Kai Tiaki
NURSING NEW ZEALAND
June 2021
VOL 27 NO 5

STANDING UNITED

District health board members have taken industrial action for better pay and conditions. They want a health service that supports them and patient safety. They are strong and united.

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ISSN 1173-2032

Vol. 27 No. 5 JUNE 2021

THIS ISSUE focuses on nurses' dissatisfaction with their current pay and conditions, amid the district health board-NZNO multi-employer collective agreement (MECA) negotiations. We examine the risks of losing more nurses across the ditch to Australia, and break down what the Budget means for health and how the health reforms will roll out. We also focus on the joys and sadnesses of neo-natal nursing.

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

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

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

Co-editors:
Mary Longmore and Joel Maxwell.

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

This issue . . .

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Cover: Thanks to Wellington Hospital nurses.
Photo: Joel Maxwell.
Cover design: Kathy Stodart.
Pre-press production: TBD Design.
Printers: Inkwise.

Nurses must find their voice, amid changes

By Jenny Carryer

Health Minister Andrew Little and the transition team have outlined significant change in the larger health service delivery structures.

These changes are intended to ensure that all New Zealanders, regardless of ethnicity, location and personal circumstances, will have the same access to care across the country.

Nurses will doubtless applaud and support this goal.

Scant detail has been released on the proposed changes to community-based services and the current private business model of general practice or aged residential care services. Like hospitals, all these areas are experiencing significant work pressure and nurses are currently pushed to the limits to maintain patient safety and clinical quality.

Workforce decisions

Regardless of structural change the success of health service delivery will rest with the issue of workforce. I am hopeful that there will be major changes in how workforce decisions are made and funded.

As a former chair of the nursing advisory group to Health Workforce NZ, I can recall multiple pieces of well-researched advice that were offered on behalf of that committee.

The advisory group set the goal several years ago of ensuring the number of Māori nurses in the nursing workforce achieved equivalence with the percentage of Māori in our population.

We produced evidence showing that a third of all nurses were self-funding their postgraduate education.[1] I have seen recent anecdotal evidence that the gap between those wanting to study and those being funded has further widened.

We offered solutions to the fact that very few nurse graduates choose aged care as a career destination despite the desperate need in that area.

I have seen no tangible response to any of this advice with the exception of some minor increase in the investment in nurse practitioner training.

Recently, New Zealand research showed a clear relationship between the level of postgraduate education and the level of practice across a number of domains regardless of role title.[2] Investment in education is a core aspect of releasing the potential of nursing yet – after many years of a supposedly focused workforce development strategy – I can see little change in investment or support for the largest health workforce in the country.

I have spent 50 years in the profession, wondering why it is so difficult for us to be taken seriously.

I have spent 50 years in the profession, wondering why it is so difficult for us to be taken seriously.

Canadian journalists Bernice Buresh and Suzanne Gordon made some pertinent observations about nurses – their personal and public presentation, alongside their extreme reluctance to speak of their work in public.[3]

As journalists, they noted that despite frequently seeking a nursing opinion they were constantly avoided, or told by nurses that they could not speak or did not wish to speak due to patient confidentiality or a ban on nurses speaking by their employing organisation.

Certainly we can never breach patient privacy but there is no reason not to express a professional generic opinion relevant to the matter under discussion.

First-hand experiences

This can be done without breaching privacy or organisational rules. We can share our first-hand experiences of the consequences of child poverty on child health, of the consequences when funding is cut to shelters for the homeless or women fleeing domestic violence.

We can always speak of what all patients encounter in prolonged intensive care unit stays and the exquisite nursing work required to maintain the stability and sanity of such patients and their families.

Yes it is risky to publicly condemn our employing organisation but we could be a great deal more strategic about briefing our professional organisations and academic colleagues who can safely do this on our behalf. •

Jenny Carryer, RN, Dip Counselling, PhD, FCNA(NZ), MNZM, CNZM, is professor of nursing at Massey University and executive director of the College of Nurses Aotearoa.

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Tell us what you think

'Superb article highights abysmal retention'

I READ 'Why are experienced nurses leaving work?' by Janine Ellison in the May issue of *Kai Tiaki Nursing New Zealand* (p22) and thought it was a superb article.

She highlighted our abysmal nurse retention rate (three times higher than Australia and one of the worst in the world), the reasons why and the consequences.

There were no surprises for people who are at the coalface. Feeling unappreciated by management, lack of support, high workload, low staffing, more paper work, less patient-centred care, more complex patients, less opportunity for professional development.

Email your letter to:

coeditors@nzno.org.nz

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

Is it possible for Janine Ellison to forward this article to all district health board CEOs and the Minister of Health?

For those that live in a much higher salary bracket than us, it will be an uncomfortable read. It could open their eyes and strengthen their resolve to stop the receding tide of health-care workers from flowing away forever. We need our voices heard, as it is plainly obvious all DHBs in New Zealand are struggling to find and keep experienced staff.

I congratulate Janine Ellison for a fine piece of work. Thank you for the mahi you put in.

Alana Whiting, RN
New Plymouth

Hopes for restructuring

I WISH to respond to the excellent and thought-provoking viewpoint by Heather Came and Dominic O'Sullivan ('New Māori health authority needs independence and accountability', May 2021 issue, p16). On my first reading, my reaction was strong – are we beaten before the restructuring has begun? On my sec-

ond reading, I became more reasonable but there are huge challenges ahead. I admire this restructuring by the current Minister of Health, who has put a serious plan on the table. As these writers strongly state, there have been many investigations which have recommended a Māori health authority. No previous government has taken this step.

Came and O'Sullivan raise challenging questions. For years it seems to me that nursing and nursing education have worked hard to honour te Tiriti o Waitangi in some ways. We took seriously the work of Irihapeti Ramsden and the revolution of cultural safety, in our regulatory processes, education and practice. In spite of our hard work, it has not made much difference to Māori health outcomes. But things could be worse if this had not been done.

The matter of future health funding is certainly complex. I have no idea how to figure out a methodology for funding the new health authorities. New Zealand can hardly afford our current health service and I think we are years away from coming to terms with a health-care rationing philosophy and way of life. New research, technology and treatments all contribute to greater expectations and tend to generate more expense for the health budget.

The issue of institutional racism leading to varying opportunities for health care is also difficult. History cannot be undone, nor can it be rewritten. As a country, New Zealand can only go forward after the damage which has been done, as reflected in our health statistics. We are fortunate to have our founding document as a starting point. Racism in any form is damaging to humanity and should not be tolerated.

The questions raised by Came and O'Sullivan are important for policy makers. The responses will determine the success of this new structure and will certainly mean doing things differently at all levels. I suggest more sharing of power, greater co-operation than we have ever known, and commitment to the intended outcome.

I encourage all readers of *Kai Tiaki* to read and reflect on this article.

Isabelle Sherrard, RN,
Auckland

'What is going on at the top?'

AS A nurse and union member since graduating in 2008, I have long supported our union and the struggles faced by NZNO members. But like many of my colleagues, I am becoming increasingly disillusioned with NZNO and the actions of those in charge.

What is going on at the top of NZNO? Where is our leadership that we pay nearly half a million dollars annually for? Why do two of the three leadership positions remain vacant, months after their predecessors left?

When the Government announced a public sector worker pay freeze, most other union leaders jumped to their members' defence. The silence from the NZNO leadership team has been deafening. Where is our president, kaiwhakahaere and CEO when we need them? Have they abandoned us when we're about to go on strike? Are they going to replicate the travesty of the last district health board (DHB) negotiating round by undermining strike action at the 11th hour?

Where is our full independent review of the NZNO constitution that we voted for? September is not far away, and it doesn't appear to have started. Why isn't the board releasing the full governance review to members? Do they have something to hide? Or are certain people's interests being put before the collective? Is that why a certain previous president is now banned from asking questions in our nursing magazine?

Where is the governance that we as members pay so much for?

Nico Woodward, RN,
Auckland

NZNO acting chief executive Mairi Lucas replies: Thank you for your letter. Your continued support is genuinely appreciated.

Many of your direct questions have been addressed by the board in various communications to members, but I will attempt to answer them again, and provide updates where I can.

The board is actively seeking a new chief executive and will take as long as required to find the right person. An offer was made to one potential candidate, but this offer was rejected so the process is ongoing. Obviously, the board cannot publicly comment while it is negotiating with candidates beyond assurances that it is continuing with the process (see Board Kōrero, May 3, 2021).

The president's position is full-time and paid, so our current vice president would have had to leave or suspend her employment to fill the position. This is unreasonable for an eight-month appointment; the previous president resigned in January and elections will be held in September (see Board Kōrero, April 7, 2021).

It is not true to say two leadership positions are vacant. Both roles are filled on an acting basis, so leadership is there, and this is also normal practice.

NZNO spokespeople directly involved in DHB MECA negotiations were very active in the media and received a lot of coverage around the public sector wage freeze. Please see the Media page on our DHB MECA website (dhbmeca.nzno.org.nz) where these stories are archived.

The board has communicated to members that the scope of the constitutional review is enormous and that it is unlikely to be completed by September (see Board Kōrero, May 3, 2021). I can now confirm that it will not be completed by then. However, the board has promised to provide a full and transparent update on progress at or before the AGM.

The board has explained that it will not release the full governance review to members because it contains private information about identifiable individuals. There is nothing unusual in that. However, the board has released the recommendations from the report, which should give members a reasonable picture of the matters the review contains (see Board Kōrero, February 11, 2021). The board has also indicated willingness to pursue the recommendations, but many are subject to constitutional change so cannot be acted upon until that occurs.

Finally, the letter you refer to was not published because, in our view, it breached Kai Tiaki*'s letters to the editor policy.*

I truly regret that you feel increasingly disillusioned with the organisation and its leaders who are your elected representatives. To work best as a union, we need to be strong and united. I hope that our members, leaders and staff can continue working together in a spirit of openness and that one day your trust may be regained.

Strike 'a warning' to DHBs

Incensed by a public sector pay freeze and a one-off cash payment instead of a long-term pay rise, NZNO's district health board (DHB) members this month voted 'overwhelmingly' to reject the DHBs' latest offer and go on strike.

ONE-OFF payments don't cut it – we want a real pay rise and safe staffing. That's the message from nurses and other NZNO members to the Government and district health boards (DHBs), after a resounding rejection of a second offer under the DHB-NZNO multi-employer collective agreement (MECA) negotiations.

South Canterbury District Health Board organiser Stephanie Duncan said the Government's plans to freeze public service pay salaries over $60,000 for three years, announced last month, had been "really upsetting" and pushed many over the edge.

Stephanie Duncan

David Wait

"The wage freeze had a definite impact, on top of how the workforce was already feeling from COVID-19," Duncan said. "We have been given so much support from people over the past year and told by the Government how vital we are. . . so hearing about their plans for a public service pay freeze was really upsetting."

'We are very angry that the pay equity is being made an issue in this, when it's a completely separate thing.'

In May, Public Service Minister Chris Hipkins announced an extension of an effective pay freeze for people earning more than $60,000 in the public sector. This would include nurses, and would be reviewed in 2023.

Nurses and members felt "strong, committed and excited" about the strike. "We want to push forward – we want to make some progress towards a pay rise," Duncan said.

NZNO lead advocate David Wait said the clarity of nurses' response was a "warning" to DHBs that a one-off payment wouldn't cut it and a "genuine offer" was needed over staffing and pay.

"I think it's a warning that the DHBs should heed – they need to make a genuine offer to bridge the gap and a lump sum payment clearly isn't that," he said. "Our members have been told for a number of years that staffing levels will be fixed, that their pay will be addressed through pay equity… but neither of those have eventuated and they're long overdue."

'Enraged' over offer

The revised DHB offer included a $4000 lump sum "advance" on pay equity claim work underway. But the offer still only amounted to a 1.38 per cent annualised increase for registered nurses (RNs) on the top end of the scale.

"Because it's not increasing those rates of pay, it doesn't do anything for making the occupation more attractive or entice people back from overseas or who have left, or doesn't stop nurses wanting to leave."

Hutt Valley DHB delegate Julie Pritchard told *Kai Tiaki Nursing New Zealand* members who might have been sitting on the fence before, were enraged by the second offer.

"In my department, we are not happy. We are very angry that the pay equity is being made an issue in this, when it's a completely separate thing."

What members wanted was a meaningful pay rise and safer daily staffing levels, she said.

West Coast DHB delegate and nurse manager Nelly Hofman said staff felt united and determined, and had been delivering leaflets and preparing hats for weeks in preparation.

"We're full-on, we're going, we can't keep anyone away – we're going on strike!"

Waikato not exempt

Hamilton organiser Jenny Chapman said members had decided to go ahead with the strike, despite a request from Waikato DHB to be exempt due to the hack of their IT systems.

"The delegates and the organising staff met together and the delegates were quite clear: they'd talked with quite a number of members before the meeting, and it was quite a significant majority who really wanted to continue with the action. They felt it was important to be part of a national strike. They felt as though they'd let some of the team down if they didn't participate."

NZNO acting manager, professional and nursing services, Kate Weston said the public salary freeze "incensed" members, along with an offer of a lump sum "they were going to get anyway" [under Fair Pay agreements], causing voting to spike.

NZNO also wanted DHBs to pay penalty rates when nurses were forced to work in environments which did not meet agreed safe staffing targets, Wait said.

However DHBs had "refused to engage" on this. •

Old MECA promises still unmet

NURSING SAFETY – in everyday work and the age of COVID-19 – were scrutinised by the NZNO board as strike action rolled out across Aotearoa.

Amidst a district health board (DHB) strike in a battle over a new collective agreement, board members have warned key promises from the last settlement remain unresolved.

NZNO kaiwhakahaere Kerri Nuku said nurses accepted the 2018 offer because of its safe staffing accord. The accord was meant to ensure the implementation of care capacity demand management (CCDM, a safe staffing system). "What's happened is it seems to now have been absorbed into 'business-as-usual'."

The longer the issue dragged on unresolved, the less likely there would be a commitment to make change.

NZNO was now negotiating a new agreement before the last one was fully implemented, she said. "And so we're at the table yet again, talking about safe staffing and the same issues."

Board member Simon Auty said DHB nurses were angry, "but they're angry about more than just their pay packets". Safe staffing was central to the latest DHB negotiations, he said.

However, Auty said multiple DHBs had failed to meet the deadline to fully implement CCDM. "We've still got new grads who haven't been employed, which was also part of the accord."

DHBs were not regularly reporting progress, and some had not even bought the software to implement it, he said.

New COVID-19 variants

Meanwhile, the board had discussed the Government's response to the potential arrival of new COVID-19 variants.

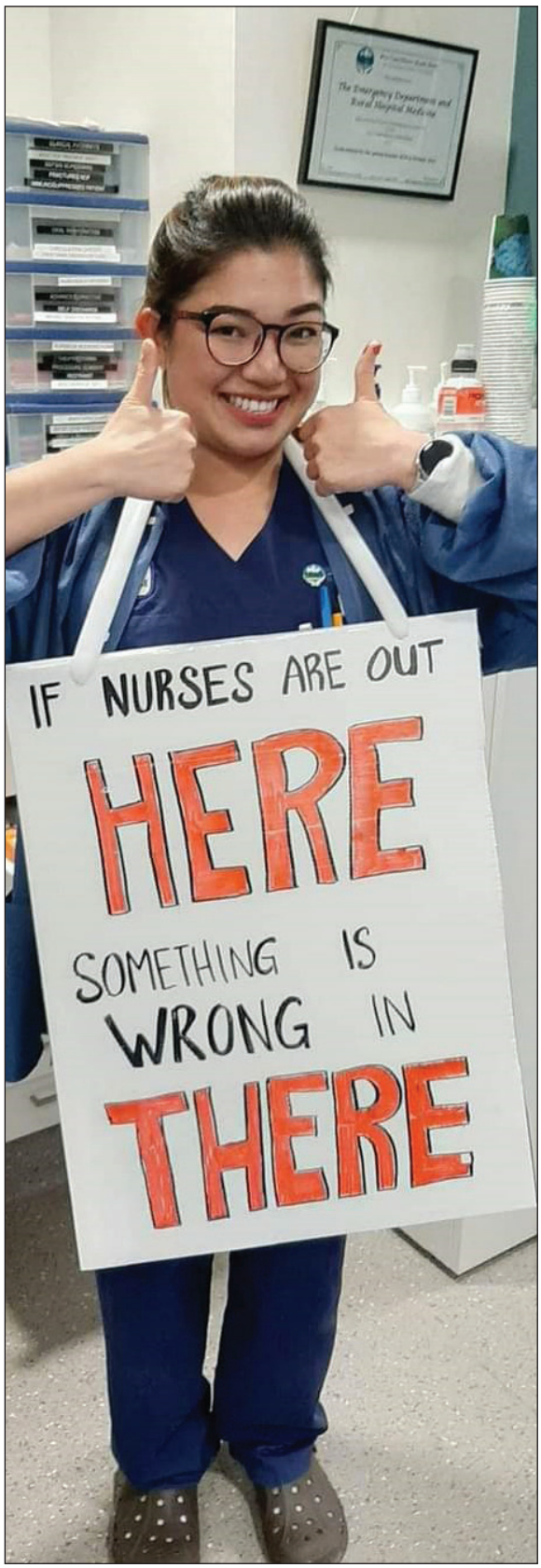
Nuku said members were keen for the Office of the Auditor General to independently review Government preparedness to deal with new variants.

She said 12 per cent of the COVID-19 cases in Aotearoa were suffered by health workers.

The lack of support for nurses was another example of the Government ignoring nurses' concerns. "It's a criticism of the fact that nurses don't seem to be important in the re-development and management of a crisis."

Auty said the Ministry of Health still had the same PPE advice on its website from July 2020.

"Nurses were never brought in to the Government's advisory group. We were never there during the response, when we were responding to our members' inquiries." •



Above, Patruzka Dizon-Ferrer and left, other West Coast nurses prepare for strike action.

Late legal threat fails to derail strike

A LATE threat of legal action from Canterbury District Health Board (CDHB) over a lack of contingency staff nearly derailed this month's strike, NZNO industrial services manager Glenda Alexander said.

It was only the frantic hard work of NZNO staff and members throughout the Queen's Birthday holiday weekend which managed to pull together enough nurses and staff to provide basic life-preserving and patient safety services during the June 9 strike. The DHB then withdrew its notification of legal action, she said.

'It was close'

"It was close, but we got there," Alexander told *Kai Tiaki Nursing New Zealand*. "It was a really big team effort [which averted it]. Delegates and staff were all weekend calling people, one by one, trying to persuade them [to work through the strike]," she said.

If CDHB had won a legal challenge over inadequate staffing levels, the strike would have been called off, Alexander said.

Under the Employment Relations Act's public health sector code of good faith, as part of collective bargaining NZNO was obliged to work with DHBs to ensure adequate staffing was provided during strike action to maintain patient safety and preserve life.

Painstaking

This had required weeks of painstaking negotiations with DHBs involving NZNO staff, delegates and members, Alexander said. "Just finding people willing to work through the strike, to provide life-preserving services (LPS), was challenging and put a lot of pressure on us staff and delegates."

Members weren't usually keen, which was understandable. Yet providing these services was essential to allow the strike to proceed, Alexander said.

NZNO acting manager, professional and nursing services, Kate Weston acknowledged it was a "big ask" for members to provide LPS cover when they wanted to be on the picket line – but failing to fill those rosters gave DHBs an opening for legal action. "These members putting themselves up for LPS are equally important to a strike going ahead."

Wherever possible, non-union staff were asked to work. However as NZNO membership was so high, it was not always possible. "They voted to strike so people want to strike and be out there picketing, so it's quite a big ask to be part of LPS," she said.

MidCentral health-care assistant Jenny Galvin amid strike preparations.

Nurses – unlike some other essential services such as police – were legally able to take industrial strike action under the ERA, but only if LPS rosters were agreed and filled, Weston said.

NZNO had spent weeks negotiating with the country's 20 DHBs on what these would look like. As well as CDHB, there had also been sticking points at Taranaki, Southern and Auckland DHBs requiring adjudication; however these had all been resolved by strike day, Weston said. "Thanks to the really hard work of members and staff we came to agreement with all DHBs over the [Queen's Birthday] weekend."

Staffing inflated

Some DHBs inflated the required staffing beyond what DHBs would have on an ordinary day, which had caused "major distress" for members trying to organise contingency staffing in good faith, Weston said.

"Seventy to 80 per cent of the time, there are not enough staff to meet patients' needs." •

Sore arm ‘worth it’

NZNO organiser Justine Sachs (front, far right) with NZNO and PSA organisers post-jab.

NZNO AND Public Service Association (PSA) members got their COVID-19 vaccinations at Auckland District Health Board (ADHB) recently.

NZNO organiser Justine Sachs said the roll-out had been going well, with 90 per cent of ADHB staff having received their first dose. With most members’ vaccinations completed, NZNO and PSA organisers were also invited, and “jumped at the chance”, Sachs said. “We are often in and out of hospitals and aged-care facilities and want to play our part in keeping members and the public safe.”

Sachs said the organisers encouraged all health-care workers who were hesitant to get vaccinated, which was “quick and relatively painless”, she said. “Either way, receiving immunity from COVID-19 is well worth a slightly sore arm.”

Nationally, DHBs were ahead of vaccination targets, by 109 per cent, in early June, the latest Ministry of Health figures say. Under the roll-out, border workers and their families are first in line to be vaccinated, followed by front-line workers including health-care and residential aged care, followed by at-risk populations. The general population rollout is scheduled to begin from late July.

ADHB board members were criticised after they received their vaccination in March, ahead of staff. A spokeswoman said they were leading “by example” and wanted to encourage uptake by staff. •

Concerns over roll-out

NZNO IS “very concerned” at the pace with which unregulated vaccinators are being introduced to the COVID-19 roll-out, acting manager, professional and nursing services, Kate Weston says.

There was also a lack of “effective or meaningful” consultation with stake holders such as NZNO or the Nursing Council. Other nursing leaders had also expressed concern at this “devaluing of the nursing role in this critical phase of COVID-19 management”, Weston said.

Concerns related to how regulated vaccinator nurses would be responsible for supervising up to six unregulated vaccinators, as well as the devaluing of nurses by substituting them with unregulated practitioners.

NZNO – a key stakeholder – had not been directly consulted on embedding unregulated vaccinators, which would require legal and regulatory changes, she said. Only in mid-May was there a chance to feed back on the proposal, with only a few days given by the Ministry of Health (MoH) – a process she described as “lip service”.

NZNO was highly supportive of the COVID-19 vaccination programme, but would prefer unregulated staff to support whānau, facilitate education, manage patient flow and other supporting roles rather than the vaccinating itself, Weston said.

Describing the vaccination programme as a way of providing “entry-level” health roles to Māori and Pacific people, “exemplifies the abject failures to ensure the Māori and Pacific communities are properly supported with quality health services”, she said.

NZNO remained committed to a safe and effective roll-out of the COVID-19 vaccination programme and working with the MoH to achieve this. •

Unregulated staff risks

NO CONSULTATION, no idea of the training regime, but lots of responsibility – an unregulated COVID-19 vaccination workforce has set off alarm bells for NZNO kaiwhakahaere Kerri Nuku.

“You’ve got an unregulated workforce that is being trained to do a specific task – and the task isn’t just taking a blood pressure, the task has significant ramifications if somebody has an anaphylactic shock,” she said.

Registered nurses (RNs) would have to take responsibility for any unregulated staff working underneath them. “Unregulated staff don’t have indemnity. So ultimately who becomes responsible . . . is the RN – so their practising certificate is on the line.”

There was always a need for unregulated kaimahi in health services – linking with communities, providing support and education, she said. However, NZNO was concerned COVID-19 was an excuse to roll out an unregulated workforce, and devolve nursing responsibilities to this workforce.

It would place the burden of a nursing task on kaimahi in Māori health providers – already at the bottom of the pay scale.

Some Māori providers might have welcomed the move – but that viewpoint came from a management position, not from the nurses, Nuku said. “And when somebody’s had an anaphylaxis, they’re [the manager] not going to be there to hold the nurse’s hand – the manager’s going to be trying to free themselves of any blame or responsibility.”

It appeared there were no details yet on what the training programme would look like, she said. “And given that they haven’t consulted with us, as the largest group of health-care workers’ representation, that’s a real concern.” •

'Culture of fear' in NZ health system

TWO-THIRDS OF nurses surveyed have witnessed unsafe nursing practice by their peers, new research suggests – double the rate of some international findings.

Yet few report it due to a punitive "culture of blame and fear" in New Zealand's health system, NZNO professional nursing adviser (PNA) Wendy Blair said. "They fear speaking out, because of what the repercussions might be, for them and for their colleagues," she said. "Nurses are actually being set up to fail."

Wendy Blair 'shocked' by extent of unsafe practice.

Blair recently completed her PhD research *Nurses' recognition and response to unsafe practice by their peers* for which she surveyed 231 nurses including 13 interviews. Sixty-six per cent of participants reported working with a colleague they felt was practising in an unsafe manner, over the previous year. That was higher than reported in previous studies[1,2,3] in which the rate ranged from 30 to 40 per cent.

Blair said she was "shocked" by the extent of the problem, which appeared to be across all sectors.

Low staffing ratios and poor skills mix, along with excessive workloads and poor organisational cultures meant nurses often took "short-cuts", Blair said.

"We [NZNO] deal every day with nurses who have made errors, because they're under enormous pressure."

NZNO had recently supported nurses who had lost their jobs in aged care over errors – but had been responsible for up to 60 patients in a facility. "Nobody should have a patient ratio that high," Blair said.

"The environments are so challenging, it's very hard to practise within them, and then, when things go wrong, nurses are blamed and punished."

A culture which supported nurses to seek help was needed – not punishment, she said. "There are very few who are truly unsafe practitioners. Most just need help, support and education – but also to work in an environment where it is okay to make mistakes, to ask for help, and not be blamed or punished when things go wrong."

Nurses needed to be able to talk about their practice in an "honest, non-punitive way" with issues resolved at the lowest possible level. "But our current blame culture doesn't allow that."

She blamed a health system driven by "dollars" rather than providing good care.

"We need to change the way we talk about health. We talk about dollars, finance, but we don't talk about people, health and suffering. We are working in a depersonalised system – it's frustrating."

Dealing with nurses fearful of making or reporting mistakes was something NZNO dealt with every day, so it was "immensely frustrating" to see how widespread the problem was, Blair said.

Blair's research has been published in the international *Journal of Advanced Nursing*[4] and is also being published in the international *Journal of Clinical Nursing*. •

* *See pp34-35*

Māori and Pacific nursing degrees remain

MĀORI AND Pacific nursing degrees will still be available under a national nursing curriculum being developed by new super-institute, Te Pūkenga.

As part of vocational reform, Te Pūkenga is charged with bringing the country's 16 polytechnics into a single network with one curriculum per programme. Scheduled to roll out in 2023, this has ignited concerns from nursing leaders of a loss of regional diversity and autonomy in nursing training.

The National Nursing Leaders (NNL) group has expressed fear the merger could "fracture" nursing education and "disrupt the nursing pipeline", impacting on health care.

Nursing had spent 20 years training a "flexible, fit-for-purpose" workforce able to extend their roles in rural areas and small towns, NNL co-chair Jenny Carryer and former co-chair Lorraine Hetaraka have told Te Pūkenga chief executive Stephen Town.

Dr Angela Beaton

It was the "breadth" of programmes from non-degree to post-grad, that supported this. ". . . it is abundantly clear that any fracturing and splintering of education and the pipeline could have disastrous consequences".

Nursing educators, employers and other NNL members must be involved in any changes to how the training is delivered, they said.

Te Pūkenga deputy chief executive delivery and academic Angela Beaton said at a recent hui [with Nursing Education in the Tertiary Sector (NETS)] it was agreed to progress with three registered nurse programmes – the bachelor of nursing (BN) and BN Māori and BN Pacific.

Te Pūkenga would now be "leaning in" to collaborate with "nursing leaders from across our subsidiary network and the sector to rethink nursing education". That would include te Tiriti-led governance of the nursing programmes, she said.

A range of nursing representatives including NZNO would be invited to be involved in designing and testing a new curriculum, "to ensure the voice of the profession and wider sector is heard".

Nursing programmes are currently delivered at 14 polytechs, six universities and one wānanga. •

Downsides of smartphones for students

FORGET PPE or vaccines – it appears nurses are no more immune to the risks of the digital age than everyday people.

A new review has found mixing smartphones and study, for nursing students, can come with its downsides – including digital addiction.

Whitireia nursing tutor Belinda McGrath (right) was part of an international team that published the review on the impacts of smartphones on nursing students.

'The negative impact of smartphone usage on nursing students: An integrative literature review' took a fresh look at the downsides of digital reliance.

Results from research in countries such as Korea, Turkey, France, Canada and Egypt found "worrying" smartphone addiction amongst nursing students.

The devices have been snapped up as a useful study tool – allowing quick, portable access to textbooks, pharmacology resources, and standards for practice.

However, McGrath said while using the "wonderful world of digital knowledge" could help students, the review found a worrying level of negative impacts.

These impacts "caused stress and anxiety, and adversely affected sleep, learning and academic performance, as a result of a reliance on this learning resource", she said.

The review said nursing students reported significant benefits to smartphone use, which extend beyond learning, *"to include enhanced communication, clinical decision making and evidence-based practice.*

"Despite these benefits, little is known about the negative impact of smartphones on student learning."

The review found personal smartphone use was reported *"to be a distraction within clinical and classroom learning, and considered as uncivil, and compromised professionalism . . . Frequently, smartphones were used for entertainment . . . rather than professional purposes."*

A concerning level of nomophobia (fear of losing your cellphone) and smartphone addiction was found among nursing students.

Excessive smartphone use among nursing students *"may adversely affect physical and mental health and potentially impact on student learning within the classroom and clinical environment"*.

McGrath said the right policies needed to be put in place, in training, to ensure "a positive outcome" from smartphone use as part of the nursing curriculum. "We are currently doing research into this to inform development of policies and guidelines to address this, which can complement Whitireia's current ICT policies." •

'Drastic' action on nurse shortage needed

"DRASTIC" ACTION is needed to train and recruit millions of nurses globally amid a pandemic and shortage of six million nurses, says the International Council of Nurses (ICN).

President Annette Kennedy said the organisation welcomed a new World Health Organization (WHO) global nursing strategy, and urged nations to adopt it as soon as possible.

"Unless governments . . . act now, the current situation, with nurses being overworked, underpaid and undervalued, will continue, with potentially disastrous consequences for us all," Kennedy said. "Nurses are the lifeblood of health systems everywhere, and they must be recognised for what they are – a precious commodity that needs to be nurtured and protected."

The World Health Assembly (WHA) – WHO's governing body – adopted *Global Strategic Directions for Nursing and Midwifery 2021-2025* in May.

The strategy addressed many issues ICN had campaigned on over the past 18 months, including the ongoing global shortage of at least six million nurses; the need for investment in nursing jobs, education, leadership and practice, as well as nurses' safety in the face of a pandemic.

WHO also recommended establishing government-led chief nurses in every WHO member state, Kennedy said. WHO has 194 member states.

ICN chief executive Howard Catton said ICN's own research suggested millions more nurses would retire over the next decade due to "mass traumatisation" from the effects of COVID-19. He called for "drastic action" from governments to train and recruit nurses, "to safeguard our future health-care systems".

Catton was pleased to see how many countries had committed to the strategy – the first to be adopted by the WHA. ICN would work with national nursing groups to track progress.

New Zealand's National Nursing Leaders (NNL) group has estimated New Zealand will be short of 15,000 nurses by 2035, due to an ageing workforce. NNL is also focused on growing the Māori nursing workforce from 7.5 per cent to better reflect the national Māori population of around 16.5 per cent. •

New health entities 'fully functional' by Sept 2022

Transition unit bosses give clues on how sweeping health reforms will roll out.

By co-editor Joel Maxwell

New laws underpinning the Government's proposed health reforms will be introduced to Parliament in September.

And everything – including health workers' employment contracts – should be switched across to the new health entities by July next year.

September is shaping up as a key month for the Government's fast-tracked changes to the health system.

In April, the Government announced it would replace district health boards with Health NZ (HNZ), and create a new Māori health authority (MHA).

Speaking to members of General Practice NZ, former director-general of health Stephen McKernan said new legislation was expected to be introduced by September this year. McKernan was appointed last year to head the transition unit.

He said an interim MHA and HNZ would likely also be established in September this year. By January 2022, some functions and staff could be transferred to the interim entities.

Data and digital services, performance monitoring and mental health services were the sort of functions that could shift across in the six months it would take for the legislation to move through Parliament.

The new law would be passed by April and come into force from July 1, which would see remaining staff, assets and liabilities transferred to the new entities.

It was expected they would be fully functional, carrying out all legally required work, by September 2022. The transition unit would then be disestablished.

Deputy director of the transition unit Martin Hefford said it was expected contracts with DHBs or the Ministry of Health that ran past July 1 next year would be switched, with "same terms and conditions", to HNZ or the MHA.

The employment contracts DHB staff such as nurses and doctors would be transferred as well.

"There will be changes, but a system that employs something like 80,000 people and contracts with another 100,000-odd: we do not want to destabilise 'business-as-usual ... we want a bit of time to clear away some of the roadblocks that have been there."

He said commissioning powers under the present system were spread too thin.

Some functions and staff could be transferred to the new entities by January 2022.

McKernan said the MHA would have the power to commission kaupapa Māori services – and so would HNZ.

Both would work "incredibly closely", he said, including having co-commissioning powers.

The 12 public health units would be rolled together into a single, national public health service within HNZ, he said. They would work together in a single system.

In May, the Government set aside about $250 million in Budget 2021 to set up the MHA. Finance Minister Grant Robertson said the money was only for the transition. There would be "plenty" more money coming for the MHA's operation.

Overall, the Government tagged $486 million to kick start the revamp. It is expected the 2022 and 2023 Budgets would be where a true indication of the funding levels would become clearer.

The reforms were largely based on the recommendations of the Health and Disability System Review, chaired by Heather Simpson. It recommended keeping a smaller number of DHBs, and a creating a non-commissioning MHA, but the Government pushed further than those recommendations.

The changes come amid long-term health inequities for Māori, which see them die on average seven years earlier than other New Zealanders.

In May, Health Minister Andrew Little announced a steering group to pick interim MHA board members.

Tā Mason Durie was appointed to select the steering group, which comprised Dr Matire Harwood, Parekawhia McLean, Tā Mark Solomon, Rāhui Papa, Kim Ngārimu, Amohaere Houkamau and Lisa Tumahai.

Harwood (Ngāpuhi, Ngāti Rangi, Te Mahurehure, Ngāti Hine) would be the only steering group member with clinical experience.

She is associate professor in the Department of General Practice and Primary Care, at Auckland University, and is also a general practitioner at the Papakura Marae Health Clinic.

Tā Mason (Rangitāne, Ngāti Kauwhata, Ngāti Raukawa) has spent more than 40 years involved in Māori health and is emeritus professor of Māori Research & Development at Massey University. •

Jumping the ditch

Is the nursing brain drain real? And if it is, can you blame nurses for leaving?

PHOTO: ADOBE STOCK

Where's the strategy?

Opinion

THE GOVERNMENT is at a crossroads with its strategy for keeping and building its health-care workforce. Or rather, there doesn't appear to be a strategy.

The pay freeze, dropped midway through district health board (DHB) collective agreement negotiations, couldn't have made Australia more appealing to some nurses than if the Government had handed them tickets and waved farewell from the airport.

This, and a weak initial offer by DHBs in protracted negotiations, were still only part of the puzzle.

There are caregivers, nurses, midwives, working in all areas of the health system, struggling to make ends meet from week to week.

This includes nurses working for Māori health providers who, even at their highest paid, scrape in at the bottom of the band for DHB counterparts.

With internationally sought-after skills, a tough job and little appreciation in Aotearoa, why wouldn't our nurses look to leave the country?

– Joel Maxwell, co-editor

By co-editor Joel Maxwell

It was hundreds of years ago that the first explorers navigated the vast ocean of Te Moana-nui-a-Kiwa in waka, using prevailing winds, the guidance of the stars – sheer guts – to make their way to these islands. An incredible feat.

Later arrivals had to embark on arduous journeys themselves.

Aotearoa is a nation of travellers, so it's probably not surprising that taking another step across the Tasman Sea – now as simple as carrying a passport, Kiwi skills, and an Australian practising certificate – might be the next Great Migration for nurses.

With word seeping through from wards, clinics and practices of staff leaving New Zealand, *Kai Tiaki Nursing New Zealand* spoke to people within the health sector to find out whether the brain drain was real.

NZNO acting president, and first Māori vice president Tracey Morgan said she loved nursing, and Māori nursing. "That's regardless of the money, that's the passion of why we're here."

At one time, Morgan was going to head to Perth herself, before the arrival of COVID-19. Her children were living in Australia and she had been keen to head over.

"We'd actually sold our house and we were ready to go . . . [but then] I got approached to be a nurse manager here in a medical centre."

Morgan ended up staying because of opportunities with the new role, but said heading to Australia came with plenty of its own opportunities for nurses.

"I've been talking to a lot of the nurses doing the agency nursing . . . they go away for six months, get an astronomical bank account, come back, pay off their mortgage, have a good couple of months of holiday, then go back again."

Meanwhile, nurses in Aotearoa were "fighting for pay parity, fighting for better conditions, fighting, mainly, for nursing", she said.

Nurses working in the Māori health sector in particular were doing it tough – facing pay rates on average 25 per cent lower than district health board (DHB) counterparts.

Morgan said there was already a shortage of Māori nurses in communities. "I know we've got Māori nurses [in the system], but a lot of them won't leave the DHB . . . burnout is real."

NZNO kaiwhakahaere Kerri Nuku said a Māori nursing shortage in Aotearoa meant there was a risk there would be no cultural change in its organisations.

"Our systems already endorse us to be taught through a mainstream lens. Anybody that's in a bachelor of Māori programme – some of the employers will say 'is that a Weetbix qualification?' So

they're continually undermining it."

Why would a Māori nurse invest time in a system and not get recognised, she said, "when you can do the same in Australia and get paid more?"

All this raises the question of how big an impact the appeal of overseas work has had on nursing numbers.

The data is yet to stream through from the last 12 months, but anecdotal evidence is accumulating, rumours swirling.

One nurse, who did not wish to be named, told *Kai Tiaki Nursing New Zealand* she had heard there was a mass exodus from her hospital's emergency department – the number of the departed ran into double figures.

The latest Nursing Council numbers leave it unclear whether there's been a brain drain, or even gain (with nurses escaping back to fortress Aotearoa), since the start of the COVID-19 pandemic.

Council data suggests that till March 2020 at least, there had been a steady but achingly slow year-on-year climb in nursing numbers since 2016.

By the end of March last year, there were 58,866 nurses in Aotearoa, covering registered nurses, enrolled nurses and nurse practitioners.

This was a 1.8 per cent increase from the previous year (in line with percentage changes back to 2016). Overall nursing numbers had increased by about 5000 from 2016.

The numbers are not yet out on what happened in the 12 months since the start of lockdown in Aotearoa and the global spread of COVID-19.

However, NZNO board member Simon Auty, a Wellington theatre nurse, said in one week, in one unit in the Capital & Coast DHB catchment, they had lost seven nurses to Australia. Some were previously planning to leave, but not all, he said.

Nurses would be "silly not to" look at heading overseas after the Government's pay freeze announcement, Auty said.

People could go to work in Australia where they could earn more money and also receive smartly-structured salaries that included the likes of tax-free portions tagged to buy appliances for newcomers getting set up in their new home.

There was a "massive shortage" of nurses in places like the US, he said. "And they're prepared to pay a hell of a lot to get people," he said.

There had been no workforce planning by successive governments in New Zealand for at least 40 years, he said.

He said nurses working for Māori health providers in particular where "there for the love" – earning less than their DHB counterparts.

Sunny in Queensland

Occasionally in the life of a nurse, you need to take stock – have a bit of a life audit. That is what is happening with one senior nurse, working in a hospital in a "moderate-sized" DHB.

He did not wish to be named – he hadn't told his managers he was about to apply for an Australian practising certificate.

He's weighing up the pros and cons of chucking in his Kiwi job and working somewhere sunny – Queensland sounds good right now.

A "demoralising" government pay freeze dropped right in the middle of

MONEY MATTERS

FROM OCTOBER this year, the starting rate (step 1) for a qualified registered nurse (RN) working for Queensland Health, which operates the state's public health system, would be NZ$79,749.

This RN band includes seven annual steps, with the midrange (S4) sitting at NZ$90,694, and the top (S7) at NZ$101,947.

The current district health board (DHB) collective agreement in New Zealand sets the starting rate (S1) for RNs at $54,034. This rises across seven annual steps to $77,386. It doesn't even make the starting rate in Queensland, once converted into Australian dollars.

But things get even tougher for RNs working for Māori health providers.

A recent agreement shows the starting rate (S1) for RNs at one provider was $51,611, which went up five annual steps to $61,665.

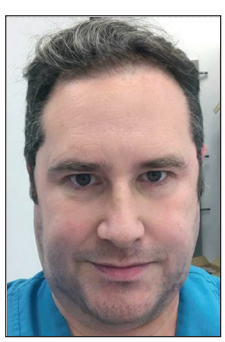
The highest rate squeaks in just above the starting rate for RNs in DHBs, and well below the Queensland system. •

Tracey Morgan

. . . nurses in Aotearoa are 'fighting for pay parity, fighting for better conditions, fighting, mainly, for nursing'.

Kerri Nuku

Why would a Māori nurse invest time in a system and not get recognised 'when you can do the same in Australia and get paid more?'



Simon Auty

Nurses would be 'silly not to' look at heading overseas after the Government's pay freeze announcement.

DHB collective negotiations left a bitter taste in his mouth.

He will likely look at the "fly-in, fly-out" contract work approach.

Some nurses he's spoken to loved their work in often-remote parts of Australia.

He was looking at Queensland. There were a lot of carrots being dangled by various agencies, he said.

If you look to work in remote rural location, they'll pay a $10,000 bonus at the end of a two-year contract; he's heard there's options for tax-free portions of income, $10,000, tagged for set-up costs like utilities and rent.

Those are the upsides – but there's downsides too.

"I can't get family in Australia, I can't get [his New Zealand] friends in Australia . . . it would be the financial reward that would make me feel valued for what I do."

Either way, he thinks the Government needs to do more to encourage new recruits, and keep them once they graduate.

These days he's sick of finding burnt-out nurses crying in drug rooms, sluice rooms and in their cars after a shift.

'Second-class citizens'

The grass might be greener on the other side – but sometimes climbing the fence is a huge hassle.

NZNO lead organiser Paul Mathews has some words of advice for those considering the shift to Australia.

He said he went over to work in Australia about 30 years ago. On paper it looked great, but with living costs and different penal rates, he was actually about 25 per cent worse off.

"You've got to look at the big picture stuff, not just the base rate."

He said nurses, and Kiwis in general, forgot that with changes to immigration status for New Zealanders, "we're effectively second-class citizens" over the ditch.

"We can access absolutely nothing over there. If something happens to you, 'you're on your own mate'."

Nurses needed to be careful: while they might be worse off on an hourly rate in Aotearoa, there were social services and the likes of ACC that were simply unavailable in Australia.

"If we have any kind of responsibility to our members, it's just about saying 'have you thought about the big picture: have you thought about where you stand if you fall over and break your leg . . . if you develop multiple sclerosis or have a stroke?'"

So with new generations coming into nursing, skyrocketing rental and housing costs, stagnant pay and tough conditions, nurses have to decide whether they will stay or go.

There are risks with leaving, and losses. Not least of all separation from whānau, friends, and islands to which our ancestors journeyed – maybe recently, maybe 800 years past.

In the end, nurses face the age old decision between pragmatism and something else – something found, in a completely non-clinical way, in the heart. •

'Ready for something simpler'

LYNDA DEACON is wearing a new kind of PPE.

By the time this issue comes out, Deacon, registered nurse, will be gone from her paediatric ward. There will be no more children in her care – just saplings.

After more than 30 years in in nursing, Deacon has left the profession to become an orchard contractor: planting, pruning and harvesting trees.

Her working life, almost entirely in paediatrics, included stints in Starship, North Shore Hospital and Whangarei Hospital.

She moved to Western Australia in 2007 to become a clinical nurse specialist for the paediatric tertiary hospital in the state's surgical and burns unit. After other roles, she returned to New Zealand in 2018.

Dealing with the abuse of children, and experiencing abuse herself, took their toll. Deacon is ready for something simpler.

"I will be working Monday to Friday with some seasonal breaks. During these breaks I am planning to travel around New Zealand with my partner: fishing, hunting, hiking and picking up some seasonal work as we travel around our beautiful country."

Deacon might have stayed in New Zealand, but she is worried for the future of nursing. "My biggest fear for nursing in New Zealand is the skill drain that we will experience if we do not improve how nursing is rewarded."

Lynda Deacon, exchanging paediatric nursing for tending trees.

She said work conditions, lifestyle and standard of living were similar in Western Australia, "but the pay and benefits for nursing is so much better".

"I fear that we will lose many skilled staff to Australia if we don't do something drastic." •

Leading from the two houses

New co-chair, Māori, for the National Nursing Leaders group Brenda Close talks about the two houses of modern nursing leadership.

By co-editor Joel Maxwell

For Brenda Close, taking on leadership roles in multiple high-level nursing groups never gets in the way of her day job. In fact, she says, the kaupapa of leadership provides an across-the-board boost.

Close (Ngāpuhi, Te Rarawa, Ngāti Maniopoto) spoke to *Kai Tiaki Nursing New Zealand* about becoming new co-chair Māori of the National Nursing Leaders group (NNL), and the work ahead.

It is a job that has become even more important as health reforms, including a Māori health authority (MHA), loom.

The NNL is a national forum of nursing leaders, and organisations including employers, the Nursing Council and the Ministry of Health.

In June last year, the NNL announced a new bicultural approach. This included creating a Māori co-chair role, initially filled by Lorraine Hetaraka. However, she stepped down after becoming chief nursing officer.

Close has a longstanding history in nursing leadership, which included a stint as kaiwhakahaere of Te Rūnanga. Nowadays she is director of nursing for Ashburton and Rural Health Services in the Canterbury District Health Board.

This year Close became co-chair Māori of Nurse Executives of New Zealand, which saw her gain membership to the NNL.

The extra leadership work was important, she said. "I think for me the kaupapa in NNL is directly reflected in my day-to-day work. So my day job and my leadership participation . . . they really do uplift each other, and I can translate both areas into each."

Brenda Close – 'my day job and my leadership participation . . . they really do uplift each other.'

In May, Close took on the NNL co-chair Māori role as well, which is part of the two-house, Te Tiriti-based approach adopted by the group.

One house, she said, was for tangata whenua, and the other was for "tangata Tiriti".

Dealing with health reforms

"So that model really reflects the partnership and I guess allows the group to enact a commitment to Te Tiriti and Māori taking leadership for things Māori, but the group having a collective responsibility for making improvements."

This collective responsibility would be important as the group deals with upcoming health reforms, including an MHA.

"Our expectation is that we will contribute into that space and help shape what that looks like," Close said.

The NNL's structure and philosophy could give insight into how the MHA would be shaped.

Māori might lead in areas such as Māori development, and equity through access to nurse training, Close said, but the NNL "also recognises there's a collective responsibility for that".

"And I think in terms of the new health structure that's really important. Because correcting the system for Māori isn't going to be the responsibility of the Māori health authority – it's everybody's responsibility."

Having an MHA would allow that to happen from a Māori worldview "rather than our mainstream services imposing how they think that should be done", she said.

The collaborative approach was important too, in the work of the NNL, she said. "Our role is to ensure a collaborative approach to nursing from a professional lens, and I guess, ensuring an opportunity for nurse leaders to collaborate around not just nursing issues, but also health issues."

Understanding health was important with the upcoming changes, she said.

"I think now more so than ever it's really important that we are connecting and having a consolidated voice around that [health], so that we can actually participate and influence for any future changes," Close said.

This would ensure health service development was responsive "for the communities we live and work within".

The current work includes looking at Māori recruitment and training.

"Again, the challenge is about how do we adjust the system? Because if you continue to run a mainstream programme of recruitment and retention into training, you're going to continue to get the same results that you've had."

Close has studied in mainstream universities and schools, but also in wānanga.

"And I guess, the health view is different: also the way we educate is different, and participate in learning.

"So we continue to challenge our schools of nursing in particular about how they might do that better." •

Government lays out cash for tr

Budget 2021 had an extra $4.7 billion for health, along with nearly half a million to kick-start its health reforms. But there was no indication of new funding for health worker salaries.

By co-editor Joel Maxwell

Launched in the curving, second-floor auditorium of the Beehive, Budget 2021 was announced far from the wards and clinics and theatres – and hopes – of the health world.

There was, nevertheless, a brisk play by this second-term Government to appear to be wanting to support health and, in particular, Māori health.

Firstly, the Budget launched Government spending on its ambitious health reforms. It tagged $486 million to kick-start its planned health system revamp.

This included $98 million to set up its proposed Māori health authority (MHA), and $127 million for Hauora Māori programmes – run by the MHA – including money for boosting "provider capability, and a Māori health innovation fund".

Finance Minister Grant Robertson was at pains to point out the money was only the beginning of funding for the MHA.

"Just to be clear . . . that is just the initial set-up and transition costs. It is not the costs, or the amount of money we're going to invest in Māori health over the next few years. This is to establish a Māori health authority, begin its commissioning work – but there will be more resources as we develop . . . "

Overall, the Government would spend an additional $4.7 billion on health, he said. This included an extra $200 million for PHARMAC and an additional $2.7 billion for district health boards (DHBs), over the next four years.

There would also be $700 million infrastructure cash for DHBs to invest in new assets over four years.

Health Minister Andrew Little said the Budget increased funding for primary health care by $46.7 million annually.

He said the funding would double the number of adults receiving cochlear implants, an increase that means 320 more people would get implants by 2025.

The $486 million set aside for the health reforms would run over four years, to replace the 20 DHBs with a single agency, Health NZ, create local networks and establish the MHA.

The changes will be rolled out over the next three years, with supporting legislation expected to be in place by this time next year.

Meanwhile the Government allocated $1.5 billion for the COVID-19 vaccine and immunisation programme. Robertson said about $1 billion of that was for advance-purchase agreements for vaccines, and $357 million for the immunisation programme.

"We are also continuing to invest in our managed isolation, quarantine and other border facilities. We still have $5.1 billion available in the COVID Response and Recovery Fund."

Housing and health

Asked why Whānau Ora had not received additional funding in the new Budget, Associate Health Minister (Māori Health) Peeni Henare said housing and health were the main issues being flagged by Māori communities – therefore funding was prioritised in those areas.

NZNO senior policy analyst Lucia Bercinskas said there was no indication if any of the new funding was targeted at health worker salaries.

Bercinskas said a proposed social unemployment insurance scheme, paying out people left unemployed by the likes of COVID-19, was simply reactive.

"Again that is almost like the ambulance at the bottom of the cliff – but there was no incentive for people to keep their jobs in the health sector." She asked who would pay for it.

While there was additional money for PHARMAC, it was not as much as had been requested, Bercinskas said. This meant there would still need to be rationing, to get first world drugs and devices.

Finance Minister Grant Robertson – just the start of funding for the Māori health authority.

Similar questions remained about the extra cash for DHBs, she said: would it be used for actual investment, or just to pay off national debt?

However, Bercinskas said the Budget did take a more holistic approach to working on the social determinants of health, like child poverty, housing, and Māori housing.

The Budget would raise weekly benefits by between $32 and $55 per adult. Student living support would increase by $25 a week from April 1 next year.

Other health spending included:

- $516 million to develop and run ef-

ansition to new health system

fective health infrastructure, including a national health information platform, so health records can be read and approved by health professionals anywhere in the country.

- $399 million to support people with long-term physical, intellectual or sensory impairment.
- $100 million to improve air and road ambulance services.
- $16 million for Pacific health providers to implement the Ola Manuia Action Plan.

Brown Budget?

Māori face some of the biggest health inequities in Aotearoa – including lower on-average life expectancy and higher mortality rates for multiple diseases.

These inequities are the unavoidable result of Māori doing it tougher in all areas of society.

With a 15-strong Labour Māori caucus, five Māori Cabinet ministers, plus potential "by-Māori, for-Māori" changes in the works, there was anticipation that Budget 2021 could fuel a genuine handover of power to Māori.

Massey University associate professor Matt Roskruge (Te Atiawa, Ngāti Tama) said, pre-Budget, there had been "encouraging signals" – even a genuine belief among ministers – that the Budget would be transformational.

In the end it felt like a positive "but slightly underwhelming spend", with a large portion going into scoping and planning for "next steps".

Roskruge said from a health perspective "we know our health infrastructure, workforce and system are all in serious trouble". The Budget, he said, was an attempt to deal with these systemic issues through reforms. But it was still very much in "seeding and scoping stage".

The next Budget or two would be the ones to watch for a steer on whether this was more neoliberalism – contracting out health services – or a genuine attempt to reform the public health service.

Meanwhile the additional $200 million for PHARMAC was a let-down. It was "well below" what most were hoping to see. Some were asking for a $400 million a year increase, not $50 million per year for four years, Roskruge said.

> **'. . . the eye always needs to be on health outcomes and not bureaucratic processes or expensive contracts, consultancies.'**

For Māori, the health authority funding was "a bit of a black box" (ie, its internal workings were unclear). A lot of money was set aside for consultation, which was a positive, he said. However it was also put aside for consultancy, which was a "bit worrying".

"I think it's encouraging that there is a lot of scope for Māori to help shape this authority and its mandate to deliver on Māori health priorities, but the eye always needs to be on health outcomes and not bureaucratic processes or expensive contracts, consultancies."

Victoria University economist Peter Fraser (Ngāti Hauiti ki Rangītikei, Ngāti Toa, Ngāti Raukawa, Ngāti Kahungunu, and Ngāpuhi) said the amount of money for the reforms seemed good, but, he asked, compared to what?

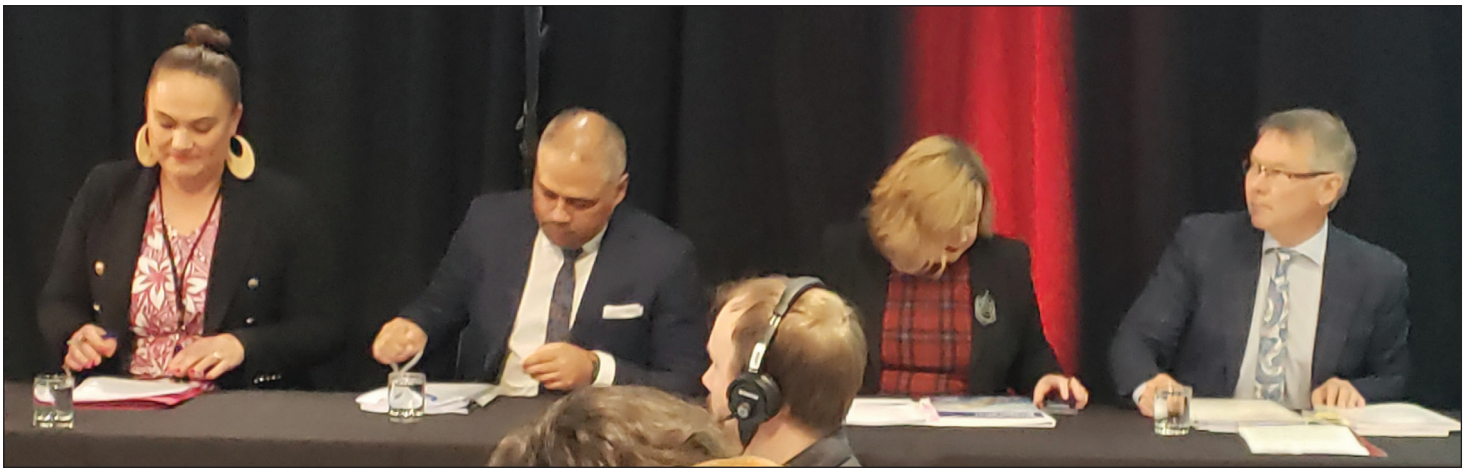
If National were the Government, then it was "probably pretty good". But, he said, this was a Labour Government with an overwhelming majority, and "a huge Māori caucus".

"Compared to what's been in the past, it's actually pretty bloody good, but it's still pretty bloody underwhelming."

Fraser, himself involved in health reform policy in the '90s, took a historical perspective – questioning the willingness of the Government to act while it had the chance.

"Imagine if Norman Kirk [a reforming Labour Prime Minister from 1972] was Prime Minister now. What would he be doing? He wouldn't be p*****g around."

Similarly, the first Labour Government (in 1935) went out and got things done, Fraser said. •



Cabinet ministers prepare to speak at the Budget launch, from left: Minister for Social Development and Employment Carmel Sepuloni, Associate Minister of Health (Māori Health) Peeni Henare, Minister of Housing Megan Woods and Associate Finance Minister David Parker.

Neonatal nurse Helen Barwick with father Brodie Gray and his surviving twin daughter Moana Cassidy, aged 30 days, at the Waikato neonatal intensive care unit. The twins were born at 25 weeks but Moana's sibling, Selah, did not survive. Her passing is marked by the purple butterfly on the incubator.

Learning she had twin older brothers who died as premature babies helped Helen Barwick commit to a nursing career in neonates.

'A lot more joy than sadness' in neonatal care

By co-editor Mary Longmore

Waikato neonatal nurse Helen Barwick wanted to be a nurse from a young age – it ran in her blood. Her mother was a nurse and her grandmother completed two of three years of nurse training.

But it was only after hearing about the death of her premature, older twin brothers at 26 weeks – one in-utero and the other a few hours after birth – that her specific interest in neonatal nursing grew.

Growing up, Barwick noticed her mother was always sad around early December. Her mother eventually opened up about the loss of her twins in 1968. "I already had an inclination to go nursing and as I got older, mum opened up [about her loss]," Barwick said. "Just talking with her about my brothers and their journey, my inner being felt 'maybe this is what I'm meant to be doing'."

Her mother, too, had been a premature baby. But born in the 34-36 week range, she survived – without medical support. "She was brought home in a cot, lined with brown paper and kept by the fire," Barwick said. "My grandma used to say 'we're not sure how your mum's still here'."

These days, premature infants can survive as early as around 23 weeks' gestation, although the shorter the gestation, the more likely a poorer outcome, says Barwick. And survival this early is still relatively new in New Zealand. When it is known a baby will be born early, steroids can be given in utero to aid lung development.

When she started as a neonatal nurse, in 1999, the cut off "age of viability" was around 25 weeks. For anything earlier, intervention would not have been offered.

Today, a mother going into labour at 23 weeks, or parents of an infant born that early, are generally offered a choice on whether they want intervention, with an explanation of possible risks. It is not always an easy choice – risks for the preterm infant include increased vulnerability to infections, lung and respiratory problems including chronic lung disease, intraventrical haemorrhage (bleeding in the brain's ventricular system) and necrotising enterococcus (perforated intestinal tissue).

Born on the West Coast, Barwick lived in south Otago before moving to Taranaki, aged 10. Her first job was working in a bakery. But when her boss refused to give her an apprenticeship (believing it would be too physically demanding for a female), she took up an earlier offer to take the then-Taranaki Polytechnic's diploma of nursing. She later completed her bachelor of nursing at Wintec in Hamilton in 2003, then a post-graduate diploma in neonatal nursing at Massey University in 2004.

Barwick's first nursing job was in aged care, before she moved to Waikato Hospital working with older people's rehabilitation, then on the renal ward. By 1999, she had finally reached the neonatal ward, her true passion, where she has stayed for 22 years. "I found my place in neonates and it's something I have enjoyed very much," Barwick said. "I had a passion for it. I believe in holistic care – you look after the baby and the whānau."

Waikato has one of the country's six neonatal intensive care units (NICU), so often deals with the more premature births, generally requiring complex and long-term care. Barwick started out working with the less premature babies ("prems"), born from 32 weeks on. She supported parents with feeding, bathing and medications, if needed, and loved the work. "I had a sense of connection and being a part of their journey."

After gaining more experience, she went on to work with earlier prems. Barwick is part of the team which goes out and picks up prems and whānau from around the Waikato region – from smaller hospitals, birthing centres or remote areas – by helicopter, airplane or ambulance, depending on the terrain, and brings them to the Waikato NICU.

Neonatal care can be an area of intense emotions, but "we see a lot more joy than sadness", Barwick says.

She remembers many years ago looking after a premature baby born at 26 weeks. "The eyes had not yet opened. The baby didn't do so well – their eyes remained closed, so they never saw the world."

Another time, a family from the United Kingdom lost a premature baby in the Waikato NICU. The family had no relatives in New Zealand, so several NICU nurses attended the infant's service to show support. "It's the New Zealand way. If you've got no whānau or family, there will always be someone there."

But on the "joy" side, recently, a pregnant woman in Te Awamutu unexpectedly gave birth at 25 weeks at the local birthing centre after a check-up. Barwick said her team was able to reach, intubate and transfer the baby to NICU where over several weeks he progressed "fairly smoothly", despite getting no steroids in utero. The baby eventually went home with no need for further medical support.

Families stay longer

With the earlier survival rates, Barwick said, families tend to stay for longer. "You can build up a rapport, as they often stay for weeks, or even months." One child born very early – at just 23 weeks – stayed for more than six months.

The lower survival threshold, though, means more pressure on the units, as the resources have not always grown in proportion. "We won't turn anyone away. We will find space for them, somewhere," Barwick says.

Waikato Hospital's NICU has 41 beds, and 18 nurses per shift – a high ratio for a high-needs area. It runs at 100 per cent occupancy most of the time. When really busy, the unit will liaise with the paediatric ward to accommodate older or more stable babies.

Barwick – who voted to strike this month – said some nurses were getting tired, with the increased occupancy and stretching of resources. "As nurses, we are not getting valued. We should be paid as professionals, for how hard we work, the hours we work."

Despite the challenges, she loves it. "My ethos is the day that I stop learning is the day I should consider what area I am in – and if I should still be in nursing," Barwick said. "But it's been more than 20 years in neonates, and I'm still learning." •

Wellington neonatal unit gets big staffing top-up

WELLINGTON'S NEONATAL intensive care unit (NICU) has hired an extra 26 full-time equivalent (FTE) nurses, after safe staffing acuity tool TrendCare helped identify a large shortfall.

Capital & Coast District Health Board (C&CDHB) neonatal nurse manager Rosemary Escott (pictured) said after two years of data collection, in 2020 the tool produced "robust data" identifying a 26-FTE nursing shortfall in the busy 36-bed unit. That included 3.24 FTE senior nurses such as educators and clinical nurse managers.

The external care capacity demand management (CCDM) safe staffing team checked the results, confirming a large increase in nursing hours was needed to safely staff the unit.

C&CDHB initially planned to recruit new staff gradually, to allow them to be supported into the role, Escott said. However, after delivery suite bookings predicted "the busiest year ever" in 2021, they sped up the recruitment process.

All 26 positions had now been filled, by a combination of new graduates, overseas nurses and nurses from other areas, she said. "It's been really positive, going through this robust process of data collection, which has resulted in a really effective team."

"The speed of the recruitment has put a strain on the unit and educators, but staff have been magnificent," she said. "It's been exciting to see the calibre of new nurses joining the NICU team."

Poverty, violence, mental health issues and addiction had all contributed to increased pressure on the neonatal unit in recent years, she said. "Neonatal care has become more complex in the current social environment, meaning that nurses are under pressure."

A national review of neonatal care by the Ministry of Health in 2019 found NICUs consistently exceeded the desired occupancy levels of 85 per cent, for which they were resourced. This put pressure on staff and more staff, cots and equipment were needed, it said.[1]

TrendCare measures staff – skill mix and numbers – and patients, to inform the safe staffing programme, CCDM. Under the NZNO-DHB 2018 safe staffing accord, CCDM was to be implemented at every district health board (DHB) by June 2021.

Escott said implementing safe staffing at the NICU had been a "real partnership" between the DHB and NZNO. •

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Sounding the alarm in EDs

By professional nursing advisor Suzanne Rolls

Lately, I have been spending time with NZNO's College of Emergency Nurses NZ (CENNZ) as they desperately try to find solutions to overcrowding in emergency departments (EDs) around the country.

I've been hearing about patients being shunted daily into corridors – blocking fire exits – where they are treated, with no emergency equipment, call-bells or privacy to speak of, in areas defined only by tape on the floor.

ED overcrowding means an ED is using "*inappropriate spaces not intended for patient care*"[1]. It leads to negative clinical outcomes for patients such as increased mortality and longer inpatient stays, and loss of dignity for patients, eg when they are housed in trolleys in corridors, the Ministry of Health (MoH) says.[2]

In March, CENNZ chair Sue Stebbeings wrote to Health Minister Andrew Little, requesting attention be paid to the growing overcrowding problem. With no response beyond a brief acknowledgement, the college was forced to write again in May, pleading for intervention.

Emergency nurses say their job satisfaction is low and they're constantly worrying about patient outcomes. Additionally, senior ED nurses are also worried about wellbeing of staff – and they're all worried about safe staffing.

In the face of these challenges, a significant number of ED nurses have resigned. While there are always people entering and leaving emergency nursing, the current high turnover means nursing expertise isn't at the required level, as nurses new to a practice area need time to build up their skill.[3]

Nursing staffing is not increased when a patient is moved into a corridor – the extra load is carried by the ED team until the patient is either discharged or admitted to an inpatient bed.

ED nursing staff requirements have been poorly addressed by district health boards (DHBs) over time. Exacerbating the problem is that EDs have not been included in safe staffing and healthy workplace reports to the MoH, as part of the care capacity demand management (CCDM) programme.

Suzanne Rolls – a crisis of overcrowding and under-staffing.

However, this is changing. In the final months of implementing CCDM this year (the deadline is June 31), some DHBs have introduced the TrendCare safe staffing tool throughout their EDs. NZNO is aware of at least two EDs – Tauranga and Whakatāne – where staffing has increased as a result of the tool, and after the review of Whakaari/White Island disaster.

High stress levels

In another region, ED staff were promised extra space more than 18 months ago, but this has yet to eventuate. Stress levels remain high as the DHB plans its rollout of TrendCare, which will hopefully monitor workloads and predict staffing requirements.

Since 2009, health targets have been reported to the MoH and published, including ED shorter-stays. But research suggests gaming – data manipulation – was occurring in four EDs between 2007 and 2012.[4,5] Researchers found "*. . . [hospital] relied more heavily on gaming behaviours such as moving patients to ward corridors because it had less capacity to increase levels of staff and beds*".[4]

Emergency nurses have had to deal with their patients being moved around the hospital. While corridors are certainly not ideal, at least the capacity problem is visible rather than hidden.

However governments choose to receive their health-care reporting, it remains crucial all DHB data is independently verified, to ensure gaming is eradicated.

Increased patient times in EDs inadvertently becomes a nursing issue, to manage or solve. Yet, despite lengthier times, there has been no substantive increase in nursing positions across the country's EDs.

DHBs need to develop contingency and escalation plans for when EDs get overcrowded. CENNZ suggests a first step would be to analyse the time patients spend in corridors or other "inappropriate" spaces. Routinely, executives tell me they do not know what to do to solve this. A second step should include chief nursing officers, medical officers and chief executives meeting those patients and their whānau who are waiting in ED for 24 hours or more, for an inpatient bed or for other reasons.

DHB executives should engage with the community, listen to their experiences and the impact of treatment delays, before apologising and finding solutions. Every day, emergency nurses apologise to the community, but the problems they face are not being addressed.

ED overcrowding will only resolve when senior hospital managers, directors, the MoH and the Minister of Health find ways to solve the overcrowding and nursing workload demands. •

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Nan Kinross: Trailblazer and disruptor

Emeritus Professor Nancy Kinross, RN, PhD, CBE, 1926-2021

By Joy Bickley Asher

I first met Nan Kinross when I was a Southland school girl. She presented the prizes at my 1965 high school break-up – part of her commitment to community service as the local chief nurse.

A decade later, Nan's exciting new nursing programme at Massey University drew me back from Australia. For registered nurse students, the programme was both radical and transformative in an environment that was empowering and liberating. Nursing theories, research and innovative practice beckoned us, including the possibility of becoming nurse practitioners.

Forward to the nineties, when Nan's eclectic intellectual interests made her a wise and much appreciated co-supervisor for my PhD. More recently, we maintained friendly if sporadic contact. With her passing, I feel a sense of loss, gratitude and everlasting respect.

The intent of university education for nurses at Massey was lasting change and innovation – changing practice by changing the way nurses thought about themselves and nursing. The underpinning belief was that effective nursing practice motivates, informs and challenges. It assumes an active role for clients, family and whānau.[1]

The result was a major disruption in late 20th century Aotearoa/New Zealand nursing. Professor Dr Nancy Kinross was the first and chief disruptor, although she always acknowledged the encouragement she and her academic colleagues got from inside and outside academia, in particular, government administrators and other nursing colleagues.

Nan Kinross (right) with Norma Chick at the 2006 launch of their book, *Chalk and Cheese*.

Nan took on major change in her own career in 1987, when she moved to the department of management systems at Massey to teach the diploma in health administration, where many health professionals and managers benefited from her skilled and erudite teaching. Her influence extended far beyond academia – she was a formidably astute player in nursing, education, research and health care.

From the 1990s, Nan's most significant contribution to community service was her involvement in MASH, a trust that provides Mana Whaikaha support services to people with disabilities living in the lower North Island. She was very proud of her role in setting up the MASH Trust in 1992, in Palmerston North, with two staff. The fact that MASH now employs more than 500, providing services for 1700 people, is testament to her effectiveness as a board member, chair and, later, patron. MASH was one of a number of community organisations in the Manawatu that Nan belonged to, chaired and expanded. Recognition came in the form of a CBE and various community awards.

Nan was many things to many people: vital, passionate about lifelong learning, not afraid to get her hands dirty, sometimes fierce, good fun, resilient, an indomitable will, emancipatory teacher, caring and tolerant, a direct communicator, courageous, determined.

Nan showed there was life after nursing and other work, welcoming everyone to her cottage and garden, the dogs and pigeons, scone-making, shopping for shoes. A remarkable woman who lived a good long life, got things done and changed people's lives for the better. •

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Vera Allen: Hutt Hospital's former principal nurse dies

FORMER PRINCIPAL nurse at Hutt Hospital, Vera Ellen, died in April, aged 94.

Ellen trained at Wellington Hospital, and worked in the United States, England, Whanganui and Hamilton, before taking up a role at Hutt Hospital in 1969 where she eventually became matron/principal nurse. Her role included giving Queen Elizabeth II a tour of the hospital in 1970.

She also hired Andrew Cameron in 1976, a nurse who went on to be awarded the Florence Nightingale Medal by the International Red Cross – nursing's highest accolade. At the 2011 ceremony, Ellen said it had been rare for men to become nurses and she was breaking tradition in accepting him. "But Andrew knew what he wanted and was not afraid to seek that out."

PHOTO: STUFF

Vera Allen with Andrew Cameron in 2011.

Ellen also served in the Royal New Zealand Nursing Corps as a lieutenant colonel from 1965-75. She was honoured in 2011 with a New Zealand Defence Service medal for her non-operational military work; and in 2012 with a Queens' Service Medal for services to nursing.

After retiring from Hutt Hospital in 1987, Ellen successfully ran for the Wellington Area Health Board, serving from from 1989-1991. •

'Double, double, triple-checking'

How do registered nurses with disabilities or impairment manage their work and ensure they practise safely?

By Margaret E Hughes, Gayle M Rose and Henrietta Trip

In New Zealand, people with disabilities are assured access to health, education, accommodation and employment. For nurses, this means employment free from discrimination or stigmatising attitudes. Perceived discrimination of any sort is not only unkind and unfair, but it can also prevent people from accessing the help they need to carry out their roles.

This article identifies some of the guidance available to nurses for working alongside people with disabilities, and the supports nurses who have a disability or impairment develop for themselves to manage their nursing responsibilities.

The terms disability and impairment are often used interchangeably in descriptive and research literature. According to the New Zealand Disability Strategy 2016-2026,[1] disability is defined as:

> *Something that happens when people with impairments face barriers in society that limits their movements, senses or activities.* (p49)

Conversely, an impairment is:

> *A problem with the functioning of, or structure of somebody's body.* (p49)

Definitions

The definitions used in the disability strategy are consistent with the social model of disability, where disability stems from societal, environmental and social attitudes causing barriers which dis-able the person. This differs to the medical model of disability in which disability implies a deficit that reduces the person's quality of life and needs to be fixed or treated.[1,2,3,4]

The disability strategy urges society, the community and government agencies to incorporate inclusion of people living with a disability and move towards a non-disabling society. The strategy, intended to guide policy development and practices nationally, explains the role and responsibilities required of society and the community so people with disabilities are not discriminated against or excluded from opportunities that other non-disabled people have access to in employment, health and recreation.[1]

The Human Rights Act (1993) goes further. This act states it is unlawful to discriminate against people living with a disability.[5] This requirement is reflected in the New Zealand Nurses Organisation Code of Ethics for nursing which mentions that *"Good collegial relationships are free of discrimination or harassment".*[6]

While the Nursing Council's Code of Conduct for nurses does not specifically include working with colleagues with disabilities, it does acknowledge that:

> *"Your behaviour towards colleagues should always be respectful and not include dismissiveness, indifference, bullying, verbal abuse, harassment or discrimination. Do not discuss colleagues in public places or on social media."*[7]

In addition to this generic advice, the Nursing Council's *Guidelines for Cultural Safety, the Treaty of Waitangi and Maori Health in Nursing Education and Practice* acknowledge (in the categories of difference, principle 1.2) that consumers/clients should not be discriminated against because of age, gender, sexual orientation, ethnicity, race or disability. However, relationships with nursing colleagues who live with a disability are not acknowledged in this guideline.[8] Furthermore, the Nursing Council's *Guidelines: Professional Behaviours* do not discuss nurse colleague relationships at all.[9]

The Health Worker Rights fact sheet, based on The Employment Relations Act 2000, stipulates that all health workers should be free from discrimination on the grounds of race, sexual orientation, age, gender, beliefs and disability.[10] In addition, the fact sheet states that employment relations must be based on dignity and good faith, which includes not taking any action that would deceive or mislead another party. These statements are generally aimed at employer/

employee relationships.

In a qualitative descriptive research study in 2019/2020, we gathered the experiences and perceptions of 10 registered nurses (RNs) who work with a disability, as defined by the nurse. Many of the nurse participants described their reluctance to disclose their disability or impairment or their support needs, for fear of being treated differently or discriminated against.

Nurses' experiences

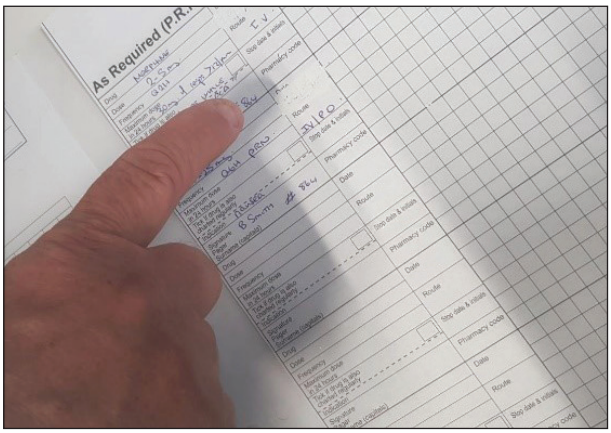
Some of the nurses in the study described the lengths they went to, to be very safe practitioners. Over time, the nurses had each developed a skill that included being "doubly" safe. However, this level of safety often took extra time, and some of their colleagues were not as patient as others.

"Terry"* went beyond the second checker requirements during medication administration. She asked that her nursing colleagues understand that it may take her longer "to process things". Compounding that, as a new graduate she also needed time to develop her emerging nursing practice. She asked for tolerance, patience, an understanding of her need to be very safe, and a manager who could separate the "disability" from the new-graduate role.

"Emma" asked that her nursing colleagues not try to separate her from the skills she had developed to be doubly safe when writing up progress notes and correctly describing the wound-care products she had used that day. She asked for her nurse colleagues to encourage her, not discourage her. And she also felt that being able work with colleagues "who don't make a big deal" about her challenges and being able to have a "bit of a laugh" with colleagues were important to her.

"Tammy" was adamant that she did not "want to give substandard care". She felt she was very safe and because patient safety was so important to her, being a safe nurse was something she thought about and reflected on all the time. She asked that her colleagues "talk to me, don't talk about me to others" and: "Please don't look down on me as I take up non-nursing roles".

"Cindy" believed that living with a disability made her more aware of safety issues. She felt it was vital to be "confident if you want to double-double check for safety." She had found that being reflective and being able to "work on yourself and your own attitudes towards others with disabilities" were useful skills and attitudes.



Checking, double-checking and triple-checking a patient's drug chart is one technique nurses working with a disability use to ensure they practise safely.

"Pat" had made a mistake early on in her career. This had shaped her belief that "double-checking is important", so things aren't missed. She preferred a practical approach to problem-solving conditions for nurses with disabilities such as organising the work "space" to suit their needs, being unafraid to ask, and being upfront about their disability or impairment.

New Zealand nurses, their colleagues and their managers have a national health strategy document, a law and professional guidelines stipulating how they should treat patients and/or colleagues living with disabilities. Despite this, some nurses told us they were reluctant to disclose their disability or impairment in the workplace.

There were a number of reasons for this, including past unpleasant experiences and a perception that they may not get the position they applied for if they were open about their condition. Some also believed that revealing their condition was not necessary as they could manage their disability or impairment by very safe practices and "double, double, triple-checking".

Nurses in this qualitative study worked hard to ensure they delivered safe nursing care – often going beyond usual practices to be doubly safe. •

** This article was reviewed by Dina Whatnell, RN, MN, NP, a nurse practitioner in the mental health and addictions service at Palmerston North Hospital. She specialises in disabilities.*

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Amjith Krishnanivas – SIT Nursing Graduate

Five years ago, tyre industry worker Amjith Krishnanivas had a very different life. Since then, he's moved to New Zealand, retrained, and now has a new career in Nursing which he loves; he achieved it by studying at the Southern Institute of Technology.

Hailing from Kerala, in south-western India, Amjith came to New Zealand in 2016, joining his wife who worked as a Registered Nurse in Central Otago. Amjith worked and settled into NZ life for nearly two years, then made the decision to study the Bachelor of Nursing at SIT Invercargill, graduating in December 2020.

He knew SIT had a good reputation and 40 years experience in Nursing programmes. Because of this, there was a certain level of expectation prior to starting his course, and Amjith wasn't disappointed.

"To be honest, SIT has been wonderful in all aspects and I must say it exceeded all my expectations", describing his degree course in one word - "fantastic!"

He found the tutors to be extremely supportive, super approachable, and had good, in-depth subject knowledge.

"The clinical suite is excellent and the Hololens Augmented Reality is an amazing futuristic tool to assist learning", he added.

Amjith engaged with all that campus life offered, he loved the on-campus ambience at SIT - "The atmosphere is very considerate... SIT instilled a lot more kindness and friendliness in me", he said.

Even with a family, Amjith found his study commitments workable. He would drop his son at pre-school and spend his days at SIT, attending classes and studying. He said he made friends both inside and outside of class.

He found the best aspects of SIT's Nursing programme were the structured course/timetabled sessions and face-to-face sessions; he especially valued the School of Nursing being supportive during the COVID-19 pandemic.

Finishing his degree on a high note, Amjith won the CEN Award - the trophy awarded to a third-year student who has demonstrated excellence across all subjects taught at the 700-level of the Degree programme.

SIT's high level of support continued as Amjith looked towards employment. Upon graduation, he received more than one job offer and immediately found work as a nurse.

Six weeks after his first job started Amjith was offered a Nurse Entering To Practice (NETP) position at Southern District Health Board, in a medical ward at Southland Hospital.

"I grabbed the opportunity and now I am working as a Registered Nurse at Southland Hospital in Invercargill".

Amjith is committed to a Nursing career and has long-term plans to progress in the sector.

"I would like to become a nurse specialist and then a nurse practitioner/prescriber. And I would love to teach nursing students as a nurse educator, part-time in the future", he said.

He highly recommends SIT to prospective students. "The tutors love what they are doing and are passionate about student progression in becoming a safe practising Registered Nurse", he said.

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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:
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"Dying, like birth, is a human event that everyone will go through. It is a normal part of life, and we all have a role to play in caring for others," says Raelee Jensen, Clinical Nurse Specialist, Education Coordinator and passionate advocate of compassionate communities.

Raelee Jensen, Clinical Nurse Specialist and Education Coordinator at Te Omanga Hospice in Lower Hutt.

Raelee has spent 28 years working in the field of palliative care. Her role at Te Omanga Hospice in Lower Hutt involves supporting health professionals to increase knowledge and innovation in education. She also works with patients living with terminal or life limiting illnesses, and their families as carers, to empower them with increased knowledge and resilience. She acknowledges the learning health professionals gain from patients and their carers is invaluable.

A firm believer in the work of Professor Allan Kellehear, Raelee considers death to be a social event with a medical component, not a medical event with a social component. "Dying doesn't just belong in a hospice or a hospital; people can die comfortably at home or in Residential Care Facilities with the right support."

Raelee challenges us to look at how communities support people at the end of life. "In reality doctors and nurses are involved in a very small percentage of people's care at the end of life. What happens the rest of the time and how as a community can we support people to live well until they die?"

Te Omanga's Changing Minds Conference will challenge you to think about dying, grief and end-of-life care in a different way. It will inspire greater collaboration and connections within our community.

Raelee encourages anyone with an interest in palliative care or compassionate communities to attend the conference. "Caring for people at the end of life and in grief is everyone's business and we can all play a role in coming together to support each other."

Changing Minds Conference – 29 October 2021
Lower Hutt Events Centre, Wellington
Register at teomanga.org.nz/education

"The greatness of a community is most accurately measured by the compassionate actions of its members." *Coretta Scott King.*

Whitireia nurse overcomes challenges to return to study and graduate

Shawnee Watson-Darbyshire, 28 years, always wanted to be a nurse, but when she left college in 2010 she felt like her dream was out of reach.

After withdrawing from study in 2011, nine years later Shawnee decided to give it another go and show her seven year old son that it was possible to achieve your dreams. She enrolled in the Diploma in Enrolled Nursing programme at Whitireia and is only weeks from graduating as an enrolled nurse.

"My turning point was my son telling me he wanted to work at the supermarket like Mum," Shawnee says. "There's absolutely nothing wrong with that, but I want to encourage him to dream bigger and show him that he's capable of anything.

"It was daunting going back to study but the support Whitireia provided has helped me get through it."

The Diploma in Enrolled Nursing is an 18 month course that prepares students to become an enrolled nurse, through a combination of theory and practical, hands-on experience.

Juggling study and raising her son has been a challenge for Shawnee, but she credits support from her family, her employer and Whitireia tutors for making it possible.

Shawnee has noticed a positive change this time around with her studies, both with herself and with the course. "When I first enrolled I wasn't prepared and couldn't keep up," she says. "Now I'm not afraid to ask for help. The tutors are amazing, they provide lots of resources and student support and help you learn the way you like to learn.

"I don't learn from a book, it's the lab classes, and hands on learning that works for me."

"The Diploma in Enrolled Nursing caters for students like Shawnee, who haven't necessarily had the best experience at school, but absolutely have the ability to apply the knowledge through hard work and study," Denny McLeod, Enrolled Nursing tutor says.

"Whitireia is a polytech with a heart – we strive to support the students to be the best they can be, and with hard work they prove time and time again, they can have this career that will not only change their lives, but those of their patients."

Shawnee has been able to translate her practical learning into real-life experience through placements at Huntleigh Rest Home, Kenepuru Hospital and currently Hutt Hospital.

"I have loved my experiences on placement, they have been difficult, but rewarding," Shawnee says. "I want to work with elderly after being in the rest home. Hearing their life experiences is so interesting and I think we can learn a lot from them. They deserve to be looked after."

Being on placement in the rest home during Level 3 lockdown was also a learning experience for Shawnee. Residents' families were unable to visit their loved ones due to the restrictions and Shawnee would provide a comforting presence by taking the time to sit and talk with them.

Shawnee is currently interviewing for jobs in nursing and is excited about putting her skills into action and working in the career she loves. She has a preference for working with elderly after the rewarding experiences she had on placement in Huntleigh Rest Home.

"Sometimes I question whether I have enough knowledge, but then when I'm out there I know I've got it and I'm ready," Shawnee says.

Further information can be found here:

Whitireia offers a wide range of nurse programmes from diploma to post-graduate level. More information on the Diploma in Enrolled Nursing course can be found at https://whitireia.ac.nz/study-programmes/nursing/new-zealand-diploma-in-enrolled-nursing-level-5

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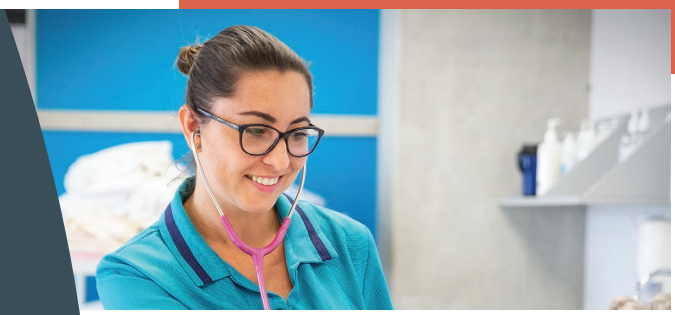

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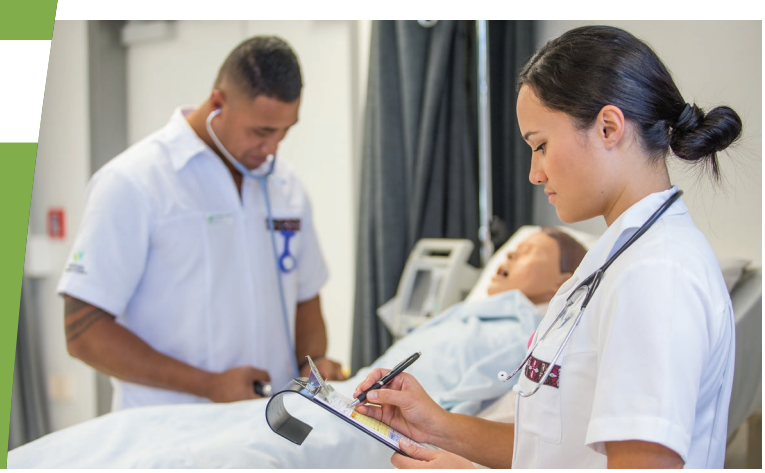

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Nursing support for people with mild mental health needs

What can a nurse do in everyday practice to support a person with mild depression and anxiety? A clinical nurse specialist recommends a variety of practical tools and advice.

By Helen Duyvestyn

The depressed or anxious patient who comes to see their general practitioner (GP) may be given the option of a prescription medication, but often very little else. Talking therapy is increasingly offered; however, there is often a waiting list and at times there are challenges in finding the right fit for the person. There is also the issue of whether it will be funded – either through GP provider services, employee service providers or Accident Compensation (ACC).

A mildly depressed or anxious individual who isn't at risk of self-harm or suicide doesn't need crisis input, may not need long-term psychotherapy or the type of intensive care that a community mental health centre (CMHC) would provide. However they could benefit from some practical strategies and support to improve their mood and well-being.

Psychiatry within conventional medicine has previously had little to offer the individual when it comes to preventative and interventional mental health strategies. While people are regularly exposed to "eat 5+ a day" and "quit smoking" strategies to improve physical health, there has been little attention paid to mental health and well-being.

The Mental Health Foundation has "Five Ways to Well-being" (give, connect, take notice, keep learning and stay active), but even these are not often taught to people who first present with mild symptoms of mental illness and some of these strategies may be difficult to implement.

Part of a model of prevention is having people get the right care at the right time. We know that there are many factors which contribute to a person's mental well-being and we know that early intervention – including support and the right practical tools – will often enhance the resolution of a mental health issue.[1] Nurses in primary and secondary care are in a perfect position to provide short-term intervention to people who suffer from mild mental health disorders, either while waiting for an appointment with a psychologist or counsellor, or as part of the treatment process itself, without going outside our scope of practice.

So what can you do, as a nurse, to support someone with mild depression and anxiety?

Nurses in primary and secondary care are in a perfect position to provide short-term intervention to people who suffer from mild mental health disorders . . .

The basics

A listening ear

Never underestimate the power of a friendly face and a listening ear. Even if all you do is listen patiently, this can have incredible power. Sometimes a person just wants to feel heard and sometimes, even in their own story-telling, they come to answers themselves about to what to do next. A good cry, reassurance that you are there for them if they need it, may be enough to support the person through a difficult time.

An explanation

Although we don't actually have a clear understanding about what causes depression or anxiety, we can explain that:

a) it's not their fault

b) depression is usually self-resolving, and

c) there are things that they can do to help themselves get better.

It's important they understand they are not alone and there are many organisations (and people) there to help them.

Additional supports

Offer a phone call every few days to see how they are getting on. Ask if they would like more support from a social worker, budgeting advisor or religious leader (if they are that way inclined). Pull in people around them; sometimes this might mean calling in a friend or family member (with permission).

Attending to self-care

The basics of self-care include eating in a way which nurtures, sleeping and resting as appropriate, and physical movement and breathing in a way which promotes relaxation.[2] These are all interventions which can support recovery. Along with these are social relationships, time outside (exposure to sunlight) and attending to basic hygiene. Explaining that improvements in these areas can lead to improvements in their mental health can be very empowering and will make them more likely to engage and take steps to help themselves.

Below are more specifics regarding some of these areas.

Nutrition

Probably one of the least-asked questions in mental health is: "What are you eating?" You might be surprised how many people who present with low mood or anxiety are eating minimally or eating a very nutrient-deficient diet. If minimal food is being consumed, ask whether they are fasting or dieting (which can raise cortisol[3] and contribute to anxiety, depression[4] and fatigue symptoms) or if

it's simply an issue of having no appetite. Find out what types of foods they are eating – sugar,[5] caffeine,[6] highly-processed carbohydrates, poor quality food,[7] dietary transfats[8] and pro-inflammatory[9] diets can significantly affect how a person is feeling.

Studies such as the Smiles study[10] suggest that changing from a SAD (standard American/Australasian diet) to a Mediterranean-style diet can reduce depression in more than 30 per cent of depressed people. As a nurse (and excluding other health issues which may require specific diets, such as coeliac disease, diabetes etc) you are able to offer basic nutritional advice based on the Ministry of Health[11] guidelines (see poster above). Encourage a simple but whole food diet (fruit, vegetables, meat, whole grains), as this alone has been shown to help improve mood.[12]

When asking about diet, be specific – don't let them tell you their diet is "good" without asking what that means:

- What exactly do they eat for breakfast? When?
- What do they eat for lunch?
- What do they eat for dinner?
- Do they consume energy drinks or soft drinks?
- How much coffee do they drink?
- How much alcohol are they drinking?
- Do they eat carbohydrates, fats and proteins?
- Does their diet have variety?
- Are they following a specific diet (such as vegan or keto) which may be eliminating certain food groups and nutrients?

These may be basic questions, but you will be surprised how far someone can get through the mental health system before anyone asks questions about diet – an important factor for mental health and wellbeing.

Sleep

It's important to understand the significance of the impact of poor sleep (including sleep apnoea)[13] on anxiety, appetite, depression and mood.[14] Research has found that poor sleep often precedes mental health deterioration[15] and often accompanies depression, anxiety or other mood disorders. People who have experienced nightmares or suffer from post-traumatic stress disorder (PTSD) often put off going to bed until very late – significantly decreasing their length and quality of sleep.

Ideally, a person should get a minimum of seven to eight hours a night. Less than six hours or more than nine or 10 hours increases the chances of stroke[16] and developing metabolic syndrome.[17]

- Find out when they sleep – are they staying up until 3am and sleeping until 1pm?
- Are their circadian rhythms disrupted?
- How do they feel when they wake?
- Are they waking regularly and not able to return to sleep?
- Do they have trouble getting off to sleep, or wake early?
- Is pain stopping them from sleeping?

They may be able to use sleep strate-

PHOTOS: ADOBE STOCK

SLEEP, EXERCISE, DIET, MEDICATION and SUPPLEMENTS can influence mental wellbeing.

gies (sleep apps, mindfulness, relaxation, breathing exercises or supplements) to support sleep. Encouraging exposing eyes to natural light first thing in the morning stimulates melatonin production to support night-time sleepiness,[18] whereas exposure to LED lighting may suppress melatonin.[19] Exercising during the day supports sleep at night.[20]

Other tips may include reducing screen time in the evening, writing down everything that's on their mind before they go to sleep, ensuring the room is cool and dark and sometimes removing themselves from a snoring partner.

Movement

Exercise has a significant impact on mood and is shown to decrease depression in up to 30 per cent of those who participate.[21,22] Exercising outside may also help vitamin D levels (shown in some studies to be low in more than 90 per cent of people admitted to psychiatric hospitals).[23]

For those that are exercising, check they aren't overdoing it. A depressed or anxious person may be driven by the exercise they do as it helps improve their mood – but aren't eating or resting enough to sustain their energy levels, leading to exhaustion, poor sleep, anxiety and low mood.[22]

Physical assessment

Assess hair, nails and skin pallor and ask about slow-healing wounds which may suggest a zinc[24] or other vitamin deficiency which can affect mental wellbeing.[25] Is the person overweight or obese? This can increase inflammation (associated with depression) and is associated with lower vitamin D levels.[26] People with diabetes also have a higher risk of becoming depressed.[27]

Observe their breathing pattern. Are they mouth or nose breathing? Is it shallow, tense? Encouraging deep, relaxed, slow and long belly breaths through the nose can be calming, reduce cortisol levels and help support sleep and relaxation. This type of breathing also has a number of other positive health benefits, including reducing anxiety.[1]

In some cases, testing can take a look into some of the contributing issues associated with depression. Low vitamin D levels are associated with mental illness,[19,25] while low ferritin/iron levels are associated with fatigue and depression. Low B12, folate and other B vitamins can affect energy levels, memory function and cognition,[25,29] and thyroid disorders can present as anxiety or depression.[30,31] Compare the current blood test to previous blood results – are there significant changes? Is their cholesterol not only not too high – but not too low (associated with low mood)?[32] Vitamin levels are often thought to be optimal in the upper range of normal[33,34] (except for ferritin – high levels may indicate other disease states and illnesses).

In some cases, the medication the person is taking may be contributing to their symptoms. Ask if there is an association between starting a medication and onset of symptoms. Are they on medications which may affect their nutrient status? For example, methotrexate can contribute to a folate deficiency,[35] statins can reduce CoQ10, diuretics can contribute to a magnesium, calcium or potassium deficiency, Omeprazole reduces vitamin B12 absorption,[36] while Accutane has been associated with psychiatric disturbances.[37] Also consider the effects of beta-blockers and hormone therapies, including the oral contraceptive pill.[36]

Supplements and nutrients

Although most nurses can't prescribe or advise specific treatments, we can look at some of the research available and explain these results to the person. Use evidence-based research, but also be pragmatic. Waiting for a meta-analysis to tell us that a simple intervention is shown to be statistically significant can be a long wait.

There is some good clear evidence on use of omega three fatty acids[38,39] for depression and research on the impact a multivitamin might have for premenstrual syndrome.[40] Treating a vitamin D,[41] B12 or folate deficiency can have an impact.[39,42]

Specific herbs and supplements have been shown to support mood. Ashwagandha and Rhodiola are fantastic to support people under a lot of stress.[43] St Johns Wort has good evidence as an antidepressant.[44] N-acetylcysteine has been shown

to help with mental health issues.[39] Always check for interactions with any medication they may be taking, and ask them to check with their pharmacist or prescribing doctor.

Summary

Nursing is a complex task – and knowing what to do for someone who is anxious or depressed can be challenging. We often want to "refer on" to psychological therapists or to mental health services. However, there is a lot we can do to support the person during this time. We can (and should be) knowledgeable and comfortable providing some basic advice and support, which may mean the difference between a relatively quick recovery and a downward slide into a worsening or chronic mental health condition.

Many patients miss out on techniques, lifestyle advice, dietary changes and tools that might help them take those extra few steps towards wellness. These tools and knowledge may last them a lifetime and help to prevent future relapses. •

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How important nurses are in pro

Palliative care is led by nurses in the isolated North Island East Cape, as there are few GPs. One nurse providing this service, Linda Hauraki, spoke at a symposium on end-of-life care for Māori.

By co-editor Mary Longmore

The importance of nurses in providing end-of-life care for Māori was shared at a recent Mary Potter Hospice symposium, Whetū i te Rangi (stars in the sky), held in Wellington in May.

Tairāwhiti palliative care nurse liaison Linda Hauraki said she looked after whānau from Gisborne to Potaka – about 200km apart – in the isolated East Cape region, where much of the care was led by nurses as there were few GPs. She cared for anything up to 13 families at a time, trying to lighten the load as much as possible for people facing the end of their lives.

"I just go in and ask: 'How can I help to make life a bit more tolerable for you, day by day?", Hauraki told *Kai Tiaki Nursing New Zealand*. "I'll say to them: 'You may be dying but you're not dying today'."

I just go in and ask: 'How can I help to make life a bit more tolerable for you, day by day?'

Palliative care nurse Linda Hauraki

Once she had their symptoms and pain under control – she is able to provide certain medications – she tries to "just remain in the background" while coordinating care with the wider health team and family. "People just want to be at home and our goal is to care for them wherever they want to be."

It was always important for the family to lead the care, she said – although it could be "complicated" with large whānau. "We must let the family lead us and not take control – it's always the loved ones and whānau at the centre of care."

Sometimes, if requested, she helps take a person to their marae for the end of their lives, caring for them wherever they need to be. "I'm always mindful of

Rongoā practitioner says people are better for havin

People who most need help don't come to clinics, says a rongoā practitioner who travels the country to reach those in need.

Traditional Māori healing – rongoā – has a place in the modern health system, says practitioner Donna Kerridge (Tainui), but she is happy to work independently of it.

Kerridge spoke at the Whetū i te Rangi symposium on end-of-life care for Māori, held in Wellington in May.

"My goal is to nurture and strengthen rongoā Māori, to make it available to those who want it," Kerridge told *Kai Tiaki Nursing New Zealand*. "I have mixed feelings whether we want to be part of the system that doesn't get us, and has different values. To operate outside of your own system, in a system with different values, it's not good for practice," she said. "But I believe those who want it, should have access to it."

While she's based in Oakura, Northland, Kerridge gave up her clinic after she found it mostly drew the "worried well". "What I really discovered was that the people who need the most help don't come to clinics."

Now, she travels all over Aotearoa, to reach those in need – often at the end of their lives or managing long-term or painful conditions. "I'm hardly in one place for very long."

During lockdown last year, she said many Māori became cut off from a health system they already had little trust in. Those were the people she tried to reach, treating wounds and conditions such as leg ulcers, prolonged chest infections and muscle and bone pain. The practice involves use of medicinal plants as poultices or cough elixirs, mirimiri (massage), karakia and waiata. Traditional kai such as bone broth could also help build immunity and strength.

Much of her work involves people coming to the end of their lives – young and old. Recently, she spent three weeks on the Chatham Islands supporting a Māori man with a terminal illness. Working alongside a team of doctors and nurses, she fed him high–protein kai moana such as oysters and mussels, as well as providing mirimiri for several hours each day to relieve swelling in his legs so he could continue to move around. Guided by the person's wishes, she provides karakia and connection. "He had visitors, prayers – and that lifted his spirits hugely. You would not have been able to do that in a facility," Kerridge said. "He was able to die on his own terms."

Some people she is close to, she cares

viding end-of-life care for Māori

people's spirituality – I try to practise within what is meaningful to them.

"I wouldn't stand in the way of the sun streaming in onto the person as they're lying in bed."

At the symposium, Hauraki shared a story of a patient diagnosed with three months to live, who moved back to the region to die among his whenua and near his marae. Five years later, he was still alive and being cared for by her team, with his whānau, at home, she said. "He says it's because we've provided such fantastic care.

"Spirituality, culture, they make a huge difference – people feel secure and relaxed."

Part of her role is also to support and mentor other health-care workers – nurses and kaiāwhina – across the region. "Kaiāwhina have a huge role to play," Hauraki said, as they often have existing connections with whānau and provide support and monitoring in between her visits. "Kaiāwhina live in the community usually, so people know them and have that trust."

Vanessa Eldridge

Mary Potter Hospice health equity manager Vanessa Eldridge (Ngāti Kahungunu, Rongomaiwahine) said the number of Māori dying was forecast to grow over the next 20 years, so it was timely to look at how care could be improved.

Māori tended to prefer to die at home, and hospice care could be provided in homes, but it could be challenging, she said.

With the launch of palliative care framework Mauri Mate last year, and the current focus on health equity, now seemed a good time to focus on the issue, she said.

Eldridge said she was mindful end-of-life care for Māori could involve whānau, alongside community, hospital and hospice care. "So, to connect everything is an important kaupapa."

National Hauora Coalition clinical director Rawiri McKree Jansen laid down a "strong wero" at the symposium, on the need for more Māori nurses, and to address poverty. "You can't give good palliative care if someone's living in a car."

There was also a panel discussion where kaumātua were interviewed by rangitahi, facilitating an "important knowledge exchange", she said.

Mary Potter community manager Norma Hickland spoke about her nursing work caring for whānau in Porirua, including support through the lockdown when people were unable to gather for tangi.

The hospice holds a symposium every two years. •

g a choice – 'no one system has all the answers'

Donna Kerridge: Many of the old ways are as relevant as ever.

for at her home during their final days, weeks or months. "But my husband has asked me, 'Please, don't bring anyone else home'."

Providing end of life care, she says, is "the highest privilege – that complete and utter focus on that one person".

Her care also extends to non-Māori, although she has faced scepticism from some families. She recently cared for a woman whose "husband didn't want a bar of it, he said 'don't get involved in that hocus-pocus'. But she really wanted it", Kerridge said.

"I absolutely value our modern health system, but no one system has all the answers," she says. "I believe that many of our traditions have equal value. The people are better for having a choice."

Many of the "old ways" are as relevant as ever. At a recent rongoā workshop at Kaipara Harbour, a Māori elder recalled how during the polio epidemic of the late 1940s, his mother gathered up her 10 children, took them out of school and kept them at home for the next two years. "They only left when absolutely necessary. They gardened and grew their own food and had bone broth," Kerridge said. "It's what they did to keep their children alive and healthy."

For her, it's about giving back to people the power to manage their own health and wellbeing. "I try to remind people that our health and wellbeing is in our hands. Our old people had some really good ways of managing some of the less serious health things."

Northland District Health Board now offers rongoā services, and since last year ACC has also accepted rongoā claims. •

Perioperative nurses 'no longer handmaidens'

HEARING HOW far perioperative nursing has come, at the theatre managers' and educators' conference held in Dunedin in May, made me feel proud of my profession and achievements as a nurse educator in perioperative services.

Kevin Henshall

Amber Cox

Anis Parker

Hearing from experienced theatre nurse managers such as Anis Parker, Robyn Bissett, Sue Frost and Pam Nichols helped me appreciate the more level playing field for nurses today.

Historically, theatre nurses were akin to handmaidens to the surgeons, and didn't feel they could speak out, or felt they would be ignored. These days, perioperative nurses are more valued, trusted and respected as they deliver care alongside surgeons and anaesthetists, and are appreciated when they speak out on patient safety. Being aware of this sense of history makes me excited for the future of nursing.

The newly announced health reforms, too, were a strong focus of many speakers at the conference, with its theme *What's coming – are we flexible?*

Speakers such as public health professor Michael Baker, economist Brian Easton, health scientist and professor Des Gorman, biochemist Anthony Manning and Auckland trauma nurse specialist Kevin Henshall discussed past, present and future health issues.

Easton painted a rather bleak scene regarding the Government's decision to re-organise the health system at an inconvenient time, amid a worldwide pandemic.

Gorman highlighted ongoing health inequalities in New Zealand, urging the medical profession to take the lead in rectifying this, while Baker covered off New Zealand's response to COVID-19 so far.

New Zealand biochemist Anthony Manning has recently returned from the United States, after selling his biotech company that focuses on developing novel therapies for diseases the health system is unable to treat effectively.

Listening, I wondered if new gene therapies are coming our way that will prevent common diseases like osteoarthritis, negating the need for joint replacement surgeries. Manning has lived in the United States for 30 years – how fantastic it is that New Zealand can benefit from the "brain gain", COVID-19's silver lining.

But it was trauma nurse Kevin Henshall's reminder, to always be prepared, that was my biggest take-home message. With the Whaakari/White Island eruption, Christchurch mosque attacks and a global pandemic, it is timely to ask ourselves – how prepared are we for dealing with mass casualties in our workplaces? Do we have processes in place to handle a mass-patient event? What do they look like – and will they work? Most importantly, how can people find this information and do staff know how to find it in our managers' absence?

New Zealand is quite isolated and operating theatres are a closed door, so it was wonderful to connect with peers from around New Zealand, to share our experiences and knowledge, alongside the NetworkZ programme for multidisciplinary teams many of us belong to. The theatre managers and educators conference is an annual event. This year, we drew the largest group ever at 121. The 2022 conference will be held in Tauranga on a date to be confirmed (see www.theatremanagerseducators.nz). •

Report by Wellington representative for the Perioperative Nurses College and Wairarapa nurse educator Amber Cox (edited by co-editor Mary Longmore)

Compulsory orders 'safety blanket' for some patients

SOME MENTAL health patients should be able to remain under compulsory treatment orders without yearly reviews, NZNO's mental health nurses section (MHNS) suggests.

The Mental Health (Compulsory Assessment and Treatment) Amendment Bill 2021 includes the proposed elimination of indefinite compulsory treatment orders, as recommended by the 2018 He Ara Oranga mental health and addiction inquiry.

Instead, if a patient is deemed unfit to be released, an order can only be extended for 12 months.

But this could "devastate" some patients, the MHNS committee said in a submission last month. " . . . there are a number who see being under compulsory treatment as a safety blanket for quick brief access to inpatient treatment to keep them relatively stable and would be devastated to have to return to court every 12 months".

Instead, the amendment should allow patient requests to remain on compulsory treatment orders to be considered, the NZNO section said. A report on the bill is due on October. •

Enrolled nurses must wait for new scope

ENROLLED NURSES (ENs) are not likely to have their scope of practice extended until next year, Nursing Council chief executive Catherine Byrne told the EN section at their recent conference in May.

Chair Robyn Hewlett said the delay was "disappointing" as it was something the section had pushed for many years.

ENs are frustrated they must practise under direction and delegation of colleagues, research last year found, leading to its call to have the scope reviewed by the Nursing Council.

The new Te Rūnanga representative on the Enrolled Nurse Section, Gwen Ahuriri (Ngāti Porou, right) wears the korowai donated by former representative Lea Thompson (Tainui) in 2019. Ahuriri said she would like to see more Māori consider enrolled nursing as a career option. •

Critical care training for 'surge' workforce

NURSES AROUND the country are being taught basic critical care skills, in case of a surge of patients due to a COVID-19 outbreak or any other event.

"The idea is to be prepared for a pandemic, particularly in critical care units, and ensuring we have a workforce with some skill in supporting critically-ill patients," College of Critical Care Nurses chair (CCCN) Tania Mitchell said.

The $2 million initiative will provide up to 32 hours per year of online and hands-on learning for nurses who are experienced in other areas but new to critical care. "It will allow them to come and work in critical care and know the fundamental nursing cares for the critically ill – without full critical care training, which takes years," Mitchell said.

Wellington ICU nurse educator Tracy Klap, left with surge nurse Catherine McKnight (centre) and Tania Mitchell.

The plan was for nurses to complete the seven online learning modules – currently being finalised by critical care nurse educators – before working in intensive care areas alongside experienced critical care nurses to learn the "fundamental" nursing cares, Mitchell said.

"They come from their normal areas of practice in other parts of the hospital to do some bedside training, working with an experienced ICU nurse to up their critical care skills," she said. "We're aiming to get people to a basic standard where they can work as part of the team."

Keen volunteers

Mitchell said nurses had been keen to work in critical care units last year when COVID-19 emerged. "This time last year, we certainly had many keen staff who wanted to be able to help and volunteer to work in this area."

Critical care nurses, she said, were "very on board" with the training scheme. "These are people who have offered to come and work here. We would not be able to manage without them, so we are keen to support and encourage them."

CCCN successfully lobbied the Ministry of Health (MoH) to invest in a pandemic "surge" workforce last year, after raising concerns with then-chief nurse Margareth Broodkoorn that district health boards (DHBs) weren't doing enough.

The MoH then announced last July it would provide $2 million to DHBs to train surge workers to step into intensive care roles during an outbreak or other mass patient event.

While New Zealand has not experienced the onslaught faced by many overseas hospitals over the past year, COVID-19, along with events such as the Christchurch mosque shooting and the Whakaari/White Island disaster, were reminders to be prepared for mass events, Mitchell said.

"Our goal is to have a nursing surge workforce ready to support such events." •

What happens when workers don't want to be vaccinated

What happens when a health worker doesn't want the COVID-19 vaccination? What if they work in a sector particularly vulnerable to the virus? NZNO aged care industrial advisor Lesley Harry gives insights into the state-of-play in a sector with 'disproportionate' risks to residents.

Aged residential care (ARC) is vulnerable to COVID-19 – with disproportionate deaths in this sector compared to the wider population.

Therefore ARC providers' cautious approach in dealing with COVID-19 is understandable. A community outbreak can take hold rapidly, and the threat to residents should be taken seriously.

Health-worker vaccination – during a global pandemic – is an important strategy in fighting the virus. However, mitigating the risks, including staff vaccination, needs to be balanced with workers' rights.

Employment rights need to be upheld even during a crisis, and health unions are important in curbing some employers' tendency to overstep their powers.

Aged residential care appears to be far more risk averse than other sectors in dealing with COVID-19.

We are seeing some providers taking a punitive approach towards workers who decide not to be vaccinated, for whatever reason; or cannot be vaccinated because of their own health status.

Health workers and unions can reasonably expect to be consulted on vaccination policies.

These should outline practical support the employer could provide for staff to be vaccinated – as well as what workers who decided not to be vaccinated can expect.

This includes an obligation to carry out a health and safety risk assessment to work out correct mitigation measures.

Employer support for staff vaccination may increase vaccination rates. This could include giving time off work for vaccination, reimbursing costs for vaccination, and special paid leave for staff who experience an adverse reaction and can't work.

Employers could increase leave for those unable to be vaccinated – removing financial barriers to staying home when they're sick.

Gaining a better understanding of why staff might decline vaccination is also important.

For some staff, sharing their reasons requires a trusting relationship – knowing what they share will be treated with respect.

These reasons include personal health conditions or concerns about the effect of the vaccine on fertility. Or it could be based on mistrust of public health campaigns or efficacy of health treatment, due to their own or others' experiences.

It is only by understanding a person's decision that a genuine conversation can begin to happen. •

WHAT EMPLOYERS MUST DO

Employers must treat staff fairly and reasonably. In the COVID-19 environment that includes:

- Complying with employment law, the Ministry of Business, Innovation and Employment guidelines for employers and the Ministry of Health guidelines for aged care providers.
- Treating the vaccination status of staff as confidential information, and that means not telling other staff, or anyone else including residents or residents' families without the express agreement of the employee.
- Not imposing a requirement on unvaccinated staff to wear PPE when there is no community spread and without an assessment of risk.
- Carrying out a health and safety assessment in conjunction with the employees and the union.
- Taking an approach that relies on nurses' clinical assessment of risk and the application of professional judgement. (There is a risk that wearing PPE could become an indicator of COVID-19 vaccination status.)
- Treating all staff individually and not imposing a one-size-fits-all policy.
- Considering an employee's culture, religion and health status when working with them on vaccination.

Lead organiser and former Labour minister Iain Lees-Galloway shares insights on how the Government shapes policy and laws – and its recent pay-freeze mistake.

Pay freeze is bad policy and unions are fighting it

When the Government announced the pay freeze for public sector workers, a lot of people asked me if I felt conflicted, given my current role with NZNO and my previous role as a minister in Jacinda Ardern's Cabinet.

My answer: Not at all!

The pay freeze wasn't just bad politics. It was a slap in the face for thousands of nurses, teachers, doctors, police officers and others who have slogged their guts out helping the Government navigate not just the COVID-19 pandemic but also the March 15 terror attack, and the eruption of Whakaari/White Island.

New Zealand's Government and our Prime Minister are rightly lauded for the extraordinary way they have guided our nation through a profusion of crises. But as brilliant as our politicians have been at those key moments, we wouldn't be basking in the world's admiration without the efforts of frontline public sector workers like NZNO members who make sure the political decisions have a real and positive effect on people's lives.

People don't want to be "rewarded" for their efforts through the pandemic. People want their professions to be valued and to know that future generations will want to follow them into jobs like nursing and policing so our communities will get the benefit of their contribution to everyone's wellbeing. So no, I'm not at all conflicted. I know exactly what I think and now I have the freedom to say it out loud.

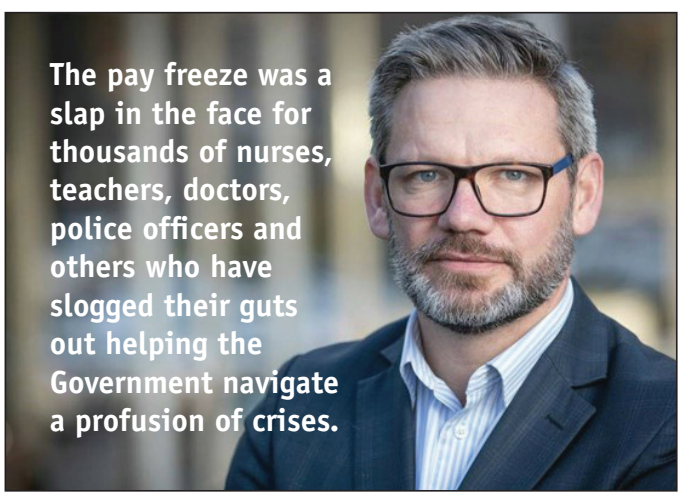
Nevertheless, having been a decision-maker in government, I do understand the constant balancing act that they perform. When it comes to Budget time, you can guarantee that ministers will submit proposals worth about eight times as much as there is available to spend. When it comes to passing legislation, there are only so many people available to support the enormous amount of work that goes into developing the policy and drafting the legislation. There are only so many hours of parliamentary time available to debate bills through to completion.

No government ever has the resources to do everything that it wants to. What actually gets done comes down to priorities.

Unions play a vital role in making sure the Government prioritises the things that matter to their members. When I was Minister for Workplace Relations & Safety, Immigration and ACC, unions took great interest in the work I was doing. I met at least monthly with the Council of Trade Unions (CTU) and regularly with specific unions.

For me, it was an opportunity to let unions know what progress the Government was making on the issues that mattered to them. For the unions, it was a chance to make sure their members' interests stayed firmly on my radar and to prod me when they thought the Government was moving too slowly or not prioritising the right things.

I took those meetings very seriously. Unions represent more than 375,000 New Zealanders and that number is now increasing. Politicians pay attention to that. Unions aren't the only groups that meet regularly with ministers. I saw as much of Business New Zealand and industry sector groups as I did of the CTU and unions. Part of the value of belonging to your union if you're a worker or to your industry council if you're a business is that you get that representation at the table and your voice is heard, no matter who is in government.



The pay freeze was a slap in the face for thousands of nurses, teachers, doctors, police officers and others who have slogged their guts out helping the Government navigate a profusion of crises.

This Government has delivered a lot of things that are helpful to unions and our members. Union action influenced the prioritisation of improving the Employment Relations Act, establishing the process for achieving pay equity, introducing fair pay agreements and a host of other changes for the better.

When the Government got it wrong with the pay freeze, unions stood up for our members. A delegation including NZNO met ministers to deliver the message that we wouldn't accept a freeze and to remind them of their obligations to bargain in good faith.

Union membership is about so much more than collective bargaining and assistance with disputes. It's about influence and using our collective power to help our politicians of all political stripes to steer the country in the right direction.

Together, we make a tremendous difference to the society we live in. Our collective power is greater than we sometimes think. Let's use it. •

PHOTOS: ADOBE STOCK

UNSAFE PRACTICE

How nurses recognise and respond to unsafe practice by their peers

NZNO professional nursing adviser Wendy Blair, RN, PhD, shares a summary of her research on the extent nurses in New Zealand recognise and report unsafe practice by their peers.

This study provides insight into nurses' recognition of and responses to unsafe practice by their nursing peers. It also identifies the early warning signs of practice creeping across the safety boundary in clinical settings.

Using a mixed methods approach, the study identified the behaviours and cues that nurses recognised as unsafe and what influenced such practice by their peers. In addition, this study sought to report the actions and responses by nurses when they encountered unsafe practice. Initially, a small number of participants were interviewed about their perceptions of working with colleagues they thought were practising unsafely. This data was combined with relevant literature to develop the survey used in the study.

The survey collected quantitative (measurable) data from 231 nurses in New Zealand about organisational practices and policies for the prevention of unsafe practice, identification of the potential for unsafe practice, identification of behaviours and factors associated with unsafe practice, and nurses' responses to unsafe practice.

The prevalence of witnessing unsafe practice in the previous 12 months was similar for nurses and managers, and higher in this study (66 per cent) than reported in other studies.[1,2,3] All the behaviours in this survey were found to be strongly associated with unsafe practice, with scores ranging from 68 to 97 per cent.

Unprofessional behaviour was identified as being related to unsafe practice by the majority of participants (90 per cent). The most frequently reported cues that alerted participants to the potential for unsafe practice by their colleagues were failing to document information accurately, not demonstrating expected knowledge and failing to collaborate effectively with colleagues.

The most frequently perceived contributing factors were high workloads, taking shortcuts, poor teamwork and being in an unfamiliar situation.

Comparisons between nurses and managers showed that managers had a better understanding of organisational approaches to assessing practice and were more likely to formally report a colleague for unsafe practice. Issues such as poor organisational culture and leadership, inadequate training, workload, staffing and skill mix were identified by both groups as factors that influenced the occurrence of unsafe practice.

The most frequently perceived contributing factors were high workloads, taking shortcuts, poor teamwork and being in an unfamiliar situation. Poor skill mix, organisational culture and leadership along with inadequate training prior to re-entry to practice were also identified as contributing to unsafe practice.

The rate of reporting was lower in this study (77 per cent) than in other studies[1,3] and the odds of reporting were significantly higher for managers.

Participants reported a variety of different responses to witnessing unsafe practice, with the most common action being speaking to the nurse involved.

Overconfidence

Interview data identified cues to unsafe practice including overconfidence, hiding practice, complacent attitude and approach, scope of practice transgressions, unprofessional behaviour, failure to follow accepted practice standards, poor interpersonal and communication skills, culturally unsafe behaviour and bullying as a precursor to unsafe practice.

The influence of collegial and organ-

isational culture on the recognition of unsafe practice was also identified.

Nurses' responses to witnessing unsafe practice included experiencing the challenge of taking action, watching and waiting (increased vigilance), and self-monitoring. They also felt influenced in their responses by a perceived lack of other responses, the collegial and organisational culture on response, and other conditions that influenced responses to unsafe practice.

Level of proof needed

Themes of uncertainty, sensing unsafe practice and disrupted professionalism emerged from the data. Uncertainty permeated all aspects of nurses' recognition of and response to unsafe practice. This included uncertainty about what behaviours constituted unsafe practice, how it was recognised, what level of proof was required and how to respond when it was witnessed. While some behaviours were obviously unsafe, the subtle nature of many cues led to some nurses describing a "sense" that something was wrong with a colleague's practice.

Fear of possible consequences and the repercussions of reporting was also described, and this influenced participants' responses. Organisational and collegial influences left participants in the difficult position of weighing up whether or not they should respond to/report unsafe practice and this caused disruption to expected professional responses. Keeping the patient safe was an important deciding factor in intervening when unsafe practice was witnessed; however, this did not necessarily mean that reporting also occurred.

Work environments need to support safe practice and nurses need to feel safe and confident about speaking out to protect patient safety.

Organisational and collegial culture played a pivotal role in the development of unsafe practice through tolerance of substandard practice and the development of customary practices. It is clear that to maintain safe practice, the work environment must support a high level of professionalism, open and honest communication and safe workloads, staffing levels and skill mix. Significant barriers to responding to unsafe practice for many nurses are identified in this study and these barriers need to be addressed by individuals, teams and organisations to improve safety.

When combined with uncertainty about what constitutes unsafe practice and how to respond, nurses can be left in a situation where they know what their professional obligations are and how they should respond, but feel unable to do so. When nurses sense issues with the practice of a colleague or the safety of a work environment, they need to be able to raise their concerns without fear of negative repercussions.

COMMON CUES

The most frequently reported cues that alerted participants to the potential for unsafe practice by their colleagues were:

- failing to document information accurately,
- not demonstrating expected knowledge, and
- failing to collaborate effectively with colleagues.

Fraught with uncertainty

To conclude, recognising and reporting unsafe practice in nursing peers is a process fraught with uncertainty. To meet expected practice standards, work environments need to support safe practice and nurses need to feel safe and confident about speaking out to protect patient safety. Expecting nurses to practice safely in an environment which does not support safe practice is unrealistic and has the potential to cause harm to both nurses and patients.

Study results provide comprehensive insight into the behaviours and cues that nurses recognised as indications of unsafe practice and how they responded to unsafe practice by their peers.

When unsafe practice is recognised, organisations should have a response which focuses on excellent clinical practice. Organisations require policy and guidelines which are non-punitive and support practice improvement. •

** Wendy Blair's research can be found in the* Journal of Clinical Nursing,[4] *or in full via the University of Newcastle, NOVA open access repository.*[5]

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2) Maurits, E. E. M., de Veer, A. J. E., Groenewegen, P. P., & Francke, A. L. (2016). Dealing with professional misconduct by colleagues in home care: a nationwide survey among nursing staff. *BMC Nursing, 15*(59), 1-11. https://doi.org/10.1186/s12912-016-0182-2

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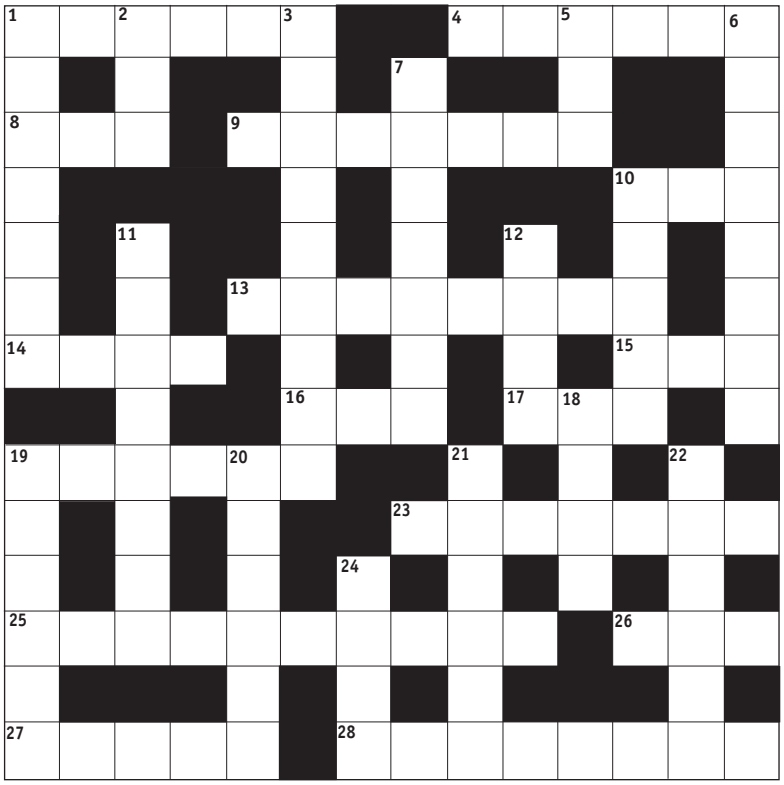
5) University of Newcastle, NOVA open access repository. http://hdl.handle.net/1959.13/1422832

crossWORD

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



ACROSS

1) Withdraw labour.
4) Short sleep.
8) Industrious insect.
9) Ceremony of greeting (Māori).
10) Wager.
13) Pining for roots.
14) Church, in Scotland.
15) Night before.
16) Donkey.
17) Atmosphere.
19) Worldwide.
23) Lack of enough to live on.
25) Educational course content.
26) Native mountain parrot (Māori).
27) Dark time.
28) Independence.

DOWN

1) Unwell, in a boat.
2) Rodent.
3) Related to feelings.
5) Parson bird (Māori).
6) Blood particle which aids clotting.
7) Shakes with cold.
10) Bread maker.
11) Rate of staff resigning.
12) Permit, to enter country.
18) A thought.
19) Boy (French).
20) Has a destructive dependency.
21) Plague insect.
22) Small river.
24) Large brass instrument.

June answers. ACROSS: 1. Hepatitis. 6. Wig. 7. Discharge. 8. Date. 9. Ail. 10. Sock. 11. Vow. 14. Opinion. 16. Less. 20. Chisel. 21. Mihimihi. 24. Easter. 26. Papal. 27. Telehealth. 28. Mow. **DOWN:** 1. Handover. 2. Aided. 3. Insulin. 4. Stars. 5. Agile. 6. Weakness. 12. Worth. 13. Fog. 14. Imam. 17. Salary. 18. Shear. 19. Phobia. 22. Irate. 23. Image. 25. Team.

wiseWORDS

“ We're not getting the respect and now pay that we deserve. I'm just sick of it. So I've handed in my resignation. ”

– Invercargill nurse Jenny McGee, who has been working for the UK National Health Service and helped care for UK Prime Minister Boris Johnson when he was ill with COVID-19

it's cool to kōrero

HAERE MAI and welcome to the June column. The tangi (or tangihanga) is the most important ceremony in Māoridom – it is about mourning and farewelling the dead, and is accompanied by much ritual. The tūpāpaku (dead person) lies in an open casket for three days – often on a marae, but increasingly in people's homes – before burial. Guests are formally welcomed, and there are lamentations, speeches and waiata. Women often wear the pare kawakawa (mourning wreath) on their heads. "Tangi" means to cry or weep, and expressing emotion is encouraged.

The dead play a vital role in Māori culture – they are referred to often in kōrero, ceremonies and waiata to remind people of their whakapapa and emphasise the importance of family relationships.

Kupu hou

New word

- **Tangi** – *pronounced "tah-ngee"*
- **I haere mātou ko ōku tuakana ki te tangihanga o tōku matua kēkē.**

My sisters and I went to my uncle's tangi.

Rerenga kōrero

Phrases

Many NZNO members have been voting on industrial action in the past month:

- **Ko au tētahi o nga mema o te Tōpu-tanga Tāpuhi Kaitiaki o Aotearoa.**

I belong to NZNO.

- **Kei te hiahia he pikinga utu.**

We want a pay rise.

- **He teitei rawa atu ō mātou mahi.**

Our workload is too high.

- **E kore te nuinga o nga neehi, te tokoiti kē.**

We don't have enough nurses.

E mihi ana ki a Titihuia Pakeho and Keelan Ransfield.

Classified advertising

APPLICATIONS NOW OPEN

The PSNZ Education Fund supports attendance to conference. For application and conference information:

www.psnzconference.org.nz

The Paediatric Society of New Zealand
Te Kāhui Mātai Arotamariki o Aotearoa

72nd Annual Scientific Meeting 2021

Novotel Rotorua Lakeside, Rotorua | 2-5 November 2021

CALL FOR ABSTRACTS NOW OPEN - submissions close Wednesday 4 August

Need information, advice, support?

Call the NZNO Member Support Centre

Monday to Friday 8am to 5pm
Phone: **0800 28 38 48**

A trained adviser will ensure you get the support and advice you need.

If you have an issue related to your employment or nursing practice including: a Police, Coroner's, Nursing Council, Disciplinary or Health and Disability Commissioner investigation, seek support from NZNO.

www.nzno.org.nz

NEW ZEALAND NURSES ORGANISATION | TŌPŪTANGA TAPUHI KAITIAKI O AOTEAROA

DISCLAIMER: Recruitment Agencies: Kai Tiaki Nursing New Zealand accepts advertising from nurse recruitment agencies but cannot guarantee the quality of their service, however, we expect agencies to provide a good service and that their advertisements should not be misleading. Complaints about poor service from advertised agencies should be directed to: Co-editors, Kai Tiaki Nursing New Zealand, PO Box 2128, Wellington 6140. Ph 04 4946386. These complaints will be treated confidentially but the nature of them will be passed on to the agency concerned.

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

Conference Programme
15 September

- **Karakia, Welcome**
  Keelan Ransfield – Kaumātua / MC
- **Conference Opening**
  Hon Andrew Little, Minister of Health
- **All of us thriving: A possible nursing led future**
  Dr Ruth De Souza
- **Equity in Education – the pathway to better health in Aotearoa for pacificans**
  Professor Palatasa Havea, Massey University
- **Equity from a Maori Perspective**
  Professor Denise Wilson, AUT
- **Panel discussion: Living through a Pandemic**
  Facilitator Kerri Nuku, NZNO Kaiwhakahaere
  Kimmel Manning, NSU TR Chair, Southern Institute of Technology
  Clare Buckley, Head of School, School of Nursing, Eastern Institute of Technology
  Dr Ashley Bloomfield, CE of Ministry of Health, Director General of Health
  Associate Professor Siouxie Wiles, The University of Auckland
- **End of Life from a Nursing Perspective (post referendum)**
  Dr Michal Boyd, UOA
- **Creating a sustainable health care system**
  Stephen McKernan, Lead of the Transition Unit for Health Reforms
- **Karakia and Close**

OUR FUTURE
The health of AOTEAROA

NZNO CONFERENCE AND AGM
15-16 September 2021
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Wellington

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 15 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 events, 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/2021 conference

Registrations will open mid June 2021

Annual General Meeting
16 September

The Agenda will be added to the website once confirmed.

A selection of our conference speakers, meet them all and read their bios at **nzno.org.nz/2021conference**


Dr Ruth De Souza


Professor Palatasa Havea


Professor Denise Wilson


Kimmel Manning


Clare Buckley


Dr Ashley Bloomfield


Dr Michal Boyd


Stephen McKernan

Notice of NZNO 2021 Board Elections and Call for Nominations

Nominations are now being called for the following positions on the NZNO Board:

- President
- Vice-President
- Kaiwhakahaere
- Tumu Whakarae

Financial NZNO members are eligible to stand as a candidate. All candidates must be nominated and seconded by two financial NZNO members and be endorsed by regional council, Te Poari or national colleges or sections.

Any financial NZNO member who is considering submitting a nomination is encouraged to read the candidate information booklet and familiarise themselves with the code of conduct and campaigning guidelines.

The election is being conducted by *electionz.com Ltd.* Most of the election information will be sent to NZNO members by email, including the calling for nominations and sending out voting details. Members are encouraged to update their contact details via the NZNO website.

The key election dates are:

Nominations open	Friday 18 June 2021
Nominations close	12 noon, Friday 16 July 2021
Voting opens	Wednesday, 4 August 2021
Voting closes	12 noon, Friday 10 September 2021

Nominations will be called for on 18 June 2021 through an email to NZNO members, a notice on the NZNO website and in the June edition of Kai Tiaki. Members without an email address will be posted a letter.

Completed nominations must be received by the Returning Officer by 12 noon on Friday 16 July 2021.

If elections are required, the positions for President and Vice President will be elected by a postal and online ballot of financial members between Wednesday 4 August and Friday 10 September 2021. The positions for Kaiwhakahaere and Tumu Whakarae will be elected by majority vote at the Hui ā-Tau.

For further details, call the election helpline on free phone 0800 666 044 or contact the Returning Officer at iro@electionz.com.

Warwick Lampp
Returning Officer – 2021 NZNO Elections
iro@electionz.com, 0800 666 044


Emergency Registered Nurse roles available in Northern Tasmania
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Thinking of an overseas experience?
Come and enjoy all that Victoria has to offer.

Austin Health is the major provider of tertiary health services in the northeast of Melbourne. With three campuses and community services, exciting opportunities are now available for nurses who want to have some fun while continuing to develop their career.

Austin Health is renown for its welcoming culture, friendly staff and positive employment arrangements. We celebrate, value and include people of all backgrounds, genders, sexualities, cultures, bodies and abilities.

Contact us now to speak with our friendly nursing team to discuss opportunities in acute, subacute and Mental Health nursing.
Ask about our specialty practice areas and our generous remuneration and benefits programs.

email: nursingworkforce@austin.org.au
Phone: +61 (03) 9496 3370

At Austin we support the professional dreams and careers of all nurses.