Kai Tiaki
NURSING NEW ZEALAND
May 2021
VOL 27 NO 4

A new life, as an NZ nurse

Migrant nurses, or IQNs, form a vital part of the NZ nursing workforce. Their journey to a new nursing life in this country is about hope, hard work and battling bureaucracy.

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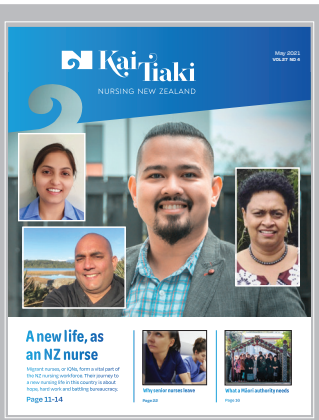

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THIS ISSUE focuses on migrant nurses, their contribution to the nursing workforce, and the sometimes difficult path they travel to life and work in New Zealand. We look at what primary health care means and how nurses can incorporate it in their practice. This issue also examines the role of nurses and Māori in health restructuring plans, and why experienced nurses leave the profession.

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.

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

This issue . . .

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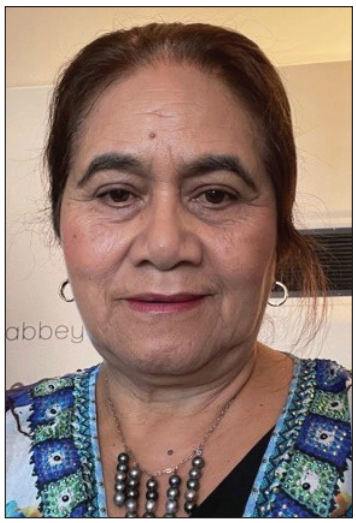
Pacific migrant nurses need fairer pathway



By 'Eseta Finau

Warm greetings in the many Pacific languages spoken in Aotearoa. Kia ora, malo e lelei, talofa lava, ni sa bula, kia orana, fakaalofa atu ki a motolu oti, taloha ni, kam na mauri, namaste, aloha mai, iorana, alofa atu, halo olketa, noa 'ia 'e mauri, koe kia, malo le kataki, talofa, kulo malulo, kaoha nui, ali'i, dada namona, kaselhia maign, bonjour and hello!

A more equitable and fair pathway is needed to support our Pacific sisters and brothers coming to work as nurses in Aotearoa New Zealand. We have an untapped and rich resource of skilled and highly trained nurses from many different Pacific nations, but there are so many hurdles for them to overcome before they can practise here, many just give up.

Before registration, their qualifications have to meet New Zealand standards. First, they must pass the occupational English test. Then they need to pass a competency assessment programme (CAP), which is costly. Only then, can they apply to the Nursing Council of New Zealand for registration and a practising certificate. This can end up costing thousands of dollars, and take incalculable hours of extra work on top of a day or night job with which most have to support themselves in the meantime.

So many give up, especially if they don't pass all these hurdles on the first attempt. They take up roles as health-care assistants (HCAs) or work in other non health-related jobs instead – a loss not just for themselves, their families and communities, but for Aotearoa.

Only 2.3 per cent of the nursing workforce identify as Pacific, whereas 7.4 per cent of New Zealand's population identify as Pacific. We need more Pacific nurses to match the need for culturally appropriate care of our people.

We understand the importance of regulations and standards to ensure our nurses are competent to practise here, and can communicate and relate to the people they work and care for. We don't want to downgrade New Zealand's nursing standards – we want safe care for everybody. But we feel that more can be done to support the pathway of Pacific-trained nurses into practice here.

In recent decades, there have been initiatives to encourage Pacific nurses to work here. But these programmes have been one-off and not sustained, evaluated or embedded. And it is timely to take another look into how we can support this untapped resource, given the ongoing nursing workforce shortages.

These Pacific trained nurses are new migrants, trying to set up a new life here – they don't have thousands of spare dollars, especially if they don't pass first time around.

The NZNO Pacific Nursing Section would like to see ongoing, wraparound support for nurses migrating from the Pacific. This should include financial, psycho-social, mentorship and cultural support to help them pass the English test and CAP and to transition into practice in the New Zealand health system.

These Pacific-trained nurses are new migrants, trying to set up a new life here – they don't have thousands of spare dollars, especially if they don't pass first time around. But they come with experience, commitment and a dream to contribute to the health-care needs of New Zealand. For many, however, their dreams and aspirations are shattered as they are defeated by the barriers.

Investment in this pipeline will bring long-term gains for our nursing workforce and we need to be more intentional and innovative about supporting the different workforce pipelines that we have. An investment in migrant Pacific-trained nurses would see more Pacific nurses, who are culturally and clinically experienced, working in the New Zealand system. This would help address the current nursing shortages – projected to become worse over the next few decades. We would see better health outcomes for our Pacific communities – who, statistically, die younger and suffer disproportionately from chronic health conditions such as cardiovascular disease and type 2 diabetes – the latter is three times as prevalent in Pacific communities than in the New Zealand population overall.

COVID-19 has only amplified the problem. Migration has been at a standstill for the past year or so. Yet now, more than ever, we need to support our Pacific communities to get vaccinated. Nurses are stretched and Pacific communities more than ever need professionals who can speak their language, to help them navigate COVID-19 and immunisation. This requires knowledge of the many Pacific languages, to ensure our people can find their way through.

This need is only going to grow. We need supports in place for the future – to manage future pandemics and health crises as well as the inequitable health needs of Pacific communities and to purposely build our workforce to fit our increasingly diverse population. •

** See also 'Connecting with our people', p12.*

'Eseta Finau, RN, MPH, is chair of NZNO's Pacific Nursing Section

Tell us what you think

Nurse objects to midwife groups' comments

AFTER A long night shift recently, an article in the *Dominion Post* caught my eye. 'Safety concerns as nurses fill in for midwives on short-staffed wards´ (*Stuff*, April 14) quoted College of Midwives chief executive Alison Eddy saying: *"A registered nurse wouldn't have the ability to diagnose and treat within that scope. It's putting them in a difficult position."*

As I read further, I became more and more angry and insulted at this portrayal of nurses. I started my maternity career in 2018, spending two years in a complex and high-risk maternity ward at National Women's Hospital. No two patients were the same. As an individual who made it through a nursing degree and then postgraduate study, I considered myself not an idiot.

Nurses are trained to care for people of all ages, in all stages of life, and in any state of sickness.

I phoned the Nursing Council and asked if antenatal care was, in fact, outside of a nurse's scope. I was told *"Nurses are trained and expected to care for any patient, in any stage of life, including pregnant women."*

According to the Nursing Council, a registered nurse (RN) uses *"knowledge and complex nursing judgement to assess health needs and provide care . . . They practise independently and in collaboration with other health professionals . . . They provide comprehensive assessments . . .[and] interventions that require substantial scientific and professional knowledge, skills and clinical decision-making . . . RNs may practise in a variety of clinical*

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coeditors@nzno.org.nz

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contexts depending on their educational preparation and practice experience".

In the article, Eddy went on to say: *"Registered nurses were not as skilled in the physiology of newborns and could not provide the same level of breastfeeding expertise".*

All RNs have comprehensive education on the physiology of all stages of life, including newborns. Many nurses working in maternity units have a background in neonatal intensive care or Plunket, and just as much experience with breastfeeding. RNs working in areas where breastfeeding knowledge is required must undergo 21 hours of initial training, and have annual breastfeeding updates, the same as midwives working in hospitals.

Eddy then states: *"This is in no way wanting to discredit the value of the role they [nurses] play, but midwifery is a specialised degree and a specialised profession".*

Nurses are not trying to be midwives. We respect and value the unique specialised training they have.

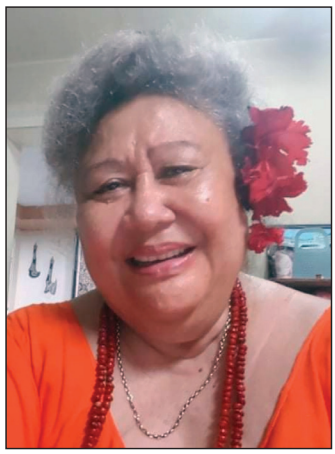
Co-leader of the midwives' union MERAS, Caroline Conroy, is then quoted as saying nurses *"weren't always able to pick up the early warning signs of a sick mother or baby. Midwives appreciated nurses helping, but there was a limit to what they could do and midwives had to oversee their work . . ."*

Short staffing issues mean that most shifts will have at least one, if not many, casual pool staff. These staff do not have the experience to recognise early warning signs that an experienced nurse would. Equally, a nurse who usually works in obstetrics would not recognise early warning signs if they were plonked into a cardiac or orthopaedic ward for one shift. Experience builds over time. Furthermore, by hiring nurses on temporary contracts and not advertising vacancies open to nurses or midwives, maternity services have created a revolving door of inexperienced staff. Breastfeeding rates are dropping as staff shortages skyrocket.

Although creating more midwives needs to be the solution long-term, nurses are the only solution we have right now to a system that is increasingly failing its patients.

For those interested in joining, there is an 'obstetric and maternity nurses NZ' forum on Facebook (https://www.facebook.com/groups/311411720334803/) (abridged)

Anita Cook, RN,
NZNO delegate, Hutt Valley District Health Board maternity ward
(see also news, p7)



Samoan health leader seeks former nursing colleagues

A RESPECTED friend of mine is looking for her former nursing colleagues. Her name is Palànitina Toelupe (née Mala), pictured above left.

The photo on the right was taken in 1975 at the Rotorua Public Hospital School of Nursing. Palànitina is 3rd from the right in the top row. She was the only Samoan student nurse. There were two Māori student nurses and the rest were Pākehā.

Palànitina went back to work in Samoa, becoming the Ministry of Health director-general and general manager of Samoa's National Health Services. This was a remarkable career of mana for a woman in Samoa.

If anyone can help her find her fellow students from all those years ago, please email palanitina@yahoo.co.uk

Ireen Manuel
(Auckland/Tāmaki Makaurau)

Changes in polytechnic sector

I WANT to alert nurses to the significant changes underway in the polytechnic sector in regard to nursing education.

Te Pūkenga is now the overarching body of the 16 formerly independent polytechnics around the country that offer undergraduate nursing degrees.

It is now being suggested that there be only one curriculum for nursing in institutes of technology and polytechnics (ITPs) that will cut across the 13 curricula currently taught.

The five separate Māori and Pacific bachelor of nursing programmes have their own curricula and we are not sure how these options will be contained/managed/delivered.

It is vital the nursing voice is gathered through consultation, and heard, for the Te Pūkenga reform process. Yet it seems the Ministry of Education has allocated no extra resourcing to assess nursing education needs for the new Te Pukenga structure.

We urge you to be informed and involved.

Anne Brinkman
NZNO professional nursing adviser

Taonga error

"Taonga" (treasure) was spelt incorrectly in one of the advertisements in last month's issue acknowledging the value of nurses on International Nurses and Midwives' Day. South Canterbury District Health Board apologises for the error and any offence it may have caused. A corrected version is running this month on p35. •

Nurses will help 'shape' reforms: Minister

HEALTH MINISTER Andrew Little has promised nurses will help "shape" profound changes mooted in the Government's health reforms.

This promise comes amid warnings that nurses need to maximise their voice in planning stages, before those changes are set in law next year.

Little told *Kai Tiaki Nursing New Zealand* that "nurses and all health workers" would get an opportunity to shape the system and their role in it.

"My expectation is the new organisations Health NZ and the Māori Health Authority, both of which will have workforce planning and development functions, will be regularly engaged with all sectors of the health workforce to get the best out of it."

In April, Little announced changes, to roll out over three years, which included replacing all 20 district health boards (DHBs) with Health NZ, and creating the Māori Health Authority.

The authority would be run by Māori, for Māori, with the ability to buy its own services, set policy and evaluate progress.

"Interim" versions of the organisations would work with health staff to plan how they would function. New legislation, underpinning the changes, would be in place by next April.

Other specifics, however, were still scarce on how the process would work – including funding.

Andrew Little

'Hutia te rito'

Acting NZNO chief executive Mairi Lucas said she wanted to acknowledge the effect of the reforms on nurses, "and the expected positive impact these should have".

Nurses wanted to be heard, and were the "backbone" of the health system, she said. "We need to finally see equity in the way nurses are recognised."

Lucas pointed to the Māori expression, *"hutia te rito o te harakeke, kei hea te kōmako e kō?"* (If you pluck out the central shoot of the flax, where will the bellbird sing?)

"If the heart of nurses is lost, where will our voices come from?" she said.

NZNO acting manager, nursing and professional services, Kate Weston, said nurses needed to maximise reform opportunities.

A "not-negotiable" would be nursing leadership at every level of the new entities – "visible nursing leadership that has actually got the authority to make change."

Previous health reforms weren't necessarily good for nursing – so this time, as a majority in the health workforce, they needed to "own it from the outset".

"Where nurses have a strong voice and strong input, you tend to get improved patient outcomes."

The Health Minister surprised many – including people in the health system – by the size of the proposed shake-up. The proposals went further than Health and Disability Review recommendations released last year. •

New co-editor: 'Nothing more important than health'

TĒNĀ KOUTOU, e ngā rangatira, e ngā tāngata manawanui, e ngā kaimahi pai rawa atu i roto i tēnei ao hauora, otirā, i te ao o te roopu nei, NZNO.

Ngā mihi nui ki a koutou katoa, e pānui mai ana.

Ko Joel Maxwell ahau, he kairīpoata hōu i te tīma nei ki a Kai Tiaki.

Nō Te Hiku o te Ika ahau, nō Te Rarawa.

Kia ora. My name is Joel Maxwell, new *Kai Tiaki* co-editor, and this month marks my first edition as part of the team that creates this journal, in print and on our website.

I'm proudly of Te Rarawa, an iwi from the Far North (Te Hiku o te Ika – the "tail of the fish"). My marae is called Te Rarawa also, which sits in beautiful Pukepoto, between Kaitāia and Te Oneroa-a-Tōhe (Ninety Mile Beach).

I come to *Kai Tiaki* from *Stuff*, the news website, where in my most recent role I worked in the press gallery at Parliament.

Joel Maxwell

I feel privileged and excited to be working with NZNO, and at *Kai Tiaki*, and see the role as a natural extension of my work covering politics, where I had a particular focus on Māori affairs.

I think there is nothing more important than health: of our body, mind, whānau and spirit – and surely there are no more important people in helping foster and grow these aspects of our health than our members.

So, I look forward to sharing our stories, and helping those members stay informed. Ngā mihi nui.

▶ Acting chief executive Mairi Lucas said she was thrilled to welcome Maxwell to *Kai Tiaki Nursing New Zealand* but also to the wider NZNO team. "We know his skills and experiences will enhance the magazine and provide a bicultural perspective to the stories and information we share with our members." •

‘Strong’ response in DHB strike ballot

NZNO’s DISTRICT health board (DHB) members have given a “strong” response in an online strike ballot, says lead advocate David Wait.

The ballot relates to the NZNO/DHB multi-employer collective agreement (MECA) negotiations. NZNO was still hopeful of reaching a settlement, Wait said.

The ballot closes on May 13 and while he was reluctant to pre-empt the results, Wait said there had been a strong response, in favour of strike action.

Should the DHBs come up with a revised offer, there would be time for members to ratify it before the date of the strike, planned for June 9, Wait said. NZNO planned to give 23 days’ strike notice (more than the required 14 days) to allow for that possibility.

Members working in managed isolation or quarantine (MIQ) facilities, or at the border, would not be required to strike, he said. “Those members will take part in campaign action, but are not going to be asked to participate in the strike, because that’s the right thing to do.”

But that was the only exemption, he said. Members working in the COVID-19 vaccination programme would be expected to strike. “That service is quite different . . . DHBs can easily schedule around it with minimal disruption to the vaccine roll-out.”

Members had been clear, determined and united in their rejection of last month’s offer from the DHBs, Wait said, giving the bargaining team a strong mandate. “One of the things we’re pleased about is that our members are unified and it’s really clear what they want and what they are prepared to do about it.”

THE OFFER

- **Health-care assistants (HCAs):** $900 lump sum; pay scale introduced over two years to increase HCA pay by 5.6–12.2 per cent.
- **Registered nurses (RNs) steps 2-4:** $900 lump sum and $1200 flat-rate increase in May this year.
- **Senior RNs steps 5-8:** $1200 flat-rate increase in May 2022; no lump sum.
- **Registered midwives (RMs) steps 2-4:** $900 lump sum; 1.25 per cent pay rise from May this year.
- **Senior RMs:** 1.25 per cent increase from May this year; no lump sum.
- **All midwives:** $1200 flat-rate increase from May 2022.

David Wait

If it went ahead, the nationwide strike would be for eight hours, from 11am to 7pm. It would be a very “visible” protest as nurses walked off the job mid-morning, and would spread the burden of salary loss, affecting just half a shift for most workers, “rather than a full day’s pay,” Wait said. “It also means that if further strike action is necessary, there will be room to escalate that action.

“We know that members feel like they’re not valued for the work they do, and it’s been a long time coming for them, in terms of pay and safe staffing that DHBs have committed to but members are not seeing.”

Wait said that at a meeting last month the DHB bargaining team seemed open to members’ concerns over the current offer, which largely excluded senior nurses. The DHB advised they would have to consult ministers – including health, finance and the public service – to make an offer “outside their existing mandate.

“The DHBs are certainly looking for a way to reach agreement,” Wait said.

DHBs spokesperson Dale Oliff said last month that DHBs were “disappointed” by NZNO’s response to an offer “deliberately weighted” towards those at the lower end of the pay scale. Increases of up to 11 per cent for them would close the “growing gap” with those at the top, who had rises of up to 16 per cent in the last DHB MECA round, she said.

“For senior nurses and midwives, there is an element of restraint that applies to all higher paid public servants, but the offer is reasonable in the context of other public and health sector settlements.”

Wait disputed that, saying pay restraint for senior nurses and midwives was a “blunt tool” and more to do with the DHBs’ bargaining mandate than principles around pay negotiations. “They’ve arbitrarily decided if you’re paid a certain amount, then you don’t need a decent pay rise, regardless of the value those members bring to the health system.” •

NZNO in talks with DHBs over life-preserving services

NZNO IS working with district health boards (DHBs) and delegates on contingency plans for patient safety in case a strike by DHB members goes ahead next month.

A strike ballot was to close on May 13, after members rejected an NZNO/DHB multi-employer collective agreement (MECA) offer which largely ignored pay rates for senior nurses. An eight-hour strike is scheduled for June 9, if members voted to go ahead with industrial action and no revised offer was forthcoming, lead advocate David Wait has said.

A plan to maintain life-preserving services (LPS) was required during any industrial action arising from DHB MECA bargaining, NZNO industrial services manager Glenda Alexander said. Alexander and acting manager, nursing and professional services, Kate Weston have been meeting with DHB representatives and their national contingency planner.

“There are high-level processes and protocols required to be agreed as part of Schedule 1(b) of the Code of good faith for the public health sector,” Alexander said. “Discussions have been held on what these would look like if there is any industrial action taken arising from the current bargaining.”

The code had specific requirements that needed to be met upon the issuing of a strike notice, which included how members would be involved in determining their local LPS agreements, she said.

“Information and delegate education is being prepared now for those who will be directly involved.” •

Pay freeze 'unpleasant bolt from blue'

AN EXTENDED pay freeze across the public sector for staff earning more than $60,000 was disrespectful to nurses and "the entire public sector", says NZNO lead advocate David Wait.

Wait is leading pay negotiations for 30,000 nurses and other health workers at district health boards (DHBs), who are considering strike action.

It is not yet clear if, or how, the freeze will affect the negotiations, but it was an "unpleasant bolt from the blue", he said. "It's a blanket approach that disrespects the entire public service, including our members. It completely devalues the work our members do."

Wait said NZNO would not know what the impact would be until mediation with the DHB bargaining team scheduled for May 18-19. It might have no effect if it kicked in after June 30, but this was not yet clear.

'Moderation and restraint'

Making the May 5 announcement, Public Service Minister Chris Hipkins said an existing 12-month freeze, ending in June, would be extended for the next three years "across the public service". He said it was "important for the public service to show moderation and restraint".

The freeze was technically considered guidance – but most of the public service, including the Ministry of Health, must pay heed to it. It was immediately slammed by health and wider public service unions.

Staff earning between $60,000 and $100,000 – about half of the public service – could only get pay increases under select circumstances. This would be if there were recruitment pressures within that sector that could not be met through modest progression increases.

There would be no pay increases for people earning more than $100,000.

Wait said the announcement could not only have "significant" impacts on negotiations, but also DHBs' ability to attract and retain staff.

NZNO industrial services manager Glenda Alexander said the extension could stifle ongoing efforts to resolve gender pay equity, and the "longstanding undervaluation" of members' work.

"Three years effectively freezing our pay rates would put us backward in closing the gender pay gap between the female-dominated nursing occupation and male-dominated occupations, many of which are in the private sector."

Nurses, midwives, healthcare assistants and kaimahi hauora employed by DHBs could all be affected by the announcement. •

NZNO 'disappointed' at midwives' comments

NZNO WAS "very disappointed" at comments made about nurses by midwifery leaders, reported in an April 14 *Stuff* article ('Safety concerns as nurses fill in for midwives'), acting manager, nursing and professional services, Kate Weston said.

Co-leader of the midwives' union, MERAS, Caroline Conroy was reported as saying that *'nurses weren't always able to pick up the early warning signs of a sick mother or baby. Midwives appreciated nurses helping, but there was a limit to what they could do and midwives had to oversee their work'.*

College of Midwives chief executive Alison Eddy was reported in the same article as saying that registered nurses (RNs) *'were not skilled in the physiology of newborns and could not provide the same level of breastfeeding expertise'* as midwives.

Their comments were inaccurate, damaged public confidence in nurses and "caused distress to our nurse members, who are making a valuable contribution in maternity", Weston said.

NZNO did not dispute the problem of high midwifery vacancies, "but to state that nurses do not have the 'same level' of training as midwives is inaccurate".

Both nursing and midwifery were degree programmes, and many nurses also had post-graduate qualifications, she said. "Nurses and midwives have different training and different scopes".

In terms of caring for newborns, "nurses working both within the maternity service and in Well Child, paediatric and neonatal/special care baby units possess a very high level of technical skills, experience and knowledge" to support women in breast-feeding and other aspects of parenting, Weston said. Caring for sick or pre-term infants, including transitional care, was also a nursing skill, she said.

The suggestion that nurses *"weren't always able to pick up the early warning signs of a sick mother or baby"* was particularly damaging, inaccurate and disrespectful.

"Nurses are accountable within their own scope for all care, which includes surgical and medical care and all care of the baby.

"Nurses are educated to care for people of all ages, in all stages of life and in any state of sickness or wellness," Weston said. "Nurses are not trying to be midwives. Nurses respect and value the unique, specialised training of midwives. It is reasonable to expect the same professional courtesy to be extended to nurses."

Conroy told *Kaitiaki Nursing New Zealand* the *Stuff* article comments were about inexperienced nurses, rather than those experienced in maternity. She had not intended to denigrate nurses, who made a "valuable contribution" in maternity. "I fully appreciate why nurses are upset and that was not my intention."

However, MERAS did believe maternity wards should be "100 per cent midwife-staffed", she said. "Loading up maternity wards with nurses is not the solution."

Midwives "have the legal responsibility of overseeing and supporting the care provided by the RN" yet the midwifery shortage meant this was not always possible, which was cause for "concern", she said.

Conroy said she and Eddy had agreed to meet Weston to discuss nurses' concerns and "clear the air". •

Nurses 'profoundly affected' by end-of-life law

NURSES MUST not be forgotten in the End of Life Choice Act (EOLCA), due to come into effect on November 7, NZNO says.

NZNO kaiwhakahaere Kerri Nuku and policy analysts Leanne Manson and Lucia Bercinskas (right) were among nursing representatives who in April met the Ministry of Health (MoH) team leading the EOLCA's implementation, to ensure nurses' views inform guidelines to it.

"While RNs [registered nurses] do not have an explicit 'specified role' under the Act, it is undeniable that nurses will be profoundly affected…," an NZNO document prepared for the MoH states.

Bercinskas told *Kai Tiaki Nursing New Zealand* that nurses needed clear guidance on what they can and cannot do. "What are the parameters? Who does what? How does conscientious objection work? Who is going to be looking after the patient's family?"

Clarity was needed on:

- Conscientious objection and how it might be applied in different situations – and whether it might affect a nurse's employment.
- Cultural considerations including a culturally-safe process and equity in access to quality end-of-life care (EOLC).
- Scope of practice and training in EOLC.
- Professional obligations and patient rights.
- Patient eligibility, the meaning of "unbearable suffering" and communicating this.
- Improper pressure and what that looked like.
- Managing patients wishing to initiate – or defer – EOLC.

The EOLCA provides that a nurse practitioner (NP) must only act under instruction from the attending medical practitioner. NZNO's paper suggests that guidance should make clear that this is a requirement, even though this was not consistent with the generally accepted NP scope of practice.

In addition, NZNO suggests the EOLCA could be misconstrued to require a NP called in by a medical practitioner to administer the medication. Guidance must clarify that this should not occur without prior NP involvement with the patient.

Guidance was also needed on the NP's role at the time of administering the medication, if doubt or other barriers arose, NZNO's paper said.

EOLC was a "fraught" issue, said NZNO medico-legal lawyer, Sophie Meares, who anticipated complaints being laid against nurses if things went wrong. Guidance and training were essential, she said.

Chief nursing officer Lorraine Hetaraka confirmed she would be part of the governance group overseeing assisted dying, Support and consultation for end of life in New Zealand (SCENZ).

"I recognise the importance of having a nursing perspective on this governance group as patients and whānau in our hospitals, primary care and community settings alike rely heavily on the services nurses provide."

A MoH survey of 1980 health professionals earlier this year found 30 per cent were possibly or definitely willing to participate. •

Late CTU leader 'unionist to her boots'

SHE WAS a "unionist to her boots" and had she lived, Helen Kelly might even have a nice view from a Beehive office by now.

Journalist and author Rebecca Macfie launches her biography of the union champion on May 15 – covering the extraordinary life of the first female head of the Council of Trade Unions (CTU).

Macfie said she started work on *Helen Kelly – Her Life* in 2018, and knew Kelly for about three years before her death in 2016 from lung cancer.

In 2018, NZNO donated $5000 towards the publication of the book about the life of the staunch workers' advocate.

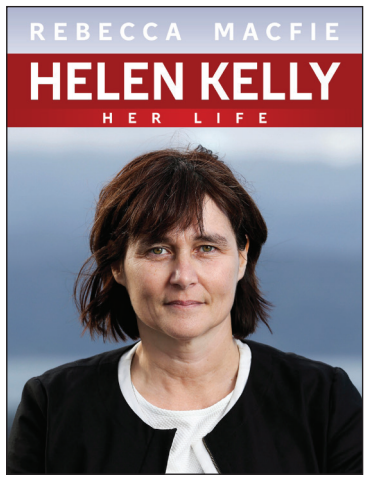
"Kelly had grown up in a union household – Pat Kelly (her father) was a very prominent militant unionist who she saw at work all through her [early] life."

Kelly "absorbed" that the union movement was a means for improving life for working people, Macfie said. "It was more than 'I belong to this club': it's an identity."

Over the years, that commitment to unionism saw Kelly involved in a series of high-profile battles on behalf of workers. This included a stoush with Sir Peter Jackson over pay and conditions for workers on *The Hobbit* films, seeking improved safety for forestry workers, and seeking justice and safety improvements for miners after the Pike River tragedy in 2010.

Macfie said that Kelly would likely have become involved in politics as another avenue for improving people's lives.

She was approached to stand in Wellington for Labour – which she turned down at the time because of her union commitments.



"I think if Helen lived she would have been in Parliament now … had she lived she certainly would have been in caucus now, and certainly would have been a cabinet minister." •

Concerns over unregulated vaccinators

QUESTIONS REMAIN over plans to use lay people in the Government's ambitious COVID-19 vaccination rollout.

NZNO acting manager nursing and professional services Kate Weston (right) said there was no "conversation or consultation" with the organisation over how nurse members, in particular, would work with proposed unregulated vaccinators.

"I'm not sure what the actual specifics of a relationship to a registered health professional will be," Weston said.

Usually, she said, responsibility for the new workforce would fall on the regulated health professionals. In the case of the rollout, this could be anyone from nurses to doctors to physios, with a raft of people needed to actually deliver the programme.

Despite the lack of consultation with the NZNO before the decision by director general of health Ashley Bloomfield, there would still be "roles for everybody" in the programme, Weston said.

"There's the consent process, there's the crowd control, there's the meet-and-greet, there's recovery. There's a lot of places where we could really welcome and use lay people in the team."

If lay people were going to be delivering the vaccine, then their training should be robust, Weston said.

"So it's not just minimised to just a [single] skill. It's not just about jabbing someone in the arm. It's actually a much wider skill of ensuring that person's wellbeing throughout the whole process."

Another concern was whether community members would be made aware their vaccinator was not a registered health professional.

Under the Code of Rights people did have the right to know, she said.

There were worries too that lay vaccinators might be working predominately with Māori health providers, she said.

"If it's going to be across the board for everybody, ok let's talk about it . . . but is it just going to be put into those communities? What's the rationale for that?"

Weston said she would like to know if it was genuinely about providing a high quality service, "or is it actually about providing something that's a bit second rate?"

The Ministry of Health and Bloomfield have come under pressure to muster a vaccination workforce.

This has created further concerns that the demand would soak up nurses from other areas of the health system – leaving them understaffed.

NZNO recognised vaccinating the best part of 5 million people would require "a huge workforce", Weston said.

"But we would have appreciated a bit more consultation before the decision was made."

Weston said it appeared the unregulated vaccinators were not yet in the vaccination workforce. •

'Complex' constitutional review pushed back

A REVIEW of NZNO's constitution is unlikely to be completed in time for the 2021 NZNO annual general meeting (AGM) in September, says NZNO's board of directors.

"Because of the scale and complexity of the task, it is unlikely this review will be completed in time for the 2021 AGM," the board said in its kōrero email to members on May 4.

However, the board was close to selecting a reviewer, it said.

"This review could impact on every aspect within NZNO, so again it is important we select the right people for this job – people with constitutional expertise who understand the union environment."

Board member Diane McCulloch (left) has been elected chair of the constitutional review advisory group (CRAG). Other members of the group are tumu whakarae Titihuia Pakeho and board member Andrew Cunningham.

Representatives from the Cancer Nurses College (Sarah Ellery) and Mental Health Nurses' Section (Jennie Rae) – which jointly submitted the remit calling for an independent review at the 2020 AGM – are also part of CRAG along with Te Poari members (Lizzy Kepa-Henry and Moana Teiho) and the membership committee (Brent Doncliff).

Terms of reference would be finalised when a reviewer/s was appointed, the board has previously stated.

The board said in its kōrero that now was a good time for members to start discussing how NZNO could be best "fit for purpose".

Chief executive appointment

The board said it was still "working through the process" of appointing a new chief executive. "This is a very important appointment for a role that will lead us through a period of significant change," its kōrero stated. "Therefore we [the board] will take whatever time is needed to find the right person." •

Filipino nurses stopped at border

THE AMBASSADOR to the Philippines has stepped in to ask the New Zealand Government to change its visa rules after eight Filipino nurses trying to fly to New Zealand were halted at Manila's airport earlier this year.

Urgent talks are underway between the Philippines ambassador Jesus Domingo and the Ministry of Foreign Affairs and Trade (MFAT) and Immigration New Zealand to fast-track a solution for hundreds of nurses after the Philippines Government cracked down on current visa practises.

Domingo said the Philippines Government was concerned about global human trafficking risks when citizens left without work or student visas and did not return.

He would love to see a new bilateral agreement allowing an open work visa for Filipino nurses, so they had a "clear route" to working in New Zealand.

More than 1000 Filipino nurses enter New Zealand every year, often on a one-way ticket and visitor's visas, to complete a short competency assessment programme (CAP), then find nursing work. They can then apply for work visas with the support of their employers.

Auckland nurse Melody Opanes-Kircher, who administers a social media group involving 43,000 Filipino nurses in New Zealand (Pinoy Nurses in New Zealand), said the group successfully lobbied to let the nurses travel, through the Phillipines' Embassy, after they were stopped on January 29.

Melody Opanes-Kircher

Ambassador Jesus Domingo

She believed the Philippines Government was cracking down after global concerns about human trafficking. After being reassured it was a legitimate practice, the nurses were let through in February and an extension given until the end of April. After that, the Philippines Government has said they will no longer let Filipino nurses travel to New Zealand on visitor's visas.

The nurses were not eligible for student visas as the CAP courses were too short, at just eight to 12 weeks, Opanes-Kircher said. While the visitor's visa had been a recognised pathway for some time, it was an uncertain, expensive and difficult one for Filipino nurses – and an easier, smoother one was needed, she said.

It cost about $30,000 for a nurse to travel here, stay in a managed isolation facility and complete their CAP training before they could even apply for registration and jobs, she said. Those who failed to pass their CAP, often ended up working as health-care assistants (HCAs) in aged residential care facilities and trying again to qualify to register as a nurse here.

"At this time, when nurses are in such demand around the world, can New Zealand not make it easier for Filipino nurses to come here?"

Opanes-Kircher came to New Zealand on the same pathway, arriving in September 2010, completing her CAP in December and starting a job at Middlemore Hospital in February 2011.

Pay rates for nurses in the Philippines are low and working overseas was a popular way for Filipino citizens to support themselves and their families, Domingo said. But Filipino nurses were in huge demand right now, globally, due to the pandemic.

Ten per cent of the New Zealand nursing workforce is made up of Filipino nurses, according to 2018/19 data from the Nursing Council – the largest single ethnicity of nurses qualified overseas.

An MFAT spokeperson said: "We have been in contact with the Philippine authorities to provide reassurances about the competency assessment programme and the visa process for arriving nurses. Officials will continue to communicate with Philippines authorities to address any concerns they may have." •

(See also 'Filipino nurse will keep advocating', p11)

NZNO launches equity framework: 'Everyone has a role to play'

"EVERYONE HAS a role to play" in making equity a core part of NZNO work, staff were told at the launch to staff of NZNO's new equity framework last month.

NZNO acting chief executive Mairi Lucas said it was time to be courageous and "active disruptors" for change. "NZNO has a role to play and is accountable to the voices of our communities."

Lucas said inequities had impacted on her own life and that of her whānau and children. NZNO's kaupapa was to "create a fair and just health system" which would better support iwi, hapū and whānau.

"We need everybody to be on the waka," she told staff. "We've done the talk for years and now we need to be able to walk it."

NZNO acting president Tracey Morgan said COVID-19 had further highlighted inequities in the system which needed changing. "Members need to know we are going to support them."

Board member Diane McCulloch said she had come to New Zealand from a system of apartheid in South Africa, "so I know what it's like and I do not want anyone else to go through that".

But here, she found the problem was "rife and was being swept under the carpet".

Speaking about aroha, board member Anamaria Watene said aroha was about relating to others with empathy, respect and generosity. The framework will be launched to members later in the year. •

Migrant nurses make up more than a quarter of the New Zealand nursing workforce. In the first of four profiles of migrant nurses in this issue, co-editor Mary Longmore spoke to Auckland community health nurse Emmanuel (Manu) Pelayo. He is one of three new Nursing Council members elected recently but will keep advocating for Filipino nurses trying to reach New Zealand.

Filipino nurse leader will keep advocating

Manu Pelayo was seven when his older sister Suzette became severely ill. Having had measles as a baby, by nine she was developing neurological symptoms including loss of balance and speech. Diagnosed with subacute sclerosing panencephalitis – progressive brain inflammation, a rare side-effect of the particular measles strain – she spent the next 14 years bedridden at home, cared for by her family. "She was in bed, doing nothing but breathing really," Pelayo remembers. "Mum was her full-time carer and the house basically became a hospital."

From 10, Pelayo began helping with personal cares, tube-feeding, oral suctioning – "all sorts of nursing work"– at home, guided by his mum and uncle, a nurse. The care was so good, that despite being bedridden, "in 14 years, she never developed bedsores", Pelayo recalls. "This was my main motivation for becoming a nurse. It was just the most sensible path for me, and it's my calling."

Suzette died shortly after Pelayo graduated and registered as a nurse. While she couldn't communicate, Pelayo believes she knew what he had achieved.

After two years at Manila Doctors Hospital, in 2009 Pelayo responded to a Philippines' recruitment drive from Counties Manukau District Health Board (CMDHB). He was interviewed in Manila by CMDHB staff and hired to work in the orthopaedic wards – once he'd completed the competency assessment programme (CAP) and met Nursing Council requirements.

CMDHB paid for his flights and accommodation while he was completing his CAP and guaranteed him a job – but things are more difficult now.

In the Philippines, jobs are few, hours are long and the pay for qualified nurses low (NZ$200-400 a month). For many, nursing overseas is an escape from poverty, and a way to provide for families.

Today, Filipino nurses wishing to emigrate have to go it alone, or pay consultants – who can be unscrupulous. "Expenses can be huge, with the CAP course then they also have to look for jobs themselves plus consultancy fees – it's really hard."

Pelayo is part of a small network advocating for those Filipino nurses, and countering "misinformation" spread by consultants and even media advising nurses to take the student visa pathway into New Zealand. But signing up for unnecessary "health management" courses can be the longest and most expensive route. "It's a legal pathway but I don't think it's ethical for agencies to make their money from vulnerable people this way," he said.

'If I see an injustice, I'll call it out.'

"When you hear something too good to be true and you are desperate to leave the country, you will grab anything."

Petition

In 2018, he started a petition to stop student trafficking. (www.change.org/p/stop-promoting-student-trafficking). Drawing more than 3000 signatures, the petition protested that media outlets in the Philippines were promoting false information about student schemes being the best way into New Zealand, when "it costs our fellow Filipinos an arm and a leg (maybe a kidney too) to pay the consultancy firms, pay for tuition at an international student rate and there is no guarantee that they will acquire a job afterwards or be offered a work or resident visa."

The petition drew support and attention from the Filipino community and embassy in New Zealand, which is now in talks with different government agencies over the situation.

Manu Pelayo

For Pelayo – a busy dad of three – it was unconscionable. "If I see an injustice, I'll call it out. Some people think, 'I'm settled here, why meddle in other people's lives', but obviously as an advocate for the profession, I'd like them to be able to come here and work as nurses."

He advises nurses to apply for work directly, after gaining at least two years' experience in the Philippines, then organise their own CAP and competency assessment at the Nursing Council.

Since orthopaedics, Pelayo has worked in critical care and private hospitals. At Middlemore's intensive care unit he led an initiative on delirium sedation and pain relief, sparking a love of leadership.

He became involved with establishing a new "winter ward" at Middlemore Hospital in 2018, leading the development of a new model of care. The experience was "exhilarating" but, when the ward closed within a year, found it "heart-breaking" to see the close team dispersed.

He has since moved on – first to building project management at the DHB, then to community health provider, Healthcare New Zealand, where he is now regional clinical leader for the Northern and Midland regions. Seeing how much health care takes place in the community has been an "eye-opener". •

Kelera Batiwale (right) on the job at Christmas 2020, with Auckland City Hospital colleagues Clayre Jamieson (left) and Shonam Maharaj.

'Connecting with our people'

New Zealand is a land of opportunities for Fijian nurse Kelera Batiwale and her family.

By co-editor Mary Longmore

Auckland nurse Kelera Batiwale initially came to New Zealand for a holiday with some nursing colleagues, back in 2008.

But, with a recent military coup in 2006, the future was feeling uncertain for many Fijians. So, while here, Batiwale applied for the (now defunct) Pacific return to nursing scheme at Manukau Institute of Technology (MIT), in partnership with Counties Manukau District Health Board (CMDHB).

Having trained at the Fiji School of Nursing, Batiwale had worked in Fiji as a nurse for 18 years, doing everything from obstetrics to emergency to public health nursing. But she needed to pass the occupational English test and competency assessment programme (CAP) before she could practise as a nurse in New Zealand.

She won a place on the scheme, which supported her through her English tuition. While studying during 2009, she also worked as a health-care assistant (HCA), pulling hospital night shifts between tutorials, then as a community support worker at the Pacific Integrated Family Centre on the North Shore.

Having passed her English test, in 2010, she embarked on her CAP at Waitemata District Health Board while continuing her community support work.

By mid-2011 she was struggling with being apart from her four children and husband for nearly two years, after planned trips at Christmas and Easter clashed with her studies. She was considering giving up – but her children encouraged her to stay and complete her qualifications.

"I was so homesick but I wanted to go back home," Batiwale said. "But my oldest son said 'you should do this, for me'. That really hit me."

So, she persevered, completing her CAP by mid-2011 – just before her visa ran out. She successfully applied for her nursing registration that year – three years after her arrival. With a new work visa, she was finally able to go home for Christmas and reunite with her family.

Back in New Zealand, she resumed work at the Pacific Integrated Family Centre, this time as a registered nurse, before moving to Pacific community clinic, the Fono, in 2012.

In 2012, her family was able to come and join her, eager for the opportunities afforded in New Zealand, away from the troubles of a military-run Pacific nation. "There are so many problems in Fiji and better opportunities here," she said. One son is now practising law, another is studying law and her daughter studying tourism. Her youngest child is still at high school.

Batiwale has since moved into secondary nursing, at North Shore Hospital then Auckland City Hospital. "I wanted to challenge myself and do hospital care, after working in community care for so long."

Last year, she agreed to be seconded into the hospital's critical care unit to prepare for the potentially overwhelming impact of COVID-19. While the global pandemic did not devastate New Zealand's health system as it was beginning to in other countries, it was a very different environment. "I thought 'oh my God, what have I done!'."

Batiwale became involved with NZNO early on and is now president of the Auckland branch of the Pacific Nurses' Section, which she says is great for networking.

She always tries to encourage other Pacific nurses following the path to working in New Zealand, acknowledging how challenging it can be to support themselves through the English and competency exams. Even with the support of the Pacific return to nursing scheme, the path to nursing in New Zealand had been challenging, Batiwale said.

Yet it was so important to Pacific communities to be cared for by those from the region. "The way we connect with our people – we try to make the utmost difference, so they will never forget the care they received," Batiwale says. "I always give them the bula smile!"

She also makes time to hear about their lives and give "holistic" care – rather than just the medical advice or whatever they presented for –"the whole package".

With eight siblings still in Fiji as well as her husband's family, they keep in touch on video calls. Where they are living is reasonably safe from COVID-19 outbreaks. •

New Nepalese RN enjoys respect and autonomy

After a long bureaucratic journey, worsened by the lockdown, an RN from Nepal is thriving in her first New Zealand nursing role.

By co-editor Mary Longmore

Recently registered Nepalese nurse Pooja Gupta enjoys the respect and autonomy given to nurses in New Zealand, compared to her home country.

It has taken Gupta nearly three years to successfully register as a nurse in New Zealand, after COVID-19 delayed an already bureaucratic process.

But it's been worth it – she has finally landed her first nursing role at a private aged residential care (ARC) facility in Christchurch, and is loving the status and leadership opportunities of being an RN in New Zealand.

In Nepal, Gupta said, hospital hierarchies were entrenched, with doctors at the top. In New Zealand, nurses had more autonomy and decision-making powers. "Back home, we always had doctors advising us, but in New Zealand we don't need the doctors to do everything – we can do some things ourselves."

Pooja Gupta – 'nursing is very different here than in Nepal'.

Job satisfaction

This autonomy made the profession enjoyable, she said. "It gives us job satisfaction, and people appreciate our work."

Gupta trained in her home town of Butwal – three years at Mayadevi Technical College of Nursing for her basic nursing certificate, then another three years at the Sanjeevani College of Medical Sciences for her bachelor of nursing. In between, she worked for two years at the town's private Crimson Hospital as a medical and surgical nurse.

She travelled to New Zealand in 2018, to meet and join her husband Pradeep, who was already living here. It was a marriage arranged by their families, as is traditional in Nepal, but the couple had come to know each other on social media before deciding to go ahead with the marriage.

Gupta studied English for two months online, successfully passing the occupational English test (OET) required for health workers in 2019, while working full-time as a health-care assistant (HCA) in an aged residential care (ARC) facility in Kurow, just out of Oamaru.

In 2019, she applied to the Nursing Council for registration. After five months, they advised she needed to complete a competency assessment programme (CAP). The nine-week course at Ara Institute of Technology was then delayed for several months with the arrival of COVID-19, but she finally completed it by the end of 2020 – two and a half years after her arrival.

Finally, in January this year, she successfully registered as a nurse. It has been worth the wait, she said. "Although it took a long time, I never felt like giving up as my husband was there to support me every time."

Compared to her caregiving role, Gupta says she now spends less time talking with residents and more on providing the medication and "paperwork".

Working in a rest-home environment was a new experience, as in Nepal elderly people normally stayed with their families. "They're not really common in Nepal. When people grow old, the families look after themselves, we don't really have rest homes." But she enjoyed working with older people – "they're like our parents and grandparents".

'Learn as much as I can'

After two or three years, Gupta hoped to move to a hospital nursing role, as this was what she trained for originally. "In hospital, you get a chance in a diverse environment, I want to learn as much as I can," Gupta said. "Nursing is very different here than in Nepal."

In New Zealand, Gupta said people had generally been friendly. She worked with other nurses from Nepal and was also part of an extended Nepalese community in Christchurch – but misses her family and friends back home.

Her previous manager, Natalie Seymour – chair of the NZNO College of Gerontology Nursing – said she was "one of a kind.

"She's one of those nurses that just stands out and you instantly know that she is going to make a difference."

As a hospital aide in aged care, Gupta demonstrated compassion and expertise in her work, quickly taking to the aged-care environment despite having no previous experience.

Her road to working as an RN in New Zealand had been "complicated and, at times, could be seen as demoralising", Seymour said. "She has held herself with grace throughout and I am proud to have been her colleague."

Gupta said that as a child, she spent a lot of time at the local hospital, as it was close to where her family lived so was like their local drop-in clinic. She and her sister Seema always wanted to be nurses – and both have achieved their dreams. Seema is a nurse in Australia. •

At ease with a rural way of practice

Randy Gopalla: 'To be honest with you, I have never felt homesick from the moment we came.'

It's a long way from Mauritius to the South Island's West Coast, but Randy Gopalla is comfortable with small-town life and more generalist rural practice.

By co-editor Joel Maxwell

At first glance, the tropical island nation of Mauritius, in the Indian Ocean, a smidge to the east of Madagascar, seems to be more inviting than Greymouth, on the West Coast, a smidge to the east of the cold Tasman Sea.

But for clinical nurse manager Randy Gopalla, 42, the West Coast has become a true – if slightly chillier – home away from home after his move from Mauritius, to live in Aotearoa.

Gopalla spoke to *Kai Tiaki* about his journey, in life and work, to the rugged and isolated West Coast.

Nursing runs in his family, so Gopalla always intended to become qualified – starting his training aged 18. "Since I was in high school, my goal was to do my nursing studies."

He came to New Zealand in 2015 to complete his competence assessment programme (CAP), completed further tertiary education in Mauritius, and returned with his family to stay in 2017.

"We were mainly looking for a country where you had a good work-life balance. And then the level of practice here matches what we do at home as well, so it was easy for me to practise here."

Most Mauritians wanted to leave home to work in places like England, Canada or Australia, he said. "But for us we chose New Zealand mainly for my daughter, a nine-year old . . . it would be the best place for her to grow."

In Mauritius, the weather is warm. They have two seasons there, but "what we call winter there, is probably the summer here", he said. Mauritius is a busy, densely-populated island nation with a strong tourism industry.

The sparsely populated West Coast might seem like an odd choice for his new workplace, but he said he wanted to get away from big cities.

"We thought of moving to New Zealand and relocating to a small town . . . and when we came to Greymouth we really fell in love with that little town. And then last year we bought our own house."

Settling in to life at Te Nīkau, Grey Hospital and Health Centre, was not necessarily a big change either from his practice at home. There they tended to practice what he described as a rural model of care. Nurses might be expected to practice across multiple areas – "like medical, surgical, paediatric, ED".

"This is something that I did back home – and it was easy for me to go back to this rural way of practice."

Last year they shifted to new hospital premises and merged medical and surgical wards into a single, general ward.

Training staff as generalists

One of the challenges he was given when he came to the West Coast was to train staff to become more "generalist" practitioners.

"I had to train the medical into surgical and the surgical into medical, and merge the two together – and so when we moved last year it went really smoothly."

This jack-of-all-trades approach includes Gopalla himself. He is clinical nurse manager (ICU, medical-surgical ward), but after hours he is an on-call hospital-wide duty manager; at other times he fills in on shifts as duty nurse manager.

Gaining his registration in New Zealand was not problematic, he said. "I've done most of my studies with the Royal College of Nursing in England, and then the training in Mauritius is equivalent to the training in England [as a Commonwealth country] so we tend to have the same practice and education."

In 2015, he completed his CAP course work in Hawke's Bay and gained his registration. Now he is continuing to deepen his understanding of life in Aotearoa – training in te reo and tikanga Māori. It is something that makes him feel more like he is back home in multilingual Mauritius.

There were similarities between the Mauritian creole culture and the Māori culture, he said. "So it's quite easy for us to adapt."

After decades training and working around the world, Gopalla has found a home away from the traffic jams and long supermarket queues of big cities elsewhere.

"To be honest with you," he says, "I have never felt homesick from the moment we came. We've always been surrounded here with friends, and colleagues . . . so we've never felt we're on our own." •

Nurses' COVID-19 contribution

Nurses' contribution to the COVID-19 pandemic has been significant in all areas of health care.

By NZNO acting manager, nursing and professional services, Kate Weston

The theme for this year's International Nurses' Day is *Nurses: A voice to lead – transforming the next stage of health care*. Announcing the theme, International Council of Nurses' (ICN) president Annette Kennedy said the global COVID-19 pandemic had significantly disrupted health care but *"there has also been significant innovation that has improved access to care. In 2021, we will focus on the changes to and innovations in nursing and how this will ultimately shape the future of health care"*.[1]

COVID-19 has not overwhelmed the New Zealand health system with critically ill patients or led to a massive death toll. But it has led to significant changes in how nursing care is delivered and access to that care. It is interesting to reflect on how the pandemic has affected all health sectors, including nursing education.

COVID-19 had a significant impact in aged residential care (ARC), with the greatest loss of lives in that sector. This, in turn, has contributed to much tighter restrictions, with many facilities working under an alert level above that of the country/region, to manage risk.

A 'trickle' of IQNs

The closure of our borders since March 2020 has drastically affected the availability of internationally qualified nurses (IQNs). The usually steady flow is barely a trickle and there is little relief on the horizon. This has major implications for all sectors – 27 per cent of our nursing workforce is made up of IQNs.

The management of COVID-19 has largely been based in the community, with testing stations and vaccination centres now a routine feature of the primary health care landscape. Many NZNO members have been employed specifically in this work; others have taken it on in addition to other work in the community, general practice and Māori/iwi and Pacific providers.

The emergence of managed isolation/quarantine facilities (MIQs) has seen nurses and health-care assistants (HCAs) from other parts of the system seeking employment in MIQs – there are approximately 1500 nurses employed in these facilities. This has been at the expense of other sectors. This outflow has created additional staffing pressures in other parts of the system, as attempts are made to plug the gaps.

As the COVID-19 vaccination rollout gathers momentum, our members are both the vaccinators and the vaccinated. NZNO, along with other Council of Trade Unions-affiliated unions, supports the rollout and wants to ensure the public is well educated about it. Work is still being done to support "vaccine hesitant" workers and those declining the vaccine for medical or other reasons.

To deliver the vaccination to "the team of five million" in a timely manner is going to require about 2000-3000 nurses, who will form the bulk of the vaccinating workforce. Nurses are appropriately skilled and qualified and, for many, vaccination is part of their routine work.

To include lay vaccinators, ie non health professionals, in the vaccination workforce, as mooted by the Ministry of Health (MoH) last month,[2] will require some law changes. There are many roles for those who are not regulated health professionals to support the rollout, without becoming vaccinators. More clarity on the MoH's suggestion is needed before NZNO could support it. NZNO would want assurances that this is not a second-tier service aimed at already disadvantaged communities. It would also want to know the impact on regulated health professionals (mostly nurses) who will be legally responsible for those working under their delegation.

All this has added pressure to an already stretched workforce. And more nurses are being siphoned off to undertake key roles in COVID-19 management, but without their roles being back filled.

'Significant challenges'

The admonition to "grow our own" nursing workforce has met significant challenges. During alert level 4, nursing students were removed from clinical placements and their education interrupted. While efforts have been made to make up for this loss of practicum and theory hours, some students have found the delays and the ensuing additional costs too much and have been unable to complete their studies.

Despite the provisions of the 2018 nursing accord, which were to protect new graduate places and ensure 100 per cent employment of all new graduates, we are still seeing only 80 per cent of new graduates employed within six months. Anecdotally, there are fewer new graduate places available in DHBs this year.

Meanwhile, back in DHB land, the usual seasonal variation in patient numbers has not occurred this year, with many DHBs working above capacity over summer. Nurses in the sector have made clear their displeasure at the initial DHB multi-employer collective agreement offer. They are burnt out and overworked, with an alarming number leaving or intending to leave. It is high time nurses – the backbone of the COVID-19 response – are valued for their contribution. Their innovation in care delivery and improving access will, ultimately, contribute to shaping the future of health care. •

References

1) International Council of Nurses. (October 15, 2020). *International Council of Nurses announces International Nurses Day theme 2021.* Retrieved from www.icn.ch

2) RNZ. (April 15, 2020). *COVID-19 vaccine rollout plan briefing with Bloomfield and officials.* Retrieved from www.rnz.co.nz/news/national/440543/covid-19-vaccine-roll-out-plan-briefing-with-bloomfield-and-officials

NZNO Te Rūnanga members make their way on to Tūrangawaewae Marae, at Ngāruawāhia, in October 2018, where the Waitangi Tribunal 2575 kaupapa inquiry into health services heard evidence about the Crown's failure to provide adequate health services to Māori. The tribunal recommended establishing an independent authority to oversee Māori primary health services.

New Māori health authority needs independence and accountability

By Heather Came and Dominic O'Sullivan

As part of a major overhaul of the health system, Health Minister Andrew Little in April announced a new Māori health authority.

The authority will be able to commission primary health services and make joint decisions with a newly created centralised health agency. It's a simple idea, and one with radically transformative potential. But it's not new.

In 2019, the Waitangi Tribunal found consistent Crown failure in the health care and well-being of Māori. It recommended establishing an independent authority to oversee Māori primary health services.

The Government's announcement responds to a 2020 Health and Disability System review, which also called for a separate Māori health authority, but could not come to a consensus on the powers it should have. Four of the six members thought the idea that it should have the power to commission health services had such merit they dissented from the recommendation the authority should have only advisory powers.

The potential is for a Māori primary health system explicitly focused on Māori needs. Māori decision-makers would decide what needs to be done, how and by whom. The success of the authority hinges on how independent it will be, and its accountability to Māori people.

By Māori for Māori

The 2019 Waitangi Tribunal report also found that decision-making models don't adequately reflect Māori experiences of what works and why. Tureiti Lady Moxon, one of the claimants to the tribunal, explained the proposed authority's logic:

"We would prefer to be the designers of our own destiny."

While the new authority will provide policy advice, its most important influence will come from the decisions it makes about what primary health services to purchase and from whom. It will then be able to decide whether these providers do a good enough job to have their funding continued.

Opposition leader Judith Collins claimed there wouldn't be much public support for a "separatist model" that would give "people operations based on race, not on need".

But the idea that anybody would demand an operation they don't need is not

a sensible starting point for the serious debate we need to have about how the authority should work with other parts of the revamped health system.

Getting funding levels right and eliminating racism

The tribunal found chronic underfunding is one of the reasons for poor Māori health outcomes. It recommended the Crown and the health inquiry claimants work out a methodology for determining how much money is needed to achieve fair outcomes.

It's a complex question, at the intersection of te Tiriti o Waitangi policy, moral philosophy and health economics. Answering it accurately will determine how well the authority can do its job.

But an equally important question relates to the institutional racism the tribunal found in the health system, and how this gets in the way of people's opportunities for good health.

Many questions remain about the scope the authority will have to develop the health system to give everybody the same opportunity for good health.

Accountability

How will it be accountable to Māori as well as to the health minister? How will Māori be able to show they have confidence in the knowledge and expertise of the people appointed to the authority?

What relationships will it have with the Ministry of Health and the newly created public health agency? How independent will it be and will there be significant Māori engagement in the ministry's oversight function?

The minister's announcement spoke of enabling Māori "leadership and partnership". But leadership and partnership don't always work well together.

The bicultural partnership people often read into te Tiriti o Waitangi (the Māori text) or the Treaty of Waitangi (English version) usually positions the Crown as senior partner and Māori as the junior partner. This view doesn't foster the independent leadership the authority will need if it's to make a real difference and, as the Health Minister said, give "true effect to tino rangatiratanga", or Māori people's authority to make decisions for themselves.

Heather Came

Dominic O'Sullivan

. . . its most important influence will come from the decisions it makes about what primary health services to purchase and from whom.

Considering te tiriti in all decisions

We have developed the Critical Tiriti Analysis policy framework, which could help ensure the transformed health system respects te tiriti and puts the Māori health authority in the best position to succeed.

The framework requires policy makers to consider how te tiriti informs both existing and new policies. In relation to the minister's announcements, it provokes the following questions:

- How will the health system maintain tika (correct) relationships with mana whenua (groups with authority over land), mātāwaka (kinship groups) and other Māori communities?
- How will the health system's processes, actions and decision-making be informed and shaped by Māori world views?
- How will Māori-led decision-making and leadership (which is a bigger aspiration than partnership) be put into practice across the sector?
- How will barriers to Māori advancement, such as institutional racism, be eliminated?
- Given the history of health inequities, how will resources be distributed and prioritised to ensure equitable outcomes for Māori?
- How will Māori world views, values, tikanga (correct processes) and wairuatanga (spirituality) be normalised within the health system?

The proposed changes are potentially transformative. But just how transformative depends on how these questions are answered and on the strength of the Government's commitment to no further breaches of te tiriti. Abolishing the authority, as the opposition National party proposes, would be such a breach. •

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Embedding the primary health care approach

What is primary health care and how can nurses embed the primary health care approach into their practice?

By Jill Clendon

What is primary health care, how is it different from primary care and and how can nurses incorporate the principles of primary health care nursing into their practice?

Firstly, what do we mean by primary health care? In 1978, the World Health Organization (WHO) held a conference at Alma-Ata in Russia, called the International Conference on Primary Health Care. WHO member nations accepted the Alma-Ata Declaration, which called for urgent and effective action to develop and implement primary health care throughout the world.

Primary health care was defined as essential health care based on scientifically sound and socially acceptable methods and technology, that was accessible to all people in a community at a cost the community and country could afford. It was an approach to health that went beyond traditional systems of hospital care and concentrated on health equity. It drew on ideas of prevention, reduction of health disparities, collaborative models of health provision (ie participation by communities in decision-making) and integrating health into all social sectors through public policy reform.[1]

Primary health care is a wide-ranging concept that requires us to view our entire system – including public health, primary care, acute care, health policy and the wider housing, social, food and technology systems – as part of an approach to improving health. In Aotearoa, the terms "primary care" and "primary health care" are frequently used interchangeably, but they are not the same. Primary care is part of primary health care, more often than not referring to care provided in general practice and pharmacy. But providing primary care does not necessarily mean we use a primary health care approach to our practice.

In 2001, the Ministry of Health published the Primary Health Care Strategy, which outlined a comprehensive system of first-line access to health care in New Zealand.[2] Nurses were at the forefront of the strategy and the profession held high hopes for a change in the way health services were provided. We hoped nurses would become the primary providers of first-line health care to all New Zealanders.

In 2012, I gave a presentation at the College of Primary Health Care Nurses conference, where I argued for the pirmary health care approach – that nurses needed to consider the social determinants of health as part of their assessment of an individual or whānau, to identify community resources that could help address the challenges facing whānau, and to advocate for health equity. Nurses could address the social determinants of health using a variety of easy strategies.

However in 2016, I wrote that the recently released New Zealand Health Strategy had failed to identify and promote primary health care as a core approach to improving health outcomes.[3] Although we have seen a number of health priorities identified by government since 2016, including equity and sustainability, the 2016 strategy failed to make explicit the importance of primary health care.

So what progress has there been? When the Primary Health Care Strategy was released in 2001, nursing's vision was for an integrated nursing workforce that spanned the boundaries of the many practice silos we found ourselves in. We saw practice nurses, district nurses,

public health nurses, occupational health nurses, school nurses, Well Child/Tamariki Ora, Plunket nurses, Māori and iwi provider nurses and so on, all working together to achieve health in our communities. We coined the phrase "primary health care nursing" to encompass all of these diverse roles under one umbrella. We established the College of Primary Health Care Nurses NZNO, which drew together the practice nurse section with the district nursing and public health nursing sections. We developed standards of practice, we held conferences and we all bought into this vision for an integrated primary health care nursing workforce where we could work much more closely and cohesively to improve health outcomes.

Our national policy documents frequently do not recognise the role of nurses who sit outside general practice. Because our political rhetoric is framed around primary care and interpreted at a ministry level as the work of providers predominantly in general practice and pharmacy, this misses a massive proportion of our workforce and fails to recognise the much wider role of nurses working across the community. This means policy is failing to draw on the combined strength that a non-siloed workforce brings to improving health.

Some DHBs tack "community" on to their guidance and we see "primary and community" crop up in the odd document, but this is a far cry from the vision of an integrated and agile workforce able to respond to community need. Individually, we see pockets of excellence in each of our specialty areas, but have we been truly able to draw together as a combined workforce? In some places yes, in others, no. The consistency isn't there.

One way this is identifiable is in our workforce statistics. Data from the Nursing Council shows us there are 2875 practice nurses and 3440 nurses working in areas such as district nursing, family planning/sexual health, public health, school health, youth health, iwi and Māori health and occupational health. There are a further 4238 who identify as working in primary health care. This is great. Just under half of all nurses working in community settings identify as primary health care nurses. What about the other half? This group, rightly or wrongly, continue to identify within their various practice silos. This is useful from a workforce planning perspective, but if we are still trying to achieve a truly integrated primary health care nursing workforce that spans the various boundaries of our practice, then this speaks volumes to the progress we have (or rather haven't) made.

What does a primary health care approach to the way we provide nursing care actually mean? There are a useful set of principles that nurses can use to assess and improve our practice.[4]

1) Accessible health care

This is about ensuring people can access the care we are providing. Nurses can ask themselves:

- How easy is it to get to see a practitioner in your service?
- Do people have to make an appointment, what hours are available, and can they attend outside working hours?
- Do you have the ability to reduce cost for people or allow them to pay it off?

2) Technology

This is about ensuring we use appropriate technology to provide care and that the people we nurse have access to technology that will improve their lives. Telehealth is a good example of where inequities are being addressed using technology – particularly in rural areas.

- How will technology help this person improve their health and how can we help them access that?
- Can they access their own health records and do they have the technology and wifi or data to do this?
- Can we provide these for them, and do they know how to use them?

3) Health promotion

A simple example of using health promotion in nursing practice is when the Health Promotion Agency is running a campaign and we focus on promoting this in our own work.

- What are we doing as a service to promote people's health?
- Have we reviewed our educational material to make sure it caters for people with all levels of health literacy and language?
- How are we working with our local health promotion team?

4) Cultural sensitivity and cultural safety

- Do I need an update on cultural safety and the Treaty of Waitangi?
- How culturally safe is my practice?
- Do I know what unconscious bias is and how it impacts my practice?
- How do we tap into Whānau Ora approaches in our work?
- Is my service providing equitable care?
- How many Māori are accessing my service and does this reflect their need? What can we do to improve this?

. . . policy is failing to draw on the combined strength that a non-siloed workforce brings to improving health.

In Nelson, the ratio of Māori patients in our district nursing service is 4 per cent. That neither reflects our Māori population, which is 10 percent, nor does it reflect actual need. What are we doing about this? We've joined with our local Māori provider, Te Piki Oranga, and its nursing service, and are working on a joint cultural competence workshop for staff, doing joint visits and providing products and education to Te Piki nurses to support best practice.

5) Intersectoral collaboration

Many people have needs the health system cannot help with.

- If I identify a patient's need for food, income or housing support, do I know who to contact?
- Do I even ask whether they need this?

6) Community participation

- How do we involve the community in our day-to-day service provision?
- Can we even do this – is it feasible?
- But how do we know our services are meeting community, whānau and individual need if we don't design them in collaboration with those who we are providing them to?

One way we can draw on the resources around us is to use our nursing students. At the Nelson Marlborough Institute of Technology, third-year nursing students undertake a community needs assessment as part of their course require-

ments. Why not ask nursing students to focus on your practice or workplace? Get them to do their assessment on your community and the needs of the people who live there. This could help identify what your community see as priorities and help you make decisions about the focus of your practice.

These are just a few of the ways we can integrate the principles of primary health care into our everyday practice. We then have a broad focus and our practice reaches beyond the needs of the individual who may be sitting in front of us to addressing the issues that may lead to them sitting in front of us in the first place. Our challenge is that we are frequently time poor, and stretching beyond the presenting problem means more work. But hopefully these suggestions are things nurses can try.

I want to touch a little more on why the varying interpretations of primary health care and primary care in policy are problematic for nursing.

Policy dictates practice. We need policy to enable funding, direct the development of models of care, and guide the way the health system works. If true primary health care is based on a broad understanding of the social determinants of health, epidemiology, first point of contact care and consumer involvement in decision-making then, actually, while efforts have been made, there is still relatively minimal focus on these areas. Inequalities continue to grow, the social determinants of health are affecting more and more New Zealanders and access to first point of contact care is frequently limited by cost.

Thus not only is our system not focused on a primary health care approach to health improvement, most of our policy rhetoric uses the term primary care, with little distinction between the two. Not only is the Government a little muddled in this respect, but it is also easier for it to focus on silos than on systems.

So if government focus is on primary care, with little understanding of primary health care, and the vast majority of funding continues to go to secondary and tertiary services, where does this leave primary health care nurses? Assuming the vast majority of us do have that wider understanding of primary health care and wish to assess whānau for the impact of the social determinants of health, identify community resources and advocate for whānau and community health needs, then where is the policy to support this approach? Without policy, there is no support for change and little to enable nurses to work in this way.

Jill Clendon

If a population health approach is the rhetoric that government is going to start using in policy, then we need to tap into this.

Should we persist with trying to get the Government to understand there is a fundamental difference between primary care and primary health care? Or would we be better to reframe our position in a way that makes the work of nurses practising primary health care more visible? Our original vision and goal of an integrated health system is a worthy one and one we should continue to strive for, but do we need to change the framing of this to something that is more accurately reflected in policy and doesn't miss the vast proportion of nurses working in primary health care settings?

Voice not strong enough

We become frustrated when we can see the change we want to achieve, but have been unable to do it. The primary health care strategy is a prime example of an opportunity we couldn't capitalise on. The structural changes required to alter the system to address inequities just never happened and our voice was never strong enough. This was partly due to the employment structures many of us work in, partly due to historical and cultural barriers within our own profession and partly because our leaders are often lone voices in a medically dominated system.

However, we have made huge inroads at a local level in many places and we need to build on these. We have an opportunity to change our framework to align with the future policy direction of government more effectively. It will take political savvy and bravery, but if we line our ducks up right, this could be the way forward.

The Health and Disability System Review gives us another opportunity to achieve change. We need to lever off the review and take our understanding of primary health care to move forward. The review is strongly committed to the idea of population health. Population health is an approach aimed at improving the health of an entire population and requires us to work across systems to achieve this. It includes many of the principles of primary health care. So it aligns well with primary health care nursing. Thus, population health is a core component of primary health care and it is a core component of the Health and Disability Systems Review.

If a population health approach is the rhetoric that government is going to start using in policy, then we need to tap into this, rethink our strategic approach to position nursing within this and think about taking the next step in advancing primary health care nursing. •

** This article is based on a speech Jill Clendon gave to the March 2021 symposium 'Nursing diversity brings nursing strength – a focus on primary health care nursing'.*

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References

1) World Heath Organization. (1978). *Declaration of Alma-Ata.* www.who.int/publications/almaata_declaration_en.pdf Alma Ata Declaration.
2) Ministry of Health. (2001). *The Primary Health Care Strategy.* www.health.govt.nz/system/files/documents/publications/phcstrat_0.pdf
3) Clendon, J. (2016). Primary health ethos missing from strategy. *Kai Tiaki Nursing New Zealand, 22*(7), 34-35.
4) Clendon, J., & Munns, A. (2018). *Community Health and Wellness*, 6th edition. Elsevier.

PHOTO: ADOBE STOCK

Low platelet numbers can indicate abnormal clotting.

Still much to learn on clotting and COVID-19 vaccines

A link has emerged between certain COVID-19 vaccines and blood clotting. The risk is very small, and, depending on the country, could be far outweighed by the risks of the disease.

By Georgina Casey

There is a very small risk of developing a complex and rare clotting disorder associated with the use of AstraZeneca and the Johnson and Johnson vaccines for COVID-19. The outcome of this clotting disorder is the development of a cerebral venous sinus thrombosis, where venous drainage from the brain is blocked potentially leading to intracranial haemorrhage or haemorrhagic stroke. It has been labelled vaccine-induced prothrombotic immune thrombocytopenia (VIPIT).[1]

Similar to heparin disorder

VIPIT has been identified as similar to the rare clotting disorder caused by heparin therapy: heparin-induced thrombocytopenia (HIT). Typically, HIT appears four to 15 days after initiating heparin therapy, and a similar delay is seen in most cases associated with the vaccine.[2,3]

In both syndromes, the sequence of events leading to clotting starts with platelet factor 4 (PF4). PF4 is a positively charged protein that is released into the circulation when platelets are activated. Platelets (thrombocytes) are fragments of cells without nuclei manufactured in the bone marrow. Once released into the circulation, they have a lifespan of about a week before being broken down in the liver.

Normally, platelets are early initiators of the clotting process. They clump together to form a "white clot" (without red blood cells) and release clotting factors that trigger the coagulation cascade and formation of a stable red clot.

Heparin is a negatively charged molecule and in some people, it binds to PF4 through electrostatic bonds. How vaccines bind to PF4 is not yet known.

Both the AstraZeneca and the Johnson and Johnson (as well as the Russian-made vaccine) use an adenovirus vector for their delivery of the immunogenic component of the vaccine, and there is speculation the adenovirus component triggers VIPIT.[3]

When heparin binds to PF4, clumping occurs to form large complexes that trigger immune responses. Antibodies develop against the heparin-PF4 clumps, forming larger complexes which then attack circulating platelets.[4] This triggers activation of the platelets, releasing further PF4, creating a positive feedback loop. Platelets are consumed at a high rate, causing thrombocytopenia.[3]

This overwhelming activation of platelets creates extensive white clots in the veins and widespread triggering of the coagulation cascade. HIT presents as a drop in platelet count (thrombocytopenia) with associated venous thromboses.[5] In reported cases of VIPIT, cerebral venous thrombosis, splanchnic (abdominal, including liver) vein thrombosis, pulmonary embolism and other clots have been detected. Disseminated intravascular coagulation (DIC) has also been a feature, with subsequent consumption of clotting factors and increased risk of haemorrhage.[3]

In countries such as New Zealand, careful consideration of *individual* risk will be taken before decisions are made about the type of vaccine to administer.

There is still much to learn about this adverse effect associated with certain COVID-19 vaccines. In many countries where the impact of COVID-19 has been severe, the risk of VIPIT is far outweighed by the risks associated with the disease itself. In other countries such as New Zealand, if these vaccines are to be used, careful consideration of *individual* risk will be taken before decisions are made about the type of vaccine to administer. •

References

1) Dyer, O. (2021). COVID-19: EMA defends AstraZeneca vaccine as Germany and Canada halt roll outs. *BMJ,* 373, n883.
2) Linkins, L. (2015). Heparin induced thrombocytopenia. *BMJ,* 350, g7566. https://doi.org/10.1136/bmj.g7566
3) Greinacher, A., Thiele, T., Warkentin, T., Weisser, K., Kyrle, P., & Eichinger, S. (2021). Thrombotic thrombocytopenia after ChAdOx1 nCov-19 vaccination. *New England Journal of Medicine.* doi:10.1056/NEJMoa2104840
4) Nevrozova, T., Mordakhanova, E., Daminova, A., Ponomareva, A., Andrinova, I., Minh, G., Rauova, L., Litvinov, R., & Weisel, J. (2019). Platelet factor 4-containing immune complexes induce platelet activation followed by calpain-dependent platelet death. *Cell Death Discovery,* 5, 106.
5) Arapelly, G. (2017). Heprain-induced thrombocytopenia. *Blood, 129*(21), 2864-2872.

Why are experienced nurses leaving work?

Experienced nurses are quitting the profession in droves. What's driving them out and what might keep them working in acute care?

By Janine Ellison

PHOTO: ADOBE STOCK

Why do experienced ward nurses leave acute settings? This is a timely question during the COVID-19 pandemic with the additional pressure it has put on hospital nurses, and many others in the profession.

This issue is near to my heart, as I produced an integrative review on this topic as part of my master's studies and this article has been produced from that research. The search terms used in my review were: tertiary, in-patient, acute, RN, nurse, leave, retention, stay, turnover and attrition, and the timeframe for the search was 2009-2019. Electronic databases searched included CINAHL Complete, Cochrane Library, ProQuest, PubMed, MEDLINE Complete, Clinical Key, Science Direct, Health Business Elite and Nursing Reference Center Plus. Thirty-six primary studies were evaluated and 16 met the selection criteria for inclusion in the integrated review.

Junior staff in majority

Also, I have been employed by a large tertiary hospital for the last 16 years, the majority of that time as a staff nurse working in various acute wards. Reflecting on the past 16 years, I realise I have lost many experienced and knowledgeable colleagues from the acute setting and I have worked as a staff nurse in areas with up to 75 per cent junior staff as a result of nurse attrition.

Rising nurse turnover has become a major concern globally, with the World Health Organization (WHO) urging countries to institute policies to stem the attrition of nurses.[1]

High experienced-nurse turnover in acute hospital wards and units affects the quality of patient assessment and care, as these nurses perform assessments and recognise patient deterioration quickly.[2,3]

New Zealand has some of the worst statistics for nurse retention in the developed world. A New Zealand study carried out between 2004 and 2006 revealed a nurse turnover rate of 44.3 per cent – nearly three times higher than Australia.[4] It is important to know why experienced nurses are leaving acute settings, as nurses are the largest workforce in health care and most of the nursing workforce is employed in acute settings.[1,5,6] Retaining experienced nurses in acute care hospital settings is important because patient safety is linked to adequate staffing and skill mix.[7]

More paperwork and documentation with less time for patient care left nurses feeling dissatisfied and with a sense they had not provided quality care.

Adverse patient events and medication errors increase in areas of high experienced-nurse turnover. This turnover leads to inadequate staffing, potentially increasing length of hospital stay and contributing to patient mortality or delayed recovery.[8,9,10,11]

Each experienced nurse lost to acute care in New Zealand is equal to half the salary of a nurse – approximately $30,000 – due to the costs involved in replacing them. These costs include advertising, training, temporary staffing and orientation periods,[12] which are additional costs for district health boards (DHBs). With current DHB debt, and the

cost of nurse turnover, retaining nurses in the workplace is important.

Implementing retention strategies for experienced nurses could save organisations substantial amounts of money.[13]

The three themes that emerged from my integrative review were:

- support;
- workload; and
- professional development.

The first theme of support included factors such as organisational and manager support, appreciation and relationships with co-workers. A perceived lack of support or recognition from the employing organisation and its management was a major reason why nurses intended leaving their workplace.

Nurses felt 'unappreciated'

Nurses felt unappreciated and their skills and knowledge unrecognised at a direct manager and organisational level. Having a manager who didn't offer help when staff were busy, was not visible on the ward, or was insensitive to staff needs were also identified as reasons staff intended to leave.[14,15,16,17]

Unapproachable managers who didn't listen to staff needs or support staff when there were complaints, led many respondents to voice an intention to leave. Lack of support from colleagues, along with bullying, mistrust, fault-finding, and disrespect among colleagues led to dissatisfaction with work and intent to leave.[14,16,17,18,19,20]

The second theme related to workload, including patient acuity, poor staffing, and high nurse workload. Coupled with this was the perception that health was treated as a business and was no longer patient-centred. Nurses suggested patients' needs were getting more complex, but the nurse-to-patient ratio remained the same, and working short-staffed was becoming more common.

Increased patient acuity in the acute setting has been identified as the reason many nurses intended to leave their workplace.[14,19,21,22] Experienced nurses reported having the most complex patient load and being required to support their junior colleagues with their unwell/high acuity patients, leading to feelings of being overwhelmed.[22,23] More paperwork and documentation, with less time for patient care left nurses feeling dissatisfied and with a sense they had not provided quality care.[15,22,24]

In one New Zealand study, nearly half of nurses who had left said they would have stayed in their workplace if there had been more staff on the wards.[25] Inadequate staffing leads to feelings of job dissatisfaction, emotional exhaustion and burnout, as staff have less time for patient care.[14,21,22,25,26,27]

A perception that health care had become business-focused was a reason some nurses intended to leave[17,27] because they perceived nursing was no longer patient-centred and this led to less personal satisfaction in their role. Nurses felt the real rewards in nursing were forming relationships with patients and providing quality care, which was no longer possible in the business-driven model of health care.[17]

The third theme related to professional factors, including career and professional development and participation in hospital affairs. Perceived poor education opportunities, along with limited possibilities to upskill, were reasons nurses left their workplace. The education nurses wanted was directly related to the job they were employed to do, so when they couldn't access this learning, they felt dissatisfied and this led to an intent to leave.[20,24,26,28,29] Some nurses felt their employing hospital made decisions without consulting nursing staff and some of these decisions made it difficult for them to give quality patient care.[26,27,30]

Recommendations from this integrative review included:

- educating nurse managers about leadership and strategies to support nurses;
- recognising the value of nursing staff;
- increasing manager visibility on the wards;
- improving communication with nurses;
- fostering collegial and professional relationships between nurses;
- involving nurses in decision-making and policy development at an organisational level;
- providing paid leave for professional development and education;
- instituting professional recognition and reward programmes,
- decreasing nurse-patient ratios; and
- managing workloads safely.

There was limited recent New Zealand research on this topic, so another recommendation was for further research involving New Zealand nurses.

With 2020 designated the International year of the Nurse and Midwife by the WHO and the crucial role of nurses in the COVID-19 pandemic, the value of nurses should be obvious to all those involved in health care. That does not appear to be the case in the initial DHB multi-employer collective agreement offer which has been roundly rejected by nurses. The offer did not appreciate or recognise nurses' skills, flexibility or work ethic, especially in this uncertain time and is likely to exacerbate the exit of experienced nurses from the sector. If DHBs want to retain these nurses, then the offer needs to reflect the importance of the nursing workforce in health care.

Large numbers of experienced nurses are still leaving acute settings. To ensure quality care, nurse satisfaction and to increase the future nursing workforce, we must find strategies – and properly valuing nurses' work is a key one – to stem this attrition. •

Unapproachable managers who didn't listen to staff needs or support staff when there were complaints, led many respondents to voice an intention to leave.

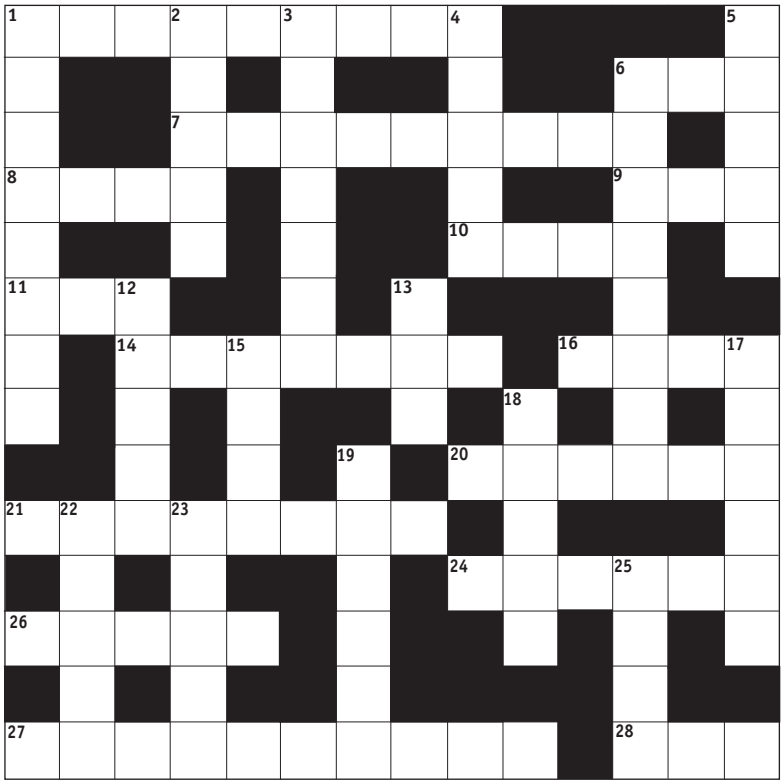
References for this article are on p31.

* This article has been reviewed by the associate director of nursing and operations manager, ambulatory care, at Nelson Marlborough District Health Board, Jill Clendon and the *Kai Tiaki Nursing New Zealand* co-editors.

Janine Ellison, RN, BN, MN, is a nurse educator in the professional development unit at Waikato District Health Board, with the older persons and rehabilitation service portfolio.

crossWORD

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



ACROSS

1) Liver disease.
6) Artificial head of hair.
7) Process of leaving hospital.
8) Small dark palm fruit.
9) Deteriorate in health.
10) Clothing for foot.
11) Promise.
14) Viewpoint.
16) Fewer.
20) Popular Aussie rock band from '70s and '80s: Cold _____.
21) Speech to introduce oneself in te reo (Māori).
24) Most important Christian festival.
26) Relating to the Pope.
27) Health care delivered via communication technology.
28) Cut lawn.

DOWN

1) Important process when nursing shifts start/end.
2) Helped.
3) Hormone vital for absorption of glucose.
4) Heavenly bodies.
5) Able to think or move quickly.
6) Lack of strength.
12) Value.
13) Thick mist.
15) Muslim cleric.
17) Payment to employee.
18) Trim wool from sheep.
19) Extreme fear of object or situation.
22) Angry.
23) Picture.
25) Group who work together, eg in sport.

April answers. ACROSS: 1. Pharmac. 4. Potato. 7. Whenua. 8. Tent. 9. Nazi. 12. Expertise. 14. Data. 15. Orderly. 16. Humid. 18. Affair. 22. Illiterate. 23. Cold chain. 24. Bake.
DOWN: 2. Hawk. 3. Mentor. 4. Puma. 5. Ace. 6. Orthopaedics. 8. Tired. 9. Nasal. 10. Fewer. 11. Spoonful. 13. Tie. 17. Mānuka. 19. Attic. 20. Satin. 21. Zinc.

wiseWORDS

“ There aren’t many professions in which you can have so much impact on people’s lives in such crucial and vulnerable times. I think nursing is very intellectually challenging and demanding and very interpersonally challenging as well. ”

– Patricia Benner, US nursing theorist and author of *From Novice to Expert*

it’s cool to kōrero

HAERE MAI and welcome to the May column. A pōwhiri is a welcoming ceremony. It can be as big and grand as a state occasion, or a small and intimate welcome for a new staff member.

Traditionally it is held on a marae, with the tangata whenua (hosts) welcoming the manuhiri (visitors). The pōwhiri can include a wero (ritual challenge), and a karanga (call) from both sides before the visitors enter. There may be a haka, whaikōrero (speeches) from both sides and waiata. The final speaker for the manuhiri presents the hosts with a koha.

Kupu hou

New word

- **Pōwhiri** – *pronounced "paw-fee-rree"*
- **I pōwhiri mātou tētahi kaimahi hou.**

We welcomed a new staff member at the pōwhiri.

Rerenga kōrero

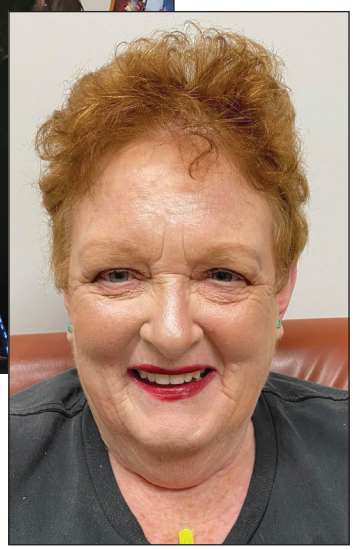
Phrases

Māori have long played an important role in Te Ope Kātua o Aotearoa (New Zealand Defence Force) and Māori culture ("guitars and haka" rather than weapons) is increasingly seen as an asset on peacekeeping missions. On Anzac Day, the Ode of Remembrance is recited in both te reo and English:

E kore rātou e kaumātuatia
Pēnei i a tātou kua mahue nei
E kore hoki rātou e ngoikore
Ahakoa pehea i ngā āhuatanga o te wā
I te hekenga atu o te rā
Tae noa ki te aranga mai i te ata
Ka maumahara tonu tātou ki a rātou

They shall grow not old, as we
that are left grow old:
Age shall not weary them, nor the years condemn.
At the going down of the sun and in the morning
We remember them.

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



The team at Wellington Hospital's oncology, haematology and renal ward throw a farewell party for long-serving HCA Annie Pahina (right).

Farewell to Annie:

Making connections part of her HCA role

AFTER 21 years, Wellington Hospital health-care assistant (HCA) Annie Pahina is retiring, but says she has "loved every day" working on the oncology, haematology and renal ward.

"There has never been a day when I didn't want to go to work," Pahina says. "I just feel I made a difference in people's day-to-day lives, and their families – I've really loved it."

Pahina has known both sides of the ward, too. Not long after she began working as an HCA, a close relative was admitted to the hospital with Hodgkin's lymphoma. They survived – but it was close.

"Seeing [the relative] sick, changed my perspective. [My job] was never about money. I have got my health and the necessities of life and I have been very happy in my job."

Pahina has always felt a sense of purpose. "I used to feel I made a difference to their day, in their family dynamics."

She has not been shy of making friends with patients either – despite the high mortality rate on her ward and emotional impact. "I'm not afraid to make those connections – if it makes a difference to them, me being close and personal, then I am."

She has been to many patients' funerals. But this doesn't mean she's unaffected. "I've cried buckets, and I've cried with them – if I need to say goodbye, I do it." But she can also let go – she has to. "I don't dwell on things, as I can't change the outcomes, I can't turn it around – so I just try to enjoy the good times and celebrate their lives, and think 'it wasn't meant to be'."

"You could walk around feeling sorry, thinking 'oh, poor me', but where does that get you? And it's not about me, it's about them."

'You have empathy'

She was managing a cleaning contract at the hospital in 1999 when the director of nursing at the time, Anita Bamford, suggested she take up a caregiving role. "I said 'I don't know if I would be any good'. She said 'yes you would – you have empathy'."

Along with the practical tasks – personal care, helping patients shower or eat, changing beds and checking equipment – Pahina sees making connections as part of her role. But increasing workloads have made it harder to find the time for this. "Talking to people is a huge part of my job, but there is less and less time for it."

Pahina also had some All Black connections in the early 2000s and used to get a few of the players into the wards to cheer up patients – Andrew Mehrtens, Carlos Spencer, Richie McCaw, Piri Weepu – to name a few. She has tended to well-known New Zealanders along with every day people, such as the young teacher with terminal cancer who adored glitter and requested her coffin be covered in it. "She was the kindest person."

Chair of the infection, prevention and control nurses college Carolyn Clissold, who works with Pahina at Wellington Hospital, said she had been an ardent NZNO member and an asset to the ward. "Annie often provides the personal touches of continuity, humour and cares to a very challenged group of patients. Along with the showers and washes, she offers a friendly face."

The HCAs helped organise infection, prevention and control at ward level "and provide me with help and ideas for improvement".

Pahina, who is 70, says the only reason she's leaving is her "body is going – the arthritis", after more than two decades during which she's only taken seven days of sick leave. She says the senior team on the ward were very supportive and had made her job easy.

Now she intends to wake up and enjoy each day as it comes. •

Report by Mary Longmore

Child and youth nurses go places with Dr Seuss

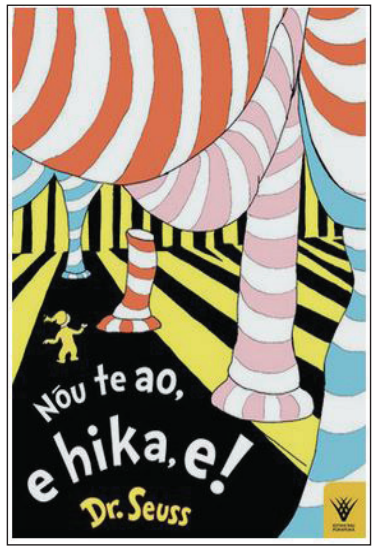
DR SEUSS Enterprises has given the NZNO College of Child and Youth Nurses permission to use imagery from the famous book *Oh The Places You'll Go!* and its te reo Māori translation *Nōu te Ao, e Hika, e!* to promote their symposium, after a nurse went straight to the top.

After the committee discussed basing the theme of their September event on the children's book, Christchurch nurse educator Emma Densem searched online and emailed the president of Dr Seuss Enterprises, Susan Brandt, to ask permission.

An assistant quickly responded, granting permission for the college to use the theme and images from the book for its symposium in Christchurch on September 24, Nōu te Ao, e Hika, e!: Oh, the places you'll go – Empowering Nurses for a healthy future.

Densem said she was surprised and delighted with the result, which would inject some fun into the day. "We wanted something positive for nurses after all the challenges we've had over the past year."

Speakers so far include poet and GP Glenn Colquhoun on how the health system can better serve young people, and Ministry of Health Well Child Tamariki Ora (WCTO) principal clinical adviser Alison Hussey on reviewing the WCTO framework. Abstract submissions are welcome by May 31 to submissions.ccyn@gmail.com. •



Diabetes, heart health huge problem in North

A NURSE-led symposium to help Northland nurses working in primary care develop their skills working with long-term conditions such as diabetes and poor heart health last month had an "overwhelming" response.

It was led by Northland primary health organisation, Mahitahi Haoura. Its nurse director, Josephine Davis, said 95 nurses attended from general practices and Māori health providers from all over Tai Tokerau. More than 120 nurses were involved in total, including presenters and planners. "That is a huge response. Most of these nurses gave up their own time in the weekend to be there."

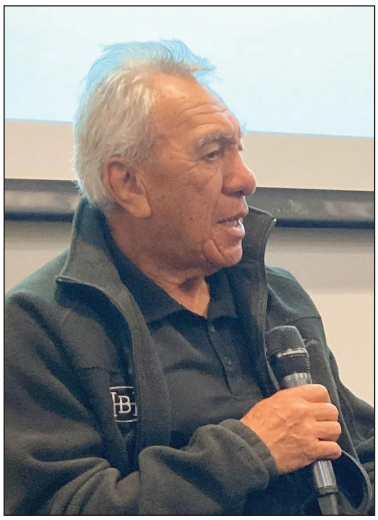
She said Mahitahi Hauora believed nurses needed more support to tackle diabetes and heart health, which were a huge problem in the region. "Northland has some of the worst diabetes and heart health outcomes in New Zealand, particularly among Māori. Nurses were asking for support in this area."

'Northland has some of the worst diabetes and heart health outcomes in New Zealand, particularly among Māori. Nurses were asking for support in this area.'

New Northland District Health Board chief nurse Maree Sheard urged nurses to step forward as leaders. "What we need are leaders stepping forward who have the knowledge and the confidence to be able to say 'I can do this'," she said. "This is our time. We can step up. But we need to have that knowledge, the confidence and the frameworks to support us."

The day included an interview with a Māori man about his experiences with type 2 diabetes and a presentation on the "predict" tool used in primary health care to screen and manage patients with diabetes and heart conditions.

Mahitahi Hauora nurse director Hemaima Reihana-Tait spoke about the importance of mauri ora – connecting with patients. •



Bill Davis speaks to the symposium about his experiences as a diabetes patient.

New Northland District Health Board chief nurse Maree Sheard urged nurses to step forward as leaders.

Speaking up when things go wrong

HEALTH WORKERS must feel safe to speak up when things go wrong, and raise concerns without fear of retribution, a patient safety expert says.

Health Quality & Safety Commission patient safety specialist Leona Dann told the College of Critical Care Nurses (CCCN) in late March that a safer and resilient health-care system was achieved, not by preventing errors ("that's like trying to understand a successful marriage by only looking at the divorces"), but with a deeper understanding of what contributed to a safe system.

That meant creating the "space and respect for different voices to be heard", Dann said. "The focus must be on how we create the conditions for success – a strengths-based approach, where psychological safety is paramount." Listening to and acting on concerns was also crucial.

A health system is complex, and is made safer by people being adaptable – able to adjust their actions "even when the unexpected happens", Dann said.

"Complexity is the challenge – people are the solution," she told college members at an education session ahead of their annual general meeting, held via Zoom. Many different perspectives, team work and a distributed leadership model all contributed to a safer system.

Moving from focusing on preventing errors to understanding safety was something that occurred every day, by working as a team and responding to events, Dann said.

Patient safety, as a concept, had been around for about 20 years, over which period the health environment had grown increasingly complex. According to the World Health Organization, one in 10 patients experienced harm while in hospital, she said.

She cited Danish psychologist and patient safety expert Erik Hollnagel – "the father of resilient health care" – who said "the key feature of a resilient system was the ability to adjust how it functions".

Leona Dann – different perspectives, team work and a distributed leadership model all contribute to safer systems.

To be resilient, a system must be designed to support adaptations – "to anticipate, monitor, respond and learn" – beyond any one person's performance or error. "So resilient health care understands that systems are made of people . . . so we need to understand how humans work."

Dann said achieving resilient health care in Aotearoa required:

- The inclusion of a te ao Māori perspective.
- A person-centred approach.
- Understanding of how all parts contribute to the whole system of care.
- A dynamic system to cope with uncertainty.

The commission is working with a "three pou" model to help understand resilient health care in Aotearoa through a te ao Māori world view:

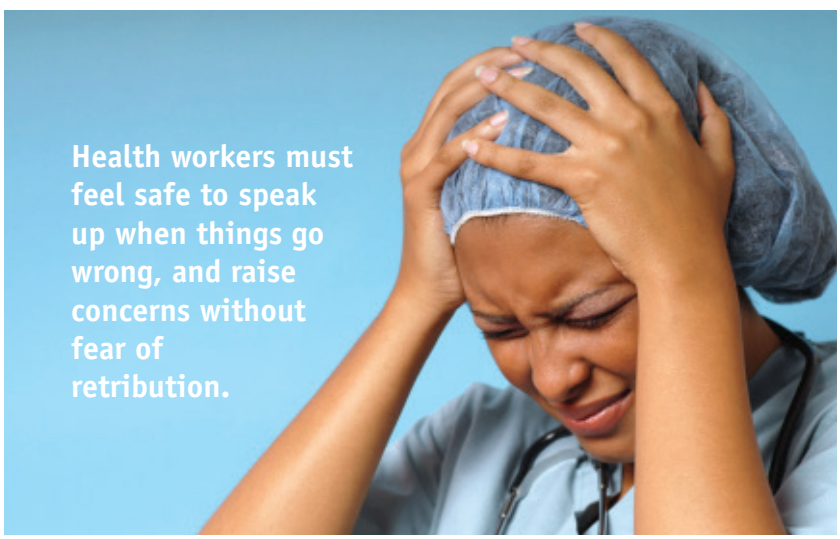
- **Pou tuarongo (back post):** understanding our purposes.
- **Pou tamanawa (middle post):** understanding our relationships.
- **Pou tahu (front post):** understanding the effect of our actions.

Dann said the commission was encouraging DHBs to look at patient safety by understanding the work done from the perspective of staff doing the actual work.

In summary, she said resilient health care aligned with a te ao Māori approach and recognised that people worked in a complex, adaptive system. It was people and teams who created safety and systems should be designed around them.

A commission hui on resilient health care in is planned for November 23 and a hui on restorative practice for June 30, both in Wellington. Details can be found at www.hqsc.govt.nz.

Further resources on patient safety:
1) Systems engineering initiative for patient safety (SEIPS) https://chfg.org/works-system-design-for-patient-safety-the-seips-model
2) www.suzettewoodward.org
3) www.safetydifferently.com •



By acting industrial services manager, Glenda Alexander

Pay equity – are we there yet?

Ensuring the pay equity process is robust is complex and time-consuming. But the end is in sight.

Work on the district health board/NZNO pay equity claim for our members continues but, at this stage, much of it is behind the scenes. It revolves around proving our case and establishing the evidence that nursing work, compared to male dominated occupations, is, or has been, undervalued.

The initial work assessments we undertook using the pay equity assessment tool did not provide the level of descriptors we needed. They were too broad or did not provide the level of "granularity"/detail that adequately reflected the complexities of nursing work.

A stage-two work assessment was undertaken using the more detailed equitable job evaluation tool (EJE). This work assessment has been underway since February. It is being undertaken by work assessment committee members, many of whom are NZNO members who are doing it on top of their normal work. The statistics (see box) give some idea of the amount of work undertaken. These statistics do not include the time committee members have spent on the quality review panel, which has met weekly.

In the stage-two process, the EJE tool was applied to both the claimant (nursing) and the comparator summary role profiles. The work assessment committee comprises representatives of NZNO, the Public Service Association, midwifery union MERAS, (for the midwifery part of the claim) and district health boards (DHBs). The work assessment process was overseen by a facilitator and moderator. Once this work was completed, a quality review was undertaken.

Consistency and fairness

The quality review ensured the EJE tool was applied correctly by the work assessment committee, that the rationale for the scores was supported by the evidence provided and that there was consistency and fairness in the work assessment process. The quality review panel reflected on the score for each role and the scores across all claimant and comparator roles.

At the end of the work assessment process, the quality review panel, facilitator and moderator met with the bipartite coordination group to review the overall assessment outcomes. Where there were undecided scores, this group agreed on the score, according to the evidence.

The next step was for the bipartite coordination group to analyse all the assessed and reviewed role scores for comparability, ie to ensure the roles that were compared were actually comparable, taking into account all the roles. This happened in mid-April. With the exception of one nursing role, more than three male occupation comparators for each nursing role were considered comparable, looking at the scores across factor groups.

The remuneration data of these comparators will now be analysed, based on remuneration reports developed by an independent remuneration consultant. These reports provide the history and context of the remuneration information. That is happening this month. Once it is completed, the parties will develop bargaining strategies for the negotiations on the outcome of the pay equity process.

Throughout the work assessment process, we have had to ensure that, as much as possible, the work assessments were free from bias and that the evidence supported the outcomes across all the factors of the work assessments. The Ministry of Health and other stakeholders will have access to the data collected for their own review.

Male comparator occupations

We have been asked many times what male comparator occupations were used. This information does not belong exclusively to NZNO. The male comparator occupations that agreed to participate did so voluntarily and on the basis of confidentiality regarding financial and other employment information disclosed. Until the point where the male occupations were assessed as being comparable, they were only "potential" comparators. We hope that, once the claim is settled and all the assessment data is stored in the Pay Equity Data Repository, we will be able to release which comparator occupations were finally used in our claim.

All parties to the claim agree this information should be withheld at this stage. It is not a lack of transparency or a secret agenda that prevents this information being shared; it is out of respect for the agreements that were made so we could get the cooperation and information needed from other workers – cooperation and information that these workers provided voluntarily. •

The work of the work assessment committee

- 29 roles were assessed against 12 work assessment factors = 348 factors
- 29 role assessments take 1.5 hours per assessment = 43.5 hours (pre-scoring)
- 43.5 hours multiplied by 12 committee members = 522 hours (pre-scoring)
- 18 days at four hours per day = 72 hours (assessment committee work)
- 72 hours by 12 people = 864 hours of assessment time
- 522 pre-scoring hours + 864 assessment hours = a total 1386 hours
- 1386 hours divided among 12 committee members = 115.5 hours per person

Plunket negotiations underway in early May

COLLECTIVE AGREEMENT (CA) negotiations between NZNO and Plunket were to take place on May 4 and 5, after members around the country endorsed a range of claims including a focus on Family Start and administration staff.

NZNO members in clinical roles at Plunket currently have pay parity with district health board (DHB) community rates and want that to be maintained in any new agreement. Also, those in frontline clinical roles want the option of being paid for eight hours a day rather than 7.6, as currently occurs.

NZNO lead advocate Danielle Davies said this was a "historical anomaly" and did not apply to other Plunket staff.

Family Start members in Tauranga and the Manawatū also want pay parity with Oranga Tamariki social workers.

Davies said there had been a good turnout from members at meetings. The new CA, when it was agreed, would likely have a short term as some pay rates and conditions would be aligned with the DHB multi-employer collective agreement, when it was settled. •

NZNO's hospice negotiating team, from left: Julia Fletcher (Harbour Hospice Hibiscus Coast), Shelley Bignell (Te Omanga Hospice), Rachel Clarke (Arohanui Hospice), Nicki Twigge (Waipuna Hospice) and Donna Burnett (Nelson Tasman Hospice).

Hospice talks go to mediation

NZNO IS going into mediation with Hospice New Zealand, after members rejected its proposed multi-employer collective agreement (MECA) in April.

NZNO industrial adviser Danielle Davies said the NZNO negotiating team "stood fast" at a meeting on April 14, but an improved offer was not forthcoming from the employers. The hospice team requested mediation and this was agreed to by NZNO's bargaining team.

A key reason for rejecting the offer was that a new step six for registered nurses (RNs) was not going to be implemented early enough. Hospice NZ offered to implement it from April 1, 2021, but members felt it should have been earlier – particularly as the previous MECA expired last August, Davies said.

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

The current MECA covers 520 members in 21 hospices around the country.

A date for mediation is yet to be confirmed. •

Family Planning salaries benchmarked

WORK TO benchmark salaries for Family Planning (FP) nurses and other staff has been completed, primary health care industrial adviser Chris Wilson said.

A national strike earlier this year was averted after mediation saw a revised collective agreement (CA) ratified in February. It would have been the first-ever national strike at Family Planning.

The newly ratified CA includes wage increases of at least three per cent, backdated to April 1, 2020, but will expire on August 31 this year.

Also agreed was a joint approach between FP and NZNO on setting salary benchmarks for registered nurses (RNs), medical receptionists and health promoters against similar roles in district health boards (DHBs) and primary health care. This had been completed and a joint FP-NZNO briefing paper was ready to present to the Ministry of Health and Minister of Health Andrew Little this month, Wilson said.

Chris Wilson

She expected any funding shortfalls identified in the joint briefing document to be addressed in the next CA.

FP had said at negotiations that while it fully supported higher pay, it had no funds for pay increases unless it received additional funding. The Ministry of Health indicated to FP that they could advise NZNO at mediation that there was a "budget bid" for FP for the July 1, 2021–June 30, 2022, year.

Potential breakthrough

Wilson said this was the first sign of a potential breakthrough; however the size of the bid was not yet known. NZNO was now working with FP to ensure the bid was well informed, she said.

NZNO and FP also agreed to start a joint national healthy workplace forum and establish a working group on nursing classifications. Both were planned for May. •

NZNO's negotiating team (from left): Barbara Too Too (health-care assistant), Veniana Rabo (HCA), Mata Ariki (HCA), Robin Moll (RN) and Therese Tating (RN).

Sick leave key to deal at CHT Healthcare Trust

A PROPOSED agreement between NZNO members and residential aged care provider CHT Healthcare Trust has been "overwhelmingly" ratified by 96 per cent of voting members, organiser Christina Couling said.

A commitment to increasing sick leave was a crucial factor for members in deciding to accept the offer, she believed.

The offer included a 3.5 per cent pay increase for registered and enrolled nurses, backdated to July 1, 2020; and the inclusion of miscarriage in the bereavement leave clause.

Couling said while bereavement leave for miscarriages had since became part of New Zealand legislation, it was good to acknowledge the team's effort.

While the offer had not met NZNO's "ideal position on sick leave", it did provide for an increase to sick leave entitlements in future. This would align with a government bill to increase sick leave for all workers to 10 days, which comes into effect later this year. Any increase to sick leave would be done through the next negotiations, she said.

CHT is based in Auckland, but also has facilities in Waikato and Bay of Plenty. The MUCA covers about 250 members. •

Aged care members 'doing more with less'

MEMBERS WORKING in aged care are under increasing pressure to do more with less, NZNO industrial adviser for aged care Lesley Harry says.

COVID-19 had highlighted the need for better staffing standards to support a skilled workforce and an increase in staffing levels, Harry said.

Work this year has included NZNO submitting to the Health and Disability Services Standards review in January 2021. That included real-life stories from members working in aged residential care (ARC) and a call for mandatory minimum staffing levels and skill mix, as well as the need for ARC managers to be experienced nurses, she said.

This year NZNO would be focusing its ARC campaigns on mandatory staffing levels and skill mix, the development of shared union resources and another round of joint union regional delegate leadership seminars and stopwork meetings, she said.

NZNO will also be canvassing members' views on this year's bargaining priorities.

National delegates hui: E Tu and NZNO delegates got together in Wellington in April to prepare for this year's mahi. The day included affirming the joint union strategy and preparation for bargaining; a session on lobbying MPs and members telling their own stories to illustrate the benefits of improved staffing levels. •

'Overwhelming solidarity' at St George's

"OVERWHELMING SOLIDARITY" has seen a proposed collective agreement (CA) between St George's Hospital in Christchurch and NZNO ratified by 88 per cent of voting members.

NZNO industrial adviser Danielle Davies said most members did not vote on the basis of their individual gain, but rather in support of a more even playing field for members in non-nursing roles and those on lower salary steps.

"This overwhelming solidarity is something to be proud of and sets us in a position of strength when we come to renegotiations early next year," Davies said.

Key features of the deal include:

- A five per cent increase on the respective district health board (DHB) rates for anaesthetic technicians and central sterile services department (CSSD) staff, (bringing them into line with nursing members).
- Automatic annual salary scale progression, as with other NZNO collective agreements.
- A living wage, meaning all CA rates will be at $22.10 or above.
- A 50 per cent increase to the on-call allowance.
- A new salary step (six) for CSSD members.
- A two per cent pay increase on all CSSD steps from April 1, 2021.
- A two per cent increase on all anaesthetic technician steps from April 1, 2021.
- A 12-month term.

Davies said delegates were proud of their achievement and looked forward to signing a new collective agreement soon. There are 230 NZNO members at the hospital, which has 12 operating theatres and a six-bed intensive care unit. •

Why are experienced nurses leaving work? p22-23 – references

1) World Health Organization. (2016). *Global strategic directions for strengthening nursing and midwifery 2016-2022*. https://www.who.int/hrh/nursing_midwifery/global-strategy-midwifery-2016-2020/en/

2) Hirschkorn, C., West, T., Hill, K., Cleary, B., & Hewlett, P. (2010). Experienced nurse retention strategies: What can be learned from top-performing organisations. *Journal of Nursing Administration, 40*(11), 463-467. https://doi.org/10.1079/NNA.0b013e3181f88fd3

3) Perkins, S. (2009, Oct). Ways to retain experienced nurses. *Trustee, 62*(9), 4.

4) Hughes, V. (2017). Leadership strategies to promote nurse retention. Scientific Journal of Nursing & Practice, 1(11), 001-005. https://www.scireslit.com/Nursing/SJNP-ID11.pdf

5) Huntington, A., Gilmour, J., Tuckett, A., Neville, S., Wilson, D., & Turner, C. (2011). Is anybody listening? A qualitative study of nurses' reflections on practice. *Journal of Clinical Nursing, 20,* 1413-1422. https://doi.org/10.1111/j.1365-2702.2010.03602.x

6) Nursing Council of New Zealand. (2017). The New Zealand Nursing Workforce: A profile of Nurse Practitioners, Registered Nurses and Enrolled Nurses 2016-2017.

7) Menella, H. (2018). Retention of healthcare personnel: Retaining older nurses: Evidence-based care sheet CEU. *CINAHL Nursing Guide.*

8) Buffington, A., Zwink, J., Fink, R., DeVine, D., & Sanders, C. (2012). Factors affecting nurse retention at an academic Magnet hospital. *Journal of Nursing Administration, 42*(5), 273-281. https://doi.org/10.1097/NNA.0b013e3182433812

9) Fagerstrom, L., Kinnunen, M., & Saarela, J. (2018). Nursing workload, patient safety incidents and mortality: An observational study from Finland. *BMJ Open, 8.* https://doi.org/10.1136/bmjopen-2017-016367

10) Hairr, D., Salisbury, H., Johannsson, M., & Redfern-Vance, N. (2014). Nurse staffing and the relationship to job satisfaction and retention. *Nursing Economic$, 32*(3), 142-147.

11) Perrine, J. (2012). Strategies to boost RN retention. *Nursing Management, 40*(4), 20-2. https://journals.lww.com/nursingmanagement/Fulltext/2009/04000/Strategies_to_boost_RN_retention.6.aspx

12) North, N., Leung, W., Ashton, T., Rasmussen, E., Hughes, F., & Finlayson, M. (2013). Nurse turnover in New Zealand: Costs and relationships with staffing practises and patient outcomes. *Journal of Nursing Management, 21,* 419-428. https://doi.org/10.1111/j.1365-2834.2012.01371.x

13) Lartey, S., Cummings, G., & Profetto-McGrath, J. (2014). Interventions that promote retention of experienced registered nurses in the health care settings: A systematic review. *Journal of Nursing Management, 22*(8), 1027-1041. https://doi.org/10.1111/jonm.12105

14) Choi, S., Pang, S., Cheung, K., & Wong, T. (2011). Stabilizing and destabilizing forces in the nursing work environment: A qualitative study on turnover intention. *International Journal of Nursing Studies, 48*(10), 1290-1301. https://doi.org/10.1016/j.ijnurstu.2011.03.005

15) Choi, S., Cheung, K., & Pang, S. (2013). Attributes of nursing work environment as predictors of registered nurses' job satisfaction and intention to leave. *Journal of Nursing Management, 21,* 429-439. https://doi.org /10.1111/j.1365-2834.2012.01415.x

16) El-Jardali, F., Merhi, M., Jamal, D., Dumit, N., & Mouro, G. (2009). Assessment of nurse retention challenges and strategies in Lebanese hospitals: The perspective of nursing directors. *Journal of Nursing Management, 17*(4), 453-462. https://doi.org/10.1111/j.1365-2834.2009.00972.x

17) Tuckett, A., Winters-Chang, P., Bogossian, F., & Wood, M. (2015). 'Why nurses are leaving the profession … lack of support from managers': What nurses from an e-cohort study said. *International Journal of Nursing Practice, 21*(4), 359-366. https://doi.org/10.1111/ijn.12245

18) Labrague, L., Gloe, D., McEnroe, D., Konstantinos, K., & Colet, P. (2018). Factors influencing turnover intention among registered nurses in Samar Philippines. *Applied Nursing Research, 39,* 200-206. https://doi.org/10.1016/j.apnr.2017.11.027

19) Moloney, W., Gorman, D., Parsons, M., & Cheung, G. (2018). How to keep registered nurses working in New Zealand even as economic conditions improve. *Human Resources for Health, 16*(45). https://doi.org/10.1186/s12960-018-0312-x

20) Van Dam, K., Meewis, M., & van der Heijden, B. (2012). Securing intensive care: Towards a better understanding of intensive care nurses' perceived work pressure and turnover intention. *Journal of Advanced Nursing, 69*(1), 31-40. https://doi.org/10.1111/j.1365-2648.2012.05981.x

21) Baernholdt, M., & Mark, B. (2009). The nurse work environment, job satisfaction and turnover in rural and urban nursing units. *Journal of Nursing Management, 17,* 994-1001. https://doi.org/10.1111/j.1365-2834.2009.01027.x

22) Hayward, D., Bungay, V., Wolff, A., & MacDonald, V. (2016). A qualitative study of experienced nurses' voluntary turnover: Learning from their perspectives. *Journal of Clinical Nursing, 25,* 1336-1345. https://doi.org/10.1111/jocn.13210

23) Aiken, L., Sermeus, W., Van den Heede, K., Sloane, D., Busse, R., McKee, M., Bruyneel, L., Rafferty, A., Griffiths, P., Moreno-Casbas, M., Tishelman, C., Scott, A., Brzostek, T., Kinnunen, J., Schwendimann, R., Heinen, M., Zikos, D., Sjetne, I., Smith, H., & Kutney-Lee, A. (2012). Patient safety, satisfaction, and quality of hospital care: Cross sectional surveys of nurses and patients in 12 countries in Europe and the United States. *BMJ, 344,* e1717. https://doi.org/10.1136/bmj.e1717

24) Alasmari, H., & Douglas, C. (2012). Job satisfaction and intention to leave among critical care nurses in Saudi Arabia. *Middle East Journal of Nursing, 6*(4), 3-12. https://eprints.qut.edu.au/50984/23/50984_acceptedVer.pdf

25) Walker, L., & Clendon, J. (2018). Early nurse attrition in New Zealand and associated policy implications. *International Nursing Review, 65*(1), 33-40.

26) Dimatiio, M., Roe-Prior, P., & Carpenter, D. (2010). Intent to stay: A pilot study of baccalaureate nurses and hospital nurses. *Journal of Professional Nursing, 26*(5), 278-286. https://doi.org/10.1016/j.profnurs.2010.06.005

27) Nantsupawat, A., Kunaviktikul, W., Nantsupawat, R., Wichaikhum, O., Thienthong, H., & Poghosyan, L. (2017). Effects of nurse work environment on job dissatisfaction, burnout, intention to leave. *International Nursing Review, 64*(1), 91-98.

28) Abubakar, R., Chauhan, A., & Kura, K. (2014). Relationship Between Perceived Organizational Politics, Organizational Trust, Human Resource Management Practices and Turnover Intention Among Nigerian Nurses. *International Journal of Business and Development Studies, 6*(1), 53-82. https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2447140

29) Nowrouzi, B., Rukholm, E., Lariviere, M., Carter, L., Koren, I., Mian, O., & Giddens, E. (2016). An examination of retention factors among registered nurses in north-eastern Ontario, Canada: Nurses intent to stay in their current position. *Work, 54*(1), 51-58. https://doi.org/10.3233/WOR-162267

30) Heinen, M., van Achterberg, T., Schwendimann, R., Zander, B., Matthews, A., Kozka, M., Ensio, A., Sjetne, I., Moreno-Casbas, T., Ball, J., & Schoonhoven, L. (2013). Nurses' intention to leave their profession: A cross sectional observational study in 10 European countries. *International Journal of Nursing Studies, 50*(2), 174-184. http://dx.doi.org/10.1016/j.ijnurstu.2012.09.019

Classified advertising

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

THE NEW ZEALAND NURSING EDUCATION AND RESEARCH FOUNDATION

- **Dr. Jane Nugent Pharmacology Scholarship (Healthy Possibilities Fund)**
- **Short Course/Conference Attendance Grant**
- **Undergraduate Study Scholarship**
- **Postgraduate Study Grant**
- **Innovation Fund**
- **Travel Grant**
- **Wellington Nurses Education Trust Scholarship**
- **Catherine Logan Memorial Fund**

Eligibility:

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

Applications close on 30 June 2021 at 4.00pm

Apply online:

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

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

The 29th College of Emergency Nurses New Zealand (CENNZ) conference is being held in Christchurch 5 to 6 November 2021. It has been 12 years since CENNZ nurses have joined together in Christchurch to celebrate our passion for emergency nursing.

CENNZ is dedicated to promoting excellence in emergency nursing within Aotearoa / New Zealand, through the development of frameworks for clinical practice, education and research. Our conference theme is 'Ready to Respond', something emergency nurses embody every day.

KEYNOTE SPEAKERS – Dr Ashley Bloomfield, Prof Michael Baker and Prof Dame Juliet Gerrard.

CALL FOR ABSTRACTS – NOW OPEN

The organising committee invite submissions for oral presentations (10 or 20 minutes), and posters. Full details on the CENNZ website. Submissions close 2 July.

REGISTRATION – Online registration will open in June.

FURTHER INFORMATION

For further information on the conference or **sponsorship opportunities**, please contact the Conference Organisers;

The Conference Team

E: marg@conferenceteam.co.nz
P: 03 359 2614 | 0274 359 578

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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

Events

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

20-22 May 2021 **Dunedin**
NZNO Women's Health College Annual Conference
https://web.cvent.com/event/4b814937-d490-4321-b85e-7bbe685ff331/summary

6-7 September 2021 **Whangārei**
Ear Nurse Specialist Group Aotearoa/NZ Study Days and AGM
http://www.ensg.co.nz

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

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

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

7-9 October 2021 **Christchurch**
Perioperative Nurses College Conference
https://perioperativeconference2021.co.nz/

For more **Events & Reunions** go to **www.kaitiaki.org.nz**

OUR FUTURE
The health of AOTEAROA

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

Conference and AGM

Wednesday 15 and Thursday 16 September 2021

Museum of New Zealand, Te Papa Tongarewa, Wellington

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

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

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

Call for Abstracts

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

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

Share your ideas, innovations and expertise.

Closing date 4 June 2021 at 5.00pm

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

Conference Sponsorship

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

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

OUR FUTURE
The health of AOTEAROA

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

CALL FOR AWARD NOMINATIONS

NZNO Award of Honour

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

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

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

National Awards

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

Service to NZNO

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

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

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

Service to Nursing/Midwifery

The nominee must be an NZNO member:

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

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

Closing date 4 June 2021 at 5.00pm

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

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

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