Kai Tiaki
NURSING NEW
August 2021
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Cervical self-testing

After years of fighting, a network of passionate nurses, doctors and advocates have won the right for women to easily test themselves for signs of cervical cancer.

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…a Little good cop/bad cop

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Choose your new president

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New Zealand Nurses Organisation 2021 Board Election

Further Notice of Election

Nominations to fill four vacancies on the New Zealand Nurses Organisation (NZNO) Board closed at 12 noon, Friday 16 July 2021.

The following confirmed nominations were received.

President (1 position)

Anne DANIELS

Diane McCULLOCH

Tracey MORGAN

Clivena NGATAI

Vice President (1 position)

Cheryl HAMMOND

Tracey MORGAN

Nano TUNNICLIFF

As the only nomination received for Kaiwhakahaere was for Kerri Nuku, I therefore declare **Kerri NUKU** elected unopposed as Kaiwhakahaere to the NZNO Board.

As the only nomination received for Tumu Whakarae was for Titihuia Pakeho, I therefore declare **Titihuia PAKEHO** elected unopposed as Tumu Whakarae to the NZNO Board.

As there were more nominations received than positions available for President and Vice-President, an election will be required.

All financial members with a valid email address recorded with NZNO will be emailed their voting details on Wednesday 4 August 2021. Financial members who do not have an email address recorded with NZNO will be posted a voter pack on Wednesday 4 August 2021.

Members are encouraged to update their details, including their email address via the NZNO website, **www.nzno.org.nz**

Voting will close at 12 noon on Friday 10 September 2021.

Warwick Lampp
Returning Officer – New Zealand Nurses Organisation
iro@electionz.com, 0800 666 044

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THIS ISSUE focuses on the long fight to allow women to self-test for signs of cervical cancer. The Health Minister shows both sides of his persona in dealing with striking nurses. Two nurses receive a frightening diagnosis and warn us of the dangers of asbestos. Economist Brian Easton gives his verdict on the proposed health 'redisorganisation'. And Matariki celebrations are shared with Canadian nurses.

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

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

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

Co-editors:
Mary Longmore and Joel Maxwell.

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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 . . .

Need information, advice, support?
Call NZNO's Membership Support Centre: **0800-28-38-48**

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Cervical self-testing a long time coming

By Jane Grant

In July 2023, Aotearoa's National Cervical Screening Programme (NCSP) will make its biggest change since it began in 1990, following the Cartwright Inquiry into experiments being conducted on patients at National Women's Hospital without their consent.

Instead of being tested for abnormal cervical cells, people will be offered a test for human papillomavirus (HPV) which causes almost all cervical cancer. HPV testing is more sensitive in detecting pre-cancer than cytology, so tests will only be needed every five years instead of the current three.

This change also brings options: A self-test in the privacy of a clinic bathroom or at home, or a clinician-taken test where the experience of cervical screening is the same as it is now, with laboratory testing for HPV.

The World Health Organization has called for the elimination of cervical cancer through vaccination and screening for HPV (including self-testing) and treatment.[1] International and local research suggests that HPV self-testing is more acceptable and likely to improve equitable access compared to current screening.

So why has it taken so long to have HPV testing available here?

In 2016, then-Minister of Health Jonathan Coleman announced that Aotearoa would move to an HPV primary screening programme within two years.[2]

At the time, international data suggested self and clinician tests were similarly effective in detecting pre-cancerous cells, if a PCR (polymerase chain reaction) test was used.[3] A subsequent study into the views of wāhine Māori was overwhelmingly positive.[4]

Local studies began in Auckland and Northland to determine how acceptable self-testing was to people – and whether it might encourage those who weren't participating in cervical smears. These studies showed that HPV self-testing was highly acceptable and empowering.

Further, the Auckland study showed a mail-out test drew higher participation for Māori than a clinic-based test. Together, the studies suggested that – with the right design – self-testing was likely to increase overall participation in cervical screening.[5]

In 2018, an updated meta-analysis confirmed self-testing was equivalent to a clinician-taken HPV test to detect pre-cancer if a PCR laboratory test was used.[6] Studies in Aotearoa were well under way by this time with universally positive feedback on self-testing, particularly powerful from those who had detected HPV through self-testing and gone onto have treatment.

"Thank you so much I really appreciated being able to self-test. It had actually been nearly 30 years since I had a smear test because of embarrassment and bad experiences. . . .[7]

". . . when I got home to my son I really felt how lucky I am, lucky that my GP and nurse picked me for this study and lucky that I don't have cancer, a couple more years and it would have been too late. You know I would not have had a smear. Dr [X] would ask me to have one every time I came in, but I didn't mind getting on the table when I knew I had HPV."[7]

However, the existing NCSP register needs to be upgraded or replaced to track HPV test results, as required by law. Funding for this was finally achieved in May 2021, when it was also announced that self-testing would become an option in 2023.[8]

Many have influenced this change. Researchers, Māori health advocates, colposcopists, cervical screening nurses, sexual health doctors, public health physicians, community advocates and whānau have kept the mission in front of Government. Momentum grew with hui in 2019 and 2020. We have approached ministers and shared petitions, evidence and feedback from participants and health professionals. Trailblazers from the Cartwright Inquiry, Smear Your Mea and women's health groups have all contributed to making HPV testing a priority.

Aotearoa now has an opportunity to design a screening programme focused on equity, partnership and autonomy for women.

For many nurses who are cervical sample takers, the option of self-testing will mean changes to the screening procedure and how it is communicated – particularly ensuring those needing further investigation are followed up.

For nurses who both vaccinate and screen, conversations about HPV are more important than ever. A campaign on the importance of having vaccination and screening for HPV together, rather than separately, will support health literacy.

We can start working towards a successful transition now by ensuring people have access to evidence-based information.

Let's collectively contribute to the elimination of cervical cancer in Aotearoa now and in the future through positive, empowering, evidence-based messaging for our patients, whānau and ourselves. •

**See also: Nurses celebrate, lament long fight pp14-15. References and key messages p18.*

Jane Grant, RN, BHSc Nursing, is a clinical nurse specialist working for Auckland and Waitematā DHBs. She is also a cervical screening coordinator and involved in HPV self-testing research.

Tell us what you think

Where are the board minutes and reports?

THE 2021 DHB MECA campaign is demonstrating what a great union NZNO can be. The campaign is engaging, united, member-driven, transparent and strong.

Now we need an NZNO board that mirrors the union at its best. It isn't what we have at the moment, and this means members are missing out.

In 2016, delegates at the NZNO AGM voted, *"that the NZNO board meetings agendas and minutes be made available to the membership and staff"*.

In moving that motion, the Nurse Managers Section said, *"Board members are elected to ensure resources are used to carry out the mission of the NZNO. Board meeting minutes should be made available in the interests of transparency and engagement."*

Under NZNO's member-driven constitution, AGM votes are binding on the NZNO board. Yet the board is not making its agendas or minutes available on the NZNO website. None have been posted since the departure of the previous chief executive in February.

It is concerning that the board now appears to believe it can flout the constitution, disregard the will of the membership and operate in secrecy.

More concerning still is their failure to release NZNO's 2020/21 audited financial statements and annual report.

The acting chief executive is constitutionally required to make these available to all member groups at least two months before the NZNO AGM, to give members time to scrutinise the documents and hold the board to account. That deadline came – and went – on July 16.

Members seeking transparency are now being told that the auditors have not yet presented their audit opinion.

I personally oversaw four annual audits of NZNO's finances, so I know what they normally involve. Did the board simply fail to commission the audit on time, or have the auditors perhaps uncovered financial irregularities requiring a longer investigation?

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.

The lack of transparency from a board disengaged from its membership seems to be a continuation of the disturbing failures uncovered in last year's NZNO Governance Review – in areas such as board ethics and capability – although we can't know for certain as they have refused calls to release this report, too.

Thankfully, members will soon have a say about their board. An election for two leading board members – the NZNO president and vice-president – runs from August 4 to September 10. Seven more board members are up for election next year.

With great people standing in this election, members can have hope that we will soon have a board willing and able to achieve NZNO's full potential.

Grant Brookes, RN,
Wellington

NZNO acting chief executive Mairi Lucas responds: Thank you for your kind words about the NZNO/DHB MECA campaign. Staff and members have certainly been working hard, but they could not have been so successful in this work without the backing of NZNO management and the board. All are working together to support the campaign and to make sure members are supported to get what they need and want.

Your points about the board meeting minutes, audited financial statements and annual report are accepted in part. We have been remiss in terms of making the April board meeting minutes available in a timely fashion and I will endeavour to have this rectified by the time this issue goes to print.

In terms of the annual report and audited financial statements, there have been some unforeseen delays this year, which we regret. We are working on getting this information to members as quickly as possible. However, I can assure you there are no irregularities with the financial statements being investigated, and there has been no deliberate attempt to flout the constitution or operate in secrecy on the part of the board.

Your points around the board not releasing the 2020 Governance Review have been raised in these pages before and have been answered in a straightforward manner on more than one occasion (see Kai Tiaki, June 2021, p4 and Board Kōrero, February 11, 2021).

The kaiwhakahaere comments:

By Kerri Nuku

Tēnā koutou to NZNO members as we move into the Māori new year, Matariki, a time to balance progress and stability.

Elections for NZNO president and vice-president are underway, following a period where leadership has been working hard to regain stability.

Now, more than ever, we need to consolidate our membership, and work collectively.

The people elected to these roles will be key to this, as will the chief executive's position, to be appointed by the board.

These three positions, along with tumu whakarae Titihuia Pakeho and myself, are critical – not only in finding stable footing for the organisation, but also challenging it to keep moving forward.

After all, we have hugely significant upcoming health reforms that offer an opportunity for progress.

And progress, it appears, has been a long time coming.

I am currently preparing to speak at a nursing and the law conference in Auckland – a presentation about Māori tikanga, law and nursing professional practice.

My research has reminded me that despite apparent progress in these areas, the reality is that little – if any - constructive headway has been made.

I understand that when it comes to the reforms (which include a Māori Health Authority, and consolidation of all 20 district health boards), we – as an organisation – need to hit hard, and be present for the transition.

I also know we will fight to be at the decision-making table. (I've met transition unit head Stephen McKernan – who assured me nursing was important.)

But the reality from historical documents about Māori nursing, is that efforts for change have been lip service: Dependant on the political party and political will of the day.

Document after document has been written about necessary changes – but we end up, decades down the track, making the very same recommendations all over again.

Thirty years ago there were efforts to create a strategy to develop the Māori nursing workforce.

These days we're still saying the same things.

In early 2018, the NZNO was referenced for its work in Māori equity and pay parity, in a shadow report to the United Nations from a group of major NGOs.

The document, *Committee on the Covenant on Economic Social and Cultural Rights Shadow Report: Aotearoa New Zealand*, called for urgent actions by the Government.

One of them was for the Ministry of Health (MoH) to reconfigure contracting and funding processes. Then later in 2018 there was another recommendation for a Māori nursing workforce development strategy.

It is 2021 and we're still asking for these same things.

Examining the counter history

What I've seen through examining this counter-history of nursing in Aotearoa, is that the voice of nurses comes second in any conversation. The voice of Māori nurses is silent.

Māori make up about seven per cent of the total nursing workforce. We were at that level a decade ago when the MoH put out the *Whakapuāwaitia Ngai Māori (Thriving as Māori) 2030* document.

It said we needed to have a nursing workforce that matched the overall population make-up by 2030.

NZNO kaiwhakahaere Kerri Nuku.

Now we know that is never going to be delivered.

It required us to have employed almost 10,000 nurses annually to match an overall Māori population of 15 to 20 per cent.

There were no initiatives to achieve it. But then again, there's been nothing for mainstream nursing either.

Instead, we've relied on internationally-qualified nurses to make up a significant proportion of the workforce

The only thing that has changed over the years has been the country of origin of these nurses: shifting from South Africa and the United Kingdom, to the Philippines.

At the end of the day we still have an undersupported indigenous workforce.

My challenge at the conference will be to share the kaupapa – that if we truly embrace a different way of doing things, and te Tiriti, it's more than just talk, more than just lip service.

It is about sharing the power to protect, define and assign.

Sharing the destination. Truly sharing the power. •

Opinion: Good cop, bad cop, a Little bit of each

By co-editor Joel Maxwell

Health Minister Andrew Little speaks to NZNO DHB members outside Parliament.

IN ANY government, there are portfolios that cut across problematic issues.

Andrew Little is one minister who has negotiated these challenges with some success – politically, at least.

As Treaty Settlement Minister he has breezed through rough – and still ongoing – disagreements within hapū and iwi.

Pike River re-entry, another Little portfolio, never worked out as hoped, but that fell by the wayside too.

Say what you will about him, Little has a likeability he employs to teflon effect.

It appears, however, nurses might be his stickiest challenge.

It's not surprising: when you've spent hours pumping litres of saline through someone's urethra, post-prostate resection – a long spell of delivering continuous bladder irrigation – then Little's low-key charm isn't quite so irresistible. Nurses have seen it all before, and they're over being sweet-talked by politicians.

Little hasn't helped himself much either, playing both good cop and bad cop after members rejected the latest DHB offer.

Firstly, he appeared on a video speaking directly to members via social media.

Little said it wasn't acceptable that safe staffing tool care capacity demand management (CCDM) had not been rolled out to all DHBs by the deadline set in the last multi-employer collective agreement (MECA).

The rejected DHB offer included a ministerial review into why it had not been implemented, and what needed to be done to get it sorted "as quickly as possible", he said.

There would be another $5 million to complete the rollout.

Little said there would be a recruitment campaign to fill the 1450 nurse vacancies across the country. He said it was too important to delay, and he would be "taking action".

To show how seriously the Government took the problems, Little said the review would go ahead anyway. There would be investment (although it was not clear if it would be to the $5 million level of the offer) to complete the rollout and a recruitment campaign.

He said officials would look to promptly and fairly settle the ongoing pay equity claim, running alongside the MECA.

However, I still had a few questions after the video.

If they were going to offer the likes of a review into why half the 20 DHBs failed to meet the CCDM deadline, then it begs the question: why didn't they just do the review in the first place?

At this stage I have a sinking feeling that any findings won't even be relevant by the time they come out. After all, according to the Government's own timeline, the 20 DHBs will be history by this time next year. They will be replaced by Health NZ, alongside a Māori Health Authority.

Perhaps instead of an inquiry into what happened in the past, they should be pouring resources into the transition unit to make sure CCDM is in place from day one for Health NZ.

After his charm offensive to nurses via video, Little then spoke to the rest of the country, via media, about what he claimed went down at the negotiating table.

Little said the NZNO itself went to the Government with the latest offer, subsequently rejected by its own members.

As NZNO negotiators themselves have pointed out: if they had the power to draft the DHB's offer, then the whole MECA would have been sorted 14 months ago, and it would have been a lot better.

I don't know how these negotiations will eventually play out, but I do know that it might cost Little, and this Government, a bit of their political capital.

Not least among members working in the midst of a nursing crisis. •

‘Disturbing’ Employment Court action by DHBs as members vote in droves to strike

The vote was in, and the DHBs’ gloves came off.

NZNO kaiwhakahaere Kerri Nuku and acting president Tracey Morgan lead members through Wellington during the first DHB members’ strike.

NZNO DISTRICT health board (DHB) members voted in strong numbers to push ahead with strike action on August 19.

The decision to reject the latest offer from DHBs saw Health Minister Andrew Little blame NZNO itself for formulating an offer made to its own members.

It also saw DHBs take NZNO to the Employment Court over life preserving services (LPS) during the upcoming strike action.

NZNO kaiwhakahaere Kerri Nuku said the organisation was disturbed by the DHBs’ actions.

NZNO industrial services manager Glenda Alexander said she was unaware of any DHB facility that did not have its LPS needs met during the first strike on June 9.

“We wonder why the DHBs did not approach us to discuss the matter before issuing a media release about their decision to take this action, which seems just another distraction from meaningful negotiations.”

Alexander said NZNO believed it had met all its obligations and complied with its agreements. “We will continue to do so in the future.”

Alexander said members put a massive effort into ensuring LPS were provided and were gearing up to do the same for the August 19 strike.

She said it was an “affront” to NZNO members who worked hard to ensure LPS was provided. “Our members have bent over backwards to make sure patients were not harmed as a result of strike action, and the services were certainly provided.”

Alexander said the DHBs should instead focus on devising an offer centred on guarantees that safe staffing will be in place every day to ensure the future of safe nursing practice was secure.

Negotiations were set to continue from August 5.

Meanwhile, after the latest vote by members, Minister Little told media that the rejected offer had come from the NZNO itself.

An NZNO statement to members said this was not the case: the organisation was asked for its views by the Government on how to address members’ concerns.

“The Government is the funder of the DHBs and has the ability to address these concerns, so of course we spoke with them. We are making every effort to reach an acceptable deal for members.

“The offer that came through from the DHBs after the discussion with the Government was different to the advice we gave, and particularly different regarding our advice on DHB accountability for unsafe staffing.”

The latest offer was rejected after ongoing bargaining that has focused on pay and safe staffing conditions.

It comes as nursing appears to be in a state of crisis, with an ageing workforce, and offers of better pay and conditions overseas.

Little said to show how seriously the Government took the problems, it would push ahead with a ministerial review of why care capacity demand management (CCDM) systems weren’t in place across all DHBs by the June 30 deadline set for this year in the 2018 MECA.

Only half of the nation’s 20 DHBs met the deadline.

Little said there would be investment to complete the CCDM rollout and a recruitment campaign.

Officials would look to promptly and fairly settle the ongoing pay equity claim, running alongside the MECA, he said.

Notice of the August strike, running for eight hours, was issued on August 2.

Lead advocate David Wait said while the DHBs made promising moves on pay, the offer contained too many ambiguities.

“Members have been clear from the beginning that their safety at work and the safety of their patients is a priority, and that is where they most deserve certainty.

“Better pay will make nursing more attractive, but it is not clear how the DHBs will be held accountable if they do not provide safe staffing. Nurses don’t want more vague promises that the problem will be fixed in the future – which is what we have received once again.” •

Nurse students hit hard by COVID-19

NZNO students in Wellington last month, to share their research with schools, with co-leaders Kimmel Manning (rear, centre), and Mikaela Hellier (second from right).

AN NZNO study has found students were hard hit by COVID-19 last year, particularly in their clinical placements.

"By far the biggest hit was the clinical placements. Everything else they could learn online but not their clinical skills," NZNO principal researcher Jinny Willis said.

Willis hoped the schools would be better prepared to support those students who struggled during lockdown, if another one occurred. "Most did well and got through but a particular few who didn't so let's explore the issues for those students."

Just under 700 student members responded to the April/May survey – nearly a third of the 2266 invited, Willis said.

Students shared the findings with 18 or so heads of school in Wellington on July 9.

The biggest problems reported were lack of practical experience, collegiality and feedback, as well as a quiet place to work.

Clare Buckley

Nearly 70 per cent reported disruption from COVID-19, including 18 per cent "significantly". Clinical placements were an issue for 83 per cent of respondents – including 40 per cent who experienced major impact as placements were dropped, fewer or shorter.

However, just over half – 55 per cent – said they were well supported to catch up with the lost clinical hours. Schools extended future clinical placements or the 2020 academic year, offered catch-up labs or altered their 2021 programme to help with catching up, students reported.

Te Rōpu Kaiako Tapuhi – Nurse Educators in the Tertiary Sector (NETS) co-chair Clare Buckley said the students' presentation "reinforced" what schools already knew.

Schools went to "huge lengths" to support students, which she believed was reflected in the survey and 2020's completion rates. Schools supplied laptops, internet bundles and hardship grants, as well as ensuring staff were available and a flexible timetable. Extra "clinical labs" and other alternatives to practicum were arranged, she said.

Student co-leader, Te Runanga Tauira chair Kimmel Manning, said, "we felt heard and you could see they would want to work with us.

"Today, what I saw was a willingness to have the research and to hear about these issues and take them back to our regions and discuss with our leadership."

Lack of understanding

A third of students surveyed also reported being asked to work outside their scope of practice on placements, suggesting a lack of understanding by preceptors.

Only half regarded their preceptorship as "high quality". Students valued patience and understanding most highly in their preceptors, Willis said.

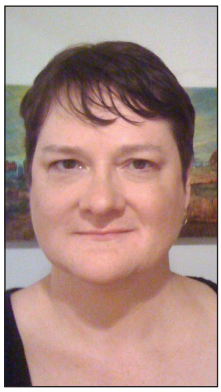
She also hoped nurses who were asked to be a preceptor would try to remember what it was like – and how valuable patience and understanding were to students. "We forget we were at the beginning once."

Nurses were usually asked to be preceptor on top of their everyday work, with no extra reward or acknowledgement, which could be "frustrating", Willis said. "I wonder if they were acknowledged or rewarded if it would make a difference." •

- Just under a third of respondents considered dropping their studies because of COVID-19. Most – 82 per cent – were able to complete their studies but 18 per cent were not able to.
- Just over a quarter believed their future plans were jeopardised or affected in some way.
- Increased financial pressure was experienced by 49 per cent of respondents during lock-down with less part-time work available, closure and redundancy or becoming the sole income earner.
- Sixty per cent did not have a peer mentor or buddy at their school, or opportunities to meet students from other nursing classes. A quarter reported mentors outside of their school, such as qualified nurses.

NPs excluded from end-of-life prescribing

NURSE PRACTITIONERS (NPs) have been excluded from prescribing or administering life-ending medication under the under the End of Life Choice Act (EOLCA), says Nurse Practitioners New Zealand (NPNZ) chair Sandra Oster (right).


Sandra Oster

The EOLCA comes into effect on November 7, but its wording sidelined NPs from practising at their full scope, which was an "error", Oster said.

Under the act's current wording, NPs can only work "under the instruction" of a medical practitioner – despite being designated as authorised prescribers and autonomous practitioners since 2016, Oster said.

NZNO and NPNZ were working together to try and ensure NPs could practise to their fullest scope, and had raised the issue with the Ministry of Health. But the ministry advised it did not want to risk delaying the new law by attempting any changes to its wording, Oster said.

"The Ministry [of Health] has drawn that line, and it's not going to change," Oster said.

She hoped the act would be modified when the law was evaluated, possibly in 2022.

Oster said sidelining NPs would have an impact on access and equity, particularly for those in rural areas and aged care. "Patients should be able to talk to their preferred provider. . . some people are only covered by an NP, not a doctor."

In a second blow, NPs are banned from prescribing some unapproved medications supplied under section 29 of the Medicines Act 1981, which would also limit their ability to provide end-of-life care, Oster said.

A global medicine shortage, due to COVID-19, meant many medications NPs were authorised to prescribe under the Medicines Act were not available. But it was not yet clear whether the life-ending medication being considered for use in New Zealand was one NPs were authorised to prescribe.

NZNO acting manager, professional and nursing services, Kate Weston said NPs appeared to have been "sidelined" by the ministry, which was not good for patients. "NPs work in a very holistic way and would be the preferred practitioner of some people. It's a matter of equity and choice. Why hasn't the law been created in such a way to support NPs?" •

NZNO analyst on end-of-life group

NZNO POLICY analyst Māori Leanne Manson (Ngāti Tama Ki Te Tauihu, Te Ātiawa) has been appointed to the End of Life Choice Act oversight group SCENZ – support and consultation for end of life in New Zealand.


Leanne Manson

A registered nurse (RN) with a degree in Māori studies and a master's in public health, Manson has an in-depth understanding of te reo and tikanga Māori and governance experience on several iwi boards, including as an iwi representative on a district health board.

Her master's thesis was about Māori nurses' perspective on assisted dying.

Manson said she hoped to improve and guide the group in terms of cultural care in end-of-life care settings. •

Students can strike – but not in uniform

NURSING SCHOOLS have reassured students they are entitled to take part in NZNO strikes, as negotiations continue between district health boards (DHBs) and NZNO – as long as they're not wearing nursing school uniforms.

Acting manager professional and nursing services, Kate Weston, said students had the right to support striking DHB members and wanted to clarify that. "They asked 'why are we here? We are nurses, we are about the future of our profession'."

Student co-leader, Te Rūnanga Tauira chair, Kimmel Manning said in 2018 students had been "really unclear" on whether they should be working on clinical placements during strikes. This year, no-one would be working on placements during strike action, he said.

Te Rōpu Kaiako Tapuhi – Nursing Education in the Tertiary Sector (NETS) co-chair Clare Buckley said schools "cannot (and would not) deny students the right to take part in the strikes and show their support for the profession.

"We ask that students do not wear their uniforms, as that would present the position as being the institution's".

She confirmed there would be no practicums during strikes, but said students could choose to work and/or volunteer, "and some do". •

General practices, pharmacies join COVID-19 vaccination rollout in droves

Health providers clamour to join rollout, but Māori vaccination rates still lag.

Associate Health Minister (Māori health) Peeni Henare receives his first COVID-19 vaccination.

THE COVID-19 vaccination rollout stepped up in August, with people aged 60-plus invited to book a time for a shot.

It comes as the Māori vaccination rate continues to lag behind the general rate.

On July 28, Prime Minister Jacinda Ardern announced the Government was extending the rollout to the first age tranche from group 4.

Ardern made the announcement the day after 350,000 vaccine doses landed in Aotearoa: bringing total deliveries for July to 1 million. A further 1.5 million are due to arrive this month.

There were 676 vaccination sites operating around the country at the end of July, including general practitioners (GPs) and pharmacies, and more were planned to come online in the first weeks of August, she said.

By the end of the first week of August, about 1.3 million people had received their first dose of the Pfizer vaccine. About 783,000 people had received a second dose.

Director-general of health Ashley Bloomfield said there had been a sharp rise in the number of vaccine providers around the country. This, he said, included a "much greater number of general practices and pharmacies than we anticipated at the outset".

In the last week of July there were 180 new vaccination sites brought onto the programme, "and the number of GPs and pharmacies that come on board will continue to increase".

Despite the increasing numbers of vaccinated in Aotearoa – at the end of July the rate of Māori COVID-19 vaccination was about half of the general rate.

Associate Health Minister (Māori health) Peeni Henare said about three quarters of the Māori population was aged between 16 and 54.

"Which means that as we look to the age bands that we've got scheduled in phase 4 of the roll-out of the vaccine, we expect to catch a heck of a lot of Māori communities and Māori people across the country."

He said the expectation was that Māori vaccination numbers would "grow significantly" through to September.

There had been "challenges" in the booking system for Māori people living in rural communities, and without internet access, Henare said. •

Millions of nurses left without full vaccination

MILLIONS OF health-care workers are still not fully vaccinated against COVID-19, sparking concern from the chief executive of the International Nursing Council.

CE Howard Catton called for action over World Health Organization (WHO) figures showing about 17 million health-care workers were not yet fully vaccinated.

The majority came from low to low-middle income countries.

Countries in Africa, for example, need about 66 million doses of the vaccine to double jab all their nurses and health-care workers.

"There is a fundamental problem with a lack of supply and not enough going into some of those countries. We have had reports that nurses have queued overnight, waiting to try and get a jab, but still then waiting for their second one."

Catton said health-care workers in these countries should gain priority access to vaccines over young people (12 to 18) in developed nations.

"I also believe there is a clear health and economic argument as well. We know how interconnected the world is, we know that the virus is mutating. The best way to close this down will be to vaccinate the world. It's not a country race, it's a global race."

Unless the virus was dealt with on a global scale, it would hinder the opening of borders between nations, he said. •

Conference runs ahead of biggest health system shake-up in decades

Head of health reform unit to speak to nurses.

THE NZNO conference and annual general meeting (AGM) runs again on September 15 and 16 at Te Papa in Wellington.

The conference is open to nurses, health professionals, and anyone with an interest in nursing – the AGM is for members only.

Guest speakers at the conference will include high-profile health professionals and academics.

They include director-general of health Ashley Bloomfield, who has been in the national spotlight as Aotearoa grapples with its COVID-19 response.

Also speaking is Professor Denise Wilson (Ngati Tahinga, Tainui) – a registered nurse (RN) with intensive and coronary care, acute medicine, and community nursing experience.

Her research has focused on whānau violence, equitable health service for Māori, cultural responsiveness, and workforce development.

Meanwhile the conference comes on the eve of the biggest shake-up of the health system in several decades.

The government announced this year that it would combine all 20 district health boards into a single entity known as Health NZ. It would also create a Māori Health Authority with the authority and budget to commission its own services.

Legislation underpinning the changes is planned to be introduced by September this year.

Speaking at the conference will be former director-general of health, Stephen McKernan – who heads up the transition unit for the changes.

They are expected to be largely in place by this time next year; with McKernan reporting to a ministerial group consisting of the Prime Minister Jacinda Ardern and the ministers of finance, health, disability and associate health.

Other speakers at the conference include NZNO kaumātua Keelan Ransfield, who has also served on Te Poari, Kimmel Manning, NZNO co-chair of the National Student Unit; and Professor Palatasa Havea, Dean of Pacific Students' Success at Massey University, in Palmerston North. •

NZNO STAFF at the Wellington office, pictured here, were gifted their own marching PPE – against the cold, and drab colours – by a group of supportive older knitters.

The hats will be on show for the August 19, and any future, strike marches in support of DHB members. •

Push to boost election engagement after years of low member turn-out

Changes to help members learn more about candidates

IT IS hoped changes to the NZNO election process will encourage more members to participate in the upcoming vote for president and vice-president, NZNO communications manager Rob Zorn says.

NZNO president and vice-president elections are underway now, with voting closing on September 10.

Last September's by-elections for president, vice president and three board members had one of the lowest voting turnouts for NZNO, with just six per cent of members voting.

Voter turnout has generally been low in recent years, hovering around the eight per cent mark. Such low turnout did not suggest a healthy engagement with NZNO by members and NZNO was keen to look at why, Zorn said.

While there were likely to be many reasons, Zorn said two main ones emerged in social media conversations: That it was difficult to find anything out about candidates because of brief profiles; and unclear information scattered across locations, requiring logging in.

Candidate profiles can now be slightly longer, up from 150 to 170 words, and include contact details. Members no longer need to log into the NZNO website to view candidate and voting information, which is all accessible in one dedicated election page on the NZNO website www.nzno.org.nz/2021_nzno_board_election.

Zorn said early voting patterns had been encouraging, and significantly higher than in 2020's by-elections.

Post-election, NZNO also hoped to survey members who didn't vote in the hope to find out why, Zorn said.

There were also plans to make complex remits easier to understand and vote on – however there were no remits this year, Zorn said.

See candidate profiles pp11-13. •

Vote for president and vice-president

VOTING IS open now for a new NZNO president and vice-president.

- Four nominations have been received for the position of president and three for the position of vice-president. The profiles of these election candidates can be read over the following three pages. (NB: These profiles are not edited by *Kai Tiaki* staff.)
- Kerri Nuku was the sole nomination for the position of kaiwhakahaere and Titihuia Pakeho the only nomination for tumu whakarae so both are elected unopposed.
- Members will have received voter packs by email or post earlier this month.
- **Voting closes at 12 noon on Friday, September 10.**

PRESIDENT

four candidates

Anne DANIELS

PROFESSIONAL QUALIFICATIONS
RGON, BHSc, PG Dip in Leadership and Quality, MHSc (Hons)
Expert Nurse on PDRP (current) - in Dunedin Hospital Emergency Department ED - Triage, Resuscitation, Early Assessment Zone, Fast Track
ED Research Nurse (current)
Health and Safety Representative for ED - Unit 29315 (current)
NZNO Delegate Training Level 4

CANDIDATE STATEMENT
Our union needs to change. How? I helped write the current strategic plan, advocating for a member led union. A constitution that reflects this ideal where members' priorities are heard, acted on, a union that empowers members to take the lead, and an infrastructure to support the realisation of members' hopes for nurses and nursing in New Zealand is next. Right now, nurses must win fair and equitable pay and safe staffing to enable us to do our job the way we are meant to. In 2019, I co-wrote a successful remit to start the work towards safe staffing legislation. This must happen to keep our government, public/private nurse employers accountable. I am a delegate of 30 years with integrity, standing for President to work with all members so we can be Freed to care, proud to nurse. Want to know more? Please contact me. Go to https://annedanielsfornznopresident.wordpress.com/

PREVIOUS RELEVANT EXPERIENCE
RGON - CCU, Medical, CRN, CNM ED.
Convenor/Delegate Thames Hospital/WDHB Regional Council.
Delegate leader for nurse colleagues on strike (1999 and 2021).
NMAC for NZNO Board of Directors for 6 years.
Nursing Research Committee Member/Conference Convenor/Chair.
Delegate Dunedin Hospital ED/Regional Council/2021 (current).
Liaison delegate and SDHB LPS negotiator/Reference Group (current).

DECLARATION OF CONFLICTS OF INTEREST
SDHB RN employee.

METHOD OF CAMPAIGNING
Website: https://annedanielsfornznopresident.wordpress.com/
Campaign will use email, phone, Facebook and the above website.
Email: annednz@gmail.com
Phone: 022 656 9208

Diane McCULLOCH

PROFESSIONAL QUALIFICATIONS
Master of Health Science Nursing
Bachelor of Health Science Nursing

CANDIDATE STATEMENT
NZNO is positioned to represent nurses and will bring about positive change. As a Board member, involved in strategic planning and governance I continue to learn. I owned my own business, am a clinical expert and am leading the current constitution review. I continue to champion nursing/medical and paramedic students, from these experiences I have been trained in and continue to learn about human resource development and accountability. My aim is that we will be a leading voice and have a seat at

the table before decisions are made that effect our working environment. This will include increasing our membership, developing position papers, creating new alliances with government and industry, creatively involving students, and taking up important nursing issues. It would be my great honour to take these next steps with you as your President.

PREVIOUS RELEVANT EXPERIENCE

I display effective communication skills as a Board and committee member. My business enabled me to interact with staff and customers. I have the displayed character and integrity in my decisions within nursing and NZNO. I practice effective cross-cultural communication. I am self-aware and prioritize personal development. I develop others encouraging strategic thinking, innovation, and action by developing guidelines and protocols and training.

DECLARATION OF CONFLICTS OF INTEREST

Board member NZNO
Workplace Delegate
Member Greater Auckland Regional Council

METHOD OF CAMPAIGNING

Personal Facebook page
Poster at work
Word of mouth - colleagues/friends

Email: dianemcc77@gmail.com
Phone: 021 772 603

Tracey MORGAN

PROFESSIONAL QUALIFICATIONS

Postgraduate certificate in Primary Health Care Speciality Nursing in Well-child/Tamariki Ora, New Zealand Royal Plunket Society/Whitireia Community Polytechnic, New Zealand, 2008
Registered General Nurse, Eastern Institute of Technology, New Zealand, 2006

CANDIDATE STATEMENT

I am the current Acting President for NZNO. I value the contribution of all members and their aspirations. I am a skilled Practice Nurse Manager who utilises an integrated partnership approach, and clinical and cultural expertise across governance and project boards. I have extensive knowledge of ensuring the voice of the people and their whānau are integrated using Models of Care as a way of normalising culturally responsive practices. I am committed to ensuring equity across systems and services and students, staff, whānau and communities are valued. I consistently integrate both Non-Māori and Māori Mātauranga, worldviews as an authentic contributor to innovation and change management. I am a positive role model who creates opportunities to engage with nurses. I am passionate about creating advanced nursing pathways and creating strategies for recruitment and retention of all Nurses while ensuring they are supported and have access to cultural supervision.

PREVIOUS RELEVANT EXPERIENCE

NERF Elected Board member
Te Aute College and Marae Board Trustee
Hawkes Bay DHB Nursing Midwifery Shared Governance
Te Poari NZNO
MWWL Waipatu
Nga Ringa Manaaki Māori Nurses Forum
NZNO Primary Health National Executive Committee
NZNO Te Rau Kokiri Project Team
Te Rūnanga Rep - Te Rūnanga Tauira and NSU

DECLARATION OF CONFLICTS OF INTEREST

I declare that I have to the best of my knowledge no conflicts of interest.

METHOD OF CAMPAIGNING

Facebook and other media channels.

Email: traymorg6@gmail.com
Phone: 021 025 94927

Clivena NGATAI

PROFESSIONAL QUALIFICATIONS

Dip. Bus admin (Health Management)
BA Health Science (Nursing)

CANDIDATE STATEMENT

My commitment to nursing is as strong now as it was when I first started. My vision for nursing is to promote excellence in patient care, contribute to and advocate for the development of nursing education programs and the ongoing professional development of members. Strengthening workforce planning, sustainability and leadership, and ensuring NZNO is engaged with their members and understands the issues that nurses today face.

Manaakitanga encompasses how I nurse today. Upholding the values of integrity, honesty, trust is my central focus ensuring the "mana" of both NZNO and nursing is upheld.

PREVIOUS RELEVANT EXPERIENCE

CHARGE NURSE MANAGER

My specialty is surgery. My main area is the perioperative setting; however, I have also run radiology department, district nursing and been a clinical service manager for a private practice. I have worked in Christchurch, Auckland, Hamilton and now Rotorua as the Charge Nurse Manager of Operating theatres.

DECLARATION OF CONFLICTS OF INTEREST

I hereby declare that I have no conflict of interest and will remain impartial and unbiased in my duties as a Board member of NZNO representing the nursing workforce.

METHOD OF CAMPAIGNING

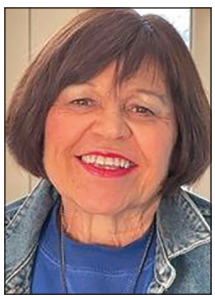
Facebook and other media channels.

Email: clivenangatai@xtra.co.nz
Phone: 027 485 2824

VICE PRESIDENT

three candidates

Cheryl HAMMOND



PROFESSIONAL QUALIFICATIONS
RN, Post graduate diploma, EN

CANDIDATE STATEMENT
I'm currently working as a Clinical Nurse Specialist with 43 years of experience, passion and enthusiasm is what I feel about nursing and its future. Nursing needs strong leadership to address current retention and recruitment issues, I believe I can provide this with my passion and leadership skills and my political awareness. Nurses need to be at the forefront for any change within health. As an active member of NZNO, National delegate and member of Regional Council, I understand NZNO diversity within its organisation and the roles others contribute to the organisation.
I have governance, leadership/management experience and financial acumen, bringing a new voice to the table, with an opportunity to make a difference to nursing and ensure our membership stays strong. I believe in honesty, integrity and openness, I am dependable and knowledgeable and take my responsibilities and commitment seriously.

PREVIOUS RELEVANT EXPERIENCE
Past Board member and Audit and Risk Chair
Previous member Institute of directors
Managing and leading nursing teams

DECLARATION OF CONFLICTS OF INTEREST
None.

METHOD OF CAMPAIGNING
Facebook /hammondchez, email hammondchez@xtra.co.nz, What's app and messenger. Linkedin.
Email: hammondchez@xtra.co.nz
Phone: 021 048 5664

Tracey MORGAN

PROFESSIONAL QUALIFICATIONS
Postgraduate certificate in Primary Health Care Speciality Nursing in Wellchild/ Tamariki Ora, New Zealand Royal Plunket Society/Whitireia Community Polytechnic, New Zealand, 2008
Registered General Nurse, Eastern Institute of Technology, New Zealand, 2006

CANDIDATE STATEMENT
I am the current Acting President for NZNO. I value the contribution of all members and their aspirations. I am a skilled Practice Nurse Manager who utilises an integrated partnership approach, and clinical and cultural expertise across governance and project boards. I have extensive knowledge of ensuring the voice of the people and their whānau are integrated using Models of Care as a way of normalising culturally responsive practices. I am committed to ensuring equity across systems and services and students, staff, whānau and communities are valued. I consistently integrate both Non-Māori and Māori Mātauranga, worldviews as an authentic contributor to innovation and change management.
I am a positive role model who creates opportunities to engage with nurses. I am passionate about creating advanced nursing pathways and creating strategies for recruitment and retention of all Nurses while ensuring they are supported and have access to cultural supervision.

PREVIOUS RELEVANT EXPERIENCE
NERF Elected Board member
Te Aute College and Marae Board Trustee
Hawkes Bay DHB Nursing Midwifery Shared Governance
Te Poari NZNO
MWWL Waipatu
Nga Ringa Manaaki Maori Nurses Forum
NZNO Primary Health National Executive Committee
NZNO Te Rau Kokiri Project Team
Te Rūnanga Rep - Te Rūnanga Tauira and NSU

DECLARATION OF CONFLICTS OF INTEREST
I declare that I have to the best of my knowledge no conflicts of interest.

METHOD OF CAMPAIGNING
Facebook and other media channels.
Email: traymorg6@gmail.com
Phone: 021 025 94927

Nano TUNNICLIFF

PROFESSIONAL QUALIFICATIONS
Diploma of Health Science (Nursing), Bachelor of Nursing, Post graduate certificate in musculoskeletal management, Post graduate Diploma in Nursing.

CANDIDATE STATEMENT
I am an active member who has been involved in all levels of NZNO. I have over 30 years' experience as a workplace delegate. I am currently a regional council member. I was a founding member on the National DHB delegates committee. I have been a NZNO negotiation team member, Board of Directors representative and former NZNO President. I am passionate about nursing and health.
I want to see improved transparency of governance processes at NZNO and will work towards the goal of the strategic plan to ensure that NZNO is a membership driven organisation. I will advocate for nurse patient ratios and delivery of pay equity to all NZNO members regardless of where they work.
I will work collaboratively with all NZNO members to ensure that our organisation delivers on NZNO members being "Freed to care, Proud to Nurse".

PREVIOUS RELEVANT EXPERIENCE
My diverse clinical nursing experience and NZNO membership activities have developed my governance skills, leadership skills and strategic abilities. My service record reflects my passion for nursing and health.

DECLARATION OF CONFLICTS OF INTEREST
Employee at CCDHB.

METHOD OF CAMPAIGNING
Social Media such as FaceBook and Twitter.
E-mail: nanotunnicliff@gmail.com
Email: nanotunnicliff@gmail.com
Phone: 027 422 1654

Nurses celebrate, lament long fight for cervical cancer self-test

After years of fighting to be heard, a network of passionate nurses, doctors and advocates have won the right for women to easily test themselves for signs of cervical cancer – but are angry it took so long.

By co-editor Mary Longmore

After a five-year battle for women to be able to test themselves for signs of cervical cancer, a group of wāhine toa are celebrating a new screening programme planned for 2023.

"This is about women having autonomy over their bodies – de-medicalising our bodies, from a procedure which requires us to get up on a bed and have a very invasive experience," Waitemata District Health Board (WDHB) cervical screening nurse specialist Jane Grant told *Kai Tiaki Nursing New Zealand*.

Associate Health Minister Ayesha Verrall announced in May $53 million in funding to develop a new test for human papillomavirus (HPV), which causes 99 per cent of cervical cancer. The new HPV test will allow women to perform a simple vaginal swab themselves with a cotton bud-like tester instead of facing the dreaded speculum – and is much more accurate, at 99.8 per cent versus 90 per cent, Grant said. Because of this, an HPV test would only be needed every five years, rather than the current three.

But there is frustration, too – the self-test could have been piloted here five years ago, says Grant. Nobody has studied how many cancers may have been prevented in that time – "that would have been a useful piece of work!" But HPV primary screening provides 60 to 70 per cent more protection against invasive cervical cancer when compared with cytology screening – a smear – she says.

Self-testing would particularly benefit Māori, Pacific and Asian women, as well as those living in high deprivation – all groups with low screening rates, Grant said. Ministry of Health (MoH) statistics show more than twice as many wāhine Māori are diagnosed, and close to three times as many die, from cervical cancer as non-Māori.[1]

Research she had been involved with suggested cervical smears were often viewed as a violation of a sacred space, Grant said. Previous sexual trauma, negative smear experiences, lack of awareness and being whakamā – shy – were also reported as barriers by women in New Zealand.[2,3]

Jane Grant with a speculum vs an HPV swab

Georgina McPherson

'It doesn't matter how much we try to make it good, we are still asking women to take off their pants and get up on that bed and invade something sacred.'

One Pacific woman in her 60s said her first smear felt like being "slaughtered" and hadn't returned since her early 20s. A Fijian woman in her late 40s had never had a test due to early sexual trauma.[2,3] Other women said bad smear experiences had put them off for years, even decades.

"It doesn't matter how much we try to make it good, we are still asking women to take off their pants and get up on that bed and invade something sacred," Grant said.

Grant herself is overdue for screening, after a "painful and degrading" experience last time, and says she is very much looking forward to the option of self-testing. New Zealand's current screening programme she says is "a beast" dating back to the 1990s.

Delays

With the benefits of HPV testing emerging internationally, in 2016 then-Health Minister Jonathan Coleman announced plans to introduce it here. However, at the time, the accuracy of a self-test compared to a clinician-led exam had not yet been established, Grant said.

Keen not to delay a new and potentially life-saving approach to cervical screening, Grant and colleagues at Waitemata and Auckland DHBs, along with Victoria University's Te Tātai Hauora o Hine (Centre for Women's Health Research) began researching whether self-testing would encourage more engagement from reluctant communities in New Zealand.

The results were decisive. Recent studies in New Zealand have been universally positive on the response to self-testing across a range of communities – a recent one in Northland showing 51 per cent of women who had rarely or never been screened would self-test and that Māori were three times as likely to self-test.[4]

Yet introducing self-testing had not been prioritised until now – and should never have taken this long, said Grant. "We've been promised this HPV testing programme since 2016 with the National Government, but it never came. . . it was never seen as a priority."

Conversations with successive health ministers went nowhere until it was raised with Verrall in May.

"What's heart-breaking is it wasn't until [Labour MP] Kiritapu [Allan] was diagnosed [in April] that they put any action on it."

Waitemata DHB colposcopist and women's health nurse practitioner Georgina McPherson agrees, saying she felt "aggrieved" when ministers recently claimed credit for the move. "There is a whole group of people involved who are passionate about this – the Government has been the handbrake."

Passionate network

Grant and McPherson are part of an extensive local and international network of around 80 health professionals, Māori health advocates, whānau and researchers drawn together by Tātai Hauora o Hine director Professor Bev Lawton (Ngāti Porou). Its members have given countless free hours over the years, researching and campaigning for self-testing, says Grant.

"We are a group of similar-minded women, I guess – we are maybe a little bit naughty and subversive, where other DHBs are inclined to pull the party line a bit more."

McPherson credited many "amazing women" for getting the initiative across the line. "We do the work for free, because we are passionate about it. . . We come from different places but we are passionate about the best way forward on how to improve care for women, especially Māori, Pacific and Asian women."

McPherson herself is something of a trailblazer. Trained by Dr Ron Jones, a whistleblower on the experiments carried out on women at National Women's Hospital without their consent, McPherson was the first Pacific NP in New Zealand and the first colposcopist with a nursing background. She has researched how Pacific women navigate colposcopies (cervical examination) and now leads the colposcopy team at Waitemata DHB.

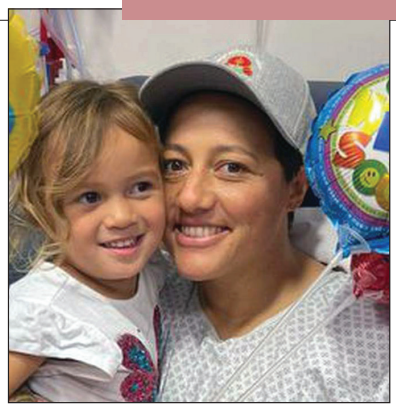
"I just want to make this the best experience for someone, even though it's not a very nice experience to go through."

That includes offering Māori, Pacific and Asian women a female colposcopist when they book appointments and allowing time to discuss people's fears and experiments.

"I will tell them 'if you need me to stop, please tell me – it's your space, not mine'. When people feel like they have some control over what is going on, it helps."

She said her Cook Island heritage heavily influences her approach. "I very much identify as a New Zealand-born Cook Islander. I care for people by being kind, compassionate, empathetic, gentle with people – this is my cultural background," McPherson says. "I consider how I would feel if I was in this person's shoes. I think showing humility and caring goes a long way with people, and they're more likely to open up to you."

Self-testing, she says, is "giving women power back".



Labour MP Kiritapu Allan with daughter Hiwaiterangi

'I think showing humility and caring goes a long way with people, and they're more likely to open up to you.'

Grant expects HPV-testing will make cervical screening far more equitable, but also hopes to see a wider shift.

"My second agenda is empowering all women to have options and autonomy over their bodies," says Grant. "It's so powerful and so exciting to be part of something that enables people to hold their health in their own hands."

Ideally, women will be able to choose what they want, says Grant, "either a speculum exam by a clinician that collects cervical cells and test for HPV. . . or a self-test that does not include cervical cells so if HPV is detected a follow-up smear or colposcopy would be required…"

For nurses, she believes this is also an opportunity to bring more women's health specialty roles into primary care – pipelle biopsies or IUDs for example – making health care for women more accessible and equitable.

Grant emphasises, too, the need for fully funded culturally and clinically safe follow-up services for women, when HPV is detected through a self-test.

"Finding a provider where you feel safe and respected is important and this will be more important than ever in future when providers are screening less frequently." •

– see HPV factbox, p18

References

1) Ministry of Health Tatu Kahukura. (2018, August 02). *Ngā mana hauora tūtohu: Health status indicators: Cancer*. www.health.govt.nz/our-work/populations/maori-health/tatau-kahukura-maori-health-statistics/nga-mana-hauora-tutohu-health-status-indicators/cancer

2) Adcock, A., Cram, F., Lawton, B., Geller, S., Hibma, M., Sykes, P., MacDonald, E. J., Dallas-Katoa, W., Rendle, B., Cornell, T., Mataki, T., Rangiwhetu, T., Gifkins, N., & Hart, S. (2019). Acceptability of self-taken vaginal HPV sample for cervical screening among an under-screened Indigenous population. *The Australian & New Zealand Journal of Obstetrics & Gynaecology, 59*(2), 301–307. https://doi.org/10.1111/ajo.12933

3) Brewer, N., Bartholomew, K., Grant, J., Maxwell, A., McPherson, G., Wihongi, H., Bromhead, C., Scott, N., Crengle, S., Foliaki, S., & Cunningham C. (2021, April 15). Acceptability of human papillomavirus (HPV) self-sampling among never-and under-screened Indigenous and other minority women: a randomised three-arm community trial in Aotearoa New Zealand. *medRxiv*. www.medrxiv.org/content/10.1101/2021.04.11.21255231v1

4) MacDonald, E., Geller, S., Sibanda, N., Stevenson, K., Denmead, L., Adcock, A., Cram, F., Hibma, M., Sykes, P., & Lawton, B. (2021). Reaching under-screened/never-screened indigenous peoples with HPV self-testing: A community-based cluster randomised controlled trial. *The Australian and New Zealand Journal of Obstetrics & Gynaecology, 61*(1), 135-41.

NZ's first nurse hysteroscopist-in-training

WAIKATO NURSE practitioner (NP) and colposcopist Lauren Moore (right) says she hopes training nurses in hysteroscopy – examination of the uterus – will benefit women at an "extremely frightening and vulnerable time" in their lives.

Moore is the only nurse in New Zealand training as a hysteroscopist, a role which involves examining uteri, often for cancerous or pre-cancerous conditions.

She began training in August 2020 on a pilot programme at Waikato District Health Board (DHB), developed by head of gynaecology Dr Tavaziva Mudzamiri. Currently on maternity leave, she hopes to finish in 2022.

With a "forever increasing" waiting list for women requiring hysteroscopies to diagnose pre-malignant or malignant conditions, the gynaecology team had struggled to keep up, she said.

Until now, hysteroscopies have primarily been the domain of gynaecologists in New Zealand, unlike the United Kingdom (UK) where nurses had been performing the role for 20 years.

Having worked alongside many nurse hysteroscopists in the UK, Moore said Mudzamiri was keen to introduce the concept to Waikato DHB to help speed up cancer diagnoses and treatment and reduce waiting times for women – with the ultimate aim of improving health outcomes.

Moore says having a permanent nurse hysteroscopist at women's health outpatients would provide continuity of care and a "holistic" approach where broader needs can be met.

"This is an extremely frightening and vulnerable time for women – having a female hysteroscopist is a significant benefit".

'This is an extremely frightening and vulnerable time for women – having a female hysteroscopist is a significant benefit'

Already working as the DHB's only nurse colposcopist, examining the cervix, Moore had been able to offer women regular weekly clinics. A permanent nurse hysteroscopist would have the same benefit of consistency and reassurance.

Moore said as a women's health NP and nurse colposcopist she was "instantly attracted" to the idea of training for this position, "leading the way for other nurses within New Zealand".

The training standards are adapted from the British Society for Gynaecological Endoscopy and the programme – run over 12-18 months – combines theory and practical elements. Her clinical mentor is obstetrics and gynaecology consultant Sean McConnell, who had given many hours of training to both inpatient and outpatient hysteroscopy, she said.

The pilot programme was intended to test how to successfully complete hysteroscopy training for nurses in New Zealand.

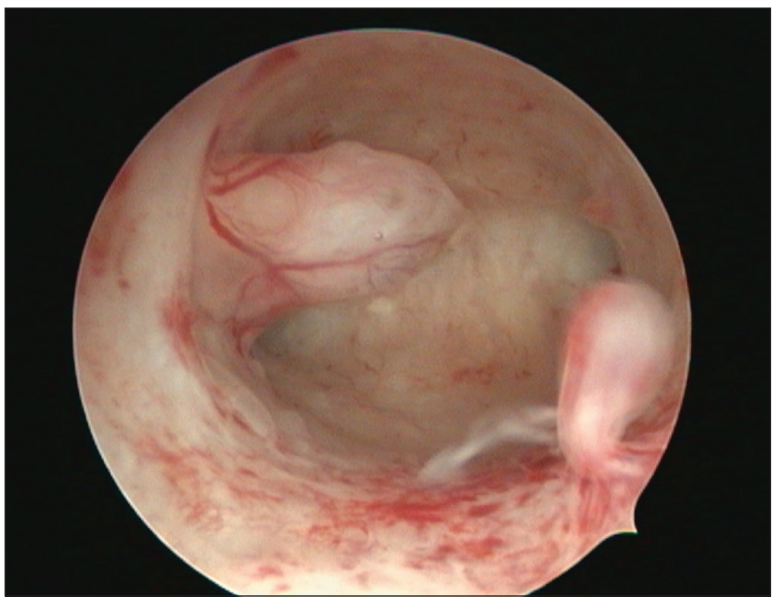
Moore is also helping develop NZNO Women's Health College (WHC) national hysteroscopy training standards. They will form the basis for a polytech-based hysteroscopy training programme for nurses hoped to be launched in New Zealand in 2022, Moore said.

Endometrial cancer, which affects the uterus lining, is one of the fastest-growing cancers in New Zealand, but about 80 per cent of cases can be treated if detected early.

Training nurses to provide this care would make it more available and equitable and save lives, Christchurch NP and colposcopist Jill Lamb has said.

Endometrial cancer rates were disproportionately high in Māori and Pacific populations, with wāhine Māori mortality rates almost twice that of non-Māori.

Lamb said she hoped to see nurse-led hysteroscopy services available throughout Aotearoa. •



Hysteroscopy image of the uterine cavity with endometrial polyps

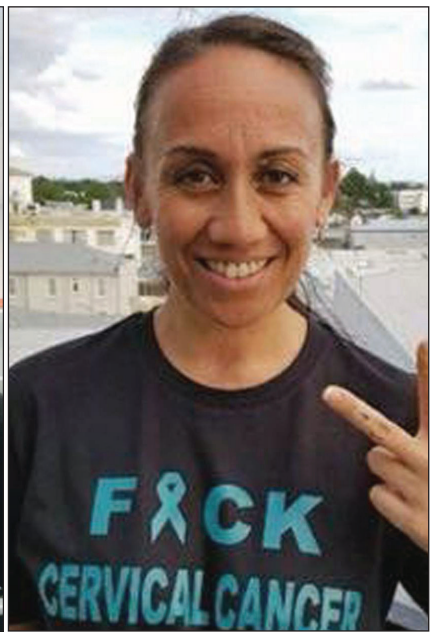
Nurse continues campaigner's fight

CERVICAL SCREENING coordinator for Waikato, specialty clinical nurse Nadine Riwai, (Ngāti Porou, Te Uri o Hau, Ngai Takoto) has been heavily influenced in her approach to caring for women by the Smear Your Mea (SYM) founder Talei Morrison.

Morrison had not had a smear for several years after an uncomfortable one and was diagnosed with cervical cancer in 2017.

She blogged about her experience, encouraging others not to miss their smears, which turned into SYM.

Nadine Riwai



Talei Morrison

'Know my face before you know my cervix' – Waireti Walters

The slogan was gifted by whānau at Korowai Aroha health centre in Rotorua where Morrison lived and the campaign has continued with the support of her whānau.

Morrison died at 42, in 2018, shortly before Riwai took up her role, but had made a huge impact on Riwai, who sits on the SYM Trust alongside her role at Waikato District Health Board. "I wanted to have an influence in this area. . . and keep her legacy going."

As a nurse, Riwai knows how important it is to have regular smears, but also knows women can be too busy, embarrassed or put off by an unpleasant smear experience. Her approach is to make women as comfortable as she can – she connects, chats and reassures them, and often travels to people's homes if they prefer, including on evenings and weekends. "I just want to make it a positive experience."

She uses a small plastic speculum and finds a bit of humour can break the awkwardness of the intimate examination. For her home visits, she tries to allow an hour, as often women open up about their lives and health – which she sees as an opportunity. "You're not just there to find a cervix!" she laughs.

"I have got a real passion for just being there. It's not just what suits me, it's what suits who I'm going to."

Her focus is all women, but she travels widely through the region, visiting homes, marae and wānanga and talking to kaumātua, in an effort to reach as many Māori as she can. "Anything I can do to normalist and promote regular cervical screening."

Research in 2019 showed wāhine Māori aged 25-44 were three times more likely to die from cervical cancer than non-Māori in the same age bracket.[1]

Back when the National Cervical Screening Service began in 1990, there were outspoken wāhine Māori like former Māori Women's Welfare League president Dame Mira Szaszy, who connected wāhine Māori to the service, Riwai said. But over time, Māori testing rates had "waned".

Riwai travels with screening kit in her bag, ready to perform a smear at any time – and her team has set up mobile screening clinics at events such as field days and waka ama throughout the region, as well as at COVID-19 clinics on marae. Her team also are busy promoting and normalising the need for regular cervical smears. "You can screen anybody who is willing – it doesn't matter where they're from, I just do it."

She hopes the less invasive self-testing will be free to all and available outside clinic hours.

When she took up the role, friends asked her if she would be looking at vaginas all day, to which she says yes… and no! There is a lot of talking and she takes all the time she needs for that.

Riwai quotes the late Māori health advocate Waireti Walters who said, 'Know my face before you know my cervix'.

"It's the first job I've had which doesn't feel like a job."

Waitemata cervical screening nurse specialist Jane Grant describes Riwai as an "early adopter, seeing the potential to improve outcomes, and using her strong voice and connections to keep talking about self-testing as an option for those who want it". •

– Profiles by co-editor Mary Longmore

August marks the four-year anniversary of Talei Morrison's diagnosis. On Sunday August 29, the Smear Your Mea Trust will be running free cervical screening clinics across Aotearoa to mark Smear Your Mea day, in honour of Talei's legacy. Check Smear Your Mea's Facebook page for details.

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Cervical self-testing a long time coming, from p2 – references and key messages

Key messages for health professionals

- HPV testing has a very high negative predictive value (so can have a longer screening interval) and is a more sensitive test than cytology.[9]
- A self-test for HPV is equivalent to a test taken by a clinician with a speculum (as long as a PCR test is used at the laboratory).
- Finding and sampling the cervix is not required for self-testing – viral DNA is found all over the lower genital tract.
- People who have symptoms including pelvic pain, unusual bleeding or discharge should be encouraged to have a speculum examination.
- If HPV is detected on a self-taken sample, a smear test or colposcopy is required to determine whether cell changes have occurred.
- The current screening programme continues to be safe and effective. It is important that people keep having their regular cervical screening tests and not wait for the change to HPV primary screening in 2023. •

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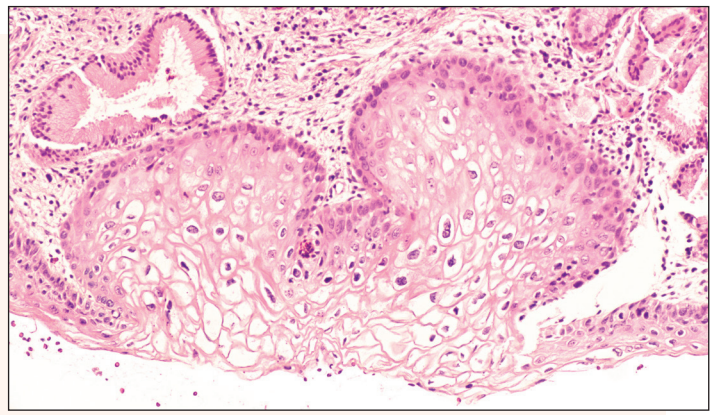
HPV self-test fact box

- In 2023, a five-yearly human papillomavirus (HPV) test will replace the current three-yearly smear test for 1.4 million eligible women aged 25-69. Swabbing the genital tract for HPV virus can be done by a patient or clinician using a tool similar to a cotton bud. Results are 99.8 per cent accurate compared to a current accuracy rate of about 90 per cent.
- Cervical cancer is almost entirely preventable through vaccination screening – yet every year 160 women develop it and 50 die from it in New Zealand.
- Clinical modelling predicts the move to HPV screening will prevent about 400 additional cervical cancers over 17 years and save around 138 lives. A third of the cases prevented and lives saved will be wāhine Māori. Wāhine Māori die from cervical cancer at more than twice the rate of non-Māori.
- Only 61 per cent of eligible Māori access New Zealand's National Cervical Screening Programme, which has reduced cervical cancer rates and death rates by more than half since 1990.
- HPV primary screening provides 60 to 70 per cent more protection against invasive cervical cancer when compared with cytology (cervical smear) screening. •

– Sourced from Waitemata DHB cervical screening clinical nurse specialist Jane Grant and Associate Health Minister Ayesha Verrall.

PHOTO: ADOBE STOCK



Cervical lesions due to HPV

Life as a nurse practitioner opens a world of possibilities

Northland primary health nurse practitioner Ebson Abraham.

By Ebson Abraham

Nurse practitioners (NPs) are highly skilled autonomous health practitioners who have advanced education, clinical training and demonstrated competency; they have the legal authority to practice beyond the level of a registered nurse (RN).

NPs provide a range of assessments and treatments, have a broad scope of practice, and the same prescribing authority as doctors or medical practitioners; these services are funded and subsidised by the Ministry of Health (MOH) and they can work across the spectrum, influence health services and wider professions.

I am an NP in Te Tai Tokerau (Northland). Nearly 10 years ago, I moved to Whangārei. As a comprehensive RN, I worked for organisations including residential care homes, general practices, and for the Northland DHB hospital.

I completed a clinically focused master's degree from the University of Auckland.

Most of the current NP workforce are in general practice, due to a shortage of doctors or GPs in primary health care. As a primary health care NP, my job includes, but is not limited to:

- Registering patients under my care for both short (acute) as well as long-term care. Completing a more thorough assessment of their health (telehealth or face-to-face).
- Ordering and interpreting diagnostic tests. Prescribing medicines including controlled drugs (Class A, B & C).
- Referring to specialists as required or liaising with secondary care.
- Completing certifications (such as driver's licence, ACC18, WINZ and insurance).
- Performing skin biopsies, minor surgeries, and arthrocentesis, joints, or trigger finger.
- Ordering intravenous infusions, antibiotics, vaccinations, and procedures etc.

Is an NP pathway a possibility?

If you are an RN and passionate for change and ready for a challenge over four to five years, then this is for you.

Which nursing area is best for me to develop this role?

The area you are practising now is the best space for your growth. For clarity, you must be a clinically interested person, hands-on with assessments, monitoring, care and follow-up. If you have more passion for education, management or leadership roles, this may not be your best choice.

What is the minimum educational qualification required?

You must complete a Nursing Council accredited master's degree programme. The best place to start is contacting your post-graduate education coordinator at your DHB or PHO.

How long must I be in practice first?

A minimum of four years' experience in a specific area of practice is required. Some universities require at least three years of full-time practice in the designated area.

Do I need employer support?

Yes, you must have employer commitment to support you through the developmental stage as well as an assurance of employment at the end before entering NP practicum programmes.

Do you need a doctor or GP at any stage?

NPs are authorised prescribers; no reporting is legally required to any clinicians like GPs or NPs except the supervision required in first year post registration. However, as an excellent clinician, you are expected to maintain a collegial relationship with GPs, NPs, pharmacists, RNs, specialists, management and multidisciplinary teams.

How does your patient see you?

Every revolutionary role takes time for acceptance. From most NP note books, the community sees you as a primary provider, a person authorised to take decisions on their health. Some call you a "doctor", others call you a "doctor-nurse" or "nurse-doctor": it's our responsibility to disclose our role as NP to maintain a long-term trust as well as to deliver our best care possible.

I would like to see a college for NPs set up at NZNO to support our current and future NPs. •

Nursing recruitment needs a boost. It might just be time for the great. . .

. . . fees Wipe-out

By co-editor Joel Maxwell

New nurses are coming into the profession facing daunting student debts.

The idea that nurses are essentially taken for granted might be a truism within the profession itself, understood by few on the outside.

But in a nation facing an aging population, the challenges of an ongoing global pandemic and new generations less interested in nursing (look no further than an on-average aging workforce), and you soon realise there is another group taken for granted too.

What about new nurses?

People joining nursing are doing it for love – and it appears the prospect of a whopping student debt could stop some from ever beginning the journey.

Now some are calling for the government to remove what might be one of the biggest hurdles to recruitment.

They want a great fees wipe-out.

Vince Paala is on a mission to get changes to the cost of a nursing education.

Paala has worked for 14 years as a health-care assistant – 12 spent in critical care in Middlemore Hospital.

It took him years to finally make the decision to study to be a registered nurse – because of the cost.

Now aged 52 he is studying a Bachelor of Nursing at Manukau Institute of Technology. But, as he told *Kai Tiaki Nursing New Zealand*, he will be aged more than 55 when he finishes his course.

He was not able to get the first year fees-free, because of previous study, so will walk out into the workforce in his mid-50s with three years'-worth of student debt.

Paala launched a petition to Parliament calling for the government to consider fees-free study.

"I noticed the decline of interest in nursing. . . from the young people of today's generation, despite the one year of free tertiary education and other scholarship grants."

Apart from the pay and staffing issues in nursing, one of the major obstacles was the cost of a nursing degree, he said.

"As we know there are other deterrents, why there's a lack of interest in nursing…but if this fees-free for nursing degree is available, it can stir or encourage more young people to get into a nursing career."

'I knew no one, and I knew I wouldn't like the cold. Even so, it was the logical thing to do.'

As part of the fees-free degree, there could be a post-study period where the graduate must work in New Zealand, Paala suggests in his petition. It would help stabilise numbers in the profession.

There has been a fees-free set of programmes running in the deep south, at the Southern Institute of Technology, for several decades.

NZNO National Student Unit co-representative from Invercargill, Nic Brasch, said it was offered to New Zealand and Australian students through the entirety of their course.

"Zero fees was the entire basis for my return to study. I tried, and failed, to study at a tertiary level straight out of high school, which meant I wasn't eligible for the fees-free initiative. I've always had potential, but not a lot of direction – so the prospect of undertaking student debt in a field I mightn't enjoy definitely deterred me from further study."

Brasch said she had never been to Invercargill before starting her Bachelor of Nursing.

"I knew no one, and I knew I wouldn't like the cold. Even so, moving down here was the logical thing to do – I would emerge with the same accreditation, but $20,000 less debt than students who had studied elsewhere."

She said she would be "delighted" to see free, or heavily subsidised, study for

the future of nursing in Aotearoa.

"The baby boomers are getting old, and the median age for nurses in New Zealand continues to rise.

"More patients and fewer nurses mean we are facing catastrophic shortages…in the not-too-distant future if we don't see some change soon."

Access to education, better pay, and safe staffing would contribute to people joining the nursing profession - as well as the longevity of those who take on the challenge, Brasch said.

No Government policy plans

Health Minister Andrew Little told *Kai Tiaki* that making the entire degree fees-free was not Government policy at the moment.

"What attracts people into a profession isn't whether they get their student fees paid for – it's the job itself.

There is a range of things we need to do to encourage people into nursing, including remuneration, the working environment and job satisfaction, and we are working on those."

He said enrolled nursing qualifications were already fees-free under the government's new targeted training and apprenticeship fund.

There was also first year fees-free study available for degree students, he said.

I knew I was going to come into a lot of debt, particularly for someone my age, and thinking, 'I'm going to be paying that off till I retire'.

In the midst of an industrial dispute with NZNO district health board (DHB) members, Little has previously said the Government would launch a recruitment campaign. He did not give specific details.

One person who faced a hefty cost, but took up the challenge anyway, was Christine Hay.

Now a registered nurse in women's health with Capital & Coast DHB, she said she "absolutely" supported the idea of full fees-free study for nursing.

Hay, 50, ended up with about $60,000 student debt. As a mature student with previous study under her belt, her entire living costs had to be loaded on her student loan as well.

Nursing faces huge pressure with an ageing population in Aotearoa.

"I only finished studying at the end of 2019. Having fees-free would be a huge difference. That was something I took a lot of consideration of. I knew I was going to come into a lot of debt, particularly for somebody my age, and thinking 'I'm going to be paying that off till I retire'."

She started studying nursing in the 90s, but family commitments meant she had to wait till her youngest child was 14 before she considered a return.

Vince Paala.

Hay said the likes of secondary teaching study was previously not only fees-free, "they actually got paid to study, at one stage".

"So nursing definitely needs something like that to encourage people in."

However, they also needed jobs ready to go for new graduates when they've finished study – allowing them to gain experience.

She started at her job with C&CDHB in July, after having to travel to the West Coast – from her Wellington home - for a year-long stint at her first job.

She enjoyed her rural work, which had its challenges, and a broad scope. "We had anything and everything coming through the doors".

But with her family in Wellington, she jumped at the chance to return.

Hay said the most sensible thing to have done was study in other fields – but she always wanted to be a nurse.

She put a lot of consideration into how long her nursing career would be, versus the cost to become qualified.

"I ended up having to put the emphasis on what I wanted, rather than what was practical, purely because the cost."

Hay said it appeared she would likely pay off her debt about five years before reaching her retirement age.

Any support can't come soon enough for Vince Paala, who has shaken up his life and taken on a large debt to study. A labour of love, not financial security.

"I'm 52-and-a-half years old, doing my Bachelor of Nursing…so by the time I finish…I will be over 55 and still have to pay my student loan too." •

The Secret Joys of Working in Private Healthcare Agencies

Protests against wages, working conditions and understaffing is taking a toll on the nursing industry in New Zealand. With outrage from nurses working in hospitals and other medical settings, it's an opportune time to see how the nurses working for private healthcare agencies are faring, and according to Registered Nurse Donna Talagi, it is significantly better.

Ever since Donna was young, she has wanted to be a nurse, "I'm a real people person and love being around people of all ages. This was really confirmed for me when my granddad became ill, I loved being able to take care of him, helping with his care and being there for him." This passion, as well as a love for children, led her to pediatrics. As a nurse in pediatrics however, she felt that "the doctors did all of the invasive procedures and the healthcare assistants provided all the care. I felt a bit surplus to requirements!"

Donna decided to step away from pediatrics and moved into oncology for her second NETP placement at the DHB, "it was a six-month placement and I absolutely loved it, I was asked to stay and was there for eleven years. Oncology was great and covered care for all ages, right through to palliative care. I love being hands on. I really enjoy the practical clinical work and it was so easy to stay in one place and get comfortable".

After a while Donna left the workforce to be a stay-at-home mother for her two boys. She says "I never thought of joining an agency at the time, I thought I'd go back to oncology. I was a stay-at-home mum for five years, after that I was ready to come back to work, it wasn't financially motivated at the time – I didn't need to work, I needed to keep my Annual Practicing Certificate. I had some great advice from a senior colleague years ago to never let your APC lapse, and that really stuck with me."

When Donna entered back into her role at the DHB, she was hoping for the odd shift to help her maintain her skills. However, what she found was a demanding environment that didn't allow her any time with her family, so "luckily a colleague suggested Nova Health, a nursing provider, as a good option. They offered all the flexibility and support I needed, and got me up and running and back on shifts really quickly. I love Nova, I choose the shifts that I want to work, it fits in really well with my family – I can work as little or as much as I want."

During her transition to working for Nova Health, Donna found that "the communication is so easy, the staff are really great, there's no pressure if you can't work, everyone is supportive – it's such a contrast to other places where there can be so much pressure, even down to making you find your own shift cover when you're sick. I know nurses that work for other agencies and they are always under pressure to work, even when they say they're not available. Nova's different… I can show up, do a job to the best of my ability and I don't need to get involved in any politics or issues. It's so nice to go in, make a difference and be able to leave."

When medical issues took her family by surprise, Donna's husband was unable to continue as the main breadwinner. Because of this, Donna had to pick up more shifts and "again Nova provided just what I needed. The staff are so lovely and really supportive, they reassured me that things would be ok, and I would get the hours I needed to keep my family afloat. .
They have been so supportive."

Donna Talagi hard at work with Nova Health

I never thought I'd be an agency staff member, but I absolutely love it. It's so nice to have a break from doing the same thing, a change of scenery; I've had some really brilliant placements and love the variety, I have learnt so much and the access to education is so good. You can learn and then go and put it into practice. I was really senior and experienced in my previous role, but it's great to get out and learn."

As we all know, issues regarding wages have been a catalyst for recent strikes; Donna herself found that Nova Health, as a private healthcare agency, paid her fairly. She says that "it's really great pay, I've been blown away by how different the pay is compared to other places, especially aged care and practice nursing. I feel lucky to be appreciated and very well paid, it's a big help
– and there's no need to strike!"

With the demanding nature of many nurses' roles, Donna is concerned about the future of nursing, "It's changed, it's become so busy and so task orientated, the compassion side of nursing has changed. I get thanked everywhere by patients for caring and, while that's nice, it worries me that it's not the norm anymore. There seems to be a lot of "that's not my job"." Her concerns are not only for the direction that nursing is taking, but also the wellbeing of people working in public healthcare systems, "I worry about nurses being burnt out and tired and it blows me away the level of inexperience I see in some places. The knowledge just isn't being passed on and we're losing so much of it as older nurses are retiring. I see the lack of experience and confidence as a big problem; nurses need to know their limits to keep themselves and their patients safe. I hope that the proposed safer staffing level changes
make a difference."

The flexible timetable, fair pay and rewarding interactions with patients have provided Donna with an environment that accommodates for her every need. She has had an abundance of experience in both public and private healthcare settings, yet it is the variety with Nova Health that Donna believes really allows nurses to flourish and enjoy their work. Donna says "I can say from experience that you can get really comfortable in one place and end up stuck. I talk to old colleagues and they're not happy and it affects them mentally and physically. I say take a leap, just do it – it works so well, leave the politics behind, have the confidence to change. I'm sure you'll love it. Private healthcare agency work is really rewarding, it's refreshing and it's great to challenge yourself. I'm so grateful and I absolutely love my job."

ADVERTORIAL

Mesothelioma:

The deadly legacy of asbestos

Two long-serving nurses and NZNO delegates describe how their lives led up to a diagnosis of mesothelioma – the cancer caused by swallowing or inhaling asbestos fibres. They want to raise awareness of mesothelioma and the dangers of asbestos.

By Leonie Metcalfe and Donna Thomas

Lurking behind the walls, ceilings and floors of our older hospitals, in the lift shafts and pipe lagging, lies asbestos – an unseen killer responsible for the cancer, mesothelioma.

In 2020, we were both diagnosed with mesothelioma.

- **Both of us** have had long nursing careers and were working in district health board hospitals.
- **Both of us** have had ACC claims accepted for accidental workplace exposure to asbestos.
- **Both of us** want to raise awareness of the risk to the many nurses working in older hospitals where asbestos is disturbed during remodelling, repairs or demolition.

Mesothelioma

Mesothelioma is a rare and aggressive form of cancer caused by asbestos.

PHOTO: WAIKATO TIMES

Leonie Metcalfe – a devastating diagnosis for her and her family.

A message from Leonie Metcalfe and Donna Thomas

WE HAVE been NZNO delegates for many years. As our last advocating act for nurses, we want to warn you about asbestos.

Asbestos is in public hospitals built or renovated between the 1930s and 1980s. If it is disturbed, the fibres are released into the air. If you inhale or swallow them, you are at risk of getting mesothelioma.

Fortunately, most people who are exposed will not go on to develop mesothelioma . . . but some will. Be aware of the dangers, be wary of old hospital buildings being remodelled, BEWARE – there is no safe amount of asbestos exposure when it comes to mesothelioma.

Mesothelioma may not be curable, but it is the most preventable cancer, because the cause is known – ASBESTOS. •

It affects the cells that make up the mesothelium, the lining that covers and protects various internal organs of the body. Mesothelioma most commonly occurs in the lining of the lungs or the abdomen.

It is a terminal disease with a poor prognosis and is much more common in males and tradespeople. This disease has a long latency period after inhaling or ingesting asbestos, so it can be difficult to get a diagnosis and often presents in advanced stages. Mesothelioma has limited treatment options.

It has been described as a cruel, hideous, unlucky, devastating and – sadly – terminal disease.

Leonie's story

I AM a nurse with 50 years' nursing experience, a wife, and a very proud mum and nana. Life was really busy. I was working full-time and held positions on regional and national nursing committees – I was national chair of NZNO's Enrolled Nurse Section from 2014-2018. I had been doing

lots of overseas travel and was feeling fit and healthy.

On July 29, 2020, I was admitted to Waikato Hospital for investigations after casually mentioning to my GP that I had noticed some increasing shortness of breath over the previous four months and a cough that I'd seemed to have had forever. Thanks to my GP for quick intervention, I was admitted to hospital within five hours.

Initial investigations showed a large pleural effusion, which resulted in having four litres of fluid drained from my right lung. A CT scan showed a diffuse nodular right pleural thickening in keeping with malignant mesothelioma, confirmed by a pleural biopsy.

I had stage 3b pleural mesothelioma, which I knew nothing about. I was told it wasn't very common in females, had a poor prognosis, and my only treatment option was palliative chemotherapy. Currently immunotherapy treatment is not approved for mesothelioma in New Zealand, but can be self-funded at a huge cost, making it prohibitive for the majority of patients. This was a devastating diagnosis for me and my family. With a scary journey ahead, I'm very thankful for my amazing family and friends walking this road with me.

I started chemotherapy in September 2020 and had my last dose on December 24. I felt really unwell in my later chemo treatment, with trips to the emergency department for sepsis screening and blood transfusions, as well as further fluid drainage from my lung. I am currently in remission, and retired from work in March to spend good quality time with family and friends and to help raise awareness of this silent killer.

Following my diagnosis, I lodged an ACC claim, as almost all mesothelioma is caused by exposure to asbestos. I was told that if I was male and in a trade where there was possible exposure to asbestos in the workplace, my ACC claim would have been accepted. As a female in employment not usually associated with asbestos exposure, I was expected to prove where and when I could have been exposed to asbestos. I had had no known asbestos exposure and no family members had been in occupations with a "high risk" of asbestos exposure.

I continued to challenge ACC decisions, detailing my work history and instances when renovations were undertaken in the hospital buildings . . .

I have only ever had two employers, both DHBs, and can remember working when building alterations were undertaken while hospital staff and patients remained on site. While I was able to provide my work history, I was unable to provide any particular instances/dates to pinpoint asbestos exposure. During information-gathering, my family and I had conversations with anyone who cared to listen, such as engineers, asbestos-removal experts, and workplace health and safety. We also accessed some DHB asbestos management plans and policies.

I was constantly reminded that due to the nature of my occupation as a nurse, the risk of asbestos exposure in the workplace was deemed very low risk. ACC continued to argue insufficient evidence of work-related asbestos exposure to accept my claim. I continued to challenge ACC decisions, detailing my work history. This included instances when renovations were undertaken in the hospital buildings, where asbestos was never discussed, no protective precautions were taken or offered to nursing staff.

My ACC claim was finally accepted in October 2020 as work-related occupational exposure to asbestos.

I was told there were no mesothelioma support groups in our area, because the disease has such a poor prognosis, people didn't want to waste precious time setting them up. This has motivated us to work on setting up a national group. •

Donna's story

LAST OCTOBER I was told I had mesothelioma, and my world tipped up. It tipped me into a hole I can't find a way out of and dragged my family into a place of sadness and worry. Before that, I was a 61-year-old nurse who loved her work but was starting to look forward to retirement.

Now I'll never get my super. Now I'm a patient.

I had not been right for a few years. I had been having chest pains and noticed I couldn't keep up with others when walking down hospital corridors. I had daily sweats and ran low-grade fevers, but nothing was found on tests. My abdomen felt tight. I had severe reflux and I had changed shape – was this just old age? Occasional abdominal pains would make me lie down. I had a CT scan and gastroscopy, but apart from a hiatus hernia and oesophagitis, nothing was found.

I carried on working, but went from the emergency department to a more sedentary role in community, as I was just too exhausted to keep up. In February 2020, I woke with severe spasms of coughing – this turned into a chest infection, and I was treated with antibiotics, but never came right. I continued to have chest pains and a dry cough. I would cough and cough until sometimes I vomited.

If I lay down, I was breathless. If I carried anything, I was breathless. If I bent over, I would cough. I went to the doctor and was swabbed, as it was COVID times, and was given inhalers. I had a respiratory function test that showed I had 64 per cent of expected function

in a restrictive pattern. But because I was a smoker, it was thought I had chronic bronchitis – I have a drawer full of inhalers that didn't help.

Eventually, in September last year, I was found to have a dullness in my right lung. An x-ray showed a large pleural effusion and atelectasis. When all the results from pleural fluid cytology and immunohistology, and scans came through, it was decided I had right pleural mesothelioma, with nodules in my peritoneum as well. The outlook was bleak. I was terminally ill.

How could this happen to me?

Hospital renovations

I remember I had gone on to the asbestos exposure register 20 years ago, because of renovations being done at the hospital I worked at. I had been working in the surgical ward when renovations were done to join the ward to the theatre suites. Staff had continued to walk through the building site daily, taking our patients back and forth to theatre and recovery.

There were no signs up, no plastic sheeting to seal off the dust. At one stage we had to steer the beds along a black sticky mat to avoid tracking it into the theatres or back into the ward.

It was several months before we were told that asbestos was found in the fabric of the building that was being renovated. I didn't know about mesothelioma then. I didn't know that for some people, breathing in or swallowing even small amounts of that dust was deadly – and that 20 years later I would develop this terminal cancer.

This news was devastating – mainly because there didn't seem to be any way to fight back. It was incurable. I was offered palliative chemotherapy, which might increase my survival by a few months, or best supportive care. I struggled to believe there was no Hope. I took up the offer of chemotherapy, but life became a misery, and it was stopped after three cycles. During this time, the pleural effusions kept reaccumulating and I had four chest drains, the last one left in permanently.

I went hunting for information, research, new therapies, support groups, to find what was happening with mesothelioma in the rest of the world. I didn't find a cure, but people were living longer by having more treatment overseas: repeated chemotherapy, immunotherapy, going on trials. Immunotherapy has been approved and is funded by the National Health Service in Britain, and in Australia the Pharmaceutical Benefits Scheme has just fast-tracked funding of immunotherapy for mesothelioma.

There were no signs up, no plastic sheeting to seal off the dust. At one stage we had to steer the beds along a black sticky mat to avoid tracking it into the theatres or back into the ward.

In New Zealand, immunotherapy is only available to those who can pay via the private system. This is not equity. My oncologist requested immunotherapy for me from Pharmac and ACC, but both were declined. I am in the process of seeking a review with ACC. I am scrabbling at the walls of this hole I'm in, fighting for my life.

My life has changed. One of the things I miss is nursing – I miss being on the inside of the health system. But from the outside, as a patient, I would like to say KINDNESS is the most valued care, along with honesty and advocacy. If you can do these three, you can be proud to be a nurse.

I want to say thank you to all those who have looked after me along the way, especially Rita, who is always there for me, and Mary, who is still fighting my corner and has not consigned me to the bin. Thanks to all my friends and colleagues for their support and for their hugs when I go into hospital – it must be hard for you.

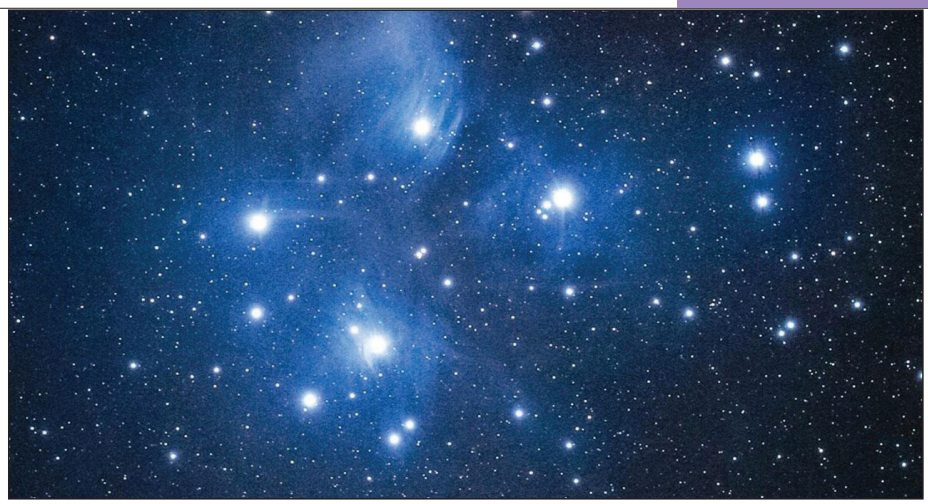
But special thanks to Leonie, my dear meso buddy, who has held my hand through all this horror. Because of you, I am not alone. (Wish you didn't have it, though.) •

Donna Thomas – immunotherapy only available to those who can pay. 'This is not equity.'

The future: Information, support and funding

- Both Leonie Metcalfe and Donna Thomas want ACC to automatically provide compensation, following a diagnosis of mesothelioma.
- They also want ACC and Pharmac to fund immunotherapy for mesothelioma sufferers, in line with advances in international treatments.
- They are working with other interested people to set up a mesothelimonia support group in New Zealand which would provide links to important information and advice on navigating the ACC system.
- For more information on New Zealand mesothelioma patients and ACC, see also www.stuff.co.nz/national/health/125013347/the-breath-of-death--asbestos-cancer-mesothelioma-and-the-fight-for-compensation
- Mesothelioma Awareness Day is September 26. It was started in the United States in 2004.

Special day of Matariki events includes Canadian nursing link for new year



Matariki is the constellation marking the start of the new year.

Matariki has appeared again in the skies, and NZNO celebrated the start of a new year with a special day of events in July.

In true Matariki spirit they included strengthening links with nurses from the other side of the world.

On July 8, Matariki started early with Te Rūnanga, Te Poari and staff gathering on the Wellington waterfront to watch the constellation rise over the harbour.

During the gathering, including karakia and waiata led by NZNO kaumātua Keelan Ransfield, the entire proceedings were streamed to members of the Canadian Nurses Association, watching from the opposite hemisphere and different time zone.

The overseas link continued after the Matariki gathering, with an online hui back at NZNO headquarters.

Kerri Nuku

NZNO kaumātua Keelan Ransfield speaks at the Matariki dinner event.

'Because, it needs to be raw and authentic; it needs to be about connecting with the environment and sharing with others.'

Kaiwhakahaere Kerri Nuku said Matariki was a special event and she hoped that across Aotearoa it didn't become commercialised.

"Because, it needs to be raw and authentic; it needs to be about connecting with the environment and sharing with others – and that's where the engagement with the Canadians came on."

She said the Canadian association was on a journey to improve its own relationship with the indigenous people of that country.

She said the members had the "right heart" to make necessary progress.

"They're changing the structures to accommodate the new way of doing things. But it takes small steps in a country where people have been brainwashed all those years."

The Matariki events continued into the evening with a special dinner, including a video presentation on the constellation that signals the start of a new year in te ao Māori. •

The audience enjoys a night celebrating Matariki.

Learning about travel medicine in a time of COVID-19

With more New Zealanders beginning to think about future travel plans as the COVID-19 vaccination programme ramps up, nurses are being urged to take the opportunity to upskill their travel medicine skills.

Travel medicine doctor and convenor of the postgraduate travel medicine programme at the University of Otago, Wellington, Dr Jenny Visser says more overseas destinations will likely open up in future to those who have been vaccinated.

She says all international travellers, not just those heading to developing countries or tropical destinations, should be offered a COVID-19 risk assessment.

"COVID-19 will impact all travellers, not only those travelling to low- and middle-income destinations, who have traditionally been the ones seeking pre-travel health advice."

Dr Jenny Visser

Pre-travel consultations will need to cover COVID-19 related risks, particularly for older and immunocompromised travellers. Advice on the efficacy of vaccination against original and emerging strains of COVID-19 will also be important, she says.

With many stand-alone travel medicine clinics having closed during the pandemic, the need to provide travel health advice will fall primarily on those working in primary health care.

Dr Visser says many travellers will require proof of COVID-19 immunity, including vaccination against COVID-19. This might be on an International Certificate of Vaccination or Prophylaxis (ICVP) issued under International Health Regulations (IHRs) as is required for yellow fever or on a digital platform as is currently being rolled out in Europe.

Health professionals applying to become IHR-authorised yellow fever vaccinators need to have postgraduate qualifications in travel medicine – and this could become a requirement for those issuing COVID-19 travel certificates, she says.

And with many countries requiring visitors to be tested before travel, general practices will need staff on site who know how to facilitate this.

The University of Otago's travel medicine programme has been fully updated. Students learn about COVID risk assessment, education on risk reduction, pre-travel screening and certification, the role of vaccination and ICVPs, and accessing up-to-date resources, including specific country requirements.

Dr Visser says evidence is emerging that a number of tropical and vaccine-preventable diseases are increasing as a result of COVID-19 disruption to intervention programmes, and health care providers will need to remain up to date and know how to access the latest information.

"Those diseases haven't gone away. In the Cook Islands, for instance, travellers must be made aware of the risk from mosquito-borne diseases such as dengue fever and chikungunya."

Jane Probert is one nurse who is seeing the value of postgraduate study in travel medicine. Probert travelled to the 2021 Tokyo Olympics last month to work with the New Zealand team as part of her role at High Performance Sport New Zealand. As well as providing direct nursing care to athletes, she is also involved in cardiac and general health screening, caring for the athletes' mental health and providing logistical health support.

With the support of her employer, she is studying for a Postgraduate Certificate in Travel Medicine.

"I spent more than seven years in emergency nursing, and my role with High Performance Sport New Zealand requires me not only to use my nursing skills but also dovetails with my interest in international travel, my passion for sport and my 16 years of sport coaching."

She says with international travel such a crucial element of an elite athletes' life, it's been hugely helpful for her to expand her knowledge and understanding of travel medicine. And with the postgraduate programme being offered by distance education, she can keep up with her studies while in Tokyo.

Dr Visser says students can choose to do a Postgraduate Certificate in Travel Medicine, which includes two papers and can be completed in one year of part-time study, or a Postgraduate Diploma in Travel Medicine, which comprises four papers. All papers are distance taught and can be completed in flexible time frames while students continue to work.

"The whole point of the postgraduate programme is to ensure that general practices and practice nurses have the tools and education necessary to be able to deliver good and safe travel medicine."

Enrolments for the programme are now open for 2022, with semester 1 starting on 28 February.

For more information, please visit **otago.ac.nz/travelmedicine**

ADVERTORIAL

Too long taken for granted, nurses are waking up to political realities

Nurses march earlier this year in the first of a potential series of strikes across the nation.

The predominately female profession of nursing has been ignored for too long, and nurses' attitudes are hardening.

By NZNO professional nursing advisor Anne Brinkman

District health board (DHB) nurses have had enough, when it comes to working conditions.

They've faced continual heavy workloads; unsafe nursing practices where the level of resourcing becomes perilous; pay that doesn't recognise the knowledge, skills and responsibilities that many nurses hold; and all this topped off with the personally challenging demands of rostered and rotating work.

Many nurses are voting with their feet and walking away from the profession, as they're no longer able to endure workplaces where they feel neither acknowledged nor respected, let alone adequately recompensed.

In contrast to the comparatively timid responses of nurses and their leaders in 2018 and 2019, support for decisive action has been overwhelming in 2021.

Why have nurses' attitudes and determination changed so much?

When DHB nurses rejected the latest multi-employer collective agreement (MECA) offer, Health Minister Andrew Little pointed the finger, claiming the NZNO negotiating team was at fault. However, the reason why members have not ratified the latest offer is that they are tired of being dismissed with nebulous words that neither hold the DHBs to account on safe staffing nor give them any confidence that the Government understands why nurses are asking for changes.

It's vital to our profession's future growth that we think about the causes and effects of nurses' heartfelt job dissatisfaction.

It's tempting to write searing commentary about the length of time that it's taken nurses to become "woke" and realise the price to be paid if dedication and innocence overrule clear, substantiated thinking.

Nurses are sick to death of DHB management failing to recognise and appreciate the contributions they make to the health of the nation and this has undermined our morale.

More than ever, nurses need to be objective and analyse our way out of oppressive practices that serve no one.

Nursing is a predominantly female profession, so it is hardly surprising that male-dominated and designed health systems have affected our ability to recognise our strength in numbers.

No other health professional is at the DHB/patient interface like we are. Having continuing patient proximity places us in a privileged position of knowing the patient and their whānau better.

Yet our voice, on behalf of those vulnerable patients, has not been clearly articulated or heard. If our voice had been heard, then staffing quality and numbers would have been improved to ensure patient safety.

An obvious example would be the effectiveness of care capacity demand management (CCDM). In the 2018 negotiations, DHBs were charged with fully implementing CCDM by July 2021. This has not happened, with a number of DHBs hardly off the starting blocks. And just because a system is meant to be implemented doesn't mean it is effective.

Some of the 23 databases meant to be collected shed light on patterns of staff

behaviour – illness, annual leave, shifts below (baseline) target and more but it hasn't stopped the haemorrhaging of staff. There are now constant stories of understaffing (backed up by the nationally disparate levels of CCDM data).

For example, consider a morbidly obese patient who has not been bathed in weeks because it takes five nurses to transfer him from his bed to a bath using the right equipment. There are usually only three nurses – two nurses and a charge nurse – on the shift, with 15 patients needing complex cares in that ward. This patient has had piecemeal washes but they are inadequate. The nurses are uncomfortable but feel helpless. There are virtually no casual staff to call on and the duty managers are too stretched to offer much assistance beyond advice and reassurance.

The patient has strained relations with his family – who rarely visit – so is mainly alone and is not seeking change.

How can this situation be improved?

There are a number of factors contributing to nurses' discontent. DHBs and the Safe Staffing Healthy Workplaces Unit (SSHW) have tried to produce "essential care" guidelines. However NZNO legal opinion does not support the document as it places too much risk on individual nurses trying to prioritise and

Health Minister Andrew Little flanked by government MPs while speaking to NZNO DHB members.

No other health professional is at the DHB/patient interface like we are.

ration care when faced with wholly inadequate levels of staffing combined with high patient acuity.

Who does hold the ultimate responsibility for what happens at the clinical interface – the Government through available resourcing? The DHB's board, whose chair, vice-chair, and two of the 11 members, are government appointees? Or is it the executive leadership team?

Whatever happened to the medical staff's responsibility in running DHBs?

Their absence at CCDM governance discussions is obvious. A DHB's response on medical staff responsibility when the hospital was in code red or code black was that they would come if needed.

Nurses seem to have gradually taken over the running of hospitals, yet still struggle to be heard at executive leadership meetings, let alone at the DHB board, its political fulcrum.

It was over five years ago that many directors of nursing lost line management responsibilities for staff. It was decided (despite NZNO submissions) that these directors would just be responsible for staff professional development, which means they are not at the executive table to debate numbers and quality of nursing staff. These structural changes do not augur well for nursing's professional recognition. Even in the face of CCDM full-time equivalent calculations, some chief executives have postponed the hiring of nurses needed to reach baseline levels. And, given the dearth of nurses willing and/or available for recruitment to those to-be-approved-and-funded positions, a vicious cycle has been established.

The 93 per cent female profession has been ignored and abused for too long. The goodwill of nurses is stretched to breaking point. It is the broken systems, with inherently disrespectful attitudes and practices, that have caused nurses to declare they have had enough. They are expressing their anger and disenchantment with being taken for granted. For holding the fort. For being "so dedicated" to their vocation. For being told what to do in the face of increased risk and in dealing with patients' broken bodies and/or broken minds.

Now is the time to stand tall and stand strong. Nurses are finally waking up to the political realities of needing an effective voice. •

Health and safety law prompted by Pike River tragedy, now helping hospital staff

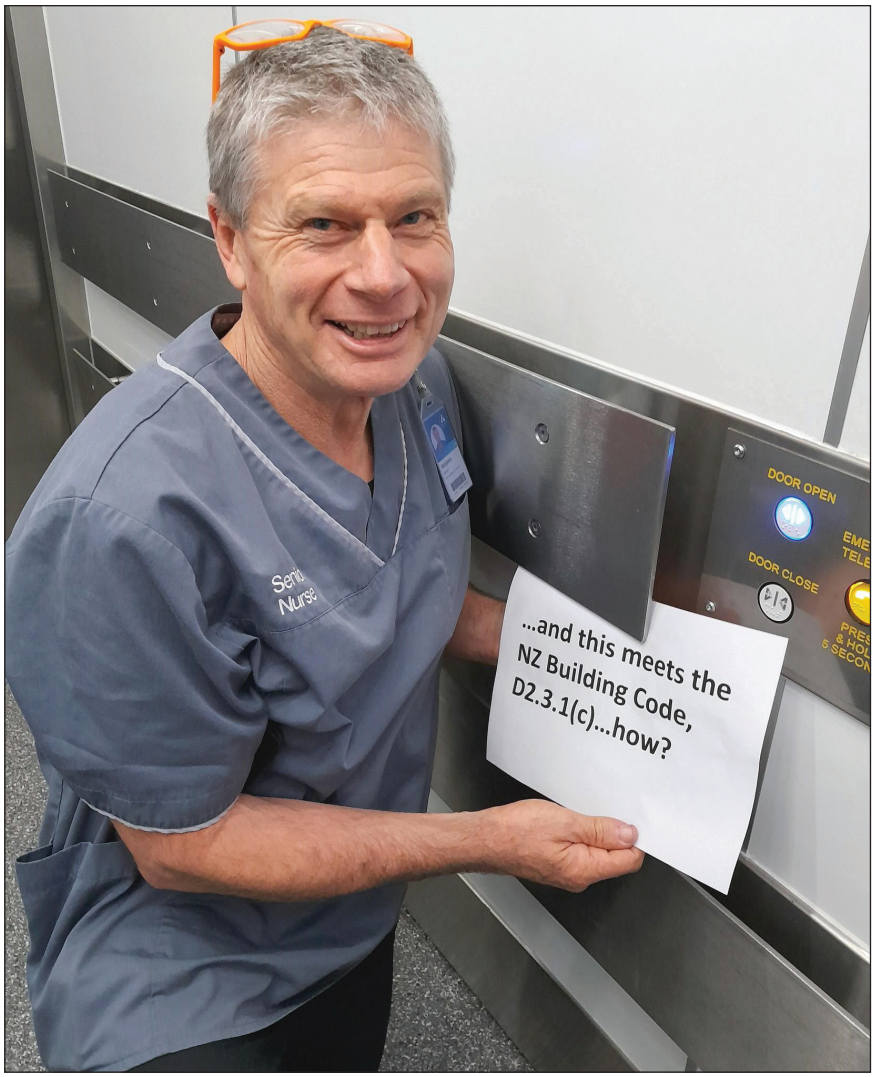
Until now the focus in hospitals has been mostly on patient safety – but a law crafted to protect workers after a horrifying tragedy, puts the focus on staff as well.

By co-editor Joel Maxwell

There is a long journey, spanning time and distance, between the tragedy in the Pike River mine, northeast of Greymouth on the West Coast, in 2010, and hospital wards around Aotearoa in 2021.

Both, however, are connected by a single piece of legislation, devised to fix systemic problems behind a disaster that took the lives of 29 workers.

The Health and Safety at Work Act, introduced in 2015 in response to the Pike River mining disaster, is now being used to deal with the safety concerns of health professionals in district health boards (DHBs).



Health and safety representative Ben Basevi.

'It's a very significant piece of power that's given to an ordinary person.'

One of those who sees the importance of worker safety as a tool in the fight for better staffing levels, is health and safety representative at Auckland District Health Board, Ben Basevi.

Speaking to *Kai Tiaki Nursing New Zealand*, Basevi – safe staffing co-ordinator with the DHB – said till now, the act had been under-utilised.

Under the law, the ability to serve what is known as a provisional improvement notice (PIN) was one of the significant powers given to representatives who had completed the necessary unit standard, he said.

The notice includes a description of any possible breach of the health and safety law and could include possible remedies and include a fix-by date.

The DHB was obliged to respond within that timeframe – a minimum of eight days. It could then contact health and safety agency Worksafe to review the notice.

"Worksafe has the option of cancelling the PIN . . . they can say that it's not valid. Or they can say 'yes, we agree with it. It stands' . . . or they say 'we agree with it but we'd like to modify it'."

Once served, the notice cannot be ignored – if it is, then the representative can call in Worksafe because the employer had breached the notice.

The health and safety law is a relatively new tool in helping boost staff safety in hospitals.

Law offers protection

"It's a very significant piece of power that's given to an ordinary person."

Basevi said that power needed to be treated with care – but it offered good protection for the representative, and also protected the employer.

"If a health and safety rep is going off the track, then Worksafe can come in and actually remove that role from an employee . . ."

Multiple notices served

Basevi had served four notices on the DHB: the latest on July 6.

He said the notices triggered a series of high-level meetings between NZNO, the health and safety representative and management.

The ultimate aim of the notices was for a zero-tolerance approach by the DHB to the non-supply of staff to attend patients.

Ironically, Basevi said negotiations around life-preserving services (LPS) before the last strike had seen both sides agree there should be zero tolerance for non-supply of patient attenders.

"The one day where we had zero tolerance was the day of the strike."

It was unacceptable, he said, that at other times this was not the case.

The July 6 notice related to an incident involving a single patient attender.

The notice said four patient attenders were requested to monitor four patients in separate but adjoining rooms. The patients were all clinically assessed as needing an attender for their safety.

Up to now, the nurses have carried this – they're the ones who have worked in unsafe situations, where they feel completely unable to say 'I don't want to do this, this is unsafe; this is putting my registration at risk'.

However only one patient attender was provided – and while they were providing care to a single patient, one of the other three fell and suffered a serious injury.

The notice related not to the patient, but the state of the worker – who had "incurred a degree of mental harm and anguish from being placed in an impossible work situation".

Meanwhile, PINs were issued in other hospitals around Aotearoa in July.

A health and safety representative issued Capital & Coast DHB with a notice for its emergency department. The notice covered multiple issues including staff security concerns, and systemic problems covering the management of 35 after-hours patients with insufficient staff.

A similar notice was issued in Palmerston North Hospital as well, covering the psychological stress on staff dealing with too many patients.

"It's unrealistic to try and fix the world, but we can have a go . . . because the non-supply of patient attenders has caused harm to staff," Basevi said.

The act was not about patient safety – it was about worker safety, he said.

"This is why it's maybe taken this long to get into the health arena, because it's quite difficult to see how it fits."

Changes come after notices

He said as a result of the notices, the DHB was doing work to fix the problem.

Under the law, the board, the chief executive and senior officers were legally accountable for any problems. He said the notice had brought management to the table "pronto".

"Up to now, the nurses have carried this – they're the ones who have worked in unsafe situations, where they feel completely unable to say 'I don't want to do this, this is unsafe; this is putting my registration at risk'."

With the DHB starting discussions on the patient attender situation, Basevi agreed on July 23 to take down the notices.

"We expect that the number of patient attenders that are not supplied will sharply fall . . . close to that zero line."

PINs new tactic for safety

Realistically, there would be occasions on any shift when there would not be a patient attender, Basevi said.

"But the expectation is that a patient attender will become available during that shift and be supplied within a time that would not significantly compromise the health of the worker and the cares of the patient."

Basevi said he was not aware of previous widespread use of PINs in the health sector – but now it was becoming recognised as a useful tool, "and it's a really good one". •

Action across sectors, but some 'wait and see' what happens with DHBs

Bargaining is on the go, and NZNO supports calls for change to immigration rule.

The DHB MECA negotiations rolled on, with a new strike called.

Primary health care has seen a raft of activity over the past month.

Bargaining was initiated with 500 individual employers, and there were six newly initiated parties as a result of a member ballot

NZNO received notifications from some employers saying they had no member employees – and these would be double-checked before any withdrawal took place.

Bargaining started in the Family Planning sector, with the existing collective agreement expiring on August 31.

Meanwhile, negotiations with the NZ Blood Service remained postponed: new dates were still to be set when the outcome of district health board (DHB) MECA bargaining was clearer. The multi-employer collective agreement expired on December 10, 2020.

Also, due to the ongoing bargaining over the DHB MECA, and to support resourcing, an online ratification was expected for the Prison Health Services bargaining. The collective agreement expired on June 30, 2021.

Hospice sector

The ratification process continued for the hospice MECA, covering 18 hospices, which are divided into two groups.

An online ballot for the hospice MECA 14 group ran till August 3.

With the other four hospices' MECA, there were Zoom information meetings held with members, to be followed by an online ballot running from August 6.

District health board MECA

Broader sector bargaining has gone on against the backdrop of the DHB MECA negotiations, which took another turn in August with about 30,000 members rejecting the latest offer from DHBs.

NZNO issued strike notices to DHBs, ahead of a planned eight-hour nationwide strike on August 19.

The notice was for the second of three planned strikes and came after members voted to reject the DHB offer on the grounds that it failed to set out how safe staffing will be addressed and how the DHBs would be held accountable for it.

The nationwide strike will take place on August 19 from 11am to 7pm.

MIQ and border workers would be exempt and life-preserving services would be provided in negotiation with the DHBs.

Internationally qualified nurses

NZNO internationally qualified nurse (IQN) members have been supporting efforts to change immigration rules that prevent partners from joining them in Aotearoa.

Efforts included a petition presented to Parliament on August 4, requesting the removal of the rule requiring partners to be living together to be considered partners.

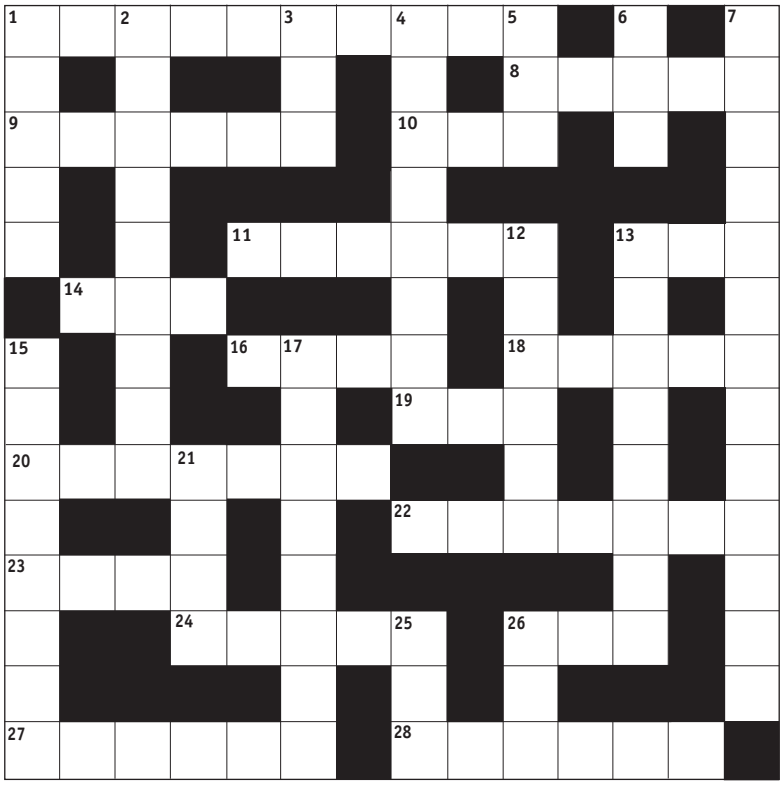
The rule affects the likes of people who were engaged but not living together.

While the rules do not apply specifically to nurses, some IQNs have decided to leave the country rather than remain separated from loved ones.

NZNO has given its support to the petition. •

crossWORD

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



ACROSS

1) One who wields the needle in pandemic response.
8) Annoyed.
9) Vote.
10) Climbing plant.
11) Modest.
13) Attaches items to clothesline.
14) Rules passed by Parliament.
16) Accessible.
18) Corroded.
19) The self.
20) Tree-lined streets.
22) Where palliative care is given.
23) Worn by gentlemen of Ancient Rome.
24) Not tender.
26) Lyrical poem, glorifying something.
27) Withdraw labour.
28) Fishing gear.

DOWN

1) Feelings/atmosphere.
2) Workmate.
3) Tree fruit with hard shell.
4) Coccyx.
5) __ Davies, lead singer of the Kinks.
6) It's good poached, fried or boiled.
7) Low blood sugar.
12) Mistakes.
13) Having hope/confidence.
15) Sections of a book.
17) Stress, tension.
21) Tidy.
25) Shed.
26) Enemy soldier in Lord of the Rings.

July answers. ACROSS: 1. Insomnia. 3. Zinc. 7. Premature. 9. Ice. 11. Art. 12. Shekel. 13. Enough. 16. Via. 17. Vacant. 18. Owe. 21. Tangi. 22. Brain. 23. Abscess. 28. Beg. 29. Axe. 30. Steroid. 31. Almost. **DOWN:** 1. Ignite. 2. Anaphylaxis. 4. Ideal. 5. Cortisol. 6. Lucky. 8. Rongoā. 10. Evolve. 14. Angry. 15. Dollars. 19. Ends. 20. Biceps. 24. Sue. 25. Ego. 26. Sad. 27. Pea.

wiseWORDS

“ There are three kinds of people; those who make things happen, those who watch things happen and those who never knew what hit them. ”

– Irihapeti Ramsden (Ngāi Tahupotiki, Rangitāne) (1946-2003), Māori nurse, educator, writer, publisher, anthropologist

it's cool to kōrero

HAERE MAI and welcome to the August kōrero column. A korowai is a cloak, traditionally woven from flax linen, and decorated with tassels and feathers. In the past, wearing the korowai would have been restricted to those of high status. Nowadays it is more common for a whānau to own one and for a whānau member to wear it on a special occasion, such as a student on their graduation.

Korowai is the word increasingly used to describe all Māori cloaks, though strictly speaking, the korowai is a cloak with tassels. A cloak decorated with feathers, such as the one worn by Prime Minister Jacinda Ardern when she met the Queen in 2018, is a kahu huruhuru.

Kupu hou

New word

- **Korowai** – *pronounced "core-rrraw-why"*
- **Kei te mau korowai mo taku rā pōtaetanga.**

I'm wearing a korowai at my graduation.

Rerenga kōrero

Phrases

Women's health is featured in this issue of *Kai Tiaki*, particularly cervical health and the importance of getting tested. Here is some vocabulary and some of the messages from the Cervical Screening Programme:

- **Tōku hauora, tōku tinana, tōku anamata.**

My body, my health, my future.

- **Atawhaitia te wharetangata.**

Take care of your womb.

- **Waha wharetangata**

Cervix (mouth of the womb)

- **Mate pukupuku o te waha wharetangata**

Cervical cancer

E mihi ana ki a Titihuia Pakeho rāua ko Joel Maxwell.

PHOTO: ADOBE STOCK

Over-centralising the health system will not help

In the second of two articles on the Government's planned health reforms, economist Brian Easton looks at the pros and cons of a more centralised system.

By Brian Easton

Many New Zealanders are more centralist in their view of the governance of society than I am. I come from the tradition that sees local autonomy as a critical part of a democratic society – not to mention its benefits in terms of innovation, responsiveness and dealing with diversity. Sometimes it is necessary to have collective and central solutions to public policy problems, but when I am thinking about their design or evaluation, I never forget a decentralisation perspective.

The current "redisorganisation" of the health system is a shift towards centralisation. I am not inherently opposed to such a shift, but I am concerned we may be over-centralising.

In last month's article, I concluded we should not be surprised if there are pressures to centralise the system further, even at the cost of the loss of local, and even clinical, autonomy and innovation. This conclusion was underpinned by four general propositions:

1) There is an inherent tension between the centre (which funds health care), together with the complex organisations it charges to implement its plans, and what goes on at the clinical and local level of professionals dealing with patients. The tension is unavoidable in a publicly-funded system.

2) The complexity of the sprawling health system is substantial. It has been described as a "disorganisation". Plans to "redisorganise" it need to be humble, aiming for incremental improvements rather than those that are ambitiously neat, plausible and wrong.

3) One of the sources of the sprawl in the health system is its historical development from the 19th century system when hospitals were small, not very technically advanced, local and isolated. Medicine then was primitive but not wholly ineffective. Despite the spectacular changes in the following 150 years, there are still fossilised remnants of the old system.

4) The centre has made errors, but it generally does not acknowledge them. It is easy to blame the districts for everything. Mistakes are inevitable but failure to acknowledge they can happen will corrupt a planned redisorganisation.

A critique of the proposals

This analysis is based on a (released) Cabinet paper, which sets out a sevenfold justification for the proposed changes.

Māori issues:

The first two justifications concern Māori issues. One is constitutional, arguing that the *"public health system does not meet the Crown's obligations to Māori"*. The second is that the *"overall system performance"* (which the Cabinet paper emphasises is *"high"*) *"conceals significant underperformance and inequity, particularly for Māori and Pacific peoples"* (although there is little attention to Pacific peoples' needs).

This issue requires a lot more teasing out – but not here. The danger is that if we characterise the problem as "Māori", with little thought about what is actually going on, we shall have an expensive failure. Such concerns are already justified given that those who have welcomed the new Māori health authority have so many different views on what it will do.

The paper admits there is also significant underperformance and inequity for others who are not Māori (or Pacific). It is not obvious that the paper addresses their needs. By focusing on the Māori dimension, the system may fail to identify general problems and continue to leave others behind.

Funding issues:
Justification 7 is that *"funding has not increased in line with increasing costs and rising demand"*. However, the redisorganisation does not address the funding issue. The transition will add to costs; if the 1990s redisorganisation is any indication, they may be very large. Nor should we be surprised if the new system is more costly to run. Additional layers of management often reduce the productivity of those who deliver services.

Moreover, if we deploy more health resources for Māori health care, as the Cabinet paper argues, and provide more resources to the other groups which the paper mentions as not being adequately covered, this means there will be less for the rest. Are we willing to accept fewer resources for the rest, perhaps compromising their health and wellbeing or pushing them into the private sector?

So the funding issues are not going to go away. At least nobody is making the stupid claim of the 1990s redisorganisation, that this time it will generate substantial cost savings.

Population health issues:
I have little trouble with justification 6, that the *"system does not routinely take a population health approach"*. Twice in the past three decades there have been attempts to deal with this, and twice the approach has been castrated because of powerful lobbies which profit by ignoring population-based health promotion.

Only insiders appreciate how magnificently our public health profession has responded to the COVID-19 pandemic, performing well beyond what we might expect, despite the gutting of the relevant institutions.

It is easy to reduce the focus of population health policies to the big ones of alcohol abuse, tobacco use and obesity. But, for instance, epidemiologist and public health expert David Skegg has drawn attention to the failure to provide quality water; we also need to prepare for the next pandemic. A wider perspective will reduce the leverage of the lobbies who want to close down advocacy of policies which will decrease their profits.

I add here a criticism of a too-common canard – that better prevention will reduce treatment costs. It may not. For instance, banning smoking increases costs because people live longer – perhaps an extra 10 to 20 years – and will be a charge on the future health system during their longer life. From a health and welfare perspective, we may celebrate that outcome, but from an accounting perspective the ideal is the cigarette which explodes on the day the smoker retires.

Brian Easton

As for justification 4: *'the public do not have a consistent say in the operation of the system',* the kindest thing to say about the proposed redisorganisation is that it provides consistency across the public by reducing everyone's say to zero.

The provider capture issue:
Justification 5 says: *". . . services are too often built around the interests of providers, and not around what consumers value and need. Improvements in service design and adoption of new technologies have been sluggish, resulting in little shift of services from hospital to community environments, despite this having been government policy for more than 20 years. Virtual consultations only became common during the height of the COVID-19 pandemic; and since the lowering of alert levels, have retrenched again."*

What this cryptic bureaucratic passage may indicate is the view that health professionals use their political power to divert resources from high priority care to their less important practices – especially from preventative and primary care to treatments.

It is true that some treatments are not as efficient as their proponents argue. There is also a phenomenon called "supplier-induced demand" (SID), when a professional proposes a course of treatment which the funder would not choose if they were fully informed. (Often the SID treatment is to the financial benefit of the promoter, which is why it is a greater problem in the private health sector.)

However, that account is only partial. The main reason resources are used in some areas and not others is that public demand prioritises urgent treatments. It insists, for instance, that inflamed appendices be dealt with immediately.

Perhaps a plodding economist or bureaucrat would do an analysis which showed there were more valuable treatments than the urgent ones and that the higher priorities are being neglected. Perhaps the public, given the information, would agree. But that would lead to the conclusion that there should be more resources.

It is too easy to invent such bureaucratic jargon as in the passage I quoted to divert attention from its real content. The writers ought to provide a jargon-free account of what they actually mean.

System complexity issues:
Justification 3 is that *"the system has*

become complex and unnecessarily fragmented, with unclear roles, responsibilities and boundaries".

In my first article, I argued that complexity and fragmentation are inevitable. It may be useful to make the traditional distinction between surgeons and internal medicine. The patient arrives at hospital with an inflamed appendix and the surgeon deals with it. The patient arrives at hospital with an internal ache; in the course of the diagnosis the medical team finds they have a host of other problems, including perhaps excessive drinking and not getting on with the spouse. There is no simple remedy, even if the clinicians were certain about what is going on.

Centralisation policies for the health system are usually based on the surgical model, ignoring the complexity and fragmentation clinicians face. Thus they miss the problems identified in justifications 2 (underperformance for certain groups) and 5 (the failure to integrate primary and secondary care). That was what happened in the early 1990s re-disorganisation – even the promises of productivity increases reflected a view of health care as a series of a surgical operations.

Do people have a say?

As for justification 4: *"the public do not have a consistent say in the operation of the system"*, the kindest thing to say about the proposed redisorganisation is that it provides consistency across the public by reducing everyone's say to zero. It was never great, but under the new system it is going to be less.

We have a health and disability commissioner who does an excellent job of remedying a failure by a health professional after you are dead. However, if the problem is one of various services not interfacing, the commissioner is unlikely to be involved. A stiff letter to the head of the proposed Health New Zealand, which is to supervise the running of the hospitals, will likewise get no remedy.

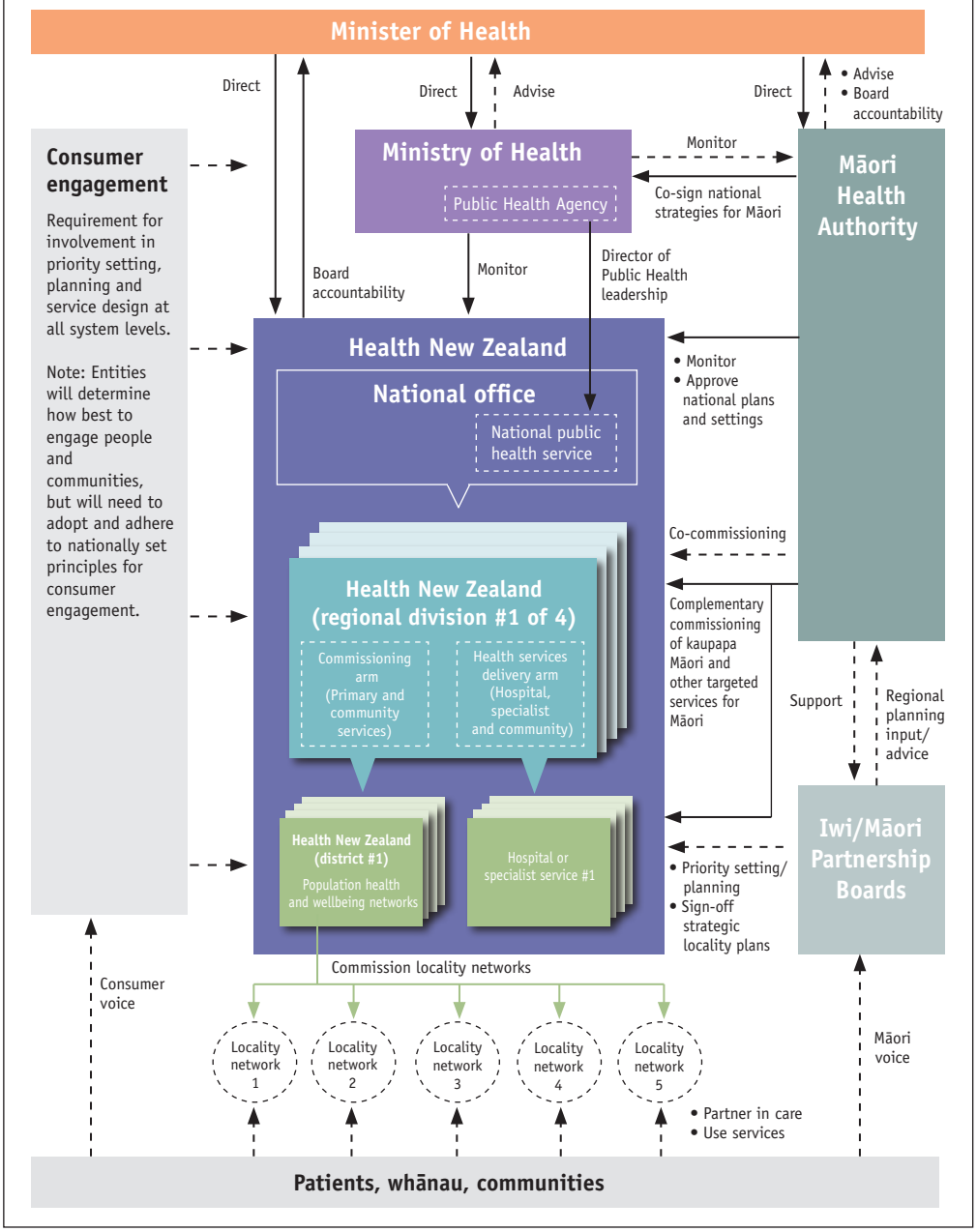
The proposals hardly elaborate how consumers of health care will have a voice. (The exception may be Māori.) Voice is required at the personal level. Consider those in hospitals (or rest homes) who fall between the cracks because no one seems to be in charge; a problem quickly fixed with goodwill and an effective advocate – if there is one. (I do not think clinicians should fear such a well-designed complaint system, especially if it is built around a no-fault but "fix it" culture.)

Voice at the local level matters too. The likelihood is that rural and provincial communities will feel disenfranchised under the new system. When the folk in Whangārei have a community complaint, they will have to picket in Auckland (or possibly Hamilton) – or even Wellington.

Recall, too that one of the reasons for separating out the Counties-Manukau crown health enterprise (later a district health board) in 1992 was because the Auckland Area Health Board was thought to be underplaying the needs of South Auckland; a similar local concern generated the Wairarapa CHE/DHB. For a locality, a regional centre can be over-centralised.

I have long doubted the effectiveness of elected representatives on the governing boards. Friends with the best intentions who got elected would leave after one term because they felt they had no effect. But they did grumble and they were a part of a system which gave people a feeling they had some say. Because they grumbled, elected representatives were killed off by Parliament one night in 1991; this time they have been

Proposed health system operating model



Source: https://dpmc.govt.nz/sites/default/files/2021-04/cabinet-minute-cab-21-sub-0092-health-and-disability-system-review.pdf

neutered – told not to comment.

The public has to have confidence in those whom it asks to take up its cases. Centralised appointments will not be trusted, especially in the regions. There are a number of ways representation can be organised. All should require some local input in the selection.

While I would like to say that the 1990s redisorganisation collapsed because of the severe technical deficiencies of the underlying theories and the resulting implementation failures, probably far more important was the popular uprising against the imposition of what seemed to be a foreign culture of commercialisation by Wellington.

Back to the inherent tension

The usual reason for more central control is the demands of public funding, which pushes the balance away from the patient, the clinician and the local. Thus we see the decades-long efforts to increase central control of the health system. The abolition of the district health boards follows a logical continuation from the limitations of the local hospital boards of the 1950s when the central government took over total responsibility for funding.

Yet, as the central government has got involved, the problem of the increasing fiscal burden has not been resolved. A solution has been to offload on to private health care, but that adds to the inequity of the system. This redisorganisation will not resolve these problems. The danger is that other strengths of the current system will be lost.

Centralisers make mistakes

A major weakness of centralisers is their tendency to design systems on the assumption they never make mistakes. Had they been more realistic, the planned redisorganisation would have observed that some part of the various failures can be attributed to the failure of the centre (Wellington).

In my first article I went through the sad story of the recent Canterbury DHB fracas. I know the centre has never given its side of the story – perhaps it does not want to admit failure.

It is likely that such things will happen again under the new regime. Despite its brilliant handling of the COVID-19 crisis, there is little confidence in the Ministry of Health as one of our better government agencies (at a time when there is much pessimism about the quality of the public service generally). A covert purpose of the redisorganisation may be to improve the functioning of the ministry. If it happens, it will be welcome.

The failure to acknowledge that the centralisers will make errors – grievous errors – is why the designers think there is no need to build the public's involvement into the new system. Voice is unnecessary if you never make mistakes.

If one never acknowledges mistakes, one never learns from them. There have not only been poor appointments to DHBs but some of the appointments to the ministry itself have also been of poor quality (also true for some ministers). The system also needs to be designed to insulate itself from a minister who is unsympathetic to the principles underlying the system and who systematically undermines them – as has happened. Should we design a system so heavily dependent upon those at the centre?

Of course mistakes are also made at the local level. Good design which accepts they happen makes a decentralised system more robust.

Local innovation

Centrally organised systems are not very good at genuine innovation. DHBs offered the promise of local innovation and experiment, which could then be applied elsewhere (for instance in primary-secondary integration). Experiments may have happened, but usually the lessons did not percolate through the whole system. The shortage of funds inhibited them as boards focused on urgent care. (It is difficult to get GPs to address alcoholism if you are desperately removing appendices.)

Some of the "experiments" are interestingly subversive of the current centralisation proposals. I have a personal interest in paediatric endocrinology. Quite large provincial DHBs may have work for only one specialist; professionally that leaves them isolated. Who can the sole endocrinologist consult on a particularly tricky case? Who provides cover when he or she is on holiday?

One answer has been to build up a collegial network across a number of DHBs. This sounds sensible to me. It suggests that to work properly one needs centres of advanced health-care excellence – in effect a tertiary hospital associated with medical schools together with a remit to support a set of identified secondary providers.

The role of medical schools in the system is hardly touched on, in part because universities are allergic to central direction. But the schools are repositories of much knowledge, not only about hospital medicine, but about public health, care of the elderly and disabled and primary care.

You may wonder whether the proposed four regional offices for Health New Zealand are such centres of excellence. That is not the intention. Their purpose is funding and governance, not provision. They are more an echo of the later-discarded regional health authorities of the 1990s redisorganisation.

I have deliberately not gone through the new structure, instead focusing on its design principles. However the diagram provided says it all. At the top is the minister and Ministry of Health, power descending from the top. Patients do not appear.

My perspective is the other way up, with the patients at the top. I do not deny the necessity of central structures, especially given that the centre is the source of funding.

But I start with the people, and those treating and supporting them, and build the structure with their wellbeing at the centre of our vision – not the dollar. •

** This article – the final 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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PHOTOS: ADOBE STOCK

A patient diary helps bridge memory gaps for intensive care patients, thus helping their psychological recovery.

How diaries help ICU patients recover

By Joanne Lomax

A patient diary is an informal record of a patient's stay in an intensive care unit (ICU), while they are sedated and ventilated. It takes the form of a narrative and contains contributions from nurses, doctors, therapists, chaplains and family members.

The purpose of the diary is to help the patient bridge the memory gaps that can occur while in the ICU, and thus help them in their pyschological recovery once discharged.[1]

ICU patient diaries were first introduced in the 1980s in Denmark, and, during the 1990s, were gradually introduced to other European cities and the United States. Today, countries where ICUs use patient diaries also include New Zealand, Australia and Indonesia.

In the ICU, patient control is low – the person's basic physical functions are removed from them through sedation and, occasionally, paralysis. This can lead to psychological challenges for intensive care survivors.[2] ICUs are noisy too; machine alarms often ring out and staff move in and out of rooms and around the patient's bed space. This noise and constant disruption can also contribute to significant sleep and mood disturbances. Patients who have a prolonged ICU admission (defined as being equal to or longer than 10 days)[3] will often have altered memories of what happened during their time in intensive care and can suffer from flashbacks in which unreal memories are re-experienced. Sedative medications, as well as the disease process, can also, and often do, result in confusion and delirium, which contribute to a poor psychological recovery.

Research shows that more than 80 per cent of ICU patients can suffer from delirium *during* their hospital stay and that 25 percent of *all* ICU patients will suffer from post-traumatic stress disorder (PTSD) once they leave hospital.[4] Patients with ICU delirium are less likely to survive, and those that do are more likely to suffer long-term cognitive damage.

Delirium is a state of severe confusion – sufferers are unable to think clearly and have trouble paying attention and understanding what is going on around them. They may also hallucinate – seeing and hearing things that are not there but which seem very real to them. This can lead to patients feeling frightened, angry and ashamed.[5]

Research shows ICU patient diaries can be effective at filling in memory gaps, as well as helping patients reclaim ownership of lost time.[6]

Patient diaries have also been shown to improve patients' psychological health after recovery from their critical illness.[7,8] The use of diaries is an evidence-based practice that improves the quality of life of patients in an ICU,[9] and has also been proved to reduce the incidence of depression, anxiety and other PTSD symptoms.[10]

The number of patients admitted to ICUs and requiring mechanical ventilation worldwide has increased exponentially over the past year as a result of the spread of COVID-19, and patients admitted with COVID-19 are averaging a length of stay in the ICU of 10.4 days.[11] With that length of admission, and given the stressful ICU environment, psychological challenges are to be expected for these COVID-19 survivors.[2] These patients fit the criteria of a prolonged ICU admission, and as diaries have been shown to improve patients' psychological health after recovery from their critical illness,[7] use of a patient diary to fill the loss of time and place for these patients will be essential in their recovery.

The ICU diary is useful as a medium for patients to process emotions, gain insights, reduce stress and track information.[12] Patients have commented in research that the diaries have also helped them connect with their families, whether through confirming the information presented in the diary, or as a way for the patient to comprehend and come to terms with what the family has been through during the patient's ICU admission.[13] For this reason, it is especially helpful if there are contributions from the family in the diary.

The use of diaries has also been proved to reduce the incidence of depression, anxiety and other PTSD symptoms.

Critically unwell patients who have received a diary post-recovery have most appreciated that the diary is personally written – this has made them feel *"confirmed and valuable as a person"*.[14] Another researcher commented that a diary with contributions from nurses, doctors, physiotherapists and chaplains is likely to hold more meaning than a diary filled in by one person alone.[8]

Research into patient diaries shows they are beneficial to the recovering patient. However the process is a delicate one and the introduction of diaries to ICUs must be supported with policies, committed staff and a strong follow-up and/or support network. Diaries can be painful and distressing for the patient to read as they reawaken traumatic memories.[6] So it is recommended they should form one aspect of a rehabilitation programme, such as a follow-up clinic or an ICU Steps programme in a controlled, well-managed and safe environment.

Documentation needs to be accurate and complete; it works wonders at telling a patient's story and can even improve patient care.[15]

Diaries that are given to the patient but are incomplete or have big gaps between entries have been shown to be more harmful than helpful[6] and therefore it is important to have a committed team behind them.

ICU diaries are very popular in more established ICU departments in wealthier western countries and this is evident on the map on the patient diary website (icu-diary.org). There is no real evidence to prove why this is. However one research study comments that diaries are a relatively new concept in low to middle-income countries, likely as a result of literacy and socio-cultural inhibitions affecting their introduction.[16]

My own experience with patient diaries has been very positive. It was really encouraged on my previous ICU unit in the United Kingdom, with great support in place to follow-up with staff to encourage them to write entries.

One experience I can speak of with fondness: I was informed by one of our clinical nurse specialists (CNS), who ran the follow-up clinics with the former ICU patients where they receive their diaries, that a patient read my diary entry and remembered our interaction from that time. The CNS said the patient had been struggling with memory loss during her time in ICU (which is not uncommon) and that while reading the diary entries at the meeting she was triggered by something I had written about a conversation I had with her. Apparently she became emotional at the memory and having the CNS there to support her in a controlled environment was extremely beneficial to her progress.

The evidence is there to show that patient diaries are beneficial to a patient's recovery following their ICU experience, as long as the diaries are written in a respectful and safe manner and the patients receive the diaries while having some psychological support from experienced staff.

For nurses wanting to know more about patient diaries, there is a website and a newsletter you can sign up to (icu-diary.org). •

** This article was reviewed by Steve Kirby, RN, MN, BA hons, a clinical resource nurse in critical care at Middlemore Hospital, South Auckland, and vice-chairperson of the NZ College of Critical Care Nurses.*

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Participants in the integrative nurse coaching workshop are welcomed on to Te Kōpua Marae, on a foggy morning in Te Awamutu.

Learning the role of the integrative nurse coach

A group of nurses are introduced to the role of the integrative nurse coach – a way of helping people achieve their health goals which sees them as a whole integrated person, with their own beliefs, culture and story.

By Louise Bobbitt

On a spring morning shrouded in fog, 12 nurses came together at Te Kōpua Marae, Te Awamutu, for the first face-to-face workshop in New Zealand on integrative nurse coaching. This was the first course outside the United States to be endorsed by the International Nurse Coach Association (INCA) and Nurse Coach Academy (NCA).

The weekend workshop was run by Anah Aikman and Heather Leong, the first two New Zealand nurses to have completed the integrative nurse coach certificate program (INCCP). Having just completed the INCCP myself at the time, to become the third integrative nurse coach (INC) in the country, I was keen to go along to support my colleagues and participate in coaching and learning in a group setting.

Integrative nurse coaching is the *"emergence of a distinct nursing role that puts clients/patients at the centre and assists them in establishing health goals, creating change in lifestyle behaviors for health promotion and disease management"*.[1] Its roots can be traced back to Florence Nightingale, and her vision of what a healthy world might be. Nightingale was integral in the reform of sanitation and health care in England, and identified environmental determinants of health such as clean air, water, food and housing, as well as social determinants including poverty, education, family relationships and employment.

Individual change

Today, an INC is a *"registered nurse who views clients/patients as integrated whole beings and honours and emphasises each person's unique history, culture, beliefs, and story."*[1] An INC recognises that a person's health and wellbeing are influenced by their internal and external environments. They understand that individual change begins from within, before it can be manifested and sustained externally.

We were welcomed onto Te Kōpua Marae with a pōwhiri led by kaikaranga Waitiahoaho Te Ruki. Te Kōpua Marae is Anah's spiritual home – a sacred place to connect with ancestors, recognise their contributions and uphold and embrace the enduring values, knowledge and holistic concepts of te ao Māori, the Māori world view. This traditional welcome set the scene early for the creation of a peaceful space to learn and bond as a group of nurses that is rarely experienced in other learning environments.

What led me to choose the INCCP was its nursing focus and philosophy. The INCCP is the only nursing-focused, evidence-based, internationally recognised nurse coaching course that teaches nurses the skills to help clients/patients reduce their risk of illness or improve a long-term health condition. As nurses, we are in an ideal position to take the lead in promoting healthy lifestyles and behaviours, and transforming the way we and others live in a way that focuses on healing from and preventing illness.

Like many other nurses, I am in the privileged position of working with clients/patients who are facing a life-threatening illness and wish to make changes to how they live and manage the emotional burden of their illness. What I particularly enjoy about the INC role is that we work in partnership with our clients. We use motivational interviewing, "nonviolent communication" and other techniques to help clients find their motivation and use their inner strength to work out, plan and achieve their health and wellness goals.

The INC process is gentle and compassionate. The client is listened to without judgement, and is able to make their own choices, and set their own personal and professional goals in a manner that works for them. A client-centred approach allows the decision-making process to be fully driven by the client.

The first day focused on examining the theory that forms the foundation of

INC, the role of the INC and implications for health-care reform. We also became familiar with the validated integrated health and wellness assessment used by INCs. We then worked with a partner to set some real goals and get a feel of how the coaching process works.

The nurse coach role is founded on five core values in the areas of: philosophies, theories and ethics; the nurse coaching process; communication and the coaching environment; nurse coaching research, education and leadership; and nurse coach self-development. The theory of integrative nurse coaching (TINC) has five components (see Table 1). Professional nurse coaches also follow a scope of practice and adhere to competencies that are linked to the American Nurses Association (ANA) standards of practice and professional performance.[2]

TINC guides the practice of nurse coaching, education, research and health-care policy. It describes how an INC views clients as integrated whole beings who are defined by their individual and unique history, culture, beliefs and story. Knowledge of these components allows the nurse coach to assist clients to embody new behaviours for sustained change.

It is important as a nurse coach to be able to understand and convey to others the concept of healing as defined in nurse coaching: *"Healing is viewed as a lifelong journey of seeking integration and stability in life. Healing involves recovery, repair and renewal of the whole person, including physical health, mental, social, and spiritual health, leading to contentment with what is and freedom from struggle. Healing in this context is viewed as synchronous but not synonymous with curing".*[2]

As nurse coaches, we are encouraged to continuously explore our own self-development and healing, and during the first day, we had the opportunity to reflect on our own dreams and desires. As I met with clients during the practicum phase of the course, it was useful to share with them that I too was on a journey, just as they were, to improve my own health and wellbeing.

I was able to empathise with them and recognise the real struggles that can be experienced when making changes. This adds authenticity to coaching and helps the nurse move easily between the expert nurse role of knowing, being an educator and managing symptoms, to the nurse coach role of not fixing, but rather assisting the client to access their own inner wisdom. Using reflective and open questions, the nurse coach helps the client gain better insight into their lifestyle behaviours and choices. This can lead to them making sustainable change and flourishing.

We were introduced to integral lifestyle health and wellbeing (ILHWB), which is a science-based approach to health. It deals with primary prevention and underlying causality through a whole-person perspective. The INCA uses a validated integrative health and wellness assessment (IHWA). The IHWA was developed over 30 years of integrative and integral clinical nursing practice, education and research. This assessment is part of the nurse coach five-step process and covers eight components that are constantly interacting with each other. These are: life balance/satisfaction, relationships, spiritual, mental/emotional, physical/nutrition, physical exercise and weight, environmental and health responsibility.

Using reflective and open questions, the nurse coach helps the client to gain better insight into their lifestyle behaviours and choices.

The workshop was run by the country's first two integrative nurse coaches, Heather Leong (left) and Anah Aikman.

Although not essential for use in the coaching session, the IHWA can be a tool to help clients focus on what matters to them the most at that time, and to guide them toward where they are ready and motivated to make change.

Having spent time learning and understanding the TINC, we then moved onto the practice of nurse coaching. Nurse coaching aligns with the nursing process – the core focus is on creating sustainable change. Nurse coaches learn about and utilise change theory. This includes the transtheoretical model (TTM) of behavioural change. This model identifies motivation for change and whether the client sees change as a perceived threat or benefit. It also incorporates their perceived capacity for change. It addresses the intention to change and the process of change and explains how people change their health behaviours over time.

An understanding of the five stages of change – pre-contemplation, contemplation, preparation, action, and maintenance – is essential for the nurse coach to help a client establish goals that can be sustained.

Nurse coaches learn and develop skills in motivational interviewing (MI). MI guides the client to make their own choices and to explore their internal motivators for change. This involves the nurse coach listening to the client, expressing empathy, noticing ambivalence and discrepancy, rolling with resistance, and supporting self-efficacy. The nurse coach will use open-ended questions, affirming, reflective listening and summarising in their conversations. Nurse coaches also use nonviolent communication – a method which enhances empathy – and appreciative enquiry in their coaching sessions.

Nurse coaches assist clients with planning specific, measurable, achievable, realistic, and timebound (SMART) goals. SMART goals can help create sustainable change. With my clients, I also like to add an ER, for SMARTER goals. This reminds clients that if they wish to achieve sustainable goals, it helps if those goals are also enjoyable and rewarding.

In the evening, it was uplifting to be among a small group of nurses with so much experience and passion for nursing, who were seeking new knowledge on how they could improve their practice.

Those of us who slept on the marae overnight were watched over by the many pictures of whānau covering the walls. The photographs of ancestors displayed on the walls of the wharenui (the meeting house) are reminders that Māori are interconnected with the past, present and future through their ancestors. Their stories and contributions are an integral part of daily life.

The focus of day 2 was self-development and "a nurse's journey to wellbeing". We looked at the impact of burnout, stress and anxiety on the self and the nursing profession. Emphasis was placed on the importance of nurses using awareness practices such as mindfulness.

In mindfulness, attention is paid to what is happening in the present moment, such as what you are thinking, feeling and sensing. Using awareness practices, the nurse coach and the client can cultivate loving kindness, compassion, calmness, concentration and insight. Becoming more aware of our actions and choices is essential to recognising areas for change, while also helping create balance and harmony. By personal experience of this practice, a nurse coach will discover the benefits that increased awareness offers. Only then can a nurse coach lead a client through the process with understanding, confidence and ease.

As research grows, the benefits of awareness practices like mindfulness, meditation, imagery, yoga and qi gong are now being recognised and introduced into mainstream health care.

Research over the last 50 years into awareness practices has found their benefits include physical effects, such as initiation of the relaxation response, calming the amygdala (fear centre of the brain), reducing heart rate and blood pressure and easing the response to pain. Emotional benefits include reducing negative states such as anxiety, worry and inner criticism, as well as empowering self-regulation of thoughts. The work of American cardiologist Herbert Benson has led to these practices becoming accepted components of the practice of mind-body medicine. They also support conventional medical care.

By the end of the workshop, we felt empowered, inspired and open to the myriad possibilities that nurse coaching has to offer for ourselves, our colleagues, our patients, and our whānau. •

** The author received funding from NZNO's Florence Nightingale Memorial Fund and from the Breast Cancer Foundation NZ to complete her integrative nurse coach certificate program. She thanks Anah Aikman and Heather Leong for their support in preparing this article.*

Table 1. Theory of integrative nurse coaching – five components

Component 1: Nurse coach self-development

Self-reflection, self-assessment, self-evaluation, self-care.

Component 2: Integral perspectives and change – four perspectives of reality

1 - individual interiors (personal/intentional)
2 - individual exterior (physiology/behavioural)
3 - collective interior (shared/cultural)
4 - collective exterior (systems/structures)

Component 3: Integral lifestyle health and wellbeing (IHLWB) – Personal approach dealing with primary prevention and underlying causality through a whole-person perspective. Based on five principles:

1 – Energy fields and dynamics – stress, toxic environments, cultural isolation and nutritional imbalance can disrupt our energy field.
2 – Interconnectedness – all communication is an orchestrated network of interconnected messenger pathways and signalling systems and not autonomous or in isolation.
3 – Patient-centred – honours each person's unique history, culture, beliefs and story.
4 - Biochemical availability – recognises the importance and variation of metabolic function deriving from genetics, epigenetics, strengths and vulnerabilities unique to each individual.
5 – Health and wellness is a continuum – our human capacity seeks to identify, restore and support our innate resilience and reserve to enhance wellbeing and healing throughout life.

Component 4: Awareness and choice

Knowledge and self-regulation skills of mindfulness, cultivating the qualities of loving kindness, calmness, concentration and insight.

Component 5: Listening with HEART

Healing, energy, awareness, resilience, transformation

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LOOKING TO **ADVANCE YOUR NURSING CAREER?**

Kirsteen Haynes emigrated to New Zealand from the United Kingdom in 2013, and went first to Christchurch, where she worked in the Christchurch Hospital emergency department, and then to Wellington, where she took an associate clinical nurse manager role in the emergency department at Hutt Hospital. Postgraduate study was a requirement of the role—and Kirsteen admits she started her Master of Nursing Science in 2016 reluctantly. However, she was soon enjoying it.

"As the course progressed, I became more engaged and now I'm sad it's finished!

"The courses I chose were a mixture of clinical ones that have helped underpin my practice in emergency nursing, and theoretical courses that have helped to develop my managerial and leadership abilities in a senior nursing role."

After completing the first two courses at Massey University, she transferred to Te Herenga Waka—Victoria University of Wellington because it "had a better choice of courses and a more mature approach to adult learning … the approach there suited my maturity and experience. The learning was more self-directed though guided, and the classes were inclusive and interactive".

She says she became more and more engaged with the study as she progressed, and enjoyed exploring both the subject matter and academia.

"The last couple of courses focused on my desire to improve health outcomes for women and children who live in the Hutt Valley and are victims of domestic violence. I have utilised my studies to explore this topic in greater depth, and now I am applying my knowledge clinically and attempting to change the current practices in the emergency department in which I work."

Part of her research involved identifying and reducing barriers to routine screening for domestic violence in the emergency department where she was working, and giving the nursing team greater confidence in caring for patients who presented as a result of domestic violence.

Kirsteen says her study not only improved her knowledge and confidence in the subject but also helped improve her ability to develop project plans and lead and influence change.

"I feel the spark for learning was ignited after many dormant years. The lecturers were key in keeping this spark alive and helping to direct my learning towards topics that interested me and have now become my passion. I also really enjoyed meeting nurses from other clinical areas and embraced the shared learning this encouraged.

"I would encourage all nurses to consider further postgraduate study. Just take it one course at a time at a pace that suits your work–life balance. The courses completed soon add up."

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Te Omanga Hospice Changing Minds Conference
https://www.teomanga.org.nz/education/changing-minds/

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Registered Nurses Foot Care Forum 2021
Enquiries: feetretreat4u@gmail.com, attention Lyn Harris

2-5 November 2021 Rotorua
The Paediatric Society of New Zealand
72nd Annual Scientific Meeting 2021
https://forumpoint2.eventsair.com/psnz-72nd-asm-2021

5 November 2021 Wellington
New Zealand Familial Breast and Ovarian Cancer conference
https://www.nzfboc.org.nz

5-6 November 2021 Christchurch
College of Emergency Nurses NZ Conference
https://au.eventscloud.com/website/1024/

12 November 2021 Hamilton
Breast Cancer Conference Day
For information contact Jenni Scarlet at Jenni.Scarlet@waikatodhb.health.nz

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