Kai Tiaki
NURSING NEW ZEALAND
April 2021
VOL 27 NO 3

Cultural care, critical care

Mâori patients need better cultural care, says a critical care nurse. Working through the pandemic, she puts whânau front and centre – both the patients' and her own.

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The problem with 'heroism'

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Childhood obesity care

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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 considers the International Nurses Day theme with a group of nursing leaders, includes practice articles on childhood obesity and caring for those with hepatitis C, has a viewpoint article on the longer-term impacts of COVID-19 on the profession and a professional focus on the importance of nurse advocacy. The professional education feature examines type 2 diabetes.

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.

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

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Increase nurse workforce now

By Pipi Barton

With International Nurses' Day approaching, I was asked to share my views on the future of nursing in New Zealand. I am currently in the midst of PhD study, and recently completed a literature review that included examining the New Zealand nursing workforce, with a particular focus on Māori. With this in mind, I wish I could say that the future will be all "rainbows and unicorns". But, unfortunately, the reality is quite the opposite.

Before anyone had heard of COVID-19, New Zealand was already hurtling towards a potential nursing workforce crisis. An ageing workforce, combined with increasing demand for health care from an ageing population, has set the scene for a collision predicted anytime now with pretty serious consequences. The projected workforce shortfall was thought to be as much as 15,000 nurses.[1,2]

In recent times, employers have been increasingly filling vacancies with internationally qualified nurses, who now represent 27 per cent of the total New Zealand nursing workforce[2]. However, there is no way of knowing now how the projected shortfall will stand when taking into consideration a global pandemic.

The pending nurse shortage is not an issue for New Zealand alone – it is set to be an international issue,[3] and will undoubtedly have repercussions for recruitment here. But considering the current COVID-19 climate, having maintained a relatively low mortality rate in comparison to other countries around the world, perhaps we should ask: Just because we can lure international nurses to New Zealand, should we? Moreover, is it ethical to be enticing nurses here from countries that possibly need them more than we do?

With these uncertainties, how will the future look? What are the implications for nursing care? We need only to look back to the 1990s to get a view of the possible fallout. During that time, New Zealand underwent considerable economic and social reform, successive governments' austerity measures forcing the health system through various changes, including a mass reduction in the number of nursing full-time equivalents across the country. This had a significant impact on patient care and resulted in increased adverse outcomes potentially sensitive to nursing (OPSN), such as decubitus ulcers, deep vein thrombosis, pneumonia, urinary tract infections and other health issues[4]. During this time, Māori experienced higher rates of medical OPSNs and a shorter average length of hospital stay than non-Māori.[5,6] Although today's looming crisis is due to different circumstances from those experienced in the 1990s, the outcomes are potentially the same.

Māori continue to experience considerable barriers to equitable health care in Aotearoa;[7] there is no doubt that a nursing shortage will further increase the disparity and inequity.

Also, Māori nursing represents only seven per cent of the total nursing workforce, and we potentially will be seeing nearly a third of our Māori nursing colleagues heading into retirement over the next five to 10 years.[2] This will have huge repercussions for Māori nursing leadership and Māori health, putting incredible pressure on Māori services and communities.

In anticipation of a critical global nursing shortage, the World Health Organization has recommended countries place more emphasis on growing their own local nursing workforces.[3] With an overhaul of Aotearoa's health sector underway and recent tertiary sector changes that may affect nursing programmes, if there was ever a time to consider how we might grow our nursing workforce and prevent a health workforce crisis, then that time is *now*.

If we are to increase nurse numbers, then nursing leaders – who must include Māori – must collaborate with the Ministry of Health, district health boards, Māori providers, other employers and the tertiary sector on a strategy to secure the health workforce needs of our country into the future. Because right now, the future of nursing in Aotearoa is not looking too good. •

Pipi Barton (Ngāti Hikairo ki Kāwhia) RN, MPhil(nursing), is a nurse lecturer at North-Tec and PhD student at Auckland University of Technology.

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Tell us what you think

Interim practising certificates – why free only for some nurses?

I WOULD like to know why the Nursing Council is refusing to extend free-of-charge interim annual practising certificates (APCs) for registered nurses (RNs) who have returned to the workforce to work at community-based assessment clinics (CBACs) swabbing for COVID-19, but are extending them to RNs who are vaccinating against COVID-19.

I was informed of this by the Nursing Council last month. The Nursing Council representative also told me she did not know why this was the case.

This is inequitable, unfair and unreasonable, due to the probable continued need for managed isolation facilities/managed quarantine facilities (MIFs/MIQs) and CBACs, even when the vaccination programme is completed.

I do not want a reply telling me to complain to the Nursing Council, because I have done that twice in writing to no avail. Verbally, council registration staff have agreed with me when I have voiced these concerns, which I also intend sharing with the Ministry of Health.

Vaccinators are being paid $40 an hour, MIQ nurses are paid $35/hr and those taking swabs at CBACs are paid $30/hr. Most of the people in these workforces are employed on a casual basis and have no employee benefits. Which RNs in the COVID-19 response surge workforce are at greatest risk to themselves and/or their families' welfare due to their work and who among the above are receiving the lower pay rates?

I would like an explanation as to why NZNO would allow these inequitable and discriminatory situations to exist and, by remaining silent, allow it to continue.

NZNO represents nurses. That is what we pay for in our membership fees, and are not receiving it, despite NZNO's mission statement: *"NZNO is committed to the representation of members and the promotion of nursing/midwifery. NZNO embraces Te Tiriti O Waitangi and works to improve the health status of all peoples of Aotearoa/New Zealand through participation in health and social policy development."* Really?

Marcia Ashdown, RN
Porirua

Email your letter to:

coeditors@nzno.org.nz

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

Nursing Council chief executive/registrar Catherine Byrne replies: The Nursing Council has issued over 1000 interim practising certificates (IPC) free of charge to nurses who have responded to the Ministry of Health's request to assist with the COVID-19 pandemic surge workforce. The IPCs were first initiated in March 2020 and extended until March 2021. The intention of the IPC was for an interim period until the full scope of the surge workforce was established. The council is unable to extend the free IPCs beyond March 31, 2021.

Many nurses in New Zealand have been assisting with COVID-19 related activities, most of whom have paid for their annual practising certificates (APC). It is not reasonable for nurses who pay for an APC to subsidise nurses working with an IPC indefinitely.

In the face of this global pandemic nurses have stepped up across the country and remain at the forefront of eliminating COVID-19. Nurses are to be commended for their tireless efforts to ensure the public receive the best and safest care.

NZNO acting industrial services manager Glenda Alexander replies: In terms of payment for work in MIQs, and now for vaccinators, we have made some progress, particularly in the South Island, in getting pay rates to the district health board (DHB) level and consistency of pay across the workforce. (See p7.) This should allow us to leverage the North Island counterparts.

We have not developed a strategy for vaccinators yet, but as DHBs are their employers, we would need to ensure these nurses are also paid the appropriate rate, as per the DHB/NZNO multi-employer collective agreement.

Clarification re Totara Hospice:

IN SEPTEMBER 2020 a brief article was published in the NZNO journal, *Kai Tiaki Nursing New Zealand*, in the sector news pages ('Job losses at South Auckland hospice', p43).

The article, in which a former NZNO organiser was quoted, discussed the outcome of a recent "radical redesign" staffing review at Totara Hospice.

While the organiser based her comments on the formal outcome document of the above review, the information disclosed, together with other comments made, may have been interpreted by some *Kai Tiaki Nursing New Zealand* readers as inferring that Totara Hospice staffing levels were unsafe for patients and staff.

NZNO notes no such inferences were intended and apologises for any potential adverse impacts that may have arisen in consequence for Totara Hospice.

Glenda Alexander
acting industrial services manager

Staunch trade unionist and ex-NZNO staffer dies

FORMER CHRISTCHURCH NZNO office manager and long-time trade unionist Andy Lea died last month, aged 72. He started at NZNO in 2005 and retired because of ill health in 2019.

Announcing his death, NZNO acting chief executive Mairi Lucas said he was remembered for his kindness, passion and commitment as a staunch trade unionist. NZNO corporate services manager David Woltman said Lea had led NZNO's corporate administration across the South Island and lower North Island and was sorely missed. "Andy was very well liked by staff," he said.

Lea began his union career in 1972 with the Clerical Workers' Union as a delegate, then executive member and finally as a field officer. He worked for a range of unions, including as the South Island organiser for the Food and Chemical Workers' Union; for the Dairy Workers' Union; as South Island secretary of the National Distribution Union; and was a lead organiser with the Service and Food Workers' Union.

He was also involved in politics, originally with the Values Party and later with the Labour Party. Lea was a JP for 36 years, a Civil Defence volunteer for many years and involved in a range of other community activities. Speaking at his memorial service, Christchurch Mayor Leanne Dalziel said Lea had given a lifetime of service to his community. He is survived by his wife Judy and three adult children.

Co-editor retires

Kai Tiaki Nursing New Zealand's longest-serving editor Teresa O'Connor retired this month. She joined Kathy Stodart as a co-editor in 1992, after working as a surgical nurse.

Lucas said O'Connor's organisational knowledge and journalistic expertise would be sorely missed, "but we wish her the very, best in her retirement as she enjoys the next 20-30 summers soaking up the beautiful Nelson sunshine without having to worry about mahi".

O'Connor said it had been a privilege to record the stories of nurses, the profession and the politics of health. But at the end of her career, she felt nurses had still not fully realised their potential to bring about much-needed change to the power structures of health. (See p30-31.)

She will be replaced by a senior political journalist with *Stuff*, Joel Maxwell (Te Rarawa from the Far North), who covered Māori affairs. Announcing his appointment, Lucas said Maxwell was a fluent te reo Māori speaker who would bring some very specific skills "we are excited to receive". He will start on May 3.

Nelson-based organiser Denise McGurk is leaving NZNO after nearly nine years in the job. Before starting work for the organisation, McGurk had a long history with NZNO as a delegate and was part of a number of significant bargaining teams. She was also active in the college of emergency nurses. Announcing her resignation, acting industrial services manager Glenda Alexander said McGurk had made a great contribution as part of the industrial team and broader NZNO work.

Acting associate manager, nursing and professional services (AMNPS), Kate Weston has been appointed to the role permanently. She has been AMNPS for the past year, taking on the role when Hilary Graham-Smith left. Weston began as a professional nursing adviser in 2008.

Announcing the permanent appointment, Lucas said in the past year Weston had made significant contributions to the professional services team and NZNO in general, "including her tireless dedication to ensuring nurses are safe at work and personal protective equipment is readily available during the pandemic". •

Elected council members appointed

A FORMER NZNO president Marion Guy, a former NZNO board member Maria Armstrong and Filipino nurse Emmanuel Pelayo are the three successful candidates in last year's Nursing Council elections.

Health Minister Andrew Little announced their appointments last month – six months after the elections were held. Thirty-one nurses stood for the three positions, which the profession elects every three years.

Guy served as NZNO president for two terms: 2005-2009 and 2012-2015. She has also been on the Bay of Plenty District Health Board (DHB).

Armstrong, a charge nurse at Auckland DHB, was first elected to the council in the 2017 elections. She was elected to the NZNO board of directors in 2017 and stepped down in 2019.

Pelayo came to New Zealand from the Philippines in 2009. He lives in Auckland and works for community provider Healthcare New Zealand as regional clinical lead for the Northern and Midlands regions.

Little also announced senior academic staff member at Wintec Linda Chalmers and nurse director of Māori Health at Hawkes Bay DHB Ngaira Harker as ministerial appointments to the council. •

Chief executive to be appointed soon?

NZNO's BOARD of directors is still "working through the interviewing and selection processes for a new chief executive [CE]", board member Simon Auty said this month.

"We are making good progress but, as this is an appointment of the highest importance, we will take the time required to find the best person for the role. In the meantime, we are confident Mairi Lucas is doing an excellent job as acting chief executive and that the organisation is in safe hands."

Former CE Memo Musa left NZNO in February. •

DHB offer 'insulting'

NZNO MEMBERS working in district health boards (DHBs) are poised to reject the multi-employer collective agreement (MECA) offer, now out for consideration. As *Kai Tiaki Nursing New Zealand* went to press, indications were the offer would be roundly rejected, with some members describing it as "an April Fool's Day joke" and "insulting".

NZNO's lead advocate, David Wait, said he was not surprised members were feeling that way, as the offer was "divisive". It split the nursing and midwifery scales, with DHBs pointing to the cost of applying the offer across RN and RM scales. And it disregarded the value of senior nurses – those on grade 5 and above – who would not get a pay increase until May next year.

Under the offer, health-care assistants (HCAs) would receive a lump-sum payment of $900 on ratification, which was not added to the pay scale. Over two years, a four-step, qualifications-based pay scale would be introduced. This would boost HCAs' pay by 5.6 to 12.2 per cent.

The start of the enrolled nurse scale would retain relativity with the top of the HCA scale.

Registered nurses (RNs) on steps 2-4 would receive $900 on ratification and a $1200 flat-rate increase on May 1 this year. Senior RNs on grades 5-8 would not receive the lump-sum payment. They would get a $1200 flat-rate increase from May 1, 2022.

Registered midwives (RMs) on grades 2-4 would get the $900 lump sum on ratification and a 1.25 per cent pay increase from May 1 this year. Senior RMs – grades 5-8 – would receive a 1.25 per cent pay increase from May 1 this year, which would bring their rates into line with midwifery union MERAS pay rates. But they would not get the lump sum.

All midwives would get a $1200 flat rate increase from May 1 next year.

In its presentation, the DHB team said that in the last round of bargaining there was a "real focus on nurses and midwives at the top of the MECA", including the new steps 6 and 7 for RNs and RMs.

Their rationale for the offer also included an "atmosphere of pay restraint" and the Government's commitment to closing the gap between the highest and lowest paid.

"While we are committed to making an offer that provides something for all members, we want to do something additional for your lowest paid members ahead of the pay equity settlement," the team said in its presentation on the offer.

Wait rejected the DHB team's contention that the last bargaining round focused on RNs and RMs at the top of the MECA. "That is not an accurate representation. The new steps 6 and 7 do not represent the top of the scale."

He said it had been a long and difficult process for the bargaining team. "My overwhelming feeling now is that this is the point when members make their voices very clear and make a decision about what's on offer and the next steps. Our focus continues to be on member voice and leadership."

Mediation this month

Assuming the offer is dismissed, that will be relayed to the DHBs, along with what members think needs to be improved. Members' views on the offer and what needed to be improved were being sought through a survey, which was still underway in early April. Members' views would be presented to the DHB team at mediation, tentatively scheduled for the last week of this month.

If members indicate the offer is not acceptable, delegate-run member meetings are also scheduled to start at the end of this month. These will consider possible actions, including strike action, and campaign activities. After these meetings, an online strike ballot was possible, Wait said, unless the DHB team came back with a significantly improved offer.

"We will have had 20 days of bargaining, mediation and member meetings, so will have a very clear idea about what members want to do."

Members would not take strike action lightly and would be mindful of the impact of any strike on the public, he said. "But COVID-19 has highlighted the importance and value of nursing work – the public know how important it is." •

Morgan takes up presidency on as-needs basis

TRACEY MORGAN, elected unopposed as NZNO vice president last October, will act as president on an as-needs basis until new board elections in September.

Kaiwhakahaere Kerri Nuku announced the decision to members this month, on behalf of NZNO's board of directors. She said Morgan would remain as vice president, but would act as president "as and when required until the next round of board elections later this year (as per section 18.2 of the NZNO constitution)". The remainder of the work would be covered by Nuku, as has been the case since January.

Canterbury forensics nurse Heather Symes was elected president last October, but resigned for family reasons in December, effective from January 8 this year.

Tracey Morgan

Nuku said the presidency was a full-time, paid position. "While Tracey had the opportunity to step up to acting president on a full-time basis (as per section 10.1.5), she has chosen not to. Instead, she will remain in her current employment, working for her patients in Rotorua and providing for her whānau," she said.

'Ongoing stability'

"Tracey has a long history of work and support for the organisation and it is reassuring to know she will be there to help steer the waka for the short time between now and the next elections, and we are grateful for her willingness to provide ongoing stability."

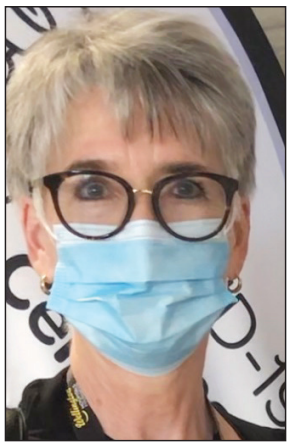
Following standard policy, when Morgan acted as president, her costs and any lost wages would be covered for that time, Nuku said. •

Nurses 'best advertisers' for vaccine

NURSES CAN make a real difference in encouraging people to have the COVID-19 vaccine, says the nurse leading Wellington's border vaccination programme, Marie Habowska.

"We are the best advertisement for the vaccine, as we have all had it," said Habowska. "Just like a cook eats their food, it's a good vote of confidence."

The team of 13 nurses has vaccinated around 480 border workers – from stevedores to security personnel to hotel housekeepers – at Wellington's port, airport and managed isolation or quarantine (MIQ) facilities since mid-February.



Marie Habowska: Most people 'happy and relieved' to be vaccinated.

Community education

Conversations with these people made her realise the key role nurses play in community education. "It's really important to be clear why it's safe, why they can tell their families it's safe and about the clinical trials. They can take that message home – our safety is only as great as the uptake in the community . . . If they can't be confident then we don't get that herd protection – and we want the vulnerable to be protected."

Most were "happy and relieved" to be vaccinated, and for the hesitant few, nurses were mostly able to reassure them.

About 95 per cent of all border and port workers would have had both vaccinations by Easter weekend, she said.

Vaccinators had been working up to 10-hour days and at weekends to get the border workforce vaccinated. "It's high priority and we need to get it done, so Capital & Coast District Health Board [DHB] can get its resources into our own health staff [who are next in line]."

Watching the rapid spread of COVID-19 in previously disease-free nations such as Tahiti, New Caledonia, and the Wallis and Futuna islands was a sobering reminder of the importance of her work.

Habowska said the logistical challenges of handling a vaccine requiring ultra-cold storage "spins your head". But the DHB had thrown its resources behind the immunisation team, with "hundreds" of people organising things behind the scenes. "It's like a military operation – and it all does run like clockwork."

According to the Ministry of Health website, the next phase was border workers' households, which would be run by primary health organisations, then "high-risk, frontline health-care workers".

Habowska was planning a "bit of a rest", before taking up a new role as a nurse educator at Wellington's MIQs. •

$6 million for more Māori, Pacific midwives

A $6 MILLION initiative to triple the number of Māori midwives and quadruple the number of Pacific midwives over the next four years would make a big difference to those communities, chair of NZNO's Pacific Nursing Section 'Eseta Finau says.

"It will make a difference, having someone who understands your culture or who can refer to an appropriate provider or carer."

The initiative – Te Ara ō Hine for Māori and Tapu Ora for Pacific – was launched in March across the country's five schools of midwifery, and will fund financial, cultural, academic and pastoral support.

Less than 10 per cent of midwives identify as Māori and less than three per cent as Pacific, Auckland University of Technology (AUT) national Māori lead Teresa Krishnan said. Yet the population of women giving birth was 20 per cent Māori and 10 per cent Pacific – rising to 27 per cent in south Auckland for the latter.

AUT holds the contract with the Ministry of Health (MoH), and will work with Victoria University of Wellington, Otago Polytechnic, Ara Institute of Canterbury and Waikato Institute of Technology to support Māori and Pacific students.

A liaison person at each institution will provide "wrap-around care" and academic support and will actively recruit Māori and Pacific students. There will also be a discretionary hardship fund for students, Krishnan said.

At the launch, AUT midwifery student Rose Leauga described her struggle to balance family life with study and paid work. "Many of us who come into study find that we have to still remain in paid employment just to pay for travel and parking costs as a student. Because of this, Pasifika students make the tough decision to leave study in order to still be able to work to support their families."

Midwifery student Rose Leauga – a struggle to balance family, study and work.

Pacific liaison staff and mentors provided crucial support. "They were people we could talk to without having to explain cultural nuances that were quite often missed by other staff simply because they could not see it with a Pacific lens." •

MIQ nurses 'shunned' by communities

A SENIOR nursing lecturer says the stigma faced by nurses working in managed isolation or quarantine (MIQ) facilities is "concerning" and nurses should know what they are signing up for.

"It is interesting to think about nurses as protectors of our borders. In a time of war, they would be considered heroes, but for now many are being excluded from the very community they are serving," Ara Institute of Canterbury principal nursing lecturer Isabel Jamieson told *Kai Tiaki Nursing New Zealand*. "We wonder about the ongoing impact this may have on nurses and their families."

Jamieson worked with Ara associate professor Cathy Andrew and Canterbury District Health Board registered nurse Jacinda King to interview 14 of the 84 registered and enrolled nurses working in Canterbury's six MIQ facilities in December, as part of research into nurses' experiences in these facilities.

In preliminary findings, shared at the primary health care nursing symposium in March, nurses described being "shunned" by their communities.

One told of how relatives refused to attend their family barbecue; one had to fight to visit her mother in hospital; others were turned away from public buildings and dentists. One nurse's husband was ostracised from his sports club, and was told; "As long as your wife works there, you cannot be part of the club." One nurse visiting her grandmother on her birthday was offered cake on the doorstep, Jamieson said.

Jamieson said stigmatisation was common during pandemics, and had occurred during the severe acute respiratory syndrome coronavirus epidemic in 2003, which spread from China to four other countries.

"So nurses need to know about this before they 'sign up' for this work," she said.

Caring for "guests" who were detained in isolation was also unusual for nurses, she said. "In the MIQ, the 'patient' is a guest in a hotel that they cannot leave. It is a very unique situation . . . we may need to rewrite the text books." •

Equal pay win for Canterbury MIQ nurses

ABOUT 60 NZNO nurses working in Christchurch managed isolation or quarantine (MIQ) facilities will be getting paid the same rates as their Auckland colleagues, after lobbying from NZNO.

Mary Duggan, Danielle Davies and Gemma Kelley – 'over the moon' at pay rate move.

Organiser Danielle Davies said she and delegates Mary Duggan and Gemma Kelley were "over the moon" after incoming Canterbury District Health Board (CDHB) chief executive Peter Bramley agreed in late March to move the region's MIQ nurses from the DHB registered nurse (RN) to community nursing scale which has higher pay rates.

"This goes a very long way towards helping our members feeling valued as nurses and employees," Davies said.

Davies advised the CDHB director of nursing (DoN) Becky Hickmott in February that Auckland MIQ nurses – who are employed on the community nursing scale – were being paid up to $5500 more annually than Canterbury's, who were on the RN scale. The scales are identical until steps six and seven, on which community nurses are paid higher. It also has eight steps, compared to seven on the RN scale.

The change would take effect from the start of each nurse's employment in MIQs, meaning back-pay of up to a year ago for some, Davies said. She hoped it would be implemented within a few weeks.

CDHB also agreed to move more than 25 nurses on to the correct salary steps to reflect their years of nursing experience, after Davies found in a survey some were being paid less than they should have been. CDHB also agreed that members seconded into MIQs from the DHB would receive a week of special paid leave before returning to their original role, Davies said.

A four-week notice period for MIQ nurses, as required under the NZNO-DHB collective agreement, was also rectified, as some had been appointed with just a one-week notice period, Davies said.

Hickmott told Davies the DHB wanted to express its "gratitude and respect for all of our nurses working so hard to care for our returning residents and their whānau and protecting the New Zealand borders".

"The care they provide is exemplary and it is essential for the safety and wellbeing of all New Zealand."

Davies said she hoped MIQ facilities in Rotorua, Hamilton and Wellington, where nurses were still on RN rates, could now attain pay parity.

Setting a precedent

NZNO organiser Jo Coffey said Christchurch nurses were leading the way and hoped it would set a precedent for other sites.

Davies now planned to keep pushing the CDHB to match incentive payments of up to $6000 per annum made to Auckland's MIQ nurses, after getting a mandate from members.

Davies said she, Duggan and Kelley had lobbied strongly over the pay disparity, which had the potential to become "highly politicised". •

Emergency nurses plead for help

EMERGENCY NURSES are pleading with the Government to urgently step in to alleviate "critical" and unsafe pressures on emergency departments (EDs) and hospitals around the country.

College of Emergency Nurses NZ (CENNZ) chair Sue Stebbeings (right) wrote to the Health Minister Andrew Little in March to "highlight our ongoing concerns regarding the impact of hospital overcrowding on safety in the emergency department".

CENNZ members around the country were expressing concern about patient safety and professional risk "due to staffing and department capacity being overwhelmed on a daily basis", the letter said.

Safe staffing was key to a healthy workplace, Stebbeings wrote. "Daily short-staffing, requests to work double shifts, fatigue and burnout are not. The staffing shortages within our emergency departments have reached crisis point."

Stebbeings told *Kai Tiaki Nursing New Zealand* problems with short-staffing and overcrowding were "not new but had

grown to be almost overwhelming". There was "no capacity" to move patients needing hospital admission out of ED, leaving emergency staff scrambling to care for them as well as new patients coming into ED.

EDs were like "barometers" for systemic problems in hospitals or the health system, Stebbeings said, describing the problem as "complex and multi-factorial.

"It is absolutely a systemic problem. It's not a new problem, it's an escalating problem that has reached crisis point and is widespread in the majority, if not all, of our EDs."

The letter asked for "robust" data to inform safe staffing requirements. CEENZ was also unhappy the implementation of safe staffing system care capacity demand management into EDs had been delayed "without consultation", the letter said. "Further delays to finding solutions for this complex issue will only exacerbate the dilemmas faced by nurses each day and increase the risk of poor patient outcomes."

Stebbeings told *Kai Tiaki Nursing New Zealand* CENNZ was deeply concerned for its members, and "the moral distress nurses feel when they cannot give the care they would like. They are concerned that the environment is unsafe for our patients and our staff".

NZNO professional nursing adviser Suzanne Rolls said demoralised and stressed ED staff were exposed to professional critique by the Nursing Council and complaints from the public – which were increasing at all district health boards.

The minister had not responded to *Kai Tiaki Nursing New Zealand* by deadline. However, Stebbeings said Little had acknowledged the letter, saying he had asked officials to advise him on this matter and would respond "in due course". •

Māori authority must have 'power'

NZNO SUPPORTS a fully autonomous Māori Health Authority (MHA) with the power to create, commission and fund health services for Māori, acting chief executive Mairi Lucas (right) says.

"As an organisation, we support the Māori Health Authority, but it must have full authority," she said.

Differences across Aotearoa

Lucas, who has worked in Māori health for 25 years, said funding and targets had always been problematic. "Not all hauora [health services] are the same, our kawa [protocol] and tikanga [culture] are different across Aotearoa. Our access is different – there is no one-stop shop and different areas' needs are not the same. These are things that Māori understand, they know the issues because they know the people."

The Association of Salaried Medical Specialists and the New Zealand Medical Association also support full commissioning rights for an MHA, as a path to health equity for Māori.

The health and disability system review recommended an MHA and new entity Health NZ be set up alongside the Ministry of Health (MoH). Health NZ would manage contracts and funding, while the MoH would take a "stewardship" role and build its public health capacity.

However, the review panel was divided over how much authority the proposed MHA should have to fund and commission services for Māori. Review leader Heather Simpson recommended funding powers rest with Health NZ. However, a group of panellists has said only a fully empowered MHA would make a difference to Māori health inequities. Health Minister Andrew Little has said any decisions are still several months away. •

Pacific approach 'essential'

PACIFIC COMMUNITIES must be reached through community groups and churches to encourage COVID-19 vaccination, chair of the NZNO Pacific Nursing Section, 'Eseta Finau, says. Any campaign must also be led by Pacific health professionals, she said.

"Ensuring you have Pacific staff, who understand the culture and how to get into the communities – who to contact – is essential."

Currently, she said the vaccine was being mainly promoted through media, but community groups and churches would be more useful. Home visits would also be useful to ensure the vaccination reached the most vulnerable.

"This vaccination programme for Pasifika must be brought to them by ethnic specific Pasifika health workers." •

Making a connection beyond the mask

THE COVID-19 epidemic has highlighted the deep need for more culturally supportive care for critically ill Māori patients, a Waikato critical care nurse says.

Megan Stowers (Ngāpuhi) had been providing cultural support to Māori patients informally in her various roles at Waikato District Health Board (DHB) critical care unit for years. After a conversation with critical care nurse educator Sarah Rogers last year, as COVID-19 emerged, they agreed to formalise her role as a Māori resource nurse.

While there was no salary attached and it was alongside her critical care nursing role, Stowers agreed to it, although it "feels very alone at times" she told *Kai Tiaki Nursing New Zealand*. "I just can't not do anything about this. It's heavy and I am burning out as a mum and a nurse, but I can't let our people come through our unit and not be there for them."

Stowers told the NZNO College of Critical Care Nurses in March that nursing Māori with COVID-19 had been "delicate, complex but honourable.

"The hard thing for Māori was [missing] the kanohi ke ti kanohi – face to face, rongo – the feel, smell and how you perceive a person, and tūhono – the bonding connection you create, which are really important parts of the delivery of care."

Doing this in full protective gear was "nearly impossible", she said. Nurses struggled to provide the holistic, spiritual care expected by whānau Māori when a patient was dying. The emotional burden felt "heavy", Stowers said. "At times we felt really helpless, as we knew there was a crucial part of he korowai oranga – the cloak of wellness – we were unable to provide."

Caring for one Māori patient in isolation, however, had shown the importance of her role. "I shook his hand through two layers of gloves. I looked him in the eye and introduced myself in te reo Māori to establish that connection with him, through whakawhanaungatanga [connecting]. Looking beyond my glasses and my respirator mask, I offered strength and comfort and warmth, hoping he could see the smile in my eyes. Most importantly of all, I got to ask him who he was – ko wai koe mātua? I needed to know who this gentleman was."

Megan Stowers –' That's what I would want to hear when I wake up – my name said properly.'

Taking the time to do this, she said "set the foundation of care for the rest of this man's journey.

"Hours after this conversation, I held his hand while we called his daughter to say her papa was deteriorating and we would need to intubate quite quickly." She became the link with his whānau, who was unable to visit him, keeping them in touch by phone.

'I looked him in the eye and introduced myself in te reo Māori to establish that connection with him, through whakawhanaungatanga.'

This experience was both "special, delicate and scary" for her. After the man died, several of the critical care staff were invited to his tangi – a huge sign of respect, Stowers said.

In her role generally, Stowers identifies Māori patients and introduces herself to them and their whānau – then introduces the whānau to the other nurses. She makes sure the patient has been referred to the hospital's kaitiaki – Māori cultural support worker – and supports colleagues with whakawhanaungatanga protocols, te reo Māori and pronunciation – particularly of names. "That's what I would want to hear when I wake up – my name said properly."

Some colleagues view her mahi as "special treatment," which could be hard. "I make time to make a kaumātua a cup of tea. I will go and collect a family member from the waiting room and walk them in," she said. "Some colleagues are absolutely fine with me doing this, some are used to me doing this and some think otherwise.

"I just want to remind us that in te ao Māori this is normal, this is respectful, and this is the level of care that is expected."

Rogers said the effect of Stowers' work was clear, with happier and calmer whānau in the unit. "They understand what's going on and have a greater level of trust, because they are connected with and trust Megan." She acknowledged the role could be a lonely one and said she and the DHB cultural support office tried to support Stowers.

There had been lots of interest in the initiative from other departments, and she was putting together a role description, hoping it could eventually be resourced and extended to other parts of the hospital, region and country.

NZNO professional nursing adviser Angela Clark said the initiative could be a "trail-blazer" for critical care and/or intensive care units nationwide. "The current health system is not fit for all and we must address disparities and prioritise Māori health experiences and te ao Māori." •

Report by co-editor Mary Longmore

How can nurse leaders fulfil the

A group of nurse leaders at Canterbury District Health Board recently met and pondered how they could fulfil this year's theme for International Nurses Day.

By co-editor Teresa O'Connor

"Radical change" is needed if nurses are to fulfil the mandate of the International Nurses Day (IND) theme: *Nurses: A voice to lead – transforming the next stage of healthcare*.

A group of directors of nursing (DoNs) from across Canterbury District Health Board (CDHB) met with *Kai Tiaki Nursing New Zealand* last month to consider the IND theme. What emerged was the need for radical change in funding, in power structures within health, in nursing education, in service integration and in how nursing is viewed, both within the health system and by the public.

What also emerged was the frustration these DoNs feel at the ongoing underfunding and undervaluation of nursing nationally and the pressure that places on nurses and those they care for. Other frustrations include the continual ignoring of the nursing voice at decision-making tables (the transition unit to implement the review of the health and disability system appears not to include a nurse), the gap between the rhetoric of health policy and the reality of practice and the continuation of competitive funding models that create significant barriers to accessing care.

How to achieve radical change?

But how to achieve the radical change needed and how to overcome the barriers to nursing assuming its rightful place at every health decision-making table did not emerge so readily.

Current and looming nursing shortages, historical power structures in health, ongoing health inequities and the importance of the Māori nursing workforce in ameliorating these, nursing education responsibilities, the impact of digital technologies and the actual nature and location of nursing work all must be considered when pondering the future of the profession.

And defining nursing leadership can often be problematic. Specialist mental health DoN Joan Taylor said all nurses were leaders "within their own families, their communities and in workplaces". Others agreed and acknowledged that DHB nursing leaders were part of a bigger system, which was not just hospital-based.

Becky Hickmott

All agreed with Ashburton and rural health DoN Brenda Close's contention that they did their jobs "so frontline staff can do their jobs"; ideally that they were not so caught up "in daily stuff" and had the space to strategise. But all admitted that the space to strategise was, in reality, too often filled with fighting battles on behalf of frontline staff and with navigating the complexities and demands of the system itself.

Last year, the DoNs decided to focus on developing new nursing leadership as part of celebrating the World Health Organization's International Year of the Nurse and Midwife. They decided to implement the Nightingale Challenge, a global initiative to ensure the development of nurses able to meet future leadership challenges, locally. The Nightingale Challenge, launched by Nursing Now in 2019, aims to develop the leadership skills of early-career nurses. Nursing Now is a global campaign to improve health by raising the status and profile of nursing and operates under the auspices of the International Council of Nurses.

CDHB has chosen 16 nurses from across the DHB, who are all under 35, to be part of the challenge. There are also eight nurses in community and primary health care undertaking the challenge. These nurses attend senior nursing and midwifery meetings and governance meetings. They are also undertaking postgraduate study and professional development in leadership and are being mentored by senior nursing leaders. They have all undertaken a quality improvement project which has taught them how they can create institutional change and make a difference.

Empowering nurses

Recently-appointed executive DoN Becky Hickmott said the nurses were being empowered to drive change and a priority was to ensure the nursing voice was at every decision-making table.

"We want them to be involved in decision-making, to have a political voice, to understand governance. Many of these 16 nurses have told us they had no idea of the scope of senior nursing leadership roles and that is something that has emerged for us – that nursing leadership decisions are often invisible," she said.

The initiative would continue, regardless of whether there was specific funding for it.

All know that courage is needed to tackle the status quo within health, otherwise current inequities and power structures will continue.

"If we continue to do what we have always done, we are not going to see the changes that are needed. Radical change is needed, otherwise we will

International Nurses Day theme?

perpetuate the current system which is not working for many people, notably Māori and Pacific people and other vulnerable populations," Close said. "We have always been predominantly focused on tertiary hospital settings and have not invested enough in other spaces and that message has to be shared at a political level."

Hickmott said, politically, the time had never been better to push that message. "Strategising through a nursing lens, the review [of the health and disability system] is timely. It may provide the impetus for keeping people in the community and ensuring resourcing."

PHOTO: ADOBE STOCK

We have fantastic staff who just give and give and give, so we just ask and ask and ask. But there will come a point when nurses will say 'we can't do this anymore.'

Some hope of change

All felt the review report (commonly referred to as the *Simpson Report*), offered some hope of change, but that a change in power structures – "the structures have been established around the needs of medicine", as one put it – was essential to release the full potential of nursing. And that would not be easy.

Hickmott said the value of being politically connected could not be underestimated. "Our medical colleagues have done that well. Generations of wonderful nurses have not yet managed to shift that basic power differential."

Christchurch Campus DoN Lynne Johnson cited the difficulties of enabling nurse-led discharge at the weekends. The situation reflected the difficulties of changing the status quo and navigating power dynamics, combined with underfunding. Effective, safe nurse-led discharge, when medical staff were not available, depended on adequate resourcing and on adequate resourcing of community agencies. While the negotiations to enable it had taken place, a lack of resourcing created barriers to its success.

Different doors to push through

Close believed the heath and disability review provided some opportunities for nurses "to have different conversations and for different doors to open and for nurses to push through them".

Equity in health care was now on every agenda and would remain so well into the future. But how to measure progress was more difficult. "We have to be doing something other than talking about equity," Close said. Māori nurses felt obliged "to talk in that space" but the onus was on all nurses to fight for equity.

The DoNs pondered how to ensure nurses were able to "get into spaces where we can make the difference".

Close said nurses didn't have enough power, as their voice was not heard where it needed to be heard. Hickmott agreed. "We are the right people to be at the table but how to get the invitation can be difficult. Decisions are being made without us. Everybody should be at the table, but the fact nurses, the biggest workforce in health, are not continues to surprise me," she said.

All the DoNs agreed nurses had the power to mobilise, thus had the power to drive change but were often their own worst enemies. "If we decided to pull the plug, the system would come crashing down. But nurses are very reluctant to do that because they feel strongly that they are 'here for patients and for whānau'," Close said.

And all the DoNs acknowledged the reality of current nursing shortages and the immense stress nurses were under because of short staffing. "We have fantastic staff who just give and give and give, so we just ask and ask and ask. But there will come a point when nurses will say 'we can't do this anymore'," Johnson said.

The pressure on nurses was evidenced in high sick leave and high Accident Compensation Corporation claims, Hickmott said.

All believed care capacity demand management (CCDM) was an "empowering tool" for nurses and nursing. "It is a powerful tool to describe the care delivered. We can use the data derived from CCDM to tell our stories. Data is heard at the board table, rather than stories," CCDM nursing director Janette Dallas said.

It was essential that CCDM data be utilised because nurses' stories of chronic

short staffing had not been heard without accurate data to back them up.

Dallas said nurses were "a little cynical" about CCDM, but "once we start to see some outcomes, they may start to understand the value in the programme".

How to attract and retain people to the profession was a complex issue which all DoNs were grappling with. CDHB nursing leaders had invited career counsellors from secondary schools around the region to a workshop on nursing. The feedback from counsellors indicated some understood the scope of nursing, but others were surprised at the career options within the profession. And the DoNs also felt the public perception of nursing needed to change.

DoNs had "significant roles to play moving forward, if we can continue to attract people into nursing and foster them through", Close said.

The shock between education and clinical reality remained and the unrelenting pressure in the clinical environment was having an impact on all health providers' ability to retain nurses.

Nursing education also had an important role to play. Taylor said undergraduate education was not providing what was needed for mental health, addictions, and intellectual disability.

Hickmott said relationships with the education sector locally were well established, but nursing leaders had to drive the needed changes and to exert their influence at a national level. "What are the education requirements for the future and how can we enable the workforce to work differently to provide health care into the future?" she asked.

The shock between education and clinical reality remained and the unrelenting pressure in the clinical environment was having an impact on all health providers' ability to retain nurses, she said.

The ageing workforce in nursing education mirrored the ageing workforce in clinical practice.

"We want education to be producing resilient nurses, with critical thinking abilities and who are able to work in stressful environments – that's a tough ask for our academic colleagues," Dallas said.

The importance of boosting the Māori and Pacific nursing workforces was also on the minds of the DoNs. CDHB has increased its intake of Māori and Pacific new nursing and midwifery graduates this year. How Māori and Pacific new graduates were recruited was examined and training on perceived or unintentional bias was undertaken. In this year's nurse-entry-to practice/specialist practice programmes, 13 Māori and five Pacific graduates were employed, the biggest in a single intake. "We have managed to turn this equity issue around and will work at continuing to drive the message home," Hickmott said.

But it was "outrageous" that nursing leaders had to contest for funding nationally to provide cultural support for local Māori and Pacific nurses in their new graduate and postgraduate education.

It also "beggared belief" that the funding model for this education hadn't been adjusted by Health Workforce New Zealand since 2011, even though course prices had dramatically increased.

Other threads to emerge from the conversation included:

- The importance of having community, primary health care and private hospital leaders' input to ensure the whole health system ran effectively and the need to break down silos within the wider system.
- The importance of service integration. While work had been done in this area, more was needed.
- The ability of primary health care to transform care delivery. "Bits of that are happening already but not enough of a collective move to create the swell which is needed across the nation," Close said.
- The impact of COVID-19: "Is this our new normal?" acting nurse manager of nursing workforce development Jacinda King asked. While its impact on patients and staff was immediate and ongoing, it would also have a long-term impact on future planning.

Mental health had never considered the need for negative pressure rooms before the pandemic. While Christchurch campus had a new building, the design principles for pandemic areas 10 years ago are not what is required for COVID-19. Future designs will have to take a different approach to airflow, to enhance negative pressure capacity.

- The continuing movement of care into the community, but the importance of remembering there would always be a cohort of very unwell and/or very old people who needed a lot of care. A workforce was needed that could provide that care in hospitals.
- The increasing and continuing pressure on staff, with patient volumes and acuity increasing. If the population in Canterbury stays as it is, all beds in the new Christchurch Hospital would be filled up within a few years, Johnson said. It requires a whole-of-system response to address this.
- The increasing demand for mental health care for children who experienced the earthquakes.
- The plethora of nursing groups – many of which held similar views – potentially diluted the nursing voice.
- The increasing opportunities for nurses, eg nurse prescribing initiatives and the nurse practitioner pathway.

While the DoNs acknowledged there was pressure everywhere in the system and there was no miracle cure for that, they believed "calm, steady, professional leadership" had got people through in the past and would continue to do so.

"Nurses in Canterbury are not unfamiliar with disasters and we will continue to provide that leadership," Hickmott said.

Nursing leaders would continue to fight for inclusion and influence, and to build the capacity and capability of the workforce.

Similar difficulties

The difficulties nursing leaders have in influencing change at the highest levels are in many ways similar to those of nurses at the coalface. While the particulars may be different, the forces behind the challenges – primarily underfunding and rigid power structures – are the same.

While the IND theme can only ever be viewed as aspirational, the struggles of nurses to achieve it – whether at the bedside or in the boardroom – are very real. •

Pandemic's impact on the profession

Nurses have been hailed as 'heroes' for their efforts in the pandemic, but this type of recognition potentially normalises the risks they face, and doesn't accurately reflect their skilled professionalism.

By Patricia McClunie-Trust

As the COVID-19 emergency unfolded internationally, the elimination strategy New Zealand implemented reduced the impact of the pandemic on our population and its health services. Given the severe nature of COVID-19 in overseas populations, New Zealand chose strategic suppression to eliminate community transmission within its borders.[1,2] Decisions were informed by timely evidence, which enabled case detection, contact tracing and quarantine. Together with border closures and community engagement measures, these strategies enabled New Zealand to avoid the worst effects of COVID-19.

Māori, Pacific and Asian people were disproportionately affected in community outbreaks, so elimination of community transmission helped to protect those most at risk, especially those communities that already have inequitable health outcomes.

Across all sectors of the health service, population health has been the focus of the COVID-19 response, especially in terms of preventing infection transmission and providing timely and appropriate patient care.

Challenges for nurses

Nurses have been hailed as heroes in the international media, focusing attention on the collective response of thousands of nurses around the world for their care of people with COVID-19.[3] Nurses' contribution to managing the New Zealand response has been significant across all health sectors, but that contribution has also had its challenges. Nurses working in managed isolation and quarantine (MIQ) facilities have been identified as a particularly at-risk group for contracting the virus and taking it home to their families. These nurses are working in conditions that are uniquely demanding because of staff shortages and the use of facilities that were not designed for infection control.[4]

The impact of nurses' work during the pandemic has created public attention globally.[5] Naming nurses as "heroes' makes the contribution of nursing visible, but at the same time potentially normalises risks nurses are subject to during a pandemic, especially when they are required to work in uncertain and sometimes dangerous conditions.[3] Nurses are held up as outstanding examples of morality because they provide safe, effective, timely and equitable health care in adverse conditions. In an analysis of perceptions of nurses in the pandemic, one group of researchers made it clear that valuing nurses' well-being was equally as important as valuing their expertise.[6] It is important not to minimise the emotional and physical costs of the extra-ordinary responsibilities involved in practising in these circumstances, and the degree of support required to sustain nurses effectively in that practice.

Acknowledge professionalism

It is also important to value professionalism, leadership, knowledge and teamwork as qualities integral to how nurses respond to challenging situa-

tions.[7] A 2020 study examined how rural primary care nurses responded to the challenges of the pandemic.[8] The nurses in this study reported how they took on extended responsibilities to communicate and collaborate with health-care colleagues, local district councils and the public, to safeguard the health of their rural community. For example, they made phone calls to patients with health conditions to ensure they knew what to do and had support during the level 4 lockdown. These nurses increased the level of care they provided to patients to support their welfare and wellbeing, sometimes collaborating with welfare and other organisations.

They also rapidly upskilled their own knowledge on infection control, to support members of the community. Nurses had a leading role in providing education in primary care and rural settings, particularly in transmitting up-to-date health information about COVID-19 and the prevention of transmission.

Reflecting on events since March 2020, I've seen the the COVID-19 pandemic create a sudden shift in how our society and health services function.[9] Learning to do things differently became the hallmark of nurses' response to the pandemic. Born of necessity, a "giant leap toward telehealth"[10] saw a rapid upscaling of virtual care capacity in many health services to enable contact with patients in a socially distanced world. Phone triage or self-triage tools became the first contact people had with health-care providers,[11] utilising technologies that were already available, but not commonly used. Nurses have learnt how to "practise at a distance",[8] an innovation which is likely to become much more common in the future.

Telehealth potentially benefits greater numbers of patients, particularly in the way it reduces barriers such as distance. But for some people, telehealth may not be a perfect solution because – through lack of access to technology – they may be at risk of remaining disenfranchised in our modified world. Geographical location is also an important consideration in New Zealand, with rural areas having less access to adequate connectivity. There are also cultural, age or health related reasons why people are challenged in using technology.

Is telehealth 'equity positive'?

Māori and Pacific people carry a disproportionate burden of chronic disease and report high rates of unmet health needs through lack of access to services.[9] Whether telehealth can be an "equity-positive tool" in overcoming some of the barriers to health care for Māori and Pacific people remains to be seen.[9] Nurses will need to be careful to mediate factors that distance people from telehealth services, particularly in maintaining person-centred and culturally safe nursing practice.

Teaching online

Over recent years, New Zealand tertiary education providers have followed the international trend towards blended learning in nursing education to better meet the needs of contemporary students.[12] Blended learning approaches generally involve both online and practical or face-to-face sessions, with some delivery of content and resources online. But the COVID-19 lockdown resulted in nursing courses being delivered fully online, at least for the first part of the lockdown. New Zealand nurse educators rapidly "flipped" classes and workshop sessions to fully online modes, using a combination of video-conferencing and online activities to avoid disruption of students' learning.

It was evident during this transition to working fully online that nurse educators were skilled users of digital platforms

and had a good understanding of the challenges and benefits of online learning for students. When delivered well, blended learning has a positive impact on student achievement because it overcomes some barriers to learning, such as time and distance.[12] Further research is needed to understand the impact and experience of teaching and learning fully online for both students and nurse educators, because it is likely the scale of online learning has increased in many programmes.

Patricia McClunie-Trust

COVID-19 also disrupted nursing research and scholarship, often requiring changes to research protocols and subsequent revision of institutional ethics approval to conduct research differently to what had been proposed.[13] I was involved in a research team exploring the experiences of registered nurses becoming designated prescribers during 2020. Once the state of emergency was declared in New Zealand, requiring isolation and social distancing, we were unable to continue face-to-face interviews and had to seek an amendment to our ethical approval to collect data via virtual means, using Zoom videoconferencing.

Less time to contribute

The challenging situations that nurses were experiencing in primary care settings also meant that nurses had less time to contribute to anything outside their work role. Working together in a research team to analyse data and write research reports was also compromised without suitable alternatives.[13] Our research team was based in different locations, so we used "team management software" for planning and tracking our progress in conducting the research and collaborative writing sessions. It is likely we will continue working with this medium for future studies, because we can collaborate in real time and save time on travel to meetings.

It is possible that some researchers have experienced reduced productivity over the past year due to the changing demands and priorities of work environments, but at the same time the experiences of patients, families and nurses during the pandemic have provided a fertile ground for ongoing research.

The COVID-19 pandemic has made nursing visible in the media and the minds of the public, but that representation is not necessarily an accurate depiction of what nurses know and do in their everyday practice. It does not account for the knowledgeable, skilful, creative and capable practice that nurses contribute to health services,[7] particularly in times of crisis. New Zealand nursing leader Jenny Carryer argues that now is the time to challenge historical constructions of nursing. It is time to emphasise what nurses have achieved in leading change in clinical, academic and research roles while the health of our population has been so threatened.

It is also time to support our nursing leaders in challenging structural weaknesses in our health system, and the policies and politics that govern it.

It is also time to support our nursing leaders in challenging structural weaknesses in our health system, and the policies and politics that govern it. The pandemic has highlighted gaps in the health workforce, and chronic underinvestment in public health, and ongoing risks for our population who are already under-served by current arrangements.[7]

The pandemic has given nursing more visibility and a stronger voice to lead change and influence health policy and practice,[6] so we need to avoid limiting our potential by challenging historical representations of nurses. Nurses, individually and collectively, are responsible for representing ourselves as expert capable members of a profession that is the core of New Zealand's health service. •

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Childhood obesity – giving the best care

The causes of obesity in children and young people are myriad and complex. To deliver the best care, nurses need to be aware of these multiple determinants and tailor care accordingly.

By Kirsty Ure

While statistics on childhood obesity differ, they all point to the fact the issue is an ongoing problem in New Zealand. Children who live in lower socio-economic areas, as well as Māori and Pacific children, are consistently over represented in these statistics.[1,2]

A survey by the Ministry of Health (MoH) in 2018/19 found that 11.3 per cent of children were obese, and Māori children were 1.6 times more likely to be obese than those of New Zealand European ethnicity.[3]

There are differences in the rates of childhood obesity between communities, which can be explained, in part, by ethnicity or economic deprivation, but also by the composition of the community.[4] This latter predictor of childhood obesity can be due partly to availability of food outlets, such as supermarkets or fast food outlets, transport options and leisure resources.

Ante-natal predictors

Obesity in childhood is a strong predictor of obesity throughout adult development.[5] These predictors can start before birth, with maternal obesity and a poor maternal diet ante-natally. A high infant birth weight is also a predictor for obesity.[6] These findings are true across ethnicities.[1,7] Co-morbidities of obesity can include poor cardiovascular health, obstructive sleep apnoea, sleep issues, psychological issues, type 2 diabetes and poorer social outcomes.[1,6,7] So obesity in early childhood can lead to further hurdles and less positive health outcomes throughout the lifespan.

To assist health professionals working with children from two to 18 in managing weight and combating childhood obesity, the MoH has developed clinical guidelines.[8] These suggest four stages: monitoring, assessing, managing and maintaining. These guidelines are aimed at health professionals working with families in a clinic setting. They emphasise the need for cultural competence for all health professionals working in this specialty area. They suggest early action, if a child is overweight. The guidelines also emphasise the importance of practitioners taking time with the family, of tailoring their communication style and of building relationships. They also stress the importance of recognising and working with Māori health providers, as well as community-based providers, to ensure better access to services and consistent, comprehensive education and advice.[8]

Internationally, clinical guidelines published in the *British Medical Journal* also suggest preventative measures, such as promoting breastfeeding, and school-based interventions. They acknowledge that obesity in children has multi-factorial causes, including behavioural, cultural, genetic and environmental.[9]

The MoH also supports nurses in schools, fruit in schools, breastfeeding promotion and nutrional information to help combat childhood obesity.[3] And the first *New Zealand Child and Youth Wellbeing Strategy*, released in 2019, includes the goal of reducing food and housing insecurity.[10]

Parental perception of a child's weight status can be one of the first barriers to helpful intervention.[11] Research has found that parents' perception of their child's weight does not differ with ethnicity – all parents tended to underestimate the issue.[11] Children presenting to paediatricians in secondary care have a higher rate of obesity than in the general population. This, together with the fact many at-risk children will see a secondary health care service more often than their GP, makes hospital a great starting point to address childhood obesity.[12]

Although health professionals may be in a good position to start this conversation, researchers found that a formal diagnosis of obesity is made in only 17.2 per cent of children seen by paediatricians.[12] While Māori children have a higher rate of obesity, they also have a lower rate of diagnosis, in turn leading to a lower level of investigations and potential management.[12] Health profession-

PHOTO: ADOBE STOCK

Obesity in early childhood can lead to further hurdles and less positive health outcomes throughout the lifespan.

als need to be recognising and addressing obesity issues as early as possible, as this may be the best possible time to start change for a healthy future.

Barriers to services

Other barriers to accessing services included false or conflicting information. Families could be led to believe things such as healthy food is only food that is fresh or that canned food is unhealthy.[13] Health-care services that are biased, judgmental, or where the health-care professional indicates they do not have enough time, knowledge or tools to address the issue, will also negatively affect outcomes.[14]

The health-care professional needs to be clear and sensitive when delivering information, as the information can be challenging if parents/caregivers are also obese, as they may feel confronted by the discussion.

Past negatives experiences of health services can affect Māori families' willingness to attend health clinics.[1] Culturally appropriate services need to be more than just tokenism; they need to be integrated into the service as a whole,[15] and into policy. An Australian study of childhood obesity, specifically targeted at Māori and Pacific peoples, found one of the most important determinants of success was having health-care workers from within the local community who were themselves Māori or Pacific.[15] They both ran the service and delivered the care.[15]

A similar result was also found in the review of the Whānau Pakari study in Taranaki,[16] in which childhood obesity was addressed by health-care workers visiting homes. This was an attempt to de-medicalise the issue and provide holistic interventions. Key suggestions from the review of the progamme included incorporating a Māori worldview into the service and that public policy was aimed at ensuring services were available, accessible and appropriate.[16]

Unmet social needs, such as housing or food insecurity, lead to poorer outcomes.[17] Any childhood obesity programme needs to include dietary, physical activity and behavioural interventions to meet its goals. Cultural appropriateness is also critically important. Māori have a world view of balance between the mental/physical/family/social and spiritual domains. A reflection of this world view at government policy level may help in achieving success in childhood obesity interventions, where so many have failed.[18]

The social determinants of health must be included in interventional programmes. Determinants, such as living and working conditions, behaviours and biology, and psychosocial factors of the individual,[19] are often included, but structural determinants need to be included too. These include the socio-economic and political contexts (social policies, public policies, cultural and societal values and governance) of the individual, as well as the person's socio-economic situation, gender, social class, income, occupation, education and race.[19] Race and socio-economic position are both structural determinants of health, and both have been identified as major factors in childhood obesity.

In one study, parents identified the cost of food, followed by the ease of access to takeaway foods, as the most important determinants of childhood obesity.[20]

Although education on nutrition is important for families, this cannot be done without consideration of their economic and social circumstances. In one study, parents identified the cost of food, followed by the ease of access to takeaway foods, as the most important determinants of childhood obesity.[20] This was true, regardless of ethnicity. As parents and caregivers play a key role in childhood obesity, their perceptions need to be considered, and the cost of food, access to it and the time taken to prepare it all play a big role.[20] To ignore these factors while discussing childhood obesity with a family, can make achieving change seem unrealistic.

Health promotion ideally includes the structural determinants of health, and promotes better health outcomes across communities and society. For this to be achieved, the community has to be willing, and then empowered and then self reliant. This may foster a change and a move away from health professionals being the provider of services.[21]

Health promotion for Māori needs to acknowledge a secure cultural identity, as this is a prerequisite for good health. Ngā manukura (leadership) and te mara whakahaere (autonomy) are also important for health promotion in a community; without these, interventions will be less effective.[22] A good model of health promotion also includes mauriora (access to te ao Māori), waiora (environmental protection, as people and the environment are connected), toiora (healthy lifestyles and reduced risk-taking behaviour) and te oranga (the participation of people in society, including decision making).[22] To incorporate this model into all health promotion policy would help promote a community focus and hopefully reach more children at risk of obesity.

Different understandings

Health practitioners must also realise the concept of childhood and family may differ between cultures. Family may mean one thing to New Zealand European children, while whānau may have a different meaning in Māori culture.[23] When considering health promotion for childhood obesity, it is vitally important health professionals understand who they need to engage with in the child's environment.

When considering interventions for children, the stage of a child's development must be taken into account. Community-based interventions that deal

with primary school children, need to consider that children may only be able to process information that is in keeping with their reality and their experience.

The messages on childhood obesity are not only aimed at the adults in the family. Many organisations have now embraced the idea of using children as agents of change. The idea of including children as change agents is that, having been taught about healthy activity and nutrition, they will, in turn, teach their caregivers. However, this puts responsibility on the individual child. It is important to recognised that children are often very malleable and placing such responsibility on them can have some potentially negative effects.[24] Such effects could be that the burden of this responsibility can lead to anxiety in the child, and that caregivers can feel their child has been "brainwashed" and is now acting as a "judge" in the home.

Many children and adolescents have issues with body image, and therefore these programmes have potential to cause harm.[24] There is definitely a need to teach children about healthy eating and nutrition, but sensitivity and an understanding of a child's or young person's developmental stage is essential.

Child-centred care

Many paediatric centres will believe they practise family-centred care. While not new, this model of care is often interpreted vaguely and with some challenges.[23] Some paediatric centres and services are currently exploring a model of child-centred care. In child-centred care, the child is more active in their care and is recognised in the context of their family and their development.[23] A very dependent young baby still has the same rights as a very vocal five-year-old or teenager. An obese child must have their rights recognised, and their opinions taken into account for any health progress to be made. But do practitioners know how to implement child-centred care? It appears that practice has not yet moved forward enough to support this, as, to my knowledge, most cities still have referrals to clinics, not holistic family programmes.

Intervention programmes can have poor referral rates, poor adherence, and consequently poor success.[12] Holistic and culturally appropriate services, with the authority to run themselves according to the needs of their community, are likely to have more success at reaching children at greatest risk of obesity.[15,21] New Zealand is currently only providing such services sporadically. Looking to the future of childhood obesity programmes, interventions need to consider the most at-risk groups, the barriers to children and their families engaging with programmes and the importance of keeping the child/young person at the centre of all interactions. •

** This article has been reviewed by Donna Burkett, senior lecturer in the School of Nursing, Otago Polytechnic/Te Kura Matatini ki Otago and the co-editors.*

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Positive colleagueship

Sometimes the worst thing about work is your colleagues, but often the best thing about work is your colleagues.

By Shelley Jones

I don't know whether it's prevalence of negative work relationships or their impact, or the combination of both, but recently I've been thinking (as have others[1]) that it seems hardly an issue of *Kai Tiaki Nursing New Zealand* goes by without an article on bullying.

As it turns out, a Gale search by NZNO librarian Heather Woods found 52 articles in *Kai Tiaki* with "bullying" as the main topic in the years 2007-2021. This search also turned up the helpful insight that bullying would be a focus for *Kai Tiaki* in 2020.[2] That independent editorial commitment resonates with calls for NZNO to address bullying as a strategic priority.[3]

What I'm interested in is how nurses survive – and sometimes even thrive – given the unavoidable stressors inherent in patient/client care . . .

Organisations can try to stamp out bullying by, rightly, declaring zero-tolerance policies and implementing procedures for reporting bullying behaviour and upskilling targets to defend themselves. But that is not enough. In the pursuit of wellbeing at work, health service organisations must commit to dealing with the root causes of tension and conflict, such as barely manageable workloads, frenetic pace, change fatigue, and high staff turnover.[4] And while it's important organisations promote personal resilience for staff and a culture of respect at work, these are also only partial answers to systemic problems.[5]

What I'm interested in is how nurses survive – and sometimes even thrive – given the unavoidable stressors inherent in patient/client care and what would otherwise be avoidable stressors in the work environment. Part of the answer must rest with us.

Many years ago, I learned a great lesson from a colleague, Susie Bull. I was grumpy about something that had happened in our workplace, and Susie wasn't. In fact I was surprised to find that she had quite a different perspective. How come? *"I try to turn it around and look at it another way,"* she said.

Turning negative to positive

So, in the spirit of her example, I would like to turn a few negative ideas around into positive ideas. For instance, if bullying can be defined as *". . . a continual and relentless attack on other people's self-confidence and self-esteem"*,[6] what would the opposite look like? "Consistently appreciating and valuing others' skills and inherent worth"?

Examples of incivility include excluding others, dismissing another's ideas or opinions, and making demeaning or derogatory remarks.[7]

In contrast, civility just seems a reasonable way to conduct oneself – welcoming and including people, respecting others' ideas and opinions, seeking to understand their perspective, trying to be aware of one's own unconscious bias. What does it take to turn a risk factor into a protective factor for wellbeing at work? The smallest kindnesses, acknowledgements and appreciations from colleagues add up to making the people you work with one of the best things about your job.

It seems particularly timely to be writing about colleagueship for the last issue of *Kai Tiaki* with which long-standing co-editor Teresa O'Connor will be involved. Not only because in that role she has been, for 29 years, an articulate advocate within nursing, but also because she wrote an especially meaningful appreciation of what nurses do – an account of skilful and respectful nursing at the end of her mother's life. Though describing her own deeply ambivalent membership of our profession, she wrote that this *". . . recent exposure to the essence of nursing . . . restored my faith in the fundamental goodness at the heart of our profession"*.[8]

We should not hesitate to call out disrespectful behaviour, nor resile from acting collectively to address the stressors and pressures that predispose to unhealthy work environments. We could accept various forms of negative colleagueship as dismayingly inevitable or ineradicable. But perhaps it is more empowering and enabling to believe in the fundamental goodness of the overwhelming majority of our colleagues, and act on that. •

Shelley Jones, RN, BA, MPhil, works independently in professional development for nurses. She believes the fundamental goodness at the heart of nursing is a foundation for shared resilience among colleagues. She runs a workshop on *Personal Resilience and Positive Colleagueship*.

Shelley is grateful for the critical peer review of this article by colleague Faith Roberts, a staff nurse in Wellington Regional Hospital's Main Outpatients, whose professional interests include how we support nurses in frontline roles.

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PHOTO: ADOBE STOCK

Type 2 diabetes:

Two new medications offer fresh management paradigm

Current international guidelines for type 2 diabetes management include the use of two new classes of medication: sodium-glucose cotransporter-2 (SGLT2) inhibitors and glucagon-like peptide-1 (GLP-1) receptor agonists, in people with established kidney disease, heart disease or heart failure, or with high cardiovascular risk.[1] These new agents can reduce mortality and cardiovascular events, including heart failure, and reduce progression of renal failure. As of February 1, 2021, the SGLT2 inhibitor empagliflozin is funded for type 2 diabetes in New Zealand under Special Authority. The GLP-1 receptor agonist dulaglutide will also be funded, once approved by Medsafe.

Since nurses play a pivotal role in supporting patients with diabetes, they will need to become familiar with these medications and their place in management of type 2 diabetes.

BACKGROUND

New Zealand population

More than 250,000 people have diabetes in New Zealand, with 90 per cent of these estimated to have type 2 diabetes. The prevalence of type 2 diabetes increases with age and parallels the increased population prevalence of obesity, with known risk factors such as a calorific diet, low physical activity, family history and genetics. People of Pacific, Indian and Māori ethnicities are affected at an earlier age than those of European ethnicity. At the age of 55, the proportion of people with diabetes is approximately 35 per cent in people of Pacific and Indian ethnicity, 20 per cent in Māori and eight per cent in New Zealand Europeans (see Figure 1, p21). Although socioeconomic deprivation is associated with an increase in diabetes prevalence, there still appears to be a higher prevalence among people of non-European ethnicity, particularly Pacific peoples, Māori and people of Indian ethnicity (see Figure 2, p21).

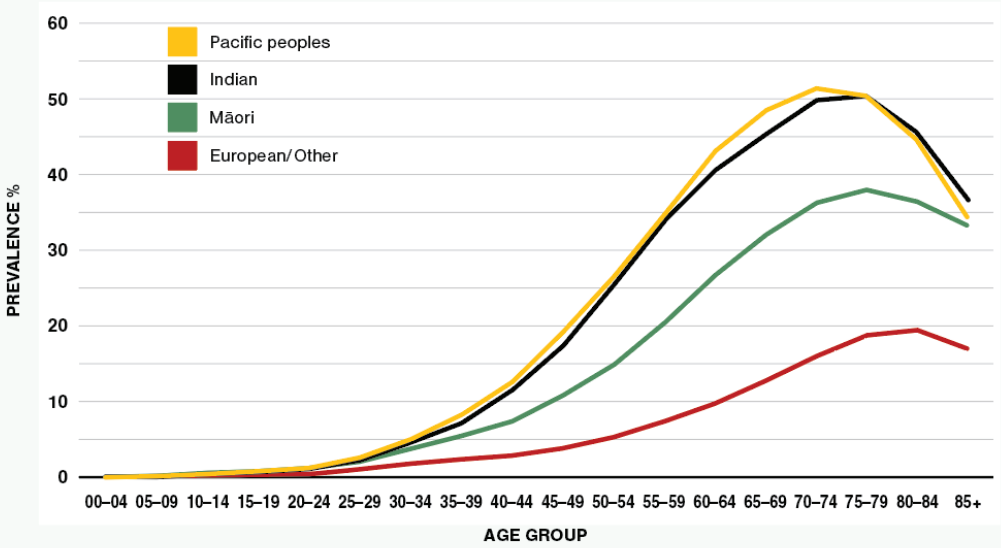
Sustained hyperglycaemia leads to microvascular and macrovascular complications, which are amplified by other

Focus on medicines equity

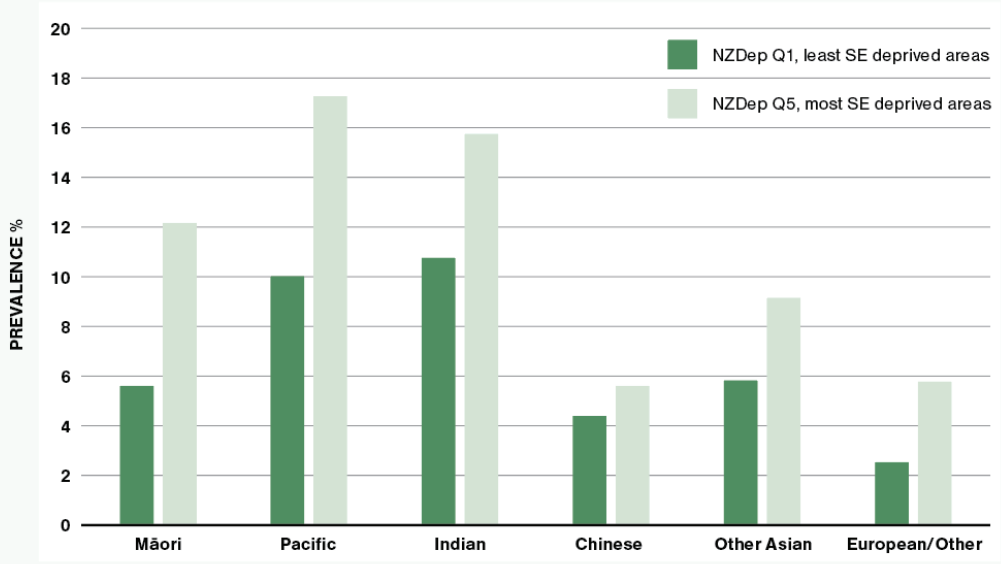
THIS ARTICLE is the second in a series supplied by He Ako Hiringa (www.akohiringa.co.nz) to support nurses' professional development.

He Ako Hiringa is a clinical education programme for primary care clinicians, funded by PHARMAC Te Pātaka Whaioranga to raise awareness of health inequities and improve access to funded medicines. Priority populations include Māori, Pacific peoples, rural communities, former refugees, and those living in high socioeconomic deprivation.

He Ako Hiringa is focusing on four conditions significantly amenable to treatment with medicine: asthma, cardiovascular disease, diabetes and gout. Five main drivers of medicine access equity have been identified: medicine availability, accessibility, affordability, acceptability and appropriateness. Nurses can have a huge impact on these drivers. •



▲ **FIGURE 1. Prevalence of diabetes in New Zealand in various age groups stratified by ethnicity.** Source: Adapted from Chan WC, Lee M (AW), Papaconstantinou D, (2020) Understanding the heterogeneity of the diabetes population in Metro Auckland in 2018. Auckland: Counties Manukau Health



▲ **FIGURE 2. Prevalence of diabetes in New Zealand by ethnicity and socioeconomic (SE) deprivation.** Source: Adapted from Chan WC, Lee M (AW), Papaconstantinou D, (2020) Understanding the heterogeneity of the diabetes population in Metro Auckland in 2018. Auckland: Counties Manukau Health

cardiovascular risk factors, such as elevated blood pressure and lipid levels, smoking, renal disease and increased age. Almost universal screening for diabetes as part of annual cardiovascular risk assessments means that more new cases of type 2 diabetes are screen-detected, rather than symptomatically diagnosed many years after diabetes onset. Unfortunately, the proportion of people with poor diabetes control still appears to be rising and an increasing number of people with diabetes require dialysis, and experience cardiovascular events and premature death. Māori and Pacific peoples are over-represented in the proportion of patients with type 2 diabetes and poor glucose control, and in those who experience complications of diabetes.

Classification and diagnosis of diabetes

Diabetes is indicated by an elevated HbA1c (glycated haemoglobin) test or elevated fasting glucose, with or without symptoms of diabetes such as polyuria and polydipsia, blurred vision, weight loss and fatigue. In asymptomatic cases, two HbA1c readings above 50mmol/mol (or fasting glucose above 7mmol/L) are required to diagnose diabetes. When symptoms are present, one laboratory test is diagnostic. Careful enquiry will often reveal a history of osmotic symptoms. After diagnosis of diabetes, correct classification is critical for ensuring people receive appropriate treatment and management.

Type 1 diabetes is caused by the autoimmune destruction of pancreatic beta cells, and results in severe insulin deficiency. Insulin replacement (usually with multiple daily injections or through an insulin pump) is required. The presentation of type 1 diabetes may be latent – an absence of a clear family history of type 2 diabetes and poor response to oral therapy may indicate latent autoimmune diabetes in adults (LADA), especially in the slimmer patient. The presence of glutamic acid decarboxylase antibodies will confirm diagnosis and the patient should be referred for specialist investigation.

Patients with **type 2 diabetes** continue to produce substantial amounts of

their own insulin and therefore respond to non-insulin therapy and have more stable glycaemia. In type 2 diabetes, hyperglycaemia occurs due to a combination of metabolic factors that culminate in insulin resistance and eventual insulin deficiency, as the pancreatic beta cells no longer produce sufficient insulin to compensate. Excessive insulin production in response to obesity-related insulin resistance can result in visceral deposition of fat, contributing to fatty liver disease. People with type 2 diabetes often have a reduced incretin response to food. Incretin hormones, such as GLP-1, are usually secreted by the intestinal mucosa and enhance insulin secretion, slow gastric emptying, increase satiety, and inhibit the action of glucagon (glucagon stimulates glycogenolysis and increases blood glucose levels).[2]

Type 2 diabetes usually requires progressively more treatments

As insulin production declines, progressively more treatments are required. Weight loss through lifestyle changes, as well as glucose-lowering therapies and other medications targeting cardiovascular risk, can lower morbidity and mortality in people with type 2 diabetes.

Recent cardiovascular and renal outcome trials show SGLT2 inhibitor and GLP-1 receptor agonist medications provide multifactorial benefits in patients with diabetes. These agents can reduce cardiovascular disease (CVD), renal disease, heart failure and mortality when used alongside existing therapies, and international guidelines[1] now recommend these disease-modifying treatments be prescribed for appropriate patients.

It is important to consider these new medications for all people with type 2 diabetes, alongside existing medications, lifestyle modification, low-energy diets and bariatric surgery.

General practice teams need to become confident in introducing these medications to patients with CVD, renal disease or risk factors for these.

New diabetes drugs have significant cardiovascular and renal benefits

Metformin and lifestyle change remain the standard management approach in patients with a new-onset diabetes diagnosis. However, updated management guidelines recommend the use of SGLT2 inhibitor and GLP-1 receptor agonist medications to produce significant cardiovascular and renal benefits, in addition to their glucose-lowering ability. These beneficial effects appear to be independent of the magnitude of glucose lowering and are additional to other desirable effects of these medications in promoting weight loss and a low risk of hypoglycaemia (see Panel 1, p23).

It is critical that health-care providers consider SGLT2 inhibitors as organ-protective agents rather than merely glucose-lowering drugs.

The main change in the international guidelines[1] is the removal of a need for glycaemic control to add a medication with cardio-renal benefit; however, there is an HbA1c requirement for funded use of these medications in New Zealand for rationing purposes (see Panel 2, p24).

The beneficial effects of these drugs do not appear to be mediated through glucose lowering and are seen irrespective of patients' HbA1c level at baseline. In fact, there is emerging evidence that benefits in chronic kidney disease (CKD) and CVD occur even in patients without diabetes.

The main advantage of these drugs and reasons for using them is their beneficial effects on heart failure, kidney disease and cardiovascular death, with the positive side benefit on blood glucose.

Diabetes prevalence in NZ

250,000

people in NZ have diabetes. Of these, 90% have type 2 diabetes.

At age 55,
who has type 2 diabetes in NZ?

PHOTOS: ADOBE STOCK

35% of Pacific people

35% of Indian people

20% of Māori people

8% of European people

SOURCE: https://countiesmanukau.health.nz/assets/About-CMH/Reports-and-planning/Diabetes/2020_Understanding_the_Heterogeneity_of_the_diabetes_pop.pdf

SGLT2 inhibitors protect organs

SGLT2 inhibitors decrease renal absorption of glucose, leading to increased excretion of glucose, weight loss of 2-4kg and modest lowering of blood pressure. There is no hypoglycaemic risk unless they are used with other medications that could cause hypoglycaemia. SGLT2 inhibitors appear to have a class effect on reducing glucose, heart failure and renal function decline, and empagliflozin has demonstrated cardiovascular benefits. This class of medications also lowers serum uric acid and reduces the incidence of gout by 40 per cent in observational studies.

It is not yet fully understood how these medications produce the unexpected benefits for the heart and kidneys, although it is thought to be related to natriuresis (sodium excretion via the kidneys). It is critical that health-care providers consider SGLT2 inhibitors as organ-protective agents rather than merely glucose-lowering drugs.

Panel 1. SGLT2 inhibitor or GLP-1 receptor agonist:

Which to choose:

- There is a clear benefit for SGLT2 inhibitors in reduction of heart failure compared with GLP-1 receptor agonists, which produce no direct benefits on heart failure.
- Clear renal benefits are seen with SGLT2 inhibitors, and results from several GLP-1 receptor agonists studies have shown reduced macroalbuminuria and slower eGFR decline.
- Patients with moderate to severe CKD will benefit from glucose-lowering and slowing of eGFR decline with GLP-1 receptor agonists.
- In moderate to severe CKD, SGLT2 inhibitors will slow renal decline but not lower glucose.
- Patients wishing to lose weight would benefit from GLP-1 receptor agonists over SGLT2 inhibitors.
- Dulaglutide is available as a once-weekly preparation. Teaching injection technique should not be a deterrent, as this is very simple with automated pens, tiny needles and simple dosing.

Starting SGLT2 inhibitors

Care is needed to avoid volume depletion, and there is an increased risk of genital fungal infections (approximately four per cent incidence) and a rare risk of ketoacidosis with normal blood glucose concentrations (approximately 0.1 per cent incidence). These medications should therefore be stopped if the patient is fasting or severely unwell. Patients need to be reminded to seek medical attention and must have their ketones checked if they present feeling unwell with nausea, vomiting or abdominal pain.

Dose adjustment of background diabetes medications

When adding an SGLT2 inhibitor, there is no need to adjust the dose of background treatment with metformin or dipeptidyl peptidase-4 (DPP-4) inhibitors, as the SGLT2 inhibitor will not cause hypoglycaemia itself. For patients already taking a sulfonylurea, the sulfonylurea dose may need to be reduced or stopped (if they develop hypoglycaemia). A patient already on insulin may require a 10-20 per cent reduction in insulin dose, depending on HbA1c and fasting glucose levels.

Use in renal disease

Cardiovascular benefits, including those related to heart failure, extend to patients with type 2 diabetes and estimated glomerular filtration rate (eGFR) reduced

Metformin and lifestyle change remain the standard management approach in patients with a new-onset diabetes diagnosis. However, SGLT2 inhibitor and GLP-1 receptor agonist medications are now recommended for significant cardiovascular and renal benefits, in addition to their glucose-lowering ability.

PHOTO: ADOBE STOCK

to 30mL/min/1.73m^2. However, the glucose-lowering effects are seen largely in those with higher eGFR.[3,4,5]

GLP-1 receptor agonists: Don't be deterred by injectables

GLP-1 is an incretin hormone synthesised and secreted by the gut in response to nutrient intake. It stimulates insulin secretion by pancreatic beta cells in response to rising blood glucose levels, promotes satiety and results in body weight loss, as well as a lowering of blood pressure and lipid levels.

How GLP-1 receptor agonists reduce cardiovascular events is unclear, as benefits are seen even in patients who don't have changes in body weight or lowering of blood pressure or lipid levels. They likely act to decrease inflammation, to stabilise atherosclerotic plaque and prevent development and progression of atherosclerotic disease, as well as preserving renal function. Some, including dulaglutide and liraglutide, have proven cardiovascular benefits.

The main side effects are transient nausea, vomiting and diarrhoea, occurring in 10-20 per cent of patients, which usually subsides within one to two months. Injection-site reactions have been described. Experience is limited in the use of GLP-1 receptor agonists in patients with gastroparesis, so these drugs are not recommended for these patients.

Dose adjustment of background diabetes medications

When adding a GLP-1 receptor agonist, there is no need to adjust the dose of background treatment with metformin, as the GLP-1 receptor agonist will not cause hypoglycaemia itself. For patients taking a DPP-4 inhibitor, eg vildagliptin, the DPP-4 inhibitor should be stopped and replaced by the GLP-1 receptor agonist. If a patient is already on a sulfonylurea and a GLP-1 receptor agonist is added, the sulfonylurea dose may need reducing or stopping to prevent hypoglycaemia. A patient already on insulin may require a significant reduction in insulin dose when a GLP-1 receptor agonist is added, depending on HbA1c and fasting glucose levels.

Panel 2. Special Authority criteria for subsidy of empagliflozin, empagliflozin with metformin, or dulaglutide

Initial application is from any relevant practitioner (including GPs, nurse practitioners and pharmacist prescribers). Approvals valid without further renewal, unless notified, for applications meeting the following criteria:

All of the following:

1) Patient has type 2 diabetes, and

2) Any of the following:

- **2.1 Patient is Māori or any Pacific ethnicity, or**
- **2.2 Patient has pre-existing cardiovascular disease or risk equivalent*, or**
- **2.3 Patient has an absolute five-year cardiovascular disease risk of 15% or greater according to a validated cardiovascular risk assessment calculator, or**
- **2.4 Patient has a high lifetime cardiovascular disease risk due to being diagnosed with type 2 diabetes during childhood or as a young adult, or**

2.5 Patient has diabetic kidney disease, and**

3) Target HbA1c (of 53mmol/mol or less) has not been achieved despite the regular use of at least one blood-glucose lowering agent (eg metformin, vildagliptin or insulin) for at least three months, and

4) SGLT2 therapy will not be funded if patient is taking a funded GLP-1, and vice versa.

Criteria 2.1-2.5 describe patients at high risk of cardiovascular or renal complications of diabetes.

** Defined as: prior cardiovascular disease event (ie angina, myocardial infarction, percutaneous coronary intervention, coronary artery bypass grafting, transient ischaemic attack, ischaemic stroke, peripheral vascular disease), congestive heart failure or familial hypercholesterolaemia.*

*** Defined as: persistent albuminuria (albumin:creatinine ratio greater than or equal to 3mg/mmol, in at least two out of three samples over a 3-6 month period) and/or eGFR less than 60ml/min/1.73m^2 in the presence of diabetes, without alternative cause.*

Summarised from PHARMAC press release, December 21, 2020[8]

Use in renal disease

Dulaglutide can be used without dose adjustments in patients with mild or moderate renal impairment (eGFR >30mL/min). If a patient has type 2 diabetes and either CVD risk or CKD risk, including persistent microalbuminuria, they may benefit from an SGLT2 inhibitor or a GLP-1 receptor agonist.

What is the place of older diabetes drugs in the new NZSSD guidelines?

SGLT2 inhibitors and GLP-1 receptor agonists will add to the variety of diabetes medicines already in the health-care provider's toolbox, some of which are described here.

DPP-4 inhibitors

DPP-4 inhibitors work by inhibiting the breakdown of endogenous incretin hormones. DPP-4 inhibitors increase GLP-1 twofold to threefold, whereas injectable GLP-1 receptor agonists increase GLP-1 eightfold to tenfold. DPP-4 inhibitors such as vildagliptin are increasingly replacing sulfonylureas as second-line agents, as they do not cause hypoglycaemia on their own and are weight neutral. However, DPP-4 inhibitors are generally less effective than sulfonylureas in lowering HbA1c.

While cardiovascular safety studies of vildagliptin have proven its safety, it is generally considered to have a neutral effect on CVD.[6] Hence, in anyone with significant CVD, heart failure or renal risk, DPP-4 inhibitors should be considered a third-line treatment after SGLT2 inhibitors.

In patients *without* cardiovascular risk factors, heart failure or CKD, early combination therapy of vildagliptin with metformin should be considered. The VERIFY study[7] indicated that patients who commenced dual therapy when HbA1c was 48-58mmol/mol had a longer period of time with a HbA1c <53 mmol/mol than those who received sequential therapy with vildagliptin after failing metformin monotherapy.

Sulfonylureas and thiazolidinediones

Sulfonylureas and thiazolidinediones (TZDs) are the last choice of drugs in the new European Union (EU) and United States (US) guidelines for type 2 diabetes.[1] These therapies are used for glucose-lowering in situations where cost is a major issue and/or there is a reluctance to use insulin to control glycaemia. They have been widely used in New Zealand.

Sulfonylureas close potassium channels at the surface of the pancreatic beta cell and lead to insulin release. The major side effect of sulfonylureas is hypoglycaemia, as insulin is released irrespective of blood glucose levels. For this reason, patients must pay closer attention to managing the balance between carbohydrate intake and activity and will need to monitor their blood glucose levels.

Pioglitazone is the only drug still available in the TZD class. It binds to the nuclear peroxisome-proliferator-activated receptor and modulates gene expression, which improves insulin sensitivity. Pioglitazone does not cause hypoglycaemia and is preferred over sulfonylureas if there is a compelling need to minimise hypoglycaemia. Pioglitazone leads to triglycerides reduction and improved fatty liver disease and possibly lowers CVD events. However, pioglitazone therapy is frequently associated with weight gain (approximately 2–3kg) and is not suitable for patients with heart failure or macular oedema, or in patients who are at increased risk of fracture.

Insulin

Insulin should be considered for patients who do not achieve target HbA1c levels on other combination glucose-lowering therapies, but GLP-1 receptor agonists are preferred over insulin when possible. Due to the progressive failure of beta cells in type 2 diabetes, many patients will eventually need insulin therapy to achieve target glycaemic levels. •

LATEST GUIDELINES

Diabetes management guidelines, including insulin initiation, are available on Regional HealthPathways and an updated New Zealand Type 2 Diabetes Management Guidance is available at t2dm.nzssd.org.nz.

This article was originally written by Auckland District Health Board (DHB) endocrinologist and diabetologist Rinki Murphy and published in NZ Doctor *late last year. It has subsequently been edited for* Kai Tiaki Nursing New Zealand *readership by Waitemata DHB diabetes clinical nurse specialist Lisa Sparks, and updated with the latest funding information.*

Diabetes clinical nurse specialist Lisa Sparks

EARN 0.5 CPD HOURS

• This article is endorsed by the College of Nurses Aotearoa for 30 minutes professional development (CNA073). Complete the short quiz on tinyurl.com/diabetes-nurses to gain your CPD.

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International Nurses' Day May 12

E ngā apuhi kaitiaki o Aotearoa, ka nui te mihi ki a koutou.

2020 was designated the Year of the Nurse and Midwife by the World Health Organization. It was meant to be a time to celebrate our kaimahi hauora. Instead, COVID-19 unleashed across the world. We saw health-care workers doing extremely risky, essential work, while continuing to be under-protected, underpaid and understaffed.

This International Nurses Day (IND), we have made it a priority to celebrate nurses not just with words and gestures but by striving for meaningful change.

We know you are heroes. We know how hard you work, and the many things that stand in the way of you doing your jobs. It shouldn't be like this. So with that in mind, I thank you and take time to celebrate you this IND. I want to emphasise that our thanks are matched by our support for you.

No matter the year, or the kaupapa, we will continue striving to make change for all NZNO members.

Ehara taku toa I te toa takitahi, engari he toa takitini.

My strength is not as an individual, but as a collective.

Acting NZNO chief executive, Mairi Lucas

International Midwives' Day May 5

ProCare

It's a shame that last year's planned International Year of the Nurse celebrations were overshadowed by Covid-19, but it did shine a bright spotlight on the amazing contribution made by nurses in our communities.

ProCare stands alongside our talented practice nurses who continue to face this global pandemic head-on as true professionals.

We thank all nurses across the network for placing themselves at the forefront of primary care, along with their GP colleagues, for the good of our communities.

We are proud to be on your team.

comprehensive care

To all nurses in general practice,

Thank you for the strength and dedication you have shown, and sacrifices you have made to support our community through these trying times.

Please know that your work is highly valued.

We are here to support you in any way that we can.

From the team at Comprehensive Care

THANK YOU
TO OUR HEROES!

Toanga - Treasure

It is truly an honour to be a nurse or a midwife.

We treasure, celebrate and thank you all for your ongoing contribution to the health outcomes of our people. It takes a team to make a difference and as such the team of nurses and midwives is certainly acknowledged.

Happy International Nurses and Midwives Day - this moment is yours!

South Canterbury
District Health Board

Lisa Blackler, Director Patient Nursing and Midwifery shows Anna Wheeler, Associate Director Nursing and Midwifery how to make a heart symbol with her hands.

NZBLOOD
Te Ratonga Toto O Aotearoa

New Zealand Blood Service celebrates and congratulates their nurses.

On this special day, celebrated on Florence Nightingale's birthday, we would like to extend a huge thank you to all our nurses for their commitment, compassion and collegial support, which has been invaluable during a year of unprecedented challenges.

Thanks to your support and trust in us, we have provided exceptional service to our donors during a difficult year while continuing to collect and provide safe blood products to New Zealand. We learn and walk forward as a united team.

Te tiro atu to kanohi ki tairawhiti ana tera whiti te ra kite ataata ka hinga ki muri kia koe.

Turn your face to the sun and the shadows fall behind you.

NURSES
A VOICE TO LEAD
A VISION FOR FUTURE HEALTHCARE

To all our nurses and midwives. You have played a critical role in our response to COVID-19. Thank you for the difference you make every day through kind and compassionate health care.

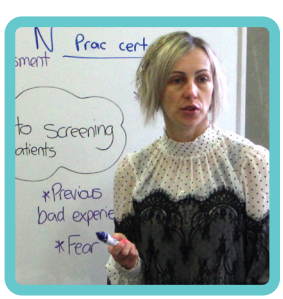
Haere Mai Welcome | Manaaki Respect | Tūhono Together | Angamua Aim High

Nurses: A Voice to Lead: A Vision for Future Healthcare

"I've been a **Family Planning nurse** for 16 years. Sexual and reproductive health care is primary health care. Every day I know I'm making a difference in people's lives."

Claire Paterson

"As a **Family Planning nurse educator**, I am proud to deliver clinical training to support expanded access to contraception. It's about breaking down barriers and ensuring real choice."



Ashleigh Pearson

NEW ZEALAND
Family Planning

www.familyplanning.org.nz

Thank you!

Hutt Valley and Capital & Coast District Health Boards would like to acknowledge all the nurses and midwives that work across our communities and in our hospitals.

The dedication, kindness and caring you all provide is very much appreciated on each shift and on every day. On International Day of the Midwife and International Nurses Day we acknowledge and celebrate the contributions you make.

We thank you for your contribution and commitment to the care, health and wellbeing of our people.

He aha te mea nui o te ao, he tangata, he tangata, he tangata

What is the most important thing in the world?
It is the people, it is the people, it is the people.

HUTT VALLEY DHB

Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

1038-0321

Happy International Nurses Day!

At Summerset we appreciate all of our nurses who truly bring the best of life to our residents across New Zealand. We thank you all and wish you a Happy International Nurses Day!

Do you want to help bring the best of life too? We are hiring!

Come and work for a market leading care provider who is passionate about providing quality care.

We can offer you:

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Providing equitable, appropriate

People living with hepatitis C are still subject to stigma and discrimination. But new treatments and alternative ways of providing care can help ensure they get the care they need.

By Nicola Caine

Viral hepatitis C (HCV) affects an estimated 80 million people worldwide.[1] Diagnosing and engaging in meaningful care with people living with viral hepatitis is an urgent priority, both nationally and internationally. Nurses are well placed to provide this care.

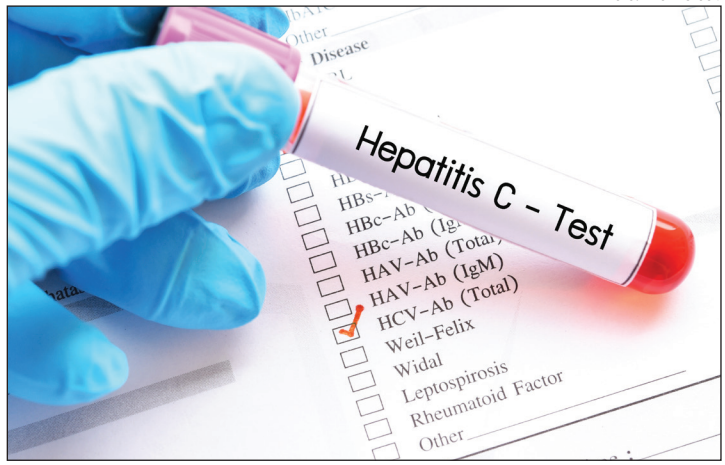
Globally, 1.1 per cent of the population are chronically infected[2] with a viral infection that can lead to significant negative health outcomes, including death. The World Health Organization (WHO) states that, in 2015, 1.34 million people died from consequences of viral hepatitis infection.[2] While this statistic relates to hepatitis B and C combined, it shows the seriousness and worldwide impact of these viral infections. In 2017, the WHO released its *Global Hepatitis Report* that called for the elimination of viral hepatitis as a public health threat by 2030.[3] Unlike hepatitis B, HCV does not have a preventative vaccine. Elimination targets are focused on harm reduction to prevent infection, and treatment and cure of existing infections.

Arduous treatment

Historically, HCV treatments were arduous, with low efficacy and ill-suited for many, resulting in poor uptake.[4] The advent of highly effective, well tolerated, oral short-course treatment regimes has paved the way for countries to realistically look at meeting the WHO's public health elimination goals. However, the availability of effective treatment is not the only consideration in successfully meeting these goals. Inequity is a major factor in HCV and the social determinants of health must be considered, alongside the pathophysiology, to succeed in achieving these targets.

In February 2019, PHARMAC fully funded a highly efficacious, direct-acting antiviral medication (Maviret) here in New Zealand.[5] The majority of people living with HCV require an eight-week course of three tablets once a day, with expected cure rates of around 98 per cent.[6] This has the potential to revolutionise the care of people living with HCV.

PHOTO: ADOBE STOCK



'Targeted testing aims to prioritise and test appropriate populations[10] but is not without problems.'

The estimated prevalence of HCV in the New Zealand population is around 1.2 per cent of the population,[7] – approximately 50,000 people. Around half of these people will be unaware they are living with HCV.[8] To find the estimated 25,000 cases of undiagnosed HCV,[8] a targeted testing approach is recommended. This means identifying people who have a current, or past risk of exposure to any of the known transmission routes of the virus.

HCV is a blood-borne virus and transmission in New Zealand is predominantly by injecting drug use.[1] However, other transmission routes must not be forgotten. Receipt of blood products before 1992; vertical transmission (mother-to-child); sexual transmission (low transmission); migration from a high prevalence country (or recipient of health care in high prevalence country); incarceration; and non-professional tattooing/piercing are all considered risk factors warranting HCV testing.[8]

Acute hepatitis C infection is often asymptomatic. Eighty per cent of people will go on to develop a chronic infection, with around 20 per cent spontaneously clearing the infection, leaving non-protective antibodies.[9] Those chronically infected with HCV often remain asymptomatic for many years; however for around one in five, the ongoing inflammatory process within the hepatocytes causes significant scarring and liver cirrhosis. Decompensated cirrhosis, liver cancer and extra-hepatic manifestations are the most serious outcomes for some of those burdened by HCV.[10] While the health implications of this virus can be very significant, the ongoing health-care requirements of those who are sickest is also significant and continues to grow.[11] The upward trend in serious chronic liver disease, liver cancer and death (related to HCV) is predicted to continue for some time, with hepatocellular carcinoma the most rapidly increasing cause of cancer mortality in New Zealand.[12]

Finding the missing thousands of people living with an undiagnosed hepatitis C infection must be a health priority, if the dramatic increase in liver-related deaths in New Zealand is to be reduced. Targeted testing aims to prioritise and test appropriate populations,[10] but is not without problems. To test the targeted person, self-identification of risk is necessary. Targeted testing fails to take into account the stigma and discrimination associated with the declaration of transmission risk activity and then pos-

care for those with hepatitis C

sible diagnosis of a blood-borne virus.[13] Sadly, stigma and discrimination in health-care settings is well documented[14] and significantly affects the power dynamic between patient and care provider. Initial diagnosis is not the only barrier; linking people into care and keeping them in care once a diagnosis is made, is vital to enable treatment. Prevention or optimised care of chronic liver disease sequelae and prevention of ongoing transmission are also essential.

To reach the WHO's elimination goals (mortality reduced by 65 per cent and new chronic infections reduced by 90 per cent, compared to 2015 rates[3]) by 2030, there must be better engagement with those most at risk of viral hepatitis. For HCV, this means breaking down barriers for vulnerable and often highly marginalised groups of patients. People who inject drugs (PWID) bear the largest burden of this chronic disease and are often least engaged with health services.[15] Addiction is noted as both cause and effect of widening inequalities in health.[16] Linking into care and treating this group not only has individual health benefits, but also significant public and population health benefits. Reduction of the infective pool is an important tool in public health[17] with treatment becoming a tool in preventing re-infection.[13] A 2017 study at an inner city Sydney health clinic showed efficacy rates for direct acting anti-viral treatment in a highly marginalised, predominantly PWID population.[18] It showed that treatment was effective and this has been the basis for extending hepatitis C treatment programmes away from traditional hospital outpatient settings.

Targeted testing fails to take into account the stigma and discrimination associated with the declaration of risk and then possible diagnosis of a blood-borne virus.

People living with housing instability are vulnerable and have an increased HCV risk for a variety of complex inter-related health determinants, such as mental ill health, alcohol, substance and drug misuse, and more frequent involvement with the prison and justice system.[19]

Hepatitis C care in the Bay of Plenty has historically been a secondary-care model, based in a hospital outpatient setting, with the service provided by a range of specialists, including a specialist nurse, infectious disease physician, gastroenterologist and hepatologist. The advent and funding of improved curative medicines, along with good working relationships between local opioid and hospital specialist services, helped improve existing services, but these were not enough. The one-size-fits-all approach to care did not provide optimum care for this population. In late 2018, enough interested parties – from primary care, secondary care, regional providers and peer-led needle and syringe programmes – were able to collaborate to create a nurse-led, GP-supported collaborative hepatitis C clinic based at the local needle exchange.

Once a month, with the support of the peer-led, harm-reduction service, a nurse-led, one-stop shop is held. A visiting nurse from secondary care provides services, including hepatitis C testing, liver assessment, treatment, education and support. This removes the need to attend a formal outpatient appointment at the hospital. By removing these barriers to care, we provide a more accepatable service. As a group of researchers has stated: *"It is the broader social hierarchies that underpin exclusion from mainstream health care and the poorer health outcomes experienced by marginalised groups. Evidence is clear that when health services are not culturally appropriate, health consumers rarely use them."*[20]

Taking health care to the population in need utilises peer worker advocacy. Peers can help navigate health processes in ways acceptable to the clients, thus enabling collaboration and fostering trust.[21] Models of care that promote community self-determination and utilise peer support help advocate for vulnerable groups.

The removal of barriers, such as appointment times, "did-not-attend" policies, initial referral, prescription costs, multiple encounters with different health staff and eligibility, increased access for this marginalised group. The service attempts to change the power differential between the service user and the care provider. This needed to be carefully balanced because of the trust and confidence issues for users of a service which provides needle and syringes within the harm reduction model. The involvement of peer workers, who promote the service, explain it and encourage others to use it, is pivotal to the success of any such clinic.[4]

An informal review of the service found it was acceptable to those directly involved in the initiative and, importantly, it was not a barrier to those accessing the primary service of needle and syringe exchange. The success of treating small numbers of people for HCV, who may otherwise have not accessed care, led to reaching out and trying to engage more with other priority groups for HCV care. In late 2019, the secondary care hospital hepatitis service, supported by peer workers, reached out to Tauranga Moana men's night shelter, to see whether a hepatitis C service could benefit to the men using that service. The disproportionate infection rates in people who experience homelessness and between men and women made this population a priority.

A meta-analysis studying gender difference in the burden of blood-borne viral infections reveals an almost two to one ratio of male to female HCV burden, though in a very particular population.[22] However, studies do show particular populations where this biological sex difference is disputed.[23]

Specialist nursing roles in hepatitis

care in New Zealand lack consistency and range from registered nurses with expert knowledge to nurse practitioners (NP) working in the field. What is consistent is that this group is highly skilled, experienced and passionate, many with advanced practice capabilities and some with advanced nursing roles. Nurses are able to deliver effective care to those with, or at risk of, or living with the consequences of HCV. Substantial research into the NP workforce shows it is highly effective at delivering care to those with chronic health conditions, as well as being able to address the health inequities that indigenous, marginalised and vulnerable populations face.[24]

By applying a social justice lens to the work of engaging with populations most affected by HCV, we bring the best of a nursing paradigm to the proven biomedical one.[25] Nurses are well placed to challenge health-care systems that further restrict, rather than enable, access to care.[13] The advanced nursing characteristics of encompassing *"not only the care delivery system in which the ANP [advanced nurse practitioner] practises, but also the community and society in which that care is provided"*[25] are pivotal to meeting the ongoing need of those most burdened by HCV.

But most hepatitis care is still delivered through biomedical care models that are not flexible or patient-centred enough for those with the complexities that often accompany HCV. To find and engage with people living with undiagnosed HCV, there have to be more collaborative, holistic systems of delivering care, many of which are best provided by advanced nursing roles.[18]

As nurses, we need to extend ourselves, seize opportunities and challenge the status quo to gain further development and recognition. Nurse prescribing within advanced nursing practice is now becoming a reality, and so may soon become more attractive to nurses caring for those with HCV. The Nursing Council is currently undertaking a comprehensive review of the approved list of medicines on the nurse prescribing list, with submissions for additions to this list including HCV antiviral treatment.[26] The challenge will then be to encourage nurses to become clinical nurse specialists with prescribing rights, thus enabling the delivery of better care.

Hepatitis nurses with the necessary advanced knowledge and experience can and should lead the way in creating better systems more suited to those with HCV. There are many other discreet, vulnerable groups where a similar alternative model of care would likely be as effective as for those with HCV. Reaching out to these vulnerable groups may be the first step towards authentic, effective, patient-centred specialised care, which reduces inequities and makes a difference in people's lives. The challenge is to recognise, use and empower nurses to break down barriers and facilitate, first, the identification of these vulnerable groups, and, secondly, to link them into, and ensure their ongoing engagement with care. As nurses, we must all take our roles in advocating for our patients more seriously. If nurses caring for those with HCV both create new models of care delivery and advocate for their clients, elimination of hepatitis C infection in New Zealand by 2030 is a realistic aim. •

* *This article has been reviewed by hepatitis C specialist nurse Jenny Bourke, who ran Christchurch's hepatitis C community clinic for 14 years, and the* Kai Tiaki Nursing New Zealand *co-editors.*

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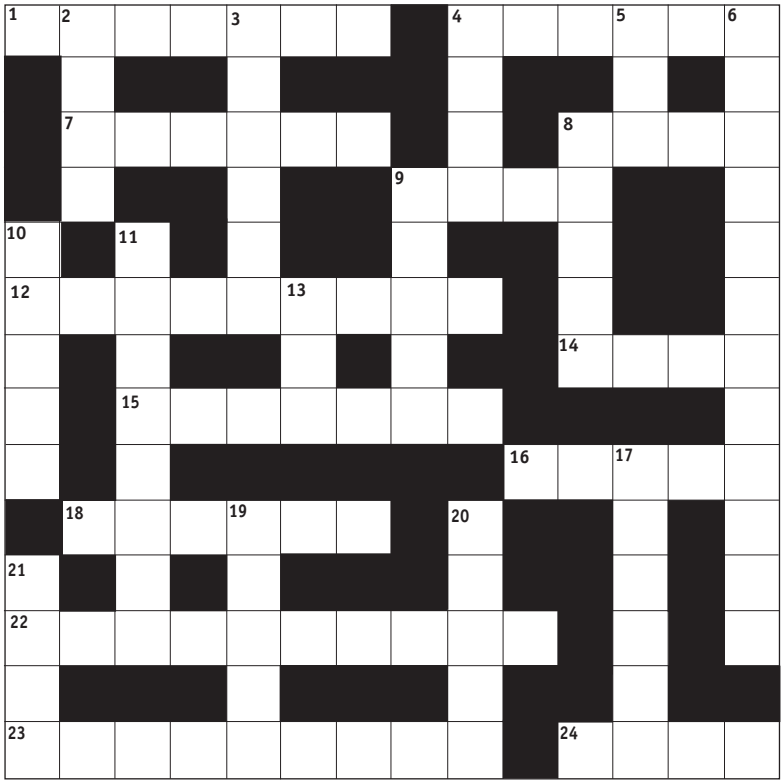
crossWORD

Completing this will be easier if you have read our March issue. Answers in May.



ACROSS

1) Government drug buying agency.
4) Root vegetable, popular in Ireland.
7) Land (Māori).
8) Temporary home, of canvas or plastic.
9) Follower of Hitler's philosophies.
12) Skill.
14) Facts/statistics.
15) Staff member who helps shift patients round hospital.
16) Muggy.
18) Extra-marital liaison.
22) Unable to read or write.
23) System for keeping vaccine at correct temperature.
24) Cook in oven.

DOWN

2) Bird of prey.
3) Trusted guide or counsellor.
4) Mountain lion.
5) Outranks king in card games.
6) Specialty devoted to musculo-skeletal system.
8) Weary.
9) To do with the nose.
10) Not so many.
11) "A _____ of sugar helps the medicine go down."
13) Part of formal dress for men.
17) Native shrub with many medicinal qualities. (Māori).
19) Room up under roof.
20) Smooth shiny fabric.
21) Trace mineral important for health.

March answers. ACROSS: 1. Lockdown. 4. Album. 8. Ash. 9. Neck. 10. Humour. 12. Bishop. 15. Rib. 17. Batman. 18. Myself. 20. Garnish. 21. See. 22. Asthma. 25. Arm. 26. Hero. 28. Yoga. 29. Amen. 30. Carrot. **DOWN:** 1. Loch. 2. Calm. 3. Nose. 5. Lungs. 6. Mokopuna. 7. Turbulent. 11. Unity. 13. Immense. 14. Honest. 16. Kawakawa. 18. Mascara. 19. Steam. 23. Hoof. 24. Gout. 27. Ear.

wiseWORDS

“ I have a strict policy that nobody cries alone in my presence. ”

– Dolly Parton, US singer, songwriter, actress, entrepeneur and philanthropist

it's cool to kōrero

HAERE MAI and welcome to the April column. A mihimihi is a short speech in te reo that a person makes at a gathering to introduce themselves, and to make connections with those present. They introduce themselves through naming what people they belong to (whakapapa) and what place they belong to. So the mihimihi will often include the person's iwi, and hapū, their marae, what waka their iwi is associated with, and the maunga (mountain) and awa (river) of their tribal land. It can also refer to tribal ancestors and chiefs.

All this information is more important than the person's own name, which is often left to last in the mihimihi.

Kupu hou

New word

- **Mihimihi** – *pronounced "me-he-me-he"*
- **I mihimihi au i te whakawhanaungatanga.**

I introduce myself with my mihimihi.

Rerenga kōrero

Phrases

This issue of the magazine features a professional education article on new medications for type 2 diabetes. Here is some te reo vocabulary about diabetes:

Huka – sugar
Mate huka – diabetes
Taiaki huka – insulin
Repe taiaki huka – pancreas
Te huka toto iti – hypoglycaemia
Te huka toto teitei – hyperglycaemia
Pēhanga toto – blood pressure
Ngenge/katete – overweight
Whiringa kai – diet
Hei mahi – exercise

E mihi ana ki a Titihuia Pakeho, Keelan Ransfield and Te Taura Whiri i te Reo Māori (Māori Language Commission).

Power structures must change for progress

If nurses are to realise their full potential within the health system, fundamental power structures have to change.

By co-editor Teresa O'Connor

In the late '80s, I left journalism to become a nurse. I was full of optimism about my new career. The pressures of daily deadlines would be replaced with other, far more consequential pressures. The contacts made in daily journalism would be replaced by the "privileged intimacy" of the nurse/patient/whānau, relationship. The milieu of the male-dominated, banter-filled (and, until the mid '80s, smoke-filled) newsroom would be replaced by the female-dominated, patient-orientated ward.

And so it turned out. But what I hadn't reckoned on was the inherent conformity of the profession I was joining, compared to the trade I'd just left. Or the rigidity and spirit-sapping nature of the system within which I had to work. While I loved that "privileged intimacy" and realised nursing was, indeed, one of the worthiest professions, I was simply not cut out to work in what I experienced as an authoritarian, hierarchical and alienating system. Needless to say, I didn't last. But I have enormous admiration for those who navigate that system under ever-increasing pressures of patient acuity, time, short staffing, workloads, technology and paperwork.

Continuous publication

On my last day of work as a nurse, I was informed by an NZNA staffer of a co-editor vacancy at *Kai Tiaki Nursing New Zealand* and I applied. The role seemed to be a perfect marriage of my two trainings. And so it turned out. For the last 29 years, I have had the pleasure and privilege of being a co-editor of a journal in continuous publication since 1908 – world wars and pandemics have not closed it down. A journal which has charted the development of nursing and the challenges it has faced within Aotearoa/New Zealand for more than a century. A journal which has been, unashamedly, a women's publication. A journal which has reflected the development of a professional association and, more latterly, a trade union, and the contradictions and paradoxes inherent in that combination. A journal which has contributed to, and hopefully will continue to contribute to, the social history of this country. I am deeply grateful to have played a small part in recording the first draft of these multiple histories.

I never intended to stay so long. But life circumstances were such that I continued longer (much longer!) than originally anticipated. And to work for an organisation whose values have, for most of my time with NZNA/NZNO, aligned closely with my own is a rare privilege in today's corporate-dominated media world.

As I reflect on 29 years of reporting on the nursing profession, the phrase which keeps recurring is: "*Plus ca change, plus ca la meme chose – the more things change, the more they stay the same.*"

PHOTO: ROB ZORN

Outgoing co-editor Teresa O'Connor with 29 years' worth of *Kai Tiaki Nursing New Zealand* journals.

Close to 30 years on, nurses are still not paid adequately for their work. District health board (DHB)-employed nurses are right now considering an offer from their employers. Primary health care nurses had to take strike action to secure a pay increase that brings them up to DHB pay rates. Many nurses working for Māori and iwi providers are paid considerably less than their DHB counterparts. Aged-care nurses are undervalued. The rhetoric about the value of nurses and nursing in the context of COVID-19, is just that – rhetoric.

Workloads for many nurses remain unreasonable, for some unbearable. Fatigue and burnout are constant. And sadly, the inevitable outcome of a highly stressed, hierarchical environment – bullying – remains endemic. Patient acuity is far greater, hospital stays are far shorter and short staffing seems entrenched.

The legacies of neoliberalism in the health sector – health and employment law "reforms", general managerialism, the overweaning focus on the bottom line – remain profoundly damaging. The latest example of this legacy is the appointment of a former director-general of health, but now a consultant with global accountancy firm EY, Stephen McKernan, to head the transition unit implementing the recommendations of the health and disability review. If that were not proof enough that neoliberalism in now deeply embedded in the collective health mindset, the fact that *not one* nurse is on that transition unit is further proof. That omission beggars belief. Or does it?

The power structures within the system are not, and never have been geared to an equality of influence. Nurses comprise around 68 per cent of the total health workforce; would that their influence within the system was commensurate

with that. But we all know the system was designed by, and for doctors, and while there have been some gains and changes here and there, the fundamental power structures have not altered. Perhaps the old triumvirate of matron, medical superintendent and hospital board secretary ensured a more powerful nursing voice at the fulcrum of power?

The only only ones who can lever that influence are nurses themselves. And, nearly 30 years on, there seems little appetite to do so. Those in power never yield it voluntarily. And until nurses are prepared to unite to challenge the foundational power structures of the system, only cosmetic changes will ever occur. While the exhausting nature of nursing work mitigates against political agitation, it is only by such action that meaningful change will be made.

If anyone doubts the power structures in health are stacked against nurses, they simply have to ask: Why are there no creches at hospitals? Why are there not more flexible shifts? Why do pregnant nurses have to formally ask not to do night shifts after 26 weeks, when that is automatic for doctors? Why do specialists receive $16,000 a year for continuing medical education when nurses receive a comparative pittance? Why have there been unconscionable delays in implementing care capacity demand management in too many DHBs?

Power of communications staff

While the worst excesses of the health "reforms" of the '90s have been wound back, another legacy of that era is the power of communications units within the sector. In the bad old days of crown health enterprises, positive media coverage was a key performance indicator. The legacy of that particular madness is that now every DHB and many private health providers have communications units churning out positive stories. That, in itself, is not necessarily a bad thing, but the fact communications staff can alter nurses' words with impunity is. Over the years, *Kai Tiaki* co-editors have often struggled with DHB communication staff – to get their permission to cover nurses' stories, we have often had to agree to let communications staff approve the stories. Way too often these non-health professionals alter nurses' words. So what about the catch cry of the nurse as autonomous health professional? Yes, but they can't really be trusted to tell it like it is. Given this disrespect for nurses' views, is it surprising so many are reluctant to speak out about what's actually happening in their workplaces?

Thirty years ago, when working as a staff nurse, I was sacked for writing an editorial in the *Listener* critical of Ruth Richardson's "mother of all budgets", which was the harbinger of the "reforms" that lay ahead. As the general manager sacked me, the director of nursing stood mute. Thanks to legal protections and NZNA, I was reinstated, but with a final warning placed on my personal file. Intimidation may not be as overt now, but it still exists. As former NZNO chief executive Memo Musa noted in his farewell interview in the February issue of *Kai Tiaki Nursing New Zealand*: *"The sector is riddled with a blaming culture. We must collectively work to . . . stop the fear of retribution for those who speak out."*

Muzzled or fearful nurses cannot be the advocates patients so desperately need in this underfunded, increasingly stressed system.

Muzzled or fearful nurses cannot be the advocates patients so desperately need in this underfunded, increasingly stressed system. But nurses must be courageous when patient care is compromised – and remember their organisation is there to support them in doing so.

So how does nursing leadership fit in all this? With some difficulty. Every nursing leader – be they in the public or private system, education or academia – is serving two masters: their employer and their profession. Most nursing leaders work tirelessly within the constraints imposed by the DHB/private hospital/polytechnic/university management, to promote and protect nursing but, when push comes to shove, the employer's agenda will always win out.

Ongoing health inequities still plague the system. Again, not until the fundamental power structures within it change, will those inequities diminish. Anything else is just fiddling around the edges. Hopefully, an independent, properly funded Māori health authority will result in a realignment of power structures, which will help ameliorate health inequities.

Another aspect of the profession that hasn't changed – and perhaps it should – is nurses' dedication to do the best they can in increasingly difficult working environments. Nurses' willingness to go the extra mile – mostly unpaid – has probably done them little good, though it has, undoubtedly, benefited those they care for. That generosity of spirit has been exploited for too long.

One of the great pleasures of this role has been telling nurses' stories, hopefully reflecting the diversity and dedication of this workforce. *Kai Tiaki Nursing New Zealand* has been the vehicle for a fraction of those stories. I hope it will continue to be, as it moves into a new online era. I also sincerely hope that its editorial autonomy – a key to its longevity – will continue. And that it will not evolve into what all other union magazines in the country have become – communications-driven publications only ever publishing positive stories.

It has been said that journalists write the first draft of history. While not wanting to sound pompous, as co-editors, we have a debt to history and to future generations of nurses: to record as faithfully as we can, a factual version of that history, not a sanitised version.

It has been personally and professionally rewarding to have worked with three talented and committed co-editors in my years at *Kai Tiaki Nursing New Zealand* – Anne Manchester (for 25 years!), Kathy Stodart and Mary Longmore. Long may it continue to attract skilled journalists who understand the importance or recording nurses', the profession's and the organisation's stories for posterity.

I'll take this opportunity to thank each and every nurse for their mahi. And to urge each and every nurse to ponder the power of their political action in creating a more just health system for all. •

Advocacy lessons from HDC cases

Last month's NZNO professional forums focused on a nurse's obligation to advocate for their patients. Cases referred to the Health and Disability Commissioner provide valuable advocacy lessons for nurses.

By Sophie Meares,
NZNO medico-legal lawyer

The job of the Health and Disabiity Commissioner (HDC) is to investigate potential breaches of patients' rights. These rights include the right to services of an appropriate standard, the right to effective communication and the right to informed consent.

Often where a practitioner or provider has breached a patient's rights, there will be a nurse in the background who has failed to advocate for that patient's rights. We can examine those cases to ensure we are learning from their mistakes so they do not happen again.

Equally, some published cases have praised nurses for the way they have advocated for the patient. We can use these cases to emulate the courageous way these nurses have stood up for their patients in difficult situations.

Here are some key lessons from those cases:

Lesson #1: Be assertive

If you are concerned, make it known. Have confidence in your clinical judgment – if something is not right, you need to insist it is checked. This can be difficult when the team is busy, but these are the times when things fall through the cracks.

The HDC investigated a case where a woman had provided written consent for a hysterectomy.[1] Three months later, when the woman was on the operating table, the surgeon approached her and recommended they also perform an oophorectomy (removal of an ovary). The surgeon amended the patient's written consent and her signature was obtained. The surgeon was found to have breached the patient's right to informed consent.

The HDC commented: *"I am concerned that none of the clinicians in the operating theatre advocated effectively for [the patient] in this case."* The nurse who had been at the patient's side by the operating table had tried to comfort the patient when the consent was amended. The nurse had also asked the patient whether she wanted to talk it over with her husband (which the patient declined because her husband had already gone home). This was not enough – the nurse should have questioned the surgeon and intervened over the faulty consent process. The HDC also criticised the DHB for failing to normalise a culture where advocating on behalf of patients was accepted – it was not enough for the DHB to just have a policy on this.

If you do not document the conversation, it is difficult to prove it occurred. Write it in the clinical notes.

Medico-legal lawyer Sophie Meares

In another case, a midwife was called in to assist a lead maternity carer (LMC) with a delivery. The LMC was concerned about the progress of the labour, but was not concerned about the foetal heart rate. The assisting midwife carried out a vaginal examination, and she *was* concerned about the foetal heart rate. However, the assisting midwife did not insist on a cardiotocograph (CTG) being attached until 40 minutes later. The assisting midwife left the room at one point to speak to a doctor about the progress of the labour. She told the doctor *"she would be happier for him to assess [the patient] immediately"*, but also that she was *"just as happy to continue"*.

The HDC found the LMC breached the patient's rights. The HDC was also critical of the assisting midwife's failure to advocate for the CTG being attached much sooner. They were also critical of her conversation with the doctor where she should have insisted on an immediate obstetric referral.

It is important you are assertive and intervene when things are not going right. If your clinical judgment is that a medical review is required, you need to insist on it.

Lesson #2: Be persistent

If your concerns are falling on deaf ears, escalate them. Start with your manager, and if they do nothing, work your way up. The Nursing Council provides guidance on escalating your concerns.[2] If you are finding escalation difficult, or are experiencing negative consequences for being outspoken (eg personal, reputational or employment consequences), seek support from NZNO.

A damning report from the HDC in 2008 found very poor practice on the part of former Whanganui Hospital obstetrician and gynaecologist Roman Hasil. This included failed sterilisations, management plans tending towards hysterectomy if the patient's uterus was not deemed "useful", cursory history-taking and exams, failure to inform patients about what he was doing, poor documentation and hurting people during exams.

A nurse who worked closely with Hasil documented her concerns and reported them to her manager, who raised the issues with Hasil's manager. Some action

was taken, but never enough to resolve the issues. The nurse continued to raise and document her concerns, and even calling the Whanganui District Health Board's (DHB's) chief executive officer (CEO) directly. The hospital failed to act on her reports, and those of other staff.

After Hasil had worked at the hosital for 14 months, a further complaint was made about him and he resigned. He was referred to the HDC. The HDC praised the nurse for her prescient remarks, and her persistence in escalating the matter. The HDC was highly critical of the hospital, pointing out the DHB ought to have known the risk Hasil posed before his resignation, due to complaints from staff and patients.

Commenting on the complaints from the nurse, the HDC said: *"Of particular note . . . a well-regarded nurse warned that Dr Hasil would make a grave mistake . . . It is startling how little was done in response to the various concerns."*

The nurse in Hasil's case would have had a very difficult 14 months – Hasil tried to blame her for being difficult to work with, and she would have felt she was getting nowhere when her concerns were not properly addressed. However, because she persisted, eventually something was done, and she was praised by the HDC.

Lesson #3: Document your concerns

Often advocacy by a nurse will occur in a conversation with a colleague or other health practitioner. If your concerns are not heeded, you will need to be diligent in your documentation. If you do not document the conversation, it is difficult to prove it occurred. Write it in the clinical notes. If you no longer have access to the notes, write an email to your manager with your concerns. If possible or appropriate, write an incident report. Be specific about the concerns you pass on. Using shorthand is OK – any kind of documentation is better than nothing.

In a case involving an aged-care facility, a clinical manager arranged a GP appointment for a resident. The resident had been unwell for several days with a cough, lethargy and reduced appetite. However, the GP said he understood the appointment was only about the patient's itchy ears.

The HDC said the nurse manager was responsible for advocating on the patient's behalf as he was unable to speak for himself. *"Although it is unclear what information was conveyed to [the GP], owing to differing recollections and a lack of contemporaneous documentation, it appears that [the patient's] deteriorating condition was not communicated to [the GP] adequately."* The HDC said that *"it was the nurse manager's responsibility to ensure pertinent information was communicated to the GP, and given the lack of documentation I consider it more likely than not that this did not occur."*

If you fail to document a conversation, it may be assumed it did not occur. Your documentation is your protection if a complaint is made about your care.

Staff were moderately busy with other patients and medical decisions were made while the nurse was out of the room.

Lesson #4: Advocacy when passing on care and at discharge meetings

Often a nurse's advocacy can fall short at key moments when care is passed on. This might be when a patient is discharged or transferred to another ward, at handover, or when the patient is referred to another service. At these times, part of your advocacy role is to highlight any concerns to the practitioner taking over the patient's care. A rushed or unclear handover can mean things are missed. Ensure you document specific concerns that you pass on to the other practitioner. The aged-care case cited above is a good example of where a nurse failed to advocate properly on handover.

Another critical moment for advocacy is when patients are discharged. If a patient is being considered for discharge, but you have concerns about this, you need to make sure your concerns are heard. If they are not listened to, you need to record your concerns.

In a case where a patient was incorrectly discharged, a DHB was found in breach of the patient's rights and was heavily criticised by the HDC: *"The team as a whole was in possession of enough information to indicate that this was a very unwell child, but there was no meeting of minds between the nursing and medical perspectives. This was a result of attitudes and opportunities. Staff were moderately busy with other patients and medical decisions were made while the nurse was out of the room."*

The HDC said an attitude of valuing the nursing perspective would have *"ensured that there was adequate communication of concerns and opinions . . . Any individual in the clinical team should be able to ask questions or challenge decisions at any time, and it is important that employers such as DHBs encourage such a culture . . . Good support systems (including the safety net of vigilant senior nurses and readily available consultants) are also crucial."*

Employers need to create a culture where the nursing perspective is valued at these critical moments when decisions about care are made.

Even if you do everything in your power to advocate for your patient, other things might go wrong, or another practitioner might fail in their duties. If a patient complains and you are asked to describe your involvement with the patient's care, your documentation will be your legal protection to prove you did what was in your power to advocate for them. NZNO's medico-legal team is here to help if you are involved in a complaint. •

** The full presentation given by medico-legal staff at recent NZNO professional forums on nursing advocacy is available at https://tinyurl.com/2cb575sh*

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1) Health and Disability Commissioner. (2015). Consent for surgery obtained while on operating table [Case 14HDC00307]. https://www.hdc.org.nz/decisions/search-decisions/2020/17hdc01225/
2) Nursing Council. (2012). Guidance: Escalating concern. *Code of Conduct for Nurses* (p41).
3) Health and Disability Commissioner. (2020). Care plans and monitoring of a rest home resident [Case 17HDC01225]. https://www.hdc.org.nz/decisions/search-decisions/2020/17hdc01225/

Pacific nurses need support to lead

About 85 participants gathered in person and online at the New Zealand College of Primary Health Care Nurses (NZCPHCN) symposium *Nursing diversity bring nursing strength* in March.

The day was a collaboration with the College of Nurses Aotearoa and despite several obstacles – COVID-19 level changes, earthquakes and tsunami warnings – was a success, organising committee chair Kelly Robertson said.

Chris Maxwell

Michele Rumsey

Director of the World Health Organization (WHO) Collaborating Centre for Nursing, Midwifery and Health Development Michele Rumsey stepped in for microbiologist Siouxsie Wiles, who was unable to attend. She talked about Pacific nursing shortages and leadership. The Sydney-based centre aims to improve population health in the South Pacific region.

Drawing on WHO's 2020 *State of the World's Nursing* (SOWN) report, Rumsey said it was crucial that nurses in the western Pacific were "empowered and educated" to improve community health.

While there were more than 200 health education programmes across 16 Pacific countries, there were few specialist or masters' courses and a lack of continuing professional development for nurses. This limited nurses' access to policy-making, Rumsey said. Nor was education integrated across the Pacific, or linked to New Zealand or Australia.

A series of leadership programmes, run in 2009-2017, by Sydney's University of Technology in partnership with the South Pacific Chief Nursing and Midwifery Officers' Alliance, drew more than 300 participants from 14 countries, the SOWN report said. Initial findings suggested 85 per cent of these participants took up senior roles in nursing and midwifery, set up projects or represented the region's nursing at global events. Six had become chief nurses and two health ministers, Rumsey said.

NZNO professional nursing adviser Angela Clark said the findings were "encouraging, powerful and relevant" for New Zealand's multicultural society.

NZCPHCN committee member Yvonne Little said Rumsey's session was "a real eye opener for us in New Zealand to realise not only the global shortage of nurses but the situation of our Pacific neighbours".

The SOWN report identified a global nurse shortage of 4.6 million. Rumsey said later this included 350,000 in the western Pacific region, which had around seven million nurses – a quarter of the global nursing workforce.

The SOWN report made a strong case for "a decade of action" to increase investment in nursing education, jobs and leadership in the region, Rumsey said.

But any future quality assurance model for nursing in the Pacific must be based on building trust, with a "ground up" rather than "top down" approach.

'Demystifying' nurse practitioners

In a panel discussion on nurse practitioners (NPs), Christchurch NP Jo Talarico and registered nurse Jeanette Banks discussed the barriers still faced by NPs, including rejected referrals from secondary care and specialists and a lack of support for becoming an NP. The panel concluded that, even after 20 years, the NP role was not fully understood. Panel members said an NP did "both what a nurse does and what a doctor does".

Wellington NP Chris Maxwell spoke about providing clinical leadership in the community, by translating strategy into practice. The NP role was developed to make services more accessible and improve health equity, not just for prescribing, she said.

NPs must be involved with governance, as a clinical voice at the table would help achieve equity and improve access to health care, Maxwell said.

Other sessions looked at the importance of advocacy in supporting at-risk families, challenges and opportunities for nurses in national health policy and how research can shape practice positively.

Ara Institute of Canterbury senior nursing lecturer Isabel Jamieson shared her initial findings from interviews with nurses working in Christchurch's managed isolation facilities (MIF) in December 2020. Their families had been turned away from sports clubs, Christmas barbecues and relatives' homes and even struggled to get a dental appointment, Jamieson said.

The diversity of nursing roles within primary health care was celebrated, as new and experienced nurses working across the age spectrum shared their stories. They included a nurse working with former refugees, a male Pacific nurse, army and prison nurses as well as rural nurses and a nurse working with people with intellectual disabilities in the community, Robertson said. "That was really enlightening."

Robertson said she hoped the collaboration could become an annual event. •

Report by co-editor Mary Longmore and NZCPHCN committee member Yvonne Little

Mandatory staffing needed in aged care

NZNO, E tū and Grey Power are lobbying hard to get as many people as possible to sign an open letter to Prime Minister (PM) Jacinda Ardern, calling for mandatory staffing levels in aged care. Close to 5000 people had signed when *Kai Tiaki Nursing New Zealand* went to press. (See full text of letter, right.)

NZNO organiser Christina Couling said the three organisations behind the letter want to meet with the PM mid-year. "We want to meet her with delegates and member leaders from the sector, present the letter and lobby her and other relevant ministers on the issue. Our aim is to get as many signatures as possible before then."

Understaffing in the sector was the focus of this year's Caregivers Week, held in late March, and campaigning for signatories to the letter was part of the week's activities.

Couling said staff shortages meant workers did not have time to provide the best possible care and often had to make difficult decisions about rationing care. "This takes its toll on care staff and many do unpaid extra hours to get through their work."

Staffing 'inadequate'

People needed to know that current staffing levels were inadequate. "We don't have mandatory minimum staffing levels in the sector. The guidelines we have are optional, out of date and do not provide for the increasingly complex health needs of older people.

"We are campaigning for mandatory minimum staffing levels across the sector. We need more nurses and caregivers on every shift to provide safe care," Couling said.

Decades of privatisation had resulted in the current understaffing and undervaluing of workers in the sector, she said.

The care of the elderly was in the hands of private companies, some of which made massive profits. "We can't let profit get in the way of care. As long as the Government delegates responsibiity for care of the elderly and frail elderly to profit-driven companies, without sufficient regard for safe staffing, then the provision of care and the quality of care will suffer," Couling said.

Caregivers Week was started by NZNO's College of Gerontology Nursing to celebrate the significant contribution of health care assistants/caregivers to those in aged residential care. It is held each year in the last week of March. •

Open letter to the Prime Minister

Prime Minister Jacinda Ardern,

When you told the country to get ready for lockdown in March 2020, you said we'd get through this if we all came together. You asked us all to be strong and to be kind.

Aged-care workers have been doing this. But it has been tough going. We all want the very best for residents in care facilities, but the staffing system is broken. Not enough staff means missed care or care not provided in a timely manner. There is ample evidence that understaffing leads to an increased risk of bruising, skin tears, falls, infections and medication errors. Residents' nutritional needs are not being adequately met.

We all need mandatory minimum safe staffing levels to keep our vulnerable elderly safe and to enable aged-care workers to deliver quality care. Safe staffing levels are now, shockingly, 15 years out of date. And worse, they are voluntary for aged-care facilities. For us, that's just not good enough.

We know this is a concern for you too, and we welcomed your Party's commitment in 2010 to minimum staffing levels for nurses and caregivers to be mandated in regulations. Now it's time to deliver on this.

Jacinda, our staffing levels in aged care are unsafe. Unsafe staffing means residents aren't getting the care required, and that's not the New Zealand you are trying to rebuild. We need your leadership to help staff to do their jobs better each day, and to give our elders the quality care they're entitled to.

We urge you to meet with Grey Power, representing the voice of our elders, and aged-care unions, E tū and NZNO, as soon as possible to take steps towards delivering the care New Zealanders deserve.

In anticipation,
New Zealand's aged-care workforce and Grey Power.

Primary health care: Plunket claims endorsed

PLUNKET MEMBERS throughout the country have endorsed a range of claims, which include a focus on Family Start and administration workers.

Members in clinical roles currently have pay parity with district health board (DHB) community rates and they want that to be maintained in any new collective agreement (CA). Another claim for those in clinical roles will be the option of being paid for eight hours a day, rather than the current 7.6 hrs/day. NZNO's lead advocate for the negotiations, Danielle Davies, said all frontline clinical staff were paid for a 7.6 hour day, an historical anomaly. This did not apply to other Plunket staff.

The claim for Family Start members in Tauranga and Manawatu, who gained coverage under the Plunket CA in 2019, is pay parity with Oranga Tamariki social workers. And administration workers' pay claim would be guided by the Public Service Association's pay equity case for DHB clerical workers, due to be finalised by mid-year.

Davies said there had been a "really good turnout" at meetings, some of which had been held via Zoom. She said the term of the new CA would likely be a short one because some pay rates and a number of conditions would be aligned with the outcome of the DHB multi-employer collective negotiations.

Davies said she expected negotiations to get underway next month.

Other members of the negotiating team are: NZNO organiser Selina Robinson and delegates Hannah Cook (Plunketline nurse and NZNO primary health care national delegate committee member, Wellington), Kathy Greenstreet (clinical leader, Auckland), Wendy Dawson (Plunket nurse, Christchurch), Laurie Stuart (community Karitane, Auckland), Vinita Pillay (administrative team leader, Auckland) and Sarah Sheppard (Family Start whānau worker, Tauranga). •

PHC MECA ratified at last

THE PROPOSED primary health care multi-employer collective agreement (PHC MECA) has been overwhelmingly endorsed by members. Online ratification closed in mid March and 84 per cent of those who voted were in favour of the deal, which delivers pay increases ranging from 4.5 per cent to 7.75 per cent and locks in a new registered nurse (RN) step 6.

The new PHC MCA was achieved after more than a year of negotiations, strike action and intense lobbying for extra funding by NZNO, and the New Zealand Medical Association and Green Cross Health Ltd on behalf of employers. Initially, more than 10 per cent of employers rejected the deal but this was not enough to disrupt employer ratification.

NZNO advocate, PHC industrial adviser Chris Wilson, is thrilled with the strength of the vote in favour of the deal and said it had seen NZNO membership boosted by more than 200. "I'm very pleased with the outcome. It's a solid step to finalising pay parity in the next MECA. The collectivity of the membership leaves no doubt that pay parity is a priority and must be achieved. And that collectivity is not to be ignored when more funding is needed in the future."

She said the additional funding to ensure pay parity with the district health board (DHB) step 6 would not have been forthcoming without PHC members' hard campaigning and collectivity and employer support. •

Hospice members reject proposed offer

MEMBERS COVERED by the national hospice multi-employer collective agreement (MECA) have rejected a proposed offer which did not reach their original claim of pay parity with the NZNO/district health board MECA.

Another day of negotiations was scheduled for April 14 in Palmerston North. "We are hoping to secure an improved offer," NZNO advocate Danielle Davies said.

One of the major reasons for rejecting the offer was that the new step 6 for registered nurses was not going to be implemented soon enough, she said. In the rejected offer, step 6 would have been implemented on April 1, 2021. Members felt it should have been implemented earlier, particularly as the previous MECA expired on August 31 last year and bargaining had been underway since September.

Senior nurses were concerned at the lack of transparency around the scope and nature of their roles. There is a five-step senior nurse pay scale, but no explanation of what roles were covered by each step and there had been no scoping of senior roles, Davies said.

Senior nurses also wanted their professional development recognition programme payments to be stand-alone allowances, not absorbed into their salaries, as they are now.

And there had been no movement on a claim to remove inidivdual hospice exemptions from the current hospice MECA. The current MECA covers 520 members in 21 hospices around the country.

The negotiating team is NZNO staff Lynley Mulrine and Danielle Davies (Christchurch), Donna Ryan and Sue Wolland (Palmerston North) and registered nurse delegates, Rachel Clarke (Arohanui Hospice, Palmerston North), Julia Fletcher (Harbour Hospice, Hibiscus Coast), Donna Burnett (Nelson Tasman Region Hospice Trust, Nelson), Shelley Bignell (Te Omanga Hospice, Lower Hutt) and Nicki Twigge, Waipuna Hospice, Auckland. •

Private hospitals: Offer at St George's

A PROPOSED settlement has been reached between NZNO and St George's Hospital in Christchurch, with ratification meetings underway this month.

NZNO advocate Danielle Davies said the proposed deal was reached after a day of negotiations. Key features of the proposed deal include:

- progression through wage steps to be based on automatic annual progression;
- all rates in the collective agreement (CA) to be at $22.10 or above (ie, the living wage rate);
- a new step 6 in central sterile services department (CSSD), open to all non-senior designated members within 12 months;
- a two per cent increase on all CSSD steps from April 1, 2021;
- a two per cent pay increase on all anaesthetic technician (AT) steps from April 1, 2021;

The St George's Hospital negotiating team from left: Caryl Reid (RN), Maike von Minding (RN), Sharyn Robertson (RN), Julia Viljoen (AT), Sam Chrisstoffels (RN), and Daryl Evans (CSSD).

- a 50 per cent increase in the on-call allowance; and
- a 12-month term.

Registered nurses were not included in the two per cent pay increase, as their rates are well above the current NZNO/district health board MECA rates.

There are 230 members at the hospital. St George's has 12 operating theatres and provides a range of surgical services, including a six-bed intensive care unit. It also provides cancer, cardiac, eye care and maternity services, including three birthing suites. It has undergone major redevelopment since the 2011 Canterbury earthquake. •

Union power prompts new offer at Labtests

NZNO MEMBERS at Auckland pathology services provider Labtests have voted to withdraw notice of a 24-hour strike, scheduled to be held on April 6.

NZNO members picket outside Labtests head office in Mount Wellington, Auckland, last month.

After negotiations since September last year, mediation in late January and two rejected offers, last month members voted overwhelmingly in favour of strike action. A large group of members also picketed outside Labtests head office in Mt Wellington, Auckland, last month.

Last month, the employer came back with an improved offer, including full back pay to July 1, 2020, conditional on the withdrawal of the strike notice, organiser Sarah Barker said. But the improved offer does not bring starting rates up to the living wage.

The collective agreement covers phlebotomists. "This workforce is a highly skilled, regulated and predominantly female workforce. They are frontline health-care workers, whose work is vital to patient treatment. They are understaffed and under pressure. Their low pay rates are a reflection of the historical undervaluing of women's work," she said.

Barker said the 150 members were highly engaged in all actions and votes.

Labtests Auckland is part of the Asia Pacific Healthcare Group, the country's largest human and veterinary pathology network, operating as Labtests Auckland, Northland Pathology, Taranaki Pathology Services, Southern Community Laboratories, Wellington SCL, Canterbury SCL, Medlab South and Gribbles Veterinary Pathology. It also provides pathology services to 13 district health boards. It has more than 2000 staff operating across its 25 laboratories and 150 collection centres. It conducts around one third of all COVID-19 testing in New Zealand.

As part of its Auckland Regional District Health Boards contract, Labtests Auckland provides a range of pathology services for all GPs, public hospital clinics and midwives for diagnostic testing for eligible patients.

Public money to private company

Barker questioned why public money was being spent on profit-driven companies, such as Labtests. "If public money is to be spent on profit-driven companies, then the expectation should be that those companies pay the living wage as the starting rate." •

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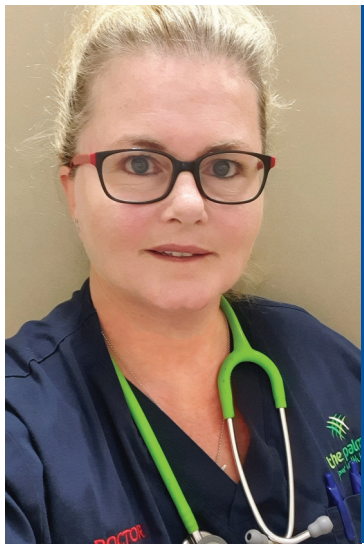

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Jenni.Scarlet@waikatodhb.health.nz

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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
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- 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.

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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
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- Performed additional work for the committee
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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.

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