Kai Tiaki
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Pacific nurses rise to Delta challenge

A sense of urgency and care for their community is motivating South Auckland's Pacific nurses as they vaccinate thousands.

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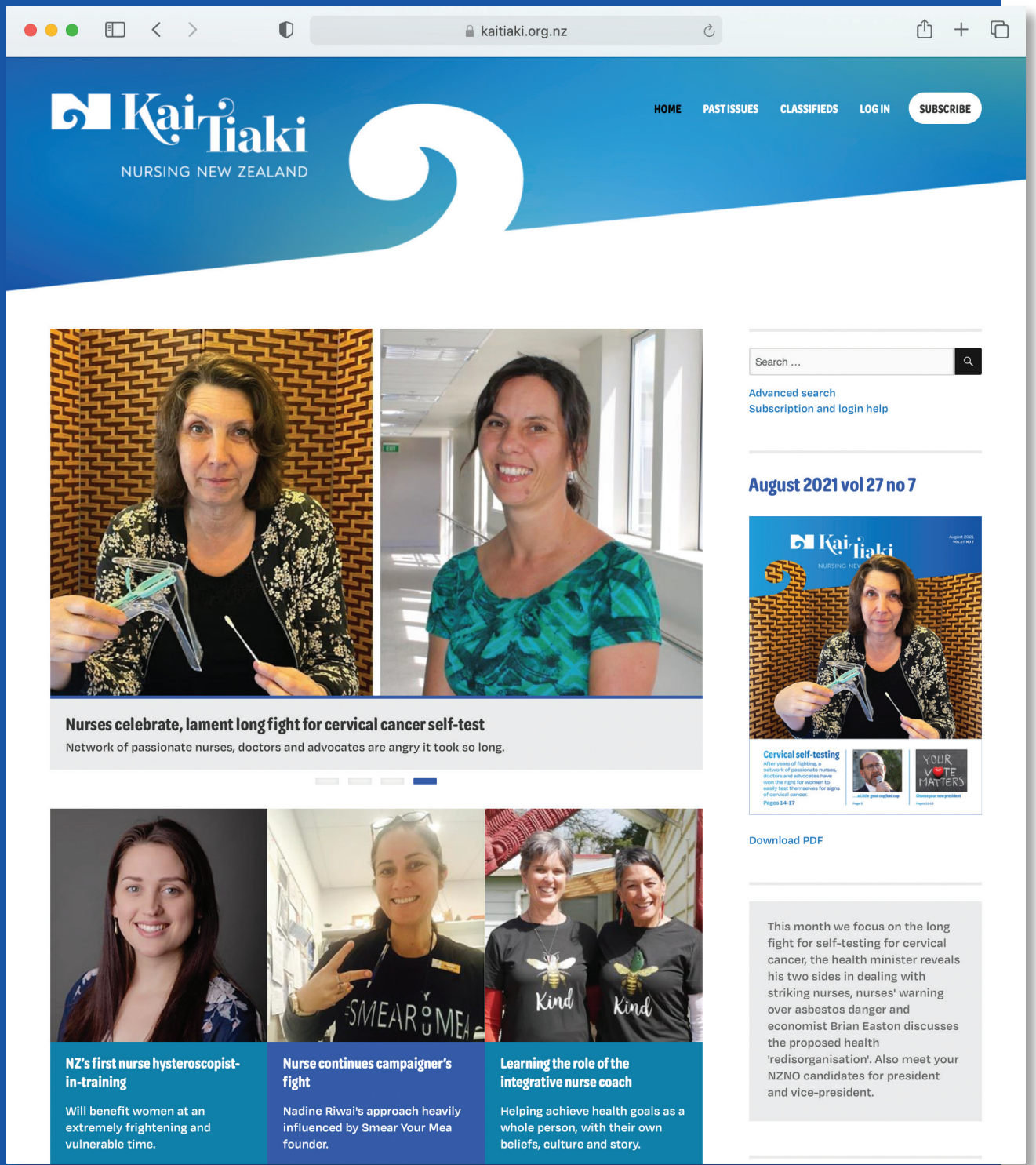

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THIS MONTH we look at how members put strike action on hold to return to the pandemic frontline, particularly Pacific nurses and caregivers whose communities have been hardest hit. We also feature extensive coverage of the Indigenous Nurses Aotearoa Conference 2021, as well as a new nursing degree with mental health at its core and a nurse's warning on the perils of Twitter.

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This issue . . .

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Call NZNO's Membership Support Centre: **0800-28-38-48**

Correspondence:
The Co-editors
Kai Tiaki Nursing New Zealand
PO Box 2128, Wellington, 6140
ph 04 494 6386
coeditors@nzno.org.nz

Advertising queries:
Chris Uljee
Kai Tiaki Nursing New Zealand Advertising
PO Box 9035, Wellington, 6141
Ph 0274 476 115 /chris@bright.co.nz/
www.kaitiakiads.co.nz

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‘Mental health nurse’ an outdated term

By Heather Casey

What an opportunity! Recent and coming health reforms will see significant changes in health structures and with that the opportunity to reconsider the ways we think about nursing and nursing care. The structural reforms also provide the opportunity for nurses practising in mental health to think about their nursing role and identity, and how it impacts on services provided.

He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction sets out a clear aspirational vision for the future mental health and wellbeing of all. As the report states, there is no health without mental health, but then there is no mental health without physical health.

If equity in health is a priority, then nurses need to understand the whole person and their health needs. When someone presents to any part of the health system, the opportunity must be used to maximise health, not just fix one part of the body or mind.

As a profession, we need to stop thinking of ourselves as “mental health nurses” – the term is outdated. We are nurses with specialist knowledge; this may be mental health, addictions, intellectual disability or a combination of all, and our knowledge and skills also include physical health. We have the same competencies as every other nurse, and the same responsibility for physical health and to support the health needs of the whole person.

There has been significant feedback about the lack of mental health sector input into the Nursing Council’s review of the RN education programme standards, so I am pleased the council is open to ongoing discussion. I would like to see the curriculum’s theory and clinical components evenly split between physical and mental health or, even better, integrated so there is no split. The current curricula focus on hospitals as the centre of specialist health care. This medicalises the complexity of issues people present with, and misses the opportunity to maximise mental health and wellbeing for all.

The focus on hospitals is further reinforced by the safe staffing priority. I embrace the idea of safe staffing and the tools we use to help achieve the numbers required to safely staff inpatient facilities. The tools are not ideally suited to mental health inpatient wards but are the best around at this time.

However, time to really care, to show care and compassion in all areas, is undervalued by these tools. The focus on tasks within inpatient services reinforces that care mainly happens in hospitals. However most mental health, addictions and intellectual disability services are delivered in the community. This means that in terms of safe staffing and the time to care, most mental health nursing work is invisible.

Nurses work across their communities. Do we, as a profession, need to have more of a community focus and ensure our employers also see the value of this focus? The pay equity debate in aged care and non-governmental organisations shows where our most vulnerable are cared for, by the least well remunerated.

Care and compassion are essential for effective nursing care, but also essential to the healthy functioning of nurses and teams. If we don’t look after ourselves, how can we look after others? Nursing is at a crisis point, in terms of recruitment and retention, both in mental health and other sectors. Does moral distress contribute to this? Nurses need to feel they are making a difference to people’s lives. They need job satisfaction and they need to have a work/life balance with work that doesn’t leave them feeling distressed.

Care and compassion are essential for effective nursing care, but also essential to the healthy functioning of nurses and teams.

Undergraduate education, health service providers and employers need to walk the talk in terms of the mental health and wellbeing challenge – but so do nurses. Yes, we do require specialist knowledge, but let’s not forget our generalist knowledge and skills, and value care and compassion, as this is at the heart of who we are as nurses. •

Heather Casey, RN, BN, PGCert(addiction & coexisting disorders), MA(nurs), is director of nursing for mental health, addictions and intellectual disability services at the Southern District Health Board.

Otara's Pacific vaccination team have reached 50,000 vaccinations.

PHOTO: SOUTH SEAS HEALTHCARE

'Sense of urgency' in Pacific community

FRONTLINE NURSES vaccinating Auckland's Pacific communities against COVID-19 have seen thousands of people since the Delta outbreak began last month, says a nursing team leader.

"There is a sense of urgency now," says Liz Tiumalu (above, front centre with mask), team lead at the Otara Pacific locality vaccination centre, a collaboration of south Auckland providers.

The centre has celebrated 50,000 vaccinations in the past five months – after a huge leap recently, she said.

"The ones who were a bit hesitant, or weren't sure, many decided to come here and get vaccinated, after realising that COVID could get here in Auckland. They were scared, but still decided to come – Pacific and Māori . . . many different people."

Vaccination rates for Māori and Pacific peoples had doubled since the outbreak, director-general of health Ashley Bloomfield has said.

With about 13 vaccinators on duty at a time, they were seeing 500 to 600 people a week, and up to 900 over a weekend, said Tiumalu, who as lead routinely worked 12-hour shifts.

Nurses took time with the hesitant or fearful, she said. "The advice we give to all our vaccinators is to make sure they take their time, to talk to and reassure people," she said. "The nurse role does everything – we are counsellors as well."

The visits were also an opportunity to ensure people were safe and their wider health needs were being met – as well as connect them with healthcare providers. "Two girls came with their mum – they had never had any vaccinations before, ever," she said. "Even our non-Pacific workers have taken on the Pacific model and applied the same care and reassurance to everyone."

For nurses with Pacific backgrounds, it could be easier to connect with a community, so hard hit by the current outbreak – "just having the language and understanding where they come from".

The centre was a collaboration of staff from South Seas Healthcare; Southpoint Family Doctors; Baderdrive Doctors; Pasefika Family Health Group and the Fono. "On our own, we couldn't have achieved this, so it's great."

A $26 million Government funding boost is also supporting Pacific communities' vaccination.

NZNO Pacific Nurses Section chair 'Eseta Finau said "ethnic-specific" initiatives were also helping, such as a drive-through vaccination clinic aimed at Auckland's Tongan community and similar drives for Samoan and Niuean communities. •

Racism stirs up dawn raids memory for Pacific nurse

PACIFIC NURSES had enough to cope with without racist comments in the media, Pacific Nurses' Section chair 'Eseta Finau said.

"We definitely don't need the extra burden on our nurses' shoulders. They are working long hours, day in and day out," Finau said. "It's not helpful, especially when they are out there trying to save lives. It just damages our will to work."

Her comments follow racist social media posts about the Samoan church community in Māngere linked to the current Delta cluster.

Pacific people were also asked for passports at COVID-19 vaccination clinics at the Bay of Plenty District Health Board, which has since apologised. "We have been encouraging our people to get vaccinated and these people turned up and were asked for their passports," Finau said. "It just brings back memories of the dawn raids."

Pacific nurses were working hard and risking themselves and their families to try and protect Aotearoa, she said. "We are all in this together and we are meant to support and help each other." •

No strike but nurses go purple

DELTA THWARTED strike plans on August 19. Instead, members rolled up their sleeves and got to work on the pandemic frontline.

But a hastily organised 'Go Purple' day made sure the message got out, NZNO campaigns advisor Katy Watabe said.

Lead advocate David Wait said the decision to call off the planned August 19 strike was "the right thing to do" amid a community outbreak of COVID-19.

The Nursing Council thanked the nursing profession for its "resilient and steadfast response in putting patients and their care first", showing true professionalism. NZNO's professional nursing advisors also expressed appreciation to nurses for putting the care of people first (see p32).

As *Kai Tiaki* went to print, NZNO was awaiting a recommendation from the Employment Relations Authority after several days of facilitated bargaining with district health boards.

In Canterbury, 6.4 balloons represent the number of vacancies on an acute surgical ward in Waipapa.

Support from Rarangi, Marlborough

Wendy Alexander's lockdown bears, in Waitara, Taranaki

Hauora Tairawhiti surgical team

Masks and PPE 'a concern'

NZNO IS concerned about a lack of access to and poorly fitted N95 masks for frontline vaccination teams in Auckland, acting professional and nursing services manager Kate Weston says.

"The programme was initially planned to be delivered in a situation without COVID-19 in the community. For the Auckland region, this is not the case now – so particulate respirator masks [which protect against airborne particles] like the N95s should be made available."

The availability of correctly fitting personal protective equipment (PPE) was "variable and remains a risk" for frontline nurses as well as those in primary health care, said Weston, who pointed out there had been 18 months of preparation time since the last level four lockdown. "However, we have an amazing workforce, standing up across the country."

Hauora Tairawhiti's paediatric team.

Staffing shortages laid bare by lockdown pressure

NZNO kaiwhakahaere Kerri Nuku has shot back over safe staffing.

THE COVID-19 lockdown has exposed chronic short-staffing as nurses were asked to work despite living with people potentially exposed to the virus.

After New Zealand went into alert level 4, the Ministry of Health (MoH) issued an exemption for essential health workers from the need to fully self-isolate as long as certain conditions were met.

NZNO says the fact nurses living with those identified as close contacts were still asked to work for Auckland district health boards (DHBs) simply showed the desperate state of the system.

Kaiwhakahaere Kerri Nuku said there was a clear public health order that housemates of close contacts were required to self-isolate because they were a health risk.

"The health direction to self-isolate is there for good reason and there should be no exceptions."

Before the latest COVID-19 outbreak, Health Minister Andrew Little promised a review into why full care capacity demand management rollout in DHBs missed a deadline set in the 2018 collective agreement.

'Successive governments have not listened'

He also promised there would be investment in completing the rollout and funding for a recruitment campaign to fill nursing vacancies.

Nuku said nurses, midwives, health care assistants and kaimahi hauora working in DHBs had been speaking out about unsafe staffing for decades.

"Successive governments have not listened, and nurses have just been told over and over to do more with less.

"The result of this is what you see now, where the Government has changed the Ministry of Health's public health advice because the DHBs don't have enough staff."

She said nurses staying away from work because they live with close contacts was also a protection for them, and that nurses were as entitled to the same protection as anybody else.

An MoH statement to media said the exemption was made with an eye to balancing the risk of non-COVID-19 patients coming to harm because essential health workers were isolating unnecessarily.

The lockdown came as NZNO DHB members were locked in a tense industrial standoff with DHBs and the Government. •

NZNO successfully defends Employment Court LPS challenge

NZNO HAS claimed victory after being taken to the Employment Court by district health boards (DHBs) in their ongoing industrial dispute with members.

The 20 DHBs involved in collective bargaining took NZNO to the court after members rejected the latest employer offer and voted to strike on August 19.

The hearing revolved around the legal obligations for NZNO in its provision of life-preserving services (LPS) during the strike. DHBs argued LPS agreements should be legally binding.

The strike was cancelled due to the latest outbreak of COVID-19.

On August 25, NZNO released a statement to members saying the judgement had been released.

"Among other things, NZNO successfully defended the view that we could hold a position of a 'best endeavours' approach to arranging LPS on the basis of an individual NZNO member's right to strike." •

Data lag could hide vacancies

Kate Weston

Maree Jones

JUST UNDER 1200 nurse vacancies were reported across the country's district health boards (DHBs) at March 31 this year – about five per cent of the 25,000 DHB nursing workforce – but the real vacancy rate is likely to be "significantly higher", says an NZNO safe staffing expert.

Figures from DHB advisory service, TAS, show vacancies across the 17 DHBs (which supply data) increased from 983 in March 2019 to 1154 by March 2021.

But NZNO care capacity demand management (CCDM) coordinator Maree Jones said the vacancy rate would be "significantly higher" if all 20 DHBs had undertaken full FTE calculations across all their inpatient wards. Three large DHBs – Canterbury, Counties Manukau and Waikato – had not supplied figures and were well behind in data collection, she said.

Jones estimated their vacancies could push rates as high as 10 per cent. And most remaining DHBs had not done a full tally, she said.

"Very few of the 17 DHBs [which provided figures] have fully completed FTE calculations in all of their eligible wards over the past 12 months."

After 12 years of pushing for safe staffing, Jones said nurses were fed up. "This is why our members are so angry and don't trust them."

In a safe staffing accord signed alongside the 2018 DHB multi-employer-collective agreement, all 20 DHBs agreed to implement safe staffing tool CCDM by June 30.

Yet, only 69 per cent had done so, which fell "way short", NZNO acting nursing and professional services manager Kate Weston said. Nor did the figures take into account increasing patient acuity nor how long it took to recruit staff – up to 86 days in some cases, she said.

Pilot evaluations of CCDM uptake had been completed at Capital & Coast, Hutt Valley and Hawke's Bay DHBs. The TAS safe staffing unit – which includes DHB and NZNO representatives – expected the rest to be completed by September 30, Jones said.

Health Minister Andrew Little has also announced a three-month review of CCDM but it was not clear what role NZNO would have, Jones said.

While vacancies had grown over the past two years, the rate had stayed the same as the workforce had increased by 2,600 FTEs over that time, TAS said.

The 2021 figures showed Lakes DHB had the highest vacancy rate at 11 per cent – 58 FTE. That was followed by Hawke's Bay DHB at 8.5 per cent, or 82 FTE. Tairawhiti DHB had a seven per cent vacancy rate or 24 FTE; while Southern DHB had a seven per cent vacancy rate, or 120 FTE.

Auckland, Northland and Wairarapa DHBs all had vacancy rates higher than six per cent. •

Get vaccinated, avoid spreading misinformation – Nursing Council

NURSES SHOULD get vaccinated – and shouldn't spread vaccine misinformation, the Nursing Council of New Zealand says.

The council has released a statement calling for nurses to stick to their "professional obligations" on COVID-19 vaccination.

In the guidance statement, the council said it strongly recommends nurses get vaccinated unless there were medical reasons not to.

"You have an ethical and professional obligation to protect and promote the health of patients and the public, and to participate in community health efforts."

It said vaccination would play a "critical role" in protecting public health by reducing the risk of catching and transmitting COVID-19.

Meanwhile, it was the council's view that there was no place for anti-vaccination messages in professional health practice.

"Nor [should there be] any promotion of anti-vaccination claims, including on social media and advertising by health practitioners."

Nurses had a role in providing evidence-based advice and information about the COVID-19 vaccination to others, it said.

The statement said nurses should be prepared to discuss the evidence-based advice to assist informed decision-making.

Patients were entitled to this under the Code of Health and Disability Services Consumers' Rights, it said. •

Aged care nurses must await DHB deal – Little

AGED CARE nurses must wait for district health board (DHB) nurses to strike a pay deal before attaining their own pay parity, Minister of Health Andrew Little says.

Nurses in aged care were already paid an average of $10,000 per year less than those in DHBs – a gap likely to widen after the DHB multi-employer collective agreement (MECA) was settled, New Zealand Aged Care Association (NZACA) chief executive Simon Wallace said.

There was now an "unprecedented" shortage of almost 900 nurses – 20 per cent of the aged care workforce – leaving a sector in "crisis" with many rest homes facing closure, Wallace said.

"This lack of pay parity has resulted in a flood of nurses leaving the aged care sector, often to work for DHBs or to work in Australia. Many are also leaving for roles as COVID-19 vaccinators."

Little said he was aware of the pay gap for aged care nurses, "and we have committed to pay parity for those nurses," he told *Kai Tiaki Nursing New Zealand*. "However we can't address the pay parity issue until we've sorted out pay equity with DHB nurses."

He was keen to move as soon as the DHB MECA was settled. "The objective is to make sure there is as little gap in time as possible between agreement between DHB nurses on pay equity, and agreement on pay parity for non-DHB nurses."

Clockwise from top left: Natalie Seymour, Simon Wallace, Lesley Harry and Andrew Little.

Little said the Government had recently provided extra funding for DHBs so they could increase their aged residential care funding.

But Wallace said the $8.8 million increase "falls far short of the $85 million required to put the sector's 5000-plus nurses on an equitable footing with the nurses in public hospitals".

The NZACA had lodged a claim with the Government over insufficient funding, given the loss of nurses and inability during a pandemic to recruit overseas nurses, who usually formed up to 70 per cent of the aged care workforce.

The funding is part of the age-related residential care (ARRC) service agreement negotiated between NZACA, DHBs and the Ministry of Health.

NZNO industrial advisor aged care Lesley Harry said the aged care sector was "very fragmented" with low union density making it difficult to achieve a collective agreement.

NZNO wanted to ensure funding was tagged to wages and safe staffing, which was as important as pay parity, she said.

NZNO College of Gerontology Nurses chair Natalie Seymour said nurses were leaving "in droves" for better paid work. "Over the last 18 months, a lot of nurses reflected on their options. Their friends have left and gone into other industries, as they were just wiped out and wanted a better work-life balance. So that's what they wanted too. If we can't get the balance right, or reward them for staying, why would they?"

See p30: The nightmares and dreams of an aged care nurse.

NZNO staff moves – retirements and resignations

AFTER 13 years at NZNO, policy analyst Māori Leanne Manson has resigned, to take up a senior role at Pharmac as pou tohu mātāmua (principal advisor) te whaioranga (Māori responsiveness strategy).

Professional nursing advisor (PNA) Margaret Cain retired in August after 26 years (see p26). Glenda Alexander has been appointed permanently as industrial services team manager, after acting in the role for the last 16 months. PNA Wendy Blair has been appointed as NZNO competency advisor.

Recruitment for a new NZNO chief executive was progressing, NZNO human resources advisor Leisanne Fraser said. Acting chief executive Mairi Lucas, acting nursing and professional services manager Kate Weston and acting associate nursing and professional services manager Angela Clark would have their secondments extended until early October.

NZNO kaiwhakahaere wins global human rights award

Kerri Nuku wins award while Indigenous Nurses Aotearoa Conference inspires Māori–healthcare professionals.

Kerri Nuku, centre, at the Indigenous Nurses Aotearoa Conference 2021 with, left, Ripeka Evans and Donna Awatere Huata.

NZNO KAIWHAKAHAERE Kerri Nuku has won a global nursing award recognising commitment to fostering human rights.

The Human Rights and Nursing Award was presented online to two nurses worldwide from an international conference about ethics in care during COVID-19, hosted by the University of Exeter in the United Kingdom (UK).

Nuku was recognised for her contribution to human rights and equitable care for indigenous nurses and the wider Māori community, through her roles as advocate, activist and researcher.

She said she merely stood on the shoulders of many great warriors "who forged a pathway that gives many like me the courage and resilience to go further".

"Our kuia and kaumātua, whānau, iwi katoa, stand in solidarity to fight for a future where our mokopuna are free to aspire to be whatever and proudly stand as Māori."

Nurses saw first-hand the ongoing injustices of colonisation through over-representation in negative health statistics, and structural discrimination and institutional racism, she said.

Māori nurses also experienced that discrimination and injustice and have survived "by living in two worlds".

"We have learned to live in contradiction while we work for social justice and the health and wellbeing of Māori."

The other winner was UK-based Suman Shrestha who helped develop health and social care both in Nepal and the UK.

Ann Gallagher, head of nursing at the University of Exeter, said both winners were role models for student nurses and caregivers globally and "show us what can be achieved when nurses are committed to human rights".

NZNO's Hawke's Bay/Te Matau a Māui Regional Council nominated Nuku for the award, run by the *Nursing Ethics* journal.

Conference success

News of the award came after the Indigenous Nurses Aotearoa Conference 2021 ran in August, narrowly beating a nationwide COVID-19 lockdown.

Nuku said every year the conference aimed to make its audience feel inspired and part of a whānau.

"From the minute you walk in there, there is a warmth, an aroha."

The conference ran for the first time at Te Papa, in Wellington, drawing nurses, health-care providers and students from around Aotearoa.

"Every one of the speakers I approached, not one of them said 'no'. That's often how our conference is," she said.

Every speaker built on the preceding speaker's kôrero, Nuku said, leaving the audience inspired and waiting to hear what would come next.

This year, speakers included Associate Health Minister Peeni Henare, Ripeka Evans, Hinemotu Douglas, and NZNO Māori policy analyst Leanne Manson.

It included a speech by Māori leader, scholar, and activist Moana Jackson.

He tied his deeply personal kôrero to the theme of this year's conference – heed the call of the maunga.

The event aimed to pick people that would tell a story about something to which they were connected, or passionate about, Nuku said.

"You get more from stories from the heart."

More coverage, p9–18.

'I do it for my whānau, hapū, my iwi'

THE INDIGENOUS Nurses Aotearoa Conference 2021 wrapped with an awards evening at the Beehive, recognising the work of Māori nurses and students.

There were 16 recipients of the Pharmac Tapuhi Kaitiaki awards, as well as a speech by nursing rangatira Marie Noa.

Noa won the 2020-2022 Akenehi Hei Memorial award – but was unable to collect it in person last year.

Pharmac director of engagement and implementation, Alison Hill, said the awards symbolised the relationship with Te Rūnanga and emphasised the agency's Te Tiriti role.

As an example of this increasing emphasis, Pharmac funded two new medicines for type 2 diabetes, empagliflozin, with and without metformin, and dulaglutide.

"So for the first time ever this year, Pharmac applied ethnicity as a criteria for special authority to help ensure that Māori and Pacific people . . . get access to those medicines."

The system should support services by Māori, for Māori, in order to improve the health of whānau, hapū and iwi, Hill said. Māori nurses had a crucial role to play in achieving this.

The 2021 recipients of the Pharmac Tapuhi Kaitiaki awards at the Beehive.

The Tapuhi Kaitiaki awards are in two categories, each with a $10,000 pool. The nurse practitioner/nurse prescriber category supports Māori nurses to advance clinical practice and expertise. The Māori nurse mātauranga category supports nurses/tauira to further study and/or develop an innovative way to help whānau, hapū and iwi.

"We received some beautifully written and informative applications. Some of them were absolutely inspirational," Hill said.

Recipients

Nurse practitioner/nurse prescriber award recipients: Tracy Black, Jacinda Childs, Racheal Smith.

Māori nurse mātauranga award recipients: Mahina Aiono, Jackie Davis, Kirsten Hepi, Eve Larkins, Wavell Madams, Serene Morrell, William Newtown, Pirihira Puata, Belinda Whare, Lucy Gotty, Kayla Rapana, Lucinda Solomon, Shannon Solomon. •

What it means to receive an award - 'my tipuna will guide me'

Three-time recipient Tracy Black shares her thoughts on why Māori nurses do what they do.

EACH TIME I've received the email to say I have been successful, I'm shocked and tears of sadness and joy flow as I remember why I chose to push myself.

My "why" is to make a difference for my whānau who are dying from preventable illnesses such as heart disease, as my immediate whānau (father, brother, grandfathers and uncles) are noted in national mortality rates for cardiovascular disease.

I'm not naïve about the challenges I face daily (institutional racism, conscious and unconscious bias from non-Māori and Māori) and I have my eyes wide open about the struggles Māori whānau face, as I've grown up trying to navigate a health system that doesn't work for my people.

As a Māori nurse, I'm available to my people 24 hours, seven days. They are why I trained: I don't just work my FTE and that's it.

"If called upon, you help": that was instilled in me as a child. One of the things I have always said is: "My tipuna will guide me on my nursing journey", so wherever my people need me I will go.

At this moment I'm working in the right place to help my people.

I know this is a foreign concept to non-Māori, but the whole reason I got into nursing was to help my whānau, hapū and iwi. Sometimes I do question if I have the knowledge and ability to become a nurse practitioner, then I work with patients, and I remember I can do this – and the need for me to continue.

The Pharmac scholarship is not just about funds to pay for course fees, travel and essential textbooks and nursing equipment; rather this will support an aspiration to be able to work in collaboration with my whānau, hapū and iwi. •

'Be inspired' – heed call of the maunga

NZNO kaiwhakahaere Kerri Nuku launches the 2021 conference.

Over the following nine pages, co-editor Joel Maxwell reports from the 2021 Indigenous Nurses Aotearoa Conference, held in Wellington last month.

It was a time for inspiration, whanaungatanga, important information – and some great news about final exams.

NZNO kaiwhakahaere Kerri Nuku launched the Indigenous Nurses Aotearoa Conference 2021 with a call for nurses to relish their time at the event, held at Te Papa in Wellington.

Nuku said the conference, with a theme of heeding the call of the maunga, gave nurses a space where it was ok to be Māori, "a space where it's ok to feel Māori".

"That's something that each and every one of us, working within the health system, doesn't always get to feel, when we go to do our mahi."

The conference was about inspiring nurses to "stop and take that breath", to build whangaungatanga.

Nuku said she was privileged to be part of the Te Rūnanga tauira (student) session the previous day.

Back in the 1900s, Sir Apirana Ngata said the nation needed to raise an army of Māori nurses.

"So yesterday was inspiring because some of that vision was coming true – a room of potential nurses. Not just wahine, but an increased presence of male Māori in the room."

It should not have taken more than 100 years to raise that army. "So the purpose of this hui is about listening to some inspirational speakers, putting a fire in the belly, and seeing how we can all be better advocates for our whānau, for our hapū, and for our iwi."

COVID-19, and its prescriptive response, had limited the way Māori nurses could work.

"Yet if we had of raised that army . . . in the 1900s, one could say that we would've learned a lot better in our health-care system, and not have such restrictive policies applied to health practice to cope with the pandemic."

The nurses should sit back and enjoy the hui and "be inspired".

"The great thing about these conferences is we have so many inspirational speakers that we want to make notes, and then they become our inspirational words to other people who haven't attended this hui."

Nuku said there were students in the audience who had just found out they had passed their state final examinations.

"So there's another Māori workforce coming. We need to make sure that we tautoko everybody . . . we will all be here to tautoko." •

Of mice and nurses: The life and times of a fighting woman

Talking tough was Donna Awatere Huata.

She was the woman in black, and shooting from the lip.

Donna Awatere Huata (Ngāti Whakaue, Ngāti Porou, Ngāti Hine, Ngapuhi) has shared a lifetime of experiences with the audience at the Indigenous Nurses Aotearoa Conference 2021.

Awatere Huata delivered an extraordinary, brutally honest and inspiring speech, while dressed in black from head to toe – including a cowboy hat.

"You're here to share your wairua, to inspire one another, to organise . . . so you can go home refreshed, not because of anything anyone said up here, but because of how you connect together."

She thanked the audience for its work to help Māori through a system not designed by them, for them or with them.

"And for those of you who work for Māori providers . . . let's all get behind Kerri [Nuku, NZNO kaiwhakahaere], and push for pay equity. It's not an accident that you are paid less."

Māori nurses faced challenges working as a minority in the Pākehā system, but were forced to "suck it up" so they could pay their bills and look after their whānau.

Awatere Huata has taken on a raft of high-profile roles – including as an activist with the likes of Ngā Tamatoa, an ACT Party MP and Māori Climate Commissioner.

It was 58 years since she took her first stand against injustice.

She took on a summer job with her mother and noticed male colleagues were paid more, despite doing less. "I thought it was such an injustice, so I went to see the manager – I was 15 at the time."

Her advice was ignored, and she discovered a "good lesson".

"Little did I know that injustice is brought to the system to privilege certain people. In this case it was to privilege men."

Injustice remained today – worsened by a National Opposition looking to fan racial animosity.

The Labour Government, while not perfect, would still craft "very useful" legislation for Māori – such as upcoming health reforms covering the Māori Health Authority (MHA), and strengthening of Te Tiriti in last year's Public Sector Act.

But once back in power, National would "slam" Māori, she said.

"The health authority will be crushed, the funding will go down; the Pākehā Health NZ [replacing district health boards] will go back up.

"Oranga Tamariki, if it goes the same way, will be minimised down . . . and we will be struggling to maintain the gains we will make over the next few years."

National would campaign on racial hatred. "They are going to foment racial hatred . . . they're going to do a Trump on us."

Awatere Huata ended by calling for the audience to stop being like mice, to be more strident, and fight harder. •

A journey through time, memory,

It was years ago, but Moana Jackson's first journey up his maunga might give meaning to new generations of Māori.

Moana Jackson speaks at the Indigenous Nurses Aotearoa Conference.

He spoke in a quiet, measured voice, to a hushed audience, about the time he walked to the top of his maunga with his koro.

Moana Jackson – scholar, lawyer, activist, and leader – delivered a powerful address, interweaving memory, experience and years of research, to a mesmerised audience at the Indigenous Nurses Aotearoa Conference 2021.

With an eye to the conference theme, "heeding the call of the maunga", Jackson told the audience of his koro's advice.

"It's not enough just to say what your maunga is in your pepeha . . . but find the time, at some time, to 'touch the maunga'. And if it's too high to climb, just be with it for a while."

He recalled his visit as a youngster to Kahurānaki, in Hawke's Bay, with his koro for the first time.

Kahurānaki, Jackson said, was not as grand or majestic as Hikurangi. It didn't tower in the sky like Aoraki, he said.

"But it's our maunga, and so it's the best maunga in the world."

They passed five "story stones" on the way up, marking spots where his koro would stop and share stories with him.

Jackson used figurative marker stones to guide the audience on its own journey: an examination of where Māori might look, to heed to the call of their maunga.

The first marker, he called the rock "of knowing where to begin".

Whatever struggles and aspirations Māori had, it was always important "to know our beginnings".

"To know where we have come from, to know the legacies that our tipuna have left. To know the struggles that we have had."

He recalled the likes of Irihapeti Ramsden who first raised the idea that Māori nurses might be a group worthy of recognition in its own right.

"She developed the idea of cultural safety as part of the educational training of nurses, but that was a difficult struggle."

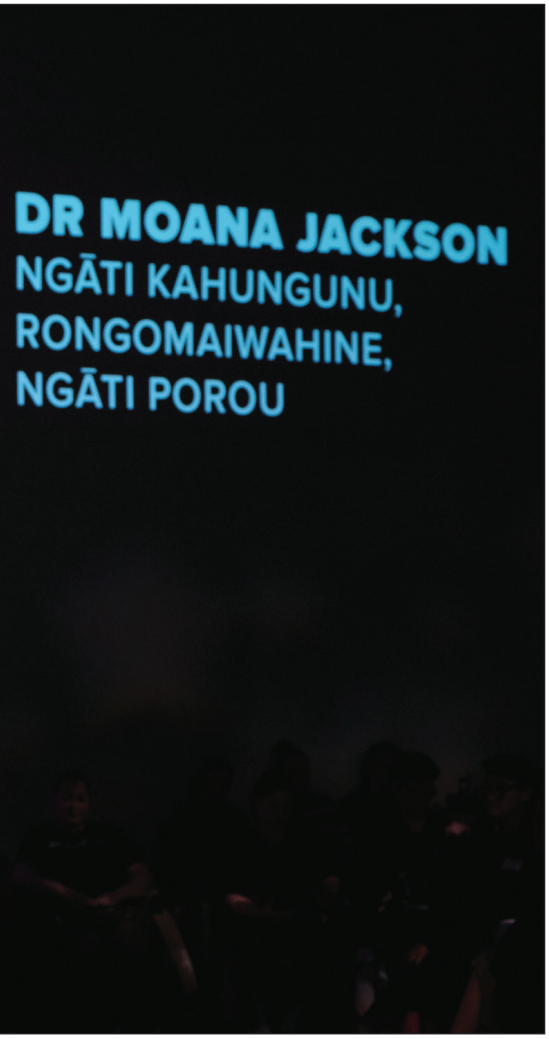
Those beginnings led to the likes of the conference where he was now speaking, he said.

The second marker was the rock of "knowing who has come before us – upon whose shoulders we stand".

These were the "brave and courageous" people who paved the way to the present.

"And many of them have been

hope, to the top of the maunga



nurses, whom you will know I'm sure, or know their history."

These people, who fought to preserve te reo Māori, battled domestic and international injustices, or improved the place of Māori in nursing, should be recognised.

"I think if we can find, in our own way, those people whose shoulders we wish to stand upon, acknowledge the contribution that they have made the path somehow easier for us, then that's a worthy step in heeding the call of the maunga."

The third rock on the maunga was knowing "where our people are at now".

Māori were at a crossroads – there was a danger that progress could be taken away, and victories, after long struggles, denied.

"I have been concerned in the last little while, about how the overt racism towards our people has begun to resurface."

This included the like of insults, "some quite vicious and nasty attacks", on Māori women who had reclaimed their moko kauae.

'Indigenous peoples are proportionately the most represented in prison.'

Despite successes, it was important to realise that the fight was not over.

Māori still fared worse in healthcare, education and the criminal justice system. "So while we are at a better place than we were 20 or 30 years ago, we always need to be honest about where we are at."

The next marker rock on the journey was called the rock of "where we might go", Jackson said.

It was important to have aspirations and ambitions.

He spoke of his years-long research examining why Māori made up such a large proportion of prison populations. Māori men comprised more than 52 per cent of the male population; while more than 60 per cent of the female population were Māori.

There were similar realities in Australia, Canada and the US, he said. "Indigenous peoples are proportionately the most represented in prison."

The thrust of his collaborative research changed to the question of why countries with a history of colonisation imprisoned so many indigenous people.

When you switched to that starting point, the research headed in a "quite different direction", he said.

"Because it seems to me that part of the colonising process was to confine and control the tangata whenua, so that their lands, their resources, could be taken."

That manifested in the criminal justice system, "the building of prisons on land which had never known the idea of prisons".

Jackson looked forward to a time when Māori were not dragged through courts and into prison, but would go through a Māori justice system.

This tied in with his work on Te Tiriti: seeking Māori self-determination – a future of "constitutional transformation" where rangatiratanga was not subordinate to the Crown.

Finally, the audience reached the summit and faced the challenge of a story still being written: the view of a land in danger from climate change and human-induced threats.

Our responsibility was to stand on our maunga and make meaningful decisions about how to look after Papatūānuku, he said.

Māori nurses were in a unique position to touch each of the marker stones and leave a legacy for their people.

"Then when you stand to recite your pepeha, having touched the maunga, having walked the path, literally or figuratively to the summit, you will heed its call, and extend that call to those of our mokopuna who are yet to come." •

Te Tiriti to bolster new health legislation

The vaccination rollout and the health reforms were discussed by the Associate Health Minister.

Associate Health Minister (Māori health) Peeni Henare at the Indigenous Nurses Aotearoa Conference.

Mana Motuhake – independence – would be baked into the proposed Māori Health Authority, Associate Health Minister (Māori health) Peeni Henare says.

Fronting to the Indigenous Nurses Aotearoa Conference 2021, Henare (Ngāti Hine, Ngāpuhi) said upcoming health reforms would profoundly change the current system.

This year the Government announced plans for a Māori Health Authority (MHA), with funding to commission its own services, as well as the amalgamation of all 20 district health boards into a single entity, Health NZ (HNZ).

He said the reform wasn't a reset – it would "wipe the slate clean, and actually start afresh".

"My job is, in particular with the legislation, is to make sure that . . . it doesn't just reflect Te Tiriti o Waitangi . . . what we want to be able to do in this legislation is be far more explicit about what we mean when we want to talk about Te Tiriti o Waitangi when it comes to the provision of health care."

The legislation should "deliver a structure for a Māori Health Authority as best we can, to give mana motuhake".

Delay in expected timeline

He said the expectation had been the legislation could be introduced by the end of August, but was looking more likely to be by the end of September.

It was expected that the governance bodies and their members for both HNZ and the MHA would be announced in early September.

The audience should mark July 1, 2022, in their diaries as the launch date for the new entities, Henare said.

However, it was "misguided", Henare said, to expect the MHA to solve all of the problems for Māori health. Most Māori people would work in, and access their health services from HNZ. Therefore a focus on equity "must be" maintained throughout HNZ, Henare said.

Vaccine nurses stretched

Henare spoke to the conference while facing pressure over the Government's rollout of COVID-19 vaccinations to Māori.

The number of Māori people vaccinated sat "stubbornly low", despite direct support for Māori health providers, he said.

These providers were stretched. "They actually can't do much more: we're delivering in marae, we're delivering in communities, we're delivering in homes for our people."

Completed Māori vaccinations (two Pfizer shots) comprised about 9 per cent of the overall total for Aotearoa: about half the Māori proportion of the total population.

"So as role models and as leaders in your community, my plea is that you continue to push the message around vaccination."

The focus on Māori and Pasifika vaccination intensified after the latest outbreak of the Delta variant.

Henare did not give an explanation of the Government's plans to boost nursing recruitment – instead throwing the issue back at the audience.

"What does a workforce strategy look like moving forward? That's what I want to hear from you."

He said he wanted to hear a "very deliberate" way of doing it.

Henare offered an example of his own Ngāti Hine upbringing, where rangatira gathered rangatahi and set them on a path towards a chosen profession.

"My offer to you is that I'm here to help you do that too. We know the Crown has a role to play in that, and I want to play my part." •

Oranga Tamariki, health reforms, sit at 'intersection' for Māori

Matthew Tutaki speaks to conference-goers at Te Papa.

The man tapped to salvage child welfare agency Oranga Tamariki says health reforms could help stop Māori children being taken from whānau.

Speaking at the 2021 Indigenous Nurses Aotearoa Conference, Matthew Tukaki said he was surprised when asked to take on the role.

Tukaki (Ngāi te Rangi, Mataatua, Te Whānau-A-Apanui) worked his way up from living rough in Sydney, to leading the Australian operations of one of the world's largest recruitment companies.

After returning to Aotearoa, he took on roles with groups such as the Ministry of Health's Māori Health Monitoring Group, and chairs the Ministerial Advisory Board for Oranga Tamariki (OT).

The OT appointment was part of a series of responses by Minister for the agency Kelvin Davis, to controversy over its treatment of Māori.

Tukaki said more than 70,000 "of our tamariki and our mokopuna" came into the state system through notifications every year. From that, 40,000 became "a report of concern", leading to more than 8000 family group conferences: and that led to about 5400 children in care.

"As of March 31, 2021, 67 per cent of those . . . were Māori. That is the wall we have to climb."

When the board's recommendations were released in late August [planned before the latest COVID-19 outbreak] the focus would be on prevention, he said.

"Why is that important? Because a third of those numbers, of notifications, come from the health system. They come from our GP practices, and our hauora [services] and in fact what we do is we channel them down without preventing them in the first place."

MHA an opportunity

Tukaki saw an opportunity for the Māori Health Authority (MHA) to be an "intersection" – for inter-agency connections – for Māori social services as well.

Tukaki welcomed planned changes to the district health board (DHB) structure – amalgamation into Health NZ (HNZ).

"I've never been a fan of the DHBs because the DHBs have got nothing for us . . . what have the DHBs done for Māori health?"

He supported the planned MHA, but the "main prize" was HNZ.

"What we need to do, and which is one of the jobs that I have, is to ensure that there's equity and balance in the governance structure of Health New Zealand."

The long-term plan for health in Aotearoa must be the complete reversal of all Māori health disparities. "Every single one."

'We need to ensure equity and balance in HNZ.'

This included greater support for regional and provincial health services, covering everything from dialysis to cancer services.

"The days of forcing our whānau to go to Auckland, Wellington and Christchurch, for cancer treatment for example, it has to be over in our aspiration.

"In fact we need to be doing more to prevent them from having these diseases in the first place."

This was why Te Hiringa Hauora, the Health Promotion Agency (a Crown entity working under the Māori Health Strategy) needed to be turned over to "Māori interests and aspirations as well", he said. •

Rawiri Taonui talks about racism and pandemics.

The virus on the racism, and our

It was a matter of when, not if, there would be a community case of the delta variant of COVID-19.

Rawiri Taonui, speaking to the Indigenous Nurses Aotearoa Conference 2021, spoke with a kind of calm resignation about the future of the pandemic in Aotearoa.

Less than a week later, he was proven correct.

In a wide-ranging discussion of racism and how it played out historically in causes and responses to outbreaks, Taonui said there would likely be community transmission of the virus before the year's end.

A researcher and semi-retired professor of Māori and indigenous studies, Taonui said he wasn't a medical doctor. "But I do have the ability to diagnose and recommend treatment for racism."

He said racism itself was a virus.

"When the racist looks at you, and us: all the bad things they think about humanity, they see in us . . . but when they go home and look in the mirror they see all the good things in humanity."

Over time that created a kind of "historical amnaesia", with society unable to see the wrongs perpetrated in the past.

"Fundamentally they cannot get over the fact that they are 'good', 'helpful', 'superior, 'advanced'."

There were multiple phases of epidemic and pandemic events for Māori in Aotearoa, he said – beginning with first contact with Europeans who spread new diseases among Māori, who had no immunity to them.

This first episode was in 1769, when James Cook's crew spread sexually transmitted diseases such as

'When the racist looks at you, and us: all the bad things they think about humanity, they see in us . . . but when they go home and look in the mirror they see all the good things in humanity.'

edge of tomorrow: what it reveals about 'historical amnaesia'

gonorrhoea and syphilis among Māori in Golden Bay.

This was the first of a series of about 20 pandemic and epidemic events affecting Māori before the signing of Te Tiriti in 1840.

He said about 70 per cent of the Māori population died from disease and muskets in the 70 years since the Cook contact.

Diseases continued to ravage the Māori population through to the 20th century.

Racism had also affected the roll-out of vaccines. Taonui pointed to a 1913 smallpox epidemic, started by a visiting American missionary.

The missionary spread the disease at a hui with Māori. More than 700,000 vaccines were made by the government, but distributed to mainly-European towns.

"Whatever was left over was distributed amongst Māori communities." He said at the time, no Māori were even allowed to administer the vaccine.

The influenza epidemic after World War I saw health services favour Pākehā, with Māori often left to look after themselves, he said.

This unequal treatment for Māori continued through the century to the modern day.

Taonui said when COVID-19 arrived in Aotearoa, the Government formed a response group with no Māori members.

"The Ministry of Health manage a $22 billion a year budget, I think there's about 300 people that work in headquarters in Wellington."

When the pandemic arrived, they employed "zero" Māori doctors in that office, he said.

Dr Rawiri Taonui said racism was a virus.

There were disparities for accessing COVID-19 testing for Māori and Pasifika communities in the early stages of the pandemic he said.

"So basically what happened is Māori health providers just decided to break the rules, and test the communities."

These providers received criticism from media, but simply carried on.

"Within two weeks, all DHBs took the same approach: Go out to Māori communities and just test everybody you can lay your hands on."

The latest problem was the vaccination rate for Māori – running at about half the rate of the general population.

"The first thing people ask me is 'why is there such vaccine hesitancy?' I say, 'Well I don't think there is that much'."

There was a one-size-fits-all strategy, rather than setting up priority communities based on social, demographic and geographic profiles.

He said Delta was dangerous and Māori needed to get as many people vaccinated as possible.

"If Delta comes to New Zealand, I think it probably will, we'll probably have an outbreak before the end of the year, we'll need as much protection as we can."

Less than a week later, Prime Minister Jacinda Ardern announced the country would go into alert level 4.

Little over a week after that, the case numbers rose to more than 500 people, in Auckland and Wellington.

While the Pfizer vaccine was one of the best in the world, it was made to fight the earlier strains of the virus, Taonui said.

"Even if you've been immunised, you can still become infected. The chances of surviving are much better, your chances of becoming hospitalised or dying are much smaller. But you can spread it to other people."

Borders should not be opened too much before at least 80 per cent of the population were immunised.

The health community needed to do as much as possible to help Māori get vaccinated, he said. •

Whanaungatanga, inspiration – and fun

The Indigenous Nurses Aotearoa Conference 2021 drew extraordinary speakers and dedicated Māori nurses and health-care professionals to Te Papa.

It recharged the wairua of participants, reconnected old friends and provided a space where Māori could be Māori.

Conference goers gather at Rongomaraeroa at Te Papa, celebrating their whanaungatanga.

Horomona Horo, left, gives an extraordinary performance to a full house at Te Papa.

Hinewirangi Kohu-Morgan, above: an artist, poet and visionary.

NZNO kaumātua Keelan Ransfield warms up the audience at the conference.

Workplace policies needed on end of life law

Nurses need to think about what their roles will be under the End of Life Choice Act and seek the support and guidance they need.

By professional nursing advisor Michelle McGrath

From November 7, people can access assisted dying in Aotearoa New Zealand. The Ministry of Health (MoH) is working on guidelines for nurses and kaiāwhina/health-care assistants. But with the service becoming available soon, it is now nurses who must ask themselves if they are happy to take part and what guidance, support and training they need to keep themselves professionally safe. Conversations must be had with colleagues and employers about what nurses will need to ensure patients' rights are upheld under the End of Life Choice Act 2019.[1]

Nurses are the members of the health team consistently involved in patient care. Although the role of the nurse is not part of the act (except for nurse practitioners (NPs) – more about that later), nurses will continue to provide care and support for patients and their whānau accessing this service. This may involve providing care for the patient up to and at the time they have chosen to die, and providing support for whānau after death. This role can be deeply affecting for the nurses involved and requires a network of support to be put around them.[2]

It is important for nurses to be clear whether they have a conscientious objection to taking part in an assisted dying service, or if they are happy to be part of it. Nurses are not obliged to take part if they have a strongly held belief it is wrong.

No matter what the nurse's personal beliefs, patients must still receive continuity of care and a clear pathway to accessing assisted dying. For nurses who have a conscientious objection and those who do not, there must be workplace policies to provide guidance in communicating with patients about assisted dying.

Knowing how to have conversations about assisted dying is essential as, under the act, assisted dying must not be initiated by the health practitioner. Of the health team, nurses most often have the rapport and relationships with patients that facilitate conversations about death and dying. Patients may talk about wanting to "end it all", or say "put me out of my misery" rather than asking specifically about assisted dying. The nurse must ascertain if the patient seeks assisted dying without initiating that discussion.[2]

Michelle McGrath

The service is not available until November 7. Patients can be referred to the MoH's community information sheet,[1] but having local policies would guide nurses in navigating such conversations.

Some organisations, such as Hospice New Zealand and some aged-care providers, have chosen not to provide assisted dying as part of their service. Such employers must have clear pathways for patients to access this service externally. Having an understanding of how nurses can maintain continuity of care for the patient if the patient is also accessing assisted dying from another provider is essential. Nurses, who already work under very stressful conditions due to short staffing, must have the resources available to guide them to support the patient's choice.

The role of the NP in assisted dying is contentious. NPs have worked as autonomous practitioners since 2016, and yet under the act are to work under instruction from medical practitioners. The act says NPs may prescribe the medication involved. However, this medication, under section 29, is unapproved for NPs to prescribe. This undermines the NP scope of practice.

While waiting for guidance from the MoH, nurses must speak up at a local level, by influencing policy to support and guide nurses on conscientious objection, on having conversations with patients about the assisted dying service, and on how NPs can partake in this service while working to their scope.

Nurses can attend MoH webinars and raise questions with the ministry's regulatory assurance team responsible for implementing the act by emailing eolc@health.govt.nz. Being part of professional nursing groups and colleges is another platform to have your voice heard. Waiting for others to provide guidance may result in complaints being laid against nurses. •

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Nurses 'can do more' in mental health

Nurses can do much more in the mental health space – they just need the confidence and experience to do so, says long-time mental health nurse Anthony O'Brien, who is weaving mental health care throughout a new nursing degree at the University of Waikato. By Mary Longmore.

Depression, anxiety, delirium, addictions, distress . . . these are just some of the mental health issues registered nurses (RNs) are likely to come across, wherever they work in the health sector.

But instead of referring such patients straight on to a specialist mental health team, as often happens, University of Waikato associate professor of mental health nursing Anthony O'Brien says a confident and "psychologically-informed" nurse is well-placed to respond and provide effective mental health support to that person.

But he hasn't seen much of that over his 46 years in the field – something he hopes a new nursing degree embedding mental health skills from the start at the University of Waikato will change.

"Nurses tend to kind of put that to one side and say 'this is somebody else's role'." Yet – without becoming specialists or therapists – nurses "can do more" with their role and scope, O'Brien says. "If we can produce nurses who are more well-informed about psychological aspects of health care, then they can do more with the role they have. It's not changing the role exactly, it's making it more inclusive of the whole scope of their practice."

Such an approach could take place anywhere from a primary health clinic to hospitals and acute settings such as emergency departments (EDs). In EDs, where many alcohol-related injuries present, "very brief interventions that are strategic and informed can be part of moving the person towards the recognition that they need to manage their drinking more safely", says O'Brien. "It's not about the nurse becoming a therapist or a specialist – a nurse might begin a conversation with the patient about what might be happening and what they might need."

Anthony O'Brien

Cheryl Atherfold

Nurses tend to kind of put that to one side and say 'this is somebody else's role'.

In communities or hospitals, if a patient expresses thoughts of hopelessness or despair, instead of referring on, "we would like nurses in that situation to go a little further with that person and explore what that's about, without thinking they need to make an immediate referral to mental health services about potential suicidality." They might have a conversation, to try and establish whether it's an understandable response to what is going on in their life – illness or stress – or something that needs a more specialist response, O'Brien says. "That takes a bit of confidence and a bit of experience. Our part of that is to provide nurses, on graduation, with a sense of 'this is what we do, this is part of our role'."

O'Brien says about half of primary health-care consultations are either for mental health reasons or had a significant mental health component

– and nurses needed the skills to respond.

"Primary care is a big focus, but we also want to see it across hospitals and acute care, having mental health as part of their kete, or basket, of skills. They will come across people with a lot of mental health issues in all of those settings," he said. "We don't want them to be mental health specialists but we do want them to be able to recognise and respond to mental health needs in all clinical settings."

Such nurses can play a connecting role between general and specialist practice as well as mental and physical health, suggests O'Brien. Poor mental health was often a barrier to accessing care for chronic illnesses such as diabetes or cardiovascular problems. Nurses able to respond to both would lead to better all-round health care.

'Siloed' approach

A mental health nurse since 1977 and nursing educator since 1983, O'Brien had long been concerned at the siloed approach to mental health care. But it wasn't until the Government's mental health inquiry, *He Ara Oranga,* in 2018 recommended a broader, more collaborative, approach – "to respond to mental health issues wherever they occur, rather than only within mental health services", says O'Brien – that he and other Waikato nursing leaders began planning a new nursing programme.

University of Waikato nursing programme leader Cheryl Atherfold said that the DHB lead directors of nursing group had in 2019 also recommended better mental health and addiction training in nursing undergrad curricula. This would better serve New Zealand's population, they said in a paper on nursing workforce priorities.[1]

Atherfold and O'Brien, along with others such as Waikato DHB chief nursing officer Sue Haywood, Waikato DHB nurse coordinator for cultural support Chris Baker and University of Waikato gerontology nursing professor Matthew Parsons, late in 2019 began developing a nursing degree with mental health and equity as core components. The hope is to better meet the health needs of Waikato's highly rural and high Māori population, Atherfold said.

O'Brien knew he did not want mental health to be a typical standalone unit of four to six weeks studied further down the track. He wanted it to be embedded from day one. "We wanted to make mental health part of our overall approach, integrated across three years into all the courses and clinical practice."

He acknowledges the extra demands this creates. Students must complete 1800 clinical hours across the three years – 700 more than the 1100 required by the Nursing Council – to gain the practical experience needed. The university has linked with eight or nine clinical nursing academics to work alongside the students in their various placements.

Students wanting to work in primary health will be able to do their primary mental health and addiction credentialing through Te Ao Māramatanga, the New Zealand College of Mental Health Nurses, before they graduate so they are ready to work. The programme leaders are also keen to open up post-graduate study options for those students who want to focus on specific areas like Māori or primary health.

"Put simply, the Waikato programme recognises the need to take a more holistic view of a person and their life when providing nursing services," the university said in a press release.

Approved by the Nursing Council late in 2020, the programme began this year with 45 enrolments – although five have since dropped out, possibly due to the demands of higher clinical hours, he believes.

Despite this, O'Brien said, training nurses to be skilled in mental health should not be seen as extra work.

"We're supporting our students to integrate mental health into their practice in a way that doesn't make it an add-on or an extra task – it just become part and parcel of what they do as a nurse, so it's kind of seamless." •

Reference

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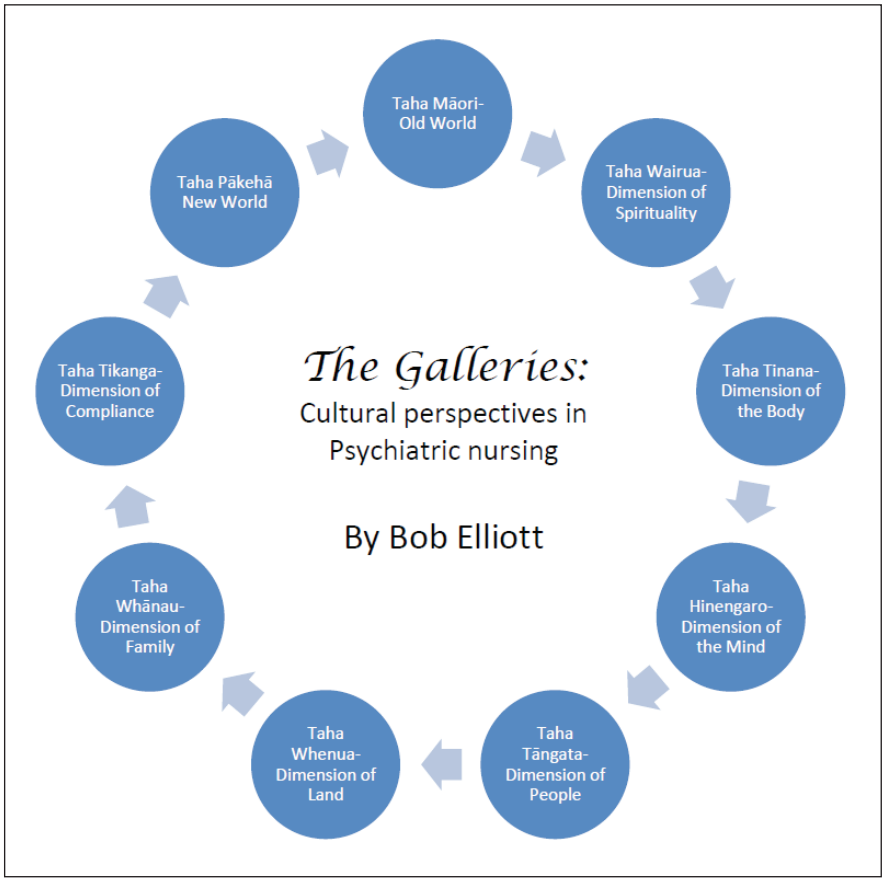
The first nursing students at the University of Waikato's new degree this year.

The Galleries: a Māori perspective on

Bob Elliott's 35-year-old model, painting a portrait of the Māori view of mental health, remains as relevant today as it was then.

By Pipi Barton



This month, September, marks 35 years since Bob Elliot and his colleagues from Tokanui Hospital presented *The Galleries: Cultural perspectives in Psychiatric nursing – A Māori Viewpoint,*[1] to the Australian Congress of Mental Health Nurses Conference in Adelaide, Australia.

Considering the psychiatric nursing environment of 1986, with the focus moving from institutionalisation to care in the community, the concepts described in their presentation would have been ground-breaking. The notion that a cultural perspective of mental health nursing could be articulated by indigenous nurses from an indigenous perspective was no doubt mind-boggling to all those listening that day, as psychiatry was then, and sadly continues to be, so dominated by western Eurocentric perspectives.

The aptly named *Galleries* is a selection of paintings with words. Like the learned orator who weaves his whaikōrero (speech) on the paepae (orators' bench) at the marae, Elliott uses descriptive prose and analogies that would not be lost on non-indigenous nurses.[1] Through his beautifully articulate narrative, he paints nine dimensions, each a step through the Māori world.

Taha Māori describes the dimension of the old world and acknowledges the footsteps and genealogical roots; ***taha wairua,*** the dimension of spirituality, recognises the influence of and affinity with the supreme being; ***taha tinana,*** the dimension of the body, reiterates its purpose, function and care; ***taha hinengaro,*** the dimension of the mind, notes the mortal aspect of the soul; ***taha tangata,*** the dimension of the people, states our common mortality; ***taha whenua,*** the dimension of the land, returns us to our natural links; ***taha whānau,*** the dimension of the family, realises its potential; ***taha tikanga,*** the dimension of compliance, finds the structure of purpose; and ***taha Pākehātanga,*** the dimension of the new world, sees the dark side of optimism.[1]

Elliott states that some or all of these dimensions touch the lives of Māori, and proposes that to lose these dimensions is to lose sanity, because they reflect *"our origins, our present location, hopes and un-slept dreams"*. They also reinforce that mental health is "total health" – something nurses need to consciously aim to achieve for their patients.[1]

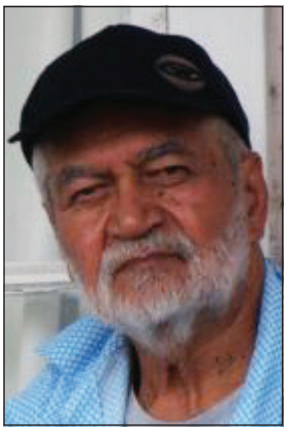


PHOTO: TUIA TE AO MARAMA

Bob Elliott – 'Aotearoa New Zealand's first nursing theorist'.

The Galleries is as relevant today as it was in 1986. It is there to remind

nurses that indigenous perspectives exist and are important, particularly when understanding issues related to Māori health inequities. The nursing care we provide does not have to be dominated by one view of the world – other views must be considered.

Bob Elliott (Ngāti Maniapoto, Ngāti Tamaterā) qualified as a registered psychiatric nurse in 1968, later going on to train as a general registered nurse. He had a prestigious career in nursing, and was involved in the development of the first kaupapa Māori inpatient unit, Whaiora, at Tokanui hospital. This led to similar units being established across the country. Elliott passed away in 2016, aged 78.

Through presenting and later publishing *The Galleries,* he provides the philosophical context for understanding how many tangata whenua (indigenous people of Aotearoa) see the world. It provides a unique insight for New Zealand nurses that can only help to enhance their practice when working with Māori and also a point of difference from nursing in other places in the world. For these reasons alone, Elliott should be recognised as Aotearoa New Zealand's first nurse theorist.

In celebration of the 35th anniversary of the conference presentation, nurses should take some time to read *The Galleries*. An excerpt, the Gallery of Taha Wairua, follows, to get you started. •

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

Reference

1) Elliott, B. (1987). Cultural perspectives in Psychiatric Nursing: A Māori viewpoint. *Nursing Praxis in New Zealand, 2*(3), 3-11. http://teipuwhakahauaa.teraumatatini.com/uploads/elliot/1986/15_Elliot1986.pdf

Welcome to the Gallery of Taha Wairua

or the dimension of spirituality

In this gallery – Taha Wairua, is the greatest gift,
Given by Io (the Supreme Being)
To mankind.

Taha Wairua is:
The timeless twinkle . . . of celestial lace in a crystal-crisp night sky;
The warm, open smile . . . of an innocent child;
The calm, caring touch . . . of a faithful friend;
The denial of pleasures . . . to give to another
And the protection . . . of basic principles
For the families . . . of nature and humankind.

Taha Wairua is also:
The gleeful joy . . . of the roaring surf;
A half-halo rainbow . . . on a clouded rain-swept sky;
The pristine gold . . . of an un-trodden beach;
The hypnotic quality . . . of natural masterpieces;
The spiraling beauty . . . of bird and people song
And the fractured reflections . . . of a mosaic raindrop.

It is the unforgettable cry of BIRTH; The magical moment of natural DEATH
And the sobering hallowed anguish from CRUCIFIED HUMANITY.

Taha Wairua allows each person, in time,
To see their true inner selves
And to amend any deficits in a more enlightened way.

EVERYONE – has some Taha Wairua,
But rarely is it used all day and every day.

Some people deny its existence
And endure a life-time of spiritual emptiness.

Others, mis-use it and are denied
further riches to their lives.

Taha Wairua is the GOD-FORCE
That transcends all man-made boundaries.

Taha Wairua can be found 'behind a grotesque facade'
In a 'wretchedly deformed container'
Or tragically mirrored 'across a brutally-shattered window'.

Taha Wairua is the most difficult gift to receive
But the easiest to use.

It is the only gift that is indescribably beautiful
With a magnificent purity that beautifies the environment.

It also shows as a quiet incandescence in the eyes of those so 'afflicted'.

Taha Wairua makes:
The intolerable . . . . TOLERABLE; The biased . . . . . OBJECTIVE;
Despair . . . . . HOPEFUL; And people-kind . . . GOD-LIKE.

It is the SEED . . . for world peace,
The POWER . . . for brotherly and sisterly LOVE
And the crucial element . . . for the MATURITY of Earth-kind.

These are some of the divine and forgotten treasures in this gallery.

Lessons learned from Twitter

By Margaret Hughes

I have been teaching nurses professional boundaries,[1] professional conduct and communication[2] and the code of ethics[3] for over 20 years. More recently I have taught nurses about the role and perils of social media using Nursing Council guides.[4]

Put another way, I thought I was a well-informed and experienced nurse lecturer. A recent mistake, though, suggests that I was not as savvy as I thought. Even though I joke with my colleagues that "I made a mistake *once* in 1987", I have in fact made many. I want to share the latest, even though it puts me in a poor light, in the hope that my story might help others.

I can share this now, although it has taken over 18 months for me to be able to talk about it. I joined Twitter four years ago and really enjoyed the humour and wit, and the fact that many news items appeared days before the mainstream media picked up on them. I learned new terms like "woke" and "gaslighting" and this was empowering and interesting for someone like me who loves words. One weekend, I tweeted a response to a New Zealand comedian who was clearly joking about her "plan" to confront a group of people intimidating some peaceful indigenous protesters in the United States. The clues that her plan was humorous was that, firstly, she was a comedian; secondly, two women threatening to "wave their arms around like a helicopter" wouldn't be a particularly effective form of aggression; and thirdly we weren't in the US.

In hindsight (and we all know about the power of hindsight) by tweeting "I'm in", I was endorsing her message. But in my mind, I was supporting the ***sentiment*** of the comedian, who was as offended as I was about the treatment of this vulnerable group of protesters. Those two little words, though, that seemed so innocent, so fun, so witty, and so succinctly supportive, can mean something so different to others – all 47 of them by the following morning.

Doxxing is a practice whereby a person reveals identifying information or details about someone online or harasses their place of work.[5] It's designed to shame. One of those outraged people tweeted my occupation and drew attention to my profile, with derisive comments, which were quickly echoed by others. He then contacted my employer and the Nursing Council to lay a complaint that I, a nurse lecturer, was supporting violence and shared this intent online.

It felt like harassment. I was beside myself – as the main earner in my family, I could not afford to lose my job. It was classic bullying really – designed to shut me up, and it worked. I just wanted it to go away.

The complaints were quickly dismissed by my employer and the Nursing Council, as they did not meet the threshold for unprofessional behaviour by either.

While that was a good outcome, it was a very stressful and uncertain time and I don't recommend any nurse going through it.

So, what lessons have I learned from this experience?

- Doxxing is a thing. It is dangerous and could hurt you.
- Be careful about what you put in your profile. Reassess it and update it regularly to suit your own privacy needs.
- Look at who you are inadvertently and unwittingly representing by the information you include in your profile.
- Be careful about what you say, even though it is innocently intended, or in jest. There are people out there waiting to be outraged.
- Re-read your tweet before pressing send. Once in the Twitter-sphere, it can be misinterpreted and can take on a life of its own (even two little well-intentioned words like 'I'm in').
- Humour is culturally constructed and what's funny to some people might not be funny to others

Twitter is an awesome place, but beware. As a mature and thoughtful nurse lecturer, I should have known better. I share my experience with my nursing colleagues, even though my naivety looks silly from where I stand today. And while nurses are allowed opinions, one lapse with how we express them, and how we represent ourselves and our profession can have consequences for our career, and personally. •

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5) Netsafe New Zealand. (2020, Dec). *Doxxing.* www.netsafe.org.nz.

‘Everybody has the right to express themselves’

INTERNET SAFETY watchdog Netsafe chief executive Martin Cocker (right) says there is recourse for people being harassed online under the Harmful Digital Communications Act (2015).

“Everybody has the right to express themselves,” he said. “If she’s been harassed off a platform she used and enjoyed, that is not acceptable and that is harmful.”

Legal options ranged from civil remedies such as an apology and removing content, to criminal such as fines and imprisonment. However, Twitter was such a fast-moving space that conversations had often moved on by the time any action was taken – which also risked re-igniting the conflict, he said.

While “disproportionate” reactions were part of an online environment, harassment, threats and the release of personal details were offences under the Act.

Cocker understood Hughes’ decision to abandon Twitter, but did not want to see people silenced. “We have to look out for ourselves. There is some truth that by not sharing an opinion, she would not have got the blowback . . . But [keeping quiet] is not something we want to promote.”

Nurses, like anyone, had the freedom to express their views, providing they were not harming someone else.

“There is a difference between expressing your view and doing something offensive online,” he said.

For support or guidance go to www.netsafe.org.nz or 0508 638 723 or help@netsafe.org.nz. •

Use social media ‘wisely’ – NZNO

Kate Weston

NZNO AND its members are currently in a phase of significant activity.

Externally, there has been the ongoing dispute with district health boards. Unsafe staffing, poor work conditions, the exodus of nurses from Aotearoa, pay equity and salaries that value and acknowledge the contribution of nurses, midwives and healthcare assistants to the well-being of our communities are all hot topics right now. This has been compounded by the stress and distress of working in pandemic conditions, drawing on what little is left in the tank to face a national crisis.

NZNO board elections are also underway, which often creates commentary on social media.

As a regulated health professionals, nurses are bound by guidelines, codes and competencies, both when they are on and off duty. Professional conduct is the interest of the Nursing Council, regardless of whether you are at work or not. There have been cases where nurses have gone through disciplinary proceedings for comments attributed to them in social media.

Nurses have an ethical and legal responsibility to maintain their patients’ confidentiality. This still applies when using any form of online tool, regardless of whether the communication is with other nurses, a specific group of people (eg “friends” on social networks), or the public (eg a blog). The anonymity potentially afforded online is no excuse for breaching confidentiality, using bullying tactics or bringing an employer or the profession into disrepute.

If you are emailing from work, there will be policies that govern email and social media use on work devices. Emails can easily be identified.

Think twice before using your work email or even a work computer to communicate.

The Nursing Council has revised its guidelines for social media and electronic communication alongside its code of conduct.[1] NZNO guidance was revised in consultation with Nurse Executives in the Tertiary Sector and the NZNO National Student Unit.[2]

Before you set your fingers afire, take a minute to consider the audience – both intended and unintended – and potential consequences if it were to come to the attention of, for example, your employer, before putting your opinions forth.

Social media can be a useful and immediate way of connecting, especially in a COVID-19 world. It is a powerful educational tool and can be used to great effect. So the message here is not to avoid social media, but to embrace it – safely and wisely. •

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

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1) Nursing Council of New Zealand. (n.d.). Ngā Paerewa me ngā rārangi tohutohu: *Standards and guidelines for nurses*. www.nursingcouncil.org.nz/Public/Nursing/Standards_and_guidelines/NCNZ/nursing-section/Standards_and_guidelines_for_nurses.aspx

2) New Zealand Nurses Organisation. (2019). *Guideline: Social media and the nursing profession: a guide to maintaining professionalism online for nurses and nursing students*. www.nzno.org.nz/resources/nzno_publications.

From the Employment Contracts Act to the COVID-19 lockdown

Retiring NZNO professional nursing advisor Margaret Cain looks back at the big issues over three decades of working for nurses.

By Margaret Cain

My first involvement in nursing activism came in 1991, when the Employment Contracts Act (ECA) came in. All multi-site collective bargaining ceased and health workers had to negotiate employment contracts with each separate employer.

My husband encouraged me to get on the bargaining team at the private surgical hospital where I worked. Although I was very reluctant, I eventually did. It was a steep learning curve, and at times a difficult experience, but we got there.

After being part of several bargaining teams, I saw a position for an organiser come up at NZNO, in 1995. I decided to apply as I wanted the interview experience but was not wanting a full-time job. To my surprise, I was offered the job and then had to explain that I really did not want it.

I spoke to one of the organisers and was given the weekend to think about it. I decided to take the job, which proved to be an excellent decision.

The ECA era was very difficult, with many employees losing working conditions. I had worked for an excellent employer, but did not realise how great they were until I left and saw how staff were treated by other employers, particularly in aged care.

Under the ECA, each DHB negotiated its own agreement, and it took a long time for the DHBs to come together under one collective agreement again. This process started with DHBs grouping in regions to negotiate with employees, before finally moving back to one agreement, being negotiated currently.

Margaret Cain as a new graduate in 1975. She had just completed hospital training at Auckland's Greenlane Hospital, where she also held her first job.

After two years as an organiser, I became a professional nursing adviser for NZNO. I have enjoyed working with colleges and sections, and on professional issues at worksites.

More recently, I have worked supporting nurses going through Nursing Council competence investigations.

It is alarming to me that in the three years I have done this particular job, three new graduates have gone though this process. Each of them accrued $30,000 in debt and spent three years of their life to become a nurse, and now only one is still nursing.

I note the Nursing Council is undertaking a review of undergraduate education. Perhaps this review should consider that it is too much to expect new graduates to be undertaking postgraduate study – as they are required to do under some nurse-entry-to-practice (NetP) programmes – while also coping with the stresses of shift work and embedding their knowledge in practice, in an understaffed health system.

Following the 1988 release of the Cartwright Inquiry into the treatment of women with cervical cancer, the Health and Disability Commissioner was enacted in 1994 and associated regulations in 1996. Where patients or relatives are not satisfied with care, they can complain. This changed the health landscape.

The Health Practitioner's Competence Assurance Act came into force in 2004, covering all health practitioners. where previously there

had been separate acts for doctors, nurses and other health professionals.

Over my time, there have also been significant advances in surgery and treatment of disease, with many more complex conditions now able to be treated in a less invasive way. This results in much shorter lengths of stay for patients, with most patients, while hospitalised, requiring increasingly complex care. There has also been a significant intensification of housing in some DHB catchment areas, placing additional pressures on hospital beds.

However staffing levels have never kept pace with the pace of change and technology, mainly due to cost, and nurses are the biggest cost.

NZNO has been working on safe staffing, in different forms, ever since I started, and this issue is part of current collective agreement negotiations with DHBs. A shortage of nurses exacerbates safe staffing problems, and with closed borders under the COVID-19 pandemic restrictions, no internationally qualified nurses are coming into New Zealand. This makes our shortage worse.

However, it is not just New Zealand that has a shortage – it is an international problem. Due to existing shortages, the ageing of the nursing workforce, and the growing COVID-19 effect, the International Council of Nurses estimates up to 13 million nurses will be needed to fill the global shortage in the future.

Margaret Cain

The cost of one year of NZNO fees is less than one hour of a good medico-legal lawyer.

The global nursing shortage was a well-recognised issue before the pandemic. In 2020, the first State of the World's Nursing report, published by the World Health Organization, revealed the global nursing workforce was 27.9 million and estimated there was a global shortfall of 5.9 million nurses. Most of the shortfall was concentrated in low and lower-middle income countries, in Africa, South-East Asia and the eastern Mediterranean. Around 17 per cent of nurses globally are expected to retire in the next 10 years, and 4.7 million additional nurses will need to be educated and employed just to maintain current numbers. In total, 10.6 million additional nurses will be needed by 2030.

In this country, the pandemic has made times tough for the hospitality and travel industries. I understand there are now more people previously employed in these industries entering nursing programmes.

NZNO now has more than 50,000 members, and employs six medico-legal lawyers. The cost of one year of NZNO fees is less than one hour of a good medico-legal lawyer. I hear some members are not happy with NZNO, but I would recommend you belong for the indemnity insurance alone. When I started nursing, I did not know anyone referred to the Nursing Council, but things are different now. You do not have to be a bad nurse to be referred and with short staffing, the risks are much higher.

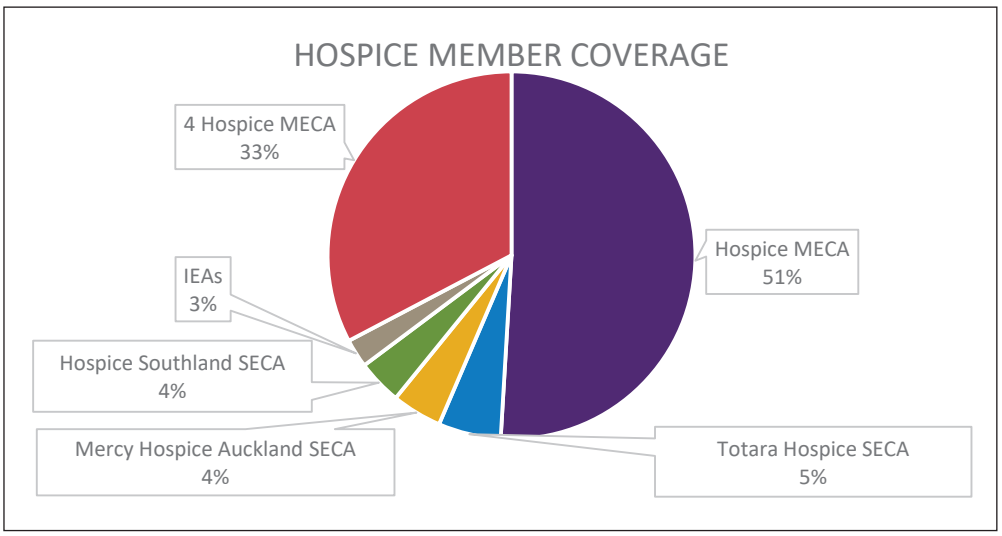
I would also say get involved and change what you don't like – you have the power, and you just need to use it. •

Significant advances in surgery and treatment of diseases has led to shorter hospitals stays and more intense work for nurses.

PHOTO: ADOBE STOCK

Hospice sector: Why political will and industrial strength matter

NZNO's hospice members are facing employer tactics aimed at breaking up a hospice MECA.



By NZNO industrial advisor Danielle Davies

In August, 107 NZNO members signed a resolution in support of industrial unity across their sector. The resolution came in response to 11 hospice employers initiating bargaining for single employer collective agreements earlier in the month.

Members from these 11 employer sites are now faced with a break-up of their hospice multi-employer collective agreement (MECA), which has existed for more than 15 years. As a union, how do we organise against such employer tactics? And how do members campaign to achieve the unity they want to see in their sector?

There are a total of 636 NZNO members across 33 hospices in New Zealand. Of these members, 532 are covered by MECAs, 88 are covered by single employer collective agreements (SECAs) and the remaining 16 members are covered by individual employment agreements.

This month's action by 11 employers – breaking up the hospice MECA by initiating bargaining for SECAs – will result in an even greater number of SECAs in this already fractured sector. For a sector in which there is roughly one employer for every 50 members, this move risks further fragmentation.

Compounded by disparate funding structures, the hospice sector can be characterised by a disproportionate amount of inequity. While this fragmentation and inequity is enabled by current industrial legislation and funding structures, it certainly isn't fair or sustainable.

The DHB MECA formula need not be unique. Hospice members, too, can use this winning formula to strengthen their industrial position.

In late July, I spoke with Kathryn Ryan on Radio New Zealand's *Nine to Noon* programme about how our hospice members' pay and conditions are behind those of our district health board (DHB) members and how a national overhaul of the hospice sector

Danielle Davies was appointed industrial advisor for the private hospital and hospice sector in March this year. She comes from a district health board nursing background, and joined NZNO as an organiser in 2014.

is not only needed from an industrial perspective, but also from a health-equity perspective for patients across the country.

To listen to the interview, go to www.rnz.co.nz/national/programmes/ninetonoon/audio/2018806159/hospice-nurses-seek-pay-parity-with-dhb-colleagues.

It's quite common for comparisons to be made between non-DHB members and DHB members. Sometimes the claim is made that smaller sectors do not feature as highly on NZNO's radar as the DHB sectior, that only size matters.

It's not just numbers that that make the DHB MECA so strong however; it's also political will and industrial strength. On the political front, the Government has heard, loud and clear, that the DHB MECA is here to stay and therefore its existence is not challenged. While in certain circumstances a DHB could legally initiate for a SECA, thereby breaking up the DHB MECA, the political uproar that would result is so strong a deterrent that it would take a very brave, or reckless, DHB to do so.

The industrial strength of DHB members is another major factor. It is not surprising that in a sector which boasts more than 90 per cent NZNO union density, our bargaining power in the DHB MECA is significant. This formula – political will + industrial strength – is a winning overarching strategy that has served DHB members well.

Building membership density

The DHB MECA formula need not be unique. Hospice members, too, can use this winning formula to strengthen their industrial position. By harnessing our industrial strength and building membership density, we can foster a will to win meaningful improvements in terms and conditions of employment in the hospice sector. •

COVID-19 lockdown affects negotiations across sector

From primary health to hospitals, the shift to alert level 4 made hard work of progress on negotiations.

With the primary health care (PHC) multi-employer collective agreement (MECA) set to expire on August 31, the nationwide shift to alert level 4 created uncertainty about negotiation dates.

However, the NZNO team requested a joint meeting with Health Minister Andrew Little, the Medical Association and Green Cross Health as soon as possible to discuss funding for pay parity in this year's MECA.

The alert level change also saw meetings and negotiations postponed on the Family Planning collective agreement – expiring at the end of August as well.

Family Planning chief executive Jackie Edmond said members would not be disadvantaged by postponement of negotiation dates.

Meanwhile NZ Blood Service bargaining on a new collective – the current agreement expires on December 10 – continued await the outcome of the DHB MECA negotiations. The DHB negotiations remained at a standstill – with a planned August 19 strike called off after the latest COVID-19 outbreak. This came after members voted in strong numbers to reject the latest offer from the 20 DHBs.

The deadline for notification of the planned strike on September 9/10 also passed. The decision to hold off came amidst concerns about being able to plan adequately for providing life-preserving services, as well as the impact on public support for members if they voted to strike during a community outbreak of COVID-19.

Bargaining continued with the DHBs, facilitated by the Employment Relations Authority. With no agreement reached with the DHBs, the authority has stepped in and would make recommendations to the parties on matters where they had not reached agreement.

The final proposal would then be shared with members, who would vote on ratification.

Meanwhile the proposed PHC MECA with Healthcare NZ and NZ Care, developed through mediation, was rejected by members. This was the second time members rejected a proposal. The negotiation team was considering its next steps.

At time of publication, there had been no response from the employers. •

Barbara Drake, of Dargaville, joins NZNO's Go Purple day instead of striking on August 19 (see story, p4).

Imagine . . . the nightmares and dreams

A registered nurse working in aged care explains over these two pages what an increase in staffing would mean for her.

Imagine what it feels like to miss out on birthdays, Christmas, celebrations, events, important memories and self-care time.

Imagine what it feels like to have anxiety about going to work because you're tired from shift-related insomnia and short staffing.

Imagine what it feels like to stay up all night to look after someone else's loved one, to be so tired you can barely speak at handover, yet be responsible for the health and care of so many lives.

Imagine what it feels like to go to work and be hit, spat at, scratched, pooped on, yelled at, peed all over, food thrown at you – all because you're in a hurry to give your residents the basic care and time they need.

Imagine the shame we feel when relatives complain their loved ones are losing weight, have uncut nails, uncleaned faces, wrinkled clothing, untidy or unwashed hair, untidy rooms, unmade beds or smell like they have soiled themselves, are not being walked enough, showered enough, or have been left at the lunch table for over an hour . . . the list goes on.

Imagine what it feels like to work through meal breaks, to barely get to the toilet, to work unpaid overtime or stay longer to help short-staffed colleagues – then go to work on your well-earned days off to complete your paperwork.

Imagine what it feels like to run out of time to contact the GP to chart the pain relief or antibiotics needed; to be exhausted and running on empty yet be legally responsible for the health and lives of so many.

Imagine what it feels like for a new graduate nurse to have no support or orientation into a busy, short-staffed and complex environment.

Imagine feeling so stressed out that you snap inpatiently and that new grad breaks down in tears because of the situation you are both in.

Imagine what it is like as a preceptor not being able to mentor and deliver the right skills, knowing both our work is under scrutiny every day and we will be the ones getting hung out to dry if we screw up.

Without mandatory safe staffing, this is what we go through.

We said yes to the aged care sector, putting our own lives on hold to give your loved ones care and support. We do this this with a smile, a laugh or a joke, without judgement, thanks or expectations. If this was my mum, your dad, her uncle, his brother, our grandchildren, their aunty or any one of our whānau, we would want their care to be the best possible.

Get behind us, support us and vote for mandatory staffing ratio numbers that we can work with to provide time, care and more support to your loved ones. I want to advocate for the best aged-care nursing that staff and families signed up for. •

In Safe Hands? Two year campaign continues

NZNO HAS been fighting for mandated safe staffing levels in aged care for more than a decade, NZNO industrial advisor aged care Lesley Harry says. In 2018, joint NZNO-E tū research *In Safe Hands?* found high levels of distress and exhaustion in aged care staff. It found recommended care levels were not met or delayed across shifts, as too-few staff were forced to "ration" their time.[1]

NZNO is calling for 15-year-old voluntary staffing standards to be reviewed and made mandatory.

An NZNO-E tū safe staffing petition is underway and an open letter to the Prime Minister can be signed here: www.together.org.nz/safestaffing-now.

Reference

1) NZNO & E tū. (2019). *In Safe Hands? How poor staffing levels and rationed care are harming aged care residents and staff.* www.flexmediagroup.co.nz/in-safe-hands/index.html.

# of an aged care nurse

As a registered nurse (RN) within aged care I have worked in an understaffed environment at least 40 to 50 per cent of the time for the past year. We have one RN for 36 to 40 high-needs residents in the hospital wing.

As I also have management responsibilities, much of my time is taken up managing staff. I have very little time to provide actual nursing care to the residents. Most shifts, I am supervising at least six caregivers and one enrolled nurse (EN). On top of this, I work as a duty nurse in the afternoon and weekends. I also oversee two other wings within the facility, which includes a rest home with at least 24 residents and capacity for 40; and a dementia unit usually with around 17 residents and capacity for 24.

Based on the current voluntary standards, nurses can only provide six minutes of care per shift to each resident. What can you do in six minutes?

During the week, we also have a clinical coordinator and a manager (an RN) overseeing the whole facility (up to 100 residents). We recently added a second manager.

But at times, we have not had a clinical coordinator, leaving the manager to do both jobs.

Currently, aged care staffing is governed by 15-year-old guidelines from the Ministry of Health, which are voluntary and based around how many weekly hours of care residents should receive.

In my workplace, the rest home has one caregiver per 30 residents plus one unit coordinator on call at all times. The hospital has one RN on duty at all times, with at least two caregivers.

There is a high level of training required for all staff who work in the dementia facility – however orienting new staff also takes time away from residents. The residents in the dementia facility have complex and often acute health needs – yet these do not change the minimum staffing requirement for the facility to meet its contractual requirement with the district health board.

Currently it is at the discretion of aged residential care (ARC) management to provide safe clinical care with the right skill mix. Based on the current voluntary standards, nurses can only provide six minutes of care per shift to each resident. What can you do in six minutes?

So, what would a mandated safe staffing ratio look like?

- We would be able to provide quality care by supporting and being available to doctors when they do rounds for their residents.
- We would be able to provide showers to all residents who choose to have one instead of only having the capacity to shower those residents with the greatest need.
- We could assist more with giving oral fluids to reduce dehydration and see fewer negative health consequences such as falls as a result of this basic need being met.
- Residents' nails would be cut regularly.
- We RNs would have time to participate fully in multidisciplinary meetings to discuss residents' care and needs. We would then have time to put those care and referrals in place.
- Paperwork and care planning for each resident would be more up-to-date and relevant.
- There would be less delay getting GPs called in when needed.
- Medications, including pain relief, would be given on time to keep pain under control before levels got too high.
- Being able to sit with residents longer, to get a comprehensive assessment and meet their concerns.

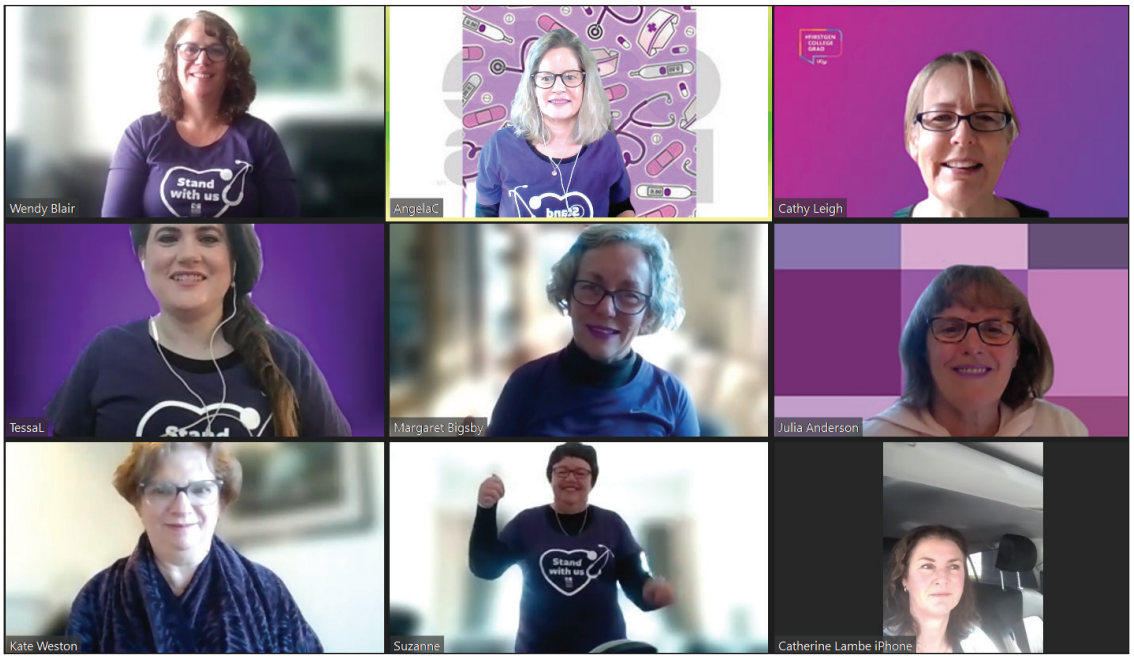
In short, minimum mandated staffing would mean that I, as an RN, would be able to provide the care that I am educated for and longing to be able to give. It would mean that residents would reach their health potential under my care and live a fuller and happier life. Families would be able to sleep at night knowing their loved ones were receiving great care. •

Kia kaha to all our members – thank you !

"NZNO'S PROFESSIONAL nursing advisors send their thanks and appreciation to all members for their tireless commitment and professional determination during these unprecedented times.

"Time and again you have stepped up and taken up the mahi to support, protect and ensure the people of Aotearoa receive the best care possible.

"You have our respect and our gratitude. Ehara tāku toa i te toa takitahi engari he toa takitini – my strength is not as an individual, but as a collective."



Campaign to fix nursing pay disparities?

NZNO'S MEMBERSHIP committee wants NZNO to focus on the difference in pay for nurses working for district health boards (DHBs) compared to those at iwi health providers, aged care facilities and other non-governmental organisations (NGOs).

At its July meeting, the committee agreed to ask the NZNO board and te poari for an update on work to address these pay disparities and suggest it be NZNO's next major campaign.

The committee also agreed to lobby the Ministry of Health to include non-regulated health staff on working within the End of Life Choice Act, due to take effect on November 7, alongside medical practitioners, nurse practitioners, registered nurses and enrolled nurses.

The need for a more user-friendly professional development recognition programme involving unions and employee groups was discussed. Nurses should not have to spend hours of their own time preparing portfolios.

NZNO professional nursing advisor Suzanne Rolls gave an update on NZNO's addressing violence and aggression in nursing (AVAN) project. Two education modules were being developed for members on how to effectively use the Health and Safety at Work Act, their "duty of care" and the right to be safe at work. A 10-point plan was also being adapted and NZNO's membership support centre briefed on how to support members reporting violence and aggression. More information would soon be available on NZNO's website.

Rolls said WorkSafe was not automatically advised when staff were injured through aggression, unless they were admitted to hospital. Injured staff should complete a WorkSafe notification (www.worksafe.govt.nz/notify-worksafe) and be sure to alert a (staff-elected) health and safety representative.

The committee has also finalised a process for delegates acting as support people for members facing disciplinary action, which will be available after board approval.

The committee has vacancies in a number of regions. Members must be elected or appointed by their local regional council. Please see the NZNO website for more information: www.nzno.org.nz/about_us/governance/membership_committee.

The membership committee is intended to bring a member perspective to the board. Its next meeting is October 13-14.

– Report by college & section representative Brent Doncliff. Edited by co-editor Mary Longmore.

New NZNO group for nurse practitioners

NZNO'S NURSING Leadership Section (NLS) is starting a new group for nurse practitioners (NPs) and registered nurse (RN) prescribers.

Professional nursing advisor Wendy Blair said NPs were recognised as important clinical leaders and the development of their role was "critical" to improving access to health care in Aotearoa New Zealand.

Wendy Blair

Siān Munson

RN prescribers, too, needed support as many would eventually become NPs, she said.

"There is currently no specific support group for RN prescribers within NZNO and many of them will move onto being NP interns and NPs, so it is important that RN prescribers are also included in this group."

These senior nurses would fit well, as a "sub-group" within the leadership section, she said.

Manawatū NP Siān Munson said the group was intended to be a "safe space" for NPs and prescribing RNs to come together and support each other, hold discussions and participate in workshops, conferences and other education sessions. It would be for all RN prescribers, including community and diabetes nurses, she stressed.

The NLS planned to expand the scope of its annual conferences to include topics relevant to clinical leadership roles.

Interested NPs and RN prescribers can email: dnsection@gmail.com for further information.

The 2021 NLS conference, *Creating Great – leading into the future,* is planned for November 4-5 in Whanganui.•

PHC nurses juggle vaccinating and contacts

PRIMARY HEALTH-CARE (PHC) nurses have been working hard to make vaccination clinics safe with two-metre distancing and personal protective equipment (PPE) for vaccinators and support staff, since August's sudden shift to level four, College of Primary Health Care Nurses acting chair Jill Clendon said.

PHC nurses were balancing this with supporting Auckland's public health response with many being called on to do contact tracing and case management.

"Most areas have sufficient staff to do both by all accounts but the pressure is on in terms of swabbing, vaccination and contact-tracing now so it will test existing systems, processes, procedures and staffing," Clendon said.

Jill Clendon

However, people seemed to be feeling "a little more in control" this time around, she said.

"Although the vaccination programme is now running alongside, the systems and processes are largely the same as the last lockdown, just needing a bit of an update."

NZNO acting associate professional services manager Angela Clark said NZNO had been prepared for the possibility of a rapid lockdown and colleges and sections were rapidly moving events online.

For details, please check NZNO website's events and colleges & sections' listings.•

PHOTO: ADOBE STOCK

Starting injectable medicine:

How to prepare your T2DM patients

Health-care providers will already be familiar with insulin, but now dulaglutide, another injectable medicine for type 2 diabetes (T2DM), is available for initiation in primary care. It is important to build acceptability of injectable medicines early in the patient journey.

By Louise Roche Farmer

Introducing dulaglutide

GLP-1 agonist dulaglutide (Trulicity) is a new injectable type 2 diabetes medicine funded by Pharmac under Special Authority.[1] Self-administered once weekly as a subcutaneous injection, it comes in a single-use disposable pen. Only a 1.5mg weekly dose is available from September 1, which means dose titration is not required.[1,6]

GLP-1, an incretin hormone released by the gut in response to food, is known to have the following actions:

- enhances glucose-dependent insulin secretion by pancreatic beta cells
- suppresses secretion of glucagon by pancreatic alpha cells
- signals satiety to the brain.[2]

By exhibiting these GLP-1 actions, dulaglutide reduces fasting blood glucose levels, postprandial blood glucose levels and appetite. Due to its appetite suppressant action, it promotes weight loss but this effect is variable. To achieve this, it must be combined with healthy eating and healthy activity.[3] Other medicines in this class are being independently used as weight-loss medications, including liraglutide (Saxenda), which is registered for use in New Zealand but not funded.

Dulaglutide is not independently associated with hypoglycaemia, but it can increase the risk of this when used with medications that cause hypoglycaemia, such as insulin and sulfonylureas. Dulaglutide can also cause nausea, and occasionally

vomiting: however, this side effect normally settles within the first few weeks.[4] A description of common adverse effects and contraindications associated with dulaglutide can be found in the Medsafe data sheet.[5]

The SGLT2 inhibitor empagliflozin was also made available under Special Authority earlier this year, with the same funding criteria as dulaglutide. The choice between empagliflozin and dulaglutide as a funded second-line agent is determined by cardiovascular and renal status, and Māori or Pacific ethnicity. The Special Authority criteria promote improved access for Māori and Pacific peoples, to address inequities in diabetes prescribing and health outcomes. Guidance is available online from the New Zealand Society for the Study of Diabetes (NZSSD).[6]

The funding of both empagliflozin and dulaglutide by Pharmac has increased the availability of funded second-line agents for people with type 2 diabetes whose HbA1c level is greater than 53mmol/mol. Metformin remains the first-line pharmacological agent.

Pharmac will fund either empagliflozin (Jardiance) or dulaglutide (Trulicity); however, some patients may benefit from using both agents in combination.[1,7] If this is the case, consider inviting your patient to self-fund empagliflozin (the least expensive of the two agents) while receiving funded dulaglutide.

Tips and strategies for initiating injectables

The thought of self-injecting a medicine will worry most patients, so having strategies on hand for managing their move to an injectable is helpful.

There appears to be little published literature on cultural considerations relating to injectable medicines in the New Zealand context. Using a respectful approach helps. Invite patients and their whānau to share their feelings, memories and stories, acknowledge these, and offer choices and understanding around the process.

KEY POINTS

- Providing patients and whānau with knowledge will help to build acceptability of their treatment.
- Most people with type 2 diabetes will require an injectable therapy at some stage, so prepare your patient for this early.
- Do not use injectables as a threat as this will contribute to your patient feeling they have failed when one of these medicines is needed.
- The thought of self-injecting a medicine will worry most patients; have strategies on hand for managing discussions about injectables.
- Before starting a patient on injectable medicine, you need to be prepared yourself.
- Don't be tempted to administer the first injection: it is important that patients/whānau manage this step independently.

At the start of the diabetes journey

Most people with type 2 diabetes will require an injectable therapy at some stage, so prepare your patient for this throughout the whole of their diabetes journey. How you prepare them and their whānau over the long term, and not just at the time they need an injectable therapy, will have a big impact on the whole family's acceptance of these therapies when the time comes.

▶ **Present injectables positively:** Talk positively and pragmatically about injectable therapies. Mention them when you talk through future medication options.

> *"There are many tools in your toolkit or kete to help you manage your diabetes well. A range of medications are here when you need them: tablets, insulin, newer medications. They are developing and improving all the time."*

▶ **Avoid using injectables as a threat:**

> *"If you don't do . . . you may have to go on to insulin/an injectable."*

Using these treatments as a threat will contribute to your patient feeling they have failed when one of these medicines is needed, and may impair or delay their engagement with them.

▶ **Allow your patient time to express any negative feelings:**

Exploring patient/whānau beliefs and perceptions of a new treatment helps improve acceptability. People often have fearful memories from a time when someone they knew was on insulin. Allow them to express their feelings about this, then validate their feelings so they feel heard. You can then ask simple questions that

will help them to start re-framing those memories and moving beyond them.

For example, if your patient says: *"I could never go onto insulin or inject myself"*, ask: *"How do you feel about needing insulin/or an injectable?"* or *"Tell me about any past experience you have of others being on insulin."*

Whatever they say, validate the feeling behind it: *"Yes, I can see how that felt/feels scary for you."*

Allow a space in the consultation to accommodate their feelings or the consequences of those feelings – it will often be tears or sadness.

Once the time is right, you can then invite them to reframe their feelings: *"Have you thought about how this could be different for you?"* or *"That was your mother's experience of insulin. Your experience doesn't have to be the same. We can help you with this."*

▶ Offer the injectable as a choice or a trial:

Some people perceive needing insulin as "the end of the line". Others believe that once you are on insulin, you can never come off it. However, in type 2 diabetes, a person's need for insulin can vary over time, particularly if their weight and activity levels change.

"There may be a time when you might need to stop this medication – especially if your level of activity increases or your body weight drops."

"You can try this for three months, then you and your whānau can decide if it is right for you".

When your patient needs an injectable

Helping a patient start insulin is a more complex process than helping them commence dulaglutide. For more on starting a patient on insulin, work through the free online NZSSD Diabetes Knowledge Programme[8] and partner with a local diabetes clinical nurse specialist to support your learning.

Starting a patient on dulaglutide

▶ Before starting a patient on dulaglutide (Trulicity), you need to prepare yourself:

- Get a demonstration Trulicity pen from your local Eli Lilly representative. Learn how it operates through your pharmaceutical representative or an online video.
- If your patient is on insulin or a sulfonylurea, dose reduction of these agents may be needed – visit NZSSD for guidance.[6]
- Vildagliptin should be stopped when starting dulaglutide, as both these agents work via a similar pathway.[6]
- Have an instruction guide on hand to give your patient.

▶ You will also need to prepare your patient:

- If your patient is taking insulin or a sulfonylurea, they should check their blood glucose levels regularly while taking dulaglutide. Their need for insulin and a sulfonylurea may change initially *and* over the long term. You and they will be able to gauge this through their blood glucose levels.
- Ask them to show you their blood glucose testing equipment and assess their skill in using it. Are their blood glucose testing strips in date? Provide them with a blood glucose record book if needed.
- Revise hypoglycaemia management with them – visit NZSSD[6] for information on this.
- Provide them with a link to a

PHOTO: ADOBE STOCK

Before starting a patient on dulaglutide (Trulicity), you need to prepare yourself: Get a demonstration Trulicity pen and learn how it operates through a pharmaceutical representative or an online video.

Trulicity delivery video, if possible. Talk through the possibility they will experience some nausea in the first weeks of treatment.

- Supply them with the prescription for Trulicity and ask them to bring the pen to their next appointment. They will not need needles prescribed as they are pre-attached to the device.
- Advise them to store their Trulicity pen in the refrigerator and well away from the freezer compartment.
- If on vildagliptin, advise them to stop it on the day of the first Trulicity injection and provide them with guidance as to any insulin or sulfonylurea reduction needed on the day of their first injection – supply this as a written plan.
- Set up a 20 or 30-minute appointment for the first injection and invite them to bring a whānau member as support.

▶ On the first injection day:

If possible, have the patient give their injection at the *beginning* of this consultation. They will be anxious before they have administered it and won't retain details when in this state. Once they've done the injection, they will be relieved and more open to receiving information.

Guide the patient through their first injection:

- Use your demonstration pen to show how the device works.
- Help the patient to choose a preferred injection site. If possible, this should be in the abdomen – avoiding the umbilicus and scars – or the outer aspect of the thighs.
- Hand the patient their dulaglutide pen and be there while they give their first injection. Don't be tempted to "help" them: it is important they manage this first step independently.
- Remind them to wait for the second click before removing the pen.
- Congratulate your patient!

Once they have completed their first injection and they are feeling more relaxed, offer the following guidance:

- Advise them to use a fresh injection site each week.
- If they are also on insulin, advise them to use widely separated injection sites for each medicine.
- Advise them to dispose of the pen in a sharps container.
- If appropriate, remind them of reductions needed to their insulin or sulfonylurea.
- If they have been taking vildagliptin, ensure they have stopped this.
- Provide written guidance on how often to inject dulaglutide (once per week, unrelated to food).
- Discuss a possible reduction in appetite and that they may want to eat smaller portions or smaller, more regular meals.
- Offer an appointment for the second injection, if needed.
- Book a follow-up for two to four weeks' time to review. •

Louise Roche Farmer, RN, BA, PGCert diabetes, is a diabetes clinical nurse specialist for THINKHauora, based in Palmerston North. Passionate about service delivery that enables people and whānau living with diabetes to recognise and develop their strengths, she takes an equity focus in her work and advocates strongly for people who have type 2 diabetes.

EARN 30 minutes of CPD

• This article is endorsed by the College of Nurses Aotearoa for 30 minutes professional development (CNA081).

ENDORSED BY COLLEGE OF NURSES AOTEAROA NZ

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The dangers of Delta

Mutations are producing COVID-19 variants more dangerous than the original.

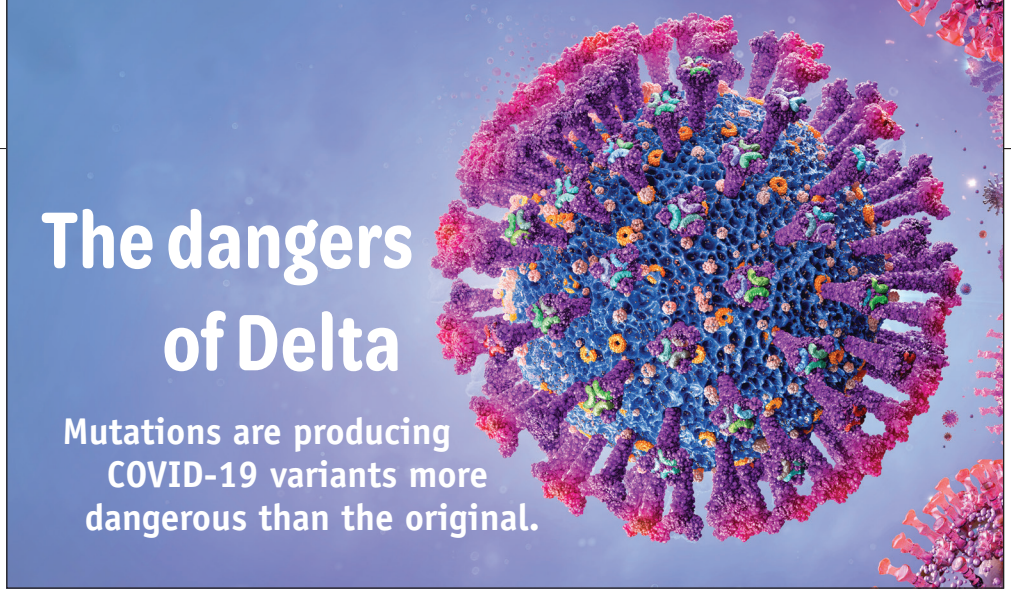

PHOTO: ADOBE STOCK

By Georgina Casey

Scientists have a detailed understanding of the way SARS-CoV-2, the virus that causes COVID-19, infects cells. A key factor is the presence of spike proteins on the surface of the virus particle (virion) that bind to the ACE-2 receptors found along the whole human respiratory tract. Unlike other respiratory viruses (eg influenza), SARS-CoV-2 spikes are highly flexible, allowing them to find and bind to more receptors. Also they are coated in sugar molecules (glycans) that help to disguise them from the immune system.[1]

The Alpha and Delta variants of the COVID-19 virus show mutations in the receptor-binding section of the spikes. The Delta variant has multiple spike mutations which both make it better at binding to the ACE-2 receptor and better at "hiding" from the immune system.[1]

Replicates much more rapidly

Strong binding, more immune evasion and more efficient entry into host cells means the Delta variant can replicate much more rapidly, making it more transmissible. Studies indicate the viral load in the airways of people infected with the Delta variant is up to 1000 times higher than the original or Alpha variant SARS-CoV-2. Even people who are fully vaccinated are shedding high numbers of virions with only mild or zero symptoms.[2]

A person's viral load is determined by the cycle threshold (CT) value. This refers to the number of times a sample from an infected person needs to be processed through the polymerase chain reaction (PCR) (a laboratory amplifying tool) before the virus is detected. The higher the CT value, the less virus is present.[3]

According to the US Centres for Disease Control (CDC), the R_0 number for the Delta variant is between 5 and 9.5. This means one person with the infection is likely to pass it on to between five and 10 other people. This makes the Delta variant more contagious than seasonal influenza, the common cold, the 1918 pandemic influenza and Ebola. The most comparable infectious transmission is with chickenpox. By contrast, the original SARS-CoV-2 has an R_0 of between 1 and 2.[2]

Delta appears to cause more severe disease in the unvaccinated. Vaccines prevent severe disease but not the spread. Further, the time between exposure and becoming infectious is reduced for Delta from an average of six days to four days.[4] This makes contact tracing a more difficult and urgent priority where there is Delta in the community.

The World Health Organization and scientists are closely watching a number of other variants (eg Eta, Kappa and Lambda). These have mutations predicted to increase transmissibility, disease severity or immune escape but have not yet reached global public health significance.[5]

Stopping transmission is essential to controlling the development of even more dangerous variants. The more infections, the more chance there is that mutations will occur and natural selection will ensure the best mutations – those that improve viral infectivity – become dominant. The greater the R_0 value of a disease, the higher the percentage of the population that needs to be vaccinated for herd immunity.

Stopping transmission is essential to controlling the development of even more dangerous variants.

These are the reasons that effective public health messaging about prevention of transmission and vaccination, and the role of nurses in reinforcing these, are so important. •

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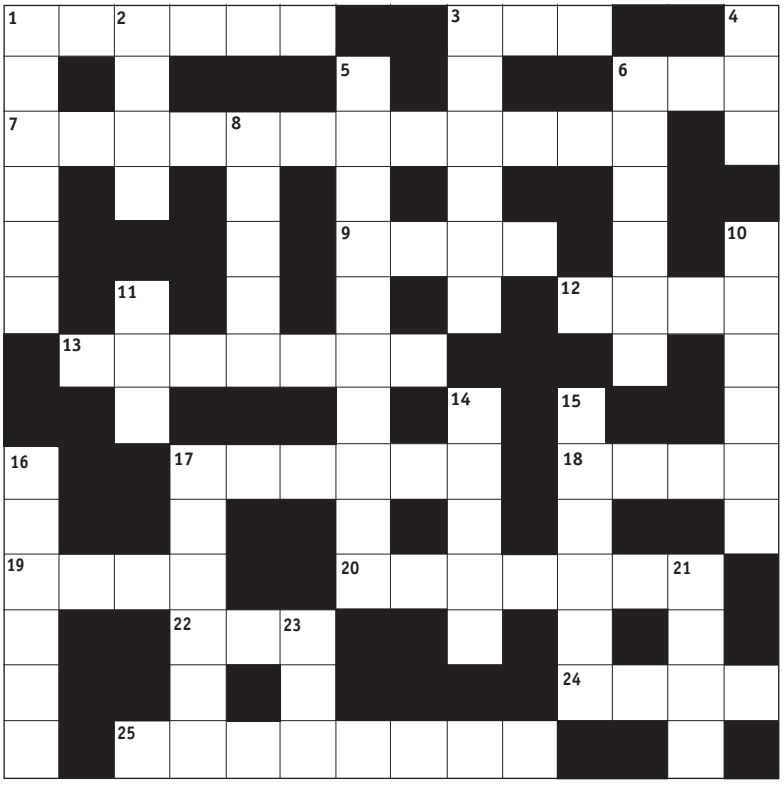
crossWORD

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



ACROSS
1) Breakfast cereal.
3) Enemy.
6) Mandible.
7) Cancer caused by asbestos.
9) Skin of citrus fruit.
12) Unconscious state.
13) Female god.
17) Woman (Māori).
18) Grain used in Asian cooking.
19) What a perm does to hair.
20) Fail to take care of.
22) Colour of rage.
24) For water storage.
25) Carcinogenic building material.

DOWN
1) Storage capacity of computer.
2) Effortless.
3) Good companion.
4) Sense of wonder.
5) Ongoing low mood.
6) Language, often obscure, of a particular professional group.
8) Fearful.
10) Disease where cell multiplication is out of control.
11) Type of lettuce.
14) Fence made of plants.
15) Needing immediate attention.
16) 10 years.
17) Tusked sea mammal.
21) Man (Māori).
23) Female deer.

August answers. ACROSS: 1. Vaccinator. 8. Angry. 9. Ballot. 10. Ivy. 11. Humble. 13. Peg. 14. Law. 16. Open. 18. Rusty. 19. Ego. 20. Avenues. 22. Hospice. 23. Toga. 24. Tough. 26. Ode. 27. Strike. 28. Tackle. **DOWN:** 1. Vibes. 2. Colleague. 3. Nut. 4. Tailbone. 5. Ray. 6. Egg. 7. Hypoglycaemia. 12. Errors. 13. Positive. 15. Chapters. 17. Pressure. 21. Neat. 25. Hut. 26. Orc.

wiseWORDS

“ Perfection of character is this: to live each day as if it were your last, without frenzy, without apathy, without pretence. ”

– Marcus Aurelius (121-180), Roman emperor and Stoic philosopher

it’s cool to kōrero

HAERE MAI and welcome to the September kōrero column. To have "rangatiratanga" means to have the qualities of a leader. This can mean a person comes from a chiefly bloodline, or that they show leadership through their actions and merit.

Kupu hou

New word

- **Rangatiratanga** – *pronounced "rrrung-ah-tee-rrra-tung-ah"*
- **Ki runga i te whare uri haumate kia whakaatu rangatiratanga tā mātou nei kaiwhakahaere.**

Our charge nurse shows rangatiratanga on the ward.

Rarangi kupu

Word list

With the country in lockdown, our attention is firmly back on COVID-19 awareness:

- **Mate korona/KOWHEORI-19**
  Coronavirus/COVID-19
- **Noho taratahi**
  Self-isolation
- **Ngā pae mataara**
  Alert levels
- **Rere ā-hapori**
  Community transmission
- **Rere ā-whare**
  Household transmission
- **Tū tirara**
  Social distancing
- **Ārai kanohi**
  Face mask

Note: Go to www.mahurumaori.com to take part in the challenge to speak more te reo Māori in the month of September.

E mihi ana ki a Titihuia Pakeho rāua ko Joel Maxwell, rātou ko Belinda Tuari-Toma, me Te Taura Whiri i te Reo Māori (Māori Language Commission).

Kai Tiaki NURSING NEW ZEALAND

writing guidelines

Guidelines for writing articles for *Kai Tiaki Nursing New Zealand*

We welcome articles on subjects relevant to nurses and nursing, midwives and midwifery. These guidelines are designed to help you write an article which is accurate, clear, easily read and interesting.

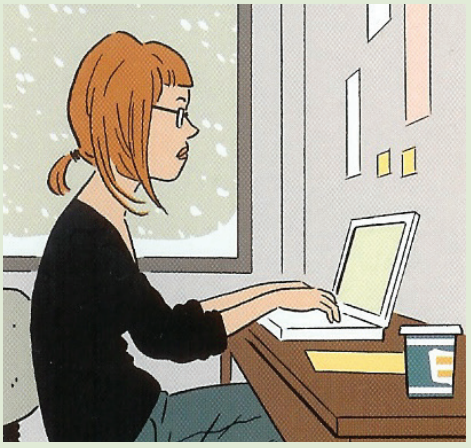
The main reason you want an article published in *Kai Tiaki Nursing New Zealand* is so other nurses/midwives will read it and hopefully learn something valuable. Therefore the subject must interest nurses/midwives and be written in a way that will appeal to them.

The essence of good writing is simple, effective communication – a good story well told. Even the most complicated nursing/midwifery care scenario, theory of nursing/midwifery practice or research study can presented in a straightforward, logical fashion.

This list should help you construct an article that will be read, understood and appreciated.

• **Always remember who your reader is.** Your readers are nurses/midwives, so what you write must be relevant to and understood by nurses/midwives. The focus of your article must be what the nurse/midwife does, how the nurse/midwife behaves, what affects the nurse/midwife. If you are writing about a new technique in your practice area, explain how it changes nursing/midwifery practice and its advantages and disadvantages to the nurse/midwife and patient/client. If you are discussing a theory of nursing/midwifery practice, link this to concrete examples of working nurses/midwives.

• **Avoid using big words, complicated sentences and technical jargon.** They don't make you smarter or your article better. Writing clearly and plainly is your goal. Widely used nursing/midwifery terms are acceptable, but avoid overly technical jargon. American writer, editor and teacher William Zinsser stresses the need for simplicity in writing: *"We are a society strangling in unnecessary words, circular constructions, pompous frills and meaningless jargon."*[1]



• **These questions will help you pull together all the relevant information needed for your article: Who? What? Why? When? Where? How?** Don't assume all other nurses/midwives know the ins and outs of your particular area of practice. If you are unsure about how to express a particular idea or technique, think how you would explain it to a student nurse/midwife.

• **Maximum length is 2500 words,** which, with illustrations, fills three pages of *Kai Tiaki Nursing New Zealand*. Longer articles need to be discussed with the co-editors.

• **References should be presented in the APA style.** Some examples:

Articles:

Sampson, M. (2013). Seeking consistency when managing patients' pain. *Kai Tiaki Nursing New Zealand; 19*(5), 26-28.

Bryant R. (2012). Nurses addressing access disparities in primary health care. *International Nursing Review; 59*(152). doi:10.1111/j.14667657.2012.01003.x

Books:

O'Connor, M. E. (2010). *Freed to Care, Proud to Nurse: 100 years of the New Zealand Nurses Organisation*. Wellington: Steele Roberts.

Websites:

Ministry of Health. (2010). *Cancer Control in New Zealand*. Retrieved from http://www.moh.govt.nz/cancercontrol

• **Submit your article via email** (to coeditors@nzno.org.nz). Type with double-spacing and wide margins and include your name, address, phone number/s, current position and nursing qualifications.

• **Photographs and illustrations are welcome.** They need to be high-resolution, at 300dpi, and at least 200kb or more. We prefer jpeg format; send them as attachments to an email rather than in the email itself. Cartoons and diagrams are also welcome, and we can also use black and white or colour prints.

• **Most clinical articles are reviewed** by ***Kai Tiaki Nursing New Zealand*** co-editors and two clinicians with expertise in the subject the article explores. Authors will be informed of the outcome of the review and the reasons why their article was accepted, rejected, or requires more work.

• **Contributors assign copyright to NZNO.** If an article is accepted for publication, copyright is automatically assigned to NZNO. Permission to republish material elsewhere is usually given to authors on request, but manuscripts must not be submitted simultaneously to other journals. •

Reference

1) Zinsser, W. (2001). *On Writing Well. The Classic Guide to Writing Nonfiction* (25th anniversary edition). New York: Harper Collins.

Classified advertising

Events

24 September 2021 Ōtautahi Christchurch
PATHA Transgender Health Symposium Training Day
Engaging in Gender Affirmative Practices: An Aotearoa Approach
https://www.patha.nz/2021-Training-Day

24-26 September 2021 Ōtautahi Christchurch
ATHA Transgender Health Symposium
https://www.patha.nz/2021-Christchurch

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

28-30 October 2021 Rotorua
New Zealand Society for Oncology Conference, in conjunction with the Cancer Nurses College
https://www.nzsoncology.org.nz/conference/home

29 October 2021 Lower Hutt, Wellington
Te Omanga Hospice Changing Minds Conference
https://www.teomanga.org.nz/education/changing-minds/

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

18-20 November 2021 Rotorua
NZ Sepsis Conference 2021: Challenges for New Zealand
www.sepsis.org.nz/conference/

24-27 March 2022 Auckland
13th International Symposium on Paediatric Pain
Diversity, Equity, Access
http://www.ispp2022.nz/

14 May 2022 Nelson
Registered Nurses Foot Care Forum 2021
Enquiries: feetretreat4u@gmail.com attention Lyn Harris

FREE EVENTS LISTING
Send us your details to be included in this free events listing.
We need the date, location, name of the event and a web address.

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Infection Prevention and Control Orientation Course

IPC Infection Prevention & Control Nurses College NZNO

This course introduces new and existing infection prevention and control practitioners to the key concepts of infection prevention and control (IPC) which underpin IPC practice in all healthcare settings.

The practitioner will complete 9-10 learning modules via self-directed distance learning, supported by an experienced infection prevention and control mentor. Learning will be enhanced via regular Zoom meetings with your mentor and other course participants.

This course is suitable for a healthcare worker who has a role or an interest in IPC and can commit to around 60 hours of study over 4 months. A certificate will be awarded to participants on completion of the course.

Participants can claim up to 60 hours professional development hours.

Modules

1. Hand hygiene
2. Standard and transmission-based precautions
3. Microbiology
4. Surveillance and monitoring of infection
5. Outbreak management
6. Communicable diseases
7. Occupational health
8. Cleaning, disinfection and sterilisation
9. Construction and renovation

Cost

The programme is currently supported by ACC and is free for NZNO IPCNC members. Non-IPCNC members will be required to pay a levy of $120.

Contact the course administrator - **Ruth Barratt** **rannalong@gmail.com** for an application form.

Directory

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L/3, 57 Willis St, PO Box 2128,
Wellington 6140.
Freephone 0800 28 38 48 fax (04) 382 9993,
website: www.nzno.org.nz
email: nurses@nzno.org.nz.

Mairi Lucas (acting chief executive), David Woltman (manager, corporate services), Suzanne Rolls, Anne Brinkman (professional nursing advisers), Lucia Bercinskas (senior policy analyst), Belinda Tuari-Toma (policy adviser - Māori), Heather Woods (librarian/records manager), Margaret Barnett-Davidson, Sarah Eglinton (lawyers), Rob Zorn (communications/media adviser).

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fax (09) 360 3898, Freephone 0800 28 38 48.

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PO Box 13474, Tauranga Central 3141. Freephone 0800 28 38 48

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Iain Lees-Galloway (lead organiser), Donna Ryan, Stephanie Thomas, Sue Wolland, Hannah Pratt, Gail Ridgway, Manny Down (organisers), Wendy Blair (professional nursing adviser), Angelique Walker (educator).
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fax (06) 355 5486, Freephone 0800 28 38 48.

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Jo Coffey, Laura Thomas, Drew Mayhem, Penny Clark (organisers).
Findex House, 57 Willis St., Wellington 6011, PO Box 2128, Wellington 6140.
fax (04) 472 4951, Freephone 0800 28 38 48.

NELSON

Denise McGurk, Shannyn Hunter (organisers), Jo Stokker (lead adviser, member support centre).
Ground Floor (south), Munro State Building, 190 Bridge St.
PO Box 1195, Nelson 7040. fax (03) 546 7214, Freephone 0800 28 38 48.

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fax (03) 377 0338, Freephone 0800 28 38 48.

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REGIONAL CHAIRPERSONS

TAI TOKERAU, NORTHLAND – SACHA YOUNG
email: sachayoung@yahoo.co.nz

GREATER AUCKLAND – ESTHER LINKLATER
email: estherlinklater@hotmail.co.nz mob: 027 282 7973

MIDLANDS – DIANE DIXON
email: diane.dixon@waikatodhb.health.nz mob: 027 463 4522

BOP/TAIRAWHITI – MICHELLE FAIRBURN email: michellefairburn0@gmail.com

HAWKE'S BAY – ELIZABETH BANKS & SANDRA CORBETT (CO-CHAIRS)

CENTRAL – ANDREW CUNNINGHAM
email: Andrew.cunningham@midcentraldhb.govt.nz

GREATER WELLINGTON – REREHAU BAKKER
email: rerehau.bakker@gmail.com mob: 021 106 0582

TOP OF THE SOUTH – JOAN KNIGHT
email: joan.knight@nmhs.govt.nz mob: 027 378 7793

WEST COAST – SARA MASON email: sara.mason@wcdhb.health.nz

CANTERBURY – CHERYL HANHAM email: cahanham@gmail.com

TE TAI TONGA/SOUTHERN – LINDA SMILLIE email: lindasmillie1@gmail.com

TE RŪNANGA REGIONAL CONTACTS

KAIWHAKAHAERE – KERRI NUKU mob: 027 265 6064
email: kerri.nuku@nzno.org.nz

TUMU WHAKARAE – TITIHUIA PAKEHO
email: tithuia.pakeho@bopdhb.govt.nz

MIDLANDS – TRACEY MORGAN
email: traymorg6@gmail.com

CENTRAL – TRACY HADDON email: trcentralregions@gmail.com

GREATER WELLINGTON – LIZZY KEPA-HENRY
email: lizzy.kepahenry@gmail.com

CANTERBURY – RUTH TE RANGI email: pocohontuz@gmail.com

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TE RŪNANGA TAUIRA – KIMMEL MANNING email: kimmel.manning@gmail.com

TE MATAU-A-MĀUI – TINA KONIA email: tinakonia@hotmail.com

TE TAI POUTINI – VACANT

TE TAI TONGA/SOUTHERN – CHARLEEN WADDELL
email: charleenpwaddell@gmail.com

TAI TOKERAU – MOANA TEIHO email: mojo.teiho48@gmail.com

BAY OF PLENTY, TAIRAWHITI – ANAMARIA WATENE
email: anamaria.watene@bopdhb.govt.nz

TOP OF THE SOUTH – VACANT

NATIONAL STUDENT UNIT CONTACTS

MIKAELA HELLIER (CHAIR)
email: mikaelahellier1717@outlook.co.nz

KIMMEL MANNING (TR TAUIRA – CHAIR)
email: kimmel.manning@gmail.com

MEMBERSHIP COMMITTEE

SANDRA CORBETT (CHAIR) email: sandra.corbett@hawkesbaydhb.govt.nz mob: 027 275 9135

ANDREA REILLY (VICE-CHAIR) email: andrea.reilly@westcoastdhb.health.nz

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