Kai Tiaki
NURSING NEW ZEALAND
October 2021
VOL 27 NO 9

On a needle's edge

With COVID-19 restrictions set to be loosened, elimination dropped and vaccination targets as-yet unfulfilled – especially for Māori – what does the future hold for nursing?

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Conference goes futuristic

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NZNO leaders speak

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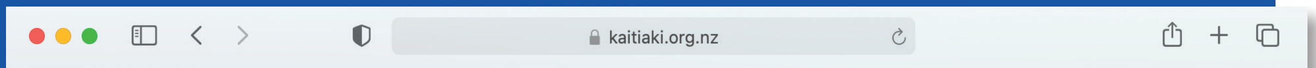

Kai Tiaki
NURSING NEW ZEALAND

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'Be inspired' – heed call of the maunga

It was a time for inspiration, whanaungatanga and important information.

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This month we tautoko members who put strike action on hold to return to the pandemic frontline, particularly our Pacific nurses whose communities have been hardest hit. We also feature the indigenous nurses' Aotearoa conference 2021, examine a new nursing degree with mental health at its core and share a nurse's warning over the perils of Twitter.

Nurses 'can do more' in mental health

They just need the confidence and experience to do so.

Lessons learned from Twitter

A recent mistake on social media suggests that I was not as savvy as I thought.

Imagine... the nightmares and dreams of an aged care nurse

A registered nurse explains what an increase in staffing would

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THIS MONTH we look at how the shift in pandemic strategy affects nurses, we have extensive coverage of speakers at NZNO's 2021 annual conference and AGM, and talk to the elected leaders on their priorities for the future. We look at what hospital visiting policies should be under pandemic conditions, and follow a quality improvement project in a fracture service.

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

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

Co-editors:
Mary Longmore and Joel Maxwell.

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

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

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Time for change to fully digital future

By co-editor Joel Maxwell

There is a Māori proverb, a whakataukī, that goes like this: *Ka mate kāinga tahi, ka ora kāinga rua*.

Like most whakataukī, it probably has as many subtle variations in meaning as there are iwi, hapū, that use it around Aotearoa/New Zealand.

But it is one of my favourite whakataukī because it has that compelling aspect of all the best proverbs — it is both simple and remarkably deep.

It suggests to me that we should always be prepared for change. If one house (kāinga tahi) is gone, another (kāinga rua) remains.

This is a time of change for nursing. It is also a time of change for this journal.

The health system as we have known it for the past two decades will be gone by this time next year.

District health boards will have vanished – in their place a single entity, Health NZ. There will be a Māori Health Authority with a budget to commission its own health services. Public health will also undergo substantial changes.

Alongside this, we have Health Minister Andrew Little tasking his ministry with devising a recruitment programme for nurses. Who knows, this could make a difference for our understaffed wards, clinics and practices.

And as many who attended the NZNO conference last month might already know, this journal is about to embark on its own changes.

It will take a giant leap into the future by switching to a completely digital presence. From the start of next year, we will publish entirely online.

Our kainga rua will be the digital realm.

From the start of next year we will publish entirely online.

I'm personally excited by the change. What it means is that instead of our monthly publication, we can publish stories whenever we need to – whenever it is most important for our members.

We will, as always, continue covering all our members' stories, faces, professional development opportunities, issues, academic research and industrial progress – all with a genuine commitment to Te Tiriti, biculturalism, equity and tikanga Māori.

So the best parts of the journal will remain, but with the added flexibility of a fully digital medium.

Over the next months we will be making sure members register for the website, so you can continue to read our stories – well, your stories, actually.

It is more important than ever that we work together, connect and maintain whangangatanga over the next year.

Not only will we venture into the brave new world of the health reforms, we face a moment of truth for the nation and its COVID-19 response.

The Government has signalled that from next year it will look to begin to open up the nation again.

If border restrictions were relaxed, modelling from research centre Te Pūnaha Matatini suggests that with 90 per cent or more of over-5s vaccinateed, plus moderate public health measures, the number of COVID-19 hospitalisations and deaths could be held to seasonal influenza rates.

However, the modelling suggests that with 80 per cent vaccination (over-5s) and moderate public health measures we could get 60,000 hospitalisations and 7000 annual fatalities.

Every nurse knows there would be no part of the system – primary, aged care, emergency, ICU, oncology, you name it – left undamaged by those numbers or their flow-on impact.

We have read the stories, seen the images as overseas health systems implode under the pressure of unvaccinated COVID-19 patients and the Delta variant.

I hope that the Government waits to achieve the critical higher rate of vaccination amongst vulnerable communities such as Māori. But the pressure to act will only build.

With these challenges, I'm glad we will be going forward together online – our kainga rua for the years ahead. It seems to me to be the best, most agile, most flexible medium for making sure we connect and respond collectively. •

Tell us what you think

Husband's ICU patient diary a 'taonga'

I WOULD like to comment on the article "How diaries help ICU patients recover", published in the August 2021 issue. In November 2020, my husband had an extended stay in an intensive care unit (ICU) due to post-surgery complications. On day two, ICU staff set up an ICU diary for him. The diary was a great tool – firstly for whānau and friends, and then for my husband as he recovered.

My husband was never left alone while in ICU – 24/7, someone from our large extended whānau sat with him. The whānau used some of that time to write down their feelings, concerns, aroha and manaaki in the diary.

The diary gave friends and whānau a place to express themselves, to articulate their hopes and fears and to send messages.

It even brought some light relief for whānau and friends, as some comments were hilarious: *"Dad, tick this box if I CAN'T go back to Queenstown."*

The diary was incredibly useful for my husband as he recovered. It gave him an insight into what he went through (photos taken by staff were included) and also what we, as a whānau whānui, went through. Being unconscious for seven days, he had no concept or comprehension of the enormity of what had happened and the diary explained it all.

It helped fill in the blanks for his delirious episodes, which for him were terrifying when they started to come back to him.

We have his diary carefully stored away and every now and then it comes out and we remember just how far he has come and how lucky we were.

For our whānau, the diary was a holistic taonga, and I would say to other people, that if they ever find themselves in this situation to use it – it really is beneficial.

My husband has made a full recovery, thanks to the wonderful staff of the ICU, critical care unit, endocrine and surgical teams from Waikato Hospital: Ka nui mihi ki a koutou katoa!

Angela Ria, RN
Tokoroa

Email your letter to:

coeditors@nzno.org.nz

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

Sustainability suggestions

SUSTAINABILITY HAS become nearly impossible in health-care settings during the COVID-19 outbreak as the majority of things we use have became disposable or single-use. For example, we must now use single-use surgical caps instead of reusable cloth caps in perioperative settings.

However, as health-care professionals, we are obliged to save both people and the environment of Aotearoa. Some of these measures are unavoidable as part of infection control. But some are not. For instance, we can minimise paper use.

I hope NZNO can also take some action on sustainability. Some NZNO members are husband and wife who live at the same address and both receive hard copies of *Kai Tiaki Nursing New Zealand*. This seems unnecessary. Either one of them can subscribe to the online version of Kai Tiaki website online. Also, some people may be interested in only reading it online. Those people can unsubscribe from the paper version.

Similarly, I ask NZNO to publish an article by an environmentalist on the importance of sustainability.

Tisson Zacharia, RN,
Hamilton

Co-editors' note: *To sign up to read* Kai Tiaki Nursing New Zealand*, go to https://kaitiaki.org.nz*
Also, see 'Health system needs climate change checkup', p30.

Dealing with dyslexia

I AM writing regarding the article "Dealing with dyslexia" in the December 2014/January 2015 issue of *Kai Tiaki Nursing New Zealand*.

I would like to pass on a huge thanks to author Carly Hawkins for the reassuring article. I stumbled across it while doing a literature search for dyslexia in nursing to cite in one of my university assignments.

I am doing postgraduate study in renal nursing through the University of Tasmania. I have dyslexia and have been ridiculed and shamed for "getting it wrong". I won't go anywhere near resus meds for fear of messing up the dose – give me airway or compressions any day.

I want to thank her for speaking out about this condition – we are intelligent and street-wise nurses in our own right and should be celebrated. Thanks from over the ditch.

Leia Clementine, RN,
Victoria, Australia

RN star 'needs new meaning'

I AM a new-graduate registered nurse (RN) working in operating theatres. The challenges faced daily by nurses have shocked me and opened my eyes. As a student, I was largely unaware of the political environment in which nursing is situated, moreover how this environment affects individual nurses – nurses whose heart and

soul is poured into every shift.

It is scary for me, navigating this terrain – the vulnerability of the workforce I am a part of is immense. This largely female workforce is overworked, silenced, undermined and taken advantage of day after day.

A light-bulb moment for me was when I found out about the roots of the nursing profession, defined through the meaning of the New Zealand RN star. This article (https://paperspast.natlib.govt.nz/periodicals/KT19231001.2.49) reveals that the NZ RN star, that I was so proud to receive upon registration, has a stifling, derogatory, silencing and suppressive origin.

I believe is time to examine, dismantle and reassemble this definition in a supportive, powerful statement. The new meaning should be one that represents the true value this workforce provides. It needs to spark passion and commitment, and foster speaking out, creative problem-solving, radical honesty and deep, compassionate listening.

I believe we ought to keep the star because I am proud to nurse, it is a privileged title and I carry it with great honour. However, rather than hiding the fact that the profession stems from subservience to the priesthood and a silencing message around "doing it for the greater good", we ought to collectively own that history and acknowledge where we continue to allow it to play out in our workplaces. We can then reimagine what a nurse in 2021 really is and own our stars.

These are what I think the meaning of the star's points could change to, to reflect our present reality:

1) The Head – our collective intellect and problem-solving abilities are fantastically undervalued.

2) The Heart – The passion nurses have for their work is what gives us such potency.

3) The Hand - Mine and my colleagues' hands know how to care, we work sleeves rolled up, fingers on the pulse.

4) The Eyes – so as not to look away from the systemic problems alive in our health-care system and workplaces today.

5) The Voice – Give us back our voices to speak when others cannot, to say no when we are too tired, to renegotiate our terms.

My hope is that this message is heard. It is from a young nurse, stepping bright-eyed and bushy-tailed into a profession I am proud to be part of, one who sees clearly the challenges faced practising as an RN in 2021 and believes that small, intelligent changes, collectively made, can have a dramatic impact.

Millie Haughey, RN
Christchurch

Racism research

I AM looking for nurses to participate in my PhD research on whether racism exists among nurses in Aotearoa New Zealand. Racism and bias cause harm and contribute to health inequity. Cultural safety and te Tiriti o Waitangi competencies set out protective criteria that aim to reduce unsafe nursing care.

This study, conducted through Te Kupenga Hauora Māori, at the University of Auckland's Faculty of Medical and Health Science, will measure bias and identify nurses's access to professional development. To qualify to participate, you need to be either an RN at least six years post-registration, or a nurse practitioner. You must also have lived solely in New Zealand for the past five years and have an unrestricted annual practising certificate.

Participating will involve completing an anonymous online survey, after which we will offer you a chance to win one of two $250 vouchers.

The study has been approved by the Auckland Health Research Ethics Committee. For any questions, contact my supervisor, Donna Cormack (d.cormack@auckland.ac.nz), or myself (srap004@aucklanduni.ac.nz).

Sonia Rapana-Hawkins, RN,
Auckland

Research on ARC caregivers

I AM working on my masters dissertation through the University of Otago, with my primary research on "the perception of caregivers working in [aged residential care] ARC during a pandemic in New Zealand".

Since the COVID-19 pandemic began, there has been an increased need for better understanding of staff self-care and wellbeing. Overseas research indicates that health-care professionals, mainly working in acute settings, are experiencing increased psychological distress and burn-out. Little research has been done on this topic in New Zealand and none in ARC facilities.

I believe my research would help improve understanding of the ARC sector, and help recruit and retain the workforce.

I invite caregivers working in any ARC facilities since March 2020 to complete an online survey at https://forms.gle/bWqgRkyi64DyfN8H8 and/or participate in a one-off interview. For more information, contact me directly at sirna173@student.otago.ac.nz. The research project has received ethics approval.

Napat Sirihongthong, RN,
Christchurch

Treasures in September issue

CONGRATULATIONS ON your September issue. During this long lockdown in Auckland, I found it a very interesting read.

The editorial written by Heather Casey emphasises what I consider to be the heart and soul of nursing – that is care and compassion. She is enthusiastic about the planned changes following the report of the Government Inquiry into Mental Health

and Addiction. Surely no one could argue against the statement *"there is no health without mental health, but then there is no mental health without physical health"*. I agree with the editorial's headline – "mental health nurse" is an outdated term.

Years ago, I met Tony O'Brien at Kingseat Hospital. I had my comprehensive nursing students on placement at Kingseat Hospital and I remember chats over cups of tea with him. Now I read that he is involved with a new nursing programme at the University of Waikato. Some of this news focus could have been me talking at the time of establishing the school of nursing at Unitec in 1985. Our curriculum focused on communication from day one, and was based on the philosophy of the mind and the body being one. I employed teachers who shared this belief.

Our graduates were prepared to respond to human need and provide mental health support to that person. I fully agree with the intentions as expressed in this article.

But observing nursing these days, effective mental health support is often hard to find. I am not about to blame the pressure of work nurses have, nor the sometimes toxic culture of some hospitals. Both of these situations are real worries.

I think the mind/body split is real in our society. The medical system is organised around parts of the body and has been for many years. There is a hierarchy of body systems involving status and financial resources. Anxiety, depression, addictions and disability are usually the poor relations and it is challenging for most health staff to support people with these conditions.

I would love to see more nurses initiate real conversations which focus on the person in their care, rather than referring them on to somebody else. What we say as a nurse is like sowing a seed – every opportunity matters.

In the account of the indigenous nurses hui, I found Moana Jackson's address on his maunga very powerful. This account of the five "story stones" could be useful for everyone. The first marker he called the rock "of knowing where to begin". I was delighted to be reminded of Irihapeti Ramsden and her development of cultural safety as a central aspect of nursing education. Irihapeti certainly knew where to begin. She was a courageous nurse and a joy to know.

Isabelle Sherrard, RN,
Auckland

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Financial statement outlined at AGM

NZNO MANAGEMENT will take a microscope to spending to cut a cashflow shortfall, the 2021 annual general meeting has heard.

Corporate services manager David Woltman said the annual financial report was delayed because of delays to the valuation of 57 Willis St Ltd from a busy valuation sector. There was also a wait for auditor Deloitte to deal with information needed as part of the audit, in this case a solicitor's confirmation.

Deloitte received the information they wanted then released the statement with no associated changes, he said.

Woltman said membership decreased in the financial year ending March 31, 2021 by 743, to 50,900 members. Of these, 412 were registered nurses, and overall, about a third left the profession altogether, Woltman said.

The budgets for the year were based on forecast membership growth, Woltman said. "We actually had a decrease."

Woltman said NZNO had an operating deficit after tax of about $1 million, coming in at about $59,000 worse than planned. The financial statement said NZNO had an income of $22.4 million, and expenditure of $23.4m.

He said total revenue was down by $1.5m. As well as lower-than-expected membership fees, there was a major drop in college and section conference income, and the likes of sponsorship and registrations.

Membership numbers were up for the latest financial year thanks to DHB bargaining.

However, he said spending was down by $1.4m including savings from reduced staff travel and accommodation. Regional and national conferences were moved online in 2020 – saving on travel, accommodation, venue and catering costs.

Overall, member funds increased from $12.6m to $13.1m. College and section funds grew by $109,000 to $1.8m. The hardship fund set up in 2018 at $100,000 sat at $98,747, with some going to support primary health care members.

Woltman said operating costs exceeded incoming cashflow by $520,000. This had grown from a $176,000 shortfall the previous financial year.

"This result must change and cannot continue in the future," he said.

The board was notified and management was reviewing income and spending to reverse the outflow.

Acting chief executive Mairi Lucas told the conference that membership had grown in the current financial year to more than 52,000. This came largely through district health board bargaining, she said. Lucas said management had made serious moves towards cost savings. This included limiting travel and associated costs, and increasing online meetings. About $500,000 could be saved this way. She said *Kai Tiaki Nursing New Zealand* would be published exclusively online in the near future, with expected savings of about $500,000 as well. •

See AGM coverage, p12.

New NZNO leadership team after board election results

NZNO HAS a new president and vice president after September's board election.

Anne Daniels was elected president and Nano Tunnicliff was elected vice president after voting closed on September 10.

They joined kaiwhakahaere Kerri Nuku and tumu whakarae Titihuia Pakeho who returned unopposed.

Nuku said the last year was a good one, with a united board, growing membership and an effective district health board member bargaining campaign. "We are particularly proud to have reached a 4000 Māori member milestone, and of the organisation's work towards becoming bicultural." Daniels thanked outgoing acting president, and vice president Tracey Morgan for her work.

Nuku and Daniels spoke to *Kai Tiaki Nursing New Zealand* about the challenges for the year ahead, on pages 10 and 11.

We hear from Pakeho and Tunnicliff in our November edition. •

DHBs obliged to staff safely in latest offer

THE LATEST offer from district health boards (DHB), in multi-employer collective agreement (MECA) negotiations with NZNO, allows DHBs to be penalised and health services cut back if they are not able to be safely staffed.

The new offer, which followed Employment Relations Authority mediation, also offered a base pay rise of $5800 for all pay scale steps, which included a pay equity advance of $4000 and general increase of $1800. It includes a $7300 lump sum payment, of which $6000 is a pay equity advance.

Pay equity negotiations were expected to be completed by November 30, 2021, and further raise pay rates, NZNO said in a summary of the offer.

NZNO urged members to consider it had been negotiating for 15 months, held 42 sets of talks, run a successful public campaign and strike action and secured an offer which went "beyond public sector guidelines" by providing increases for all members including those earning more than $100,000.

NZNO pressure had also prompted the Government to commit to settling pay equity by November 30 while making advance payments and achieving safe staffing aims.

Meetings to discuss the offer ran from September 27 to October 8, with ratification voting to follow.

NZNO said the staffing element was "significantly better" with a specific definition of an acute staffing shortage, which could be applied to areas without safe staffing tool care capacity demand management (CCDM).

If shortages can't be remedied, service range and volumes must be reduced under the offer.

The offer did "strengthen our existing rights", requiring delegates to be involved in investigating and correcting staff shortages. It also required DHBs to publicly display whether there was an acute staffing shortage at the start of every shift.

DHBs would be obliged to immediately try to fill vacancies identified by the CCDM calculations, by establishing and advertising the positions, without delay. If ratified, NZNO would run training sessions for members on using the new provisions.

Pay equity negotiations would further lift rates, and be dated back to December 31, 2019. Advances would be subject to a "reconciliation process". Offer details, including the full ERA recommendation, can be found at https://dhbmeca.nzno.org.nz/employer_offer_sept_21. •

Nelson twins Evan (left) and Henry Cooper, both 13, after receiving their second COVID-19 jab recently. Being born prematurely at 29 weeks left them with life-long health risks and their mother, public health nurse Nicky Cooper, got them vaccinated as soon as she could. "Their risk factors for maybe not getting through COVID are a lot higher." The former intensive care nurse said she saw people die unnecessarily during an influenza epidemic in the United Kingdom a few years ago. "I feel very strongly about it.. . it's a no-brainer." •

Kai Tiaki online only from 2022

KAI TIAKI Nursing New Zealand will be heading exclusively online by 2022, but will still be accessible to NZNO members through a simple online registration.

For members who haven't already registered but want to maintain their overview of the latest happenings in nursing, health and professional development, they can visit kaitiaki.org.nz/login.

From here they will be asked to register – which will require their membership number.

Members can find their 8-digit membership number on any official email from NZNO. •

The needle's edge: our COVID-19 future

ALICE GILLAN-SUTTON, first-year Massey nursing student, faces a workplace future that hasn't been contemplated in decades.

After she studies, completes her clinical placements and graduates, she will emerge into a pandemic world. When she becomes a registered nurse, she says, exposure to COVID-19 would seem to be "unavoidable".

Gillan-Sutton spoke to *Kai Tiaki Nursing New Zealand* as Aotearoa faces loosened COVID-19 restrictions, no more "elimination", and vaccination rates yet to hit critical mass. The health sector, it appears, is on a needle's edge, with borders set to start reopening in 2022.

Nursing student Alice Gillan-Sutton and her fellow students face an uncertain COVID-19 future. (She is holding a 5ml syringe and 22-gauge needle, not COVID-19 vaccination equipment.)

Gillan-Sutton said the latest district health board MECA offer of jobs for all new graduates was now something of a double-edged sword.

She simply did not know what the health system would be like as she trained and graduated – "COVID makes the future of nursing for students uncertain".

Nurses currently working in the system face that uncertainty right now.

NZNO College of Critical Care Nurses chair Tania Mitchell said she feared intensive care units (ICUs) would be "overwhelmed" if COVID-19 broke out. New Zealand was already short 90 to 100 full-time-equivalent ICU nurses, so did not even have capacity for business as usual, Mitchell said. That equated to 18 beds without enough ICU nurses.

"It's going to be tough, we are worried about being overwhelmed and looking at the vaccination rates and how we're starting to open up. There is real concern that ICUs are not going to manage," she said. "We don't even have capacity for business as usual."

Reports that there were hundreds of ICU beds available were simply not true, she said.

So if ICUs filled up with COVID patients, what would happen to people with heart problems, strokes, sepsis, bad injuries or transplants?

"All of these patients we normally see – it will impact on them, if the ICUs are full with patients with COVID. It will impact on the whole population." And the word from ICUs in the United Kingdom and Australia is that it was unvaccinated COVID patients filling up ICUs. "It is a challenge for health professional to know that these are mostly preventable [through vaccination]."

That could mean "tough decisions" for doctors about who gets treated.

For nurses, it would mean care rationing. Normally, one-to-one nurse-patient ratio 24/7 was a basic requirement in ICUs – and in some cases two nurses per patient. But with COVID pressures, that may not be possible, "and that will have an impact on patient outcomes".

Each DHB would plan how to ration care differently, but it might mean other nurses stepping in to help. However, nurses needed four to five years of experience "to be able to look after a complex, critically ill patient". The problem was underscored by a national shortage of nurses. "We don't have enough nurses and we can't get enough nurses – there is a national shortage."

It had taken just four COVID cases in Auckland DHBs' ICUs before they needed to call for help from ICU nurses outside the region, Mitchell said. "This highlights how big the issue could be."

With vaccination key, NZNO kaiwhakahaere Kerri Nuku asked Covid Response Minister Chris Hipkins in February how equity would be incorporated in the rollout.

He instead backed a "sequencing" approach, where Māori were not first or even second off the blocks, she said. "They started off with the older age group in the population, which we know there were very few Māori in that space." Sequencing had disadvantaged Māori, with a significantly younger population, she said.

Māori and Pasifika people faced a

racist backlash from a wider population now impatient for progress, she said. This was despite Māori being discouraged from vaccination by the rollout system itself.

"Now we've got a situation where they want to free up the border, they want to open it up – so they're saying 'quickly you Māori, get vaccinated'."

As at publication, 58 per cent of Māori had recieved the first dose of the Pfizer vaccine. For Europeans it was 81 per cent, and for the overall population, 79 per cent.

"What do we do? That's what we need to be asking," Nuku said. "Where does the money need to be redirected? More into Māori and iwi providers. Shift the money from PHOs and DHBs. It never should have gone there in the first place. Make the services relevant to the community."

Nuku feared Māori, already burdened with comorbidities through inequity, would be de-prioritised for COVID-19 treatment in hospitals.

NZNO board member and nurse practitioner in Te Tai Tokerau Margaret Hand, said Māori had long lived below the bottom line of society.

"And here we are asking them to be part of a community-driven campaign?" She said she had reflected on past epidemics and how many Māori died, as they could not get a vaccine. "Our urupa [graves] are marked with those fallen from the influenza epidemic."

Hand wondered whether Māori were an "after-thought" in pandemic planning this year – and we should have learned from 2020.

Māori were warriors and leaders, she said, and they were leading their people through this pandemic.

"I have admiration and pride in the way iwi have moved a nation to provide services to vaccinate the most vulnerable in New Zealand: Māori and non-Māori."

College of Primary Health Care Nurses chair Jill Clendon said a strategy to manage COVID-19 patients in the community was needed.

From left, Niuean health professionals Vaine Utalo, Sieni Lagaluga- Seve, Maliaga Erick, Jocelyn Tauevihi at a recent vaccination drive for Auckland's Niuean community, held in Māngere. Boosted by TikTok challenge *Heke Mai Kae O* by Niuean band Island Pride, an estimated 900 people were vaccinated over the three day drive "by Niueans for Niueans" said spokesperson Lynn Lolokini Pavihi.

At the primary health providers she worked with in Nelson she anticipated the team would play an important role in managing patients clinically, with tele-and-video monitoring, phone calls and home visits where required.

"We may establish a nursing response team/taskforce to support general practice and public health to respond to people who need care at home." Access to PPE, good education and psycho-social support "must go hand in hand with this".

NZNO acting manager nursing and professional services Kate Weston said nurses would come under strain across the health sector.

"We can't live restricted forever – but we are really concerned that if we move too quickly, it's going to put duress on the health system. The difficulty we have right now is we have a fixed and finite workforce group, being taken to MIQs and needing to test and vaccinate vast numbers of people."

Services ranging from primary to perioperative to intensive care would all be affected by a shift to living with Delta, with surgical backlogs and other knock-on effects. Nurses being taken from somewhere else, would leave corresponding pressure. NZNO wanted to see a "whole-of-systems" approach with resources like PPE prioritised for those in need, while easing restrictions in a way which would do "least possible harm" to the health system.

NZNO also wanted nurses to be recognised, prioritised and well-equipped under any new strategy. "Nurses are really central, they are the glue who hold the health system together," Weston said. "The consequences of the easing of restrictions, even if it's over time, is until we get everyone vaccinated and children under 12, it is our tamariki and pēpē who will be affected." •

Daniels: It's time for collective action

Safe staffing, better working conditions and pay equity across nursing sectors will be the focus of NZNO's new president.

By co-editor Joel Maxwell

New NZNO president Anne Daniels says it is time for collective action and solidarity as the organisation fights for safe staffing levels, equity across nursing sectors and better working conditions.

A registered nurse at Dunedin Hospital's emergency department, Daniels has more than 40 years' nursing experience and has been an NZNO delegate for 30 years.

She said she was urged by three former presidents and several former board members to stand in the election. After reflecting, she decided that towards the end of her nursing career, she wanted to contribute as a leader and "true blue unionist" to NZNO.

Daniels said she planned to focus on safe staffing, better working conditions and pay equity across nursing sectors.

"I find it totally unacceptable that members working in some parts of the community get paid less than others – it's not justified. I'm saying that all nurses need to be paid fairly and have the same working conditions."

She feared existing pay differences were leading to division among nursing sectors. "That has to stop."

Nurses had rarely experienced a time when their voices were heard and acted on, she said. "However, the first time that I saw this happen ... was during the "we are worth it campaign" where nurses and the community fought together for pay and conditions that reflected nurses' worth....and we won."

Anne Daniels

'I find it totally unacceptable that members working in some parts of the community get paid less than others – it's not justified.'

Daniels said this collective action and solidarity was being demonstrated through current DHB member negotiations. But, she said, it came from anger, frustration and for some, the despair of not being able to do the job in a way that meets professional, ethical and legislative standards of practice.

Unsafe staffing and "huge" workloads for nurses resulted in rising burnout, increased sick leave, and challenges to recruitment and retention of staff.

"For me, there is a grave injustice in accepting inequities in pay and work conditions, and education funding, for any nurse in New Zealand." Similarly, it was wrong to accept unsafe staffing in any sector, Daniels said.

"Individually and collectively, we must all be the change that we want to see in our world."

She said Health Minister Andrew Little acknowledged those "inequities and injustices" in his speech at the 2021 NZNO Conference. "This also gives me hope."

With the NZNO constitution about to be reviewed, it was a "pivotal" time. She hoped the review would make it easier for members to engage in NZNO work and campaigns such as safe staffing.

"Those at the coalface know the problems and know the potential solutions."

Member-driven

Daniels wanted to ensure the constitutional review was truly member-driven, with nationwide workshops and social media campaigns.

"We need to ask them what our union, our organisation should look like and how it should work."

Successive governments had lost the trust of nurses, she said. "We can rely only on ourselves as an organisation . . . we need everyone, staff and members, to be in the same waka, going in the same direction, to get to where we need to go." •

Nuku: Nursing voice needed in reforms

Te Rūnanga has worked hard to understand the long game of political decision-making, says the re-elected kaiwhakahaere.

By co-editor Joel Maxwell

NZNO kaiwhakahaere Kerri Nuku says nurses must make their voice heard in upcoming health reforms and take a strategic approach to their work – in Aotearoa, and the world.

Re-elected unopposed in September, Nuku said there were huge opportunities in the year ahead but just how much could practically be done was the "million-dollar question". It would be important the organisation did not spread itself too thin.

Upcoming health reforms would be at the top of list of these issues for many people, she said.

The reforms, announced by the Government this year, would be in place by mid-2022. They would be the biggest shake-up of the health system in two decades and see the consolidation of all 20 district health boards into a single entity, Health NZ.

A Māori Health Authority with its own power to commission services would be created.

Nuku said where nursing would sit within the system would be key. And the question of whether nursing had autonomy and a voice in this new world could be the problem, she said.

Reform transition unit head Stephen McKernan told the NZNO 2021 conference that reforms were influenced by the Waitangi Tribunal inquiry into health outcomes for Māori (Wai 2575).

But Nuku said if that were the case then witnesses who gave evidence to Wai 2575 should have been invited to help with the changes.

Kerri Nuku

"Some . . . service providers have been invited to the table, but not any of the nurses who are – as we keep hearing – the backbone to the health-care system."

This meant nurses had to trust that those providers could represent nurses' concerns. "Our members don't believe that they've heard our wishes authentically from ourselves, but from others."

Nuku said Te Rūnanga worked hard to understand the strategic long game of political decision-making: because political and funding imperatives drove decisions.

The wider community recognised the value of nurses and perhaps assumed they were involved in this decision-making. "The reality is we're not."

Nuku said work was continuing with Waitangi Tribunal kaupapa inquiries. She was part of the group looking at tribunal recommendations into keeping Māori children and future generations safe.

Māori rangatira Moana Jackson would often say he wanted to be the best ancestor he could possibly be, Nuku said.

Nobody wanted to leave behind a legacy that didn't include trying to challenge the system that was uplifting Māori children, she said. The drive to create a better social service for children would continue this year.

Whānau and nurses would give evidence in the likes of the Mana Wahine tribunal inquiry (into Treaty breaches against Māori women), and the second phase of the tribunal's health inquiry.

Nuku said Te Rūnanga was building international strategic alliances, to gain a global voice for the organisation.

The wider community recognised the value of nurses and perhaps assumed they were involved in this decision-making. 'The reality is we're not.'

She said the Indigenous Nurses Aotearoa Conference had always invited other indigenous groups to the hui. "That collective solidarity, nationally and internationally, is important to us. So now we're going to advance that forward: blow apart some of those international structures." •

Zooming in on 2021

NZNO's annual conference and AGM

A future vision of a thriving health system, updates on safe staffing and handling difficult assisted dying conversations, were among topics covered when speakers zoomed in for the 2021 NZNO conference *Our future – the health of Aotearoa* last month. Just over 200 people registered for the online event.
By co-editors **Mary Longmore** and **Joel Maxwell.**

NZNO's new president Anne Daniels and vice-president Nano Tunnicliff were welcomed into their roles at an online annual general meeting (AGM) last month, at which Kerri Nuku said she would stay on as kaiwhakahaere despite escalating racist abuse and threats.

Nuku – who has been kaiwhakahaere since 2009 – said her decision to stand again wasn't taken lightly, after experiencing personal attacks. These attacks had been against "the very foundation which I stand on which is proud to be Māori and proud to have my last name, Nuku, and not have it run through the gutter and used and abused by people who don't even know me".

But she decided to continue as a role model to others enduring similar oppression.

"We have to be fearless. We have to be accountable for our communities and our communities deserve fearless, equity, presence and a voice, so unfortunately you're left with me and we're not going anywhere. Te poari are not going anywhere, they're getting stronger," she told members and staff.

Daniels – who resigned from the board last year – acknowledged there was past "history" between her and Nuku, but felt confident the pair could work together to lead NZNO and build its member-led approach. "We must all pull together in the same waka."

Nuku acknowledged Daniels' comments. "The words 'member-led' and 'focused' are critical to any union fighting against the grain for members and union rights."

She would also work with Daniels to "inject te Tiriti into everything that we do".

"The thing that sets us apart is our ability to keep together and not be torn apart by negative stuff through all sorts of ups and downs," Nuku said. Staying together as the largest group of health-care workers – kaimahi haoura, tauira, midwives and nurses – was the most important thing that would steer NZNO in the right direction, she said.

Focus on pay equity

NZNO must now focus on pay equity, Nuku said. "We have been on this fight since 1920. We've been on this fight for far too long to get recognised as a predominantly female professional group, to be recognised and to be paid as professionals . . ."

Similarly, pay equity for workers in Māori and iwi providers must be a priority, Nuku said.

"We are an organisation that fiercely challenges social injustice, that fiercely fights for equity. But we can't do that if only half of us are fighting that fight and the rest don't believe in it."

Outgoing acting president Tracey Morgan said despite pressures, the board had been "strong in solidarity and they've stood the test of criticism and are still here".

Acting NZNO chief executive Mairi Lucas said management, in consultation with the board, had made "serious" cost savings across NZNO to avoid using any more reserve funds.

Cuts included limiting travel and face-to-face meetings, and ceasing the printed edition of *Kai Tiaki Nursing New Zealand,* which will move exclusively online. These measures were expected to together save around $1 million per annum. NZNO would also be looking at diversifying revenue by developing education and training programmes. (See news, p6)

Membership committee chair Sandra Corbett said NZNO continued to "weather the storm" after a year of uncertainty. She applauded the nurses and health professionals who "spoke up bravely when their patients, colleagues and community's health and safety was being compromised".

With its alliances locally and internationally, NZNO could be a "global force", Corbett said. She urged members to "focus on the positive attributes of the organisation while being honest about what is not working or needs to work better.

'We've been on this fight for far too long to get recognised as a predominantly female professional group . . . and to be paid as professionals.'

"We can choose to leave baggage behind, and have a future focus that is positive, just and equitable."

Plans to change NZNO structures and communications, suggested by members in a survey, were now on hold, at the request of the board, while the constitutional review report was being considered, Corbett said. •

** To watch the conference online, go to https://tinyurl.com/34v9s3rc*

Young nurse of the year: Daniel Mataafa

It was a high school injury on the rugby field in 2009 which spun Daniel Mataafa unexpectedly on to the nursing track.

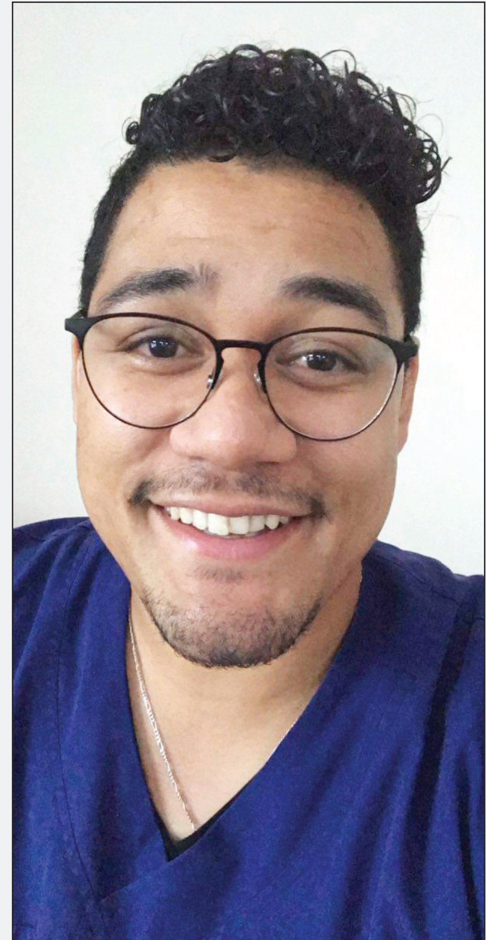
"My first goal was to become a professional rugby player, but a long-term injury when we were touring Samoa sidelined those plans," says Mataafa, 29, who has been named NZNO's young nurse of the year. He was playing in the 1st XV for James Cook High School – an Auckland college – on tour in Samoa when he sustained a peroneal nerve injury in his foot which has left him unable to play rugby since.

"Now I think it happened for a reason – if it wasn't for that injury, I wouldn't be here."

Back then, however, the 17-year-old went through some dark times over the following months. "I had hopes that I would recover and get back into playing rugby, but it turned out to be a life-long injury," he said.

"As a person primarily focused on sport, it was a big hit to my self-esteem and took me down to some dark places. But I recovered and got back on my feet and made the best of it," says Mataafa, who still manages to run and throw a ball around from time to time.

Family support helped him deal with the blow. Family is everything to Mataafa, who emigrated with his father and seven siblings to Aotearoa New Zealand from Samoa in 2002, when he was nine years old after his mother had



Daniel Mataafa emigrated here from Samoa with his father and seven siblings in 2002.

'Now I think it happened for a reason – if it wasn't for that injury, I wouldn't be here.'

died in a car accident. "It was a fresh start – with more opportunities and better education," Mataafa says.

"Dad was such a solid foundation – he was mum, dad and best friend. He's a key person for me and my siblings." And when he was grieving the loss of his dream, his father helped him get through. "He encouraged me to think about what I have at the time, and not think about the past but the future."

Mataafa began thinking about other ways he could support his family and do some good in the community. "For Pasifika and Māori, family is the centre of everything."

Thankful he had gained enough credits at secondary school, Mataafa decided to give nursing a try, completing a foundation course at the Manukau Institute of Technology (MIT) before enrolling on its bachelor of nursing. "For us Pasifika or Māori, nursing is not a new concept. We are nurses from a young age, looking after our mum, dad, aunties and uncles . . . it's just that here you need to be officially registered."

'For us Pasifika or Māori, nursing is not a new concept. We are nurses from a young age, looking after our mum, dad, aunties and uncles . . .'

He was the only male Polynesian student, which was "completely challenging", but he enjoyed great support from MIT lecturers and librarians, alongside his family. "It was quite intimidating at first, but you get used to it and just get on with it."

He registered in 2015, taking up a general medical role at Middlemore Hospital, before taking a couple of years off to travel overseas and live in the United Kingdom. Back at Middlemore in 2019, he worked in the dialysis unit before moving into the hospital's regional Pacific team, as a case manager. The team works with the New Zealand Medical Treatment Scheme, managing patients from the Pacific region requiring specialised medical treatment.

Mataafa's manager, Michelle Nicholson-Burr, who nominated him, said Mataafa provided outstanding holistic care, and worked "tirelessly" to ensure every patient, staff and carer interaction met te Tiriti principles.

She said she had never seen such a high standard of professionalism in such a young nurse, despite the stigma he faced at times as a Samoan male nurse.

Mataafa said for him, providing holistic care was just part of being a nurse. "We not only focus on the condition, but their social situation, economic, religious . . . everything about the person, we consider".

His workplace provided a very supportive environment for this approach, he said.

Mataafa used his experiences to support other young Pasifika men, Nicholson-Burr said. Mataafa said he enjoyed speaking to high school students about becoming a nurse and wanted to do what he could to support the Pasifika nursing workforce.

Mataafa said he had been "speechless" at being chosen from 20 nominees. His dad was low-key in his praise, saying 'that's good, son', Mataafa said. "I'm sure deep inside he's very happy."

The judging panel comprised Counties Manukau District Health Board (DHB) chief executive Margie Apa representing all DHBs, NZNO's kaiwhakahaere, chief executive and professional nursing staff, NZNO Nursing Education Research Foundation member Melinda Jordan and 2020 winner Kelly Talbot. •

Award of ho

NZNO's award of honour recipient Leonie Metcalfe has spent her life sticking up for the underdog.

"You forget about it sometimes, it's just what you do, but when you get something like this you realise it has been meaningful," Metcalfe told *Kai Tiaki*. "It's a team thing – I've had a huge amount of wonderful people around me who do great things."

Recently retired after being diagnosed with the asbestos-linked cancer, mesothelioma, last year, Metcalfe's award was announced at the annual general meeting (AGM) last month.

Metcalfe trained as a community nurse at Wairoa Hospital in 1969 and – from a unionist family – was part of the then-Nurses' Association from the start. "My father was a union person," she said of her fitter-turner dad. "So I naturally got involved. I always went for the underdog and being true to yourself and what you believe in. It pisses people off sometimes!"

'My father was a union person,' she said of her fitter-turner dad. 'So I naturally got involved.'

Such as in the early 1980s when she pointed out to Wairoa Hospital management that she and colleagues were entitled to a half-an-hour break after five hours, leading to "quite a bit of money" being paid out for missed breaks. "That didn't go down very well with the board!"

She moved to Hamilton in the 1980s, where she now lives, and

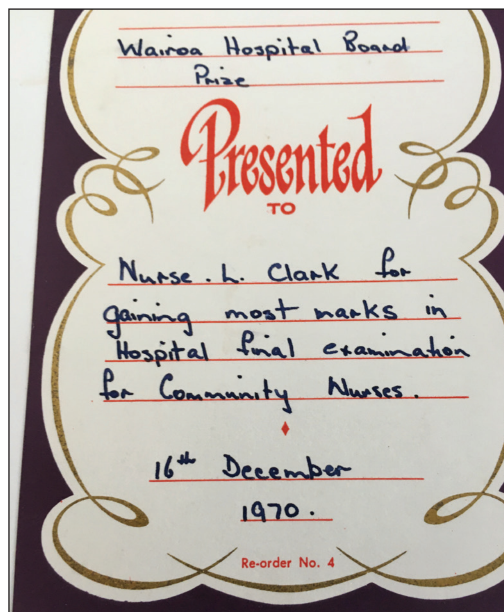
nour 'pretty special': Leonie Metcalfe

2021 award of honour winner Leonie Metcalfe: 'passion and dedication and a great advocate for enrolled nursing'.

worked as an enrolled nurse (EN) at Waikato Hospital for the next 35 years. At NZNO, she chaired the Enrolled Nursing Section (ENS) and also became vice-chair of NZNO's Midlands regional council, as well as being a delegate for 16 years.

Metcalfe says her philosophy is simple – speak up: "If you don't ask for anything, you don't get anything – you're either at the table or you're on the menu."

These days, despite the debilitating effects of her terminal cancer and chemotherapy (see *Kai Tiaki's* August edition, p24-25), Metcalfe has successfully lobbied the Accident Compensation Corporation (ACC) to accept claims of accidental workplace exposure to asbestos and is now working to create a national mesothelioma support group. "There is nothing around for people with mesothelioma, so I'm just going to try and set it up."


Wairoa Hospital Board Prize

Presented TO

Nurse. L. Clark for gaining most marks in Hospital final examination for Community Nurses.

16th December 1970.

Re-order No. 4

Graduating nurse Leonie Clark's award from the Wairoa Hospital Board in 1970.

She says while it's a lot of work, it's also very rewarding to take action and connect with other sufferers here and overseas.

The award – given every two years – includes lifelong honorary NZNO membership. Metcalfe said it was "pretty special . . . I didn't think much got past me, but that did!"

Seven grandchildren

She recently celebrated her 50th wedding anniversary and has seven grandchildren, some of whom participated in a congratulations video when the award was announced.

ENS chair Robyn Hewlett said Metcalfe showed "passion and dedication" and had been a "great advocate for enrolled nursing at every opportunity and in a variety of forums, locally and nationally".

At the Midlands regional council, she said Metcalfe always took the time to support members and encourage others to get involved. •

Hutchison honoured for setting up nurse-led palliat

Retiring nurse manager Cheryl Hutchison received NZNO's services to nursing award at the AGM, an acknowledgement of her work to set up nurse-led palliative and oncology services on the West Coast.

This allowed people to be cared for in their homes in their final stages of life. "Because I worked in the community, I could see that there was a huge need there . . . and it was growing fast," she said. "People were grateful to be able to stay at home."

Before that, people had to go into hospitals, often in Christchurch more than two hours' drive away.

District and community nurses would often put in their own time voluntarily to support dying patients, getting up several times a night to help before putting in a full shift the next day. "It was because we were so passionate about people, meeting their needs and desires. But we couldn't go on like that," recalls Hutchison, who then lobbied for specialist nursing roles based on the West Coast.

It was tough battle getting funding, but she succeeded – there are now 2.6 full-time equivalent nurses with expertise in oncology and palliative care based on the Coast. They work in tandem with district nurses and in partnership with patients, families and the wider health team, West Coast nurse practitioner Sara Mason said.

'This came out of her deep sense of responsibility to the community, to ensure that these roles existed in the rural environment where support is limited.'

Mason, a former colleague, said as district nursing manager in the 1990s

Panel discusses challenges of living

Microbiologist and science communicator Siouxie Wiles spoke on NZNO's panel on living through a pandemic about the "huge" amount of harassment she had been subjected to since becoming a public educator on COVID-19 last April.

"I'm a woman, I've got pink hair ... I'm fat," she said. "I've had a huge of harassment starting in April last year. I've had death threats, I get these regularly, I've got several cases open with the police about people, people questioning my expertise, so I've had this all the time."

Speaking shortly after National leader Judith Collins had called her a "big fat hypocrite" for cycling 5km to a beach during Auckland's level 3 lockdown, Wiles said she got particularly upset when "people in positions of power are trying to attack my credibility.

"That's really counter-productive when what I'm trying to do is get people to understand why we need to behave collectively and why we all need to vaccinate if we can in order to move away from using lockdown level 4."

'The research is really clear that those communities that come together in disasters . . . are the ones that come through it the best.'

Wiles said whats he tried to focus on was helping New Zealand understand what it was facing, and "as we move into the future, how we get out of this".

She decided early to always "give off an air of calmness" no matter how panicked she felt, and advise people to look after each other. "The research is really clear that those communities that come together in disasters . . . are the ones that come through it the best."

Vaccination, she said, was one of the most important tools available.

She said in the United Kingdom, where her parents live, people have lived under lockdown for 18 months

ive and oncology services on Coast

Hutchison used her knowledge, nursing experience and advocacy skills to develop nursing roles in both oncology and palliative care on the West Coast. "This came out of her deep sense of responsibility to the community, to ensure that these roles existed in the rural environment where support is limited."

Mason also acknowledged Hutchison's leadership. "She always finds ways to hold the district nurses and community nurses together, even in hard times."

After 56 years of nursing, at 73 Hutchison is retiring – kind of. She's still on the casual pool and hopes to pick up some work in Christchurch, where she is relocating to.

While it's been tough at times nursing on the Coast, she says "I wouldn't change a thing".

"I just absolutely love it, it's been fabulous. I've met so many lovely nurses who work so hard and deserve more recognition."

The award, she says was an acknowledgement of all her colleagues over the years.

Hutchison would be missed but had inspired West Coast nurses to be a "voice of change", Mason said. •

and learning through a pandemic

– something New Zealanders might find hard to conceive.

"Yes, it's frustrating and this is really hard. But the alternative is saying goodbye to people we love that we don't have to say goodbye to, and putting people at risk of serious health impacts that we don't have to."

Knocking New Zealand

Many critics wanted to knock New Zealand down for its approach. "You have to remember, we have been immensely successful. And if we continue to be successful, it will show that other countries could have made different decisions, and that is really hard and there are lots of people who want to see us fail."

Wiles said not everyone was in the same waka – "some people have luxury yachts . . .

"But we're all in the same seas and what we need to make sure is that everybody is on a boat that's safe, and that we get to the right place."

Panel member, microbiologist Siouxsie Wiles.

Also on the panel, Te Rūnanga Te Tai Tokerau student representative Chantelle Thompson spoke about the challenges of studying through a pandemic, captured in NZNO research earlier this year.

"If we were at home with family, with children, trying to concentrate, trying to find motivation, trying to find a space of quiet and peace to concentrate – to do that was very difficult."

Education challenges

Co-chair of Nursing Education in the Tertiary Sector (NETS) Clare Buckley described the challenges for educators of trying to keep nursing programmes going during a lockdown while caring for their own families.

"The educators were responsible for educating the student nurses but also educating their own children."

Schools sent "thousands" of laptops and internet bundles for students, and tried to reduce stress as much as possible by recording lectures for students to watch at a time that suited them. But the ingenuity of students "fills me with such joy because I know what brilliant nurses they're going to be". •

Hilary Graham-Smith

Jill Clendon

Rhonda McKelvie

Kapua Quinn

Nursing panel to investigate missed CCDM deadline

Two former NZNO staff members have been appointed to a four-nurse panel to investigate why the safe staffing accord missed its deadline.

Former NZNO associate professional services manager Hilary Graham-Smith will chair the panel, which was announced by Health Minister Andrew Little at the 2021 NZNO conference.

The other panel members are Nelson District Health Board associate director of nursing Jill Clendon (a former NZNO researcher and professional nursing advisor), Massey University senior nursing lecturer Rhonda McKelvie and Capital & Coast DHB clinical nurse manager Kapua Quinn.

The 2018 safe staffing accord included funding for an extra 3000 nurses and a June 2021 deadline to install care capacity demand management (CCDM) systems in all district health boards, Little said.

It was fully implemented in only half of the 20 DHBs by June.

"All four members [of the panel] have a deep understanding of the issues, and I'm confident in their abilities to uncover the problems and come up with solutions."

The panel would report its recommendations by December, Little said. "And then I hope that together we can work on fixing the situation and fulfil the original ambition for CCDM."

'Carrying more than your share'

Speaking at the NZNO conference, Little said nurses were on the front line of the battle against COVID-19.

"As you are in every health crisis, . . . you are carrying more than your share of the load." This included hospital, primary and aged residential care staff – but also those in vaccination stations, and caring directly for COVID-19 patients.

The health system had been under pressure for a long time, he said. "You're entitled to work in conditions that keep you and your patients safe."

Little said dealing with the nursing shortage was a high priority. He had asked the Ministry of Health to develop a nursing recruitment campaign to fill nationwide vacancies.

"This work is underway and will focus on getting more people to train as nurses and encourage those working overseas to come home."

He said Cabinet had allocated funding for the upcoming pay equity claim, directly covering about 40,000 nurses. Negotiations were underway and the Government was committed to paying nurses fairly through pay equity, he said.

"There is no place in 21st century Aotearoa/New Zealand for 1950s attitudes to work predominately carried out by women." •

Health Minister Andrew Little

. . . the Government was committed to paying nurses fairly through pay equity.

Nurses 'will be involved in shaping changes'

Nurses will "absolutely" have input on how health reforms roll out next year, according to the man in charge of the transition.

Speaking at the NZNO 2021 conference, former director-general of health Stephen McKernan outlined his role as head of the transition unit for the Government's health shake-up.

He said the new system must fix the problems facing the likes of emergency departments and mental health services.

Nurses, he said, would "absolutely" be involved in shaping the changes.

"We have nursing expertise in the transition unit now, and we're engaging with nursing groups through our work."

He said he had been encouraging nurses to be involved in the New Zealand Health Plan, the document setting out models of care for the entire new system.

In April, the Government announced it would consolidate all 20 district health boards into a single entity, Health NZ (HNZ). It would also create a Māori Health Authority (MHA), with its own budget to commission health services.

He said the bill underpinning the reforms would likely go to Parliament in mid-October. Between now and July 1 next year, HNZ and the MHA would work with DHBs and the ministry to shift functions to the new entities.

These would include workforce planning, and data and digital functions.

McKernan said moving to a national service meant inevitably people would talk about "a centralised bureaucracy".

"I'm at pains to stress that this is not a centralised bureaucracy. But . . . what we did is we took time working through where the placement of functions needs to occur on the system."

Stephen McKernan

Hospitals would operate as a national network, where service planning could halt some of the 'perverse behaviours' of inter-district flows of patients.

He said in a country of only five million people, "there are some things you should only do once". This included long-term workforce planning, and information technology.

Hospitals would operate as a national network, where service planning could halt some of the "perverse behaviours" of inter-district flows of patients.

McKernan said there was a six-fold variation in waiting times between DHBs around the country for some specialty health services.

It took a long time to roll out government programmes across multiple DHBs, such as bowel screening, immunisation and mental health support. "Much has been made of the postcode lottery impact," he said.

Nurses did not necessarily see the variations in day-to-day practice, but this could be seen at a system-wide level.

"It's also a system that's struggled for long-term sustainability, and our funding settings haven't necessarily supported . . . aspirations." •

The Māori Health Authority will have its own budget to commission health services.

End-of-life care: 'You can't go into this blind'

A geriatric care nurse practitioner says nurses must decide where they stand on end-of-life care.

Nurses must decide where they stand on the End of Life Choice Act (EOLCA) by the time it comes into effect on November 7, Auckland nurse practitioner (NP) Michal Boyd says. "This is seven weeks away – you really need to wrestle with this question if you are on the edge," Boyd told the NZNO conference.

"You can't go into this blind. It is going to get tricky. It has gotten tricky in other countries because end-of-life care is not black and white, it is full of grey areas," said Boyd, an associate professor at the University of Auckland's school of nursing and geriatric medicine.

Nurses did not have to be involved – but must ensure patients could access end-of-life care. "You cannot abandon the patient – regardless of your personal belief, you should not inhibit a person's access to lawful treatment," Boyd told nurses.

"If you don't feel comfortable doing it, you need to find the team that will be comfortable assisting this person with death."

Nurses who object must inform patients – not ignore questions – and direct them to another practitioner, who must ensure the patient understood all options, including palliative care.

Boyd implored nurses in leadership

positions to "make a policy now" on the EOLCA. The incoming law was "silent" on matters such as refusal to provide assisted dying by organisations such as Hospice New Zealand. "It is unclear if publicly funded organisations such as DHBs can decide not to provide the End of Life Choice Act services," she said.

"This has far-reaching implications . . . for example, if an aged-care facility says, 'No, we don't do this', I am obligated, as a nurse practitioner, to make sure that person does have that service if they so desire.

"And then, likely, if it's not going to happen on those premises, I have to find another place for them. And for a frail, older person that's really difficult."

Boyd said predicting whether death would occur within six months would be tough - "the older I get, the more comfortable I get, particularly with frail, elderly people, of saying 'I don't know'."

Ensuring no coercion

Ensuring there was no coercion would also be hard. "There are times there is some pressure from the family," particularly given house prices, she said.

To protect against this, medical practitioners "need to talk to nurses who are in regular contact with that person" and to whānau. A psychologist can also be called in.

Only a medical practitioner can determine a person's eligibility – and must find another medical practitioner to corroborate the decision. However, nurses were often the first to be asked about assisted dying – but could not raise the topic themselves under the law.

Safeguards included the Support and Consultation for End of Life in New Zealand (SCENZ) group; an end-of-life review committee and a registrar, who confirms the correct process has been followed. •

'You cannot abandon the patient – regardless of your personal belief, you should not inhibit a person's access to lawful treatment.'

– Michal Boyd

Assisted dying: The conditions that must be met

TO BE eligible for assisted dying in New Zealand, a person must:

- Be over 18.
- Be a New Zealand citizen.
- Have six months or less to live.
- Be irreversibly ill.
- Be experiencing unbearable suffering.
- Be mentally competent.

New Zealand's law differs from other countries as follows:

- There is no stand-down period (unlike in Canada and some United States (US) states).
- It is not only based on suffering, but also on irreversible illness and must be determined a patient has six months or less to live (unlike in Holland and Belgium, where eligibility is based on one's perception of suffering).
- It does not include mental illness (unlike the Netherlands, Belgium, Canada).
- Non-residents are ineligible (unlike Switzerland).
- Clinician can administer as well as self (in some US states and Victoria the person must administer their own dose).
- A person must be mentally competent at the time of death.
- The decision cannot be be postdated for a future time when someone no longer has capacity or by advance care plan (unlike Canada, Belgium and the Netherlands).
- Under 18s are not eligible (unlike in Belgium and the Netherlands, where, with parental consent, assisted dying can occur in children).

No access for those suffering from mental illness or advanced age (with no specific irreversible condition). •

"HISTORICALLY, PANDEMICS have forced humans to break with the past and imagine their world anew.

"This one is no different. It is a portal, a gateway between one world and the next. We can choose to walk through it, dragging the carcasses of our prejudice and hatred, our avarice, our data banks and dead ideas, our dead rivers and smoky skies behind us.

"Or we can walk through lightly, with little luggage, ready to imagine another world. And ready to fight for it."

– Arundhati Roy

Ruth De Souza

Pandemic chance to 'imagine the world anew'

Pandemics gives humanity a chance to break from the past and "imagine the world anew", says Melbourne-based academic and nurse, Ruth De Souza.

"COVID is no different. It's a portal, and a portal is a gateway between one world and the next."

Visiting "from the future", a silver-adorned De Souza cited Indian writer Arundhati Roy's essay, *The pandemic is a portal,* which suggests pandemics force humans to live differently.

"I'm inviting nurses – who are already carrying far too much – to maybe walk lightly with me to imagine other futures," said De Souza, a fellow at the Royal Melbourne Institute of Technology University's school of art.

De Souza shared two very different visions of the future – one, where people can't afford to retire or live at sea level, where robots do care work and nursing care is only available to the wealthy. "It's all about the survival of the fittest and wealthiest. The recipients of care work are the elite who can pay for it."

An alternative future involves shared land, labour, knowledge and skills. "Everyone is taken care of. Mutual care flourishes, everyone thrives. There's a focus on equity, generosity and flourishing. We've moved away from scarcity thinking."

In that future, says De Souza, "I work when I feel like it. Usually it's offering clinical supervision or career coaching in return for a good chat about where nursing is these days."

The health system is highly sophisticated, with technology allowing clinicians and staff to focus on care.

"There is a recognition of the physical and emotional demands that caring takes up, so that people working in health all have three days off a week so they have time to recover from the demands of the field," she said.

"Evidence-based care is embedded and other forms of knowledge, for example spiritual and cultural, are given space and respect."

In 2020, she said, the Year of the Nurse became the year of the pandemic, elevating the profession in unexpected ways. Nurses became contact-tracers, vaccinators, communicators – and innovators, helping sick or grieving families to connect through technology.

"The general public came to realise how indispensable nurses and nursing was. There was cheering in the streets because nurses were seen as heroes and angels."

The problem with those labels was that nurses were recognised for their courage and self-sacrifice. "But it undermined the professionalism and skills of nurses, because it reinforced the public's view that nursing was an innately feminine, nurturing role rather than one which requires skill, education, knowledge and discipline".

Hope needed

The pandemic had brought innovation and collaboration. Now, we needed hope, De Souza challenged nurses.

"Can we imagine and craft a world that is more liveable, more just and joyful for all of earth's inhabitants? Or will we hang on desperately to the familiar, pining for a return to normality?

"[African-American writer] Octovia Butler said, *'All that you touch, you change, and all that you touch changes you back'*. There's no single answer that will solve all of our future problems. There's no magic bullet. Instead there are thousands of answers at least. You can be one of them if you choose to be." •

How mātauranga Māori benefits nursing students

The benefits of mātauranga Māori to nursing students has been revealed in new research – despite ongoing prejudices against its value.

Nadine Gray (Te Whakatōhea), a 20-year registered nurse working at Capital & Coast District Health Board, and an academic with a focus on health equity for Māori, spoke at the NZNO conference about her work. Her research is a kaupapa Māori project with Te Whare Wānanga o Awanuiārangi, exploring the privileging of mātauranga Māori and strengthening of cultural identity in nursing education.

Gray said when she started tertiary education she was unaware of any Māori-specific support services. She eventually completed a nursing degree – one of only a few Māori graduates.

As a senior expert nurse she was often asked for cultural advice for caring for Māori patients, and whānau.

"Additionally I've encountered institutional racism during handover of care where colleagues display negative attitudes with stereotyped descriptions of Māori or ethnic minority groups or clients. These experiences have been confronting to challenge at an organisational level."

Working within Māori health had strengthened her practice and awareness of the need for change.

Her research looked at the Ōhanga Mataora programme, a Bachelor of Health Sciences Māori Nursing, at Te Awanuiārangi. The course aimed to meet the growing need to build the Māori workforce in nursing. Māori students made up three quarters of all enrolments in the programme.

Gray's research aimed to explore how the "interweaving" of mātauranga Māori through the degree influenced the engagement, retention and completion outcomes of the students. It explored the factors students felt helped them to succeed – and what gave them confidence and competence to make a difference in Māori health.

Nadine Gray

The project used kaupapa Māori methodology, she said. Participants were all Māori women between 20 and 43 years old (no male students chose to participate). They ranged across all three year groups, plus one recent graduate.

Succeeding for whānau

Gray said five themes came out of the research. The first was the drive by participants to succeed for whānau. While many participants talked about not feeling like they were set up to succeed, they were inspired by a collectivist value system – achieving for others.

The second theme was the value placed in the course on mātauranga Māori. It was a process of self-discovery for the students and allowed them to become involved in te ao Māori. "There's a normalisation of te reo Māori and tikanga as everyday practices."

The third theme related to participants perceiving themselves as gathering dual competency and "ethnic concordance [alignment]" to Māori people in their care. This strengthened the philosophy of for-Māori, by-Māori care in the health system.

The fourth theme was whanaungatanga. The students talked about the importance of relationships between students, and kaiako – teachers. The students valued accessibility to kaiako for support.

Gray said there was a number of Filipino students in the course as well, and these students were able to share their experiences too.

The final theme was the "threats to success" in the programme. Participants talked about the stigma and racism they experienced by choosing to study at a wānanga rather than institutions such as universities.

"They discussed . . . having challenging conversations with friends, family, community members . . . that the wānanga is not a real school, or produces real degrees, or them becoming real nurses."

This was an example how "privileging a dominant group", or place of learning, over others meant the students were subjected to racism, via the assumption that wānanga learning was inferior, she said.

"This is a really important consideration for all undergraduate programmes in Aotearoa/New Zealand that offer Māori and Pacific streams in undergraduate health sciences, to really create awareness and conversation about how students might be perceived particularly on clinical practice." •

Nadine Gray's research can be found at https://auckland.figshare.com/articles/thesis/Dissertation2020NadineGray_pdf/15121350

Equity means doing things differently

The search for equity has taken centuries for Māori – and still remains unfulfilled, the 2021 NZNO conference has heard.

Denise Wilson (Ngāti Tahinga, Tainui), registered nurse and professor in Māori health at Auckland Univrsity of Technology, said equity for Māori sat within the "oritetanga" (equality) article of Te Tiriti o Waitangi.

"It's something that Māori had affirmed almost 200 years ago with the signing of Te Tiriti."

Wilson said that in 2019, Director General of Health Ashley Bloomfield spoke about the differences in the health system for Māori, Pasifika, disabled and older people.

"These differences are for the most part avoidable, and they can be considered unfair and unjust."

Taking an equity approached required different ways of doing things for those people, Wilson said.

"The services that are delivered in a universal way are not necessarily going to achieve the [right] outcomes. They haven't achieved them now, and they're less likely to achieve them into the future."

Major health reforms set to launch next year showed promise for creating a different way of doing things, she said.

Research with Māori had shown there were key problems that came up consistently, Wilson said. "[This included] The environment of health services . . . not having their worldview acknowledged, not feeling welcome, having difficulty knowing what the rules of engagement are . . . being marginalised, being silenced."

Denise Wilson

Bad health outcomes impacted on the trust that Māori whānau had in the system, which was a deterrent for them to engage with the system in the future, she said.

Wilson said while it was well known there was institutional racism against Māori, she had a growing unease about people using it as an excuse for failings in the system.

Wilson said the aim should be to enhance people's mana, not diminish it.

"Our systems and structures don't exist on their own. They exist with the people in them. So as nurses we need to be speaking up and challenging some of the issues that are not equitable, or are not going to achieve an equitable outcome."

Systems and structures could perpetuate racism – but this flowed on from the individual people within them, setting policy and planning services.

There was also interpersonal racism, and it was a "big deterrent" for people accessing services. "It could in part explain why sometimes Māori are late in presenting to services. But also really concerning is the internalisation of that racism by Māori . . . who start believing some of the things that are said."

Another area of concern was the use of the concepts of unconscious or implicit bias as an excuse as well.

These forms of bias had an "impact and an effect", she said. "I've got incidences where it really raises the question: is this bias by design?"

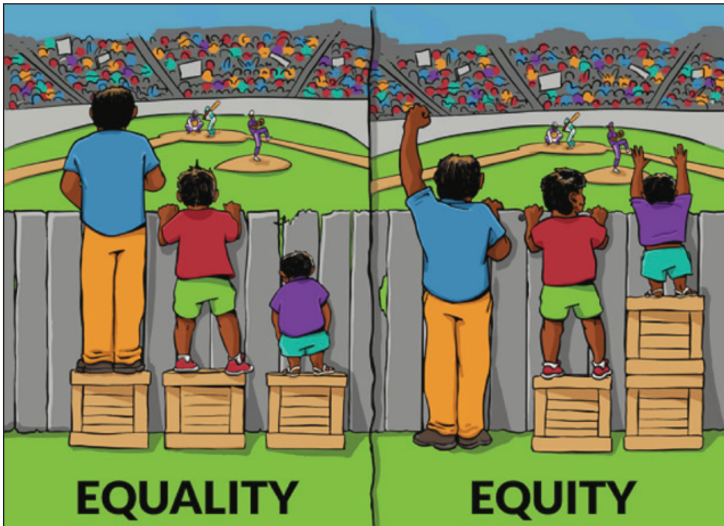
One of Wilson's doctoral students was working with rangatahi (young people) who had shared multiple examples of how they were treated differently in the health system, she said.

Her research showed that spirituality (wairua) and whānau (extended family networks) were important for Māori patients. Establishing relationships was "crucial" for simple interactions, but also for receiving and processing information.

"[It was about] Making those connections and introductions: who we are, where we're from; encounters that are kanohi ki te kanohi, face-to-face, and continuity of care where possible."

Wilson said the aim should be to enhance people's mana, not diminish it.

Aside from these specific actions, equity could not be improved without looking at the wider socio-political-health context. This included marginalisation, colonisation, and internal migration, and the racism that Māori encounter. •



'Look for potential in everyone'

Initially rejected as “dumb” and a “coconut” when seeking higher education at Massey University in the '80s, scientist and professor Palatasa Havea is urging education providers to look for potential in everyone.

“Do not ask how many seeds in the apple, but how many apples there are in the seeds,” he told nurses at the NZNO conference. “If I take the seeds and throw them in the rubbish, I won’t get any apples. Whereas if I plant the seed and fertilise and water it, I will get thousands and thousands of apples from those seeds.”

Havea went on to become a successful scientist and researcher, patenting a number of technologies and bringing millions into the New Zealand economy over a 26-year career in the dairy industry.

Havea says he does not blame Massey University – where he now works as dean of Pacific students’ success – and urges Pacific people not to focus on racist experiences but look ahead. “There were a lot of things that could be interpreted as racist in coming my way, but I chose to focus on my own journey. Success should be defined by our determination today – not by negative things of the past.”

Palatasa Havea

But ultimately, a more equitable education system would lead to better health and outcomes for all. “To achieve this, we must develop leaders to transform our institution but eliminate inequitable practices and cultivate the unique gifts, talents and interests of every child." In this way, success and failure would no longer be predictable by student identity – racial, cultural, economic or any other social factor.

The education system was based on equality, where the offerings are the same for everyone and equal benefit is assumed. “But that is also assuming that we start from the same point,” Havea said. “But the reality is, is that society is varied and we don’t start from the same point. And that’s where equality is not very helpful for our people.”

Quoting Albert Einstein, he said: “Everybody is a genius but if you judge a fish on its ability to climb a tree, it will live its whole live believing it is stupid”.

So it was with the education system – measuring people only one way was unfair.

There was much “unexplored potential” in Pacific people in many areas, but institutions needed to provide them a nurturing environment to grow.

Everyone had the potential to be a genius – and nursing was something Pacific people excelled at. “In 10 years, what if nurses were dominated by Pacific people? The Pacific people are the best nurses as they don’t do it just with their head, they do the nursing with their heart and approaching the patient with an understanding of how they feel and we are the best people to do that.”

Havea tells students there is power in being different. “You need to see what everybody else sees but think what nobody else thinks.”

Havea tells students there is power in being different. 'You need to see what everybody else sees but think what nobody else thinks.'

He advises Pacific students to aspire to high things, despite challenges. “So, the ingredients for making a good pearl – rough edges, suffering and pain and time. •

Hospital visitors must be limited in a

By acting manager nursing and professional services Kate Weston

Kate Weston

In September 2021, NZNO supported members at Auckland District Health Board (ADHB) who had put in place a provisional improvement notice (PIN), citing health and safety concerns over a permissive visitor policy.

The policy allowed visitors to the hospital while the community was in level four lockdown with a poorly contained strain of COVID-19 Delta and growing numbers of cases in the community.

Members were reporting that in shared patient spaces, there were sometimes eight or more visitors – many from different "bubbles".

This was against a backdrop of level four restrictions outside the hospital where the "stay at home" order prevented people from seeing family and friends who were not in their bubble.

Screening at hospital entry points to the hospital was based on the February lockdown with questions about overseas travel that were no longer relevant, but questions about potential locations of interest not initially included.

NZNO members and staff worked hard to try and address these health and safety concerns within the DHB, also raised by patients.

NZNO only escalated the matter to the Employment Relations Authority (ERA) when all other avenues were exhausted, with no improvement or indeed action in response.

Members were reporting that in shared patient spaces, there were sometimes eight or more visitors – many from different 'bubbles'.

Having declined to meet with NZNO, the DHB was directed to mediation by the ERA. This led to the DHB visitors' policy being strengthened, in a win for NZNO members and patients alike.

NZNO is now working to address guidance on hospital visitors nationally, to ensure it adequately refers to COVID-19 cases and alert levels in the community, not just the internal operational capacity of hospitals, as determined by a traffic light system.

pandemic

PHOTO: ADOBESTOCK

The workforce is a limited resource, which cannot withstand unnecessary risk that may require staff to be stood down.

Not a blanket ban

To be clear, NZNO has not at any time advocated for a blanket ban on visiting, appreciating that there is a great deal of evidence that visitors can aid recovery and provide cultural support.

However, we are currently in a pandemic and many things previously considered rights have been impinged in order to support efforts by the "team of five million" to control and hopefully eradicate, or at least minimise the effects of, COVID-19.

ADHB visitors' policy was not consistent with the other DHBs in the greater Auckland region and around the country. Their guidelines outlined very strict limitations while allowing appropriate compassionate visiting and cultural support, as well as supporting families at the birth of a baby, or if a baby or child were unwell in hospital.

There have been concerns with COVID-positive patients attending hospitals during the current outbreak. Many have been asymptomatic and seeking other care, including maternity. Some were not confirmed cases until after admission.

There have also been instances of COVID-positive visitors entering hospitals in the greater Auckland area, putting staff and patients at risk.

After North Shore Hospital patients were found to be COVID-positive in August, 30 staff were considered direct contacts and another 120 potential contacts. In addition, the emergency department was closed for a period.

A recent incident at Middlemore Hospital resulted in 29 staff being stood down as close contacts of a COVID-positive patient and the closure of ward to further admissions. A subsequent event at Middlemore's emergency department has seen over 60 patients being potentially exposed, many of whom had already been discharged.

Patient flow

The outbreak creates major difficulties for DHBs in terms of managing the number of patients that may require admission to hospital, including intensive care units.

When staff are stood down as a result of exposure to COVID-19, significant strain is placed on DHBs' ability to manage not only COVID-related admissions but also the general health needs of the population, which of course continue during a pandemic.

Nurse shortages

Such is the shortage of experienced critical care/trauma and cardiac nurses in Auckland, that Auckland's three metro DHBs have requested nurses-from other parts of New Zealand to assist, particularly at Auckland and Counties Manukau DHBs.

Subsequent requests have gone out for nurses with skills in primary care or who are Māori or Pasifika to support efforts to contain and manage the outbreak in the Auckland region, by testing, vaccination and care of those who are unwell.

Nurses are the backbone of COVID-19 management across all health sectors, from managed isolation/quarantine and border controls, through to testing, vaccination and the care of patients in communities and hospitals.

The workforce is a limited resource, which cannot withstand unnecessary risk that may require staff to be stood down.

NZNO has an obligation to support staff and patients to keep safe and to take steps to minimise risks wherever this is necessary. •

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www.nzno.org.nz

The beauty of nursing. Treading boards on wards, to owning a Caci clinic.

Caci is a home-grown, Kiwi franchise business with over 25 years' experience, 64+ clinics throughout NZ that revolutionised the beauty industry and continues to lead the skin and appearance market today.

Meet: Bridgette Lawrence, Registered Nurse, Caci's Senior Clinical Advisor, and Co-Owner of Caci Palmerston North.

A career in nursing offers so much variety and opportunity. There are many ways to help people - that is the beauty of nursing as a profession. Caci's unique business focusses on delivering what they call 'skin confidence', it's the intangible feeling that can be life changing for so many. From delivering cosmetic injectables, advanced skin treatments, clinical governance, and business ownership – there is a lot on offer when it comes to a nursing career at Caci. We spoke with Bridgette, to discuss her career with Caci.

Where did your nursing career start? I have over 25 years' experience working as a Registered Nurse, I started in public, progressed to private then moved to cosmetic plastics and have worked around the world. I've always had an interest in aesthetics, so approached Caci and applied for the role! We were one of the first in NZ to offer cosmetic injectables; I started injecting antiwrinkle products and dermal filler and absolutely loved the results it could deliver. As I grew in my skills and confidence, I built a large customer base and it continued to grow in popularity over the years. Then 5 ½ years ago, my colleague Liz and I, decided to take the leap and we are now the proud owners of Caci Palmerston North.

Tell us more about your role at Caci? Caci is built on a history of clinical expertise, trust and results. It's what makes us different. I have always been interested in the education side of nursing and taking on the role of Senior Clinical Advisor at Caci was a natural career progression for me. I worked closely with my team and the Support Office to ensure that we found the right balance so I could continue to practice and treat customers within my business, as well as support the clinical direction of the business and facilitating senior level workshops.

What is the nursing community like at Caci? We have a group of 60+ Registered Nurses across the country, a tight-knit group of nursing peers to support one another. I believe that knowledge helps us all grow – everyone has something to offer and teach someone else.

What do you enjoy most about nursing at Caci? I love helping to enhance a customers quality of life, the ability to truly care and 'still be nurses' while delivering real results. The people at Caci and the dedication to education and growth keeps me excited.

Lastly, how has your nursing career helped you as a business owner? It is such an honour and privilege to work direct with customers, to work in such wonderful conditions with an amazing team and have such a strong network of peers. My time spent on the wards helped build the resilience needed to run a business and lead a team. It's my passion for helping people that gets me up every day, and I wouldn't change that for the world.

If you're interested in learning more about a career with Caci, **visit caci.co.nz/careers** for more info information.

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From puffers to boilers:

Health system needs a climate change check-up

What practical measures can the health service and a health union such as NZNO take to tackle climate change?

By Mikey Brenndorfer

At this point in a global pandemic, which has affected the entire world, infecting 219 million people, and taking the lives of 4.55 million, it's hard to conceive of a greater threat to human health than COVID-19.

And yet, in the middle of increasing outbreaks caused by the new Delta variant, 230 health journals, including 15 nursing-specific journals, have released a rare joint open letter to call for urgent action to limit climate change.[1] Indeed, they have gone as far as to say: *"The greatest threat to global public health is the continued failure of world leaders to keep the global temperature rise below 1.5°C and to restore nature"*. The letter also calls on health professionals to do our part: *"As health professionals, we must do all we can to aid the transition to a sustainable, fairer, resilient, and healthier world."*

Health care has role to play

Indeed, our health-care systems, globally and here in Aotearoa New Zealand, have a major role to play in reducing carbon emissions that cause climate change.

In June of this year, OraTaiao: the New Zealand Climate and Health Council co-hosted the Sustainable Healthcare and Climate Health Conference in Wellington, with the theme "Re-thinking sustainable health in Aotearoa".

Our hospitals have a part to play in reducing our carbon footprint.

As part of the conference, there were multiple presentations which highlighted the areas where our health-care system currently contributes to carbon emissions, changes that could be made to reduce these emissions, and the importance of addressing climate change to ensure equitable health outcomes.

Mikey Brenndorfer

The findings presented at this conference are significant to the nursing workforce. There were many types of interventions identified for which nurses are and can be the leaders of change to reduce carbon emissions.

The carbon emission profiles of district health boards (DHBs) across the country paint a somewhat concerning picture. Margriet Geesink presented to the conference on "district health board emission profiles and mitigation action".[2] This presentation provided insight into areas where DHBs can intervene to reduce emissions.

Salbutamol inhalers have a hefty climate impact.

It was disappointing to learn a large portion of total DHB carbon emissions arise from just two DHBs using coal burners to heat their hospitals.

Beyond this, a large portion of carbon emissions across all DHBs come from the use of natural gas to heat hospitals, often while simultaneously running air conditioning units to cool these same buildings.

Need for change

This presents two major areas for change: one is retrofitting hospitals with energy-efficient heating systems, already under way in most areas; and secondly, ensuring that energy-efficient building approaches are used in all future infrastructure projects.

Other areas included staff flights, fleet vehicles using petrol, and patient travel.

Medical gases present an interesting challenge, as much has been done to reduce the worst offenders. But nitrous oxide used for pain relief is unfortunately also a potent climate change gas, and there is little that can be done to replace it or reduce the climate impact of its use.

No procurement measurement

Overall measurement means management, and only the areas that are measured can be addressed. Currently DHBs are not measuring the climate impacts of procurement (buying in goods and services). However, according to a presentation at the conference by Rick Lomax, procurement is likely the largest source of carbon emissions across the health sector.[3]

The propellant used in salbutamol MDIs is up to 3000 times more potent as a climate change gas than carbon dioxide.

Lomax's presentation took a detailed look at the climate change impacts of supply chain, highlighting that research on the United Kingdom's National Health Service revealed 60 to 70 per cent of all carbon emissions from the health system arose from supply chain and procurement. He said this percentage was similar to recent yet unreleased audits of the Auckland DHB.

Procurement emissions incorporated those associated with production, transportation, use, and disposal of medical consumables and equipment. Lomax pointed out the feedback loop around climate change and procurement: as climate change affects health, more people will present with increasingly complex health issues, resulting in the need for increased procurement, resulting in increased carbon emissions and air pollution, leading to more people experiencing negative health impacts of climate change seeking health care.

Increasing investment in public health measures, such as healthy housing, could reduce demand on the health system by 30 per cent. Also, devising better treatment policies that take into account the carbon footprints of health-care pathways could further reduce procurement requirements by 30 per cent.

This highlights points through the health system where interventions can reduce emissions.

A simple example of clinical deci-

Procurement remains an unknown climate-change quantity in our DHBs.

sions which affect climate change that was brought up several times during the conference had to do with metred dose inhalers (MDI) for asthma treatment, primarily the use of salbutamol.

Several presenters reiterated the fact that the propellant used in salbutamol MDIs is up to 3000 times more potent as a climate change gas than carbon dioxide.

This means a single MDI has an equivalent impact on the climate as a 300km journey in a standard petrol car.[3,4]

The irony of a treatment for asthma also containing a propellant which contributes to an environmental trigger for asthma was not lost on many in attendance.

The point is not to shame or stigmatise individual use of an MDI, but to highlight a clinical practice area which has good alternatives available. In fact, the recent change to the Global Initiative for Asthma (GINA) guidelines has recommended that best practice for first line treatment of asthma is to move towards a dry-powder inhaler, which requires no propellants, with combined long-acting beta-agonist and inhaled corticosteroid, such as Symbicort.[5]

This highlights an important area where a change to clinical best practice overlaps with climate change best practice.

This is a brief overview of a small selection of presentations from the Sustainable Healthcare and Climate Health conference. If you're interested in listening yourself, most are currently available online (https://events.otago.ac.nz/shch2021/presentations).

A challenge for us as health professionals and NZNO as our union is embedding awareness of climate change in every area.

The main points that relate to NZNO are that climate change is the greatest known threat to human health we've yet encountered, yet our health-care systems contribute to carbon emissions in many avoidable ways. A challenge for us as health professionals and NZNO as our union is embedding awareness of climate change into every area of the health system.

Incorporating climate change-informed decision-making into each college and group of NZNO's professional arm, and ensuring action on climate change is part of NZNO's industrial relations efforts is one major way, as a union, we can do our part to address this looming threat.

I would like to plant the seeds here for climate change leadership roles to be implemented through every layer of our organisation to ensure this remains an issue that informs our decisions and actions as a union. •

For more information, or to become a member of OraTaiao, go to orataiao.org.nz

Mikey Brenndorfer, RN, is a youth health nurse specialist and school-based health services nurse educator.

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Alisa Stewart – matron, QSO recipient, and archivist for the Whanganui District Health Board.

Farewell to esteemed Whanganui nurse

Ailsa Crawford Stewart's contribution to the Whanganui community was immense. The former hospital matron, staunch women's advocate and community stalwart died in Whanganui Hospital in August, at age 77.

Stewart spent most of her career working in various roles at Wanganui Hospital (as it was then called), beginning her training there in 1961. She trained in Plunket nursing, midwifery and psychiatric nursing and was appointed matron of the hospital's maternity annexe in 1977 and co-ordinator of the Te Awhina psychiatric and women's unit in 1983.

She also spent a year as midwifery adviser for the Kingdom of Tonga.

However she described the year she spent in the Solomon Islands as principal of the Helena Goldie School of Nursing at Munda as the highlight of her career. She stayed in touch with many of her former pupils afterwards.

Stewart served several terms on the Whanganui District Health Board and was an educator and assessor for nurses and caregivers through-Aged Care Education and Career Force programmes in a number of aged care facilities. Of this work, she said: "By teaching caregivers, I'm using my experience in helping them to give good care to older folk in our community."

In 2006 she received the Queen's Service Order (QSO) for services to the Whanganui community. She received the Women's Sufffrage Medal in 1993 and was named one of the 100 Zonta Women of Achievement.

Stewart was a member of NZNA/NZNO from the time she began her training. While serving on the DHB, she said she often spoke out on behalf of the workforce, as she said some board members had little understanding of the pressures on clinicians.

> 'She left a huge legacy and we are deeply saddened by her passing.'

She also served on the Whanganui District Council and was a supporter of numerous community groups.

Retiring from nursing after 55 years, she became a volunteer archivist for the 125-year history of the Whanganui DHB and its predecessors. She collated photos, maps, plans, reports, articles and memorabilia from the past, and much of these are now displayed in the hospital corridors.

Whanganui DHB CEO Russell Simpson paid tribute to Stewart, saying she "left a huge legacy and we are deeply saddened by her passing".

He said it was a fitting tribute that Stewart, who died in the hospital's critical care unit, was farewelled with a guard of honour when she left the hospital for the last time.

"The Whanganui North Rotary Club honoured her earlier this year for her amazing work in our community, not only for making a difference in the lives of New Zealand women – young and old – but for her huge community input and spirit."

Simpson said she was a life member of the National Council of Women and a member of, or volunteer for, organisations such as Alzheimer's, the Sarjeant Gallery and the Robbie Burns Society.

"We at the Whanganui DHB are incredibly proud of her and her achievements. We're thankful for her friendship, guidance, mentorship and years of service to our community," Simpson said. •

Shared medical appointments are at the heart of a quality improvement project at a fracture clinic.

THINK Hauora fracture service clinical nurse specialist Paula Eyres and administrator Leigha Osterman.

Improving quality in a fracture service

By Claire Budge, Melanie Taylor and Paula Eyres

Quality improvement (QI) should be an integral part of health service delivery. As best practice principles evolve and system changes are demanded, services need to be evaluated and assessed to ensure they are being run as effectively and efficiently as possible, while meeting the ever-changing needs of practitioners and their patients. The Ministry of Health says a quality improvement approach includes *"an explicit concern for quality, vested in teams; the viewing of quality as the search for continuous improvement; an emphasis on improving work processes to achieve desired outcomes; and a focus on developing systems and investing in people to achieve high-quality health outcomes"*.[1]

In this article, we describe a quality improvement initiative in a fracture liaison service. We aim to:

- Provide a case study of quality improvement in action, working within an existing service with patient-flow challenges.
- Share ideas and findings for others wanting to improve an existing service or establish a new one.

The fracture liaison service (FLS) in the MidCentral region is provided by the MidCentral District Health Board and the primary health organisation THINK Hauora. In this article, we focus on the primary care arm of this service, provided by THINK Hauora, and delivered by a clinical nurse specialist and one administrative team member.

This is a free service for people aged over 50 who have experienced a fragility fracture or a non-major trauma fracture, such as that resulting from a simple fall. This "signal" or "herald" fracture is a warning that may uncover reduced bone mineral density as in osteoporosis or osteopenia. The goal of the service is to decrease the risk of another fracture by doing a fracture risk assessment (FRAX)[2] and putting in place a bone health care plan to be followed up by a general practice team (GPT).

Looking at bone density and assessing falls risks is the only post-fracture model of care that has shown a reduction in the risk of future fractures and the associated trauma and potential loss of inde-

pendence.[3]

The population of this service tends to be female, of the baby boomer generation, and mainly European, Indian or Asian.[4] (There are few Māori and Pacific people, as statistically they have the highest bone mineral density in the world.[5]) They are at high risk of loneliness as they age, often outliving their spouses. Loneliness is related to poor health outcomes.

The FLS introduced shared appointments as a new service delivery model in 2020 to improve efficiency, reduce duplication and address the service's waiting list problem. The shared appointment is a single, two-hour session people attend with others to learn more about their condition. Within the session, they have a short, individual consultation with the FLS nurse to develop a care plan, including treatment recommendations. Individual appointments (either face-to-face or via the phone) are still offered where required.

As part of a more general quality improvement approach, two staff members external to the service (the health researcher and the nurse advisor for long-term conditions – co-authors of this article Claire Budge and Melanie Taylor) worked with the FLS team later in 2020 to streamline work-flow processes, and refine the delivery of shared appointments, emphasising patient self-management. This support is ongoing.

Approach

The quality improvement approach started with **process mapping**, which is the development of a flowchart documenting the steps in a process – in this case the patient pathway through the FLS. A guide to process mapping stated " . . . *the data provided by process mapping can be used to redesign the patient pathway, to improve the quality or efficiency of clinical management and to alter the focus of care towards activities most valued by the patient*".[6] A systematic review of 105 studies on the use of process mapping for quality improvement in health care identified a range of benefits. These included: breaking down complex systems; improved coordination of care across settings; identification of constraints and opportunities; enhanced understanding of roles and responsibilities; and the development of ownership and responsibility for improvement work.[7]

Process mapping involved talking to the FLS team about the patient flow through the service, starting with identification of patients (referral, self-referral, emergency department fracture list/fracture referral list/orthopaedic specialist list) and proceeding through what happened when and for whom. This depended on patient eligibility, for the service and for a free bone density (DEXA) scan, and their choice of a shared or individual appointment and follow-up. After multiple discussions with the team, notes and pathways were mapped out, culminating in the generation of a flowchart (see p36).

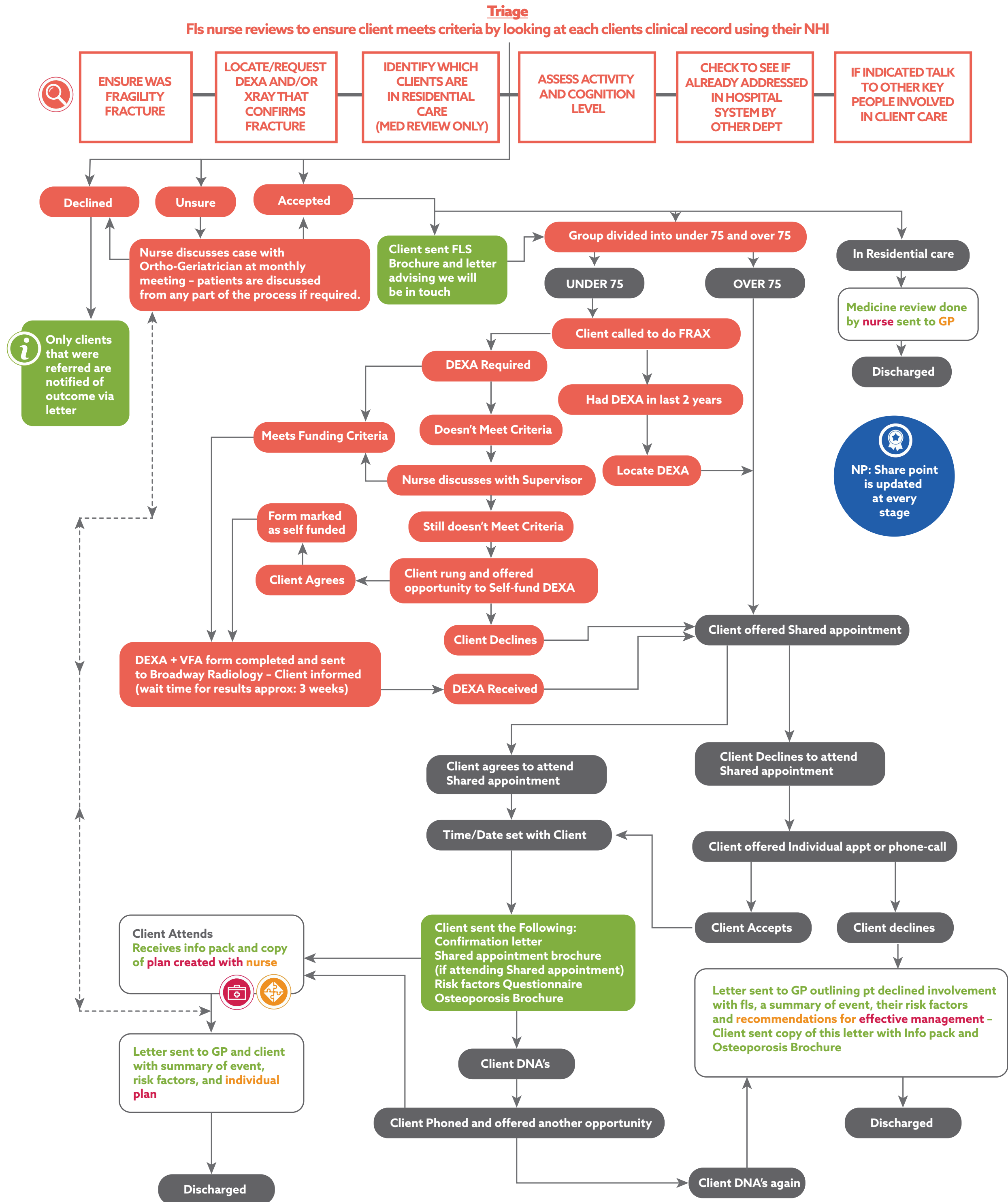
Process mapping allowed us to identify problem areas in the patient flow and, with the FLS team, we brainstormed ways of improving and speeding up processes. As part of this, we examined the **patient communication processes** and content, and made changes to brochures and letters and what was sent out when. Some of these changes related not only to communication but also to the shared appointment process.

An example was that a comprehensive falls assessment, including the collection of FRAX data for each patient, was being conducted during the shared appointment, which slowed down the group session. Instead, a questionnaire was developed to collect the necessary data and this is sent out to the patient before the shared appointment. They complete it at home and bring it along for discussion during the individual consultation component of the session. This speeds things up and also helps maintain confidentiality.

We also identified problems with the type and content of the service's first approach to patients. Instead of initiating

BENEFITS OF SHARED APPOINTMENTS FOR PATIENTS AND PROVIDERS

- Combat isolation and encourage patients to realise they can manage their condition.
- Encourage vicarious learning by patients as they witness others' illness experiences.
- Patients feel inspired by successful peers
- Build friendships between patient and providers.
- Improve collegiality between providers.
- Providers learn from patients how to meet their needs better.
- More time helps patients feel comfortable and better supported.
- Improved health knowledge for patients through input from providers and peers.
- Seeing the provider interact with other patients builds trust.


Referral
Identified via weekly ED fracture list/ weekly list of fractures referred to the hospital/ Orthopaedic specialist list collected monthly (Phishing)
Or
Clients referred to the service from community or hospital services
or
Refer self after hearing about service
Triage
Fls nurse reviews to ensure client meets criteria by looking at each clients clinical record using their NHI
ENSURE WAS FRAGILITY FRACTURE
LOCATE/REQUEST DEXA AND/OR XRAY THAT CONFIRMS FRACTURE
IDENTIFY WHICH CLIENTS ARE IN RESIDENTIAL CARE (MED REVIEW ONLY)
ASSESS ACTIVITY AND COGNITION LEVEL
CHECK TO SEE IF ALREADY ADDRESSED IN HOSPITAL SYSTEM BY OTHER DEPT
IF INDICATED TALK TO OTHER KEY PEOPLE INVOLVED IN CLIENT CARE
Declined
Unsure
Accepted
Nurse discusses case with Ortho-Geriatrician at monthly meeting – patients are discussed from any part of the process if required.
Client sent FLS Brochure and letter advising we will be in touch
Group divided into under 75 and over 75
UNDER 75
OVER 75
In Residential care
Medicine review done by nurse sent to GP
Discharged
Only clients that were referred are notified of outcome via letter
Client called to do FRAX
DEXA Required
Had DEXA in last 2 years
Meets Funding Criteria
Doesn't Meet Criteria
Locate DEXA
Nurse discusses with Supervisor
NP: Share point is updated at every stage
Form marked as self funded
Still doesn't Meet Criteria
Client Agrees
Client rung and offered opportunity to Self-fund DEXA
Client Declines
Client offered Shared appointment
DEXA + VFA form completed and sent to Broadway Radiology – Client informed (wait time for results approx: 3 weeks)
DEXA Received
Client agrees to attend Shared appointment
Client Declines to attend Shared appointment
Time/Date set with Client
Client offered Individual appt or phone-call
Client Attends
Receives info pack and copy of plan created with nurse
Client sent the Following:
Confirmation letter
Shared appointment brochure
(if attending Shared appointment)
Risk factors Questionnaire
Osteoporosis Brochure
Client Accepts
Client declines
Letter sent to GP outlining pt declined involvement with fls, a summary of event, their risk factors and recommendations for effective management – Client sent copy of this letter with Info pack and Osteoporosis Brochure
Letter sent to GP and client with summary of event, risk factors, and individual plan
Client DNA's
Client Phoned and offered another opportunity
Discharged
Discharged
Client DNA's again

contact with a phone call, a package is now sent out first, including a letter introducing the service and preparatory materials. This means patients are forewarned about pending contact.

We reviewed the pamphlets and brochures that were sent out, and found some overlapping content. Also, the sheer amount of information was overwhelming, potentially resulting in none of them being read. We selected the best booklet – covering the necessary information clearly and concisely – to be posted out, making others available for patients to take home from the appointment. The guiding principles we used were to keep in mind health literacy (people's ability to read, understand and remember health messages) and the attractiveness and friendliness of forms and brochures.

The shared appointments also required some modification. Shared appointments are where a small group of people with a common interest – in this case osteoporosis and a recent fracture – come together for education, individual assessment and discussion. In the FLS, it is a single session; other types of shared appointments can involve the same group of people meeting on a regular basis. The repeated meeting format, often used in diabetes care but also effective in osteoporosis management,[8,9] allows attendees to build relationships with each other and learn from their experiences, giving and receiving support along the way (see box, p35).

In a single session, there is less scope for these outcomes to be realised, but in our one-off intervention it was noted that participants benefitted from talking about the fracture and how it occurred. Statements like *"my fracture hurt for weeks and still aches now"* are commonplace and participants reassure each other, creating a bond of shared trauma. Attendees can gain insight from other people's experiences and learn from people asking different questions or bringing different ideas to the discussion. One big advantage is the amount of time dedicated to patient education and promoting self-management.

The content of the shared appointment is similar to that of the individual sessions, but the longer running time means more detail and group discussion can be incorporated. It includes information on bone density and osteoporosis, avoiding future fractures and falls, exercises for strength and balance and dietary advice (calcium and vitamin D). Also DEXA scans are explained and reviewed.

Statements like 'my fracture hurt for weeks and still aches now' are commonplace and participants reassure each other, creating a bond of shared trauma.

As part of the new approach, attendees are encouraged to work out a plan for themselves and set goals to improve their bone health and limit the likelihood of another fracture. Medicine management is discussed in the individual appointment.

Initially the shared FLS appointments were not well attended. This was partly due to there being too many time slots on offer, in two locations. However there was also a non-attendance issue, as around 10 people were being booked in but only a few were turning up. We addressed this by reducing the number of time slots, overbooking the sessions to allow for some non-attenders, putting in a reminder system, offering payment of taxi fares if transport costs were an issue and writing an information brochure on shared appointments. The brochure was sent out as part of the preparatory materials so people had more understanding of what to expect.

Another major change was to add a group facilitator to the shared appointment team, in line with suggestions made in the Self-Management Support Toolkit (www.smstoolkit.nz). It was an obvious choice to teach the FLS administrator the necessary facilitation skills, as she was passionate about and committed to this work. This change has enabled the nurse to focus on clinical care while the facilitator focuses on group dynamics and the flow of the session. It is important to keep her role within scope however, as she is non-clinical and clinical questions raised by participants are put aside to be addressed by the FLS nurse later in the session.

We also invited THINK Hauora's clinical quality facilitator, who is experienced in running group self-management programmes, to sit in on some sessions. He helped redesign the self-management component to maintain the flow of the session while facilitating patients stepping out for their individual nurse consultations.

We wanted to ensure participants did not feel they were just waiting to see the nurse and that they could all participate in key self-management activities. The process was adjusted by moving the tea break to the start of the self-management session and introducing some self-management activities aimed at making lifestyle change options personally applicable. This session incorporates three main activities: identifying home safety and prevention of falls; looking at diet to increase calcium intake; and practising a recommended exercise regimen.

QUALITY CYCLES: Try, learn & adjust

Date: March 2021.
Topic: Addressing poor attendance at shared appointments.
Issue: People are invited to a shared appointment and then don't attend.

TRY (What are we developing?)

- Invite 10-12 people for each session.
- Reduce the frequency of appointments to fill sessions – one in Palmerston North and one in Horowhenua each month.
- Develop a brochure explaining what a shared appointment is so patients are better informed and to make shared appointments more attractive.
- Put a system in place to pay for taxi at front office if transport is an issue.

LEARN (How are things working?)

- FLS team has more time to do other work due to spacing of shared appointments.
- Increased attendance recently – this may result from introducing the shared appointment brochure.

ADJUST (What does this mean for what we do next?)

- We need to put additional shared appointments into the calendar as more people are now attending.
- An alternative approach is needed when more than 10 people attend, as individual consults result in lengthy delays. The initial suggestion is to divide the group into those who can have a consultation that day, and others who will receive a phone call to complete this work.
- We will consider including a clinical pharmacist at shared appointments.

Feedback to general practice

Another area that required streamlining was the feedback provided to the GPT. The FLS nurse had been typing lengthy letters for the GPT for each patient she had seen, to inform them of the patient's fracture risk, and summarise her review and treatment recommendations. This process was extremely time-consuming, slowing down patient flow.

Having the comprehensive falls assessment as a questionnaire enabled her to scan the completed form and attach it to a shorter letter, with instructions to the reader to review the patient's self-reported assessment. In addition to medicine management recommendations, she also now includes information about the patient's goals and intentions for self-management. This can contribute to a more comprehensive care plan being developed with the patient when they next see a member of their GPT.

Using quality cycles

Throughout the whole process, a Try, Learn and Adjust approach to quality cycles was adopted (from work in the disability sector in the MidCentral region through Mana Whaikaha). A form was drawn up to enable ongoing documentation. This involves coming up with a possible solution to a problem or a new approach, implementing it, and then learning from the experience and making adjustments until the new idea is integrated into business as usual – or discarded if it doesn't prove useful. (See box, above right).

Outcomes

There is evidence that all members of the team are learning from the QI experience and are now asking questions of themselves when a new situation or challenge arises. QI is becoming the norm and the team can identify areas requiring change without bringing them to the QI meetings. Big issues, such as those related to funding or major obstructions in the system, are shared with management and the broader FLS team, with the goal of simplifying work flow. Real, and well thought through solutions are being identified for consideration (see flowchart, p38).

Staff are feeling better supported by the organisation and energised and motivated to keep trying new approaches. Improving patient experience and strengthening self-management remain at the core of service delivery.

The pre-appointment communication appears to be paying off as attendance rates have significantly improved, reducing waiting times for appointments and improving patient flow through the service.

Insights gained

Shared appointments: Attendees did not immediately understand or accept they now had a long-term condition requiring ongoing management and lifestyle changes. This could be because their fracture had healed and bone density messages were less salient for them or the meaning hadn't sunk in through the education they were receiving.

More effort needs to be put into repeating the message and ensuring it has been heard. It is important that general practice picks this up when discussing medicine management.

Providing practical activities to encourage conversation and consolidate learning during the individual appointment session has proved beneficial. In the future, another practitioner may be needed to halve the time taken for individual assessments.

Taking people out of the session for individual consultations requires careful management by the facilitator who needs to be aware of who has missed what and to make sure they have all got what they need.

Overall: It was helpful having somebody from outside the service look at processes and materials to see how they could be improved. People working in the service may not have the time, energy or ability to take an objective look at how things could be done differently.

When a service is being run by a limited number of staff, any staff absences immediately affect work flow and the way the system operates. This needs to be accommodated in the service plan.

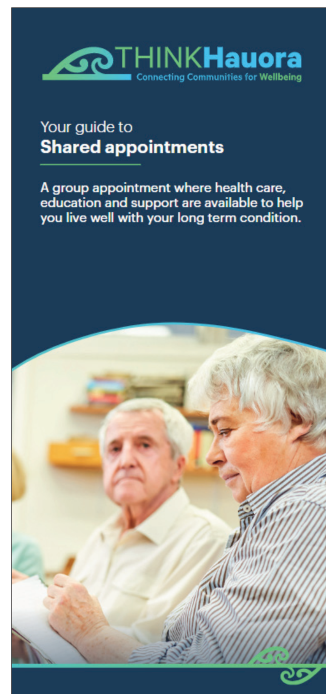
In implementing a quality improvement cycle (in this case Try, Learn and Adjust), it was difficult to get staff members to document the steps as they went. When asked, they were able to verbalise the process of identifying a problem, thinking about how to address it and making changes, but they found it hard, or did not prioritise it as important, to translate this to paper.

The process is time-intensive and involves, as a starting point, getting a sense of how other similar services are set up and what the literature says about best practice. Websites such as the Self-Management Support Toolkit are a great starting point.

Conclusions

In this article we have described a quality improvement activity to enhance the efficiency of a primary based small-scale fracture liaison service. Changes have been made to improve the patient experience - particularly in relation to patient flow. By adjusting the roles of the staff involved, improving the communication processes and patient letters/brochures, and strengthening the shared appointment format, we were able to improve attendance and manage the pressure in the system better.

One of the reasons this QI effort was successful is that the people involved were open to and ready for change. Organisational readiness for change requires a shared commitment and belief in the capability to make it happen. Where organisational readiness is strong – as in this case where there was support from THINK Hauora to make changes and commit resources and the FLS team were prepared to listen, invest effort and try – effective change is more likely to happen.[11]



With the recent national drive to standardise and optimise the identification and treatment of people with osteoporosis, and new Osteoporosis New Zealand FLS clinical standards recently released,[12] the FLS needs to remain responsive to change. Even with additional resources, the likely increase in patient numbers means the team will need to continue to identify areas for improvement, and do this in a way that does not compromise patient understanding and commitment to their ongoing self-management. •

** This article was reviewed by Shell Piercy, RN, PGDip, BHSc, a clinical nurse educator at Eastcare Urgent Care Clinic, Auckland, and an emergency department nurse and research assistant at Counties Manukau District Health Board.*

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Paula Eyres, RN, BN, PGCert, is a clinical nurse specialist in the fracture service at THINK Hauora.

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Nursing Research Section supports nurses' growth

Nursing Research Section committee members: Lorraine Ritchie, Debbie Coates, Kylie Short, Rachel Sayers, Priya Saravanakumar, Louise Chan, Wendy Blair, Ruth Crawford, Kathryn Tennant

NAU MAI, haere mai ki a koutou e te whānau tapuhi. Te Roopu Nursing Research Section/Te Wāhanga Rangahau Tapuhi (NRS) is one of a number of colleges and sections which form the professional arm of NZNO.
Our kaupapa is to support tapuhi across all areas to raise the profile of nursing research.

Since the inception of NRS in 1975, we have encouraged nurses in their research by providing opportunities to collaborate with other researchers, professional groups and relevant experts in nursing practice and academia. We also provide a platform to share knowledge and practice innovations to enhance evidence-based nursing practice.

We are continuing to explore how we can support our nursing research community. Recently, Te Roopu NRS has initiated kōrero with Te Poari o Te Rūnanga o Aotearoa to ensure our collective hikoi is not only fulfilling our obligations to te Tiriti but also upholding an equity lens at our table.

Te Roopu NRS committee includes passionate individuals from diverse fields of nursing practice, research and education. Our chair, Louise Chan, has extensive expertise in mental health nursing and is associate director of nursing for mental health, addictions and intellectual disability services for Capital & Coast, Hutt Valley and Wairarapa District Health Boards (DHBs).

NRS secretary Ruth Crawford has undertaken research on inpatient child and youth health, drug and alcohol rehabilitation and medical and surgical nursing. Crawford is director of the School of Nursing, Health and Wellness at Te Kura Matatini (Western Institute of Technology) in Taranaki.

Our treasurer, Debra Coates, has expertise in fields such as paediatric intensive care, neonates and special care baby unit, paediatric surgery, public health nursing and leadership. She is a senior lecturer at Toi Ohomai Institute of Technology in the Bay of Plenty and also completing a doctor of health science at Auckland University of Technology (AUT).

Southern District Health Board nurse consultant Lorraine Ritchie is a gerontology researcher and professional practice fellow for postgraduate nursing studies at the University of Otago.

AUT nursing lecturer and gerontology researcher Priya Saravanakumar has substantial experience in nursing education, research and leadership.

Otago Polytechnic nursing lecturer Rachel Sayers is an experienced clinical researcher interested in paediatric nursing.

Ara Institute of Canterbury senior nursing lecturer Kylie Short has extensive experience in nursing practice and education is currently reading for her PhD.

Kathryn Tenant, who has held several clinical and leadership roles in the United Kingdom, is currently clinical nurse specialist (research) at Waitemata DHB.

Te Roopu NRS is supported by NZNO professional nursing and competency advisor Wendy Blair.

If you are passionate about your specialty and want to further your evidence-based practice, joining NRS will open up opportunities to engage in research and professional development.

Our bi-monthly newsletter *SNIPS Bulletin* shares valuable information on current events and research relevant to our membership.

This year, our forum, *Promoting change into the future,* is about nursing research, review and inquiry.

It is being held on December 3 in Tāmaki Makaurau (Auckland). Further details can be found here: www.nzno.org.nz/groups/colleges_sections/sections/nursing_research_section/conferences_events.

Ngā mihi nui ki a koutou. Te Roopu NRS welcomes you to our whānau. We look forward to meeting with you kanohi ki te kanohi in December.

Ka kite anō au i a koutou. Kia pai te rā. •

Report by Lorraine Ritchie

Offer on the table for DHB members, other sectors await voting outcome

As the countdown begins for the ratification vote on the DHB MECA, other industrial sectors come to grips with COVID-19.

DHB members led by kaiwhakahaere Kerri Nuku and vice president Tracey Morgan.

Negotiations have kicked off for Te Omanga Hospice, and the group of four hospices in multi-employer contract agreement (MECA) bargaining.

They were part of work underway in the private hospital and hospice sector over the past month.

All hospice negotiations would seek gains including a registered nurse step 7, and a senior registered nurse scale such as that in the district health board (DHB) MECA.

Ongoing private hospital negotiations included those with Evolution, which operates Bowen, Wakefield, and Royston hospitals, and also with Braemar Hospital in Hamilton.

Meanwhile, NZNO staff were called to offer ongoing advice across the primary health care sector (PHC) for emerging COVID-19-related issues as the nation grappled with the latest outbreak.

It came as the negotiating dates for the PHC MECA were set for October 18 and 19.

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

With the prison health service's collective agreement offer rejected by NZNO members, negotiations were set to resume once Corrections Association of New Zealand, and Public Service Association members' ratification was completed. This was delayed by COVID-19.

NZNO is seeking a joint meeting with Health Minister Andrew Little.

Health Minister Andrew Little.

The NZNO team was working with the Department of Corrections on the COVID-19 Risk Assessment process, with cases spreading south of the Auckland border.

COVID-19 was also impacting on bargaining in the aged care sector across the operator chains.

Bargaining started with BUPA, in a combined online and face-to-face format.

Meanwhile bargaining was postponed with Oceania – pending alert level announcements for Auckland. The team was considering moving the process fully online if Auckland remained in lockdown.

Negotiations with Radius followed a similar path, awaiting alert level announcements for Auckland.

Ongoing DHB MECA negotiations saw a new offer put to members. The Employment Relations Authority offer would go out for a member vote from October 8 to October 15.

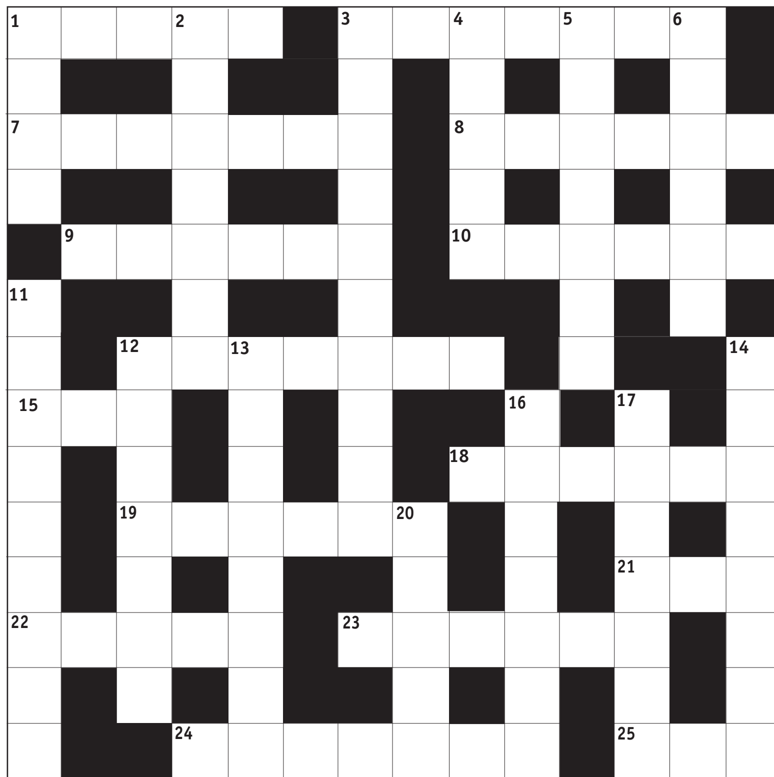
It was the latest step in long running negotiations taking place in the lead up to a major overhaul of the health system, and pay equity negotiations.

The outcome of the DHB bargaining would have flow-on effects in other sectors, such as NZ Blood Services, with a collective agreement expiring on December 10.

Once the DHB bargaining was resolved, a timeline could be set for the blood service bargaining. •

crossWORD

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



ACROSS
1) COVID-19 variant.
3) Medication that stimulates immune response.
7) Naval rank.
8) Soak up.
9) End working career.
10) Bogan haircut.
12) Secluded.
15) Keeps hair in place.
18) Nearly.
19) Frightened.
21) Cooking vessel.
22) Slides downhill on snow.
23) Brags.
24) Written on front of envelope.
25) Male child.

DOWN
1) Deceased.
2) Social media platform.
3) Easily damaged.
4) The power to please others.
5) Hormone which regulates blood-glucose.
6) Gained money through work.
11) NZNO industrial staff member.
12) Some shops have banned these bags.
13) Deaf people are "hearing ______".
14) Spontaneous genetic change.
16) Spectacles.
17) Dead bodies.
20) Small flying tool with propellors.

September answers. ACROSS: 1. Muesli. 3. Foe. 6. Jaw. 7. Mesothelioma. 9. Rind. 12. Coma. 13. Goddess. 17. Wahine. 18. Rice. 19. Curl. 20. Neglect. 22. Red. 24. Tank. 25. Asbestos. **DOWN:** 1. Memory. 2. Easy. 3. Friend. 4. Awe. 5. Depression. 6. Jargon. 8. Timid. 9. Rind. 10. Cancer. 11. Cos. 14. Hedge. 15. Urgent. 16. Decade. 17. Walrus. 21. Tāne. 23. Doe.

whakataukī/wiseWORDS

“*Unuhia te rito o te harakeke, kei hea te kōmako e kō?*
Ui mai ki ahau, ‘He aha te mea nui o te ao?’
Māku e kī atu, ‘He tangata, he tangata, he tangata.’

If you pluck the heart from the flaxbush,
where will the bellbird find rest?
If you were to ask me, ‘What is the most important thing in the world?’
I would reply, ‘It is people, it is people, it is people.’ ”

it’s cool to kōrero

HAERE MAI and welcome to the October kōrero column. A karakia was traditionally a ritual chant, recited to invoke spiritual guidance and protection. It could be used in relation to any aspect of life, from major events through to everyday activities.

In modern times, it also means a Christian-style prayer, grace or blessing. The purpose can be to give thanks, gather strength for a task, and to increase spiritual goodwill.

Kupu hou

New word

- **Karakia** – *pronounced "kah-rrrah-key-ah"*
- **I te timatanga o ta tātou mahi, i karakia tātou.**
We said a karakia at the start of our shift.

Rerenga kupu

Phrases

With the country at varying levels of lockdown, here's some te reo to use for hui ā-ipurangi (online meetings):

- **Kei konei tātou katoa?**
Are we all here?
- **Kia timata tātou.**
Let's start.
- **Tukuna mai te tono hui.**
Send me the meeting invite.
- **Whakakā i tō ataata.**
Turn on your video.
- **Whakapiki i te tangi.**
Turn up the volume.
- **Kua raru taku hononga.**
My connection is bad.
- **Kua ngū tō reo.**
You're on mute.

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).

Classified advertising

Events

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

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

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

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Part- or full-time role for our youth community alcohol and other drug service

- Competitive, market-range salary
- 5 weeks' annual leave
- Training and upskilling opportunities
- Personal work vehicle
- Service development component
- Mon-Fri working hours (hours negotiable)

We want:
a motivated and innovative health professional to join our team providing support for rangatahi with mild-to-moderate mental health issues and co-existing alcohol drug-related issues. You will be passionate about providing a meaningful and supportive environment for each individual taiohi to reduce barriers, empowering and promoting rangatiratanga.

You will:
support our Wellington-based rangatahi in their journeys, walking alongside both mental health and addiction experiences. This includes AOD and mental health assessment. Providing sound clinical support to the wider team and advising on risk and care management is also key, as is liaison with secondary services and other external stakeholders to ensure best care for our youth.

You will demonstrate:
effective time-management and prioritisation skills and excellent communication, networking and relationship-building expertise.

You will have:
a current practising certificate (Mental Health Nurse, Social Worker, Psychologist, Psychotherapist, Occupational Therapist, DAPAANZ Addictions Practitioner or NZAC Counsellor).

Our youth service provides mental health support and alcohol and other drug support, with a variety of talk therapy options for groups or individuals. We also mentor rangatahi to set and achieve their goals.

Pact is a growing NGO which already employs a number of registered health professionals in various settings. This is an exciting opportunity for a progressive clinician to join the Pact team and make a real impact in the community.

To apply for this role, go to: https://pact.elmotalent.co.nz/careers/pact/job/view/221 and for more role-specific information, contact Pact Clinical Lead Coordinator Aimee Kaulave on 027 217 3276 or aimee.kaulave@pactgroup.co.nz.

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- Nurse Lead, Central Auck, 32-40 hrs/week, fantastic practice culture and great benefits. Work with a small team of experienced nurses and make this role your own. Must have previous leadership experience

Email: careers@procare.co.nz or contact Jess Heron on 027 303 6546 for a confidential, no obligations chat.

Millie
Ara graduate

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Are the Health & Safety reps in your organisation properly trained to face health and safety challenges such as Covid-19 and unsafe staffing levels?

Did you know:

- WorksafeReps is **your** health and safety training provider.
- WorksafeReps is owned and operated by the Workers' Education Trust and **NZNO is a founding member Union of the Trust**
- If you are a health & safety rep, you have the right under the Health & Safety at Work Act to **choose your own H&S training provider** (in consultation with your employer)
- Health and Safety reps trained to unit standard 29315 may issue **Provisional Improvement Notices (PINs)** to their employers to resolve any serious H&S concerns in the workplace.

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- WorksafeReps operate across New Zealand
- WorksafeReps can train on site in your workplace
- WorksafeReps deliver training online, by Zoom or Teams and face-to-face (in the main centres)

To book a course or for more information: www.worksafereps.co.nz 0800 336 966

Who are we?

WorksafeReps is owned and operated by the Workers' Education Trust (including NZNO), a New Zealand non-profit charitable trust, to provide education courses in health and safety at work.

Directory

Have you changed your address, workplace, name or phone number? Please let NZNO know of any such changes so our records are accurate and you receive *Kai Tiaki Nursing New Zealand* and other important NZNO information. It doesn't cost anything to let NZNO know — just ring 0800-28-38-48 or fax 04 494 6370 or 0800 466 877, anytime, day or night. Post the information to NZNO membership, PO Box 2128, Wellington or email: membership@nzno.org.nz

NATIONAL OFFICE

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email: nurses@nzno.org.nz.

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Julie Governor, Odette Shaw (organisers). The Strand, Suite 1, Cameron St,
PO Box 1387, Whangarei 0140. fax (09) 430 3110, Freephone 0800 28 38 48.

AUCKLAND
Donna Simpson (team leader), Christina Couling (lead organiser), Carol Brown, Christine Gallagher, Fuaao Seve, Sarah Barker, Craig Muir, Donna MacRae, Sharleen Rapoto, Phil Marshall, Sunny Sehgal, Justine Sachs, Lewis Wheatley (organisers), David Wait (industrial adviser), Kate Weston (acting manager, nursing and professional services), Angela Clark, Catherine Montgomery, Catherine Leigh (professional nursing advisers), Sue Gasquoine (researcher/nursing policy adviser), Param Jegatheeson (lawyer), Katy Watabe (campaigns adviser), Daisy Ganjia, Celia Compain, Jenny Terry, Candy Smith (regional administrators).
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fax (09) 360 3898, Freephone 0800 28 38 48.

HAMILTON
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TAURANGA
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PALMERSTON NORTH/WHANGANUI/TARANAKI/HAWKES BAY
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).
Ground Floor, 328 Church Street, PO Box 1642, Palmerston North 4410.
fax (06) 355 5486, Freephone 0800 28 38 48.

WELLINGTON/WAIRARAPA
Jo Coffey, Laura Thomas, 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
Shannyn Hunter (organiser), 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.

CHRISTCHURCH
Danielle Davies (industrial adviser/organiser), Lynley Mulrine (lead organiser), John Miller, Helen Kissell, Lynda Boyd, Stephanie Duncan, Terri Essex, Ron Angel (organisers), Chris Wilson (industrial adviser), Julia Anderson, Marg Bigsby (professional nursing advisers), Jinny Willis (principal researcher), Kiri Rademacher (lawyer), Christine Hickey (employment lawyer), Maree Jones (CCDM co-ordinator).
17 Washington Way, PO Box 4102, Christchurch 8011.
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