Kai Tiaki
NURSING NEW ZEALAND
July 2021
VOL 27 NO 6

Winter of discontent

District health board members have committed to a further three strikes, as anger mounts over pay and staffing issues.

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THIS ISSUE focuses on district health board members' ongoing campaign for better pay and conditions, and examines the vital role of those who volunteer for life-preserving services to allow others to strike. We look at the kaupapa of equity in health, and provide professional education on managing patients on the new diabetes medications. And we wish everyone happy Matariki!

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

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Joel Maxwell and Mary Longmore.

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

This issue . . .

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This journey is part of a larger story, started by our tipuna, carried on by us

By Kimmel Manning

As Matariki nears and we begin to move into the New Year, so too comes the time for reflection.

The reflection I wish to share with you revolves around my experience of being one of four Māori students in a class of 50. Being the minority in the room is not a new experience for me; however these last three years have really challenged me in that respect.

Recently, as part of our assessments, my cohort were asked to put together a presentation for our peers exploring the various factors that contribute to inequitable health outcomes for Māori.

Come assessment day, we sat and listened about how our health, education and social systems have failed our people. We die seven years earlier, are two-and-a-half times more likely to die from preventable diseases, are twice as likely to commit suicide or self-harm, and are over-represented in nearly all negative health outcomes. Sitting in that classroom, hearing the suffering of my people being reduced to mere tick-boxed assessment criteria, hurt me.

It hurt because these were the stories of my whānau.

It hurt because, despite knowing about these issues for the last few decades, very little has been done to change course.

It hurt because of one of the comments my peer made in jest. "I'm Pākehā, so I can sleep during this."

When my turn came around and I stood to present, a lifetime of internalised racism manifested. And I broke. And I cried. And I swore. In that moment, I felt powerless and I remembered all the times I had questioned my place in the world:

- Being called an n-word by my peers in primary school, and them laughing at me for getting angry.
- Receiving death threats, in person and on social media, because "your people are what's wrong with New Zealand".
- My father teaching me to present myself in a way that is more palatable to Pākehā.
- My mother being jeered at in public for her moko kauae.
- Being told to speak English during my first placement.

When you are conditioned to believe your identity, your culture and your people don't matter, its quite confronting when you are tasked with exploring the mechanisms that perpetuate this maemae. Let alone having to do a presentation to a room full of people, who get to choose whether or not Māori health inequity is an important issue. I don't get that choice. I knew that when I left that room, I would be walking into a world where my whānau and I are not given a fair go.

After my meltdown, I was pulled aside by my tutor, who chastised me for my lack of professionalism – which was fair given my cussing.

One of the things that stood out to me was when she said: "You're privileged to be here."

At first I thought, "Well obviously you don't get it", but after some time had passed, I realised she was right. I am privileged. Here I stand, a third-year nursing student, soon to be a registered nurse. I stand here because of the hard work of my predecessors – the likes of Ākenehi Hei, Putiputi O'Brien, Irihapeti Ramsden, who challenged the status quo and set the precedent that Māori belong in nursing.

When I stood and presented, a lifetime of internalised racism manifested. And I broke.

I stand here because of my whānau, who supported me to pursue education despite not having that opportunity afforded to them. What I have come to realise is that my journey through nursing is but a chapter in the much larger narrative created by our tipuna. A narrative that ends with the return of mana motuhake, tino rangatiratanga and good health.

But we're not quite there yet.

I realise now, my role.

My role is to be an agent of change. The privileges afforded to me have empowered me to do better and be better and I have a responsibility to continue the work laid out by our tipuna.

I believe nurses have the power and influence to build a better world, a fairer world. And after I walk across that stage in December, that's exactly what I plan on doing.

He kākano ahau. •

Kimmel Manning is a third year nursing student and chair of NZNO's Te Runanga Tauira.

Tell us what you think

Sad when NZNO 'censors its members'

I READ with more than a little sadness about a letter from an NZNO member being banned from publication in *Kai Tiaki Nursing New Zealand* (see Letters, p4, June issue).

How sad when our own magazine censors its members. How is it possible to be banned for a letter? What happened to freedom of speech? Stuff and TVNZ don't seem to put the same restrictions on their reporters, or on their accuracy.

And why hasn't NZNO leadership made any announcements in any shape or form in support of its members in district health boards (DHBs), in this magazine or anywhere else? Have I missed something? Are the board/leadership so out of touch with what is going on for the everyday nurse – as long as the members pay their salaries, everyone is happy? How transparent is the election process of the board members – do we see the ballot?

Why do the DHBs get to announce anything and everything, regardless of the facts, while NZNO seems powerless? Who decides what is appropriate to read in our magazine, and what will offend my sensitive constitution? I do not believe the majority of nurses are incapable of recognising a good debate topic or ignorant of current affairs as this type of censorship seems to imply.

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.

I want to believe that I am protected by NZNO and that our magazine allows us a voice, but am I? And does it?

Tracy Andrews, RN,
Hamilton

NZNO acting chief executive Mairi Lucas responds: Kia ora Tracy, thank you for your letter. It saddens me to see the extent of mistrust in the organisation that your letter reveals, but I am grateful for the opportunity to respond to the points you have made.

We decided not to publish a letter from a member because it breached Kai Tiaki's *letters' policy. This happens very rarely and, on that basis, I do not think your assumptions about free speech being curtailed – or someone deciding what content is appropriate for you – are justified.*

The specific media strategy in place for the district health board (DHB) multi-employer collective agreement negotiations is in accordance with the recommendations from the [former Council of Trade Unions president] Ross Wilson report, following the 2019 independent review. It was important that members and delegates were the spokespeople and leadership supported, once bargaining had been completed.

Future strategies will follow a similar process where the board has full oversight. When we marched on Parliament on June 9, it was our kaiwhakahaere and acting president who led the march and spoke to the rally and our board attended and in some cases led rallies in their own regions – this was the appropriate time.

Statements in support of our DHB members have been made in the media many times by our senior staff (please see https://dhbmeca.nzno.org.nz/media). These statements have been extremely well-reported, while the DHBs' announcements have not. So I do not agree that our hardworking team is powerless.

Lastly, our election process is run according to our constitution, by Electionz.com, a trusted and independent firm, with no direct oversight from NZNO. This is done for the very reason of transparency you mention.

I hope these responses have helped to restore your trust, which is so important to us all working together in solidarity. There is no intention of removing your voice from Kai Tiaki's *pages or stifling courteous and informed debate.*

Correction: Mental health nurses call for regular reviews

IN THE article "Compulsory orders 'safety blanket' for some patients", on p30 of the June issue of *Kai Tiaki Nursing New Zealand*, we reported that the NZNO mental health nurses section (MHNS) submission had suggested some mental health patients should be able to remain under compulsory treatment orders without yearly reviews.

In fact, MHNS recommended that indefinite treatment orders should be replaced with regular reviews, *"to validate the continued compulsory treatment for patients . . . "*

In those reviews, the section suggests, *". . . the responsible clinician shall take into consideration any request from the patient to remain on a compulsory treatment order . . . and this shall be documented by way of a renewed informed consent to compulsory treatment"*. In deciding, the judge must give effect to any such request, MHNS submitted.

The co-editors apologise for the error.

Vera Ellen's name misspelt

IN THE June issue, the name of the late Vera Ellen was misspelled in the contents page and in the headline of an article about her life as a nurse leader on p21. The co-editors regret and apologise for the error. •

Apology for paper quality in June issue

THE CO-EDITORS apologise for the low quality of paper June's *Kai Tiaki Nursing New Zealand* was printed on last month.

COVID-19 is affecting global paper supplies, with delays of several months. Canterbury floods in June also forced our printers to close temporarily.

Our printer, Inkwise, is working hard to find alternatives and we will continue to investigate a range of options into the future, taking into consideration environmental and cost factors. •

The president comments:

By Tracey Morgan

Ko Hotere me Panehora ōku maunga
Ko Pokaiwhenua me Mangawhero ōku awa
Ko Ngāti Ahuru me Ngāti Te Apunga ōku hapū
Ko Mangakaretu me Paparamu ōku marae
Ko Tainui tōku waka
Ko Raukawa tōku iwi
Ko Tracey Morgan tōku ingoa

"*Whaia te iti Kahurangi ki te tuohu koe me he maunga teitei*" – Seek the treasure you value most dearly; if you bow your head, let it be to a lofty mountain.

When I think of this whakataukī, and how it has been voiced and used many times throughout many conversations, it resonates for me personally with the journey I have taken to where I am today.

I am privileged and very honoured to be in the position of acting president. I want to thank past president Heather Symes for allowing me to work alongside her again.

I also thank both tumu whakarae Titihuia Pakeho and especially our kaiwhakahaere Kerri Nuku for the continuous leadership they have provided through the past 12 months or so for our organisation.

I am a wife, a mum of four children and an even prouder nan of three grandsons.

And I am a nurse. Something which I am very proud to be, given the tumultuous times that NZNO has been through – with not only staff changes but having to deal with a worldwide pandemic.

Thankfully for nurses, both Kerri and NZNO acting manager, professional and nursing services, Kate Weston, were able to keep all of Aotearoa informed daily of updates.

COVID-19 alone has put a strain on our already stretched nursing workforce.

Also 2020 was the International Year of the Nurse and Midwife, and national and international recognition of the workforce was planned. We should have been actively celebrating nurses and midwives, both past, present and future.

When COVID-19 arrived, the nursing workforce worldwide again stepped up to the plate and performed what we all know and do best.

The fundamental basis of NZNO is to support member voices and follow the lead of members.

NZNO built on hard work

Over the past few months or more I have observed increasing tension, as anti-union propaganda about the stability and viability of NZNO appears on social media.

NZNO has been built on the hard work of those who have since passed on.

They challenged and were politically astute enough to organise and represent the professional nursing voice.

Our influence has waxed and waned but we have always bounced back due to the resilience we continue to display as nurses.

Now more than ever is our time to fight. I have never backed away from the fight. I believe in human rights and I believe in justice.

I believe nursing can be stronger if we are collective in our strength and united in our voice.

I am proud to be representing an organisation that stands in solidarity and believe now is the time to unify. Let us stand shoulder to shoulder, and let us not turn on ourselves in this pressured time.

NZNO vice president and acting president Tracey Morgan.

I am proud of the hard work and dedication required to fulfil my professional role as a nurse. I am proud to be Māori.

I, like many, am not prepared to let anyone take away my mana.

I believe nursing can be stronger if we are collective in our strength and united in our voice.

Likewise, I am not prepared to sit by and see nursing eroded by the Government's inability to recognise our profession.

I am also not prepared to buy into propaganda that our organisation is failing or dysfunctional. I am here to work with you and continue to strengthen NZNO.

As [Māori rangatira] Sir James Henare states: *"We have come too far not to go further, we have done too much not to do more."* •

Matariki rises, a new year begins . . .

NZNO kaumātua Keelan Ransfield offers karakia for the new year and explains the significance of Matariki, the constellation made up of nine whetū (stars).

The appearance of Matariki was carefully observed by tohunga (cultural and spiritual leaders) and the brightness of the different stars in the cluster, along with their movement and clarity would determine the bounty of the impending season…

• Karakia mo te urunga mai o Matariki

Whanake mai ngā mata o te Ariki
Whanake mai te tohu o te tau
Whanake mai Matariki hunga nui

(Arise the eyes of god
Arise the signs of the year
Arise Matariki who gathers the masses)

****

The names of those who had died since the last rising of Matariki were called out in the presence of the star cluster. Māori believe Matariki cares for those that die throughout the year, and when it rises again, the spirits of those passed become stars in the sky. Māori would mourn at this moment, and the tears and wailing would send the loved ones into the heavens to become stars…

• Karakia mo Pōhutukawa

E tū Pōhutukawa
Te Kaiwake i nga mate o te tau
Haere ra koutou ki te uma o Ranginui
Hei whetū i te kete nui a Tane
Koia ra! Kua whetūrangitia koutou kei āku rau kahu rangi

(Behold Pōhutukawa
Who carries the dead of the year
Onward the departed to the chest of the sky
To become a star in the Milky Way)

****

Because many of the different stars in Matariki are associated with food, and its role is to care for our dead and bring forth the bounty of the year, Māori give thanks to the star cluster by offering food. Before the rising of Matariki, special food is taken from the gardens, forests, rivers and oceans and is cooked in an earth oven. This oven is uncovered, in the steam of the food rises into the sky to feed Matariki…

• Karakia mo Tupu-a-Nuku rāua ko Tupu-a-Rangi

E tū Tupu-a-Niku
E tū Tupu-a-Rangi
Ka matomato ki raro
Ka pōkai tara ki runga

(Behold Tupuānuku
Behold Tupuārangi
Let the earth be lush
Let the sky be full of birds)

• Karakia mo Waitī rāua ko Waitā

E tū Waitī
E tū Waitā
Te tini o Tangaroa
Te mano o Hinemoana

(Behold Waitī
Behold Waitā
The abundance of the ocean
The plenty of the waterways)

• Karakia mo Waipunarangi rāua ko Ururangi

E tū Waipunarangi
E tū Ururangi
He ua kōpatapata
He hau miri i te whenua

(Behold Waipunarangi
Behold Ururangi
Give us rain
Give us wind)

• Karakia mo Hiwa-i-te-rangi

E tū Hiwa-i-te-rangi
Te kauwaka o te manako nui
Anei ngā tōmino o te ngakau
Hel whakatinanatanga mau

(Behold Hiwa-i-te-rangi
The medium of my desire
You know what I yearn for
Make my dreams come true)

• Karakia whakamutunga Matariki, hei whakaoti (karakia conclusion)

Matariki Atua ka eke ki runga
Nau mai ngā hua
Nau mai ngā taonga
Nau mai ngā mātahi o te tau
Haumi e
Hui e
Taiki e

(Matariki has risen
Welcome the fruits of the year
Welcome the many treasures
Welcome the New Year)

Opinion: What is the price of industrial action? We need those who stay behind

By co-editor Joel Maxwell

AS WE move into another phase of ongoing district health board (DHB) member industrial action, we should stop and spare a thought for those who stay on to hold the fort.

There is still ample enthusiasm from DHB members to continue with action – after all, the offers to date are far from what was originally sought.

Then, for good measure, the DHBs threw in an advance on equity money that would be coming to members anyway; and dropped a pay freeze – like a full bedpan – on the public sector in the middle of negotiations.

Members, facing intense pressure in their everyday work, and enticing offers from overseas for their valuable skills, couldn't be blamed for feeling angry.

What the ultimate outcome of this bargaining will be is not yet clear, but we do know that nothing could happen without the nurses who agree to fill the roster for life-preserving services (LPS).

I'm tipping my hat to those who made the sacrifice in the first strike to stay on for this work.

In this edition, we look at the work done by the LPS nurses, speaking to members who worked through the strike so that it could go ahead. We examine the professional and industrial complexities of LPS through the insights of our NZNO staff (see pp14-17).

Health Minister Andrew Little fronts to media over NZNO member demands in Wellington.

Regardless of the legal niceties of LPS, it must be galling for the nurses who stayed on to know that maintaining safe staffing levels – a major part of the action – is still lagging from what was promised in the 2018 MECA.

About half the 20 DHBs have yet to fully implement the safe staffing programme, care capacity demand management (CCDM) by the June 31 deadline.

There are multiple challenges facing the health system, not least the question of recruitment and retention of nursing staff. Listening to our members would be a good start, I would have thought.

Wherever this action ends up, we can't get there without doing it together.

Those that go out need those that stay behind. And those that stay behind for LPS, well, they need our recognition and appreciation.

I say, cheers to them. •

Indigenous conference looks to maunga

THE INDIGENOUS Nurses Aotearoa Conference 2021 and hui ā-tau return in August.

NZNO kaiwhakahaere Kerri Nuku said the conference, with the theme "heed the call of the maunga", captured the ideas of Ākenehi Hei, inspirational Māori nurse, midwife and leader from the early 20th century.

"Which was be proud of who you are, and remember the maunga that surrounds you, remember the tupuna that are there."

She said with the many changes to the health system, it was easy for nurses to "get caught off our feet".

"This is about always looking to the mountains, giving you stability, strength and resilience."

The conference would include empowering speakers who would help audience members with the tools and personal belief "to achieve what they want to achieve".

"And while there might be different things that pop up – keep looking to the maunga and that will steer you in the right direction. A lot of our speakers are [speaking] around that."

She said speakers included the likes of Dr Rawiri Taonui, addressing the issue of racism. "We've got some powerful speakers, and we're also hoping to connect with the Canadian Nurses' Federation, who I spoke to last week in their leadership seminar."

Nuku said the First Nation people in Canada were going through their own "real pain" after the recent discovery of hundreds of graves in Catholic schools for indigenous children.

The conference runs August 13-14, with the hui ā-tau on August 15. •

Members vote for three more strike dates

Industrial action could run for months as members send an 'historic' three-strikes message to district health boards.

NZNO DHB members and their supporters hit the streets on June 9 for strike action.

NZNO DISTRICT health board (DHB) members have voted in favour of three more strikes in a ballot that closed on July 6.

It came as the DHB bargaining team asked for a new meeting ahead of the schedule for a new round of mediation.

An initial 12-hour strike by members ran across Aotearoa on June 9. Health Minister Andrew Little fronted to members on the steps of Parliament.

The success of the strike, approved by an overwhelming majority, appeared to whet the appetite of members for further action.

A ballot of members saw three new strike dates set, running till September, in multi-employer contract agreement (MECA) negotiations.

NZNO lead advocate David Wait said the "yes" vote for the further strikes was very high.

Members were resolute about using the action to gain recognition and working conditions that would ensure nursing remained a viable profession, he said.

"This is an history-making set of actions that could take place over the next few months, but we will be continuing discussions with the DHBs . . . and we remain committed to securing a deal that is acceptable to our members."

'This is an history-making set of actions that could take place over the next few months.'

However there appeared to be a possibility that the DHBs seemed willing to "actively seek a solution".

"Progress has been made in our discussions and that has given us some hope a resolution can be found around pay and safe staffing."

The NZNO bargaining team was set for another round of mediation with representatives of the 20 DHBs on July 14 and 15. It was expected DHBs would make a new offer during this mediation.

However Wait said further discussions with the DHBs were set for later the same week of the ballot result – ahead of the scheduled mediation.

Wait said despite any optimism about bargaining progress, the issues facing nursing staff remained very real.

"We are facing a national health crisis in terms of safe staffing, recruitment and retention; and the working conditions our members face can no longer be endured and that's why our issues matter."

After the vote, Wait said he had not seen this level of determination from members before.

Story continues on page 8.

New NZNO webpage for end-of-life choice implementation

NZNO IS developing a webpage to provide timely information for members as Aotearoa counts down to November 7 this year – when the End of Life Choice Act (EOLCA) comes into being.

The new law will require an understanding on how it will impact on individual and collective nurse practitioners, nurse prescribers, nurses and other health-care professionals' scopes and practice.

Guidelines to implementing EOLCA are being developed at Ministry of Health (MoH) level. However, NZNO is aware that members require helpful and practical information to guide their everyday work. The information has been collectively prepared by NZNO policy, legal and professional nursing advisors.

The information will be updated on a regular basis following meetings with interested parties, Nurse Practitioners New Zealand, MoH, district health boards, primary health organisations and the Nursing Council.

Any contributions from members would be welcomed.

If there are any specific topics that the NZNO needs to investigate or develop, members can contact NZNO staff at policyanalysts@nzno.org.nz •

Historic strike action looms as NZNO members send message to DHBs

Continued from page 7

Wait said that if agreement was not reached, more nurses, midwives, health-care assistants and kaimahi hauora would leave nursing.

He said nursing was a "caring profession" and it was heart-breaking that nurses felt so undervalued.

Speaking in front of a purple wave at Parliament, during the first strike, Minister Little said he was committed to a pay rise and safer staffing for nurses, but made no new promises, pointing only to the Fair Pay negotiations which he suggested would conclude "in a matter of months".

The health reforms, too, he said would make a difference to conditions in the long-term.

The strike, which ran with the necessary support of nurses who remained rostered on to provide life-preserving services (LPS), drew a generally positive response from the wider community.

The planned further industrial action would start with a 24-hour strike on July 29, running from 11am to 11am the following day.

The next strike would be on August 19 – running for eight hours from 11am.

The final strike approved in the latest ballot would run for 24 hours from 11am on September 9.

NZNO members hit the streets of Wellington in June.

In each case, notice would be given ahead of the minimum 14 days' notice required under law.

Immediately after the ballot results were announced, there appeared to be strong support for the action from members.

One registered nurse (RN) who worked for Capital & Coast DHB (CCDHB) at Wellington Hospital, who did not wish to be named, said she had been part of the 2018 industrial action.

There was a very different feeling this time round, she said, with nurses angrier and more determined.

For her, part of that was triggered by the DHB offer of a lump-sum payment that was simply an advance on a payment nurses would have received anyway.

Another RN who worked for CCDHB, and also did not wish to be named, said she had been in the 2018 action too.

She was "really happy" members had voted to go ahead with further strikes.

"From last time, I was one of the people who was disappointed we chose 'yes'. I feel optimistic that everyone seems to be sticking to their guns this time."

The last result made people more determined this time, she said. •

Petition launched over nurses' prescribing powers

AMID A global medication shortage, Nurse Practitioners New Zealand (NPNZ) has petitioned the Government to urgently amend the Medicines Act to allow them to prescribe alternatives when approved medications have run out.

Chair Sandy Oster said section 29 of the Medicines Act (1981) did not allow nurse practitioners (NPs) to supply unapproved medicines – only medical practitioners.

In the past six months, global shortages meant this was now an urgent problem in New Zealand for NPs and patients, Oster said.

As some medicines run out in New Zealand, "unapproved medicines" suggested by Medsafe or Pharmac are brought in as substitutes, she said. However, NPs as "authorised prescribers" under the Medicines Act were unable to prescribe them.

These included things like oral contraceptives, common antihypertensive medications and folic acid for pregnant women, Oster said.

NPNZ wanted section 29 extended to cover all authorised prescribers, Oster said, but had been turned away by the Minister of Health, chief nurse, PHARMAC and director-general of health.

"This is now a significant barrier to practice, as any medication in section 29 must be prescribed by a doctor. GPs are not happy either, as section 29 medications require additional conversations with patients and they are being asked to sign prescriptions for patients they have not assessed."

Nearly 2000 signed the petition, which closed on July 2.

Oster said she hoped to work closely with NZNO to advocate for change. •

Andrea Reilly (left), Nelly Hofman (centre) and Sara Mason on the Greymouth picket line.

Nurses 'angrier' this time

NURSES ON strike on June 9 were angrier than during the July 2018 strike, according to senior NZNO delegate and duty nurse manager at Grey Hospital (Te Nīkau) Nelly Hofman. And the level of support for the strike, both from nurses and the public, was massive, she said.

Speaking from the picket line of 100-plus nurses, Hofman said: "This is not going to stop at just one strike. Nurses are angry now. During the last strike they were frustrated and emotional but now they are just angry. They've reached the stage where enough is enough."

Nurses were not going to accept a pay offer lower than the rate of inflation. "But this is not just about pay. It is about unsafe staffing and working conditions as much as the pay offer. The situation is unsafe for patients and unsafe for us."

Nurse practitioner Sara Mason was on the picket line because "I'm passionate about nursing and the future of nursing and our ability to do our jobs within a medical model, when more is expected of us without giving us the respect we deserve".

Mason works for the West Coast District Health Board (DHB)-owned general practice, Te Nīkau Health Centre, which is part of the hospital complex. While she supports a focus on the lower paid, she points out that the GPs in the practice earn "a whole lot more than I do for exactly the same job, get better benefits, get time to do their jobs and get $15,000 a year for professional development". Nurses working for the West Coast DHB get $15,000 over three years for professional development, she said.

Mason was heartened by the number on the picket line and the strong public support for nurses, in the region which gave birth to trade unionism in Aotearoa.

Clinical nurse specialist, cancer care co-ordinator and long-time delegate Andrea Reilly was picketing to show solidarity with all nurses, particularly her NP colleagues who earned more than $100,000 and who would not get any pay increase under the current offer.

"They have studied and worked to better themselves. Some have double masters degrees. They are autonomous practitioners and should be recognised as such."

She also emphasised that the strike was about "far more than just pay". Safe staffing and working conditions were equally important.

Reilly was pleased DHB nursing leaders had shown support for the striking nurses.

Grey Hospital registered nurse Caroline Ragg (below) was embarrassed nurses had to go on strike "to try and get what should be ours". The Government needed to prick up its ears and do something to retain experienced staff who were "haemorrhaging to Australia". •

West Coast nurse's last stand

PHOTO: ANN KNIPE

FOR ONE dedicated West Coast nurse, going on strike for a safer workplace was among her final acts of solidarity.

Barbara (Barb) Roberts (left, on June 9) died suddenly on June 22, less than two weeks after being out on the picket lines.

NZNO organiser Linda Boyd said Roberts, 65, was an enrolled nurse from the maternity ward, who had worked at Grey Base Hospital (now Te Nīkau) for more than 40 years.

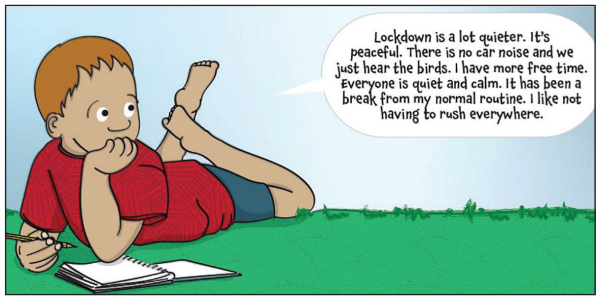
She was a committed nurse, who was passionate about newborn hearing screening, Boyd said. "Her colleagues told me she would on occasion come in on her days off to ensure a newborn had their test done – especially if they lived far from the hospital." Roberts had also previously served as an NZNO delegate.

She is survived by her husband Neville and sons Nigel and Jared and their families. •

Caroline Ragg is in mourning for New Zealand nurses lost to Australia and those who will leave because of the current pay offer.

Lockdown gets graphic novel treatment

A graphic novel is bridging the gap between nursing academia, and young research subjects.



LOCKDOWN WAS a tough time for many adults – but it might have looked a little different from a lower angle.

Academic research into the child's perspective on the COVID-19 lockdown in 2020 has been converted into a graphic novel for children.

University of Auckland School of Nursing associate professor Melody Smith led the project, which sought to demystify academic findings for children.

About 200 children submitted artwork, photos, poems and comments for the work, *Kidshare: Lockdown perceptions in Aotearoa New Zealand*, available online.

Smith said increasingly researchers were trying to innovate when it came to disseminating research findings.

"We always have our academic output, but we're cognisant that they don't always reach the people that we're talking about, who also contributed to the research."

She said the graphic novel – a story published in comic format – was a way to integrate the data from the research in a way that was relevant for children.

The biggest finding of the research was the importance of low-traffic neighbourhoods, she said.

"Not only are our kids able to get out and be more physically active . . . their emotional wellbeing was really supported through comments around feeling peaceful and calm and being able to hear the birds."

She said children were able to connect with their wider community during the lockdown. "Everybody was out and about walking and cycling and scootering."

Another important finding was "how the simple things really matter", she said.

"Maintaining continuity in kids' lives, and keeping things simple and slowing down, were all really important for supporting their wellbeing."

Research had to have scientific rigour and clear methodology, to be able to influence policy, she said.

"However, really when you have projects like this . . . creative dissemination is a really good opportunity for us as researchers to connect more."

Now the graphic novel, with art by Carol Green, will be shared to a wider audience thanks to the help of a well-known New Zealander.

Broadcaster and children's entertainer Suzy Cato had originally helped share the link for the research survey, Smith said.

Cato would be sharing the novel, and broadcasting an audio version of the book on radio. •

New NZNO student vaccinator category

THE NZNO board has launched a new student member category, providing indemnity for provisional vaccinators.

The student-plus cover would be for the specific membership category: student provisional vaccinators – COVID-19.

Members must be able to show they have completed the provisional vaccinator course and are enrolled in a recognised nursing programme.

New members would pay $120, which included regular support services, plus indemnity for their work as a provisional COVID-19 vaccinator, including being employed as a vaccinator.

Existing members would pay the balance between their student rate and the $150 – about $75.

Student membership alone does not carry indemnity for work as a provisional vaccinator, in particular if the member is employed in this role.

NZNO has questioned government plans for layperson vaccinators as the programme ramps up.

Among these concerns was the issue of nurses being left responsible for unqualified vaccinators in cases such as anaphylactic reactions to the Pfizer vaccine.

It comes as plans for the rollout of the COVID-19 vaccine appear to have changed – shaped by uncertainty about availability of the Pfizer vaccine itself.

Age cohorts

Prime Minister Jacinda Ardern has announced the rollout would not become available to all ages until October.

This new vaccination plan would be based on age cohorts.

From the end of July, the bulk of vaccines were expected to arrive, which would see the rollout broadened "considerably".

Deliveries of the Pfizer vaccine would be weekly, with the Government given about four weeks' notice of the size of each delivery.

Ardern said the first age cohort of the general population, over-60s, could book from July 28.

"We know enough about our supply to also announce that on the eleventh of August, New Zealanders aged 55 and over will be able to book a vaccine.

"From here, the rollout is indicative as we wait for exact details from our supplier."

She said it was broadly expected that those over 45 years old would be able to book from mid to late August. Those over 35 could book from mid to late September.

The vaccine would become available to everybody from October. •

Travel concerns ease for Filipino nurses in Aotearoa

RESTRICTIONS ON Filipino nurses trying to travel to New Zealand for work appear to have been lifted.

In January, several nurses heading for New Zealand were stopped at Manila Airport, as part of a Philippines Government visa crackdown.

Philippines ambassador to New Zealand Jesus Domingo said in May that urgent talks were underway with New Zealand authorities to smooth the way for Filipino nurses to work in New Zealand.

Auckland nurse Melody Opanes-Kircher, who administers a social media group for Filipino nurses working in New Zealand, with 43,000 members, said many travel to New Zealand on a visitor's or short-term visa to complete their competency assessment programme (CAP) before finding work and converting their visas.

However, the Philippines Government appeared to have taken a harder line this year over citizens leaving the country on a one-way ticket without work or student visas, she said.

But restrictions appeared to have been lifted recently, she said, with nurses reporting they were able to travel with no problems.

Domingo confirmed restrictions had eased until later this year, as bilateral discussions continued.

A Ministry of Foreign Affairs and Trade (MFAT) spokesperson said New Zealand had sought to reassure the Philippines over the visa process for nurses.

Filipino nurses make up 10 per cent of the workforce in New Zealand, according to the Nursing Council.

The Philippines has increased its quota of nurses who can work overseas from 5000 to 6500, the NZ Aged Care Association says.

However, this would not have a significant impact on New Zealand, where the aged care sector was facing a shortage of up to 500 nurses, chief executive Simon Wallace said.

MFAT advised him that health-care workers with employment contracts at May 31, 2021, would be allowed to leave and take up their offshore work.

Recruitment agencies were pushing for the cap to be raised to 10,000, Wallace said, but it was a situation the Government had little control over. •

Push for extension of free period product timeframe

PERIOD POVERTY campaigner Sarah Donovan wants the Government to commit to free period products in schools beyond three years.

Donovan – a University of Otago public health researcher – understood there was no confirmed budget beyond three years.

However a spokesperson for Associate Education Minister Jan Tinetti said while much government funding tended to be in three-year cycles, there was no intention to stop the free period products initiative in schools beyond this.

"Our commitment is to continue this programme."

Prime Minister Jacinda Ardern and Tinetti announced earlier this year that all primary, intermediate, secondary and kura students would have access to free period products from June.

NZNO Women's Health College chair Denise Braid said the college was thrilled to have supported the initiative and credited Donovan who "pushed and pushed" to make it happen over many years. •

NZNO meets with health reform transition boss

NZNO LEADERS have had a sit down and a cuppa with the man in charge of bringing about billion-dollar health reforms.

Kaiwhakahaere Kerri Nuku said Stephen McKernan, health reform transition unit head, spoke about progress on sweeping changes announced in April by the Government.

McKernan, the former director-general of health, was appointed last year to head up reforms that would see all 20 DHBs amalgamated into a single agency called Health NZ (HNZ).

They would also see the creation of a separate Māori Health Authority (MHA) with the power to commission its own services.

Nuku said McKernan talked about the work they had done to date, which had been "at pace".

"Because bedding in such a huge operation into such tight timeframes is going to be no easy task."

She said she had challenged McKernan about why nurses were not considered an important stakeholder.

"He reassured me that we were – and I reminded him I had to ask for this meeting, it didn't come to us. And that we're not just a union, we're professional organisation."

McKernan said there were about 350 applications for positions on the interim governing group for the Māori Health Authority.

Nuku said the NZNO wanted to make sure that when issues such as power-sharing, performance monitoring, accountability of procurement and workforce were being discussed, then nurses were at the table too.

Nuku said she did get the sense that McKernan was taking direction from the MHA transition group, headed by Tā Mason Durie.

New laws underpinning the proposed reforms will be introduced in September.

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

Nurses on the march

AOTEAROA TURNED purple in June as NZNO members went on strike around the nation.

The strike by district health board (DHB) members aimed to gain better pay, conditions and boost patient safety. It followed lengthy negotiations, and an effective public sector pay freeze that came as a slap in the face to members.

In Wellington, hundreds marched to Parliament to hear from MPs – including Health Minister Andrew Little.

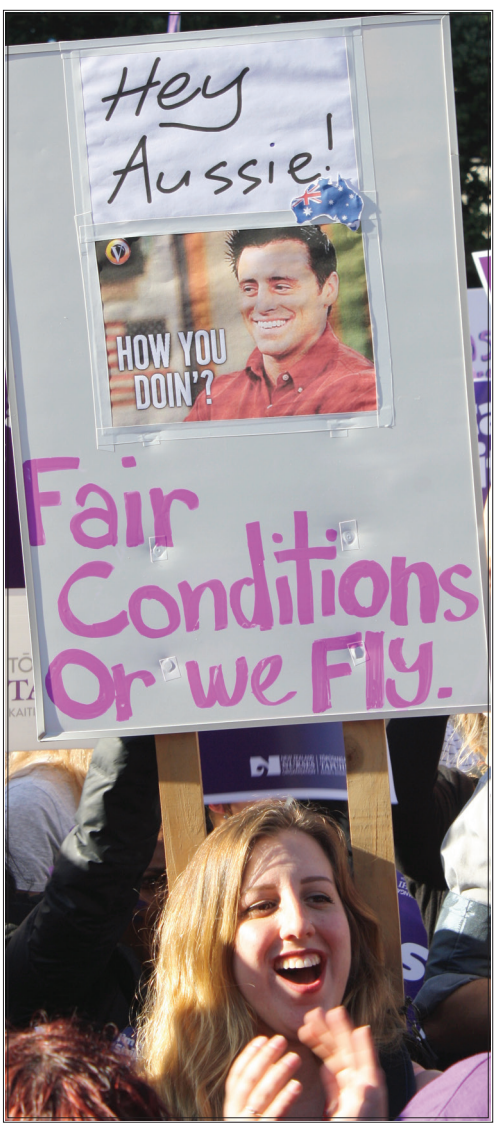
Leading off the march were NZNO kaiwhakahaere Kerri Nuku and acting president, and vice president, Tracey Morgan.

Little fronted on the steps of Parliament to a crowd of hundreds, who eventually drowned out his attempts to explain the Government's position.

But far away from politicians in Wellington, NZNO members and their supporters were gathering outside hospitals and clinics, and marching on the streets in the four corners of the whenua.

Enthusiasm and feelings were running high – but with the nation's health tied up in the negotiations, so were the stakes. •


Safe Staffing Now
UNTIL IT'S YOUR CHILD
WHO NEEDS CARE
Stand with us
HOSPI STANDS WITH US
Stand


Hey Aussie!
HOW YOU DOIN'?
Fair Conditions Or we Fly.


Safe Staffing Now
Stand with us
Fair Pay for Nursing
Safe Staffing Now
Stand with us
Stand with us
Stand with us


Fair Pay for Nursing
NEW ZEALAND NURSES ORGANISATION
TŌPŪTANGA TAPUHI

Why we need you to work, while colleagues strike

NZNO acting manager professional and nursing services Kate Weston and acting industrial services manager Glenda Alexander explain why staying behind to provide life-preserving services is crucial to the success of a strike.

Around the country, nurses walked off the job at 11am on Wednesday, June 9. Some were piped out by bagpipes, others chanted loudly, some were called to action by a haunting conch shell which made the spine tingle.

The tides of purple and the amazing public show of support for nurses, midwives and health-care assistants working in the district health board (DHB) sector were breath-taking.

Glenda Alexander

Kate Weston

The organisation by NZNO members, staff and supporters too was truly phenomenal.

However, none of this could have happened without hundreds of hours of intense preparation behind the scenes in the weeks leading up to the action – in particular, over the 14 days running up to the strike.

Nursing and midwifery services are considered essential, therefore provisions apply to our industry that do not apply to others, because a complete withdrawal of labour would place lives at risk. Those who work to provide the care on the days of the strike are as much a part of the action and are NOT strike breakers.

The actions of the few allow the many to express their anger and frustration and uphold the right to strike. They prevent legal action being taken against NZNO for failure to meet our side of the agreement.

Over the past few weeks, we have all heard a great deal about "LPS" – life-preserving services – as they relate to the current industrial situation and ongoing negotiations.

The provision of LPS during strike action is mandated in the Employment Relations Act (2000) code of good faith for the public health sector.[1] This defines LPS as:

- Crisis intervention for the preservation of life.
- Care required for therapeutic services without which life would be jeopardised.
- Care required for therapeutic services without which permanent disability would occur.

In 2021, we have applied lessons learned from the 2018 strike and recommendations of former Council of Trade Union president Ross Wilson, who reviewed how the contentious 2017/18 DHB negotiations were conducted.

His recommendations included putting much greater power in the hands of the members to see through this process.

The last week before the strike is key to its success – this is when the LPS numbers are agreed and then the rosters populated.

It was disappointing to note again that in some areas, staffing requests were made by DHBs that did not reflect how nurses work on any other day of the year – which is in situations that are unsafe and understaffed. These requests were taken through to adjudication.

For example, one DHB

argued for more RNs for its LPS than are normally rostered on a standard night shift – a situation NZNO has long-argued was unsafe.

Unsafe staffing is a key concern of members and a major reason for going down the path of industrial action. While some DHBs have had good success and considerably boosted their full-time-equivalent staff numbers, as many as 50 per cent had not fully implemented safe staffing programme care capacity demand management (CCDM) in the required time frame by June 31.

LPS provision on the strike day can cause distress, especially when an employer is putting pressure on staff to undertake prescribed tasks or to function as if it is a "normal" day or business as usual. It is not a normal day and the staff who work on the floor during the period of strike action do not have the capacity to provide normal care. Ensuring patient safety by decompressing, reducing volumes and providing supports for patient care is the role of the employer.

The employer must also abide by this and should not be pressuring staff to undertake particular "tasks". This is not only against the spirit of the code of good faith, but devalues the roles of nurse and midwives and can potentially put patients at greater risk.

NZNO delegate Debbie Handisides (second from right) and some of the LPS team at Canterbury DHB's Burwood Hospital last month.

Those who work to provide care on the days of the strike are as much a part of the action and are NOT strike breakers.

Nurses and midwives must apply their professional judgement to the situation and care provided will be specific to the patient context. Nurses and midwives remain accountable for their practice.

NZNO can **only** provide guidance and **cannot** provide an exhaustive list of what you should and should not do as a life-preserving services responder.

Workers must use their own critical thinking in every situation to decide whether an action is directly life-preserving or will prevent harm and permanent disability.

However, the DHBs also have to be supporting patients' safety – it's not the sole preserve of LPS staff to ensure patients are safe and cared for.

During strike action, the DHB has certain obligations under the code. It is the employer's role to ensure that the risk to patient safety is minimised during this time.

There is a need to decompress – reduce patient numbers as far as this is possible, ie working only with acute and time-critical needs.

It is also up to the employer to make alternative arrangements so that the usual duties and activities of nursing staff are supplemented/supported by other health professional and workers during the strike action.

Flimsy excuses that "doctors cannot triage" or others cannot access records systems or medication-dispensing systems such as Pyxis are systems issues which need to resolved – not used as an excuse to fail to comply with their part of the bargain. That is, to facilitate staff having a right to strike, while ensuring public safety. •

** See also 'Away from the picket line – those who stay behind', pp16-17*

Reference

1) Employment Relations Act 2000, Schedule 1B code of good faith for public health sector. https://legislation.govt.nz/act/public/2000/0024/46.0/DLM61726.html

This shared NZNO industrial-professional viewpoint replaces the usual industrial and professional focus sections this month.

Away from the picket line – those who stay behind

Working while all your colleagues go on strike isn't easy – but it's crucial. Nurses share their experiences of providing life-preserving services (LPS) during the June 9 strike.

By co-editor Mary Longmore.

When thousands of nurses walked out of hospitals at 11am on June 9 to march for better pay and conditions, hundreds stayed behind. Not because they were strike-breakers – in fact, without them, the strike could not have gone ahead. And in Canterbury, it nearly didn't.

It was only after a long Queen's Birthday weekend of frantic ringing around, that agreed life-preserving services (LPS) staffing levels were met and late legal action threatened by the Canterbury District Health Board (DHB) was called off – demonstrating how crucial LPS workers are.

Wairarapa registered nurse (RN) and delegate Tania Corlett-Galyer reluctantly did LPS as she couldn't find any volunteers so had to lead by example.

"I did not want to do it, I wanted to be out striking," said Corlett-Galyer, who also took on the role in 2018. "But without LPS there is always the risk that we cannot strike."

Colleagues did then step up to support her, so they had enough LPS to cover their 38-bed medical/surgical ward at Wairarapa Hospital.

Corlett-Galyer was able to escort staff out at 11am then spend a few hours on the picket lines, before her 3pm shift, but "struggled when I walked in, as my colleagues were still out there striking".

The shift turned out "pretty damn busy" with a full ward, including some very sick patients.

Unlike 2018, Corlett-Galyer said this time nurses were "pretty strict" about their tasks, only doing what they considered essential. "We only did obs and life-preserving medications," Corlett-Galyer said. This caused tension at times, such as when doctors asked them to provide pain relief.

Alan Thornton

Tania Corlett-Galyer

Annie McCabe

"I had to put my foot down and say 'no, you are not aware of what LPS we have agreed on . . . you do not get to tell my team what to do'."

That was the most difficult part of the evening, she said.

It wasn't easy for nurses to provide limited care to patients, knowing they were putting colleagues under pressure, but Corlett-Galyer felt it was important to stick to the LPS guidelines this time around.

"The last MECA was much different. It was a joke really and this time we were determined and stuck to what we were supposed to be doing," she said. "As nurses, we don't want to see harm come to our patients at all, but we had to get a bit firm this time around."

The support of their unionised nurse managers and leaders helped – they ensured all the patients got what they needed. At the end of their shift, there was an emotional debrief.

"We thanked them [nurse managers] and said we couldn't have gone on strike without their support."

Corlett-Galyer said nurses were more determined to be heard this time. "Last time, nothing really changed in terms of safety," she said. "It's not just nurses we are standing up for, it's our patients too. It's unsafe for us and it's unsafe for them."

Her ward was shedding four to five nurses every month, she said – to Australia, other nursing sectors or professions.

Wellington district nurse and delegate Annie McCabe also volunteered for LPS, after sensing a reluctance in her team.

"I thought, if the delegate, one of the most staunch, is willing to do it, it'd be a bit of a game-changer."

Colleagues have since promised they will take their turn. "Next time, I have the feeling there will be volunteers."

Covering for 11 nurses who would normally be on during the day, McCabe

received calls about insulin and blood sugar levels, compression bandages and a blocked catheter. Most were able to be resolved by phone, with friends or neighbours or family, or deferred until after the strike ended at 7pm.

"There was an unwillingness to break the strike. We didn't want to deal with things that were not causing harm or a threat to life."

Greymouth Hospital (Te Nīkau) critical care nurse Sonya Neill agreed to provide LPS cover on her day off and is also donating her wages to the strike fund.

"A couple of the young ones asked [me to cover] – they were keen to strike," said Neill, who at 60 says she's "been there, done that".

Christchurch enrolled nurse and delegate Debbie Handisides stepped up at the last minute to plug the LPS gaps. "I would have been out there picketing, but we had to get it over the line."

With community volunteers on hand – retired nurses and clerical staff – helping out, she said the day went smoothly. Workers got to share the meal provided to volunteers, patients got all their medication, she said. "I would do it again."

Southland RN and delegate Alan Thornton said "overwhelming anger" from members at the DHB's "insulting" revised offer made it hard to convince them to do LPS. "They wanted to shout from the Southland hills in protest! When I commented that this would allow others to do this for them, they reluctantly signed up," said Thornton, who also did LPS himself.

Auckland emergency nurse Mandy Chow said she and others on the LPS team were confused about what they could and couldn't do on the day. Initially, they only helped with the most urgent cases. But "it was hard to say no" to colleagues, doctors and patients, Chow said.

Eventually, Chow and her team decided to do whatever needed to be done on the day. Most patients didn't seem to be aware of the strike, or weren't interested – and because there were extra doctors on duty, were seen quickly. "So for the public it was great," but for the nurses it was frustrating that their stand appeared to have little effect, she said.

Chow hoped guidelines on what LPS workers should be doing would be clearer in any future strike action.

NZNO acting industrial services manager Glenda Alexander said NZNO was deliberately not prescriptive in telling LPS workers what tasks they should do, as that could put patients at risk.

NZNO guidelines, based on the Employment Relations Act (2000) code of good faith for the public health sector, broadly state LPS workers must provide care to preserve life and prevent permanent disability.[1]

NZNO acting manager, professional and nursing services, Kate Weston said on the day, nurses and midwives must use their critical thinking and professional judgement when caring for patients.

Being on strike did not mean nurses were no longer accountable to the Nursing Council for their practice. But DHBs, too, had an obligation to ensure patients could be cared for safely on the day by doing things such as reducing patient numbers where possible.

"It's not the sole preserve of LPS staff to provide all the care on the day." •

*See also 'Why we need you to work while colleagues strike', pp14-15

Southland Hospital LPS workers Alan Thornton, Pearl Silk and Boyd Frame

References

1) NZNO. (2021). *Guidance for Life Preserving Services During Strike Action*. www.nzno.org.nz/Portals/0/publications/Guidance%20-%20Life%20Preserving%20Services.pdf.

EQUITY: Abstract concepts have cold, hard consequences

In te reo Māori, co-editor Joel Maxwell welcomes readers to our Matariki edition, before focusing – in reo Pākehā – on the importance of equity in our work.

Nau mai, haere mai ki a Kai Tiaki Nursing New Zealand mō te marama o Hūrae.

Ko te take mātua o te marama nei: ko te rere mai anō o te kāhui whetū a Matariki.

He tau hou, he timatanga hou, he wā tika kia whakaaro mō ngā ahua o tōu tātou ao – mō āu tātou mahi, ngā wero, ngā ahuatanga katoa o te tau ki te heke mai.

He wā tika anō hoki, kia whakaaro mō ngā mahi, ngā wero – kua tutuki, kahore anō kua tutuki – o te tau kua pahure ake.

He wā whakaaro, otira, he wā maumahara ano, mō ngā tāngata kua wehe atu i te po, ki o rātou okiokinga, ki te taha o ōu tātou tupuna. He mihi nui ki a rātou – ngā tāngata kua huri tuara ki tēnei ao.

He mihi nui anō hoki ki a koutou, ki a tātou katoa, e noho tonu ana i tēnei ao kikokiko. I te ao hauora.

Tēnā koutou, tēnā tātou katoa.

E aro ana tātou i tēnei marama ki ngā ahuatanga, ngā tikanga o tēnei mea "equity", me ngā hononga o te kaupapa nei ki te Tiriti o Waitangi, arā, te tuapapa o tōu tātou whare.

I waitohutia Te Tiriti, e ōu tātou tupuna - engari, he pātai nui tēnei: Kua ū tonu te kāwanatanga i ngā ture, i ngā wahanga ke, Māori mai, Pākehā mai, me ngā take katoa o tēnei mea?

No reira, kia pai te tau hou! Kia pai tau tātou whakahirahiratanga o tēnei mea, a Matariki.

Ko te hiahia, he rangi, he marama, he tau pai, mō tātou katoa. •

Equity workshop challenging, cathartic

HAPPY NEW year to our hard-working health workers, and welcome to the latest edition of *Kai Tiaki Nursing New Zealand*.

This month we celebrate the arrival of a new year – Matariki – with an edition that includes a look at the kaupapa of equity and our foundational document, te Tiriti o Waitangi.

I was lucky enough to join a workshop run for NZNO staff covering the kaupapa.

It was a heck of an experience – confronting, challenging and, for myself at least, more than a little cathartic.

People at the workshop posed some tough questions, which were encouraged, never avoided, by facilitator Heather Came.

Personally, it focused my thinking about equity – something that had always seemed important, but was difficult to nail down.

This, I think, has always been problematic.

I know there are pressing demands on our minds and bodies every day – perhaps none more so than for nurses.

After all, health and lives are at stake.

Right now a nurse is taking a handover from the last shift; right now a nurse is getting meds out of Pyxis, prepping for an IV. They are checking vital signs, dealing with patients' bodily functions, talking to doctors on their rounds, vaccinating, organising orderlies and notes, taking phone calls, helping confused patients, helping confused families, helping confused nurses.

They can, on a good shift, even snatch a meal break.

Given the sheer weight of this workload, I also know concepts like equity and the place of te Tiriti seem distant from our everyday lives. When you're staring down the barrel of another 12-hour shift, why would you want to think about abstract concepts like equity?

But the reality is that Māori people end up needing health services at significantly higher rates than the rest of New Zealand; and when they do, they don't fare as well.

Abstract concepts always end up knocking on our door with cold, hard consequences.

I think it's worth taking a look at this equity thing. After all, as one of our contributors to this section Heather Came points out, it appears that when it comes to equity – health and lives are at stake after all.

Happy new year, everybody. •

PHOTO: ADOBE STOCK

PHOTO: ADOBE STOCK

‘Karanga of change’ calls all of us – no matter our role in health world

NZNO policy advisor Māori, Leanne Manson (Ngāti Tama Ki Te Tau Ihu, Te Ātiawa) explores the kaupapa of equity, and what it means in the health sector.

In the words of the song by legendary king of soul Sam Cooke: *“It’s been a long, long time coming but I know a change gonna come, oh, yes it will”*. This new driver of change is equity and it really does matter. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes.

Embedding it in practice

As health advocates, we should not be apologetic for expecting and wanting more for our people and communities. We need to clearly understand what equity means and we must commit to embedding it in our everyday practice. This includes asking questions about our practice such as: How do we do that? We want to look at how we work – so are we doing the right thing? Do we use a fair and social justice approach?

If not, we need a whole-of-system change. To do that, we need the right skills – many of these need to be learned.

The karanga of change is calling to each and every one of us, no matter what your role is or where you are located. The pace of this change means that we cannot afford to be inactive or complacent in our workplaces. It is clear that we will need everyone to be on this waka – he waka eke noa!

This karanga challenges us to do better to achieve equity. Dinosaurs like racism (Ray) and colonisation (Colin) will no longer be tolerated. Many who have had to deal with Ray and Colin in their life will welcome allies and positive changes in their lives, while others will have to look inside and question their entrenched behaviours and practices. This self-reflective practice is personally challenging and will now become a requirement for being a health professional.

For some this wero, or challenge, will simply be business as usual, but for others “equity” will be a new and foreign term. For some, this simply means addressing and incorporating equity and active protection into their everyday mahi; for others this will mean challenging long-held views or behaviours that are no longer acceptable in any workplaces in this new world.

Leading the call to make effective change for Māori health is the Minister of Health, Andrew Little, who wants to get it right, and there is no second option in the Government’s massive shake-up of the health system. Underlying these foundational changes is the minister’s commitment to upholding the articles of te Tiriti o Waitangi, which includes tino rangatiratanga, active protection, partnership, options and equity.

Active protection

As indicated in the Waitangi Tribunal 2575 Hauora stage one report, everyone must demonstrate active protection in their everyday health mahi. No longer will the Crown-created te Tiriti o Waitangi principles, commonly referred to as the 3Ps (partnership, protection and participation) be tolerated. Expectations for Crown employees to demonstrate the Crown’s commitment to te Tiriti o Waitangi articles will be a requirement.

Fortunately for health professionals, the Ministry of Health has defined equity for the health sector, highlighting that equity has a shared and measurable accountability to its delivery. The solutions start by us all raising our united voices. As patient advocates ensuring equity in health care means we have to walk the talk and find solutions for our patients and their whānau. Nurses and other health professionals will need to lead and play a big role as disruptors and advocates for change. This is especially important for those who have a commitment to collective action and social justice.

As health advocates, we should not be apologetic for expecting and wanting more for our people and communities.

Sometimes understanding what equity is and how it can be used in our nursing practice can be difficult to translate.

However, we know that with the right heart, and courage, we can advocate, assess, apply and embed equity into our practice. Training in equity sometimes starts with a questioning mind and a curiosity to demand more for our patients and their whānau.

Can't afford to pay

Active protection may mean removing barriers to care, like questioning whether a patient or their family can pay for the prescribed inhalers when we know the person with asthma cannot afford the prescription. Health services may have to redefine what service provision looks like. For example, equity service delivery could involve providing a wraparound service that addresses income poverty by supplying free inhalers, planned education sessions on inhaler technique, proactive referrals for priority warm housing, free curtains or bedding, letters of support for additional specialist appointments or additional benefits and planned monthly free 30-minute appointments.

Opening one's head, heart and arms to equity can be an amazing journey and an opportunity to be part of the change process.

Opening one's head, heart and arms to equity can be an amazing journey and an opportunity to be part of the change process. We can all make a difference together, in the spirit of kotahitanga and solidarity. Now is the time to be courageous, to be active disruptors for change in the health sector. Incorporating te Tiriti o Waitangi articles as part of our nursing patient assessment is something that every workplace should be preparing staff to do, with equity training. New solutions are needed – these need to include patient and whānau perspective and reviewing health professionals' cultural safety.

Equity must become the new pango – the new black – for all who work in the health sector. •

PHOTO: ADOBE STOCK

NZNO launches project to create 'staunch equity advocates'

NZNO's board has made a commitment to ensure staff and members are part of the equity journey.

By Leanne Manson

NZNO is the first to admit that it can no longer rest on its laurels. It must walk the talk, and make equity a reality for its staff and members. NZNO cannot play catch up – it needs to lead from the front.

NZNO's board of directors is committed to equity and has supported the development of an equity framework. NZNO has also commenced an equity implementation project and is currently delivering stage one – socialising the equity framework with NZNO staff. The goal is that staff should understand what equity is. They should be able to assess, advocate, apply and embed equity into the work that is being undertaken across professional, industrial and corporate services. This is a courageous step the board and organisation has taken, with a mission to extend this to members.

This will be a challenging task but the benefits are far-reaching for the wider whānau, hapū, community and iwi. Principles of collective action, and solidarity, or kotahitanga, will help inform NZNO on this equity journey.

Sphere of influence

NZNO has been fortunate to engage and work with Professor Heather Came-Friar on equity training for staff. Came-Friar talks about being a driver for change and that requires us to have the tools to aid us in our work, and to act within our sphere of influence. We need a plan – equity is the way forward. How we use it in our practice is the key.

Each of us can contribute to achieving equity by doing the things we do better, by being open to look at new ways of doing things, and by challenging our own preconceptions about how things should work. The aspiration for all NZNO members and staff is to become staunch equity advocates. •

Critical te Tiriti Analysis: A tool to strengthen te Tiriti o Waitangi compliance

A new tool to analyse documents' compliance with te Tiriti cuts through the rhetoric and gets to the nitty-gritty.

By Heather Came

PHOTO: ADOBE STOCK

The stage one WAI 2575 health report[1] gave the health sector a collective D grade for our performance in Māori health and our te Tiriti o Waitangi compliance. For me, this was uncomfortable, disappointing and a deathly accurate description of what we have (and have not) been achieving.

Although we are in the middle of a global epidemic and collective employment negotiations, this issue deserves our attention. It is, after all, a matter of life and death.

Health researcher Tim McCreanor and I were privileged to provide expert witness at the stage one Waitangi Tribunal hearings for the Māori nurses and other claimants in 2019. As part of that process Tim, political scientist Dominic O'Sullivan (Te Rarawa, Ngāti Kahu) and I developed a new method of policy analysis we call Critical te Tiriti Analysis (CTA)[2] that reviews te Tiriti compliance. It has generated a great deal of interest and we have been running sold-out training sessions. CTAs have been undertaken on a range of Crown policy documents and raw research data; others have used it to review curricula. Pleasingly, CTA is now also being used to inform policy development.

The CTA process is a desktop review of policy, based solely on what is written in the document. It does not capture the good intentions or expertise of the policy writers and advisors. It is a five-stage process. First stage involves a high-level review of how the policy talks about te Tiriti o Waitangi (the Māori text) and te ao Māori. The second stage involves a close reading of what the policy says about the five elements of te Tiriti: Preamble, the three written articles and the fourth oral article. Stage three is a determination against a set of indicators that attempts to capture how the five elements are each represented in the policy. The range of scores is on a continuum from silent to poor, fair, good and excellent. Stage four focuses on how things could be strengthened and stage five is the Māori final word, or overall assessment – this final stage is an expression of tino rangatiratanga for the Māori analysts involved.

Heather Came

The nursing competencies were among the best we reviewed . . . but further work is needed to be explicitly and robustly te Tiriti compliant across the other articles.

The CTA's point of difference is that it cuts through the usual high-level rhetoric about te Tiriti that appears in policy and, instead, gets down to the nitty-gritty. It exposes the implicit and explicit detail of the policy against the backdrop of te Tiriti o Waitangi, and also highlights what is missing. There is nowhere to hide. Different groups will find different things from the same policy based on their expertise, experience and unique insights. These potentially diverse assessments provide rich reflective material on how to strengthen policy.

We recently reviewed the regulated health professional competency documents.[3] The nursing competencies were among the best we reviewed. The competencies scored excellent on the preamble, but further work is needed to be explicitly and robustly te Tiriti compliant across the other articles. Conveniently, in our *New Zealand Medical Journal* paper,[3] we provide some concrete suggestions of knowledge and skills tauiwi health practitioners might need to be more te Tiriti compliant. I look forward to seeing the next iteration of your competencies as we continue to lift our practice in this critical area. •

Heather Came, PhD, is a senior lecturer in Māori health and head of the department of public health at the Auckland University of Technology.

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'There is no ultimate resolution to the tension between those running a complex, expensive organisation and the clinicians caring for human beings. With a bit of skill, one can reduce it.'

PHOTO: ADOBE STOCK

The roots of today's public health system

Economist Brian Easton analyses the Government's proposed health reforms, firstly from an historical perspective. In the second article in this series, in next month's issue, he looks ahead to where the reforms might take us.

By Brian Easton

In April, the Government announced the next health sector "redisorganisation". To provide an account of what is happening and where we might be going, I will first look at the history of New Zealand's public health system, and then focus on where we might be going.

Inherent tensions

I begin with an anecdote. About 30 years ago, the Government got into its head that if our hospitals were to be run like businesses, there would be a major productivity boost. They promised 20 per cent gains, although these never happened. Part of the redisorganisation – I'll explain why I use that word shortly – was to appoint businessmen and women to run what were then called crown health enterprises (notice the weasel word "enterprise") which evolved into what today we call district health boards.

The business-sourced chief executives knew little about health care. I was told of instances in which senior clinicians visited a CEO who showed much discomfort at their presence. One had 12 second-level managers reporting to him, only one of whom was a clinician.

Even so, chief executives sometimes had to front up to audiences of hospital clinicians. On one occasion, the CEO was saying how his task was to have everyone behind the organisation, metaphorically – perhaps actually – thumping one fist into the other hand. It was the sort of thing you might say to the staff if you were running a commercial company. Someone from the audience asked what exactly was the objective of the organisation. "It was," he said – thumping fist in hand – "the bottom line", but as he said it, his voice trailed off.

For even this businessman could see that the clinicians did not give a fig for the organisation's financial position. Fortunately it did not happen, but had someone in the room had a heart attack, we would have seen what the clinicians really cared about. Their priority would have been the patient's health and survival; bugger the bottom line, or what it cost the system. Nor would they expect to be paid for an out-of-hours emergency; their professionalism meant "just do it".

The central tension of running a health system is clear. On the one hand there is the complex, expensive organisation represented by the chief executive; on the other there is the clinician or clinical team attending to the intimate needs of a human being.

There is no ultimate resolution to this tension. With a bit of skill one can reduce it. Reconciliation of the tensions can never be perfect; there will always have to be compromises. That is why we call proposals to change the system a "redisorganisation" – the organisation structure churns in the belief that this time they will get it right and there will be improvements in health delivery without significant increases in funding. But the change managers never recognise the inherent tension; redisorganisations usually fail.

That is what happened, disastrously, in the early 1990s. It was a classic example of the Mencken dictum: for every complex human problem, there is a solution that is neat, plausible and wrong.

The current redisorganisation has parallels with the 1990s redisorganisation. Fortunately, it is not being run by people as ignorant of the health system. Thirty years ago, they did not even want to learn. By coincidence, the eminent British economist Alan Maynard – who warned against the notion of redisorganisation – was visiting the country at the time, but he, and other experts who were over here, were not consulted.

I begin by reviewing the sweep of history, to give a background to the current proposals. What was happening 150 years ago may seem arcane to today's

clinicians, but we can learn a lot from the past.

The medical professions were barely scientific in the 19th century. Surgeons had operated for millennia (so had barbers), but the practice of bloodletting was only abandoned in the late 19th century. The problem of infection was first identified in the middle of the 19th century, when pain control (anaesthetics) also began to be addressed. The first miracle drug, aspirin, was introduced in 1899. X-rays were only discovered in 1895.

Nineteenth-century doctors were not useless, but the sophisticated medical professionals with a solid scientific training in the health system today are qualitatively differ from their predecessors.

Settler hospitals were established early in the settlements. They were very different establishments from today's, as the affluent sick were treated in their homes. Hospitals were for the indigent with inadequate accommodation. A not uncommon reason for admission was mental incapacity; unsurprisingly, asylums occur significantly in the history of the hospital sector.

Nursing historian Pamela Wood reports: *" . . . in the early years a significant proportion of cases [in hospitals] were from accidents; people with infectious diseases were not admitted and some doctors considered that the incurable, the old or the chronically ill should not be kept in hospitals. . . . Surgical patients in particular came to be seen as representing a specific danger to others through their suppurating wounds and as sick bodies vulnerable to the dirt of the buildings surrounding them."*[1]

Medicine did not advance quickly in New Zealand. Joseph Lister wrote his seminal paper on antiseptic surgery in 1867. Two decades later, surgery at the Dunedin Hospital, one of the country's most advanced, was described as being *"in the transition state between the days of septic surgery and the development of antiseptic surgery".*[1] Contrast how quickly today's medics have adopted lessons from the COVID-19 pandemic.

Health care was not a national responsibility. Hospitals were local, funded from local authority rates and private donations (with doctors providing free services – subsidised from their private practices; Phil Bagshaw's Canterbury Charity Hospital Trust is an echo of that past). However, in 1861 Governor Grey announced that the central government would pay hospital costs for Māori and approved indigents. Four hospitals were established – in Auckland, New Plymouth, Whanganui and Wellington. The Wellington one was known as the "Native Hospital". It did not succeed because Māori cultural practices meant a place of death was tapu. Perhaps there is a lesson here.

Inevitably, central funding led to central regulation, and in 1880 the Government appointed its first inspector of hospitals.

However, initially, the main central government concern was population-based health issues, especially water and waste-water, the control of quality of food and drugs (milk could be a carrier of typhoid fever) and dealing with infectious diseases.

It was the threat of a major outbreak of the plague coming from China via Australia which led to the passing in 1900 of the Public Health Act. A separate Department of Health was established later in 1912. In that year, central government's annual spending on health, per person, cost around three-quarters of a labourer's daily wage. Local body rates contributed the equivalent of two days.

Following the pandemic of November 1918, which killed more than 8550 New Zealanders – the Māori death rate was seven times the non-Māori rate, and death rates were even higher in Samoa – there was an increase in staffing and a new Public Health Act in 1920.

So governments slowly got involved in the provision of personal health care, but by no means generously. During the row over the influenza pandemic, the Minister of Health pointed out that more money was being spent on the health of animals than on that of humans.

Medicine was changing from a craft to one driven more by applied science. It did not happen overnight, and it has not stopped as new knowledge and new techniques continue to transform the health-providing professions. A more recent development has been increasing specialisation, which means that health professionals often have to work in teams.

After the Great War, hospitals became

Brian Easton

'That is what happened, disastrously, in the early 1990s. It was a classic example of the Mencken dictum: for every complex human problem, there is a solution that is neat, plausible and wrong.'

The start of the public hospital system: New Plymouth Hospital, one of four hospitals paid for by central government under Governor George Grey in the 1840s. (Image courtesy of Puke Ariki, New Plymouth.)

widely used by patients of all classes, as their quality and safety improved and as they provided an increasing range of effective treatments.

Personal health care became increasingly important. With a wider range of treatments, and more expensive ones, ability to pay became an issue – a trend exacerbated by the poverty of the Great Depression. By the 1930s, the pressures were for improving personal access to the health-care system. Inevitably, New Zealanders turned to their government.

Under the first Labour Government, state funding of health care was steadily introduced. Whereas the public's central purse was spending 0.6 per cent of gross domestic product (GDP) on its health budget in 1935, by 1944 it was 2.0 per cent. Today it is about 7 per cent. (Including private spending, the total health spend is about 9 per cent of GDP.)

Perhaps the greatest failing of the Labour scheme was the assumption that the total amount of required medical care would be limited – a limit that was not great compared to the state's capacity to pay.

But the rate of technical change was underestimated. Many innovations improve health but are extremely expensive. Add the increasing requirements of patient care and an ageing population, and the potential cost of health care becomes near unlimited – certainly well beyond the budget of the average patient or Treasury funding for all patients. The expense has been compounded by the shift from saving lives – that is, prolonging them – to improving quality of life.

Perhaps the greatest failing of the Labour scheme was the assumption that the total amount of required medical care would be limited – a limit that was not great compared to the state's capacity to pay.

This general historical overview allows us to trace the organisational structure of the health system. In the 19th century, hospitals were small, local, isolated and not very technically advanced. Medicine was primitive but not wholly ineffective. Many ordinary people today are more knowledgeable and able to apply more effective treatments than a doctor of 150 years ago.

How things have changed! Today hospitals are huge and expensive, involving technologies that no single person can master. Medicine is much the same. Typically, our hospitals are no longer isolated, and not just multi-campus, but able to connect, for patient care, with hospitals at the end of the country and, for knowledge, anywhere in the world. We have long moved away from local public and private charitable funding. The local authority rate contribution was abolished in 1952 and charitable contributions are not great; virtually all the funding of the public health system comes from central government.

However fossils from the past remain. For instance, have we the right configuration of hospitals? Do they coordinate enough? And why the localised governance structure, especially elections to the board – what are they for?

The 1990s redisorganisation by the National Government abolished local electees to the governing board by overnight legislation, ostensibly because the consumers (patients) have no role in running a business, but also because non-government appointees would have resisted the changes being imposed from the top. The Clark-Cullen Labour Government reinstated local electees to be about half the members of the governing board. The Key-English Government left them there, but now the Ardern-Robertson Government, successor to Clark-Cullen, proposes to abolish them again.

I have focused on secondary care, but we should not forget primary care, including general practice and pharmacies. Historically, this has been much more embedded in the private sector and has never really integrated with secondary care – despite efforts to do so going back for at least half a century.

Another critical dimension is population-based health services – sometimes confusingly called "public health care". Although initially a central government responsibility, they began to be integrated into health boards about a quarter of a century ago.

We should also not forget care of the elderly, in rest homes or supported by outpatient services. There is a disability sector as well, not to mention the voluntary sector, which is both a service provider and advocate. Add in PHARMAC and a few others and you can understand why the system is a disorganisation.

Lessons from Canterbury fracas

All this reminds us that the health sector is inevitably disorganised. The kerfuffle which recently occurred at the Canterbury DHB illustrates some of the difficulties.

The essence of the problem was a conflict over funding – and over control. It resulted in the destruction of the DHB's widely admired senior leadership team which had been a champion of its region's communities and clinicians.

There is a problem over any account because the centre's case – the perspective of the government with its centralised state health agencies in Wellington – is hardly available and we have to rely on those who are critical of the centre. I mention this not only because scholarship requires drawing attention to imbalanced sources, but because if the proposed changes weaken local involvement, we would have an even less informed idea of what was happening during a future occasion.

As far as can be judged, the dispute – an example of that tension between the centre and the clinical I began with – arose from the Canterbury DHB overspending relative to its revenue. This is a regular feature of the DHBs, and their predecessor crown health enterprises, and evidence that the system of financial controls is not working properly. It arises because the clinical imperatives of treating patients in need override the financial imperatives of staying within budget.

The Canterbury DHB deficit, however, was unusually large. It arises, so the locals tells us, because of inadequacies in the DHB funding formulae. (I expect the new structure will enable a revision of the current population-based formula.)

However it appears the Canterbury DHB suffered badly because of the Canterbury earthquakes of a decade ago, which destroyed a lot of its capital works. The population-based funding formula assumes that all DHBs' capital structures are equally well off – or badly off. Clearly, in the case of the earthquake-shattered Canterbury DHB, that has not been correct.

It is also argued that the mosque massacres imposed heavily on the DHB. I've not seen precise numbers and there was some sharing with other DHBs. Even so, it raises the issue of whether the population-based funding formulae should have included a reserve for exceptional circumstances, in addition to the earlier point that it needs to make greater allowance for differences in capital structures.

The complexity of the situation is well illustrated by the Canterbury DHB's new acute services block, which opened two years late and over budget. Apparently the Wellington centre is responsible for the building phase and therefore – in principle – for the substantial additional costs (which include the overruns, capital charges and depreciation). However, the additional costs are not charged to the centre but to the Canterbury DHB, which has already been paying for more costly service provision when the building was not commissioned. That, anyway, is the local critics' assessment; I have seen no alternative account from Wellington.

The Canterbury DHB senior leadership team said they had a plan to pull back the deficit. However, central government appointed powerful advocates above them to implement the Wellington agenda, overriding the the previous board and its executive team. Whether this was justified or not depends on your perspective, but it reminds us of the power of the centre to control constructive developments in localities.

Benefits of local autonomy

At a more general level, local autonomy allows for innovation and experiment, which has improved some of the disjunctions in the health system. You may be disappointed that there is still not enough integration between primary and secondary care, but there has been a lot of progress over the last few decades. We may ask, however, to what extent the innovative successes of one locality have been quickly transmitted elsewhere. In treatment practices, the answer may generally be "yes", but one is less sure in organisational practices.

Main points

- First, there is an inherent tension between the centre which funds health care – together with the complex organisations it leads to implement its plans – and what goes on at the clinical and local level of professionals dealing with patients. The tension is unavoidable.
- Second, the complexity of the sprawling health system is substantial. Plans to redisorganise it need to be humble and aim for incremental improvements, rather than being ambitiously neat, plausible and wrong.
- Third, one of the sources of the sprawl in the health system arises from its historical development from a 19th century system in which hospitals were small, local, isolated, and not very technically advanced, in which primary care developed separately from secondary care, and in which medicine was primitive but not wholly ineffective. Despite the spectacular changes in the following 150 years, there are still fossilised remnants of the old ways.
- Fourth, the centre has made errors, but generally does not acknowledge them. It is easy to blame the districts for everything. Ignoring this will inevitably result in failures in a redisorganisation.

We should not be surprised there are pressures to centralise the system further, even at the cost of the loss of local, and even clinical, autonomy and less innovation. That is what I will discuss in my next article. •

** This article – the first in a series of two – is an edited version of a speech given by the author at the conference of theatre managers and educators in Dunedin in May. It is used with permission.*

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Nursing 'crisis' in aged care

Many of us fortunate enough to live to a ripe old age will likely end up in a rest home or aged residential care (ARC) facility and would like to enjoy a high standard of care. So why are ARC nurses fleeing?

By co-editor Mary Longmore

Underpaid, overworked and unappreciated – that is the feeling of nurses and caregivers in aged residential care (ARC), says chair of NZNO's College of Gerontology Nurses Natalie Seymour. And they are leaving "in droves", she says.

While pay rates for their district health board (DHB) colleagues rise steadily over successive collective agreements and high-profile strike action, "our nurses are feeling devalued, underappreciated and not listened to", Seymour said.

"We are losing nurses in droves – nurses are not staying in aged residential care."

Add to this roiling dissatisfaction a sudden drying up of an immigrant workforce that makes up about 50 per cent (and up to 70 per cent in some cases) of staff, according to the NZ Aged Care Association (NZACA) – and you have an explosive staffing shortage on your hands.

"We are at crisis point," says NZACA nursing leadership group member Rhonda Sherriff. "With the borders closed, as we rely so heavily on our immigrant staff, this is causing quite a crisis in our sector – it's very urgent."

Natalie Seymour

Rhonda Sherriff

'We are losing nurses in droves – nurses are not staying in aged residential care.'

Philippines' cap

The Philippines has put an annual cap of 6500 on the number of nurses who can work abroad. India's health workforce is trying to manage its own catastrophic COVID-19 outbreaks, while Fiji is shutting down its borders.

"At this stage, it's looking very much like we're struggling to tap into any overseas streams of RNs coming into our country," Sherriff says – a situation she says is unlikely to change in a hurry.

At last count there were an estimated 300 to 500 registered nurse (RN) vacancies in ARC facilities around the country out of a workforce of 5000, says ACA chief executive Simon Wallace.

"The situation is not sustainable. Care homes will close," he said, predicting small rural homes would be hardest hit.

Aged care is also competing with DHBs, which are on a recruitment drive to fill 500 RN vacancies and meet safe staffing levels agreed with NZNO in 2018 – being hammered out again in the current bargaining round.

The Ministry of Health (MoH), too, is seeking nurses for its COVID-19 vaccination rollout.

Pay gap

With DHB RNs and enrolled nurses being paid on average $10,000 more per annum –including penal rates and shift allowances – than their ARC counterparts, it's "really difficult" to recruit and retain nurses in aged care, says Sherriff. The situation was quickly becoming "desperate", she said.

"We can't compete for RNs on the same level playing field."

Large corporates were able to subsidise their rest homes from profitable retirement villages and pay better rates to nurses – but this was not possible for smaller operators, she said.

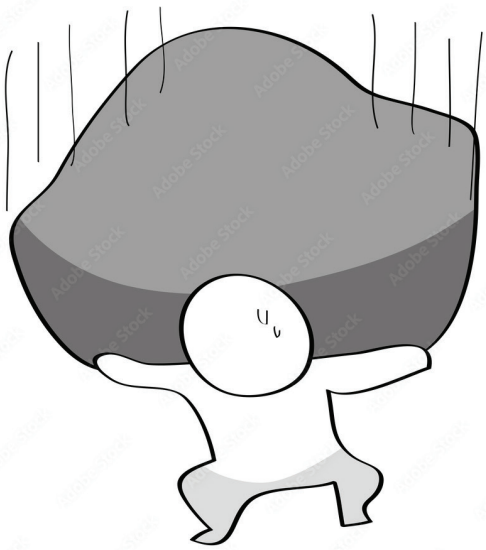
Government funding for aged care is filtered through the DHBs, which have been allocated $16.2 billion to provide services for 2021/22, according to NZACA figures.

A MoH-NZACA taskforce in 2020 estimated $85 million was needed to bring ARC nurse pay rates into line with DHBs. Negotiations were continuing, but offers so far had fallen well short, Sherriff said.

"The tragedy is the Government doesn't really acknowledge the worth of the sector. We're looking after 40,000 residents throughout the country, compared to 11,000 hospital beds. We are a

significant sector alongside them [hospitals], and in many ways act as a moat," Sherriff says. "When patients need 24/7 care, we are where these people get discharged to."

Aged care provided a "fantastic"



service yet was funded just $200 per patient per day, compared to $1000 per patient in hospitals, she said.

"We're delivering a good standard of care for a fifth of the price and the sector has been dreadfully underfunded for years."

Neither Sherriff nor Seymour can see any reasoning for the pay disparity. "It makes no sense," says Seymour.

An ARC nurse often had more responsibility than a DHB nurse, and they were frequently in sole charge.

"They are making really significant autonomous decisions every day", Sherriff said.

The NZACA set up its nursing leadership group two years ago to raise awareness of the staffing pressures and lobby Government.

Since then, there had been much sympathy but very little cash, Sherriff said.

'The tragedy is the Government doesn't really acknowledge the worth of the sector.'

Simon Wallace

"At the end of the day, if they don't fund us, there won't be beds available for people and that would be tragic," said Sherriff, noting a huge projected leap in the aged population over the next 20 years.

"We're highlighting it really clearly with the Health Minister . . . but it just seems to be falling on somewhat deaf ears, which I find rather tragic as our aged people deserve as good care as anyone else in this country." •

NZ hysteroscopy training on the way

NZNO WOMEN'S Health College (WHC) is working with a New Zealand polytechnic to bring hysteroscopy training for nurses to New Zealand.

Christchurch colposcopy nurse practitioner (NP) Jill Lamb said until now hysteroscopy – examination of the uterus – had largely been the domain of gynaecologists in New Zealand. But in the United Kingdom (UK), nurses had been doing hysteroscopies for about 20 years and could do so here also.

The WHC was consulting with the Nursing Council and working closely with a polytechnic on developing a new training programme here at a date to be decided.

Endometrial cancer (affecting the uterus lining) was one of the fastest growing cancers in New Zealand, she said. But if detected early, about 80 per cent of cases could be treated effectively.

Training nurses to provide this care would make it more available and equitable and save lives, she said.

Endometrial cancer rates were disproportionately high in Māori and Pacific populations. Wāhine Māori over 25 had cancer mortality rates almost twice that of non-Māori women,[1] Lamb said.

Making hysteroscopies more available would allow more equitable health outcomes, she said. She hoped to eventually see hysteroscopy nurse-led services available throughout Aotearoa.

The college had drafted hysteroscopy standards based on those of the Royal College of Obstetricians and Gynaecologists and the British Society for Gynaecological Endoscopy.

It was also working with te poari to ensure the programme was culturally appropriate and would promote equitable outcomes, Lamb said. •

By co-editor Mary Longmore

Jill Lamb

Reference
1) Ministry of Health. (2019). Wai 2575 Maori health Trends Report (p75). www.health.govt.nz/system/files/documents/publications/wai-2575-maori-health-trends-report-04mar2020.pdf.

NZNO bargaining continues across sectors

DHB MECA negotiations might have snapped up the limelight, but important work continued in other health sectors in June.

DHB members in Wellington on the steps of Parliament during their first strike.

Despite high-profile action happening on the district healthh board (DHB) multi-employer collective agreement (MECA) front, other NZNO negotiations were taking place around Aotearoa over the past month.

NZNO and HCNZ/NZCare requested mediation services with the Ministry of Business, Innovation and Employment, to advance collective bargaining.

The mediation, for a MECA that had been expired for eight months, was confirmed to run on August 3, in Christchurch.

There had been strong support from members after they voted to reject the proposed MECA.

The main themes were passed through to the employers with the aim of progressing a proposed MECA that met members' demands.

These included: a pay increase that was too low; disparity with DHB MECA wages; a lump sum/back pay that was too low; and unsatisfactory proposals for sick leave, which was too low and would not have immediate implementation.

Two-hospice group approach

Meanwhile in the private hospital and hospice sector, negotiations were continuing on a hospice MECA.

An in-writing employer advocate agreement was awaited – to go ahead along a "two-hospice" group MECA path.

The two separate groups were "4 Group" (consisting of Mary Potter Hospice, Hospice Waikato, Waipuna Hospice and Harbour Hospice) and in the other group the remaining 14 hospices not listed in "4 Group".

Mediation on the MECA covering the 18 hospices was previously set to run on June 1. It came after a second hospice advocate, representing four of the 18 hospices, joined negotiations.

In April, members rejected an offer made by the hospices. Negotiations have been running since the last MECA expired in August 2020.

Members were keen to see a new step 6 for registered nurses implemented earlier than offered by the hospices. There were also concerns from senior nurses about the scope and nature of their roles.

New month, new MECA

There was no rest in the primary health sector as July would see the need to initiate bargaining for the 2021 MECA.

The last one was two years old – but had only been in place for five months.

As planning started, there were calls to make sure that members working for new employers were contacted to make sure they were included in the bargaining.

Workplaces that were on the existing MECA, but had been sold, were considered a new legal entity, and would no longer be covered by the MECA.

Blood services wait for DHBs

After member feedback, it was agreed with the NZ Blood Service to postpone the next round of bargaining.

New dates would be set once the results of the DHB MECA bargaining became clearer.

Meanwhile collective agreement negotiations for prison health services were also postponed – but for a different reason – after COVID-19 restrictions were put in place in June.

Plunket negotiations were set for a potential decision on July 6, with an online proposed collective agreement ratification ballot closing that afternoon. The vote followed a raft of 13 Zoom meetings for members.

DHB planning underway

Planning has started for further potential strike action around Aotearoa by DHB members in ongoing MECA negotiations.

There had been two days of mediation at the end of June, and a further two days were booked for July 14 and 15.

It was expected that at the mid-July mediation there would be an offer put to the bargaining team.

The NZNO bargaining team was talking with the DHB about options to resolve the pay and staffing claims.

Strikes would potentially run in July, August and September. •

Before driving, check . . .

Feeling drowsy/sleepy? **Blurred vision?** **Feeling weak?**
Slowed reactions? **Headache?** **Feeling sick?**
Unable to pay attention? **Unable to focus eyes?** **Dizziness?**
Getting easily confused? **Trouble forming sentences?** **Slurred speech?**
Feeling wired or overconfident? – although you might not notice this yourself

Yes to any of these – switch to PLAN B

Driving under the influence of prescribed medication

Many prescribed drugs can impair a person's driving, even when they are being taken correctly.

By Georgina Casey and Craig Waterworth

In 2019, there were 352 deaths on New Zealand roads, and 14,742 injury crashes. Forty-six percent of deaths and 15 percent of injury crashes had alcohol or drugs as a contributing factor.[1]

Most people think of alcohol and illicit/recreational drugs as the primary contributors to substance-impaired driving. But every year in Aotearoa/New Zealand, nine million new prescriptions are written for medications that might impair driving.[2]

The role of medicines in serious crashes is under-recognised: two out of every three drivers use potentially impairing medications and one in every four prescriptions is for a medication that can cause impairment.[2,3]

No warning given

Waka Kotahi New Zealand Transport Agency found at least one in 13 people killed on New Zealand roads had medications in their system with the potential to impair driving. The real figure is likely to be much higher, as they only investigated a small number of medicines. Additionally, more than half of people prescribed these medications could not recall being warned about driving, and about one half of drivers are not aware it is illegal to drive while impaired by medications *being used as prescribed*.[2,3]

Impaired driving occurs when your body or emotions have been affected (usually temporarily) in a way that makes it unsafe for you to drive. Medication-related substance-impaired driving (MR SID) involves substances, including prescription, pharmacy-only, over-the-counter and traditional remedies. Substances, whether illegal or legal, can impair the visual, cognitive and motor functions needed for safe driving. MR SID may cause slowed reaction times, fatigue, visual disturbances (such as reduced depth perception or peripheral vision), reduced vigilance, or an increase in risk-taking behaviours.

The presence of a medication does not necessarily mean the person was impaired for driving. The forthcoming drug driving bill is likely to introduce roadside testing for substances, including some medications. If a person tests positive for the presence of a medication at a checkpoint but is not showing signs of impairment, they have a medical defence under Section 8 of the Land Transport Act.[4]

However, if a person is warned by a health-care professional of the risk of MR SID for a medication, or there is a warning label on the medication, that person may not be covered by their insurance while driving or if in a crash while driving impaired. Health professionals should routinely have conversations with patients/clients about the risks of medication and impairment, and document them.[5]

Nurses and other health professionals need to understand the risks associated with prescribed (and other) medications so they can raise awareness of MR SID and advise people about safe transport choices ("Plan B") where this risk occurs.

Self-identification of impairment, and listening to others who express concern, are key to reducing rates of MR SID. People should be advised to check for symptoms before any driving episode (see box, above) and avoid alcohol if planning to drive while taking medications that may impair driving.

For more information about MR SID, complete the free learning activity at CPD4nurses.co.nz, sponsored by Waka Kotahi. This initiative forms part of the work Waka Kotahi is doing for "Road to Zero", the Government's 10-year strategy[6] to reduce road deaths and serious injuries by at least 40 per cent. •

Georgina Casey, RN, BSc, PGDipSci, MPhil Nursing, is the director of CPD4nurses.co.nz. **Craig Waterworth, RN PGCertTT, MSc,** is the senior education advisor at Waka Kotahi New Zealand Transport Agency.

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Nurses and unionists acknowledged

Advocating for Māori 'in my whakapapa'

AUCKLAND NURSE Gwen Tepania-Palmer, Te Aupouri Ngāti Kahu, Ngāti Paoa, has cared about Māori health as long as she can remember.

"It's in my whakapapa," she said. "The most important thing is to make sure whatever we do in the health sector, it makes a positive difference. If you make a positive difference for Māori, you make a positive difference for everyone."

Tepania-Palmer has become an Officer of the New Zealand Order of Merit. The honour was "not just for myself," she said. "It's for a lot of people who have crossed my path and mentored me."

Co-designed health services "where everybody gets a look in" were the way forward, said Tepania-Palmer. Māori were entitled under te Tiriti to a partnership approach. The incoming Māori Health Authority was "another positive step" in that direction, 'but I've lived long enough to know all things take time".

Tepania-Palmer began her career in the 1970s as a psychopaedic nurse and was an early graduate of the bridging programme at the Auckland Technical Institute in the early '80s. Moving nurse training from hospitals into schools "certainly lifted the bar of nursing education", she says.

Tasked by the National Heart Foundation with leading a Māori response to heart disease, Tepania-Palmer created Te Hotu Manawa Māori (now Toi Tāngata), a Māori agency which draws on te ao Māori knowledge for healthy living.

In the late '90s, she implemented a rheumatic fever programme in Northland, which led to the development of the Ngāti Hine Health Trust. A marae-based nutrition programme she suppported led to the establishment of Ngāti Porou Hauora, several marae-based GP clinics, a Māori nursing and midwifery service and a range of Māori health services in the Auckland region.

She also helped create Te Roopu Taurima, a Māori disability support service, and supported the development of Māori health boards in Te Taitokerau, Ngāti Whātua and Tainui to oversee delivery of health services in those tribal areas.

Over the years, she has worked with indigenous populations overseas, including Canada. While finding this work sad and overwhelming at times, "I just stayed focused and had incredibly good support systems", she said. "I feel lucky and blessed – I have had all these opportunities nursing opened up for me in the world."

Tepania-Palmer continues to work in governance, including on the board of the Ngāti Hine Health Trust. •

Still 'work to do' on women's rights

FORMER NZNO organiser Carol Beaumont became an Officer of the New Zealand Order of Merit for services to the union movement and women's rights.

Beaumont – who has worked 35 years in the union movement, including at NZNO from 2014 to 2018 – said the recognition meant a lot for others in the union movement. "By their nature, they are collective organisations and there have been so many other active and passionate workers, determined to make a positive difference."

It was relatively unusual for unionists to be honoured, so it was heartening to see the work of both herself and E Tū union delegate Lalopua Sanele included.

But there remained much work to do. "There is still massive inequality, both globally and in New Zealand, in terms of access to work and how much people are paid."

Beaumont – who now works as a regional organising lead Asia/Pacific for the International Trade Union Confederation (ITUC) – said globally, women were far more likely to be in poverty than men, a gap "starkly" aggravated by the COVID-19 pandemic.

New Zealand was progressing on closing gender pay gaps, but must now consider "multiple layers of poverty and discrimination", Beaumont said. An example was the pay gap between Pacific and Pākehā women.

Finalising Fair Pay agreements would help redress continuing fallout from the 1991 Employment Contracts Act, which drastically undermined the power of unions to represent workers. Unions must continue to rebuild their membership, 30 years on.

In her global role, Beaumont said it was both frustrating and inspiring to see what people were up against in the Asia-Pacific region. "I never fail to be moved and impressed by what I see people doing. There are often very challenging circumstances yet still people are fighting for their human rights, against the odds."

Beaumont was general secretary of the New Zealand Council of Trade Unions from 2003 to 2008. She is a current board member of the National Council of Women. •

in Queen's Birthday honours

Sixty years a nurse and still caring

FOR A supposedly retired nurse, at nearly 79 Shirley Lanigan is extremely busy. *Kai Tiaki* managed to wrangle a few minutes before she went out to help with 'flu vaccinations.

She still works with sexual assault survivors and has done a bit of school nursing too in the Hutt Valley since officially retiring eight years ago. More recently, a friend convinced her to do the COVID-19 vaccination training, and she has helped vaccinate hundreds of rest-home residents in Levin and Palmerston North.

Lanigan has been made a Member of the New Zealand Order of Merit for services to nursing, an honour she was able to share with her late husband Aidan, shortly before he died recently after 56 years of marriage.

Lanigan settled on nursing aged 11, after her mother was badly burned in hot pools near Taupō, requiring weeks of hospital care. Over a 60-year career, roles have included theatre, orthopaedics, surgery and emergency nursing. In 1968, she cared for survivors of the Wahine disaster, setting up a ward at Hutt Hospital. She also later set up a short-stay unit there, to ensure vulnerable elderly were not turned away in the night.

"The major part is the caring component – you do what you can."

Lanigan started working with police in 2002 on a mobile blood-testing unit, before becoming a forensic nurse in 2004 – work she continues to this day, albeit part-time. Her work has meant sexual assault survivors could often be supported in the Hutt region rather than having to travel to Wellington.

In recent months, Lanigan has nursed her husband at home after he was diagnosed with terminal cancer.

While she remains active – she enjoys walking and going to the gym – she says she's thinking about stepping down by Christmas – properly this time. •

'Coherent push' needed for nurse leadership

AUCKLAND NURSE Judy Kilpatrick – Dame Companion of the New Zealand Order of Merit for services to nursing – says she achieved nothing alone. "Nursing is such a team collaborative thing to do, I've always worked with fabulous people."

Kilpatrick signed up for nursing on a "whim" in 1968, going on to become a powerful advocate for post-graduate nursing education and advanced nursing practice. She was a key driver of nurse practitioner (NP) programmes at Auckland and Massey Universities from 2016 and is most proud of this.

"The biggest thing for me is getting the NP model going – it has just taken so long, but people and nurses are now, finally, seeing the value of the NP role," she said. As well as giving well-trained nurses the right to diagnose and prescribe, which allowed patient care to be delivered "on the spot", having post-graduate expertise raised the profile and power of nurses.

"There's been a massive change in nursing – we became professional whether we liked it or not, and that opened doors to a lot of things such as respect."

While nursing was held in even higher esteem since COVID-19, work was needed to improve its influence. The current health reforms were a prime opportunity to see nurses at the front and centre of health-care delivery.

She said that visibility was nurses' challenge. But the health service needed to change the way it delivered care in hospitals and communities – "nurses might be the best leader of the team", she said. "We've got to remove the idea that nurses are not totally responsible for their practice – they are, not doctors . . . So utilise these nurses who are well-trained and highly competent."

A collective approach from the profession was lacking. "There are some excellent leaders . . . But do I see a strong coherent push with nurses together? I would have to say I don't."

Kilpatrick co-founded the school of nursing at Auckland University of Technology in 1999, leading it from 2002 to 2017. It became one of the largest providers of post-graduate nursing courses in New Zealand, offering a national programme for Māori nurses in disease management and in rural nursing. In 2018, the department was recognised as 32nd in the top 50 nursing schools globally.

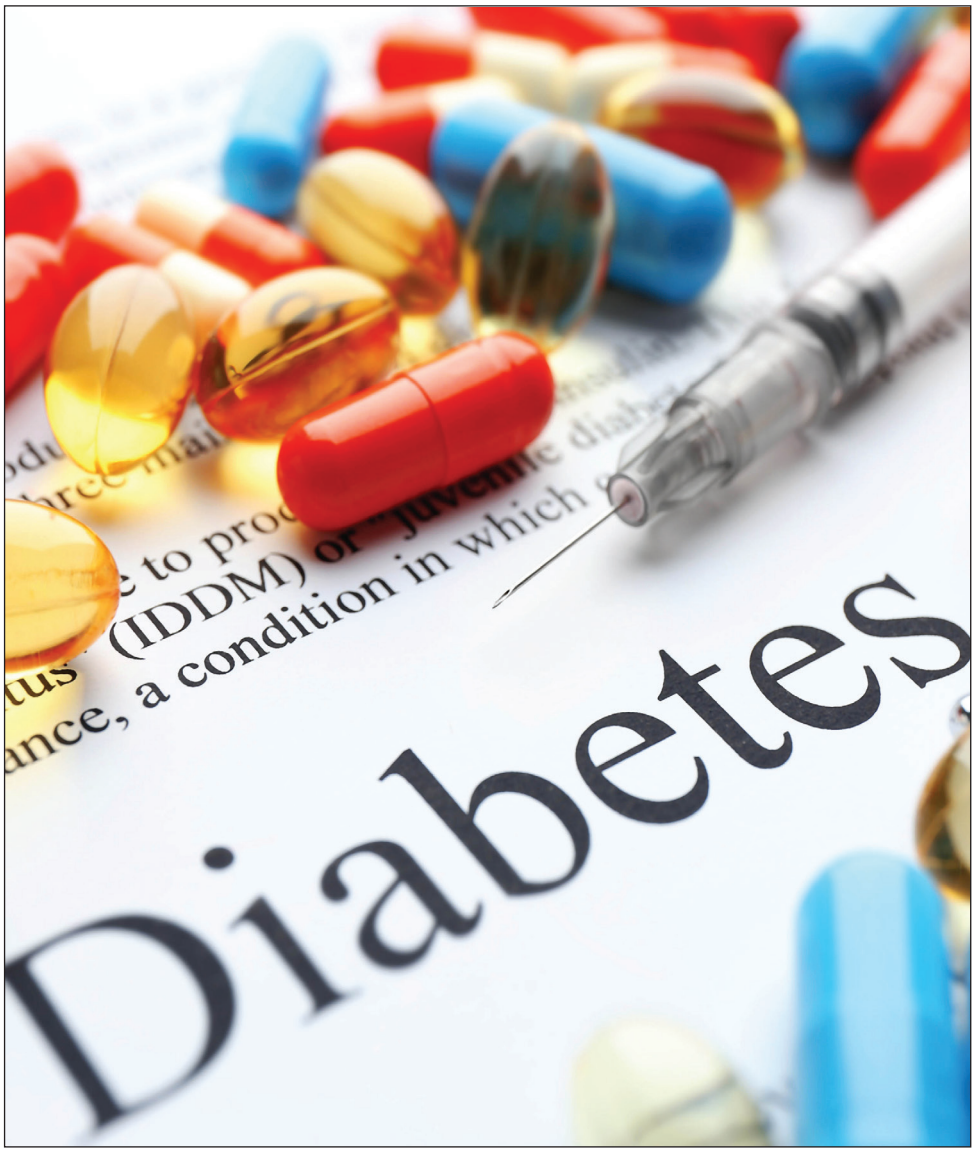
Kilpatrick also chaired the Nursing Council from 1996-2002, during which time the council began developing its regulatory framework and negotiating legislative changes to allow NPs to practise in New Zealand.

Kilpatrick retired in 2020 after 47 years. •

Written by co-editor Mary Longmore with research by NZNO librarian Heather Woods

Supporting patients on the new diabetes meds:

What you need to know



Diabetes clinical nurse specialist Lisa Sparks discusses the place of empagliflozin and dulaglutide in treatment of type 2 diabetes, with emphasis on potential side effects, sick-day management and improving patient adherence.

By Lisa Sparks

Type 2 diabetes affects a large number of New Zealanders. According to national dispensing data, about 220,000 people aged 25 and over received oral hypoglycaemic agents and/or insulin between October 2019 and September 2020.[1]

Generally, type 2 diabetes begins with a degree of insulin resistance but, over time, becomes a disease of insulin deficiency due to progressive pancreatic beta cell exhaustion. Metabolic, inflammatory and oxidative processes as well as glucose toxicity, lipotoxicity and hereditary factors underlie the disease pathogenesis.[2]

The goal of diabetes management is to prevent development, or delay progression, of microvascular and macrovascular complications, and reduce associated mortality.[3] Traditionally, type 2 diabetes management included pharmacotherapies introduced in a linear, stepwise approach, alongside lifestyle interventions. Health-care access, treatment adherence and appropriate education, as well as monitoring and follow-up around treatment initiation, all play an integral role in the safe initiation of treatment and in treatment outcomes.[4]

Until very recently, available antidiabetic agents, outside of their glucose-lowering ability, have had little effect on the incidence and progression of macrovascular complications (see table, p33).[5] Statins, angiotensin converting enzyme (ACE) inhibitors, angiotensin receptor blockers (ARBs) and antiplatelet therapy have been the mainstay of managing increasing cardiovascular risk and mortality.[2,3]

Empagliflozin, a sodium-glucose cotransporter-2 (SGLT2) inhibitor, is now

funded under Special Authority for use in type 2 diabetes, and the glucagon-like peptide-1 (GLP-1) agonist dulaglutide is anticipated to be available later this year. Both agents lower blood glucose levels but also have a significant beneficial impact on renal and cardiovascular disease progression in patients with, or at high risk of, microvascular and macrovascular complications. This benefit is independent of their glucose-lowering effects.[6,7,8]

PHARMAC Special Authority criteria are designed so patients with the greatest need gain maximum benefit from these medications.[9] Our approach, now, to managing type 2 diabetes has to be much more patient-centred.

It is important primary care practitioners are informed about these new medications so they can effectively advocate and care for their patients. They need to know how these agents work, their use, which patient populations will benefit from them and how, and their potential side effects and contraindications. Furthermore, an understanding of the degree of patient adherence and any factors contributing to this, in addition to strategies to promote adherence, are necessary for safe treatment initiation and optimal outcomes.[4,10,11,12]

SGLT2 inhibitors

SGLT2 inhibitors inhibit glucose reabsorption in the proximal renal tubule, resulting in increased renal glucose excretion and therefore glycosuria diuresis.[7,13] Empagliflozin can lower HbA1c by 1.5 per cent, which equates to 6-17mmol/mol, depending on baseline HbA1c and renal function. The higher the baseline HbA1c, the greater the reduction and, subsequently, the greater the diuresis.[5,7] In studies, SGLT2 inhibitors reduced systolic blood pressure by 4-10mmHg and, due to the caloric loss, reduced weight by 2-5kg.[14,15] This weight loss can possibly offset weight gain associated with insulin.[14] While a reduction in blood pressure is generally beneficial, empagliflozin may increase the risk of hypotension in normotensive patients, particularly in those treated with diuretics for hypertension or heart failure.[7,14]

In addition to empagliflozin's effects on weight, blood glucose levels and blood pressure, a 45 per cent reduction in renal disease progression, 38 per cent reduction in cardiovascular mortality, 38 per cent reduction in heart failure admissions, and regression of albuminuria have all been observed in trials.[7,13,14,16,17] These effects are independent of glu-

Diabetes clinical nurse specialist Lisa Sparks

> "It is important primary care practitioners are informed about these new medications: how they work, their use, which patient populations will benefit from them and how, and their potential side effects and contraindications."

Type 2 diabetes medications funded in New Zealand and their effects

Medication class	Funded	Weight change	Hypoglycaemic risk	Change in insulin resistance	Effect on CVD	Effect on heart failure	Effect on renal disease
Biguanide	metformin	neutral	no	no	potential benefit	neutral	neutral
DPP-4 inhibitor	vildagliptin	neutral	no	no	neutral	neutral	neutral
Thiazolidinedione	pioglitazone	increase	no	no	potential benefit	increase	neutral
Sulfonylurea	gliclazide, glipizide	increase	yes	yes	neutral	neutral	neutral
SGLT2 inhibitor	empagliflozin[a]	decrease	no	no	benefit	benefit	benefit
Injectable GLP-1 agonist	dulaglutide[b]	decrease	no	no	benefit	potential benefit	benefit
Insulin	various preparations	increase	yes	yes	neutral	neutral	benefit

[a]Funded on Special Authority.
[b]Funded on Special Authority; awaiting Medsafe approval

Adapted from Feingold, K. R. et al.[5]

cose-lowering action. Empagliflozin is recommended for use in people with elevated cardiovascular risk, established atherosclerotic cardiovascular disease (CVD), chronic kidney disease (CKD) and heart failure.[7]

Some studies have shown that empagliflozin can reduce uric acid levels and alter some lipid levels.[5,7,16]

Side effects

SGLT2 inhibitors are generally considered safe, but a number of potential safety issues are associated with their use. Refer to the Medsafe data sheet or the New Zealand Formulary for comprehensive information on side effects and contraindications.

• Hypoglycaemia

When used in combination with sulfonylureas and/or insulin, adding empagliflozin may increase the risk of hypoglycaemia.[14] This will depend on baseline HbA1c and the anticipated HbA1c reduction. Patients may need to stop or reduce sulfonylurea medication, particularly if baseline HbA1c is ≤64mmol/mol. Total daily insulin dose may need to be reduced by up to 25 per cent.[7,14] In patients on a combination of sulfonylurea and basal insulin, the insulin should be down-titrated first.

• Hypotension

Because empagliflozin acts as a diuretic and increases urinary frequency, it may cause hypotension. This may be particularly so in normotensive patients and patients on diuretic medications such as frusemide, or in those on ACE inhibitors or ARBs combined with hydrochlorothiazide.[14] In some instances, a reduction in diuretic medications is required, or the thiazide combination switched for ACE inhibitor/ARB-only medication.[7,14]

• Genitourinary infection

Due to glycosuria, there is a small but significant increase in the risk of genitourinary infections such as thrush and urinary tract infections.[7] Women have a greater risk than men, and uncircumcised men have a greater risk than circumcised men.[14] Good hygiene can ameliorate this.[17] Infection is not generally a reason to cease medication, although recurrent infection may necessitate discontinuation.[7,14]

Panel 1. Sick-day guidelines/considerations for empagliflozin[7]

Because illness can increase blood glucose levels and increase dehydration, patients when ill should:

- check blood glucose levels every four hours
- see their primary care provider if blood glucose levels are >15mmol/L for 24 hours
- increase their fluid intake to 1-2 glasses of non-sugary drinks per hour
- have a point-of-care ketone check if they experience nausea, vomiting or abdominal pain.

Empagliflozin should be stopped if a patient has:

- nausea or vomiting
- stomach pain (associated with vomiting)
- diarrhoea
- an inability to eat or drink

If the illness continues for more than a few days, the patient should see their primary care provider to see if a test for ketones is required.

It is important patients continue their other diabetes medications, including insulin.

Patients can restart empagliflozin once they feel better.

• Euglycaemic diabetic ketoacidosis

Euglycaemic diabetic ketoacidosis is diabetic ketoacidosis (DKA) that can occur when blood glucose levels are not elevated. The rates of euglycaemic DKA are reported as one in 1000 to one in 3000 for SGLT2 inhibitor users, and DKA is often precipitated by infection, inflammation or fasting.[5,13,18] New Zealand Society for the Study of Diabetes (NZSSD) guidance recommends empagliflozin be withheld during periods of illness or fasting and patients should have their ketones checked if they experience nausea, vomiting or abdominal pain.[18] An example of sick-day considerations can be found in Panel 1 (above).

• Fournier gangrene

Extremely rare, Fournier gangrene, a necrotising fasciitis of the perineum, has been observed in both men and women using empagliflozin. Anyone presenting with tenderness, erythema and swelling in the genital or perineal region should be evaluated for necrotising fasciitis and empagliflozin stopped immediately if suspected.[5]

Contraindications/precautions

The main contraindications of SGLT2 inhibitors are a history of DKA, type 1 diabetes and CKD (severe and end-stage disease). In patients with an estimated glomerular filtration rate (eGFR) of <45ml/min/1.73m^2, glucose-lowering effectiveness is reduced and so SGTL2 inhibitors are not recommended.[5,7,13] However in trials, cardiovascular and renal benefits have occurred in patients with an eGFR as low as 30ml/min/1.73m^2.

Caution is advised in patients on very low carbohydrate or ketogenic-type diets, as the risk of DKA may be increased, and vigilance for undiagnosed autoimmune diabetes is important.[13] Caution should be used in older adults (>75 years) who may experience greater diuresis and a greater risk of orthostatic hypotension.[16]

GLP-1 agonists

GLP-1 agonist dulaglutide is an injectable synthetic hormone that increases first-phase insulin response (insulin released in response to food ingested) and second-phase (glucose-dependant) insulin secretion. It inhibits glucagon secretion and slows gastric motility so can reduce appetite while increasing satiety.[8,19]

GLP-1 agonists can reduce HbA1c by 13-15mmol/mol and average weight loss is equitable to that of SGLT2 inhibitors (2–5kg), according to studies.[8,19,20] However, in clinical practice, much greater weight and HbA1c reduction has been observed – in some cases weight loss of ≥15kg and HbA1c reduction of 20mmol/mol.[5] Early weight loss after starting treatment is a strong predictor of significant weight and HbA1c reduction.[20] GLP-1 agonists may reduce systolic blood pressure by 2-5mmHg.[6,19]

GLP-1 agonists are associated with a significant reduction in cardiovascular events and albuminuria, and likely afford long-term protection against eGFR decline.[5,6] In the REWIND trial, dulaglutide demonstrated a 12 per cent reduction in the primary outcome (non-fatal myocardial infarction, non-fatal stroke or death from cardiovascular causes) in patients with and without a history of CVD.[5,21]

The underlying mechanisms accounting for the decrease in cardiovascular and renal outcomes is thought to be related to a composite of actions: body weight, blood pressure and postprandial triglyceride reduction, and effects on inflammatory processes that contribute to endothelial dysfunction.[6]

Side effects

Generally, dulaglutide is well tolerated. The main side effects are described here, but refer to the Medsafe data sheet or the New Zealand Formulary for comprehensive information on side effects and contraindications.

- **Gastrointestinal disturbance**

Abdominal discomfort, nausea and reduced appetite are by far the most common side effects and are primarily related to reduced gastric motility, which is greatest after the initial injection and tends to settle over a few weeks.[6,8] Some patients may experience more extreme gastric disturbance, diarrhoea or vomiting and not be able to tolerate a GLP-1 agonist.

- **Hypoglycaemia**

When used in combination with insulin or sulfonylureas, there is an increased risk of hypoglycaemia. Pre-emptive dose reductions of these medications may be necessary, depending on baseline HbA1c.[8]

- **Hypersensitivity reactions**

Injection-site hypersensitivity reactions may occur in 0.5 per cent of patients – most commonly pruritus, which is transient and generally tolerated without the need to discontinue treatment.[8]

Contraindications/precautions

- **Medications with narrow therapeutic index:** Because dulaglutide slows gastric emptying, closer monitoring of drugs with a narrow therapeutic index may be required (eg warfarin, digoxin, lithium, phenytoin and others).[8]
- **Thyroid and endocrine cancers:** GLP-1 agonists are contraindicated in patients with a personal or family history of medullary thyroid cancer.[19,22]
- **Pancreatitis:** The risk of pancreatitis associated with GLP-1 agonists has recently been invalidated; however, a subclinical rise in amylase and lipase levels has been observed and many health-care providers consider avoiding dulaglutide in patients with a history of pancreatitis.[5]
- **Severe gastric disease:** Because of gastrointestinal (GI) side effects and the direct effects of GLP-1 agonists on gastric emptying, these agents are not recommended for patients with a history of gastroparesis, Crohn's disease and other severe forms of gastric disease.[5,8]
- **Renal disease:** All GLP-1 receptor agonists can be used without dose adjustment in patients with mild renal impairment, and dulaglutide does not require dose adjustment even in patients with severe renal impairment. However, postmarketing reports for GLP-1 agonists have identified instances of acute renal failure – some in patients with no known underlying renal disease – and worsening of chronic renal failure.[22] Most events occurred in patients who had experienced nausea, vomiting, diarrhoea or dehydration. Because these reactions may worsen renal function, caution is required when initiating or escalating GLP-1 agonists in patients with renal impairment, and close monitoring of renal function should occur in those who report severe GI reactions.[22,23]

Patients with multimorbidity taking multiple medications are expected to process and understand a large amount of health information.

Where do these new medications fit?

Metformin remains the preferred first-line therapy for people with type 2 diabetes, followed by dipeptidyl peptidase-4 (DPP-4) inhibitor vildagliptin for those *without* macrovascular complications. For patients with a five-year CVD risk ≥15 per cent, existing CVD, renal disease or a high lifetime CVD risk, and who have not met target HbA1c levels, either a SGLT2 inhibitor or a GLP-1 agonist is recommended. For patients with heart failure, a SGTL2 inhibitor may be more beneficial; however, where weight loss is a priority, a GLP-1 agonist may be a better treatment option. The NZSSD treatment algorithm (tinyurl.com/Ttmtalg) provides guidance on treatment options.

SGLT2 inhibitors and GLP-1 agonists are safe to use in combination with each other and can generally be used safely with all hypoglycaemic medications.[8,14] However, PHARMAC Special Authority states funding is applicable to either empagliflozin *or* dulaglutide,[9] so should patients want to combine these agents, they would need to apply for funding for one agent and self-fund the other.

Insulin and/or sulfonylureas still have a place in treatment for patients who require greater glucose lowering in addition to an SGTL2 inhibitor or GLP-1 agonist.

Treatment initiation and follow-up

After patient medical history has been reviewed and a treatment plan agreed on, it is important patients receive appropriate assessment, education and follow-up to ensure their safety and promote optimal treatment outcomes.[7] A focus on treatment initiation can increase adherence and reduce time later re-examining patient motivation and employing adherence strategies (see Panel 2, right).[24]

Baseline assessment

Prior to starting empagliflozin or dulaglutide, patient weight, blood pressure, current medications (including current medication adherence levels) and glycaemic control (using blood glucose monitoring and HbA1c results) should be assessed.

If patient HbA1c level is ≤64mmol/mol, a pre-emptive reduction of insulin or sulfonylurea is recommended, and in normotensive patients starting a SGLT2 inhibitor, a reduction of antihypertensive medication should be considered – particularly the reduction or cessation of diuretic medication. Level of adherence may significantly influence decision-making on dose reductions of medications.

For both medications, baseline and follow-up laboratory measures should include HbA1c, renal function (creatinine, electrolytes, eGFR and urine microalbumin) and liver function tests and full blood count. For dulaglutide, baseline and follow-up amylase and lipase levels are good practice.

Panel 2. Treatment adherence strategies

Strategies that promote adherence include:[10,11,12,24,27,28]

- shared decision-making and positive interactions with health-care providers before starting treatment
- simplification of medication regimes
- understanding of patients' perceptions and beliefs about medications
- increased access to relevant knowledge delivered at an appropriate level
- use of motivational interviewing techniques

Dosage

- **Empagliflozin:** Available in 10mg and 25mg tablets, empagliflozin is best taken in the morning to avoid nocturia.[7] A missed dose must be omitted, but dosing can resume as usual the following day. A starting dose of 10mg per day is recommended, which can be increased to 25mg per day after four weeks for additional glycaemic control.[25]

Dulaglutide: Dosing in New Zealand is expected to be a weekly subcutaneous injection in the abdomen, upper arm or thigh of 1.5mg/0.5ml solution, administered via a prefilled auto-injector.[9,22] Dulaglutide should be stored in the fridge but is stable at room temperature for 14 days. A missed dose can be administered within three days of the scheduled time.[22] Patients should start on 1.5mg/week and can increase the dose if additional glucose lowering is required after four weeks.[19]

Follow-up

Follow-up should occur two to four weeks after the start of treatment (those with greater risk of hypoglycaemia or hypotension should be followed up within two weeks), and again after three months. Repeat laboratory tests should occur at one and three months.

If, after one month, blood glucose levels are not optimal, dose can be increased. Adherence and the need to reduce antihypertensives, insulin or sulfonylureas should be considered before escalating treatment. Diuresis and glucose-lowering efficacy do not appear to be as great with dose titration, compared with that seen at dose initiation.

The full extent of treatment outcomes are usually evident within six months of initiation, so routine follow-up every three to six months is recommended, to support adherence and assess for ongoing treatment requirements.

What does the patient need to know?

Before starting empagliflozin or dulaglutide, patients should receive all relevant information about the proposed treatment in a way they can understand, so they can make an informed decision.[11] Apart from information about dosage, when/how to take the medication and what it does, a patient needs to know how to recognise and treat hypoglycaemia. So home blood-glucose monitoring is vital when patients are also taking insulin or sulfonylureas.

- **Empagliflozin:** Although diuresis does not usually cause dehydration, patients should be counselled on drinking when thirsty and reporting symptoms of hypotension. They should be aware of signs and symptoms of a urinary tract infection, thrush and DKA, and to seek early treatment. In addition, they need to know how to manage illness (Panel 1).
- **Dulaglutide:** Patients should be made aware of initial gastrointestinal effects and when to report more severe symptoms, as well as the possibility of injection-site pruritus. As with all new medications, patients should be instructed to report any side effects.

What about adherence?

Adherence, or the extent to which patients take medications, can be as low as 50 per cent which imposes significant costs on both the individual and the health-care system.[10,12] Using dispensing data, a Dunedin study examined adherence to oral hypoglycaemic agents through the proportion of days covered by the medication (PDC).[26] Results showed more than half the patients had a PDC of less than 80 per cent. Extreme non-adherence, defined as a PDC of less than 50 per cent, was more common in Māori, men and people with high socioeconomic deprivation.[26] It is widely established that adherence tends to decrease and patient burden increase as medication amount and complexity increase.[27,28] For many patients, diabetes is just one of a number of long-term conditions they are living with.

Patients with multimorbidity taking multiple medications are expected to process and understand a large amount of health information.[29] A University of Otago study showed as many as 20 per cent of patients did not know the purpose of their medications and described difficulty in managing them.[28] While factors contributing to non-adherence are complex, access to appropriate information – particularly when initiating new medications – and increasing health literacy are directly correlated to increased adherence.[4,29] It is important to explore these factors with patients, to open up discussion and create opportunities to provide education and strategies to promote adherence (see Panel 2). •

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PHOTO: ADOBE STOCK

Diabetes insipidus: The diabetes that's not about glucose

Due to its name, diabetes insipidus is often confused with the more common diabetes mellitus. But it is a completely separate condition with different causes and different treatment.

By Catherine Chan

"If you imagine you have been in the desert for days, and so thirsty and so dry. I can drink and drink and drink, and still cannot drink enough to fix that thirst", says Mary, of Wellington, who developed diabetes insipidus after surgery to remove a pituitary tumour.

When we hear the word "diabetes", most of us think of diabetes mellitus (DM) – the group of diseases related to how the body handles glucose. Diabetes insipidus (DI) is not related to glucose, and thus is often misunderstood or forgotten.

DI is a rare disease with a prevalence of just 30 people per million.[1] In comparison, DM (which includes type 1, type 2 and gestational diabetes) is increasingly common, with more than 260,000 people diagnosed in New Zealand in 2019[2] – more than five per cent of the population.

Why do these two very different diseases share the same name? The word "diabetes" is the Greek word for siphon, and is used for both conditions because people with diabetes pass water like a siphon. "Mellitus" is the Latin word for sweet, describing the presence of glucose in the urine of patients with DM. In contrast, patients with DI have insipid, tasteless urine.

Recognising DI

Passing large amounts of dilute urine and an insatiable thirst are the hallmark symptoms of DI. Patients describe a thirst that can only be quenched by drinking ice-cold drinks and often need to go to the toilet several times an hour throughout the day and night.

A typical DI patient wakes up multiple times during the night to pass urine and drink large volumes of fluids. Therefore, a useful diagnostic tool is measuring urine output over 24 hrs. In severe cases, a person with DI can pass up to 20 litres of urine in a day.

Passing such large quantities of urine is due to problems with a vital hormone called antidiuretic hormone (ADH), also known as vasopressin. ADH is a life-essential hormone made by the hypothalamus in the brain and stored in the posterior pituitary gland. It regulates the amount of water and electrolytes in the bloodstream.

A decrease in blood volume or increase in the concentration of salts in the bloodstream, eg in dehydration, is detected by special sensors in the hypothalamus. This stimulates release of ADH from the pituitary gland. High levels of ADH act on the kidneys to reabsorb water back into the body, resulting in concentrated urine. Conversely, when one drinks a lot of fluids and is well hydrated, ADH secretion decreases, resulting in dilute urine.

In ADH deficiency, water passing through the kidney tubules cannot be reabsorbed back into the body. Therefore the patient will develop polyuria, passing large amounts of dilute urine. If untreated, this can quickly lead to dehydration, hypernatraemia (high blood sodium levels), and be potentially fatal.

Types of DI

There are two main forms of DI. Central DI (also known as cranial or neurogenic DI) results from decreased ADH production by the hypothalamus or reduced ADH release by the pituitary gland. Central DI is caused by damage to the hypothalamus or pituitary gland, eg after pituitary surgery.

The other type, nephrogenic DI, occurs when the kidneys do not respond appropriately to ADH. Nephrogenic DI may be genetic or acquired.

Call for a name change

In October 2020, the UK Pituitary Foundation ran a "No Need to DI" awareness campaign[3] and collected more than 5000 signatures calling for a name change for this condition. UK Pituitary Foundation CEO Menai Owen-Jones said, "Clearly, anything is better than diabetes insipidus, to get rid of that word [diabetes]". Mary agrees. "I have had a lot of nurses wanting to check my blood sugar. Last time I went into hospital, a nurse came in with the blood sugar test kit and said I'm going to check your blood sugars. Another time the nurse came in and asked how often do you check your blood sugars. I had to explain that no, I don't have sugar diabetes".

Patients like Mary often worry they will not receive appropriate treatment for DI if they are too unwell to speak for themselves. Therefore a MedicAlert bracelet is advised, and an emergency leaflet explaining their condition and the treatment required should be with them at all times.

DIABETES INSIPIDUS: TOP TIPS FOR NURSES

- Diabetes insipidus (DI) has nothing to do with diabetes mellitus ("sugar diabetes").
- Call the endocrinology team for help early.
- Do a fluid balance chart to monitor fluid input and output.
- DI is potentially life-threatening. Desmopressin medication (eg DDAVP nasal spray) is life essential.

Wellington Regional Hospital endocrinologist Richard Carroll agrees the terminology is confusing. "I think there is a real need for a bit of a rethink, whether the terminology is appropriate nowadays, and whether we should be using terminology that is not as confusing as it is currently."

Changing the name of a disease is not simple and requires international buy-in. Interestingly, the latest version of the International Classification of Diseases (ICD-11), published by the World Health Organization (WHO), has added "ADH (anti-diuretic hormone secretion) deficiency"[4] as an alternative for "central diabetes insipidus". Other suggested names include pituitary insipidus and vasopressin deficiency.

Treatment of DI (ADH deficiency)

Once an endocrinologist diagnoses the condition, treatment is readily available. Desmopressin, a synthetic form of vasopressin, is sold under the trade name DDAVP, among others.

Various formulations of desmopressin are available, including nasal sprays, sublingual melts, oral tablets, and injections. These are all available and fully subsidised in New Zealand.

The most commonly used form is the desmopressin nasal spray. This medication works within minutes and is very effective. The currently funded brand, Desmopressin PH&T nasal spray, does require refrigeration when unopened. However, it can be kept at room temperature after opening for up to two months.

Nurses need to recognise that desmopressin nasal spray is a life-sustaining therapy. (There are very few life-sustaining medications – one being insulin in type 1 diabetics, a second is hydrocortisone for those with adrenal insufficiency, and the third is desmopressin for those with DI.) Therefore, especially when a patient with DI is an inpatient, desmopressin must be promptly charted, ordered from the pharmacy, and given to the patient as prescribed.

Patients with DI need to drink to thirst at all times and are advised to have a "breakthrough" regularly. A breakthrough is the recurrence of symptoms such as thirst and frequency urination when the effect of desmopressin wears off. Regular breakthrough (briefly stopping DDAVP) is needed because using too much desmopressin leads to water retention and low blood sodium levels (hyponatraemia), which can be challenging to treat.

Problems arise when a patient ends up in a hospital unwell, particularly if they are unconscious – the risk increases when they cannot drink to thirst or are given IV fluids. "Electrolyte disturbances can get very complex, very quickly", says Carroll.

A fluid balance chart to monitor all fluid input and output is necessary for these circumstances. "Given the complexity, it requires an individual approach, and getting the endocrine team in there quickly is important," Carroll says.

Nurses must recognise DI is a potentially life-threatening condition, and desmopressin is a life-sustaining medication. If a patient misses their medication, they will rapidly lose a large amount of fluid in the urine, which will lead to dehydration, high sodium levels in the blood (hypernatraemia), confusion and even death.

Next time you see a patient with DI, don't automatically prick their finger to check their blood sugar. Instead, call the endocrine service and monitor their fluid balance. •

Useful resources

- BMJ Podcast 2019. Diabetes Insipidus – the danger of misunderstanding diabetes. (https://www.bmj.com/content/364/bmj.l321)
- Patient Stories from the UK Pituitary Foundation 2020. (https://pituitary.org.uk/get-involved/awareness/no-need-to-di/)

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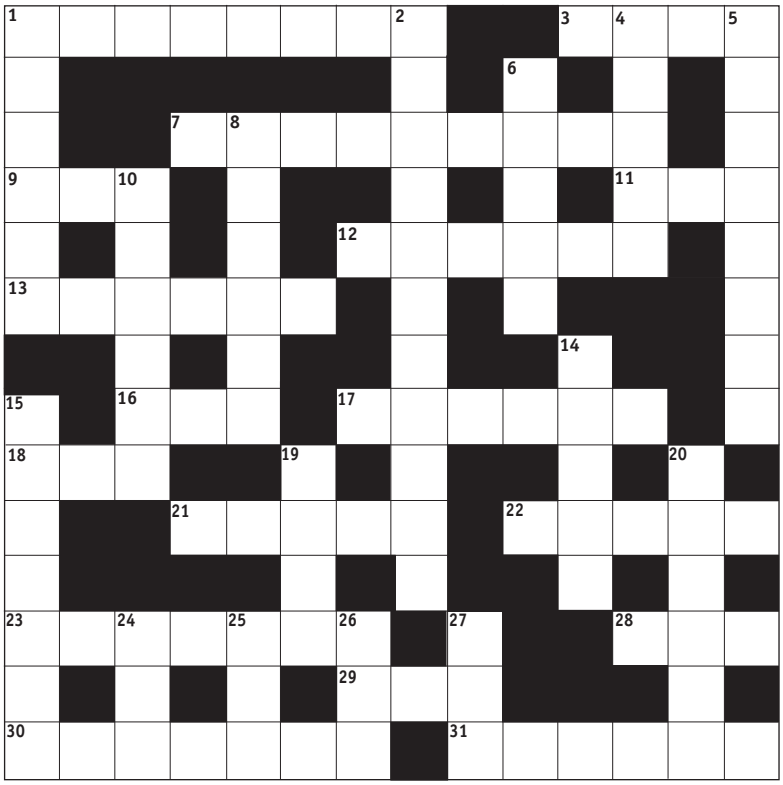
crossWORD

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



ACROSS

1) Difficulty sleeping.
3) Trace mineral, important for cell function.
7) Born early.
9) Water in solid state.
11) Creativity.
12) Currency of Israel.
13) Sufficient.
16) By going through.
17) Unoccupied.
18) Indebted to.
21) Funeral (Māori).
22) Centre of the nervous system.
23) Pus-filled swelling.
28) Plead.
29) Chopping tool.
30) Anti-inflammatory medicines.
31) Nearly.

DOWN

1) Set fire to.
2) Dangerous allergic reaction.
4) Perfect.
5) "Fight or flight" hormone.
6) Fortunate.
8) Traditional Māori medicine.
10) Adapt over time.
14) Irate.
15) Units of currency in more than 20 countries.
19) Finishes.
20) Upper arm muscles.
24) Take legal action.
25) Sense of self.
26) Miserable.
27) Frozen vegetable.

July answers. ACROSS: 1. Strike. 4. Catnap. 8. Ant. 9. Pōwhiri. 10. Bet. 13. Homesick. 14. Kirk. 15. Eve. 16. Ass. 17. Air. 19. Global. 23. Poverty. 25. Curriculum. 26. Kea. 27. Night. 28. Autonomy. **DOWN:** 1. Seasick. 2. Rat. 3. Emotional. 5. Tūī. 6. Platelet. 7. Shivers. 10. Baker. 11. Turnover. 12. Visa. 18. Idea. 19. Garçon. 20. Addict. 21. Locust. 22. Stream. 24. Tuba.

wiseWORDS

“When I was young I asked more of people than they could give: everlasting friendship, endless feeling. Now I know to ask less of them than they can give: a straightforward companionship. And their feelings, their friendship, their generous actions seem in my eyes to be wholly miraculous: a consequence of grace alone.”

– Albert Camus (1913-1960) French philosopher, writer and journalist.

it's cool to kōrero

HAERE MAI and welcome to the July column. The karanga forms the start of a pōwhiri, when visitors are being welcomed on to a marae. It is a call and response between a representative of the hosts and a representative of the visitors. The karanga is performed in te reo Māori and almost always by women.

In the karanga, the kaikaranga (the women who perform it) will generally greet each other and the people they represent, pay tribute to those who have recently died and mention the reason the groups have come together.

Kupu hou

New word

- **Karanga** – *pronounced "car-rrrah-nga"*
- **Ko tōku tuakana tō mātou nei kaikaranga e hari ana ki runga i te marae.**
My sister is doing the kāranga when we go on to the marae.

Rerenga kōrero

Phrases

Matariki, the Māori new year, is celebrated in June when the star cluster it is named after first rises in the southern sky.

- **Ko te marama o Pipiri te wā ki te whakanui a Matariki.**
We celebrate Matariki in June.
- **Ko tēnei te wā ki te maumahara rātou ngā mate tuatini o te wā e pikaungia ana e tēnā, e tēnā o tātou.**
It is a time to remember our loved ones who have passed away.
- **Ko te wā o Matariki, ki te kauhuri te whenua kia ngāwari ai te tupu o ngā hua whenua.**
It is a time to cultivate the ground for planting.
- **Nā Matariki i tohutohu mai o tātou tūpuna mā runga waka.**
Our ancestors used Matariki to guide their waka on sea voyages.

E mihi ana ki a Titihuia Pakeho and Keelan Ransfield.

NEW ZEALAND NURSES ORGANISATION | TŌPŪTANGA TAPUHI KAITIAKI O AOTEAROA

Notice of NZNO 2021 Board Elections

Nominations for the following positions on the NZNO Board closed on 16 July.

- President
- Vice-President
- Kaiwhakahaere
- Tumu Whakarae.

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. In due course NZNO members will receive an email with information about how they can vote online. Members without an email address will be sent postal voting papers through standard mail.

The positions for Kaiwhakahaere and Tumu Whakarae will be elected by majority vote at Hui ā-Tau, which will take place 15 August.

The election is being conducted by *electionz.com Ltd* who will contact NZNO members directly by email or post. Members are encouraged to update their contact details via the NZNO website.

The key election dates are:

Nominations opened: Friday 18 June 2021

Nominations closed: 12 noon, Friday 16 July 2021

Voting opens: Wednesday 4 August 2021

Voting closes: 12 noon, Friday 10 September 2021.

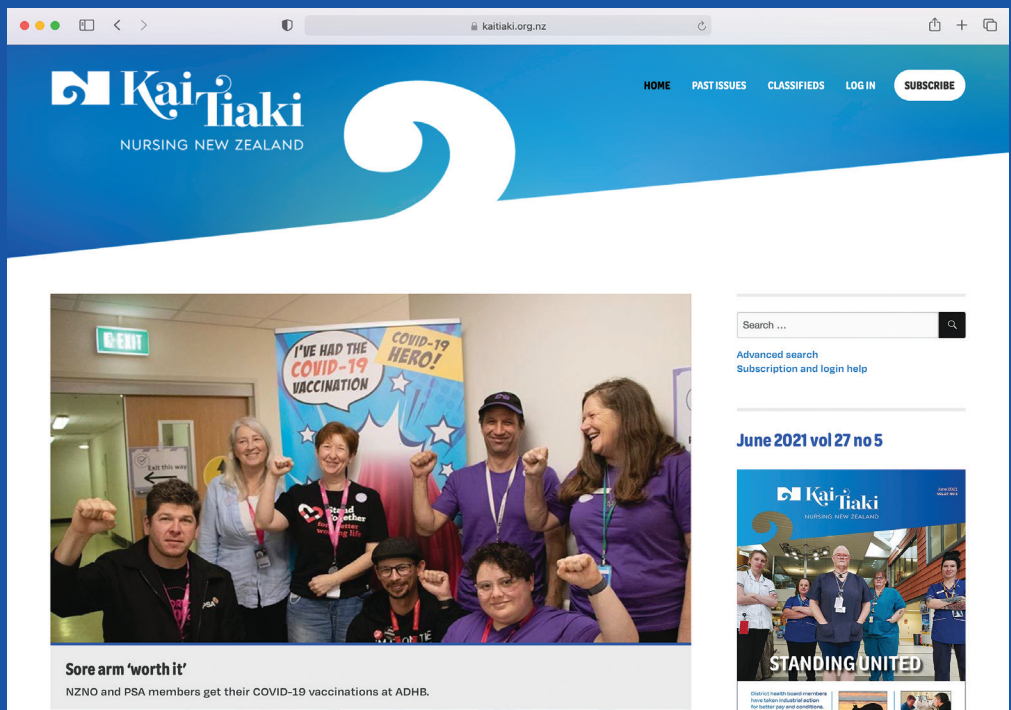
For further details, call the election helpline on free phone 0800 666 044 or contact the Returning Officer at iro@electionz.com

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

electionz.com
voting made easy

Kai Tiaki goes live

www.kaitiaki.org.nz



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

Classified advertising

IPCNC CONFERENCE | ASCOT PARK HOTEL, INVERCARGILL, NZ | 15-17 SEPT 2021

We warmly welcome you to the Deep South. The Infection Prevention and Control Nurses College (IPCNC) Conference in 2021 is to be held at the Ascot Park Hotel, Invercargill, NZ, 15-17 September.

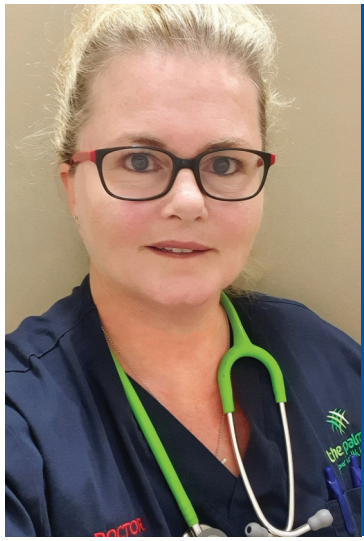
Our conference theme **"Just Bluffing It"** refers to the many metaphorical bluffs, mountains, and valleys we traverse each day. The conference will include clinical perspectives, specialist sessions on infrastructure; cleaning; MDROs; COVID-19; Community IPC and interactive forums on topical issues. We will also take time to look at our own wellbeing as we are the most valuable IPC resource! Our conference dinner on the Thursday evening will be held at the Bill Richardson Transport World.

Speakers include – Dr Arthur Morris, Clinical Microbiologist at Auckland City Hospital, Prof Michael Baker, Public Health Physician and Professor in the Department of Public Health at the University of Otago, Dr Ashley Bloomfield, Director General of Health, Ministry of Health, Zoom presentation, Ruth Barratt, RN, BSc, MAdvPrac (Hons) Infection Prevention and Control Consultant and Prof Stephanie Dancer, NHS Lanarkshire and Prof of Microbiology at Edinburgh Napier University of Scotland – pre-recorded presentation with live Q&A and many more great speakers. For full details visit www.ipcconferencenz2021.co.nz/speakers

REGISTRATION – Online registration is now open www.ipcconferencenz2021.co.nz

Early bird registration closes 30 July. Register now and save!

For further information **www.ipcconferencenz2021.co.nz** or email **joanne@conferenceteam.co.nz**



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Events

26 July-1 August 2021 webinar and nationwide events
Wound Awareness Week 2021 – Burns and Scalds
https://www.nzwcs.org.nz/wound-awareness-week/217-wound-awareness-week-2021-burns-and-scalds

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

10-12 September Auckland
2021 New Zealand Melanoma Summit
https://melanomasummit.com

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

15-17 September 2021 Invercargill
IPCNC Conference 2021 Just Bluffing It
www.ipcconferencenz2021.co.nz

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

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

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

NEW ZEALAND NURSING LEADERS' SUMMIT

NURSES LEADING CHANGE

29 - 30 SEPTEMBER 2021
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KEY TOPICS INCLUDE:

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- How nursing leadership can raise the level of nursing practice
- Nursing's role in leading health system reform and transformation

PLUS SESSIONS SHOWCASING THE BEST:

- Nursing co-design
- Nursing research informing practice development
- Nursing workforce innovation

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CAROLINE ALEXANDER CBE
Group Chief Nursing Officer,
Barts Health NHS Trust (UK)

KERRI NUKU
Kaiwhakahaere,
New Zealand Nurses Organisation

See full details: conferenz.co.nz/nurseleaders

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'This little girl stole our hearts. I cried when I had to say goodbye. I will miss her mimicking the nurses, her laugh as she runs down the hall, and her resilient joy. She is one of many kids and adults that impacted the hospital staff. Each have a story, and I'm honoured I played a small part.' Jeani

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