs to "urgently acknowledge" that ENs could and would be involved in vaccination programmes. They asked the minister to "question" the barriers to this happening and to enable ENs' knowledge and expertise to be used in vaccination programmes.

The minister had passed the letter onto the Ministry of Health (MOH). In response to *Kai Tiaki Nursing New Zealand,* a spokesperson said the MOH supported ENs as provisional vaccinators. It was aware of reports the EN section had referred to and "we are following up with DHBs".

• The MOH has asked the Nursing Council to approach nurses who have not held an annual practising certificate (APC) for five years or less to consider work as a vaccinator, as part of the "vaccination surge workforce" in each DHB. Council chief executive Catherine Byrne said the council was in the process of actioning the request. •

Unions encouraging member vaccinations

NZNO AND 26 other unions have agreed to "educate, support and encourage" their 320,000 members to have the COVID-19 vaccine.

NZNO acting industrial services manager Glenda Alexander said with more than 50,000 members, NZNO had great power and reach to influence community vaccination rates, not only within its membership but among their families, whānau and communities. "Unions have additional reach into communities – workers can potentially influence many people in their families and communities."

Leaders of 27 Council of Trade Union (CTU) affiliated unions agreed at a meeting on March 2 to step up and encourage their collective 320,000 members to get vaccinated. "As leaders, our role is supporting and ensuring our members are educated, supported and encouraged to get their vaccination," Alexander said.

Vaccine hesitancy had not been a problem so far in the first wave, but with an estimated 50,000 frontline health workers next in line, it was important to pre-empt any misinformation, she said. "We want to make sure people get the right information and respond to any concerns they might have. It's important to ensure our members and the people they care for are safe."

PHOTO: ADOBE STOCK

She acknowledged, however, that NZNO had a dual role to balance public safety with workers' rights to refuse vaccinations (see industrial focus, p35).

NZNO acting manager nursing and professional services Kate Weston hoped New Zealand would be reassured by overseas experiences of the vaccine. "We are not the first ones [to have the vaccine] so by the time we have the rollout, we'll have the benefit of lots of international data from the vaccination programmes."

Weston said there had been constant communication with the Ministry of Health and district health boards over the rollout. "Generally the information has been good and there has been good cooperation and good union cooperation."

'Precautionary' approach

A "precautionary" approach was being taken, meaning those who were pregnant or had allergies or some particular health conditions would not be given vaccinations. This was because the effects were not yet known. "At the moment, we are only vaccinating healthy people."

Weston said the scale of the COVID-19 mass vaccination programme was beyond anything experienced before. "The scale of this is new but if you break it down into manageable chunks, the initial rollout is within the capabilities of the workforce."

By early March, three-quarters of the country's estimated border workforce of 12,000 had received their first vaccinations, mostly in Auckland, COVID-19 Minister Chris Hipkins has said. That meant the most at-risk were "well on the way" to being protected, including nurses carrying out health checks in managed isolation or quarantine facilities, he said. The next stage – border workers' families and household contacts – was already underway in some regions. Vaccinations for frontline health workers, ie those dealing directly with patients who may have COVID-19, were expected to start this month, he said.

A third shipment of the Pfizer/BioNTech vaccines, containing another 65,500 doses, arrived early this month. It brought to 200,000 the total number of COVID-19 vaccines in New Zealand. However, vaccine supply would continue to be a challenge, he said. •

Nurses on wrong salary steps

UP TO 25 nurses working in managed isolation facilities (MIF) in Christchurch are being paid lower salaries than they are entitled to, NZNO organiser Danielle Davies says.

Davies has written 25 separate letters to Canterbury District Health Board (CDHB) on behalf of the NZNO members, who she says should have been appointed to higher registered nurse (RN) salary steps, given their nursing experience. "As per the DHB MECA [district health board multi-employer collective agreement] members can be appointed on any of the available salary steps, appropriate to their previous nursing experience".

Community scale

Davies is already lobbying the CDHB to move its MIF nurses from the RN scale to the community nursing scale, which offered higher rates of pay for experienced nurses, as was the case in Auckland.

That meant nurses in Christchurch MIFs were getting paid up to $5500 less than nurses in Auckland MIFs.

"I'm applying pressure on two different fronts," Davies told *Kai Tiaki Nursing New Zealand*. The data she had gathered from the 25 nurses would also be useful if the DHB switched to a community nursing scale for its MIF nurses.

She was awaiting a response from new CDHB chief executive Peter Bramley on the salary scales, which she hoped would come this month. •

Akenehi Hei award to Tai Tokerau nurse

TAI TOKERAU nurse Marie Noa (Ngāti Hine, left) has received the Te Rūnanga o Tōpūtanga Tapuhi Kaitiaki o Aotearoa (NZNO) Te Akenehi Hei Award. Noa was recognised for her contribution to the health of whānau Māori in Te Tai Tokerau and Aotearoa over several decades.

Noa started out as a hospital aide at Rawene Hospital in the Hokianga, where she worked for 20 years, spanning theatre, radiology, outpatients and outreach. After qualifying as a registered nurse, she took up a nursing position in orthopaedics at Whangārei Hospital for 12 years. She has since worked for Northland iwi provider, Ngāti Hine Health Trust (NHHT), for more than 20 years.

The award ceremony took place in early February at Tāmaki Makaurau, where the previous recipient, Moe Milne, handed the taonga over to Whāea Marie. Both were joined by their whānau as well as members of Te Poari o Te Rūnanga o Toputanga Tapuhi Kaitiaki o Aotearoa.

Noa has told *Kai Tiaki Nursing New Zealand* previously how much she appreciated working for an iwi organisation after years in the mainstream health system.

"It was great coming back. You feel you know who you are as a Māori wahine and a practitioner, and can really explore your culture," Noa has said.

As a tamariki ora nurse at NHHT Noa works with tamariki and to connect whānau to other services, such as housing, child care or social support.

Noa said working within a Māori tikanga framework has strengthened her relationship with patients and whānau, as well as strengthened her own practice. Noa said it brought back the connection she lost when working in the mainstream system.

At the ceremony, NZNO kaiwhakahaere Kerri Nuku spoke of Noa's commitment and contributions to Te Rūnanga over the years, and her role as a tuakana.

"As a rangatira, she has been to every hui for years where she actively participates and shares her knowledge. She is an honorary member of Te Rūnanga o Te Tai Tokerau, an integral part of their tuakana/teina model."

Nuku also spoke of Noa's love of creativity, playfulness and colour.

"We were at a hui for Tamariki Ora which we thought would be business as usual. Then Whāea Marie came up on stage and, rather than opening up a PowerPoint, pulled out colourful scarves and began with dance," Nuku said.

"Her insistence on play and creativity, coupled with her significant experience and dedication to helping whānau understand their health situation in a holistic way, has made a significant impact on people's health in Te Tai Tokerau, especially for tamariki."

Awarded every two years, Te Akenehi Hei Award is the highest honour awarded by Te Rūnanga o Aotearoa and allows recipients life membership of Te Rūnanga. Akenehi Hei was one of the first nurses to register under her Māori name. •

Te rangatira, he kairanga i te tira, i te tira o te hapū, o te iwi, ki ngā haere, ki ngā mahi e pā ana ki te hapū, ki te iwi. He kaiārahi. He kaitīmata, he kaiwhakatutuki i ngā mahi, ka whai ai te iwi i raro.

The chief is a weaver of people, of both hapū and iwi and in their travels and endeavours concerning both the hapū and iwi. She is a leader. She is a starter and finisher of tasks and so the people follow her. – *NZNO kaumātua Keelan Ransfield*

Nurses are biggest salary spend for DHBs

DISTRICT HEALTH boards (DHBs) spend the biggest chunk of their $6.3 billion salary costs on nurses – $2.2 billion or 36 per cent – according to a report by the Health Workforce Directorate.

The directorate is a team within the Ministry of Health responsible for workforce leadership. *The cost and value of employment in the health and disability sector* draws on December 31, 2019, figures to break down DHBs' salary spend.

There were 76,213 full-time equivalent (FTE) staff employed by 20 DHBs, according to the report. Most were nurses – 39 per cent – followed by corporate and other personnel at 19 per cent, then allied health professionals at 16 per cent. Care and support workers were next at 11 per cent, with senior medical officers at seven per cent.

The $2.2 billion DHB salary spend on nurses was followed by $1.1 billion for senior medical officers; $932 million for corporate and other services; and $884 million for allied health and scientific health workers. The smallest spend was on midwifery, at $120 million.

Māori, Pacific under-represented

The report also found Mâori and Pacific populations were not well represented in the DHB workforce.

"Māori are 15 per cent of our population but only eight percent of the DHB workforce. Pacific peoples are about eight per cent of our population and just four per cent of the DHB workforce."

Just three per cent of medical staff were Māori and 1.8 per cent Pacific. In nursing, Māori were seven per cent and Pacific three per cent.

However, the percentage of Māori nurses within the overall nursing workforce was slowly rising, increasing from 3.6 per cent in 2009 to 6.5 per cent in 2015, it said.

The number of Pacific nurses was also rising, but so was the workforce. The full report can be viewed at www.health.govt.nz •

NZNO welcomes PHARMAC review

A SIX-strong team, led by consumer advocate Sue Chetwin, is to review PHARMAC, the government agency which decides which medicines and medical devices will be funded. Prime Minister Jacinda Ardern and Health Minister Andrew Little announced the review early this month.

It will focus on how its performance could be improved and whether its current objectives maximised its potential to improve health outcomes for all New Zealanders. Little said concerns about PHARMAC included access to new medicines, timeliness of decision-making, the safety of substituting medicines due to cost and availability, and access to products funded overseas but not here.

NZNO has welcomed the review and acknowledged PHARMAC's work on "limited resources".

NZNO wants to know how PHARMAC will guarantee any changes to products, distribution, supply and administration, will be accompanied by appropriate information, particularly for providers who supported high-needs, diverse communities, living with multiple health conditions/co-morbidities.

NZNO's policy team wants to know if PHARMAC is considering the Ministry of Health's definition of equity and whether there was a plan to ensure all information reflected a culturally responsive approach to education and training. It is also keen to know how PHARMAC's intention to improve access to medicines for Māori and Pacific peoples will be implemented.

The team will be preparing a submission for the review and said it would have been a great opportunity to have a nurse practitioner on the review panel to showcase that role. •

New top nurse for Northland

NORTHLAND DISTRICT Health Board (DHB) has a new chief nurse and midwifery officer, Maree Sheard, a former director of nursing (DoN) in the New Zealand Army. Recruitment and retention of staff are among her priorities in her new role.

She joined the DHB earlier this year after working as a senior lecturer at Massey University's school of nursing, where she was involved in the development of a masters of clinical practice programme. Before working at Massey, she was an associate director of nursing at Whanganui DHB. She trained in Whangarei, her home town.

Maree Sheard

Sheard served in the army for more than 20 years and held a range of clinical and leadership appointments. •

Practice guide for cytotoxic drugs

WORKSAFE MAHI Haumau Aotearoa has produced a good practice guide to help keep workers safe when handling cytotoxic drugs and related waste.

The guide aims to help persons conducting a business or undertaking (PCBUs) working with cytotoxic drugs and related waste, to identify and control the health and safety risks of their work, and keep workers and other people, such as visitors to the workplace, safe.

Hospitals were the obvious audience for this guide and the health and safety of nurses, pharmacists, orderlies, cleaners, and laundry workers have all been considered in the advice, WorkSafe said.

The guide provides general advice and covers the possible adverse effects of cytotoxic drugs on health and the implementation of effective control measures. It examines the preparation and reconstitution of cytotoxic drugs, their administration and the handling of cytotoxic-contaminated linen and clothing. It also has a section devoted to the management of spills, including in home and community care settings.

The guide can be downloaded from the WorkSafe website, www.worksafe.govt.nz. •

Nursing Council election results not yet announced

THE THREE successful candidates in last year's election of nurses to the Nursing Council have still not been announced, a delay council chief executive Catherine Byrne described as "frustrating".

But Health Minister Andrew Little told *Kai Tiaki Nursing New Zealand* he is anticipating appointment of the three elected members later this month. "The Ministry [of Health] has drafted the appointment paper, which is currently going through sign-out and is expected to go to the Cabinet Committee for noting shortly," he said.

Voting in the elections – the profession elects three council members every three years – closed on September 4. Byrne said the council's election process was on the same cycle as general elections and this created a delay to any appointments from the Health Minister.

Little concurred. "With the general election intervening in the process, followed by the Christmas parliamentary break, there was unfortunately a significant period between the Nursing Council election and progressing the appointment of the successful candidates," he said. "It is fair to say there has been a backlog of health-sector appointments that the Ministry [of Health] and I have between working through since the beginning of the year."

Byrne said the delay had been frustrating for both the council and the 31 election candidates, but the successful candidates had recently been "confidentially informed".

The council was fortunate the remaining elected members were continuing with their governance duties until new members were appointed, Byrne said.

The minister said the ministry had treated the appointment of the elected members as a priority paper for 2021.

"Though with other significant appointment work required, such as the PHARMAC Review, Health Practitioner Disciplinary Tribunal and district health board vacancies, there has been a short delay," Little said. •

IPC nurses stretched '50 ways'

Wellington clinical nurse specialist Karen Corban has done a great deal in the past year, from preparing for an Avatar film crew flying in, to ensuring Wellington's MIQ facilities are safe.

By co-editor Mary Longmore

Wellington infection, prevention & control (IPC) clinical nurse specialist (CNS) Karen Corban (Ngāti Porou) has felt the pressure over the past year, with demand for her expertise growing phenomenally with the arrival of COVID-19. "We were needed in 50 different ways," says Corban, a member of NZNO's IPC Nurses College.

Anxiety levels among colleagues have been high. It has taken time to reassure, communicate and train staff on the correct use of personal protective equipment (PPE) and other IPC processes. "We had to train the trainers – the DoNs [directors of nursing] and senior staff across the hospital," said Corban, who works at Capital & Coast District Health Board (C&CDHB).

And while she's an experienced IPC nurse, with a master's degree in public health from the University of Otago and IPC qualification from Waiariki (now Toi Ohomai), the scale of COVID-19 preparations has been "huge" compared to anything previously encountered.

For weeks in early 2020, she worked up to 12-hour days, looking to the latest international advice from the Centers for Disease Control and Prevention and the World Health Organization, as well as the Ministry of Health, in a fast-changing scene.

Corban worked with primary health IPC colleague Barbara Vardey to check IPC processes at Newtown School's community-based assessment centre (CBACs). That involved training dozens of nurses to correctly carry out a nasal – or "nasopharyngeal" – swab and don and doff PPE ("the amount of times people videoed it so they could remember it safely"), as well as check "flow" through the testing centres.

Amid all that, Corban and Vardey were also asked to scope out possibilities for other CBAC sites in central Wellington, in case of a community outbreak.

She also oversaw the IPC processes at COVID-19 assessment and management units (CAMU), at Wellington Regional Hospital. These assessed patients who had been referred with suspected or known COVID-19 and who possibly required admission.

Karen Corban gets her COVID-19 vaccination at Wellington managed isolation/ quarantine facility, the Grand Mercure Hotel, in February.

Through April and May, Corban and her C&CDHB IPC team also provided IPC support to about 45 aged residential care (ARC) facilities in the Wellington region.

In May and June, she helped set up IPC processes at Wellington's QT Hotel, where several international crew from the Avatar movie had flown in from the COVID-19 ravaged United States. That involved organising safe processes for PPE, cleaning, housekeeping, waste, food delivery – "just keeping everyone safe".

Complaints crew members were not distanced from other guests when checking in, drew media coverage. Corban said safe systems were in place, but it appeared the social distancing rules were not applied.

Also in June, Corban was tasked with setting up a managed isolation and quarantine facility (MIQ) at Wellington's Grand Mercure Hotel, in a few days. "I got a phone call on Monday [June 24] and got asked to set up IPC processes at the Grand Mercure to be ready by Friday [June 26] for 96 people arriving," Corban said. "Everything was just evolving very quickly, so basically we set up hotel processes, from cleaning to entry flow, to swabbing processes."

Nurses practised taking nasal swabs on police and defence staff, "because some of them [Nurses] had never done it".

The MIQ team had to inform Te Aro School, across the road, and parents, whose concern sparked media coverage. But on day one, students and families greeted returnees from South Korea with welcoming placards and laminated stars. "When the group left they gifted a generous koha to us – we gave it to the school. It was just so moving."

She worked 18 days in a row over that period, as she felt it was important to be there as much as possible, answering questions and ensuring the system was safe. "It was certainly a baptism of fire." But she had really good support from IPC colleagues in NZNO's college and the DHB.

Since the initial rush, the team had set up better cultural supports at both the Mercure, and Bay Plaza Hotel, now an isolation facility. These included opportunities for face-to-face video chats

with whānau and te reo Māori resources and advice, along with Pacific and other languages. "It took a while to have these resources available in different languages."

As a Māori nurse, Corban says she was often asked to check in with Māori returnees. "Sometimes they just want to see another Māori – sometimes I was asked to go in and do a health check."

"It's about connection and that's really important. It seems to calm people down and they are less anxious."

Corban began her working life as a cardio-thoracic nurse in Auckland, working in the Waikato then London, before taking up a cardiology charge nurse role at a private hospital in Wellington. She worked in IPC in mental health services for a while, before taking up her current role at C&CDHB in 2016.

She found she "absolutely" loved the meticulousness required by the role.

Over her 35-year career, Corban has experienced frustration at getting the message through during smaller epidemics, such as the 2019/20 measles outbreak in Auckland. But these days, it was gratifying to see people really paying attention to IPC and hygiene practices. "People take notice when there is an outbreak – and never more so than now." •

No longer 'tedious' hand-washers

Infection prevention and control nursing is finally commanding the respect it deserves.

Justine Wheatley

By co-editor Mary Longmore

From feeling like bothersome aunts, always going on about hand-washing, IPC nurses have suddenly found themselves in hot demand in hospitals and health care across the world, since the COVID-19 pandemic, Auckland IPC nurse specialist Justine Wheatley says.

"IPC has been brought to the forefront, from being a somewhat tedious aspect to a crucial part of everyone's daily practice," Wheatley said. "It's been really cool to see the change in people saying 'she's going to tell us to wash our hands again', to everyone wanting to do their best."

A nurse for 29 years, Wheatley has been an IPC nurse specialist for the past nine of them. She was one of the first graduates of Toi Ohomai's master's degree in IPC in 2019, after completing a postgraduate diploma in public health at the University of Auckland in 2016.

She works across two Auckland private hospitals, where IPC nursing staff are involved in everything from mapping out the cleaners' daily regime to checking management plans and procurement of personal protective equipment (PPE). "I've been checking all the face mask samples coming in. I even had to cut them up to see if they had the layers of protection they said they had."

While it was nice to be appreciated, it could be draining being at the forefront of a pandemic. "It's pretty overwhelming, everyone wanting you to be everywhere at the same time," Wheatley said. "From being in the background, now we're having to be involved in everything. I'm coming home really late and really exhausted, as all essential workers will be able to relate to," she said.

Hospital processes have been constantly changing since the arrival of COVID-19, and IPC nurses are heavily relied on to ensure the updates are understood and applied. "There is a lot of anxiety. I have to stay really calm for everyone, reminding them they already have all the skills they need," says Wheatley. But collegial support helped – and they all vent their stress behind closed doors.

"We in the management team looked after each other, we had to be strong for everyone – there have been people crying in the office."

Fortunately alleviating anxiety is one of her skills, acquired during 12 years working in the United States, where she travelled as a new graduate in the early 1990s. Picking up work in neurology in Miami, then as a multiple sclerosis (MS) clinical nurse specialist in New York Hospital's Cornell Medical Centre (Judith Jaffe MS Centre), Wheatley found she had a natural ability to de-escalate people's anxiety and nurture the nurse/patient relationship.

This grew into a love of sharing information and best practice with both colleagues and patients. "I just love discussing things and educating people."

Emotions as part of practice

Wheatley has deliberately allowed her emotions to become part of her practice and education role, believing it makes her more effective, as both a nurse and teacher. "It's hard to make it personal and emotive. But giving that feedback in a constructive way brings it back to how our practice affects people's lives."

She went on to work at New York University, where she was heavily involved with setting up and coordinating a specialist MS clinic – Langone's MS Comprehensive Care Center – before returning to New Zealand in 2006 with her young daughter.

The personal approach she now brings to her IPC role, which is a hugely educa-

tive one. "I try to drive home how important IPC is to people's lives."

And people are listening. "It feels like we are all on a level playing ground in our team of five million," Wheatley said. "It feels like more like partnership, from the kitchen, to the cleaners to the medical specialists – they all want to do their best. They don't want to take things home to their families."

Nor is IPC just one thing – it's many things, performed repeatedly. That includes physical distancing, patient screening, hand and surface hygiene, along with appropriate PPE being donned and doffed correctly.

Wheatley said she found it surprising to discover how complacent some staff had become to transmission-based precautions, such as droplet spread. But staff were keener now to double-check their processes, constantly seeking out IPC nurses for guidance. "People are really paying attention."

Even in private hospitals, primarily dealing with elective surgery, people were scared.

"You want to create a culture where preventive behaviour is embedded in everyday practice. I don't want to be the IPC police. I just want to be a facilitator of good IPC behaviour."

Wheatley demonstrated how to wear face masks correctly on Television New Zealand's *Seven Sharp* last August (www.tvnz.co.nz/one-news/new-zealand/thats-not-very-flattering-hilary-barry-tests-covid-19-face-mask-made-bra).

She acknowledges colleagues in district health boards (DHBs) are having a much tougher time than the private sector.

"DHB IPC nursing teams have just had it so hard, and I have seen many of my colleagues breaking down under the pressure – it's relentless."

And her former colleagues in New York have shared their struggles too. The city has been "destroyed" by the pandemic, with city occupancy plummeting as residents depart.

Even IPC nurses became a bit "COVID complacent" during the recent long period at level one, but the latest cases of community transmission were a stark reminder of the importance of practising infection prevention consistently.

One of the biggest problems was people washing their hands, then touching their face. People can touch their faces about 40 times an hour and it was a "huge ask" to change such behaviours. "It's really hard. We're all human." •

Growing interest in IPC nursing – college

Infection prevention skills have never been more crucial, says college.

By co-editor Mary Longmore

The Infection, Prevention and Control Nurses College (IPCNC) is partnering with the Accident Compensation Corporation (ACC) to offer a free pilot course for new IPC nurses.

Interest in IPC nursing had grown since the emergence of COVID-19, and a skilled nursing workforce had never been more important, IPCNC chair Carolyn Clissold said. "COVID-19 has highlighted the need for constant vigilance in knowledge and practice in IPC and keeping an IPC workforce well-trained and resourced."

The four-month online course is adapted from a Canadian model and allows students to study around their work.

Seven students are currently enrolled, but there have been more 30 inquiries since its launch, said Christchurch IPC nurse consultant Ruth Barratt, who runs the course, using Zoom to check in montly with students. They include staff from district health boards, private surgical hospitals and clinics, hospices and aged care, she said.

While aimed at beginner IPC nurses from any health setting, it would be particularly helpful to those working in isolation, Barratt said. "At larger DHBs you get taught on the job, but if you're alone in a small area or facility, this is a good course to teach you all the areas of IPC you need to know."

IPC nurses were relatively few in number, but with the spotlight of COVID-19, interest was expected to grow, particularly in the residential aged care sector, Barratt said. But IPC education in New Zealand could be difficult to access and it generally took three to four years to develop the necessary experience and critical thinking skills. "There is no career path as such."

It wasn't always possible to commit to a full-time qualification, such as those offered at Toi Ohomai, she said.

Barratt, who did her master's degree online at Griffith University in Australia, has worked as an IPC nurse for 23 years.

Clissold said ACC wanted to drive down avoidable hospital-acquired infections. "As a college, we pitched the idea to ACC and they accepted our proposal for a pilot orientation programme that would involve modules and a preceptor who would check in with the orientees."

Ruth Barratt

ACC injury prevention partner Delma Augustine said health-care-associated infections were the most common treatment injury claim for ACC, yet most were preventable.

Clissold said the pilot would be evaluated in June.

The IPCNC had about 600 members. DHBs tended to have one to eight IPC nurses on staff, depending on size, but they had all been under huge pressure recently, Clissold said. "We have been hammered since last year with COVID-19 readiness and response in our areas, then in DHBs, managed isolation/quarantine facilities set up and oversight, worries about supply, fit, testing [of PPE] – and now vaccine oversight and delivery."

For more details on this and other IPC education opportunities see: www.infectioncontrol.co.nz/education •

Remembering February 22, 2011

February 22, 2011, will forever be etched in the minds of Cantabrians. At 12.51pm on that day, a 6.3 magnitude earthquake struck Christchurch, killing 185 people and destroying the central city. A decade on, the impact of that day is still felt.

By co-editor Teresa O'Connor

The events of February 22, 2011, are seared into the memory of all nurses throughout the Canterbury health system.

For Canterbury District Health Board's (CDHB) current acting executive director of nursing (EDoN), Becky Hickmott, the memories and images of that day remain vivid. She and some colleagues were visiting the West Coast DHB when she received a stark message from the EDoN Mary Gordon, delivered by her personal assistant: *"People have died; come back immediately."*

The trip back over the Southern Alps, knowing of the devastation but not knowing if their families were okay, was "an awful thing". They arrived at The Princess Margaret Hospital (TPMH) around 6pm, first witnessing the mass exodus from the city centre and then the damage that had been wrought on the TPMH buildings. Walls and floors had cracked, light was coming through the walls, filing cabinets had been flung to the floor. "When we arrived, people were everywhere, builders were trying to stabilise the building but there was an odd sense of calm and control," she said.

Becky Hickmott

'This is not going to be another Hurricane Katrina' became our rallying cry – the elderly were going to be prioritised.

Hickmott, along with so many others, worked through that night. Patients were evacuated to TPMH to make way for the incoming injured from the devastated city, as well as patients cleared from the badly damaged Riverside wards at Christchurch Hospital. An image from that night – of furniture trucks loaded with evacuated patients – brought home to her the extent of the devastation.

"At first, I was shocked not to see ambulances, but they were all dealing with the massive impact of the earthquake in the city centre. The furniture trucks full of patients couldn't fit under the eaves so the patients could not be unloaded directly. "We had to build make-shift ramps of milk cartons and plywood to unload the patients. When the backs of the trucks were opened, the image of nurses with headlamps quietly and calmly reassuring those patients was really powerful. It was a traumatic experience for those patients."

The next night saw Hickmott working at the Civil Defence operations centre at the Art Gallery as a health liaison co-ordinator, helping triage the high number of requests coming in as rescuers went through damaged neighbourhoods. She praises those community nurses who, with their backpacks of equipment, ventured out to care for their most vulnerable patients. Hickmott also acknowledged how primary health staff managed to reopen 79 per cent of general practices within days, in spite of the damage.

Over the following weeks, Hickmott was closely involved with assisting aged residential care (ARC) facilities, many of which had been severely damaged, to track and repatriate their residents who had been evacuated. "More than 500 elderly and disabled people were displaced – 285 were accommodated in other facilities and 300 had to go to other regions."

The decision to transfer 300 elderly patients to other regions had to be made quickly because of the continuing aftershocks and "we didn't know what might be coming".

She well remembers the declaration by her colleague Kathy Peri in the days after the earthquake, that the situation was *"not going to be another Hurricane Katrina"*. In that 2005 disaster, centred on New Orleans and in which 1800 people died, hundreds of elderly in residential care were virtually abandoned.

"'This is not going to be another Hurricane Katrina' became our rallying cry – the elderly were going to be prioritised."

Long-term impacts

The earthquakes have had a long-term impact on care provision. The Community Rehabilitation Enablement and Support Team (CREST) was established in April 2011, originally to ease pressure on hospitals after the earthquakes and facilitate early discharge. It has since been extended and now accepts referrals directly from general practice and provides older people with care and support in their homes, and reduces avoidable hospital admissions.

Another aspect of the ongoing impacts on health care in Canterbury, is that the the DHB is working more closely with ARC. Gerontology nurse specialists support ARC staff to manage complex residents, fostering a much closer working relationships between the DHB and ARC facilities than before the earthquakes, Hickmott said.

Reflecting on the impact of those events a decade on, Hickmott said staff had become more "solutions-focused. We had to make decisions and come up with

'We had to build make-shift ramps of milk cartons and plywood to unload the patients. When the backs of the trucks were opened, the image of nurses with head-lamps quietly and calmly reassuring those patients was really powerful. It was a traumatic experience for those patients.'

solutions very quickly. That has made us more nimble in responding to the mosque shootings, the Whakaari/White Island eruption and COVID-19. We've been able to jump to attention when we've had to. I'm not saying everything is perfect but we learned a great deal through the earthquakes and have become more creative," she said.

Another enduring impact is that the immediacy and scale of events broke down silos – "we needed each other to survive".

That led to relationships developing and strengthening across the health sector and with other response agencies. And those strengthened relationships have been maintained. "We now have more of a 'do with' rather than 'do to' approach and stronger and more trusting relationships have evolved."

She praised mental health services' work to become more flexible and responsive in the aftermath of the earthquakes, which had borne fruit following the impacts of the mosque shootings and COVID-19. Hickmott said what the service learnt was that there could be a lull in the immediate aftermath of such traumatic events – "the needs come later" – so mental health services were always looking ahead to patient flow.

All services have become used to spikes in demand and how to provide the best and most effective care in those circumstances. "Many nurses now work at the top of their scope to support more complex cohorts of patients."

Hickmott said the earthquakes fostered a "get on and do it" mentality among staff and there was now a real willingness to include "wider thinking in how to respond to events".

And she paid tribute to the EDoN at the time of the earthquakes. "Mary [Gordon] was the incident controller on the day and showed incredible leadership. There were significant pressures and she remained calm, firm and clear. She was described as the 'Winston Churchill' of nursing and guided us all and demonstrated how vital strong leadership is in such situations".

Ongoing upheaval

Hickmott also acknowledged the work of all nursing and other health-care staff, at that time, and subsequently. "Some staff have had profound shifts in their working lives, moving workplaces three times since the earthquakes, as buildings were repaired. Others have had to deal with similar upheaval in their personal lives and a proportion of staff are still dealing with earthquake repairs – that is so hard."

It is hardly surprising, then, that there is ongoing high sick leave at the DHB. "All the events staff have had to deal with over the last decade have had a cumulative effect. We are still on a journey on how we can continue to best support our staff," she said.

"We have been through a decade of significant pressures and change and it has been really tough. But we have dedicated teams of people across the health system who have a strong sense of loyalty to the Canterbury health system and just keep turning up to work, no matter what. I want to acknowledge those amazing teams who are working so hard. I can't say we've got it completely right; we are still working on ways to help."

Teams across CDHB were able to choose how they would commemorate the 10-year anniversary. "Most chose to observe a minute's silence at 12.51pm in common areas. Others went down to the river where flowers were provided. It was important to take the time to remember, to reflect.

"Everybody knows somebody deeply affected by the earthquake. A significant number of nurses died in the earthquake, many from overseas, and it is important to remember them too."

Hickmott described nurses in their responses then and now as "boundary spanners", ie able to innovate, communicate, connect and problem solve, all while managing patients' needs.

"They were and continue to be pretty phenomenal in working for the best outcomes for patients. But nurses everywhere would have done the same."

But Canterbury nurses have been severely tested in some exceptional circumstances over the last decade. Thankfully, most nurses have not endured such challenges. We salute our Canterbury colleagues. •

Caring for the Pacific community after the Christchurch earthquake

A project set up in the days following the the February 2011 earthquake in Christchurch, provided health care and other services to many Pacific people who were struggling. And that work helped shape a Samoan nursing leader.

By Tagaloa Filoi
Genevieve (Taula) Togiaso

"O le ala I le pule, o le tautua – The pathway to leadership is through service."
– Samoan proverb

February 22, 2011 – the day a 6.3 magnitude earthquake rocked Christchurch, killing 185 people – is a day embedded in the memory of many. For me, it was the day that catapulted me into becoming the person I am today. I am a New Zealand-born Samoan, educated as a registered nurse 25 years ago and now working as a nurse lecturer at Ara Institute of Canterbury.

At the time of the earthquake, I had been an acting service manager for a Pacific health clinic in Christchurch for just six months. I was the only manager onsite on that fateful day and the staff were looking to me for direction. I accounted for all the staff and led the team to Latimer Square.

Entrenched images

I will never forget the sounds of buildings crumbling, of car alarms, police, ambulance and fire engine sirens, helicopters with their monsoon buckets, of people crying, wailing, screaming and the indescribable smell. Those images are entrenched in my memory to this day.

I saw my home church, St Paul's Trinity Pacific Presbyterian Church on the corner of Cashel and Madras Sts crumble and fall. It was a place where a lifetime of family memories had been created, my second home.

Like many of the clinic staff, I wanted to go home and find my three sons. But I decided to return to the clinic with two other staff members to retrieve medical supplies. After an unsuccessful attempt, we returned with a fireman, who used his axe to break into the medication room – we couldn't open the door as the roof had caved in. Looking back, I realise it was not a good idea, but at the time medical supplies were needed and we could get them.

Genevieve (Taula) Togiaso

I concentrated on assisting where I could. I remember the moment I turned around and saw a temporary triage centre had been set up by Red Cross. This relieved us of our duties. Staff were traumatised by what was happening and we were advised to go home.

Within a few days of the earthquake, I had contacted leaders of the former Partnership Health Canterbury and Pegasus Health – since amalgamated – to see if I could get our practice staff temporary space at the 24-hour surgery, so we could continue to provide health care to our Pacific population. We had done this after the September 2010 quake. However, due to the extent of the devastation, this was not possible. Instead, I was asked to assist in the incident control room at Pegasus Health. This involved supporting medical practices to get running again, arranging for engineers to inspect practice properties for safety, checking practices had power or generators, arranging portaloos and water, and supporting staff of the practices that were able to re-open.

Leadership in a crisis

Over those few days, I watched impressive leaders scope, plan and implement support for primary health in Canterbury. I quickly learnt and absorbed strategies I would soon use. I saw them provide leadership in a crisis situation and admired how they communicated messages internally and externally, and their gratitude for the team around them. I saw their complex problem-solving/decision-making skills and their ability to delegate and manage the huge and complex workload, and they were transparent in their work. These leaders gave me the confidence to believe I was capable of working under extreme pressure in the environment and they supported me.

We were fortunate to be given two consulting rooms and the use of resources at a medical centre in south Christchurch. We had to be creative due to the confined space – the health clinic's telephone calls were diverted to a mobile phone, the medical receptionist was based in the dining room of my home, and our patients saw our doctor and nurse at the practice. Staff relied on the generosity of practice staff in our temporary location. Fortunately, we were able to quickly re-engage with our Pacific patients as we had access to electronic patient files.

During this time, two of our GPs resigned and left Christchurch and our practice nurse took much-needed extended leave. Workforce retention became a challenge but, fortunately, we had the support of Pasifika Medical Association. The association sponsored travel and accommodation for a few Auckland GPs, who volunteered to work in our clinic temporarily.

Weeks passed, Christchurch was still in a state of emergency and we could not re-enter our health clinic as it was in the Red Zone. As the weeks rolled on, the pressure to find alternative premises grew. Pacific people rarely go to the doctor alone – they often taken the whole family. For me, this is normal. However, outside our environment, it became apparent this was not everybody's view. This cultural conflict was part of the reason we were asked to leave the practice. A staff member graciously offered his home for the health clinic to use. I was then faced with the challenge of converting a four-bedroom house into a GP clinic within five days and purchasing all the equipment needed.

It soon became apparent our Pacific people were not seeking help. Our community staff were reporting that several Pacific families had fled their homes and a few houses appeared abandoned. This situation reflected the findings of a report released a few years earlier, Te Rau Hinengaro, which indicated Pacific people tended to internalise trauma.[1] We decided to seek help from the former clinical director of Pacific Health in the Ministry of Health, Dr Api Talemaitoga.

Within a few days, key Pacific health leaders met at my home and developed the Outreach Project. Its aim was to get a snapshot of the immediate needs of Pacific people in Christchurch. An assessment tool, together with a staff training package, were developed. Patient data was retrieved from our database and sorted according to ethnicity and location. We then sectioned the city into zones. Our 17 community staff, who were being deployed into unknown situations, had also experienced trauma. Staff training, led by health consultant Fuimaono Karl Pulotu-Endemann, was an emotional and therapeutic experience for all.

Daily debriefs were set up to support staff with what they were encountering in the community. We encouraged them to reflect on and talk about what they were facing.

Information from the Earthquake Commission and Civil Defence and community notices about water, road access, food parcels etc, were also provided at these debriefs. The team members took these out to families and, where needed, interpreted them in the relevant Pacific language.

The lounge of the health clinic's temporary home became the control room – the heart of the project. Other Pacific providers came on board and we worked collaboratively to support the Pacific community with additional resources, food parcels, referrals to social supports, and with the financial, employment and housing needs that surfaced.

As part of the Outreach Project, we coordinated and delivered community workshops to specific ethnic groups. These workshops were delivered in different Pacific languages and staff were given additional training to be able to facilitate these workshops in their respective language. The workshops increased the reach of the project significantly, with assessments conducted in groups and opportunistic screenings to help families access flu vaccines and health checks,

Genevieve (Taula) Togiaso with her four children, from left: Isaak (12), Ezrah (16), Abigail (6) and Kaleb (18).

So taking courage within a cultural context required me to be courageous, which I define as 'doing it scared'.

which in some cases led to urgent medical referrals.

The needs that came to surface during these assessments were immense – overcrowded living conditions, with up to 30 people in a three-bedroom house; families still living in cars more than a month after the earthquake; parents petrified to send their children back to school; families continuing to live in dangerous houses; loss of income and/or employment; and so much more.

Overwhelmed by these needs, the Outreach Project gathered the data and used it as evidence for an increase in capacity and funding to provide earthquake response services. As a result, project staff saw close to 40 per cent of the total Pacific population in Christchurch at least once during this time.

The success of the Outreach Project, together with continued delivery of clinic services, was due to the leadership that arose within the organisation. The project enabled leadership from different ethnicities to come to the fore and enabled us to support leadership growth from within the community.

Many people offered their services and the efficiencies gained were entirely due to staff's personal, team and organisational commitment and dedication to the Pacific community. The staff also endured high emotional stress during this time.

On the first anniversary of the earthquake, I was honoured with the Christchurch City Council's Earthquake Award for Heroism. I remember thinking then, and still do, that I did not deserve the award alone. So many people gave so much to serve the most vulnerable communities during a devastating time. This Samoan proverb expresses my feelings: *"O le tele o sulu e maua ai figota, e mama se avega pe a ta amo fa'atasi – My strength does not come from me alone but from many."*

As I reflect on that day, and the times that followed, I realise how much I was catapulted into a leadership role gave me the confidence to make decisions quickly and take responsibility for them. At the time the chief executive (CE) of our organisation was overseas and told me to wait for him to get back. However, I couldn't just sit back, I had to help. Former Partnership Health Canterbury CE Jane Cartwright got me involved in all that had to be done and encouraged me, as did Pegasus Health CE Vince Barry.

I knew I had leadership ability and had quietly refined my skills in the background, but having to step forward and lead from the front was something I always struggled with. I have always led from the back, which I believe has a lot to do with my cultural background as a Samoan, being young (at the time), being New Zealand-born and also being a woman. So taking courage within a cultural context required me to be courageous, which I define as "doing it scared".

My organisational skills were developed within a close-knit but large extended family. As one of the older ones, I coordinated large events and did a lot of trouble shooting. So dealing with complex or crisis situations was not new to me. And, as nurses, we know that managing direct care or service delivery is very much about organisational skills. I have always been strategic, having an overview of situations. However, over the years leading up to the earthquake, I had focused on refining my attention to detail.

My organisational skills were developed within a close-knit but large extended family.

Skills used in subsequent roles

I have been able to use the leadership skills I developed as a result of my experiences post-earthquake in subsequent roles. I left the Pacific provider in 2012, as it was going in a direction which did not fit with my values. I taught at the former Christchurch Polytechnic Institute of Technology a year and at the end of 2013 I moved with my family to Brisbane.

There I worked in primary health funding and was promoted into several positions from clinical coordinator to mental health programmes coordinator. This was initially a clinical governance role for the organisation but after national mental health reforms in 2015, I moved into a role as overall contractual programme coordinator. In this role, I also had the opportunity to advocate for Pacific research and programmes in the greater metropolitan region of South Brisbane.

I was able to confidently use the skills I had acquired or that had been brought to the fore in the aftermath of the earthquake.

Further study

I returned to New Zealand in January last year with my 4 children to complete my studies. I received a full scholarship from the Aniva Masters Programme and am hoping to finish my masters in professional practice (Pacific health) this year. Hopefully, I will then begin a doctorate.

As a nurse lecturer at Ara, I also have the portfolio of Pacific academic leader to support our Pacific bachelor of nursing (BN) students. Many of our students drop out in the first and second years and I am exploring ways of ensuring they are supported to complete their BN.

As I reflect on my career, I realise I stand on the shoulders of giants who have enabled and encouraged me to stand as a leader. I would like to acknowledge my parents, Taula Fegauia'i and Apaau Taula. I would also like to acknowledge my amentors, Fuimaono Karl Pulotu Endemann, who supervised, counselled and guided me through every step, and Jane Cartwright, who has always provided me with opportunities to excel.

I also want to acknowledge the Pacific community in Christchurch, Pacific organisations, community leaders, funders, past colleagues, my family and friends. All have contributed in different way to making me the nurse and leader I am today. •

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The catastrophic tsunami which followed the March 2011 earthquake in Japan.

PHOTO: GOOGLE IMAGES

Cultural safety in disaster nursing

Perspectives from the 2011 earthquake and tsunami in Japan and the earthquake in Christchurch featured at a forum on the importance of cultural safety in disaster nursing.

By Nahoko Harada, Lev Zhuravsky, Miki Marutani and Becky Hickmott

From a nursing perspective, a disaster can be defined as a phenomenon that interrupts life in communities, preventing people from doing their daily activities. Disaster nursing is about supporting the daily activities of affected communities as part of the disaster recovery process. This definition of disaster nursing is endorsed by the World Health Organization (WHO)[1] and the United Nations for Disaster Risk Reduction.[2]

Culturally sensitive disaster nursing is nursing that bridges a gap between familiar daily activities and destroyed life, in collaboration with the affected people. A 2020 Japanese study argued the importance of culture for the recovery of disaster-affected people.[3] The definition of culture used in this study was: the thoughts, attitudes and behaviours that are based on values, beliefs and norms commonly observed among people in a community. *"A fish only discovers its need for water when it is no longer in it. Our own culture is like water to a fish. We live and breathe through it."*[4] Being surrounded by daily cultural activities, like a familiar sleeping style or eating habits, helps people feel comfortable and gives them energy to lead their lives.

Various researchers have noted visible behaviour, such as eating habits, and invisible elements, such as values, as being important parts of culture.[5,6,7,8] Culture affects people's health and quality of life.[9,10] The Nursing Council of New Zealand has set cultural safety standards (kawa whakaruruhau) for nursing registration and for the ongoing competence to practise that nurses must demonstrate. Cultural safety is underpinned by communication; it acknowledges the beliefs and practices of different communities and the diversity of their world views; and it emphasises positive health outcomes for the person at the centre of care. Therefore, nursing care at the time of disaster also requires incorporating cultural aspects of care.[11]

Pacific Ring of Fire

The Asia-Pacific region is the most disaster-prone area of the world. Almost two million people were killed in disasters between 1970 and 2011, representing 75 per cent of all disaster fatalities globally.[12] Both Japan and New Zealand are situated in the Pacific Ring of Fire which increases their risk of and exposure to earthquakes. The Great East Japan Earthquake and Christchurch earthquake in 2011 caused massive damage and loss, both tangible and intangible, to the affected communities.

As part of a multi-country qualitative research project addressing culturally competent nursing practice in disasters, a one-day forum was planned by Miki Marutani, Nahoko Harada and Lev Zhuravsky, in collaboration with the nursing workforce development team at Canterbury District Health Board (CDHB). This article summarises the main lessons from the forum and emphasises the importance of sharing knowledge and collaborating, especially in the current climate of globalisation, cultural change and uncertainty.

Along with its focus on sharing research and knowledge, the forum also emphasised the importance of culture and cultural safety, and of empowering communities affected by disaster, based on the premise that disaster nursing should be provided according to culture. By being sensitive and aware of material and non-material culture, nurses can support and empower people in their recovery from a disaster.

The forum was held in November 2019 at the Manawa learning centre in Christchurch. Among the 25 participants were nurses, emergency management personnel from across Canterbury, nursing leaders, community leaders, along with a CDHB Māori health team and a Japanese research team. The forum started with a mihi whakatau (Māori welcome) and the Japanese national anthem, and was conducted in two parts. The first part included brief presentations from invited speakers, who described aspects of disaster response and recovery from the perspectives of disaster management and community resilience. The second part included facilitated group work.

The Japanese researchers shared research findings related to the 2011 Japan earthquake disaster, as well as outlining the mental health and psychosocial support (MHPSS) provided to victims, so New Zealand participants could grasp both the academic and the clinical practice of disaster response in Japan.

Miki Marutani presented a conceptual framework of culturally sensitive disaster

nursing, derived from a Japanese study which qualitatively examined responses of public health nurses (PHNs) in past disasters.[13] PHNs in Japan are a nationally licensed profession and the majority work for municipal or state health centres. Disaster response is a part of health crisis management, so PHNs are expected to work extensively for affected people throughout the disaster phases.

In Japan, public health nursing in disasters aims to help maintain and reconstruct a just and safe society, in cooperation with people and communities. This includes helping people improve their circumstances, reducing gaps in health services to help prevent disease and impairment, helping people maintain their health and helping those at the end of life towards a peaceful death, throughout the disaster period.[13]

Nahoko Harada outlined the four-year MHPSS project used to aid recovery from the March 2011 disaster. It included services ranging from providing basic needs through to specialised care.[14] She described the cultural characteristics of people in the Tohoku area of northern Japan and how these characteristics shaped the MHPSS programme over time. These characteristics included shyness and communities gathering at tea breaks. Informal health consultations were introduced at the tea breaks, and use of local dialects in communication was also introduced to the programme.

Other speakers included CDHB acting executive director of nursing Becky Hickmott, who spoke on "cultures of command and control" in a disaster, and how these cultures affected both victims of disasters and those responding. Agencies and groups who used "command and control" cultures were found to have rigid communication pathways, and each group tended to speak a different language and use different codes. That meant there was a lack of shared language and understanding between responding groups.

Hickmott said such agencies were often poor adapters to highly complex and unstable environments,[15,16] and these cultural differences left evacuees and staff feeling powerless, bewildered and frustrated. They struggled to understand these groups – an example of this was

Applying a cultural lens in disaster response

- Be aware of and recognise community-based leaders as well as other leaders.
- Culture is not just ethnicity; it includes age, socioeconomic status and disability.
- Look at the cultural safety response, to make sure it can be replicated, and to make sure it is stable and can be retained over time.
- Credibility comes from being open to other perspectives. Acknowledge lessons learned; have situational and self-awareness; focus on solutions.
- A cultural response is more effective if set up ahead of time. Engage with local leaders and embed plans in preparation for disaster.
- Recognising where we can engage more strongly with the community. People are more likely to recover if they feel they belong and are part of what is happening.
- Be flexible and adaptable to people's needs. The person at the centre of care defines what they need. We should be "doing with" people, not "doing to".

Cultural safety toolkit

- Keep a list of networks with key contacts, directories, interpreters, regional or geographical areas, and ensure it is a practical and ongoing register.
- Look at the role of animals in cultural response.
- Use proven tools and groups, eg schools and school systems, the family. Form "armies", eg the different student armies.
- Hold ongoing leaders' events to set processes in place in non-disaster time so networks, personal experiences and community resources are already in place, eg United States medical reserve has a list of retired/semi-retired medical staff and helps them maintain their competence.
- Specific solutions should be geared towards those with differing cultural needs.

Relationships

- Develop good working relationships across all sectors.
- Work with those in the community who have knowledge or who can help expand knowledge.
- Make sure you know who you communicate with, what relevant information is required, and keep gathering information.
- Central government should be working locally in each area now.
- Look at how to reinforce roles and responsibilities, and how to support people to stand down or walk alongside them; have indicators of progress.
- Conduct drills with multiple organisations participating. Share perspectives and roles and identify gaps.
- Identify key leaders, eg from churches, non-governmental organisations. Get them together and develop disaster response framework, policy and manuals to get the processes underway. People on the ground know who to talk to.
- Standardise language: all agencies should use the same language.
- Do a stock take of staff skills, eg as well as psychologists, there may be others with counselling experience.

Mental health, innovation and supports

- Mental health and psychosocial support – basic needs first, with family and community support; non-specialised individual care.
- Focus on self-care and looking after others.
- Mental health support needs to be multi layered; care for own mental health as well.
- Innovative technologies are good but do not always connect; we should keep using our ears and eyes.

Nursing curriculum development

- Undergraduate curriculum should include basic disaster training and resilience.
- Hold workshops on resilience for students and new graduates.

when one "command and control" agency described frail elderly evacuees who had dementia as "hazardous cargo".

CDHB emergency department nurse coordinator Polly Grainger spoke about the challenges of setting up a robust process for identifying disaster victims. Using national health index (NHI) numbers could be difficult, due to the high number of admissions and the status and nature of injuries. Nationally, it was agreed that during a disaster there was a need to assign a secondary identifier called a disaster number to help the process.

However, Grainger said that in one Christchurch disaster, when victims arrived at the emergency department they could not be easily identified because of the similar age and gender of those affected. Using the D-identification (disaster code) increased the chance of incorrectly identifying the victims. She said the process of disaster identification needed to be further reviewed to decrease the risk of misidentification, and to consider cultural safety principles.

Lev Zhuravsky, of Lazer Consulting which provides resilience training, spoke of the importance of collaborative leadership when coping with unexpected and evolving events. He said true collaboration grew out of grounded self-awareness and an understanding of the systems being managed. Leaders and managers needed to promote a culture of psychological safety to help staff perform outside their comfort zones. Zhuravsky said this approach could enable teams to look at unexpected events as an opportunity for organisational growth and development, promoting resilience, self-efficacy and job satisfaction.

Kathy Peri, a gerontology nurse specialist and senior lecturer at the University of Auckland, spoke about media representation of the elderly following the Christchurch earthquakes and presented interim results of a research project on this topic. While media played an important role in providing information and orientating people to a new post-disaster reality, they might not be entirely objective in describing elderly people, their struggles and strengths. She said sometimes the elderly could be portrayed as victims and their voice not always heard. Balanced and comprehensive media coverage without ageism could give elderly the opportunity to tell their stories and support their recovery.

CDHB emergency department (ED) researcher Sandy Richardson talked about the contribution of the Māori health workforce in the immediate response to the February 2011 earthquake. One of the main challenges related to negotiating new roles. This involved Māori health workers who worked in other areas, but came to the ED to help with the response and were not familiar with the ED. These workers discussed how they had to negotiate new roles and described their experiences and what they were exposed to and whether that changed their perceptions of their role. Making sense of that, alongside their cultural identity and their perceptions of what it was like to be a Māori health worker, enabled them to make this transition into a disaster response role.

Disaster recovery framework

Workshop discussions at the forum focused on topics ranging from culturally sensitive disaster nursing to setting up a collaborative and culturally safe disaster recovery framework. Learning points from the group work have been summarised in the table on p20.

The purpose of the forum was to look at disaster nursing through the lens of cultural safety. Sharing the experiences of the 2011 earthquake and tsunami in Japan and the earthquake in Christchurch, brought deep understanding and knowledge of the importance of cultural safety in a disaster response. Presentations from Japan and New Zealand demonstrated the relevance of cultural safety for nurses in every setting, including the importance of ensuring mental health and psychosocial support for both basic needs through to specialised care. The forum recommended actions that nursing and other agencies should examine to determine whether these should be implemented in educational institutions, community organisations, emergency response processes, or wider clinical settings.

The importance of all organisations involved in disaster relief examining their own responses through a cultural lens will improve the way we work with people in future disasters or crises in our nations. Building relationships of trust and openness across organisations in non-disaster times will help strengthen future responses and enable teams to be adaptive and responsive to the cultural needs of those we serve and care for. •

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Supporting male nursing

Many men who start the bachelor of nursing degree fail to complete it, with significant numbers dropping out in the first year. How can male students be supported to keep at their nursing studies?

Massey University lecturer Andrew Cameron (left) chats with second-year nursing students on the Wellington campus.

By Max Guy and Shelley van der Krogt

In New Zealand in 2021, male nursing students remain a minority in the classroom. While men comprise nine per cent of the New Zealand nursing workforce,[1] male student numbers often sit well beneath this figure in bachelor of nursing (BN) programmes.[2]

Reasons for these low numbers are unsurprising yet complex, occurring within the historical journey of nursing embedded within society's constructed gender roles. For male students who do battle through these societal barriers, a disproportionate number, compared to their female peers, drop out early.[2,3] The need to diversify the nursing workforce is essential, but more critically, growing the total nursing workforce is desperately needed to meet current and predicted population needs. This article explores strategies to retain male nursing recruits in BN programmes.

In nursing education, the term equity is used frequently within teaching, student support and pastoral care. For good reason, the concept is often applied to Māori or Pacific student populations. Male nursing students are also in the minority as nursing students, and often miss out on the support required to keep them in the BN programme. Judging by their low numbers and high early attrition rates, such support is surely deserved. Reasons for this oversight are numerous, but often involve unconscious assumptions that men do not need assistance.[4] Because of the socialisation of gender roles in nursing and their minority status in class, many male students may feel pressure to excel and, consequently, are reluctant to seek help.[5]

Educators should not be blamed for inaction, if they leave male students to fend for themselves in the undergraduate environment. There are some strong assumptions fuelling this situation: firstly, that they do not need support; secondly, that they are reluctant to seek help when they need it, preferring to just get on with it; and thirdly, that men in nursing frequently streak ahead of their female peers in terms of career progression and promotion.[6] You, the reader, probably know male colleagues, or males you trained with, who have rapidly moved into management, or perhaps advanced practice roles. Nevertheless, the critical point here is these males survived the BN through to graduation, when many do not.

It would also be unfair to assume nursing schools do not attempt to address this issue, as effort and resourcing is often allocated for this purpose. This can include staff members keeping tabs on male students, either formally or informally, or the formation of facilitated support groups. However, with the hectic

students – what works best?

nature of an academic's workload, exacerbated by staffing shortages and hiring freezes in the current climate, these kinds of initiatives are often not prioritised at the individual and school level. With this in mind, a sustained, equitable support strategy for male students needs to be initiated, evaluated and disseminated to enhance retention nationally.

Meaningful connections between staff and all nursing students is a central determinant of success in the BN degree and beyond.[7] These relationships are especially important for minority groups of students, such as Māori, Pacific and, of course, males. In a perfect world, staff members, male or female, should be proactively creating meaningful connections with male students from day one. Yet it is not entirely clear how these relationships may differ between female or male staff members.[7] The quality and effectiveness of the staff member's approach may be influenced by several factors, such as individual knowledge, both in nursing experience and scholarly activities, and unconscious bias.[2]

Staff-student mentorship model

Considering this, creating a mentorship model that pairs male staff with male students would be valuable. Having already experienced being the "only dude in the room", male staff should have built-in experiential empathy. Also, they themselves should possess tried, tested and perfected strategies and coping methods to address issues or roadblocks that exist only for men in nursing. These include practising safely with certain patient cohorts, navigating the feminine-dominated influences within the curriculum and dealing with their sense of masculinity being challenged by others.[2] These relationships should also offer general strategies for navigating life as a new student within a BN programme, which may be practical or academic in nature.[8] It must be stressed, however, that mentoring should not be a platform to offer males an academic advantage over their female peers. Further, these relationships should centre on respect and manaakitanga.[9] This is especially pertinent, given that in 2016, just 207 male RNs identified as Māori.[10]

Anxiety and unease for male students often peaks in the first four to six months of a BN degree, and this is often the time frame for most withdrawals from the course.[2,8] While this uncertainty happens for previously stated reasons, there may be another more powerful driver. For many male students, the choice of nursing as a career is far from accidental. Many men enter nursing later in life, as a second or third career change, after interaction with an RN.[2] Personal experience of having an RN in the family or being the recipient of nursing care themselves, frequently drives men into a nursing career.[2] The key protective factor here is having had previous real-life exposure to what nursing actually entails in the 21st century.

Others may have a limited awareness of the true scope of nursing. This is often fostered by the frequency with which certain nursing specialties are portrayed in the media, such as general ward nursing, practice nursing, or high acuity areas such emergency department or intensive care unit nursing. It is noteworthy that even in these portrayals, male RNs are often absent, unless playing a more custodial role as psychiatric nurses.[11] Additionally, nurses in television and film are usually painted as subordinate to medicine,[12] which ignores the level of autonomy and skill required to be an RN.

Compounding this is the fact that the practical introduction to nursing is often via placements in aged residential care (ARC) in the first year of the BN. In our view, this is a highly complex area, requiring skilled nursing care, with an increasing level of autonomy. However, students often are blinded to this, as they are placed in ARC with the aim of learning "basic nursing care" from health-care assistants, and not RNs. The true scope, flexibility and diversity of nursing should be showcased and celebrated early in the degree – for the

Max Guy talks with first-year student Ollie Higgison via Zoom.

benefit of all genders. However, this is especially important for males, if we want to retain them beyond year one.[2] At this time in the BN, staff-student mentorship programmes would prove valuable to enable male students to expand their internalised construction of nursing, which would help enhance resilience during early clinical placements. It would be naïve to expect students to enjoy all their clinical placements; however with a mentoring programme, strategies could be put in place to help students see beyond their current placement and to align learning objectives with their wider nursing aspirations.

Mentorship in clinical practice

A somewhat unsurprising barrier to the implementation of such a mentorship programme is that, as in the general nursing population, male staff members are also thin on the ground in education.[13] One solution could be the expansion of male mentorship roles into clinical practice. The pairing of male RN mentors to male students in a long-term assignment could help reduce feelings of isolation.

These feelings of isolation can be pronounced early in BN studies, as clinical placements tend to be in areas where there are fewer male roles models, eg aged care. Later in the degree, clinical placements tend to be in acute areas, such as mental health, emergency department and intensive care, where there are more male nurses working.[2,13] These mentors could check in on students periodically during their BN studies and could even extend their mentorship into the mentees' new-graduate year. To enhance uptake and convenience for the clinician mentor, these interactions could be virtual, via chat applications or Zoom, meaning the location of both parties is no barrier.

Grouping students together

The implementation of a peer-mentorship scheme as a stand-alone programme, or in combination with clinician mentorship, may also be valuable. Pairing, or grouping second- or third-year students with those at the beginning of their nursing education, may facilitate resilience and a growing sense of community among new male students, while simultaneously decreasing isolation through the realisation that their own position and journey is not unique.[8] Ideally, it would be beneficial if these linkages were actively mobilised by staff before the first clinical placement, to ameliorate anxiety related to the unknown.[14]

A sustained, long-term commitment must be made to recruit more males into nursing.

Rather than merely pairing men with men and leaving them to it, staff must aim to provide all mentors (from RN clinicians to student peers) with training, support and ongoing supervision.[14] The provision of mentorship is by no means a one-way process. Both mentor and mentee benefit and grow through enhanced teaching and leadership skills.[15] For those who give up their time to mentor however, professional recognition should be considered, eg, as a minimum, such mentorship should attract professional development hours.

A sustained, long-term commitment must be made to recruit more males into nursing. Doing so will not only diversify the workforce, but will help to meet increasing population health needs. In the short term, however, efforts should be made to retain male students currently studying and those about to embark on training. To support this, male-RN-to-male-student mentorships and/or the initiation of male student peer mentorship programmes should be implemented. These initiatives are low stakes and low cost in terms of resourcing but they do require a level of networking and commitment from staff and clinicians alike.

A positive by-product of COVID-19, however, is that networking and communicating via technology has meant remote relationships are now more commonplace and accepted. This same technology should be fully used to enhance male-to-male mentorship programmes, with the aim of supporting men through their BN studies and to graduate successfully as RNs. •

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Realistic patient simulations

Patient simulations that mimic high-stress, multi-patient clinical situations are important to prepare students for the realities of practice.

By Andy Redpath

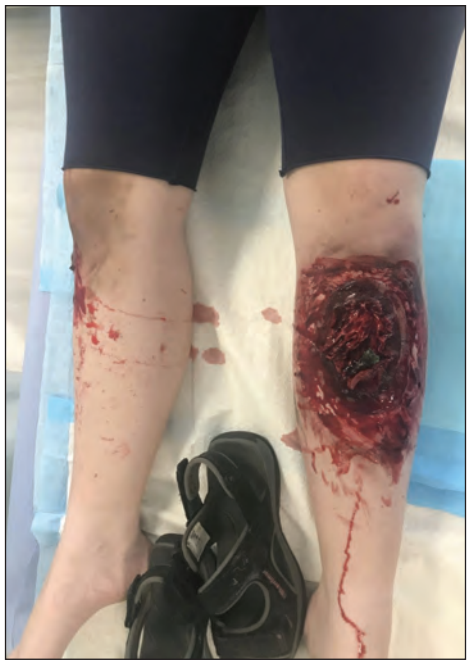
Simulation is an effective training tool in a wide variety of settings. Shifting from a clearly simulated environment to a more realistic scenario, similar to what a nurse may encounter in the ward, offers the opportunity take full advantage of this powerful training tool.

Currently the Nursing Council limits the use of simulation to augment clinical hours.[1] But using ultra-realistic simulations, training for rare, dangerous or expensive scenarios can be facilitated in a straightforward manner, while simultaneously closing the theory-practice gap.

Ultra-real simulations are often used in the military, where recruits are put into high-pressure simulation. This approach allows the recruits to gain the practical skills necessary for the work and also gives an idea of the mental and emotional strain experienced on the battlefield. Experiencing this stress in a controlled environment allows for a structured debriefing and an assessment of individual recruits' coping mechanisms. This simulated experience also provides experience in dealing with trauma, both clinically and emotionally.

Multiple-patient simulations

There is a growing realisation that including high-fidelity simulation in undergraduate nursing education can better prepare nurses for their working environment.[2] The protocols and standards for implementing single-patient scenarios are well established. However, developing a simulated environment focusing on just one simulated patient, limits this powerful learning tool. For example, the emergency department (ED) can be a chaotic environment – and a primary source of that chaos is managing multiple patients simultaneously, not just a single patient. Simulated training for the ED and disaster response should include caring for multiple patients simultaneously to reflect this reality.



Life-like injuries can be created.

The challenge with ED workflow is, primarily, the simultaneous triage and management of multiple patients with a range of needs.[3] Simulations involving a number of patients are a much more realistic representation of a typical ED nurse's day than a simulation focusing on one individual case. Ideally, the simulation would include a comprehensive, ED-based simulation with multiple patients.[4] Simulations involving a number of patients enable specific incidents or tasks to be developed to test nursing competencies. These would be impossible to assess didactically and challenging to assess in a traditional supervised training environment. For example, delegation and prioritisation of patient load can both be accurately assessed in this simulated environment.[4,5] Clearly this type of multi-patient simulation is not limited to the ED and the approach could be refined to reflect any practice specialty.[5]

It is essential these educational simulations mimic reality. This can include creating life-like injuries that replicate the injuries that would be expected to occur in the event being simulated. Specifically that could entail glass fragments from a car accident, exposed bone in a severe fracture or brain injury in the case of a fall.

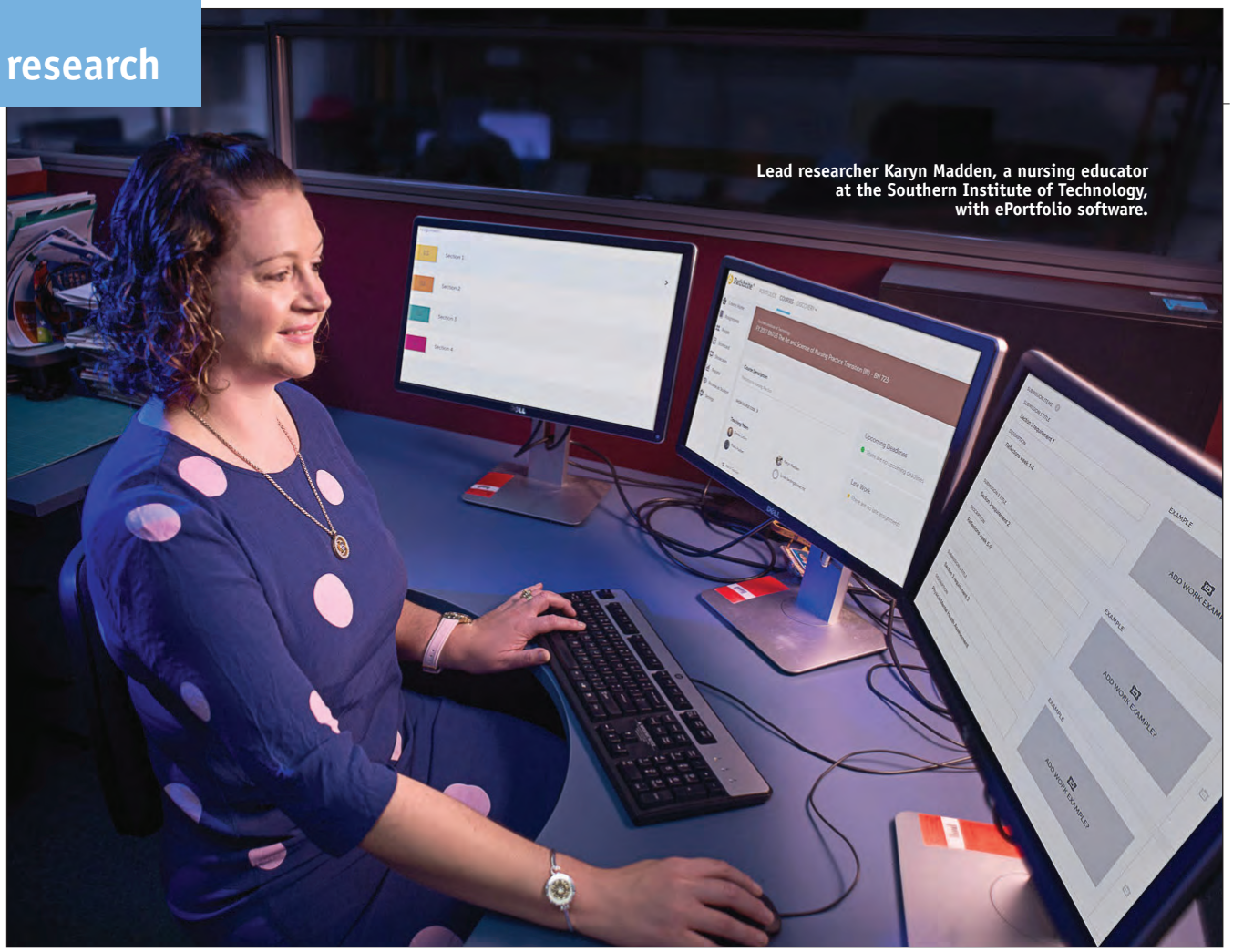
Volunteer actors

The educational power and value of simulation training is its ability to mimic reality. Thus, rather than manikins as patients, there may be value in including actor volunteers from the local amateur dramatic society or from arts programmes at the local university, technical institute or school. In the case of acting students, part of their training could be learning and incorporating the different symptoms of the assigned disorder, to increase the psychological fidelity of the training and its association with real-world consequences.[6] Video recording the actors and nurses would provide all participants with a valuable resource to assess both their nursing and acting performance.

There is no doubt that implementing individual patient simulations is a good training technique for nurses. But the real value in simulations is being able to simulate the truly testing environments that occur on wards and the complex, multi-faceted management that needs to occur for patient care. These simulations need to be focused and realistic, with minimal facilitator input and direction once the scenario is running. This style of learning in a safe environment, with effective and extensive feedback, is a powerful learning tool[7] – and we have also found it to be great fun for all the participants. •

* *References for this article are on p39.*

Andy Redpath, RN, is a lecturer in the school of nursing at Manukau Institute of Technology.



Lead researcher Karyn Madden, a nursing educator at the Southern Institute of Technology, with ePortfolio software.

Nursing lecturers at the Southern Institute of Technology have conducted a longitudinal study examining the value of ePortfolios for undergraduate students.

What value do ePortfolios bring to students?

By Karyn Madden, Katrina Bowes, Michelle Miller and Stacey Porter

EPortfolios – do undergraduate nurses find them useful or not? That is the question.

The Southern Institute of Technology (SIT) introduced ePortfolios in 2019 for both second- and third-year bachelor of nursing students. Gone are the days of collating multiple pieces of paper into a three-ring binder, agonising on the order of documents and physically delivering the portfolio when it is time for it to be handed in.

It has been well established through international literature[1,2,3,4,5] that ePortfolios can provide students with a means of learning, collaborating and presenting their academic requirements in an interactive, visual and flexible manner. Research[1,2,3,4] recognises the critical part ePortfolios can play in a student's learning experience.

There is limited research on student perceptions of ePortfolio platforms[3,6] which looks specifically at whether students find value in using them and, more importantly, whether using them enhances their reflective practice.

Paper vs ePortfolio

The Ministry of Education describes an ePortfolio as an electronic platform for students to record their work, goals and achievements, to reflect on their personal learning and receive feedback, all kept in one convenient place.[7] The merits of paper-based portfolios vs ePortfolios have been a point of discussion. As the move to an electronic world continues to evolve, which platform do students find supports their learning the most?

In the nursing profession, portfolios are commonly used to collect evidence of ongoing competence and capability. They can be defined as a collection of professional work that follows the trajectory of

a nurse's career, and that should illustrate the individual nurse's background, skills and expertise.[7] In both the profession and in undergraduate education, this method of obtaining evidence of knowledge and skill has been regarded as effective and sound. Traditionally, nurses have assembled evidence of their clinical competencies in a paper-based portfolio. Development of the ePortfolio format in education provides an alternative.

Three-year study

Do undergraduate student nurses find ePortfolios beneficial over the duration of their course? There is little literature exploring ePortfolios from students' perspectives and within the field of nursing, hence the need for exploration of this topic. Last year, 2020, was the final year of a three-year mixed methodology longitudinal study at the Southern Institute of Technology (SIT), which explored this question.

International research shows use of ePortfolios leads to higher retention and success rates for students.[8] However, there is a dearth of information about student perspectives.

In 2017, SIT nurse educator Karyn Madden started a nine-week study to explore student perspectives on ePortfolios. Ten final-year nursing students were enlisted to the study, which concluded that students preferred ePortfolios over paper-based equivalents.

The need for more comprehensive research was highlighted, which led to the development of a longitudinal study to determine if students still found ePortfolios beneficial over their three years of study.

This research followed a cohort of undergraduate bachelor of nursing students who were invited to complete an online questionnaire, with data being collected and analysed yearly. The first two years of data have been analysed. This article presents the second year of data and compares it to the initial data from the first year. Both quantitative and qualitative data was gathered.

WHAT IS AN ePORTFOLIO?

• An ePortfolio is an electronic platform for students to record their work, goals and achievements, to reflect on their learning and receive feedback, all kept in one convenient place.

Data from the second year revealed three interlinked themes – technology, feedback and reflective practice. Positive themes that emerged were that the portfolio was accessible at any time and place, provided that internet was available; also all the portfolio material was in one place, which allowed easy access and meant material could not be misplaced.

Once students understood how and where to upload documents, they found the process straightforward and efficient.

Once students understood how and where to upload documents, they found the process straightforward and efficient. Time was saved by not having to collate or handwrite documents. Trees were saved as the portfolio did not need to be printed.

Timeliness of feedback from nurse educators was identified as another important element, as it helped students improve the quality of their work and progress their portfolio, and aided reflective practice. Students were able to reflect both on areas where they could improve and where they had excelled. Through reflective practice, students were able to link classroom theory with clinical practice.

A few students did not feel the use of an ePortfolio enhanced their reflective practice, as they were required to complete the work anyway and the act of uploading had no drastic impact. The challenges identified by students in the use of ePortfolios concerned technology, personal preference and timing of feedback.

Positive view

Overall, the use of ePortfolios and their value for students in an undergraduate nursing degree has been viewed positively. Findings from this research support the claim that the integration of ePortfolios into the educational routine is effective and the relationship between technology and academic elements can be positive. In a world that is moving towards increased use of technology, the inclusion of effective systems utilising technology has the potential to create positive outcomes.

The final data, from the third year of the study, 2020, has been collected and is being collated and analysed. It will be presented during 2021. •

Lead researcher **Karyn Madden, RN, MN, DipAdultEd, PhD candidate**, and researchers **Katrina Bowes, RN, PGCert HSci-MSME, CertAdultEd, Michelle Miller, RN, BHSciNurs PGDipHSci,** and **Stacey Porter, RN, PGDipHSci, CertPH,** are nurse educators at the Southern Institute of Technology, Invercargill.

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Nurses urged to use their voice

Speakers at NZNO's first professional forum for 2021 suggest advocacy is a key part of nursing and nurses must always keep a record of their advocacy efforts.

By co-editor Mary Longmore

The importance of speaking up for patients – and documenting it – was emphasised at the first NZNO professional forum in Christchurch last month. The forum, *Every nurse is an advocate – influencing through advocacy*, was a mixture of face to face and Zoom.

NZNO medico-legal lawyer Sophie Meares acknowledged how difficult it could be for nurses to voice concerns, and challenge their colleagues, such as surgeons. Yet nurses had an essential role in upholding patients' rights, she said, and could be penalised for failing to do so. "These situations aren't easy, but the advocacy still needs to happen."

Sophie Meares

Roman Hasil

Karyn Chalk

Nurse raised concerns

It was a nurse who repeatedly raised concerns about Whanganui gynaecologist Roman Hasil from 2005 to 2007 over his competence, cursory history-taking, painful examinations, preference for hysterectomies over lower-level interventions, drinking alcohol and lack of informed-consent processes.

Frustrated by a lack of action, she warned her clinical nurse manager in 2006 by email that he would make a "grave mistake". Her nurse manager informed the service manager – who later said the concerns had not been documented. Hasil was later found to have a 25 per cent failure rate for his tubal ligations, and several complaints were laid by women who became pregnant or had unnecessary surgery. "The Health & Disability Commission (HDC) heavily praised the nurse for advocating right from the start and sticking to her guns."

But if her concerns were not documented, it would have been her word against the service manager, Meares said.

'. . . you need to be the wise person in the room, the sun-drenched rock in the middle of the river.'

Meares gave several examples of where the HDC had made adverse findings against nurses who did not object, or record objections, to decisions which had resulted in poor outcomes. In one instance, a patient complained she had been pressured during a hysterectomy to also have her ovaries removed. The HDC found the nurse had failed to advocate for her, and all staff had to go through training. "This would have been an incredibly difficult situation for a nurse to advocate in, and wouldn't have been welcomed by the surgeon," Meares said.

In another case, a child died after being discharged, despite a nurse's concerns. The HDC was critical of the hospital culture, which failed to value the nursing perspective. "Any individual in the clinical team should be able to ask questions or challenge decisions at any time," Meares said.

"My advice would be if you have concerns, raise them at the time and document at the time that you raised concerns."

Meares said she recognised the challenges of advocacy and potential employment consequences, but NZNO was there to advocate for its nurses.

NZNO organiser Karyn Chalk spoke about the need to stay calm and emotionally detached. "You want the person who's upset to be able to articulate their concerns, as much as possible. To do that – and this is the tricky part – you need to be the wise person in the room, the sun-drenched rock in the middle of the river."

"It's not your fight. As soon as you become emotionally invested, you become part of the problem and your rational brain packs up its bags and goes on leave," she said. "The chances of your colleague getting an effective outcome has significantly decreased."

'Slow down'

To be effective, it was important to slow down and take a structured approach, check if the person really needed an advocate or just a "moan, to talk things through". It was important to look for the underlying problems being experienced by that person, to ask "what's really going on here?"

Solid preparation also helped.

"It's much easier to be the angel at

the sideline than the train wreck in the middle of the room," a colleague once told her.

'Tūwhitia te hopo mairangatia te angitū! – feel the fear and do it anyway!'

Nationwide health and disability advocacy service advocate Antonio Lara said sometimes advocates must find their way through the "white smoke" of people's behaviour – "the stories behind the stories" to work out how to help, with empathy and non-judgement.

Kate Weston

Patricia Sullivan

Antonio Lara

'Once you speak, you gain courage . . . As nurses we are compassionate human beings and we want the best outcomes . . .'

Boundaries of advocacy

It was also important to know the boundaries – advocates were not there to investigate or mediate complaints – only the HDC had investigative powers. "We don't have the capacity to make any of those calls," Lara said. "We are there to talk things through and find a way forward and resolve the issues."

Nurse Patricia Sullivan shared her and others' experiences of surgical mesh injuries. "They've lost marriages, income, homes. They've lost family members, who couldn't take it anymore. They've lost bodily functions, they've lost their voices and they've lost the ability to live a life without pain – and some are so drugged up for that pain that they can't function," Sullivan said. "So I am a voice for those people."

Despite her own injuries, Sullivan has become an advocate for mesh-injured women and co-founder of the Mesh Down Under group. It successfully advocated for a restorative justice process at the Ministry of Health last year as well as a review of declined mesh-related injury claims by the Accident Compensation Corporation. A national register of mesh injuries and specialist centres for mesh support, implants and removals by credentialed surgeons were also in the pipeline, she said.

Sullivan said nurses and women have a responsibility to our "dearly loved sisters" to speak up for them.

"Once you speak, you gain courage," she said. "As nurses we are compassionate human beings and we want the best outcomes. If we see something going on that is not producing the best outcomes, then we should speak up . . . By advocating, we are doing what the role of nurse incorporates."

NZNO advocacy

NZNO acting associate professional services manager Kate Weston wrapped up the forum with a video clip created by Curative creative agency for NZNO, to acknowledge nurses' response to COVID-19 (https://hereforyou.nzno.org.nz/we_ve_made_it_this_far_together), followed by an an overview of NZNO's advocacy since the beginning of the COVID-19 pandemic.

Early in the pandemic, nurses were seeing images of overseas workers in full personal protective equipment (PPE) – but were not getting it here, she said. While the science "pushed back" on how widely available PPE needed to be, there was a "growing sense of distress", Weston said.

"There was a high concern that if they couldn't wear a mask, they weren't protected. And no science could dissuade them," Weston said. "What we were dealing with is what I call the heart and the science."

Nearly a year down the track, the value of masks and the risks of airborne transmission were more fully appreciated, she said.

In April 2020, seven nurses became infected after rest-home residents were admitted to Waitakere Hospital. NZNO was involved with the review that led to an apology by the Waitemata District Health Board, then lobbied for workplace exposure to COVID-19 to be recognised as a reportable event to WorkSafe.

NZNO also contributed to the Auditor-General's review which found serious issues around the national supply of PPE; and a review of the residential aged-care sector's response.

NZNO also continued to advocate for safer staffing, pay parity and infection, prevention and control processes at managed isolation/quarantine facilities. It's about "really looking after this workforce to make sure they're really acknowledged for the contribution they're making".

NZNO was also working on the vaccination rollout plans and advocating for authorised vaccinators, Weston said.

Professional nursing adviser Michelle McGrath closed the forum with a whakatauki from Māori psychiatrist Hinemoa Elder's book *Aroha: "Tūwhitia te hopo mairangatia te angitū – feel the fear and do it anyway*!" •

Because of level-3 lockdown restrictions in Auckland, the Auckland forum, scheduled for March 2, was cancelled. Many registered for that forum participated in the Wellington forum on March 10.

Because of COVID-19 uncertainty, NZNO only scheduled three forums this year.

Whānau must be centre of 'everything'

Placing whānau at the centre of everything nurses do and viewing the therapeutic relationship as a nurse/whānau relationship, rather than a nurse/patient relationship, were two key messages presenter Tracy Haddon delivered at the forum.

In her presentation, *Whai Oritetanga – In pursuit of equity,* Haddon, who is the quality and service improvement manager, Māori Pae Ora Māori Health Directorate at MidCentral District Health Board, posed many questions about how nurses cared and advocated for whānau and how they applied te Tiriti o Waitangi in their practice.

"As nurses, how can we create new ways collectively to ensure whānau can access care, free from judgement and have the knowledge to advocate for themselves? How, as nurses, can we enable culturally relevant support? Do we put ourselves in someone else's shoes? Do we understand their opinions and point of view? Often, as nurses, we focus through an individualistic lens, whereas we should place the entire whānau at the centre of everything we do."

Haddon (Ngāpuhi) defined equality as treating everyone the same; equity as providing the resources people needed to get ahead and liberation as removing all barriers and including considerations such as whose whenua you were on and incorporating iwi.

Māori health equity involved deliberate actions to make sure "we are doing our best for whānau", including integrating bicultural practices in everything we do.

Haddon repeated a number of statements Māori nurses heard every day:

"I treat all people the same, regardless of ethnicity." "They have too many people visiting them." "Māori patients are too complex." "They live outside this region." "I'm not from New Zealand and I haven't heard of the treaty." "Working with whānau is not as important as working with the patient."

And Māori patients often told Māori nurses: "I'm not talking to them because I feel they judge me and my whānau." "I just tell them what they want to hear."

Hearing those sorts of statements every day was sad. She urged nurses to shift to a wellness focus, to engage in whānau-centred practices and to consider how, collectively, they could advance Māori health.

"Do you connect across services or stay within your own speciality?" she asked.

Mauri ora

Nurses should use the concept of mauri ora – life force or an essence – to help Māori they cared for to increase their knowledge and their power and to restore their dignity. The concept of waiora referred to the significance of the environment on wellbeing. The environment included good housing, clean water and air and healthy kai.

Partnering with whānau, using whānaungatanga when introducing yourself, asking whānau what mattered to them and what resources they needed, working with iwi providers and kaupapa Māori services and referring whānau to them, including whānau in multidisciplinary team meetings and using Māori models of health were some ways nurses could "broker and create therapeutic relationships with whānau".

'If you change the way you look at things, things you look at will change'

Tracy Haddon

How do nurses advocate?

Nurses should also consider how they advocated for those in their care and Haddon posed some questions to consider. From whose perspective? Who do we involve? What does it look like? What does successful advocacy look like for whānau?

She challenged nurses to "think differently. If you change the way your look at things, things you look at will change", she concluded.

In her mihi, she referred to those who had died of the corona virus and to the 185 people who had died in the February 2011 earthquake in Christchurch – "aroha and respect to all involved", she said.

Haddon also provided some historical context to her presentation, stating that Māori health had been undervalued since the early 1800s. The Tohunga Suppression Act, 1907, had grown out of Western ideology and had forced rongoā practices underground. "That Act denied the ability for us to have culturally responsive practices."

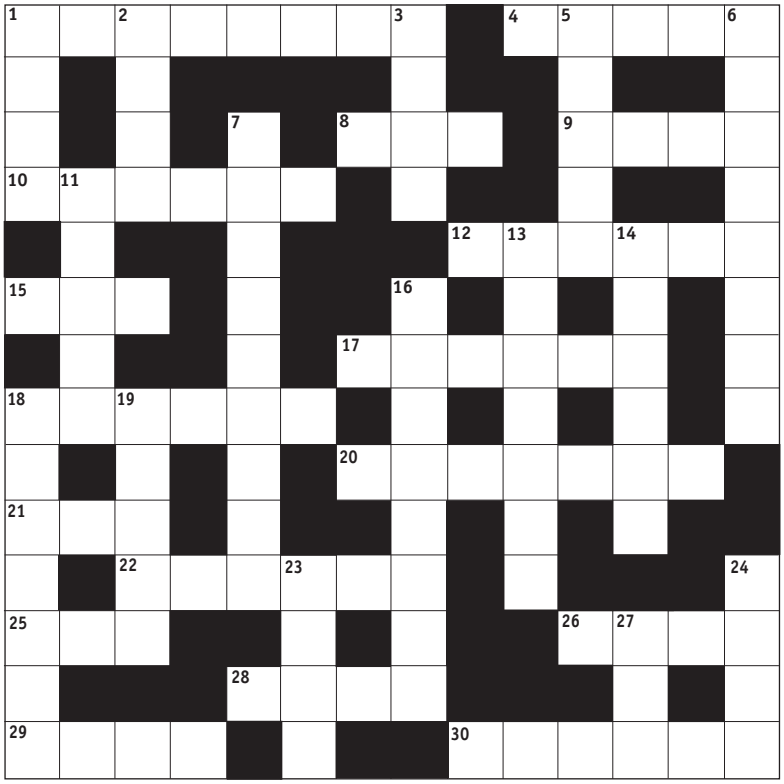
Nursing education had been modelled on the Florence Nightingale schools. "The way schools were run dismissed how we practised and indigenous knowledge was removed from the curriculum." •

Report by co-editor Teresa O'Connor

This professional forum coverage replaces college and section news for March.

crossWORD

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



ACROSS

1) Restriction of life in pandemic.
4) Book for photos.
8) Fire remnants.
9) Connects head to torso.
10) Jokes; fun.
12) Church rank; head of a diocese.
15) Long curved bone.
17) Masked superhero.
18) Me.
20) Food decoration.
21) Use eyes.
22) Inflammatory disease of airways.
25) Upper limb.
26) Courageous, noble person.
28) Meditative exercise.
29) Prayer ending.
30) Root vegetable.

DOWN

1) Scottish lake.
2) Serene.
3) Snout.
5) Breathing organs.
6) Grandchildren (Māori).
7) Unsettled, agitated.
11) Togetherness.
13) Very large.
14) Truthful.
16) Important plant in Māori medicine.
18) Make-up for eyelashes.
19) Water vapour.
23) Horse's foot.
24) Inflammatory arthritis, especially in big toe.
27) Organ of hearing and balance.

February answers. ACROSS: 1. Vaccine. 4. Emetic. 7. Tautoko. 9. Rye. 10. App. 11. Risk. 12. Grief. 13. Jerk. 14. Hasty. 17. Galaxy. 19. Sibling. 21. Elbows. 22. Listen. 23. Eliminate. **DOWN:** 1. Voters. 2. Counsels. 3. Ego. 4. Earmuff. 5. Eve. 6. Carparking. 8. Kauri. 10. Acre. 13. Jealousy. 14. Hygiene. 15. Tearoom. 16. Little. 18. Yes. 20. Naked.

wiseWORDS

“I don’t know whose side you’re on,
But I am here for the people
Who work in grocery stores that glow in the morning
And close down for deep cleaning at night”

US poet Jericho Brown, from his 2020 poem 'Say Thank You Say I'm Sorry' on life under the pandemic

it’s cool to kōrero

HAERE MAI and welcome to the March column. Mānuka, a native shrub with small prickly aromatic leaves, was extraordinarily useful in traditional Māori life. Its hard wood was good for paddles and weapons; its bark, leaves and gum were, and still are, used to treat a range of health conditions. Honey from its flowers is used for wound and burn healing.

Mānuka can also refer to the challenge stick laid down at a pōwhiri. The wero (challenge) is to ascertain whether a visitor comes as friend or foe.

Kupu hou

New word

- **Mānuka** – *pronounced "Mah-nooh-kah"*

Whakataukī

Proverb

- **Kua takoto te mānuka.**

The leaves of the mānuka tree have been laid down. (This refers to the use of the mānuka branch to challenge the motivation of visitors. More generally this whakataukī refers to someone facing a challenge.)

Rerenga kōrero

Phrases

The rollout of the COVID-19 vaccine has already started in this country.

- **Kāore he utu o te rongoā ārai i a KOWHEORI-19, ā e wātea ana ki ngā tāngata katoa o Aotearoa.**

There is no cost for a COVID-19 vaccination – it is free for everyone in New Zealand.

- **Mena e āhua māuiui ana, me noho haumaru koe ki te kāinga.**

Keep safe by staying home if you are not well.

- **Kia piki te taumata ō te haumaru, ā e horoi ana ou ringa.**

Stay safe and wash your hands.

E mihi ana ki a Titihuia Pakeho and Keelan Ransfield.

A week to celebrate 'unsung heroes'

IN OUR fast-paced world, it is easy to focus on the complexities and hardship we face daily. As a result, we often underestimate our individual power to turn one person's life around.

Caregivers are special people who have chosen to respond to the call to make a difference to the people who once cared for us. They perform many roles, from assisting with physical activities like showering and toileting, to providing residents and their whānau emotional support.

Caregivers are our unsung modern heroes. A good caregiver can transform the darkest moments into joy with a caring connection.

During this pandemic, we have witnessed the dedication and compassion of caregivers. In a difficult and uncertain year, caregivers have been steadfast companions to our loved ones in times when we cannot be with them.

It takes someone special to be a caregiver – kindness, calmness and patience are needed in great quantities. For caregiving, like any job, does not come without challenges in our busy aged residential care sector.

The College of Gerontology Nursing would like to recognise and acknowledge our health-care assistants, as we celebrate National Caregiver's Week (March 22-28). •

It is not how much they do, but how much love they put in the doing.

– Mother Teresa of Calcutta

By College of Gerontology Nursing member, Aloha Sisson.

Caregivers must get to know the person

Morrinsville caregiver Uepapa Tauariki always takes time to find common ground with residents.

By co-editor Mary Longmore

Former meat worker Uepapa Tauariki (Tainui) decided to give caregiving a try when his partner told him about an opening at Kingswood Rest Home in Morrinsville, where she worked. Working in the dementia unit for the past 18 months, Tauariki has discovered he really loves it.

On any given day, he will be doing everything from arts and crafts or colouring in, to throwing a rugby ball around outside with some of the residents.

They seem to enjoy having him around also. "Having a male caregiver I think made some of the men there feel more comfortable, especially for cares."

Not only that, but Tauariki's own father has dementia. While he lives in another rest home, Tauariki said working with residents experiencing dementia has helped him understand what his father is going through, and how better to support him.

Tauariki says he tries to always take the time to talk to residents and get to know the person they are beneath the dementia – and encourages colleagues to do the same. "I always tell them, 'don't judge them because they have dementia, just talk to them about their background'."

Uepapa Tauariki

While it can be busy, he is supported by the rest-home management to spend time with the residents.

Tauariki – who comes from a shearing family in the Gisborne region – says he'll happily spend an hour with residents, chatting with them, so they don't feel lonely and anxious, often finding shared experiences.

"I do have some similarities with some of them here, the shearers and meatworkers – so I have the opportunity to bring back those memories. They can remember what it was like to be in the working world."

And many have really interesting stories, for those who listen. "I like listening to them – our old people have so many stories."

I always tell them, 'don't judge them because they have dementia, just talk to them about their background'.

Sometimes, those stories are sad, involving loss and loneliness. Those times, Tauariki has to remind himself not to get too attached. He can also talk the experiences over with his partner, also a caregiver, who understands.

While he has an eye on police training one day, for now Tauariki, a father of five, says he's very happy in his role. "I love working here." •

Caring for people through 'ups and downs'

Dawn Jenkins discovered a love of caregiving and a new job after looking after her dying father.

Health-care assistant Dawn Jenkins with Mary Booker.

By co-editor Mary Longmore

It was her ailing father who suggested Dawn Jenkins consider taking care of older people. "I was very close to my dad. If it wasn't for him putting it into my head, I don't know what I would be doing," says Jenkins, who works as a health-care assistant (HCA) at the Summerset on Cavendish retirement facility in Christchurch.

Jenkins had been a childcare provider, a role she had juggled with parenting for more than 30 years, as she raised her own six children – now aged 11 to 31. But caring for her dad before he passed away four years ago, sparked a change in her life.

"I was at the hospital with him all the time, doing what I could to help him. It was really him who said 'you should go and work in a rest home, with the elderly'."

Jenkins, a single parent, mentioned his comment to her case manager at Work and Income New Zealand not long after. Within a few weeks a housekeeping position had arisen at Summerset, and her case manager encouraged Jenkins to apply for it.

She got the job and then began helping out with other duties. Within a few months, she was offered an HCA role – and "loves it". She has mostly learned on the job, but says there are also training opportunities.

'I don't rush anybody. If someone wants to talk, I will sit down and talk to them. '

Jenkins always tries to take the time to chat and listen to residents, as well as encouraging them to join social activities and takes them out for walks. She mainly works with the serviced apartment residents but also helps in the rest home.

"I always encourage people to go and do exercise and interact with others, not just sit in their apartment or room by themselves," Jenkins said.

"I don't rush anybody. If someone wants to talk, I will sit down and talk to them. If I'm busy, I say 'I will come back later and we'll have a cup of tea'.

"The way I look at it, is I treat everyone the way I would like to have my dad treated."

There are ups and downs in the residents' lives, and she tries to be there for them throughout. "Some days, you're comforting them when they're crying, or there are good days when they're laughing."

Jenkins says she, too, gets a lot out of the relationships. "You learn things every day and if you take the time to talk to your residents, you learn about their home life, growing up, where they've been – some have amazing stories. Some have really sad stories too."

"You can take things from what they say, too, and learn and grow. You can even take on some of the values they had when they were little – they lived through some terrible times – and try and put it into your own children's lives."

Jenkins says management are very supportive and she often will "debrief" by talking through with her village manager if she has been supporting an upset resident.

Summerset care centre manager Roxane Will said caregivers were the "building blocks" of aged care.

"They really get to know the residents – their idiosyncrasies, their likes, their dislikes. The residents' happiness often lies in the relationship that they have with their caregivers."

Despite a long list of jobs, she said Jenkins always found time to connect with residents.

"With Dawn, they're not just residents, they're people," Will said. "She doesn't see it as a job, but she sees it as loving the people she's caring for."

The work is never boring, says Jenkins. "Every day you go in and you don't know what you're going to walk into."

There have been times she's found a resident on the floor after a fall. Then, she calls a nurse for help, makes sure they're comfortable, staying calm and reassuring them until help comes.

It's hard also when they die. "You get close bonds and get to know them, then they pass on. That's hard," she says. "You don't just get the bond with who you've looked after, you get the bond with the family too – you feel for them when their mum or dad has passed." •

Education must promote nursing's voice

Nursing education must prepare confident nurses able to clearly communicate the value of nursing across the health system.

By professional nursing adviser
Anne Brinkman

A three-day medico-legal congress in Auckland last year had a central theme of "Assessment of capacity and mental illness". Capacity refers to a person's ability to make decisions.

As health professionals, we need to support people, wherever possible, to make their own decisions. It is essential to determine whether a person's decisions or actions are valid in law. If not, key issues are *who* then decides for the person, and *how* those decisions are made. The standard for decision-making is that the person's/patient's best interests are being served.[1]

A congress workshop on the theme had six participants and two facilitators, Dunedin barrister Alison Douglass and psychiatrist Mark Fisher. The six participants were four specialist doctors, one non-clinical district health board manager and me. Had I not been there to represent the nursing perspective, I doubt nurses would have even been referred to in the discussion on assessing capacity and mental illness. It was clear nurses were not considered integral players in assessing a person's mental capacity.

Nurses' role unrecognised

Yet, on a 24/7 basis, it is nurses who provide the bulk of care to "general" and mental health patients and rest-home/hospital patients. We know nurses contribute to the discussion and decision-making on a person's mental capacity, but somehow their role in multi-disciplinary teams goes unrecognised. Why is nurses' role here – and in other practice areas – potentially disregarded by other health professionals? Perhaps it is perceived by those outside nursing and education not to be important enough?

Nursing educators influence what is (and isn't) emphasised within the curriculums of the 18 schools of nursing (institutes of technology/polytechnics (ITPs), universities and one wānanga) that offer 29 programmes leading to registration as a registered nurse. The nursing curriculums are designed and delivered in line with the Nursing Council's education programme standards, which are currently being revised. The availability of clinical placements, too, is a very significant factor influencing the integration of students' learning experiences.

'. . . it is vital nursing education promotes effective communication across the health system.'

In terms of Government-directed change, opportunities for nursing input are limited and chaotic. The Vocational Education Reform Bill was introduced to Parliament in August 2019 and enacted in August 2020, resulting in changes, including the introduction of the overarching Te Pukenga, New Zealand Institute of Skills and Technology (NZIST). This umbrella body was "stood up" in April 2020.

The creation of Te Pukenga has meant that all the ITPs are now "subsidiaries" of Te Pukenga and no longer function autonomously. The Government's Reform of Vocational Education (RoVE) encompasses nursing education delivered in ITPs but *not* in universities. Under RoVE, six industry-led workforce development councils (WDCs) are proposed. Nursing will be a part of the health, community and social services WDC, with its wide coverage of vocations.

Independent of these RoVE changes, the Nursing Council is consulting on nursing education standards for programmes leading to registration. Submissions closed in December last year. Meantime, the National Nurse Leaders Group is waiting for the appointed steering group to decide the terms of reference and details to be explored in the proposed nursing education consensus workshop to be held this year.

Given the fundamental changes being considered (including one RN curriculum for ITPs), it is vital nursing education promotes effective communication across the health system. This would help steer the health sector – in the words of the Health & Disability System Review – *"on the path to equity, responsiveness and sustainability"*.[2]

It is unacceptable for nursing to remain unseen and unheard when major changes in health care, structures and administration are being formulated. Nurses' input has too often been ignored; nurses' role in assessing mental capacity is just one example.

This issue of nursing input needs to be addressed and nurses must be able to competently and confidently contribute to improving health care in its widest sense. Let's work together to find the most effective solutions for nursing education, which will lead to recognised and valued nursing practice. •

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Vaccine rollout raises many member issues

The rollout of a COVID-19 vaccine poses employment, professional and personal issues for members.

By acting industrial services manager Glenda Alexander

As NZNO and other union members work on the COVID-19 frontline, protecting our borders, they, in turn, need protection.

They need physical protection in the form of appropriate personal protective equipment. They need employment protection to ensure fair and consistent pay, adequate staffing and their health and safety. And now, in the face of the vaccine rollout, they need psychological protection from the "no jab, no job" sentiment, which takes scant regard of the complexities of the total situation.

NZNO and other unions are working hard to counter that sentiment. It is one thing to insist on a COVID-19 vaccination as a condition of employment for a new employee, but it is a very different situation regarding those already in work. In the vast majority of cases, and certainly for nurses, there will be other work those who do not want to get vaccinated can be deployed to.

It is important to remember that those not wishing to receive the vaccine cannot all be lumped into the "anti-vaxxer" brigade. Pregnancy precludes vaccination, as do 158 medical conditions. There will be some who for considered reasons decide they do not want to be vaccinated; and others who may have genuine concerns about the speed with which the vaccine was developed and its safety. These concerns may not be supported by the evidence but are real for those people. Information and education will, hopefully, allay most people's fears and we believe the majority of nurses will be willing to receive the vaccine.

. . . employers cannot require an individual to be vaccinated, but they can require a specific role to be done by a person who has been vaccinated.

But if a member does not want to receive the vaccine, they are still entitled to support, both industrial and professional.

The Council of Trade Unions has been working with the Ministry of Business, Innovation and Employment (MBIE) on developing guidance for employers and employees on the COVID-19 vaccines. While the ministry's *COVID-19 Vaccines: Employment Guidance*[1] does not include everything the CTU wanted, it does provide a basis to work through the employment relationship issues that arise.

Glenda Alexander

The guidance clearly states that employers cannot require an individual to be vaccinated, but they can require a specific role to be done by a person who has been vaccinated. Employers must have first done a health and safety (H&S) risk assessment, in collaboration with workers, unions and other representatives, to support the requirement that a particular task must be performed by somebody who has been vaccinated. Following such an assessment, employers can change an employee's duties for H&S reasons, if the worker is not vaccinated. Any such process must be fair and reasonable and carried out in good faith, and employers must avoid unfair disadvantage. The guidance states: *"Employers, in consultation with employees, must consider options, such as changing work arrangements, alternative duties or leave. If leave is used, this must be agreed and we encourage this be paid."*[1]

It says that individual dismissals are unlikely to be justifiable in almost all cases, based on current circumstances.

Workers do not have to tell their employer if they have been vaccinated or why they are unable to, or choose not to be vaccinated. But employers can ask workers if they have been vaccinated and if they worker does not state their vaccination status, then an employer can assume they have not been vaccinated. An employer cannot share a worker's vaccination status without the worker's consent.

The guidance recommends that employers "encourage and support" workers to get vaccinated. This could include on-site vaccination, allowing workers to get vaccinated during work time without loss of pay, and providing workers with relevant Ministry of Health information about vaccination and its benefits. It urges employers to engage early and constructively with unions when considering vaccination issues at their workplace.

Along with ensuring these guidelines are adhered to, NZNO is also working to ensure all nurses working in managed isolation/quarantine facilities (MIF/MIQ) are paid the same. There must be fair and consistent pay nationally, and whatever allowances/bonuses are paid as incentives to work in MIF/MIQ must be paid to all nurses working in these facilities.

NZNO is also providing other support to MIF/MIQ nurses, many of whom are feeling overworked, stressed and stigmatised.

Our work in this area will continue for some time. These issues are not going to go away anytime soon and we must ensure those working in MIF/MIQ get the best possible range of protections. •

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Aged care: Cuts at Timaru facility

JOB CUTS and reductions in hours of work at Timaru's Arvida-owned Strathallan aged-care facility have gone ahead, despite staff and community opposition.

NZNO organiser Stephanie Duncan said the restructure had cut 1.25 enrolled nurse positions, 3.5 full-time caregiving positions and combined the diversional therapy role with that of caregiving.

Staff believed the cuts would have a negative effect on residents' overall wellbeing and increase the risk of falls, medication errors and staff fatigue.

"I believe the cuts are financially motivated to reduce wage costs," she said.

The final instalment of the care and support workers equal pay settlement will come into effect on July 1 this year. The 2017 settlement considerably boosted caregivers' wages.

"We will continue to put the pressure on and keep the public aware of what's happening. We have written to the local MP, Jo Luxton, outlining our concerns. What's happening at Strathallan is indicative of wider issues in the aged-care sector, such as unmanageable workloads," Duncan said. •

Primary health care: Plunket preparations

CLAIMS ENDORSEMENT meetings for Plunket collective agreement (CA) negotiations are being held this month. Negotiations will most likely start next month.

NZNO organiser Danielle Davies said claims were gathered via an online survey. Currently, all Plunket nursing roles are paid at parity with equivalent roles in the 2018-2020 NZNO/district health board multi-employer collective agreement (DHB MECA). But claims relating to other conditions had emerged.

Davies said the focus of the negotiations this year would be on Family Start and administration workers. Coverage of Family Start workers in Tauranga and Manawatu was gained in the 2019 Plunket CA negotiations. The claim for these workers was pay parity with the Public Service Association's (PSA)-negotiated rate for social workers at Oranga Tamariki. Davies said the work of Family Start workers, many of whom had social work or education backgrounds, was similar to that of Oranga Tamariki social workers but there was a huge pay gap between them.

The negotiations would also focus on administration workers' pay and would be guided by the PSA's pay equity case for DHB clerical workers, due to be finalised mid-year.

The CA covers around 800 members. •

Parking hike at Capital & Coast delayed

A DECISION on whether to raise staff carparking rates at Wellington Regional Hospital has been postponed, after surgeons and anaesthetists joined in to protest against the hikes.

"It was very heartening that the highest paid, such as anaesthetists and surgeons, were so angry about the lowest-paid workers facing such a price hike," NZNO member Erin Kennedy said. "They were very vocal!"

An array of staff and unions lodged a petition signed by nearly 1000 people with the board in December, after it proposed increasing staff carparking fees from $4.50 to $7.50 per day, and higher monthly fees.

Kennedy, a former NZNO delegate, said staff were already struggling and did not need more financial pressure. She had since been told that any decision would be made by the board, rather than the "management-loaded" parking committee, which was hopeful.

Capital & Coast District Health Board chief financial officer Rosalie Percival said the DHB planned to engage with staff and unions further on this issue. "Overall, we anticipate being able to have a proposed solution this year." •

New and familiar faces on industrial team

SOME NEW faces have joined NZNO's industrial services team (IST), while some familiar faces have new roles. Acting IST manager Glenda Alexander announced a raft of appointments last month.

Rob George has been appointed to the full-time educator role for the Northern region and will be based in Hamilton. That leaves an organiser position vacant in Hamilton.

Former government minister, and a former NZNO organiser, Iain Lees-Galloway, has been appointed to the permanent lead organiser role in the Central region, replacing Lyn Olsthoorn.

Christchurch-based organiser Danielle Davies has been appointed to the half-time position of industrial adviser (IA) for private hospitals and hospices. She will retain her half-time organiser role. Alexander said NZNO had been "spoilt for choice" in applicants for the IA role.

A former E tū employee, Sunny Seghal, has been appointed to a 0.8 full-time equivalent organiser role in Auckland. Alexander said Seghal had done a lot of community organising within his Indian community. He starts on March 22.

A former receptionist in the Nelson NZNO office and former membership support centre call adviser, Shannyn Hunter, joined the Nelson office organising team in January. Alexander said Hunter was already making a great contribution to the team.

Lead organiser in the Auckland office Andy Hipkiss leaves NZNO this month to take up a mediator role with the Ministry of Business, Innovation and Employment. Wishing Hipkiss well, Alexander said she hoped he would take what he had learnt at NZNO into his new role. She thanked him for the work he had done for NZNO in a variety of roles – MSC call adviser, organiser and lead organiser.

Recruitment for the organiser, lead organiser and MSC call adviser roles, created by the new appointments or departures, is underway, Alexander said. •

Primary health care: NZNO ratification starts

NZNO MEMBERS working for employers who have ratified the proposed primary health care multi-employer collective agreement (PHC MECA) are voting this month on the deal. Online ratification began on March 9 and is due to finish on March 17.

The proposed MECA includes pay increases ranging from 4.5 per cent to 7.75 per cent and locks in a new registered nurses (RN) step 6, to be implemented from February 1 this year. It will be paid at $36.02 an hour, matching the current district health board (DHB) rate.

If ratified, the proposed MECA will deliver a 7.75 per cent increase on the pay rate for step 5 in the current PHC MECA. Employees who have been on step 5 for a year or more at February 1 this year will move to the new step 6 on that date.

When the deal was sent to employers for ratification – 67 per cent have to vote yes for the deal to be ratified by employers – more than 10 per cent rejected it. And 35 had not ratified it. Around 650 members worked for the 85 employers who had either rejected or not ratified the proposed MECA.

'Resource intensive' time

But after a "very resource intensive" time contacting those employers, the number who have rejected/not ratified had been reduced to around 45 by the beginning of the month, NZNO PHC industrial adviser Chris Wilson said. This had involved making individual, formal contact with all the employers who had rejected/not ratified the deal for potential "serious negotiations".

At the beginning of the month, NZNO had set up around 25 meetings, mostly by Zoom, for serious negotiations with those employers who had still not accepted the deal.

As those employers came on board, ratification for the members in those workplaces would begin. "But positively, we now have some 450 employers on board," Wilson said.

If ratified, the PHC MECA will expire on August 31 this year. There were two further opportunities to improve the MECA this year, she said – when the NZNO/DHB MECA negotiations concluded and when the DHB pay equity settlement was finalised. •

Primary health care: New deal at Family Planning

THE FIRST-ever national strike at Family Planning (FP), scheduled for February 16, was averted thanks to mediation last month and a revised collective agreement (CA). The revised CA was ratified late last month. The wage increases, the minimum of which is three per cent, are all fully backdated to April 1, 2020, and the newly-ratified CA will expire on August 31 this year.

Mediation last month resulted in formal agreements between NZNO and FP. These included starting the joint national healthy workplace forum by the end of March and establishing a working group on nursing classifications to start working in May, primary health care industrial adviser Chris Wilson said.

Budget bid

At mediation, FP made clear it did not have funds to provide any further pay increases at this time. These could only be achieved with additional funding. The Ministry of Health (MoH) gave FP the authority to confirm at mediation that FP has put in a "budget bid" for the year July 1, 2021, to June 30, 2022. FP reiterated it fully supported staff being paid more and had repeated this in discussions with relevant ministers and the MoH. The MoH's confirmation of FP's budget bid was the the first sign of a potential breakthrough, Wilson said. NZNO and FP are to work collaboratively to provide information jointly to ensure the "budget bid" by the MoH was well informed.

Separate joint working groups for registered nurses, health promoters and medical receptionists will meet later this month. These will establish occupational comparators (eg relevant district health board positions for the nurse groups) for each of the groups covered by the CA. NZNO will provide information to the working groups before their meetings.

NZNO and FP will develop a joint briefing paper, based on the results of the working groups' information, to present to relevant ministers and the MoH. They are also going to request a meeting with the Minister of Health (Andrew Little) and the MoH before mid-April to present the briefing paper and other relevant information, Wilson said. •

Changes to Holidays Act welcomed

WORKERS WILL be able to get sick leave, bereavement and family violence leave from the first days of their employment under changes to the Holidays Act. The Council of Trade Unions (CTU), of which NZNO is an affiliated union, has welcomed a raft of changes to the Act, recommended by the Holidays Act Taskforce. The Government announced last month that it would accept the 22 recommended changes.

CTU president Richard Wagstaff was a member of the taskforce and said the changes should make implementation of the Act easier. Two other significant changes are:

- extension of the criteria for bereavement leave to include more family members, including cultural family groups and more modern family structures; and
- removing the current parental leave 'override', to address discrimination against parents who take time off to care for their young children. •

NZNO finances better off due to COVID

NZNO IS facing a pre-tax deficit of $673,000 for the nine months to December 31, 2020 – $448,000 better than the budgeted pre-tax deficit of $1.121 million.

In his report to the board, corporate services manager David Woltman said both revenue and expenditure were down, with the COVID-19 lockdown last year the major contributing factor to both.

Year-to-date revenue was down $1.24 million on budget. The main contributing factors were a drop in member subscriptions ($541,000) due to lower membership numbers and lower average fees received due to a six-month delay in introducing last year's fee increase because of the lockdown, and cancellation or deferment of college/section conferences ($508,000) and associated sponsorship ($228,000).

Increases in other income included the recovery of members' indemnity insurance legal fees ($126,000). NZNO's investment portfolio performed better than the budget had forecast and was valued at $10.414 million on December 31, 2020.

Expenditure for the nine months to December 31, 2020, was $1.69 million below budget, due mainly to COVID-19 travel restrictions.

Travel and accommodation expenses were down $693,000 and general expenses were down $328,000 as regional conventions were cancelled, and hui ā-tau and the NZNO annual general meeting and conference were held online. College/section conference expenses were down $566,000; staff costs were down by $103,000 (but the outcome of staff bargaining was not reflected in the financial statements); member expenses were down $84,000 due to savings on honoraria because of board vacancies; and printing and stationery costs were down $78,000, partly because there was no print issue of *Kai Tiaki Nursing New Zealand* in April.

Legal expenses increased by $314,000 due to more work and greater complexity of legal representation of members. Vehicle expenses increased $48,000.

In his report, Woltman said membership was 50,329 at December 31, 2020, a net decrease of 2.5 per cent since March 2020. The majority of the decrease was through registered nurses retiring and students leaving at the completion of their courses.

Forecasting to March 31, 2020, Woltman said there would be a deficit in the current year of $788,000, down from the planned deficit of $890,000. Member subscriptions are forecast to be down $757,000 for the full year. Sponsorship and event registration revenue were down by $212,000 and $38,000 respectively due to COVID-19 impacts, with savings of $379,000 and $68,000 on general expenses and member expenses respectively. In the forecast, travel and accommodation expenses retained the current year savings of $693,000 and were projected to increase to $790,000, with continued use of Zoom meetings

After taxes and revaluation of the investment portfolio, a small deficit of $68,000 is forecast. •

Board approves 2021/2022 budget deficit

IN HIS report to the board, corporate services manager David Woltman presented a budgeted deficit of $478,000 for 2021/22 and small surpluses in the following two years. Following on from the audit and risk committee, he told the board he had looked closely at costs, especially travel and accommodation costs. He suggested more use of Zoom and fewer kanohi-ki-te-kanohi hui for all member groups and committees, to reach a balance of 50 per cent Zoom and 50 per cent kanohi-ki-te-kanohi hui.

The board has taken the lead, reducing its six planned face-to-face meetings to three for next year, with the balance via Zoom.

The board approved the draft budget for 2021/2022, subject to a reduction of $200,000 in travel and accommodation expenses, resulting in a revised deficit of $278,000. Members and staff will be advised to reduce the number of kanohi-ki-te-kanohi hui. From April, Woltman said every month the financial statements would identify travel expenses. •

Equity framework to be 'socialised' to staff, members

THE BOARD approved a project brief on the development of an equity framework to guide NZNO in all its work. It will be used as the basis for a more detailed project plan. Associate nursing and professional services manager Kate Weston told the board funds were needed to socialise the equity framework with member groups and that a business case would be prepared once the board agreed with progress so far.

In his report to the board, chief executive Memo Musa said NZNO was committed to developing and implementing an equity framework for staff and members. The organisation's policy team would undertake the development work needed to socialise the framework with NZNO staff. Musa said the board's confirmation and endorsement of the equity framework would demonstrate commitment to embedding equity within NZNO.

Kaiwhakahaere Kerri Nuku said the "value-add" in consulting member groups on the framework would be in educating and developing their understanding of equity. •

Pharmacists, vision and hearing specialists to become members

THE BOARD agreed to allow pharmacists and vision and hearing specialists employed by Tai Tokerau's largest Māori health provider, Ngāti Hine Health Trust, and covered by its collective agreement (CA) with NZNO, to become members of NZNO.

The inaugural CA, Ki Arahanga ki Tawhiti (The Bridge to the Future), was signed in late 2019 and expired on June 30 last year. Negotiations for a new CA are underway. Those covered by the CA include registered nurses, allied health professionals, kaiawhina/community health workers, social workers, alcohol and other drug counsellors, health promoters and administration personnel.

When discussing the request, the board considered the risks associated with granting membership to members of an unregulated profession (vision and hearing specialists). Responding to a question from the board, chief executive Memo Musa said admission to membership of the two groups would be a distraction to core business. However, it presented an opportunity in terms of marketing.

The pharmacists and vision and hearing specialists can be members of NZNO as long as they are employed by the trust. •

Ngāti Hine Health Trust staff celebrate their new site collective agreement.

Annual plan updated

NZNO's DRAFT annual plan has been revised and updated to include the three pillars included in the organisation's 2021-2025 strategic plan and to update the plan's key priorities, chief executive Memo Musa told the board.

The strategic plan's three pillars are:

- effective and sustainable organisation;
- skilled, strong workforces; and
- influencing improved health outcomes.

Each pillar has four dimensions:

- membership driven – ka peia te matatanga;
- effective communication – whawhitinga kōrero;
- equity – oritetanga; and
- effective.

Updates to the plan included the Government's key focus areas for the next three years and the response to COVID-19.

After discussion, the board asked that a more comprehensive and visible marketing and communication plan be incorporated into the annual planning cycles "to maximise visibility and revenue opportunities".

The board received the revised and updated draft annual plan.

Any further board feedback will be included in the final annual plan to be presented to the board next month. •

These pages have been written from reports and minutes taken from the February 2021 board of directors' meeting.

Realistic patient simulations, p25 – references

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Directory

Have you changed your address, workplace, name or phone number? Please let NZNO know of any such changes so our records are accurate and you receive *Kai Tiaki Nursing New Zealand* and other important NZNO information. It doesn't cost anything to let NZNO know — just ring 0800-28-38-48 or fax 04 494 6370 or 0800 466 877, anytime, day or night. Post the information to NZNO membership, PO Box 2128, Wellington or email: membership@nzno.org.nz

NATIONAL OFFICE

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

Classified advertising

FLORENCE NIGHTINGALE MEMORIAL FUND

NOW OPEN

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

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

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

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

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

There are three categories of grants:

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

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

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

Applications close 31 March 2021

Clinical Nurse Manager

Community Mental Health Services
Permanent, full-time, weekday, office hours

Life is a collection of small moments: meaningful moments, challenging moments, moments to remember. At SCDHB, we want to support our people to enjoy more of the moments that matter. Are you ready to join us?

Are you an experienced mental health services leader ready to support an exciting moment of further development for our community mental health services in South Canterbury, as we seek alignment to He Ara Oranga? Then this could be the next step in your career.

You will lead a team of committed health professionals in the community MH service and the TACT team, with a focus on improving outcomes for clients and their families/whanau aligned with He Ara Oranga.

You will have a passion for not only developing and enhancing your own strengths, but those of your team as well. As a leader, you will value and engage your staff. You will provide them with support and direction, while encouraging ongoing professional development in a client centred service.

Your sound professional judgement will also be needed to ensure clinical practice standards are met and the service running smoothly.

Why Timaru?

As one of the country's smaller DHBs our people always have room to move and grow - you'll get a wider exposure to specialties and enjoy the benefits of a flat structure: processes that run smoothly and a fun, friendly culture. With us, you're more than just a number; you're part of a team where everyone knows your name.

On top of all that, you'll get to enjoy the fantastic Timaru lifestyle: between the beach and the mountains, that much desired work-life balance is truly achievable here.

At SCDHB, integrity, collaboration, accountability, respect and excellence are at the heart of everything we do. We are a proudly diverse team, as we know a diverse and inclusive workforce achieves the best outcomes for our patients and communities. If you share in these core values and bring them into every aspect of your patient care, we can't wait for you to join us.

Step up and take the lead. Apply now - this moment is yours!

Please apply for this vacancy online at https://scdhb.careercentre.net.nz

We look forward to receiving your application directly via our Careers Site. If you have any questions regarding this role please contact Human Resources by phoning 03 687-2230.

Applications deadline: OPEN 2021.

As part of our duty of care towards our patients, it is crucial that all patient-facing staff be fully immunised. If you have made it to the later stages of recruitment, you will be expected to produce your immunisation records for infection control purposes.

South Canterbury District Health Board

scdhb.health.nz

Events

18-20 May 2021 **Dundein**
Enrolled Nurse Section NZNO Conference
The Year of the Enrolled Nurse
www.nzno.org.nz/groups/colleges_sections/sections/enrolled_nurses/conference_events

15-16 September 2021 **Wellington**
NZNO Conference and AGM
www.nzno.org.nz/2021conference

17-18 September 2021 **Wellington**
20th Annual Wellington Orthopaedic Nurses Conference
Upper Limb: Paeds & Adults
www.wgtnorthonursconf.co.nz

15-17 September 2021 **Invercargill**
IPC Conference 20201 Just Bluffing It
www.ipcconference2021.co.nz

Reunion

September 2021 **Christchurch**
Reunion for the September 1982 Class of General Obstetric Nurses at the Christchurch School of Nursing
For information contact Jane Coster at jicoster@hotmail.com

FREE EVENTS LISTING

Send us your details to be included in this free events listing. We need the date, location, name of the event and a web address.

Conference and AGM

Wednesday 15 and Thursday 16 September 2021

Museum of New Zealand, Te Papa Tongarewa, Wellington

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

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

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

Call for Abstracts

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

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

Share your ideas, innovations and expertise.

Closing date 4 June 2021 at 5.00pm

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

Conference Sponsorship

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

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

OUR FUTURE
The health of AOTEAROA

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

CALL FOR AWARD NOMINATIONS

NZNO Award of Honour

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

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

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

National Awards

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

Service to NZNO

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

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

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

Service to Nursing/Midwifery

The nominee must be an NZNO member:

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

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

Closing date 4 June 2021 at 5.00pm

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

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

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