Kai Tiaki
NURSING NEW ZEALAND
November 2021
VOL 27 NO 10


# Aged care focus

Page 2, 5, 14


## The ethics of vaccination

Page 17-25

## When COVID first hit Paris…

Page 12


## MECA settled, members united

Page 6, 10

# Directory

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THIS MONTH we look at challenges facing nurses in the under-pressure aged care sector: Sometimes a love of working with the elderly simply isn't enough. We share the story of Mahina Adams, a Māori-Frenchwoman and RN who worked through the first wave of COVID-19 in Paris. And we take a deep dive into the intricacies of the COVID-19 vaccination mandate, fighting misinformation, and convincing colleagues to get jabbed.

*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.



# This issue . . .



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**Photo: Aloha Sison.**
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# To care and be cared for

By Ruth Abad (left) and Natalie Seymour

Over the past 12 years working as an aged care registered nurse (RN) in New Zealand, I, Ruth Abad, have seen a vast change in the profession.

My colleagues, too, often talk about a time when they looked after residents who only needed minimal help. Seldom did you need two or three staff to help a resident with a task. There was time to sit down, have a conversation over cups of tea and biscuits and to just be present with residents. You could take your breaks on time, do your notes and be home to enjoy time with family.

Fast-forward to today. Along with the uncertainties of COVID-19, we are seeing more complex residents come through the doors. Often they have multiple diagnoses and varied complications. They have to be checked regularly and monitored closely. As a result, facilities nowadays often need higher staffing and training levels.

It has always been a challenge for aged residential care (ARC) facilities to be fully staffed. The stigma of ARC being too challenging, with little financial reward, does not attract a lot of interest from nurses. Retaining trained staff – always a challenge – is sadly now a battle, day after day. Many friends who are nurses and health-care workers do not stay long in this field. They turn up worried they will be working with no support, and whether they will be able to provide the care residents require.

Many go home feeling deflated, worn out and dissatisfied. More and more are cutting down their hours for their own wellbeing – with some leaving for good. And again, we are back to the problem of staff shortages.

Increasing resident complexities against poor staffing ratios can magnify existing problems. Errors and poor patient care are more likely when staff are overworked, stressed and burned out.

Our work demands physical energy, but also holistic care. Residents missing out leads to patient dissatisfaction, medical complications and complaints.

But we cannot give from an empty cup. We need others to stand with us and help us get our voices heard, so we can continue serving.

**We need others to stand with us and help us get our voices heard, so we can continue serving.**

Plenty of managers are supporting our fight for safe staffing and resident safety. One is Natalie Seymour, a beacon of strong leadership and a nurse and patient advocate. This is her statement on the crisis:

*Nursing over the past few decades has become increasingly complex and challenging. Staffing shortages have been known about but not addressed adequately until the pandemic, when they were thrust front and centre.*

*In aged care particularly, these shortages – with significantly increased patient/resident acuity – result in increased fatigue, fear of making errors and nurses dropping hours or leaving the workforce entirely.*

*New Zealand has been heavily reliant on our international colleagues to provide us with the nursing workforce that we haven't been able to grow ourselves. While this provides us with experts and experience outside of New Zealand knowledge and cultures, our borders closing has created a significant shortfall.*

*Aged and other primary care sectors are finding it difficult to recruit, retain and encourage people to return to nursing, with the significant variance between pay scales.*

*Many smaller, independent providers cannot match district health board pay rates. So they become innovative, using incentives such as supported education with guaranteed release time or supporting internationally-qualified nurses to complete competency assessment programmes.*

*There is an ongoing struggle to balance inadequate staffing against increasingly high and complex needs. Ensuring the mental and emotional wellbeing of staff cannot be pushed aside.*

*Although nursing in ARC can be a challenge, at the end of the day, it is the vulnerable older person who suffers if we don't try. And, even if it can be daunting and frustrating, I cannot see myself doing anything else – because the rewards from looking after our most precious treasures are significant and humbling.* •

*See page 5 & 14*

**Ruth Abad, RN, BN, PGDip(gerontology)** is clinical nurse educator at Nurse Maude Hospital, Christchurch.
**Natalie Seymour, RN, BN, PGDip(gerontology), PGCert HSc(mental health)** is hospital services manager at Nurse Maude Hospital, Christchurch and chair of NZNO's College of Gerontology Nursing.

# Tell us what you think

## Biculturalism not for all?

I APPRECIATED Joel Maxwell's editorial about change (October, *Kai Tiaki Nursing NZ*) but there was one word he used that concerned me, "all with a genuine commitment to biculturalism".

In my role as practice nurse, I have cared for people of many cultures.

People from as diverse countries as Ukraine, the United Kingdom, Europe, India, Asia, the Americas, Africa, South Africa, Middle East, Pasifika. New Zealanders are certainly made up of more than two cultures.

I would hope that *Kai Tiaki* would be committed to our diverse community.

Shirin Peters RN
*Auckland*

**Co-editors respond**: *Shirin Peters, many thanks for your work as a nurse, and your correspondence on biculturalism.*

*We at* Kai Tiaki Nursing NZ *agree that people of all ethnicities and nationalities, not to mention gender and sexualities have a right to the excellent services of our health professionals. Clearly biculturalism and multiculturalism are not mutually exclusive. The first recognises the special relationship between our modern nation's founding cultures, co-signatories of our founding document,* te Tiriti/the Treaty of Waitangi.

*Multiculturalism celebrates the wonderful diversity* – ngā hapori kanorau *(diverse communities) – of this modern nation.*

*If anything, the concepts support, not diminish each other.*

*Please note that NZNO's* Code of Ethics *and co-governance structure strive to embody,* whakatinana, *biculturalism. All our members benefit from the collective's work.*

### 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.

*A look at our page 8 story covering new health reform legislation shows the future bicultural direction for our system and our nurses.*

*To value and support Māori, and honour our founding document is a benefit for all, not a burden on the many.*

## Changes 'discriminate'

IT WAS disappointing to read in the editorial by Joel Maxwell in *Kai Tiaki Nursing New Zealand*, October 2021, that the paper magazine will cease.

I am a retired, multi-skilled nurse with over 30 years' experience, and continue to enjoy reading the paper *Kai Tiaki* editions.

I like to keep up with current research and information concerning nursing and health, Nursing Council voting, plus upcoming education and conferences available and being informed of nursing reunions.

I personally find this format is more relaxing than digital methods.

Unfortunately, my computer and digital technology are not ergonomically positioned and therefore have an adverse effect in my back, neck and arms, because I seem to be tense and hunched over. Additionally I am not digitally competent.

I feel saddened and discriminated against, with the digital magazine decision.

I will treasure the last remaining paper editions of *Kai Tiaki* magazines for the rest of the year.

Shirley Blackie (retired nurse)
*Wellington*

**Co-editors' respond**: *Shirley Blackie, thanks for your letter. We do hope we can keep your readership as we go fully digital in the new year.* Kai Tiaki Nursing NZ *will continue to run those research, educational and professional development articles you enjoy.*

*Plus we hope to provide a more rapid and up-to-date service with feature stories and news covering the health and nursing world.*

*Look out for our December edition where we will include an article about making the jump to the digital world, for those who are less technologically confident – including advice on setting up your computer so you can browse without back, neck and shoulder problems.*

## NZNO members asked to keep address up to date

NZNO HAS asked members to keep their membership record up to date. They are asked to advise of any change of address, email, contact phone number or workplace.

To do this they can call in on 0800 28 38 48 (option 2), log in to the members' area on the NZNO website, or email membership@nzno.org.nz

## Byline omission

NUSING RESEARCH Section committee member Priya Saravanakumar co-authored October's article *Nursing Research Section supports nurses' growth* (p40) alongside Lorraine Ritchie. The co-editors apologise for the omission last month.

# The president comments:

By Anne Daniels

*"A beginning is the time for taking the most delicate care that the balances are correct. This every sister of the Bene Gesserit knows."* - Manual of Muad'Dib by the Princess Irulan. (Dune).[1]

Relationships underpin all that we do and have done in nursing. NZNO's centennial celebration included the publication of a book, *Freed to Care, Proud to Nurse*, which identified the benefits of developing and maintaining positive relationships with government, employers, education providers and the Nursing Council, to enable the growing professionalism of nursing from the very early 1900s to the late 1980s[2].

However, relationships change and are not always mutually beneficial.

Over the years, tension between professionalism and unionism grew.

Continued expectation of nurses' sacrifice, reflected in inequitable nurse's renumeration, was at the heart of this tension.

In 1973, the first nurses' union formed but had no appetite for real industrial action until the late 1980s, when the "*gendered nature of nursing and the related disadvantage in the fight for decent conditions and pay was finally acknowledged in the pay equity campaign*".[3]

It took 20 more years before this year's district health board pay win, underpinned by the relationships built up through a different way of working. It was focused and largely member-led, supported by a phenomenal NZNO staff and member negotiating team, and many hours of discussion and debate.

This successful, ground up, approach has been done before.

Recently I was lucky enough to watch a documentary on the 12-week delegate-led strike in Kinleith, Waikato, in 1980.[4]

What struck me most is that they talked to each other, over many cups of tea, in a community hall, where they worked voluntarily together as they focused on achieving their common goal – pay equity. No-one was excluded. Respect grew through openness, collaboration, opportunities for reflection and growth, strengthening relationships and practising vulnerability.[5]

**I have been spending that time building, rebuilding and maintaining relationships. It is something we must all do.**

Many challenges are before us. We must prioritise. We must focus on a few things we can do well and get them done.

For example, throughout our NZNO history, our relationship with Māori members has been largely invisible and often silenced due to our continued acceptance of our assimilated Eurocentric social mores.

An organisational NZNO infrastructure, along with its inherent processes that reflects this history, must be challenged, to embed te Tiriti o Waitangi, eliminate inequity, and institutional racism.[6,7]

Further, inequity between public and private nurses' pay and conditions must go.[8,9] Safe staffing for all, must be mandated.[10,11,12]

Internationally qualified nurses, who make up nearly 30 per cent of our membership, suffer separation from families, due to inequitable immigration policies.[13,] This must be made visible and eliminated. The right to family life is recognised internationally as a human right.[14]

We need to build stronger, mutually beneficial relationships with stakeholders involved in these issues to achieve our priorities. We must be at the table to talk over a cup of tea.

I have been in this job for just a few weeks, and I have been spending that time building, rebuilding and maintaining relationships. It is something we must all do.

We have an opportunity at the beginning of our constitutional review to take delicate care to talk to each other and listen, so that in today's world of change and challenge, we become the change we want to see in NZNO, and in our nursing world.

*Ehara tāku toa i te toa takitahi, engari he toa takitini, takimano* – Strength comes not from ourselves alone but from the support of thousands. •

*References p40*

# Aged care nurses 'backbone' of system – Little

NZNO'S AGED care nurses are quitting, exhausted from working double shifts and long hours due to an estimated 1000-strong nursing shortfall nationally, says an NZNO aged care nurse leader, also thinking of leaving.

But Minister of Health Andrew Little says aged care nurses are "the backbone" of the system and he is committed to pay parity once the pay equity claim is settled later this month.

Natalie Seymour

Andrew Little

Chair of the College of Gerontology Nursing Natalie Seymour said she was "100 per cent reconsidering" staying in aged care nursing, after working up to 70 hours a week for the past few weeks, filling night shifts on top of her day work.

The New Zealand Aged Care Association (NZACA) estimates the shortage has grown to 1000 full-time nurses - 20 per cent of the workforce.

"I can't keep working the hours that I am doing, it is placing me at risk of becoming one of the statistics – nurse leaving the workforce due to fatigue and burn out," Seymour said.

"I am not alone in this and there are many facilities which are doing the same thing," Seymour said. Both she, a registered nurse and hospital service manager, and her clinical nurse manager had been juggling night shifts on top of their day shifts, snatching sleep in between shifts.

Seymour said all nurses should be treated equally, no matter their sector – yet aged care nurses were paid an average of $10,000 less than those in district health boards, according to the NZACA. "We are all nurses and should all be treated equally regardless of what sector we are working in," Seymour said. "I will always stand with my team and advocate for them, but it is bigger than one person and something needs to change."

COVID-19 had stopped the flow of internationally-qualified nurses (IQNs) who comprised up to 70 per cent of aged care staff, according to the NZACA. This had led to more shortages and stress on remaining staff, Seymour said.

Current work would help in the long-term, but urgent action was needed now, she said.

Little said the Government was committed to pay parity between nurses working for DHBs and other parts of the publicly funded health sector, including aged care facilities.

"Nurses working in aged-care residential centres are the backbone of our health system and this Government is committed to paying them fairly."

However, the Government first needed to settle the pay equity claim by DHB nurses, due this month. "That is what will make a real difference to the wages of nurses right across the country," he said. Negotiations were "well under way, and I look forward seeing nurses being paid what they're worth, no matter who they work for", Little said."The health system and the people who work in it have been under pressure for a long time, working long hours with not enough people, and having to deal with more and more patients" he said. "They have held the health system together, but they can't keep doing it forever."

NZNO organiser Laura Thomas said even passionate staff were leaving. "The reason they start leaving is that it's just so hard to do a decent job with less staff. People who actually really care about the residents are just finding it too difficult to keep it up."

NZNO industrial advisor aged care Lesley Harry has said a fragmented sector with low union density made it hard to attain collective agreement. Safe staffing was as important as pay parity, she said.

NZNO-E Tū's joint petition on aged care safe staffing can be signed here www.parliament.nz/en/petitions/sign/PET_116136. •

Christchurch Nurse Maude Hospital's aide team

# 'This is what unions are about' – long battle with DHBs ends


**NZNO DHB members march in central Wellington in June's strike.**

IN OCTOBER NZNO district health board (DHB) members voted by 83 per cent to accept the latest offer in multi-employer collective agreement (MECA) negotiations.

The vote drew the highest turnout of the negotiations with 69 per cent of eligible members having their say.

Members voted on the Employment Relations Authority-crafted offer, following mediation between NZNO and DHBs.

NZNO lead advocate and industrial adviser David Wait said after a long 15 months, he was happy the offer had been accepted so resoundingly.

"This is really what unions are about – active members coming together to further each others' interests. And what we have determined we are going to continue to do, is have our members as our leaders in our work."

It was the third offer put to members for ratification since bargaining began early in 2020. "It's been almost two years of my life," said Wait, who was appointed to lead the negotiations in the wake of a divided 2018 MECA campaign. A review by former Council of Trade Unions' president Ross Wilson recommended a more member-led approach this time around, as well as a reconciliation process to rebuild trust within NZNO.

Wait said he always tried to keep members at the heart of the process. Each ballot showed members were unified, particularly around the key issue of safe staffing.

Wait said most of the pay increases came in down payments on an upcoming pay equity settlement: a separate process due for completion by the end of November.

Registered nurse (RN) Chris Hay said she would have preferred more money but after long-running bargaining she was "over it".

But she said she voted 'yes' because she did not think they could get any better at this point.

RN Deb Hendry said at this stage she had just wanted a resolution, so voted yes. The latest offer was indeed an improvement on the previous one, and she did not want the negotiations "dragging on" further.

Safe staffing measures were key to the latest accepted offer. Wait said how DHBs responded over the next year would play a major role in the next collective agreement negotiations.

NZNO College of Critical Care Nurses chair Tania Mitchell said she was not surprised by the turnout and strong ratification as there was a "more positive" feeling about the offer, "from a staffing point of view, as well as remuneration.

It would be "interesting" to see how the safe staffing elements worked for specialist nursing roles such as critical care, which could not easily be filled – particularly with the inexorably growing number of COVID-19 cases in the community. Many nurses felt intimidated and overwhelmed by filling in at ICUs.

"From a critical care point of view, it's an area that requires specialist skills, experience and knowledge," Mitchell said. "We know already it's an area that it's hard to redeploy staff to, because other nurses don't have the knowledge and skills required for the role."

The ratified MECA applied to the period August 1, 2020 to October 31, 2022. NZNO would initiate bargaining late next year. •

*See p10 for David Wait's inside story on the DHB bargaining.*

# No nurse left behind: Cabinet expands vaccine mandate from original groups

NZNO IS calling for a programme of COVID-19 booster shots for frontline workers who face waning protection.

The call comes as the Government's vaccine mandate now kicks in for all nurses in Aotearoa.

NZNO industrial services manager Glenda Alexander said the first vaccinations were delivered more than six months ago.

People may now have waning immunity, she said.

"They're still much better protected than the unvaccinated, but recent infections among presumably vaccinated health workers confirms that this is a significant health and safety issue – and one for which we could reduce risk."

Alexander said NZNO supported the Government's "robust" approach to nationwide vaccination, and wanted all its members vaccinated.

She said current frontline staff faced COVID-19 "every day" while at work, with an ongoing need for protection.

"Frontline workers should be prioritised. We also want to see vulnerable populations prioritised."

Meanwhile the NZ Nursing Council said in a public statement that the health order covering mandated vaccination now included all practising nurses.

NZNO industrial services manager Glenda Alexander.

The original mandate announcement only covered nurses working with at-risk patients.

Cabinet then decided that all regulated health practitioners, no matter where they work, should be covered by the order.

## Changes include all

The change now included nurses who did not physically interact with patients, such as those in telehealth, working in non-clinical roles such as nursing research and education, policy and professional advice, or management.

The order applied to nurses working in the public health system, a for-profit company, or a charity or other non-government organisation. It also applied to the self-employed.

## Dates set for vaccination

Nurses had till November 15 to get their first shot, and January 1, 2022 to receive their second.

The council said it strongly recommended every nurse get vaccinated, unless there were clear health reasons not to.

Non-compliance with the vaccination mandate by a nurse could lead to a complaint or referral of a conviction to the council.

This would be investigated in the same way as any other complaints or convictions. •

*See p17-25 for our vaccination and fighting misinformation section.*

# High Court overturns MOH decision on Māori vaccination data

THE WHĀNAU Ora commissioning agency has won a judgement in the High Court in Auckland to gain individual information on unvaccinated North Island Māori.

In October chief executive John Tamihere took the Ministry of Health (MOH) to court to gain the data to target unvaccinated Māori.

The judicial review found the MOH was wrong to withhold the information and should drop its original decision.

It had three working days to correctly apply the law and "retake" the decision in accordance with te Tiriti and its principles.

In a media release, Whānau Ora said all New Zealanders knew "we should have been given access to vaccinate Māori from the get go".

Māori vaccination rates have consistently lagged rates for other ethnicities, and the overall population. Whānau Ora said it would not be able to meet the 90 per cent uptake by Christmas that other communities had been "blessed to achieve because they had no obstacles placed in their way". •

# Health reforms offer 'one-system culture'

Minister of Health Andrew Little has touted equity, a focus on te Tiriti, and a nationwide "one-system culture" as highlights of legislation underpinning a health sector shakeup.

In an online health sector briefing in October, the minister outlined health reform legislation, *Pae Ora (Healthy Futures)* as it was introduced to Parliament.

Little said communities such as Māori and Pasifika were missing out on services "to quite a considerable degree".

"We are now trying to create a system that means we can seriously address the gaps that have arisen."

Achieving "greater equity" was an essential objective of the changes.

It would fix the growing inconsistency between different regions of the country as well, he said.

The current 20 district health boards (DHBs) would be replaced with a single entity, Health New Zealand (HNZ).

A separate Māori Health Authority (MHA) would be set up, with a budget and powers to commission services "relevant to Māori".

Both were launched with interim boards.

Little said $46 million was set aside to develop "locality planning". Each locality in the new HNZ system would be a "natural concentration of population", he said. The likes of the local existing health services, community representation, and iwi Māori partnership boards would identify its health needs.

That would form the basis of a "health plan" that would help set funding for that locality, he said.

An initial $127m was allocated for the MHA to develop kaupapa Māori health services.

**Associate Health Minister (Māori health) Peeni Henare says the Māori Health Authority is a work in progress. (File)**

"I just wanted to affirm the importance that we attached to the Crown as a Treaty partner, properly fulfilling its obligations under the Treaty, and to seriously address the disproportionately poor health outcomes for Māori."

Little said this disparity could be seen in areas such as the COVID-19 vaccination rollout.

"It's really shone a light on some of the system problems we have."

**Health minister Andrew Little.**

He said it was important that the reforms provide a "one-system culture" around Aotearoa. There would be a common set of expectations for people working in the system.

Meanwhile, HNZ would take on all employees, assets and liabilities of the current DHBs. "So nothing will change relating to those terms and conditions," Little said.

Also speaking at the briefing, Associate Health Minister Ayesha Verrall said COVID-19 had shown the importance of expert public health advice.

A new public health agency would be set up within the Ministry of Health, to provide leadership on issues such as "strategy, policy, intelligence and surveillance".

The bill strengthened the role of the director of public health, she said. An expert advisory committee would be created to provide independent advice to ministers on public health matters.

Associate Health Minister (Māori health) Peeni Henare said the Government did not include detailed functions and powers of the boards of the new entities in the bill.

"Instead the board of the new interim Māori Health Authority will work with the iwi Māori partnership boards to further define their role, functions and powers."

Henare said he expected the Government would make additions to the bill early next year reflecting the interim board's engagement work. •

# Pakeho: More Māori nurses needed

**More kaupapa Māori wards and Māori nurses, less red tape and paper work, says returning tumu whakarae.**

By co-editor Joel Maxwell

Tumu whakarae Titihuia Pakeho, returning after standing unopposed in September's election, has warned that nurses are at risk of becoming overrun by red tape and paper work.

Pakeho is a registered nurse at Tauranga Hospital in the nation's only kaupapa ward, and is a supporter of Māori health and the Māori health workforce.

Speaking about the challenges facing nurses in Aotearoa in the new term, she said the weight of too much policy-making meant nurses had more paperwork and less time to care for patients.

She said nurse training needed to include more hands-on experience in hospitals, from the very first year of study.

"Too many nurses are coming out with a lot of new research and knowledge which is great, but they don't have the hands-on experience and they don't have communications skills to build a rapport with patients."

This lack of hands-on training also meant fresh graduates did not yet have the holistic approach needed for patients – "especially the Māori health model of wairua, hinengaro, tinana, whānau". A greater understanding of Māoritanga was needed, she said.

## Not enough Māori nurses

Pakeho joins kaiwhakahaere Kerri Nuku – also returning unopposed - as the leaders of Te Poari, part of NZNO's bicultural co-governance.

Tumu whakarae Titihuia Pakeho.

Pakeho said looking ahead, there were not enough Māori nurses yet, to nurture a strong Māori workforce "that can lead us into the future".

**'Racism is a huge part of the political health scene, which intimidates many of our Māori registered nurses. 'It is a harsh process to adhere to at times, which does not coincide with Māori whakaaro.'**

"We have many student nurses who are coming through which is great but that takes time to get them to where they want to or should be."

Pakeho said more kaupapa wards were needed around Aotearoa - not just one in the entire country.

"Then our Māori nurses will have a supportive environment to work alongside other Māori nurses."

She said she had spoken to an elderly European man once, who said Māori nurses cared differently to Pākehā nurses.

Māori nurses, she said, cared with manaakitanga, wairuatanga and aroha. However not all non-Māori nurses cared using these important concepts.

"Racism is a huge part of the political health scene which intimidates many of our Māori registered nurses.

"It is a harsh process to adhere to at times, which does not coincide with Māori whakaaro (ways of thinking)."

Other risks for NZNO included the potential departure of members once the district health board bargaining was completed (the latest offer was ratified in October).

However, Pakeho said it appeared many members, happy with operations and governance within NZNO, would remain.

"Working together as a board will be a challenge as there needs to be trust amongst leadership due to history of a previous partnership."

Pakeho said there were exciting changes ahead with the health reforms which would be in place by this time next year. The reforms would include a Māori Health Authority able to commission its own services.

The interim body has been given $127 million to develop kaupapa Māori services.

"The fact that Māori will have a right to be heard and to articulate what is good for Māori under this new health structure…has been coming for some time." •

# Together we are stronger – reflections on the DHB MECA campaign

By David Wait

We started this campaign with a clear intent that member leadership and unity would be key to our success. We finished this campaign united, strong, and with members standing together for themselves, their patients and the professions.

Planning for the campaign started in late 2019, with a series of meetings to hear how delegates wanted to see the campaign run. From those meetings and the recommendations that came out of the review of the previous multi-employer collective agreement (MECA) campaign we designed our campaign.


Starting as we meant to go on, we kicked off with delegate-run claims meetings, where delegates led discussions with members about what we should focus on for this MECA. Part way through, these were interrupted by the first COVID-19 lockdowns, and we supplemented the delegate meetings with an online claims survey.

Delegates from the bargaining team in July 2020

**There were three key issues: sick leave when we needed it; pay that valued our work and DHBs being accountable for unsafe staffing situations.**

With our claims prepared and bargaining team endorsed by members, we took 63 claims into negotiations. There were three key issues: sick leave when we needed it; pay that valued our work and DHBs being accountable for unsafe staffing situations. Matters came to a head when members reacted strongly to the DHB offer in March, with the vast majority indicating that they would reject this offer if it was presented for ratification.

Delegates ran a series of member meetings in early May to discuss our next steps and members subsequently voted overwhelmingly for strike action. Although members had become increasingly engaged in the campaign, the strike was the moment when we all pulled together with a unity of purpose.

Ahead of the strike more members came forward and were elected as delegates. Existing senior delegates took leadership roles in life-preserving services (LPS) negotiations alongside NZNO staff – particularly our organisers, many of whom worked a great deal of additional hours to keep things on track, while also preparing for strike day.

Behind the scenes, Glenda Alexander, manager of industrial services and Kate Weston, acting professional services manager, held the line on the agreements we would make around LPS. These ultimately resulted


in a legal victory for NZNO when the DHBs challenged our views.

The strike was an opportunity to show our strength and determination to resolve our staffing and pay claims. Members walked off the job together, marched together, picketed together. The public rallied behind our cause and the extensive media coverage was universally supportive. It was clear that we were a force to be reckoned with and the pressure this brought to the negotiations provided new impetus to reach an agreement.

By the end of the campaign we had progressed through mediation, further strike ballots and, finally, facilitated bargaining with the Employment Relations Authority.

When members voted to accept the offer in October, they did it the same way they had in every other vote during the campaign – with a strong majority in favour of the outcome and with a high participation rate. Members voted positively to accept the offer.

While we didn't get everything we claimed and there is work to be done, we made sound progress on the important matters of pay and safe staffing. Significant pay increases came through advances on our pay equity claim, a good portion of which will be applied to base rates.

**It was clear that we were a force to be reckoned with and the pressure this brought to the negotiations provided new impetus to reach an agreement.**

Through this agreement we help rebuild our nursing and midwifery workforce, with DHBs now required to offer permanent employment to new graduates, and to immediately establish and start recruiting to positions identified as needed through the safe staffing programme care capacity demand management (CCDM).

In terms of safe staffing, we now have a legally binding pathway where DHBs will be forced to address staffing shortages whenever they put patients at risk.

Our work now, is to use these new rights to force change upon a health system which has too often put the welfare of staff behind considerations of budgets and targets.

This will be no easy task, our journey towards safe staffing predates our first MECA and is an issue that nursing unions all over the world continue to struggle with. The new tools sit alongside and support our safe staffing programme. Our intention is to create an environment where members can utilise these tools, and delegates can enforce them.

As we look to the future there is much to be optimistic about. A whole new group of workplace leaders have emerged and delegates have grown in stature and confidence. Members have become accustomed to quick and open communication, to being involved and having a voice. Next year will see a massive reorganisation of the health system, bringing opportunities for improvement, but also potential risk. We will meet this challenge united and stronger together. •

*NZNO industrial adviser for the DHB sector David Wait was lead advocate during the MECA negotiations.*

**Delegates from the Auckland region meet in 2019 to discuss how our campaign should be run.**

# 'I'm proud to be a nurse': Mahina Ad

**It was her first week in her final clinical placement in a Paris hospital when Mahina Adams was told COVID-19 was on its way.**

Mahina Adams, the French-Māori registered nurse who experienced working in the first waves of COVID-19 in Paris. (Ir

In Aotearoa, the true nature of the COVID-19 pandemic has yet to run head-on against the true nature of nursing.

Nurses are supposed to save people, says Mahina Adams.

But when an entire system is swamped by illness, there is only the unbending, unyielding pressure of numbers: The number of patients, versus the number of health-care professionals; the number of beds and respirators; ages, oxygen levels.

In the end, it is the memory of the hardest decisions, the numbers, that brings Adams to tears, forces her to stop and gather herself again.

Adams, a Māori-Frenchwoman, and registered nurse, spoke to *Kai Tiaki Nursing NZ* about her experiences in the French hospital system at the first peak of the global pandemic.

She spoke as the Delta variant forced rapid public health changes in Aotearoa; a switch from elimination to a reliance on a 90 per cent vaccination rate as the borders eventually reopen, and alert levels give way to a new traffic light system.

The changes come amidst ominous warnings about a health system already near capacity.

Adams, 23, said while she was born and grew up in France, she was currently in New Zealand with her Māori father, but would return home, to France.

She became a nurse after caring for her grandfather; Adams also saw her cousin – a nurse – as a role model. "I was, like, 'I want to become like you, and look after people'."

## Starting young in nursing

She was 18 when she started her first clinical placement, which in the French system came four months into her nursing degree.

Patients in the Paris hospital were sometimes surprised by her age, but the nursing staff was supportive.

Many people in France might ask about her ethnicity – and were often delighted to find out her heritage.

In France, they loved New Zealand, she said. Most of her friends wanted to come to Aotearoa.

It seemed a safe place to many around the world. Adams has started to learn about her Māori culture too.

"I'm proud to be Māori."

One week into her last clinical placement, a five-month hospital stint in her final year, she was pulled aside by her head nurse and warned something was about to happen.

It was March, 2020, she was training in an emergency department (ED), and COVID-19 had arrived in France. The first patients, she was told, were arriving.

She spent two weeks in the ED before she was shifted to the intensive care unit (ICU), which was "busy, busy, busy".

Adams spoke carefully about what happened in the French system next. It's hard, she said, to find the words.

# ams on first COVID-19 wave in Paris

mage: Nick Tapp)

And she simply did not want to scare New Zealand nurses.

But it was "terrible".

ICU nurses ended up looking after up to three to four patients at any time as the virus spread quickly through the community.

Before COVID-19, most of the ICU patients were post-operative from the likes of cardiovascular surgery or transplantation. Soon the hospital was full of COVID-19 patients; it only had about 26 ICU beds.

With no space in ICU, patients would be placed on oxygen in general wards. If they worsened, and if there was a bed, and if they met criteria, including being under 70, then they might make it into ICU.

Many of the patients died. A make-shift freezer was set up in front of the hospital to take the bodies.

"In France, everybody knows someone who had COVID, or died of COVID … but last year was very hard. Especially in ICU. We are supposed to save people."

Her advice to people working in the health sector was to stick together.

"Stay close to each other," she said. In France, one of the few good things to come out of COVID-19 was that it united nurses, doctors, and health-care assistants into a single team.

The mistakes and experiences of the health systems in places like Europe could be helpful in New Zealand, which had largely been able to avoid widespread community cases, she said.

**'It's not only old people, that's not true at all … we took care of a co-worker …I took care of two doctors. Nobody is safe.'**

Nurses in Aotearoa must now get vaccinated against COVID-19. There were some in the profession who opposed a vaccination mandate.

In the community, vaccination rates for Māori remained behind the overall population.

This came after repeated warnings from Māori experts that the rollout would not be equitable.

Adams said she had seen bitter disputes over vaccination in France. But she hoped her experiences might help inform nurses in New Zealand.

"I'm only 23 but with covid I've got a lot of experience, unfortunately.

"I think my little voice can help nurses in New Zealand to really understand what's happened over there."

Adams, vaccinated since March, said she wasn't here to change the minds of people on the issue herself, or force people to change – but maybe with more information they might see a different perspective.

She said she did her own careful research before getting vaccinated.

"For me as a nurse, the main thing is taking care of patients, and for that I have to be in good health."

She understood many people might be reluctant to get the vaccine, but there was solid research available to help decide.

Adams said many people thought their own good health would protect them against COVID-19.

But the disease "chooses us", not the reverse.

She had seen patients her own age who were previously in good health, in ICU with COVID-19.

"It's not only old people, that's not true at all … we took care of a co-worker …I took care of two doctors. Nobody is safe."

The experience was hard, some nurses simply quit because of the pain. Some burned out, she said. But most carried on. As for Adams, the experience made her feel like she genuinely was a nurse.

Despite launching her career amidst some of the toughest challenges facing health care professionals, Adams plans to return to France and return to nursing as well.

"Because I'm proud to be a nurse.

"It's my voice, my way, and it just gave me more confidence." •

# A daughter's view from the inside

By co-editor Mary Longmore

Earlier this year, NZNO delegate and registered nurse Jean Al-Daghestani quit the Lower Hutt aged care facility she has worked in as coordinator for the past six years for a community nursing role.

"I can't do that big job anymore, it takes an emotional toll," she tells *Kai Tiaki Nursing New Zealand*. "My life was aged care for 11 years, but I had to leave."

Her departure was closely followed by another nurse leader at the facility's hospital, who left for a district health board role.

Similar stories are occurring throughout rest homes in Aotearoa. The New Zealand Aged Care Association estimates a shortfall of about 1000 fulltime nursing roles in aged residential care nationally – 20 per cent of the entire aged care nursing workforce.

For Al-Daghestani, it's life-changing to now be in a role which is safely staffed every day – yet she was sad to walk away from a sector she loved. "It's people like me, who they should be looking after [in aged care]."

For her, it had become increasingly difficult to ensure staff and patient safety, and the team was constantly understaffed. "That's on your mind, even after you've left, knowing they're two or three short, and you know that some people could fall or something bad can happen", said Al-Daghestani, who fronted NZNO's safe staffing campaign. "You think 'if only you had that staff member, to prevent that'."

When a resident is at the end of their lives, staff rarely had time to provide the emotional support they wanted, she said. "The pastoral support you need to give when someone is passing away and you have to run away and give care to two others [passing away] on the floor – it's not easy."

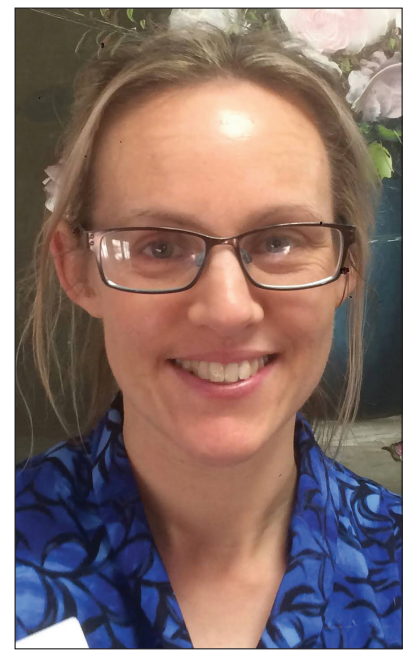
The relentlessness she describes as an "emotional drain. Staff members come to see you, showing the strain, but you can't do anything to help. [Sometimes] I can stay for another hour, but I have to get home to my family".

Aged care needed a particular calibre of person. The work is "physically and emotionally gruelling", made more so by unsafe staffing.

"You can't just pick anyone, you have to have the right person." Yet with an average pay rate of $10,000 less per annum than district health board nurses, aged care felt like "poor cousins".

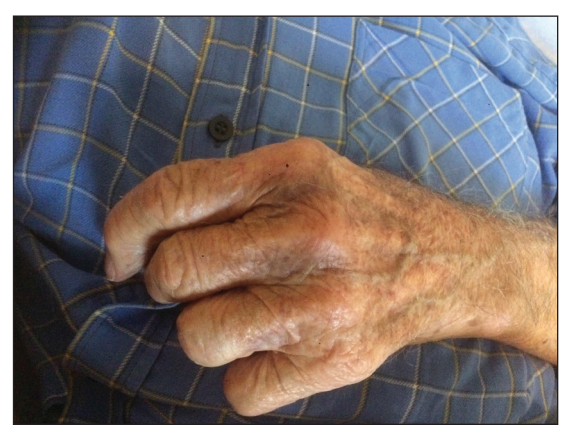
"If we had [safe] ratios, all the workers would feel safer at work every day. We have good and bad days and the bad days make you feel a bit sad. It wears you down, emotionally, you get really tired and you can't give back what you wanted."

Despite this, some nurses were committed to the work. "A lot of nurses stay in aged care because they're passionate about the care of old people and bringing joy to them each day… they go around hugging residents, who just want that physical contact."



Jean Al-Daghestani

Leaving to work in a safely staffed environment has been a "weight off my shoulders", she says. "I feel like you can give safe and competent care every day – I didn't feel that before." •



# – aged care

## ‘My life was aged care for 11 years but I had to leave’

NZNO delegates in aged care Atele Pepa and Jean Al-Daghestani at a safe staffing rally last year. Al-Daghestani has now left aged care.

In July, I witnessed the relentless nature of the 24/7 work, while spending several nights in the same Lower Hutt facility where my father was dying. Poised on a recliner, I was on high alert as he tossed and moaned restlessly after a massive stroke. I got to know a caregiver, recently arrived from northern India, who would somehow always arrive within seconds of Dad trying repeatedly to get out of bed through the night in confusion, setting off the mat alarm. This young man would patiently and gently help him to the bathroom or back into bed, reassuring him throughout with chit chat and a kind touch.

**Ken Longmore**

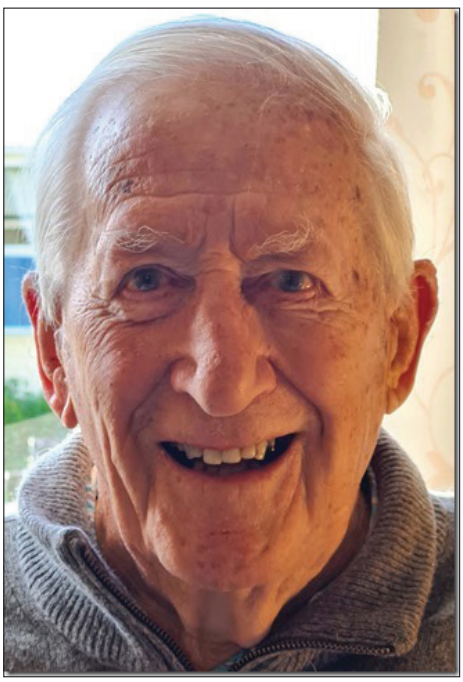


PHOTO BY PIPPA DE COURT SCENE STEALER

My father, a tough 103-year-old war veteran – unable to conceive he could no longer walk independently – would allow himself to be guided by this young man back to safety.

A new alarm would soon sound – another resident up, at risk of falling – and he would swiftly leave to head off the next discombobulated wanderer, in a twilight where nights and days merge into one. From 11pm to 7am, he and the night nurse seemed to flit almost non-stop from room to room as shadowy figures rise and totter on the rubberised mats, setting off a never-ending chorus of alerts.

At 5am, he’d be back as Dad attempted to rise from his bed for the dozenth time, ready for the day. “This is when he gets up,” he tells me, seating and shaving my father, who sits quietly on his walker, seemingly enjoying the ritual.

He brings a cup of tea, some toast with marmalade – Dad’s breakfast of a lifetime. But today, he only holds the tea in his mouth, as if uncertain of what to do with it.

The night nurse arrives with his pain relief. She, too, has been on duty all night but is smiling and fresh-faced, complete with lipstick.

From the Philippines, she says aged care nursing is her calling, despite the lower pay and tough hours.

This is the first time I’ve met her, although I have had several night phone calls over the years, when Dad needed to go to hospital after a fall or medical event.

Still in her 20s, she said her faith helped – she believed it was a spiritual duty to help and care for others.

The two have been responsible for about 35-40 residents in the rest home over the eight-hour shift, a vampire night where nobody seems to sleep for long.

By 7am, the morning staff are arriving and the nurse and caregiver getting ready to go home. She is writing up notes, for handover, tells me she normally will try to sleep later in the morning after her kids have gone to school.

He tells me he would like to train as a nurse, but cannot afford it. He talks about his family back home near Kashmir; his sister nursing in Australia.

Making a coffee, I see him walking out into the car park. He looks exhausted. •

# New health doctorate caters to working professionals

The University of Canterbury has created a new doctoral degree specifically designed for working professionals with a background in health. This exciting qualification provides an opportunity to evaluate an area of health that you are passionate about. It could include evaluating health innovations and initiatives designed to reduce disparities in health outcomes, generating evidence for improved practice and service delivery, or conducting research into population health needs.

The Doctor of Health Sciences (DHSc) will have the first intake of students in February 2022. The first two years of study are designed around a cohort model, where students will progress through the programme together while focusing on their individual research topics. The DHSc caters to those employed in the health sector by offering a part-time study workload and is ideal for those interested in conducting research into an aspect of their professional practice.

Associate Professor Cathy Andrew, the programme's designer, says that she hopes the DHSc will provide the opportunity for more professionals to study toward a doctoral level qualification.

"We've thought really hard about how we can best support people who are in employment through a doctoral degree. The cohort model allows us to support the students through areas related to their study, such as a literature review or methodology, at a pace that is manageable for them."

**Associate Professor Cathy Andrew** pictured with **UC graduate Suli Tuitaupe** (Master of Health Sciences Professional Practice (Nursing)) at the pop-up Covid-19 Vaccination Clinic held on the University of Canterbury campus in October.

Associate Professor Andrew believes the DHSc is likely to be popular with professionals in the health industry. "People who work in health are passionate about making a positive difference. Some of those people will want to pursue a topic for their study that will make meaningful change and positively affect people's lives. This programme is a perfect opportunity to do that."

During the first two years, DHSc students attend two 1–2 day workshops per year. These workshops provide students with opportunities to present their proposed study, receive formative feedback and engage with academic leaders and peers to discuss key research-related topics. This will prepare them for their doctoral thesis which will commence in Year 3.

For more information about the DHSc see https://www.canterbury.ac.nz/health/brochures/postgraduate-brochures/DHSc-infosheet-WEB.pdf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MAI I TE IHO KI TE PAE

# ‘You can’t know what you would decide’

**Nurse practitioner Jackie Robinson is a voice for nurses on the SCENZ – support and consultation for end of life in New Zealand – group overseeing the End of Life Care Act which came into effect November 7. By Mary Longmore.**

For palliative care nurse practitioner Jackie Robinson (right), a nurse’s personal view on assisted dying isn’t relevant – it is their professional duty of care to ensure patients can make their own choice.

“Ultimately, it doesn’t matter if I agree with assisted dying. . . What is important is whatever we are offering as a society in New Zealand is that it’s safe, it’s equitable and it’s available to all,” Robinson said. “The choice people make at the end of their life is entirely up to the people who are in that situation.”

The polarised debate – Hospice New Zealand has stated that assisted dying has no place in palliative care – “doesn’t help the people who need the services”, says Robinson. She has 25 years’ experience in palliative care and is a senior lecturer at the University of Auckland. For her, assisted dying is part of palliative care, not an alternative.

She says it’s important to have a strong nursing voice at the SCENZ table. “Over the years, when there has been debate about euthanasia or assisted dying in various countries around the world, it has been very much a medically dominated topic. Even some of the language that’s used – medically assisted dying – suggests it’s a medical process and I don’t think the language that’s used around it acknowledges the huge contribution that nursing has to make in all different parts of the process. . .”

Nurses often had more consistent and lengthier relationships with people and whānau, compared to the more “episodic” interactions of doctors, giving them a deeper understanding of people’s lives and needs. Nurses were trained to be “much more person-centred rather than disease-centred”, which meant they were uniquely placed to support the assisted dying process, Robinson said.

And – with more frequent patient contact and conversations – nurses should be prepared for questions. “I wouldn’t be surprised if nurses are the ones going to be asked about it,” Robinson said. “Our job is to be as informed as possible about the Act, as professionals, and support patients and show them where they can get information.”

The Ministry of Health website had a wealth of resources on the EOLCA, she said.

## Nurses ‘a little bit forgotten’

While the Act had been amended to include nurse practitioners (NPs) as health practitioners able to administer the life-ending medication, barriers remained, with the NP role “a little bit forgotten” in the legislation.

NPs were unable to initiate the process, currently. That meant if a patient raised the possibility of assisted dying with an NP, that NP would have to refer to a medical practitioner – who may not know the patient as the NP did – but had to have that initial conversation, Robinson said. This legislative “omission” would likely be addressed by Nurse Practitioners New Zealand in time, and could affect patients in aged care, communities and remote or rural areas. “But that’s what we have got and we need to work with it.”

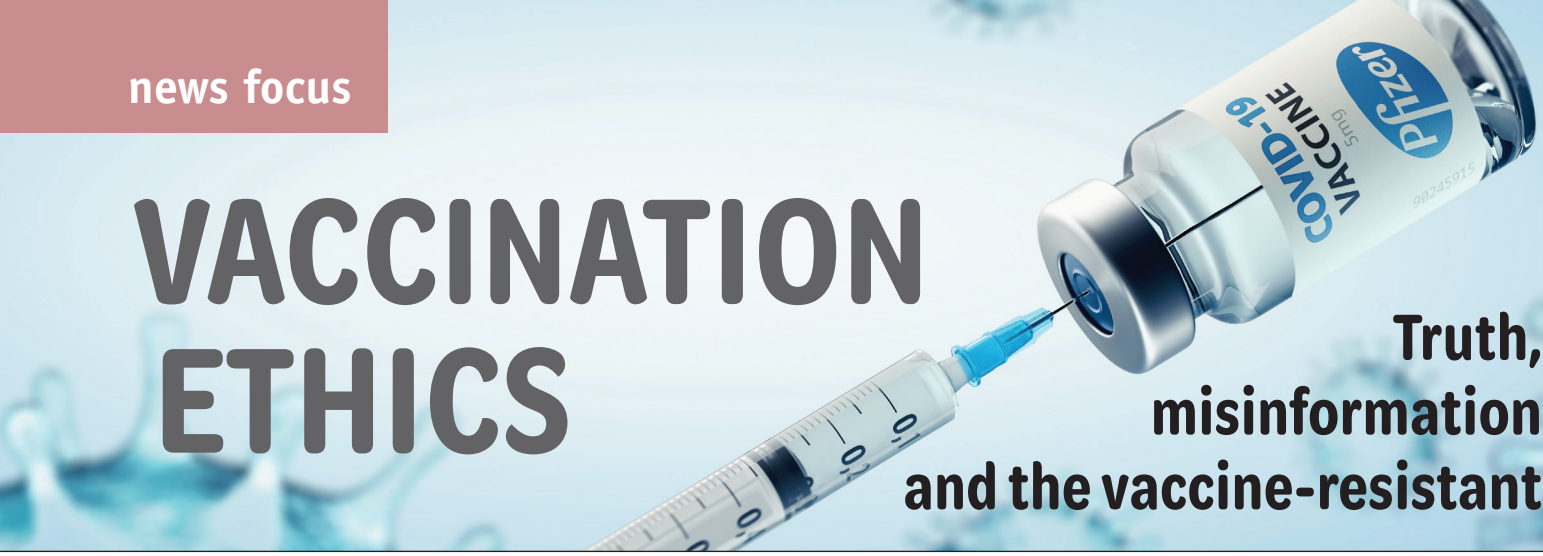
Amid a global medication shortage, NPNZ was also working to resolve barriers to NPs prescribing life-ending medications. Some replacements supplied under section 29 of the Medicines Act, required ministerial consent, and NPs were not permitted to prescribe them.

In her SCENZ role, Robinson had highlighted that for many people in Aotearoa, the NP might be their primary provider, not always a medical practitioner, and this was increasingly becoming the case. “So we need to make sure that NPs are enabled by legislation to be able to provide equitable care, so that people aren’t disadvantaged by the fact an NP happens to be their primary provider.”

As a result, Robinson had ensured NPs were part of the SCENZ register of health professionals willing to provide end of life care. “You can’t know what you would decide until you’re there yourself – we don’t know what we would choose. It’s up to the people to decide.” •

# VACCINATION ETHICS

## Truth, misinformation and the vaccine-resistant




**The Government has mandated that health workers must be vaccinated against COVID-19. Over the following nine pages, we look at why nurses and others remain vaccine-resistant, what rights workers have under such mandates and what the ethics might be for nurses and nursing students on vaccination during a pandemic.**

# Why would nurses resist vaccination?

### Even health professionals are susceptible to COVID-19 misinformation. But why?

By co-editor Joel Maxwell

Pockets of resistance to vaccination within nursing could be the result of mistrust built up against the male-dominated and hierarchal world of medicine, researcher Kate Hannah says.

Hannah spoke to *Kai Tiaki Nursing New Zealand* about viral misinformation as the Government launched COVID-19 vaccine mandates for almost all health professionals.

Hannah, principal investigator with research group Te Pūnaha Matatini, and project lead in The Disinformation Project, said a "large number" of New Zealanders believed in at least one or two pieces of misleading or false information.

All nurses must receive their first vaccine dose by November 15; and be fully vaccinated by January 1. Some nurses oppose the mandate, despite being health-care professionals themselves.

Hannah said vaccine scepticism, or a cautious response to the COVID-19 mandate within nursing was not necessarily surprising when examined through a gender lens.

The mostly female nursing workforce was forced to navigate a complex male-dominated medical hierarchy, she said.

"A lot of nurses probably have quite complex relationships with their own profession, with the system that they're part of and what that means."

Thus, she said, it made sense that some nurses who were otherwise dedicated, caring and skilled, were uncertain about vaccination in general, and specifically the Pfizer vaccine.

There was a belief that people who were better educated or had more media literacy could better withstand misinformation, Hannah said.

"But we actually know, to be honest, the smarter you think you are, the more likely you are to come to a set of cognitive biases, where you started [by thinking] 'you're right', so therefore you are right."

People then sought only evidence that backed up their initial beliefs, she said.

"There's a high likelihood there's a little bit of that going on, alongside . . . these lived experiences of a complex set of interrelationships . . ."

Jagadish Thaker, senior lecturer in journalism and marketing at Massey University, said both the virus and misinformation can be fought with inoculation.

"One of the interesting research ideas that has emerged and applied during this pandemic is the idea of inoculation against misinformation," he said. Exposure to weakened misinformation can help trigger "antibodies" so people can prevent infection, or spreading misinformation, when exposed to a much more persuasive misinformation piece.

"That is, knowing and experiencing the persuasive strategies of misinformation groups can pre-emptively help


us identify such misinformation."

It might seem people without higher education were most vulnerable to misinformation – but it wasn't necessarily the case.

"Research in areas of science and health communication indicate that sometimes, our group identities – such as our political identity – takes over and even highly educated individuals can believe and spread misinformation, such as denying climate change or the need and effectiveness of COVID-19 vaccine."

When it came to the COVID-19 pandemic, it appeared both the young and middle-aged harboured vaccine fears, he said.

More research was needed on why and how people in the health sector, "who pledge to do no harm", were against getting a vaccine, Thaker said. "The better we understand their concerns, the better we can channelise information that they need."

For some, getting a vaccine was as simple as getting a prescription from a trusted doctor. "But for some of us, it is a more complex decision-making process – we have trust issues, concerns about long-term safety, and the need to get a vaccine."

Kate Hannah

Jagadish Thaker

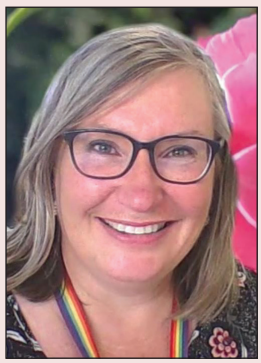
Even before the vaccine mandate for health professionals was announced in October, the Nursing Council strongly recommended vaccination.

In July, it took a strong stance against anti-vaccination information in a media release.

While it "respected" nurses' right to their own opinion, there was no place for anti-vaccination messages in professional health practice, it said. "Nor any promotion of anti-vaccination claims including on social media and advertising by health practitioners." •

# Conversations with colleagues…

**Ministry of Health workforce welfare lead with the COVID-19 vaccine and immunisation programme, Rachel Prebble, offers advice for tough conversations looming with colleagues.**



Rachel Prebble

COVID-19 HAS brought our personal and work selves together more than ever before. The vaccination mandate for health workers has created potential divisions between health professionals. How can we have respectful conversations with colleagues when there are differing views about vaccination?

Keep in mind we all want to keep our friends, whānau, colleagues and patients safe. A great starting point is to seek to understand different perspectives. As health professionals, we all comply with a wide range of health and safety and patient safety actions – what is it that makes this vaccination different?

This is a hard time for people who truly believe not getting vaccinated is the right thing to do. Let them know you value them as a member of the team and hope that they will choose to vaccinate so you can continue to work together.

People are most open to learning and change when they are calm, safe and trust the person talking to them. Ask the person who they would trust to talk to about their concerns.

Misinformation often relies on creating strong emotions – fear, anxiety or outrage to fuel the anti-vaccination movement. Be the antidote to that by creating a safe space for exploration and reflection.

It can be really frustrating to see and hear misinformation online or from a friend or colleague. Resist the temptation to argue to win the argument. Not only will it be less likely to be helpful but may affect your relationship and your own mental wellbeing.

You can't change another person's mind for them, only they can. Be kind, be respectful, offer to help by creating opportunities to access robust information – it may be just the nudge they need. •

Sources of information on COVID-19:

- https://covid19.govt.nz/covid-19-vaccines/get-the-facts-about-covid-19-vaccination/
- https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-vaccines/covid-19-vaccine-information-health-professionals
- https://karawhiua.nz/

# Mandatory vaccinations & workers' rights

By NZNO employment lawyer Christine Hickey

In October, the Government announced it would require all workers in the health and disability sector to be fully vaccinated against COVID-19 by January 1, 2022, as part of its public health response to COVID-19.

All registered health professionals under the Health Practitioners Competence Assurance Act (2003) must have their first dose of the Pfizer vaccine by November 15, along with non-regulated workers across the sector, from aged and community care to kaupapa Māori and Pacific providers.

For those working in prisons, the deadlines are earlier – November 6 for the first dose, and December 8 for the second.

A compulsory vaccination order simply means it has been deemed essential for particular roles – not that a person can be forcibly vaccinated.

NZNO supports this approach,[1] as does the Nursing Council.[2] Most health workers are already vaccinated and this order will provide reassurance and certainty to health-care workers, patients and the vulnerable in our communities.

Failing to follow the order could result in disciplinary proceedings.

The Nursing Council states: *Complying with relevant legislation is part of both the Council's code of conduct, and the competencies for each scope of practice. Failing to observe this order if it applies to you may therefore be grounds for a formal complaint, and lead to disciplinary proceedings under the Health Practitioners Competence Assurance Act 2003.*[3]

## Exemptions

The new requirement is likely to be along similar lines to the current vaccination order for border workers, including health-care workers in MIQ facilities.[4] That provides an exemption for those with a medical reason documented in writing by a health practitioner (including nurse practitioners but not registered or enrolled nurses) who has examined them. However, those who cannot have the Pfizer vaccine for medical reasons may be able to have another COVID-19 vaccination when they become available.

Employers cannot discriminate against a worker because of a disability. There is protection under the Human Rights Act (1993) on that basis. An inability to be vaccinated for medical reasons could be seen to be a disability. However, there are limits on an employer's obligation to make special accommodation for an employee's disability.

**Employers must always be able to justify a dismissal, act fairly and reasonably and conduct any process in good faith.**

Some employees may have religious reasons for not wanting to be vaccinated. There is protection under the Human Rights Act from discrimination over religious belief. Objective and verifiable proof of that religious belief, and how it prevents you being vaccinated, would likely have to be provided.

An employer would have to make reasonable accommodation for a person who refused vaccination for this reason. However, if there was no reasonable availability of redeployment or if an employee intended to advise others not to be vaccinated because of their personal religious belief, continued employment may not be possible.

## Bill of Rights Act

The New Zealand Bill of Rights Act (1990) also provides certain rights to us all, including the right to refuse to undergo medical treatment. A COVID-19 vaccine is a medical treatment. The right to refuse medical treatment, at its most literal, means you cannot be treated against your will. Such a right does not mean that you could not be moved to another area of work or justifiably dismissed, in certain circumstances, if you decline to be vaccinated.

It is important to know that Parliament can pass legislation that limits some of the rights granted under the Bill of Rights Act, so long as that limitation is reasonable and can be demonstrably justified in a free and democratic society.

There is a legal argument saying that a vaccination order could be a reasonable limitation that is demonstrably justified in the circumstances of the global pandemic and the interests of public health. NZNO considers that argument to be a relatively strong one. However, our courts have not yet made a decision on whether the COVID-19 vaccination order is a reasonable limitation.

So far there has only been one case in Aotearoa, New Zealand, of a worker being dismissed for failing to be vaccinated without a medical exemption. That employee was a maritime border worker and did not tell her employer why she would not be vaccinated. She took her case to the Employment Relations Authority, which found she was not unjustifiably dismissed.

VACCINATION ETHICS

PHOTO: SOUTH SEAS HEALTHCARE


**Nurse Sharon Sinia-Anae with essential worker Salesio Matautia at the Pacific locality COVID-19 Vaccination Centre in Otara, South Auckland. All registered health professionals must now be vaccinated by December 1.**

## Employer vs employee rights

An employer can ask you if you are vaccinated against COVID-19, as a part of carrying out a risk assessment and risk management programme, or their responsibility to ensure their workforce is vaccinated. If you decide to answer, your answer must be accurate.

Employees have the right not to disclose their vaccination status. However, the employer can assume the worker is unvaccinated and take measures to mitigate risks for that employee and others.

Generally, employers are not entitled to access information from your health records, including the COVID-19 immunisation register, without your specific consent. However, since the 2021 Delta outbreak, the Ministry of Health has given permission to some district health boards to get vaccination status information directly from the register. That is likely to continue to be the case once the mandatory health workforce vaccination order comes into force.

## Can I be dismissed if I am unvaccinated?

NZNO considers that all health employees who do not get vaccinated, and are not exempt for medical reasons, potentially run the risk of losing their jobs.

The risk is even greater for workers specified under the mandatory vaccination order/s.

NZNO will work with employers and affected workers to ensure that those who cannot be vaccinated because of a verified health exemption, or choose not to be vaccinated for other reasons, are offered reasonable information about vaccination and their options.

We will work to ensure you are offered redeployment oportunities, if possible, to roles that have not been identified as vaccine-essential. That could include a change of your role, hours of work, or location.

However, it may be that if employees decline vaccination, and cannot be redeployed, employment in the existing role or with that employer is no longer possible or appropriate.

Each case will need to be assessed on its own facts in deciding whether there are viable options to remain employed or whether termination of employment could be justifiable.

## Reasonable process

In addition, employers must still undertake a reasonable process when engaging with unvaccinated employees, encouraging those employees to be vaccinated, and when deciding on what consequences may flow from an employee not being vaccinated.

Employers must always be able to justify a dismissal, act fairly and reasonably and conduct any process in good faith.

A dismissal for a failure or refusal to be vaccinated is not necessarily an "at fault" dismissal because the requirements of the role have changed.

Therefore, disciplinary meetings, warnings and other similar processes may not be appropriate. Meetings to discuss the issues for individual workers, with their union's support, and employers clearly setting their requirements with reasonable timeframes are likely to be part of a fair process.

However, NZNO strongly encourages you to be vaccinated if you can. •

**References**

1) New Zealand Nurses Organisation. (2021). *COVID-19 (mate korona) Vaccinations.* (Position Statement). www.nzno.org.nz/resources/nzno_publications#5_229

2) Te Kaunihera Tapuhi o Aotearoa Nursing Council of New Zealand. (2021). Guidance statement: *COVID-19 vaccine and your professional responsibility.* www.nursingcouncil.org.nz/Public/News_Media/NCNZ/News-section/news-item/2021/5/Guidance_statement_COVID-19_vaccine_and_your_professional_responsibility.aspx.

3) Te Kaunihera Tapuhi o Aotearoa Nursing Council of New Zealand. (2021). *Mandatory vaccination order for nurses.* www.nursingcouncil.org.nz/NCNZ/News-section/news-item/2021/10 Mandatory_Vaccination_Order_for_Nurses.

4) COVID-19 Public Health Response (Vaccinations) Order 2021. www.legislation.govt.nz/regulation/public/2021/0094/latest/LMS487853.html.

# Rights are balanced by responsibilities

**Two nursing academics ponder why some nurses are resistant to having the COVID-19 vaccine.**

By Margaret Hughes and Karen Edgecombe

We have wondered for many months now about why there is resistance among nurses to being vaccinated against COVID-19, and why some nurses spread misinformation about the vaccine.

While we acknowledge there are genuine reasons why some nurses may not be able to be vaccinated, we are deeply concerned about nurses spreading fear and anxiety in the public, and on social media.

While trying to make sense of the reasons why some nurses are vaccine-hesitant, we came across a presentation by Dr Mike Lee on Radio New Zealand (University of Auckland) that explored some of the reasons why people may be vaccine hesitant.[1] His innovative theory has been incorporated here in an attempt to understand why this might occur within our own profession.

Lee believes people who are hesitant to accept a range of health decisions generally fall into four main categories:

- **Philosophical differences**: There are people who have a different philosophy on life. There may be religious objections to accepting the vaccine, or cultural obligations that some must adhere to that others are not constrained by.
- **A reluctance to be told what to do**: People generally do not like being told what to do. However, not following the advice of the scientific community and choosing to believe unsubstantiated online posts and conspiracy theories seems dangerous, not just to yourself but to your patients.
- **The need to weigh up the risks and benefits**: People tend to weigh up the risks and benefits of any choice they are trying to make. Weighing up the positives and negatives is a sensible thing to do when making decisions related to your health. This decision-making process could go something like this:

*"I might not get COVID-19 because others are being vaccinated, and anyway only older people are getting sick so why risk having a vaccine?"*

This is balanced alongside thoughts such as:

*"The vaccine might make me magnetised, cause seizures or infertility, or provide the government with a tracking device."*

This line of thinking, while biologically impossible, might work for some, who will inevitably have to rely on others in the community to get vaccinated. But it is a risky gamble for a nurse employed in the health sector, who is coming into contact with people who may themselves not be vaccinated.

- **Uncertainty about the safety or effectiveness of the vaccine**: People who pass on misinformation about the vaccine feed into uncertainty, promote hesitancy and place people's lives at risk. This is no longer about personal choice when others are influenced by your ideas.

Any one of these theories puts the nurse at high risk of contracting the virus, taking up intensive care unit (ICU) or hospital space and requiring ventilatory support. This has been seen in the trends both nationally and internationally for unvaccinated people. Worse still, they may pass the virus on to vulnerable others.

The nursing profession has an obligation to provide safe care to the public, uphold ethical codes and professional standards for practice and maintain a sound body of knowledge.[2,3,4,5] The theories behind why people are hesitant to be vaccinated

**Nurses must gather information from reputable evidence-based sources.**


presented above do not explain why nurses choose to share misinformation about the vaccine.

The Government has now mandated the vaccine for high-risk workers in the health and disability sector and school and early learning staff.[6] This is supported by the Tertiary Advisory Services (TAS) report released in September 2021 that stipulates that all pre-registration health discipline students who are not fully vaccinated will not have access to DHB clinical placements.[7]

**This is no longer a rights or personal freedom issue; it is about the safety of the community.**

The nursing profession is also very clear. The Nursing Council issued a guidance statement specifically related to the vaccine that clearly sets out the required professional responsibilities of nurses.

> *"The Nursing Council strongly recommends that all practising nurses take up the opportunity to be vaccinated – unless medically contraindicated. You have an ethical and professional obligation to protect and promote the health of patients and the public, and to participate in community health efforts".*[8]

In an open letter to the people of New Zealand, numerous signatories including frontline nurses, nurse leaders, nurse educators and vaccinators illustrated their support for all eligible people to be vaccinated against COVID-19.[9] These are examples of reputable, reliable sources of evidence-based information.

## Dispel uncertainty

You do not have to be a statistician to look at numbers that could help dispel the uncertainty. According to the Ministry of Health,[10] as at October 21, 2021, there were:

- 6.3 per cent of people who contracted the virus requiring hospitalisation, including ICU admissions (5315 known cases resulted in 336 hospitalisations).
- 0.05 per cent of COVID-19 cases in New Zealand led to deaths related to exposure to the virus (of the 5315 covid cases, there have been 28 deaths).
- Only 24,142 non-serious and 929 serious events (or "side effects") directly related to the vaccine have been reported. This is a very small proportion of the 5,321,863 doses administered to date – 0.47 per cent. It is important to note that one person can experience a number of "events".[10] That is, events do not equal the number of people. Also noteworthy is that the minor events are very minor, especially when compared to the possible health outcomes of an uncontrolled COVID-19 virus, such as long covid or death.

## Vulnerable people

While we are fortunate to live in a country that guarantees our rights through the New Zealand Bill of Rights Act 1990,[11] there is another side to having rights, and that is the requirement to take responsibility. This is especially important for nurses, who care for vulnerable people. For nurses, this includes not only personal responsibility but responsibility to the profession and the community, and not disregarding or overriding other people's rights.

Doctors are increasingly being investigated for misconduct by the Medical Council when found to be sharing misinformation.[12] There are also professional consequences from the Nursing Council, under the Health Practitioners Competence Assurance Act 2003, for nurses who do the same.[8] This is no longer a rights or personal freedom issue; it is about the safety of the community.

## Challenge for nurses

The challenge for nurses trying to educate themselves, to do the right thing and to access the correct information, is to gather information from reputable, evidence-based sources. That does not include social media or unsubstantiated opinion.

Until this stops, uncertainty, and the virus, are free to circulate, and unvaccinated nurses (those who could be vaccinated but refuse to be), and nurses spreading misinformation are placing others at risk. •

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**References**
1) Lee, M. (2021, October). *A marketer's insights into vaccine hesitancy*. Oral presentation for Smart Talk RNZ New Zealand.
2) New Zealand Nurses Organisation [NZNO]. (2012). *Standards of professional nursing practice.* https://www.nzno.org.nz/LinkClick.aspx?fileticket=kC5YpeNKSRk%3D&portalid=0.
3) Nursing Council of New Zealand [NCNZ]. (2012a). *Code of Conduct.* Author.
4) Nursing Council of New Zealand [NCNZ]. (2012b). *Guidelines: Professional behaviours.* Author.
5) Nursing Council of New Zealand [NCNZ]. (2012c). *Guidelines: social media and electronic communication.* Author.
6) Hipkins, C. (2021). *Mandatory vaccination for two workforces*. Ministry of Health [MOH] – Beehive press release. https://www.beehive.govt.nz/release/mandatory-vaccination-two-workforces (October 11th).
7) Tertiary Advisory Services (T.A.S.) (2021, Sept 24)). *Guidelines for Pre-Registration Health Discipline Student Placements at all DHBs.* https://tas.health.nz/assets/ER/DHB-COVID-19-Workforce-resources/Guidelines-for-Pre-Registration-Health-Discipline-Student-Placements-in-All-DHBs-COVID-140921.pdf
8) Nursing Council of New Zealand [NCNZ]. (2021, Oct 15)). *Presentation by Nursing Council New Zealand (Helen de Montalk). The Code of Conduct*.
9) Nurses of Aotearoa New Zealand supporting vaccination. (2021). *An open letter to the people of New Zealand.* https://docs.google.com/forms/d/e/1FAIpQLSdk58m6ZAmWdD3oC0lGsubpLOavLkJC_gYL7qPaiGqzSbH4cA/viewform
10) Ministry of Health [MOH]. (2021). *Covid-19: Vaccination side effects and reactions.* https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-vaccines/covid-19-vaccine-side-effects-and-reactions
11) New Zealand Bill of Rights Act 1990. https://www.legislation.govt.nz/act/public/1990/0109/latest/whole.html
12) Broughton, C. (2021). Thirteen doctors under investigation after complaints about spread of Covid-19 misinformation. *Stuff NZ.* https://www.stuff.co.nz/national/health/coronavirus/125497383/thirteen-doctors-under-investigation-after-complaints-about-spread-of-covid19-misinformation

# Mandatory vaccination – what about students?

**A nursing lecturer who has noticed vaccine hesitancy among students argues it is their duty of care.**

By Roseanne Sadd

In October, the New Zealand Government announced mandatory vaccination for health workers including volunteers and unqualified personnel in high-risk areas. While details are not yet available, it would be prudent to expect students are included.

Mandatory vaccination comes with legal ramifications: breaching the order could result in employment and/or disciplinary processes for nurses.

Regardless, the Nursing Council of New Zealand strongly recommends all nurses be vaccinated.[1]

Mandatory vaccination poses an ethical conflict between an individual's rights and a duty to protect those they care for.

For nursing students, duty of care can be applied to those they care for as well as a wider duty to public and society based on the following premises:

- Nursing students have a duty of care to protect the vulnerable.
- COVID-19 is a serious threat to public health and the vulnerable.
- Vaccination is a safe and effective way to protect against COVID-19 transmission.

Therefore, nursing students must be vaccinated against COVID-19.

## Duty of care

There is a higher expectation of duty of care for health professionals. Similarly, a nursing student has a duty of care within their education and experiential level.

Duty of care encompasses the principles of non-maleficence (minimise harm) and beneficence (to do the "most good").[2]

Duty of care requires a health professional to act in the patient's best interest and make patients their first concern.

Mandatory COVID-19 vaccination of nursing students can be justified as a duty of care to students, their patients, and the public at large.

Nursing students have a duty of care towards those they are caring for, while health-care and educational institutions have a duty of care to protect both the student and public from harm.

It is common for health profession educational programmes to require evidence of immunisation for diseases such as hepatitis B, tuberculosis, measles/mumps/rubella, varicella, diphtheria/tetanus/pertussis, and MRSA. This is currently a mandatory requirement, which, unless there are extenuating reasons, can affect the ability to place students in clinical practicums.

Nursing students are usually supernumerary in the clinical environments; therefore, health-care agencies may not provide placement for nursing students unvaccinated against COVID-19, therefore unofficial mandatory vaccination of nursing students is already in place.

It is unlikely, based on voluntary influenza vaccination statistics and intent to be vaccinated for COVID-19, that voluntary vaccination of nursing students will be sufficient to meet beneficence and non-maleficence aspects of a duty of care, especially if this encompasses a duty to society as a health professional.

Nursing students' hesitancy to be vaccinated is reportedly due to concern about the safety and efficacy of vaccines.[3,12]

Using a bioethical four principles approach of autonomy, non-maleficence, beneficence and justice, I argue that mandatory vaccination of nursing students for COVID-19 is justified as a duty of care to students, patients, and the public.[2]

**Mandatory COVID-19 vaccination of nursing students can be justified as a duty of care to students, their patients, and the public at large.**

## Autonomy

Public health measures have helped manage COVID-19, but vaccination is the only intervention showing signs of slowing the pandemic.

The World Health Organization defines mandatory vaccination policies as those which place restrictions for non-compliance rather than legal penalty.[4]

In New Zealand, mandatory vaccination of nursing students has implications for an individual's right to refuse medical treatment in defence of the "greater good".[5,6]

More than merely having self-

choice, the principle of autonomy encompasses an obligation to respect autonomy[2] and, in health care, an obligation to inform in order for individual autonomy to be respected.[5,6]

Knowledge and understanding are key to informed decision-making.[6]

For nursing students, respecting their autonomy includes being able to make knowledgeable decisions, and acting within their scope of practice.

Individuals may be hesitant to consent to vaccination due to lack of appropriate information. Inadequate or incorrect information about the vaccine and exposure to conspiracy vaccine theories add to hesitancy.[7]

Infringing on individual autonomy is unquestionably the strongest opposition to mandatory vaccination.

## Non-maleficence

Non-maleficence (do no harm, intentionally) aligns with the concept of *primum non nocere*; first, do no harm, a Latin phrase thought to be related to the Hippocratic oath. Before undertaking any intervention, the health professional should take care they will not inflict harm or at least as little harm as possible.

Nursing students move through different clinical settings, and are a risk to patients and others as a potential viral vector.

Vaccination reduces this risk. However, vaccination is an invasive procedure which does have potential risk.

To ensure non-maleficence, this risk must be evaluated to ensure it is outweighed by benefits. While early signs for COVID-19 vaccines are that they are effective for variants currently identified,[8] this may mean health professionals, including students, will need repeated vaccination or vaccination with a different vaccine in future.

The benefit to patients and the public must outweigh the increased risk of harm posed by repeated vaccination.

*Primum non nocere* supports mandatory COVID-19 vaccination of nursing students, as any harm to someone in their care that could have been prevented by vaccination is unacceptable.[9]

Nonetheless, possible harm to nursing students through loss of self-determination and possible side-effects from vaccination does exist.

The rapid development of COVID-19 vaccination means there is no data about long-term effects, including future efficacy. What is known is the significant health risk for someone contracting COVID-19, and a potential for ongoing health issues once recovered.[9]

There is precedent for mandatory vaccination for COVID-19 especially in the circumstance of no herd immunity where non-immunised individuals may pose a threat to the overall effectiveness of a vaccine to the public.[10]

The best outcome for mandatory vaccination would be to provide expert information while listening to and answering concerns. Although vaccination can be compulsory, nursing students should have full understanding and agree consent.

## Beneficence

Beneficence refers to a requirement to do good, which implies more than doing no harm; it forms an obligation to take actions which are helpful and recognised as in the patient's best interest.[2]

Does this duty constitute an obligation to be vaccinated?

To deem mandatory vaccination as ethical, there must be a high probability of benefits compared to voluntary vaccination.

Immunisation against infectious diseases has demonstrated the benefit to individuals and society, especially when herd immunity is achieved.

Areas with high uptake by health professionals of influenza vaccines have reduced the severity of influenza and influenza-like infections in long-term care facilities.[11]

Therefore it is reasonable to expect a similar high COVID-19 vaccination uptake will reduce transmission and seriousness of COVID-19 symptoms in

PHOTO: ADOBESTOCK

PHOTO: ADOBESTOCK

the most vulnerable.

Widespread vaccination for COVID-19 is expected to provide significant benefit with little individual risk. If risk to the individual is low, and benefit for the public is significant, then there is ethical justification for mandatory vaccination.

## Justice

In health care, two key concepts of justice arise – that of equitability where like persons are treated similarly, and distributive justice, referring to distribution of resources.[2,9]

Protecting the vulnerable (such as the elderly, immunocompromised and those with significant co-morbidities) is a fundamental ethical principle.

During a public health emergency such as a pandemic, societal need prevails over individual need.

COVID-19 vaccines are seen as the strongest method for reducing the seriousness of the pandemic.[7]

An obligation to be immunised against infectious disease by those who are able to may be seen by society as fair, especially for those in health care where there is a duty to reduce the risk of harm.[10]

Ethically, mandatory vaccination may reduce the liberty of an individual if that individual poses a harm to many. This can be said of mandatory vaccination for COVID-19, proportionate to the potential harm to the public.

Vaccination of nursing students helps share the burden that the disease carries. The ethical requirements for mandating COVID-19 vaccination include providing clear ethical rationale for doing so, including research findings and information campaigns,[9] justifying mandatory vaccination with full disclosure of risks, benefits, and consequences for non-vaccination. WHO have stated that ideally 95 per cent of the eligible population should be vaccinated to ensure immunisation is effective and protect vulnerable people for whom vaccination is contraindicated.[4]

Health professionals, including students, are a priority group in reaching this goal.

## Conclusion

Nursing students have a duty of care to uphold and promote public health if they do not place themselves in undue danger.

An ethical obligation to put patients first includes taking precautions to protect those being cared for, especially vulnerable people, when a potential of harm and a known prevention exist.

For educators of nursing students there is a duty of care to ensure students are not unduly exposed to risk.

There is a rationale that overriding a student's autonomy is acceptable if it reduces harm to those in their care, however there must be strong evidence of benefit that outweighs risk.

With COVID-19 significantly affecting the global community and the Delta variant now a reality in New Zealand, there is justification for mandatory vaccination if this is shown to benefit all, as long as the potential risk to nursing students remains low. •

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### References

1) Nursing Council of New Zealand. (2021). *Guidance statement: COVID-19 vaccine and your professional responsibility.* www.nursingcouncil.org.nz/NCNZ/News-section/news-item/2021/5/Guidance_statement_COVID-19_vaccine_and_your_professional_responsibility.aspx.
2) Beauchamp, T. L., & Childress, J. F. (2013). *Principles of biomedical ethics* (7th ed.). Oxford University Press.
3) Manning, M. L., Gerolamo, A. M., Marino, M. A., Hanson-Zalot, M. E., & Pogorzelska-Maziarz, M. (2021). COVID-19 vaccination readiness among nurse faculty and student nurses. *Nursing Outlook, 69*(4), 565-573. https://doi.org/10.1016/j.outlook.2021.01.019.
4) World Health Organization. (2021). *COVID-19 and mandatory vaccination: Ethical considerations and caveats* [Policy brief]. www.who.int/publications/i/item/WHO-2019-nCoV-Policy-brief-Mandatory-vaccination-2021.1
5) Human Rights Commission (2013). Article 16. *Universal Declaration of Human Rights.* In Everyone is born free and equal in dignity and rights (pp13). www.hrc.co.nz/files/9914/2399/5161/UDHR-booklet-2013-reprint-pdf.
6) Health & Disability Commissioner. (1996, 2020). Right 7 (7). *Code of Health and Disability Services Consumers' Rights Regulations*. Right to make an informed choice and give informed consent.
www.hdc.org.nz/your-rights/about-the-code/code-of-health-and-disability-services-consumers-rights.
7) Osbourne, R. M., & Clark, S. J. (2021). Should the SARS-CoV-2 vaccine be mandatory for nurses? An ethical debate. *British Journal of Nursing, 30*(2), 116-121.
8) International Coalition of Medicines Regulatory Authorities. (2021). *ICMRA statement for healthcare professionals: How COVID-19 vaccines will be regulated for safety and effectiveness.* www.icmra.info/drupal/en/covid-19/vaccines_confidence_statement_for_hcps.
9) Bowen, R. A. R. (2020, Nov). Ethical and organizational considerations for mandatory COVID-19 vaccination of health care workers: A clinical laboratorian's perspective. [Letter to the editor]. *Clin Chim Acta, 510*, 421-422. https://doi.org/10.1016/j.cca.2020.08.003
10) Giubilini, A. (2021). Vaccination ethics. *British Medical Bulletin, 137*(1), 4-12. https://doi.org/10.1093/bmb/ldaa036.
11) Galanakis, E., Jansen, A., Lopalco, P. L., & Giesecke, J. (2013). Ethics of mandatory vaccination for healthcare workers. *Eurosurveillance, 18*(45), 20627. Https://doi.org/10.2807/1560-7917.es2013.18.45.20627.
12) Patelarou, E., Galanis, P., Mechili, E. A., Argyriadi, A., Argyriadis, A., Asimakopoulou, E., Brokaj, S., Bucaj, J., Carmona-Torres, J. M., & Cobo-Cuenca, A. I. (2021). Factors influencing nursing students' intention to accept COVID-19 vaccination – A pooled analysis of seven countries. *Nurse Education Today, 104*, 105010. https://doi.org/10.1101/2021.01.22.21250321.

# Bargaining marathon on Heritage MUCA

By Lesley Harry

Bargaining for Heritage Lifecare multi-union collective agreement (MUCA) has been a marathon.

In recent years, Heritage Lifecare has purchased multiple aged residential care facilities across Aotearoa. Many of the workers in these workplaces were previously covered by collective agreements, with generally more favourable terms and conditions (weekend rates, overtime etc).

Most workers, though, have had their terms and conditions set in individual agreements and have not had the benefit of collective bargaining as a mechanism to improve these.

This has meant the union bargaining team has been working through the bargaining process to bring together the best possible clauses from across numerous agreements for a single national Heritage MUCA. Bringing together multiple sites into one MUCA is always complicated.

While there are still significant clauses to be negotiated, NZNO advocates Christina Couling and Lynley Mulrine are pleased with progress and note there seems to be a genuine commitment from all parties.

The union team has negotiated an interim wage increase for nurses of approximately 4.4 per cent to five per cent on average depending on the role. Increases for household (kitchen, cleaning etc) were also negotiated.

Employers should use standard infection prevention and control precautions rather than stop secondary employment for staff.

Bargaining has been a long haul so organisers will meet with members over the next few months to walk them through the proposed clauses so far.

It is important that Heritage members fully understand the proposed MUCA as ratification voting will take place once a proposal is reached.

Bargaining in aged care generally has continued using a blend of Zoom and face-to-face meeting where possible.

Some bargaining was delayed in anticipation that COVID-19 restrictions might be relaxed.

## Campaigning for safe staffing

After well-attended and inspiring regional member meetings in Southland, the meetings came to a standstill during the COVID-19 outbreaks.

As an alternative, NZNO and E Tū are holding online forums for members to discuss concerns with Green and Labour MPs starting with Auckland/ Northland then Wellington/ Central regions and onto Christchurch/Nelson.

Our first meeting hosted more than 100 aged care workers from across the northern region along with three MPs and representatives from Grey Power.

These hui have been organised primarily to support aged care workers to lobby MPs on important issues facing their sector.

Our union leaders working in aged care have done just that – seeking commitment from MPs to support calls for mandatory minimum staffing levels across the sector. While a little shambolic (managing more than 100 active participants can get difficult!), the meetings were very successful.

Access to Zoom technology for many members has been a challenge and we hope to return to face-to-face meetings soon.

## Secondary employment

Some aged care employers continue to restrict workers from secondary employment.

This despite district health boards not placing the same pandemic restrictions on their workforce.

At a time of nursing shortages, employers should use alternatives such as staff being vaccinated and supported to stay at home if unwell and the full implementation of standard IPC measures to reduce the risk of transmission between settings as recommended by the MoH. •

Lesley Harry is an NZNO aged care industrial advisor.

# Primary health care work continues, DHB bargaining concludes


The June strike united DHB members in their determination to continue bargaining.

A new date has been set down in meditation for long-running NZNO primary health care negotiations with Healthcare New Zealand and NZCare.

Mediation is set down for November 19 and would take place via Zoom, the bargaining team has reported to members.

It comes as all parties agreed that attending bargaining should be the next step in progressing the negotiations.

That bargaining has already run over several days and included two rejected proposed collective agreements, put out to a ratification vote.

It means the old collective agreement has now been expired for 12 months, however terms and conditions for workers in this expired MECA remain.

The main themes behind the members' rejections of the proposed collective agreements covered a range of areas.

The proposed pay increase was considered too low. There was a disparity with district health board MECA wages, and the lump sum, back-pay portion of the proposed collective was considered too low.

The bargaining team would continue to push for a better offer and would update members on progress after the November 19 meditation.

Meanwhile work continued on the Primary Health Care MECA bargaining schedule with the MECA expiring on August 31 this year.

The online ballot for member endorsement of claim principles, the negotiation team and ratification procedures was set to run at the end of October.

## Changes for MIQ workers

Staff working at isolation and quarantine facilities face changes to their COVID-19 testing frequency from November 8. Staff at quarantine facilities who are onsite more than twice a week, will have to be tested every day they work at the facility.

At managed isolation facilities they would have to be tested twice a week.

Those in dual-purpose facilities will follow the quarantine schedule if there's a case, and the managed isolation schedule with no case.

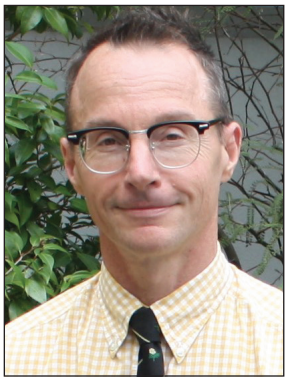
## DHB MECA ratified

NZNO's bargaining for district health board members has wrapped with a high turnout vote accepting the most recent offer.

The offer included staffing and recruitment requirements, and advances on pay equity claim increases.

It included a June strike, which cemented member solidarity and drew nationwide attention to the cause; and the campaign also saw an important employment court victory for NZNO over life preserving services agreements with DHBs. •

# NZNO court win cemented right to strike



By Jock Lawrie

Strike action in the district health board (DHB) sector saw some sabre-rattling concerning life preserving services on the part of the DHBs.

The DHBs claimed that NZNO either had or was failing to make adequate provision for the maintenance of life preserving services (LPS) to cover strike action.

DHBs also threatened legal proceedings over the issue in an attempt to force the withdrawal of lawful strike notices.

NZNO denied the DHB claims and declined to withdraw any strike notices. The DHBs then filed legal proceedings to have the matter decided by the Employment Court.

By way of brief background, whenever NZNO files strike notice in the DHB sector it is required by law to respond to any request from the DHB for assistance in maintaining LPS (generally being crisis intervention for the preservation of life or prevention of permanent disability).

Invariably such a request is made by the DHBs, and NZNO then enters into negotiations with each DHB to secure agreement on: The extent of LPS necessary to provide for patient safety during the strike; the number of NZNO members necessary to enable those LPS; and a protocol for the management of emergencies which might require additional life preserving services.

The DHBs claimed in court that when a DHB had concerns that NZNO would not deliver an agreed number of members for LPS, that DHB should be able to take precautionary legal action to ensure such numbers were provided.

The DHBs claimed NZNO's stance of taking 'all best endeavours' to honour any agreement was insufficient and of itself a breach of good faith.

However, the court found in favour of NZNO and held that:

- an LPS agreement is not the same as, for example, a binding commercial contract, although a failure to comply by NZNO may give rise to a claim that NZNO has not acted in good faith.
- However, it is not open to a DHB to initiate legal proceedings to enforce an LPS agreement over a concern that the roster numbers provided may not be delivered by some agreed future date. Rather there needs to be an *actual* failure to deliver the roster numbers before enforcement could be considered appropriate. Even then a close examination of all the circumstances would be required to ascertain whether enforcement action is indeed warranted.
- NZNO's position, that it will use its best endeavours to give effect to any LPS agreement while being mindful of members' right to strike, is in accord with NZNO's good faith obligations.

The court also awarded $20,000 to NZNO to cover some of the legal costs defending the DHBs' claims.

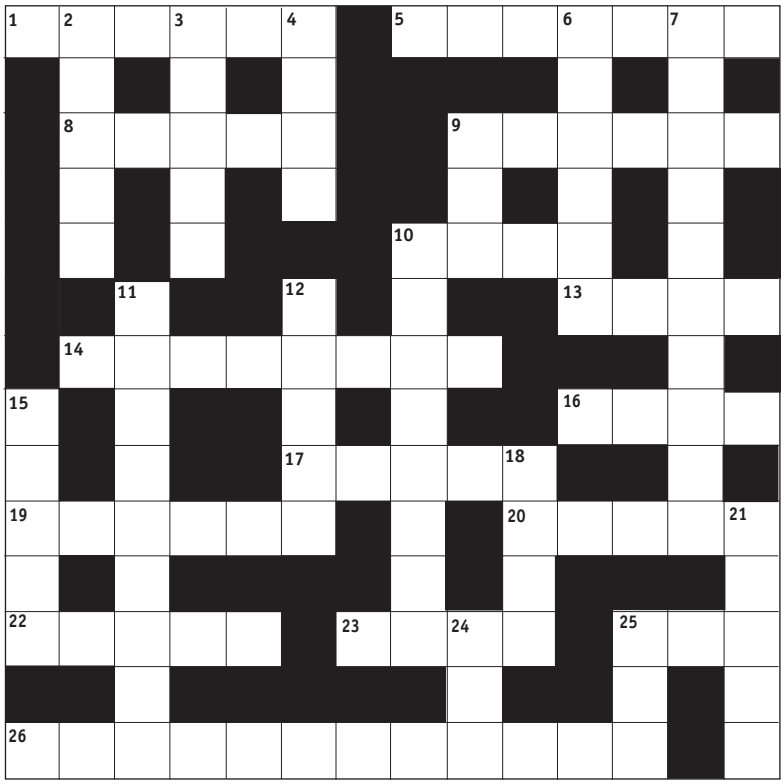
While it is likely that LPS agreements may continue to be a source of tension during industrial action, hopefully the judgment opens the door to a more constructive and conciliatory approach by DHBs in future. •

Jock Lawrie is an NZNO employment lawyer.


DHB members strike in June, but NZNO later faced court action over life preserving services.

## crossWORD

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



**ACROSS**

1) Tool to deliver vaccine.
5) Sons of siblings.
8) It comes after life.
9) Extended family (Māori).
10) Baby (Māori).
13) An entry on a patient's chart.
14) These provide end-of-life care.
16) Belonging to you.
17) Haven in a desert.
19) Desire for water.
20) Poisonous.
22) Small creature used medicinally to suck blood.
23) Jump high.
25) Firearm.
26) Condition where bones get thin and brittle.

**DOWN**

2) Finished.
3) Journal.
4) Reflected sound.
6) Supernatural place of bliss.
7) Proverb (Māori).
9) Small (Scottish).
10) Stressful force.
11) Self-assured.
12) Red wine variety.
15) Causing death.
18) Come to a halt.
21) Man-made waterway.
24) Shakespeare work: *Much ___ About Nothing.*
25) Vapour.

**October answers. ACROSS:** 1. Delta. 3. Vaccine. 7. Admiral. 8. Absorb. 9. Retire. 10. Mullet. 12. Private. 15. Gel. 18. Almost. 19. Scared. 21. Pot. 22. Skier. 23. Boasts. 24. Address. 25. Son. **DOWN:** 1. Dead. 2. Twitter. 3. Vulnerable. 4. Charm. 5. Insulin. 6. Earned. 11. Organiser. 12. Plastic. 13. Impaired. 14. Mutation. 16. Glasses. 17. Corpses. 20. Drone.

## wiseWORDS

“ Our worst fault is our preoccupation with the faults of others. ”

**– Kahlil Gibran, Lebanese-American writer and philosopher, 1883-1931**

## it's cool to kōrero

HAERE MAI and welcome to the November kōrero column. Waiata are songs and chants which are an important part of Maori culture. There are three main types: waiata oriori (lullabies), waiata tangi (laments), and waiata aroha (love songs). Waiata mōteatea traditionally follow whaikorero (formal speeches) on the marae.

Different iwi often have their own waiata, some composed centuries ago.

### Kupu hou

New word

- **Waiata** – *pronounced "why-ah-tah"*
- **I muri mai ngā korero, i waiata mātou.**

We sang waiata after the speeches.

### Rerenga kupu

Phrases

We live in a digital world and it's good to be able to use te reo for some of the technology we use:

- **rorohiko**
  computer
- **rorohiko pōnaho**
  laptop computer
- **pūhihiko**
  charger
- **hopuoro**
  microphone
- **papa pātuhi**
  keyboard
- **purutaringa**
  headphones/earphones
- **ahokore**
  wifi
- **rokiroki**
  storage

*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).*

# Where to now for enrolled nurses?

NZNO'S ENROLLED Nurse Section (ENS) has been asking the Nursing Council for a review of the enrolled nurse (EN) scope of practice for some time.

It is more than 10 years since the EN scope of practice was reviewed. In 2009, then-Minister of Health Tony Ryall directed the Nursing Council of New Zealand (NCNZ) to work with district health boards (DHBs) and the Ministry of Health (MoH) to "expand the role and training of ENs".[1]

The NCNZ consulted widely with DHBs, polytechnics and the ENS on expanding the scope, before releasing a consultation paper.

A revised scope suggested by ENS was used in the initial consultation then – after some changes – accepted. It allowed ENs to practise to the top of their scope. However its adoption has varied around Aotearoa, particularly in our DHBs and aged residential care (ARC) facilities.

Since 2010, EN positions have evolved into the following areas:

- Providing home haemodialysis.
- General practice.
- Prisons and corrections facilities.
- Authorised vaccinators, for those ENs having undertaken the provisional vaccination programme from the Immunisation Advisory Centre (IMAC).
- Working with intubated patients in a spinal unit, with registered nurse (RN) support.
- Assessors and co-ordinators in home-based care organisations and needs-assessment and service coordination (NASC) assessors in some DHBs.
- DHB mental health settings across New Zealand.
- In 2019, the Government provided funding for 40 EN positions in primary health care in mental health and addictions. A project group is assisting ENs to gain positions within this setting.

In 2019, ENS surveyed 756 ENs to ask if they understood their scope and thought colleagues understood.[2] In response, 99 per cent said they understood their own scope but only 37 per cent believed colleagues such as RNs, midwives, nurse practitioners, directors of nursing, workplace educators and other regulated health professionals understood it.

More than two-thirds believed that the most restrictive part of the EN scope was the requirement to practise under direction and delegation of colleagues.

So the ENS suggested to NCNZ that direction and delegation should be replaced with "in collaboration and partnership with the Registered Nurse or Nurse Practitioner". NCNZ responded that it would probably be undertaking a full review of the EN scope of practice.

However, we are still waiting for confirmation of when this will happen.

We are now hearing reports from ENs that health-care assistants, who are unregulated, are being allowed to do assessments, observations, blood sugar levels and wound care and provide medication from blister packs. This is mainly happening in ARC facilities but has also been seen slowly creeping into DHBs.

ENs believe it is time for our scope to be further expanded, enabling us to practise to the extent of our skills and abilities, and that we be recognised for the skills, knowledge and education we bring to our roles.

While we now have a national curriculum for enrolled nursing in the form of a national diploma, our practice varies around the country.

A new scope of practice should be extend and enable ENs, and not be a backwards step. This should also be aligned to the revised RN education framework and competencies, so an achievable pathway is available into

*By ENS chair Robyn Hewlett*

**Robyn Hewlett is waiting to hear when the Nursing Council will review the scope of practice for enrolled nurses.**

*Nursing Council chief executive Catherine Byrne said the council was currently developing a new strategic plan for 2022-2024.*

*"The EN scope and education standards I expect to be part of the council's future strategic work. The timelines for this work are uncertain, however the council recognises the importance and the need for this work.*

*I hope to have more information to share later in the year when we are in a position to determine the strategic imperatives to the plan."*


**References**

1) Beehive. (2009, March 28). *Enrolled nurses on the agenda* [press release]. www.beehive.govt.nz/release/enrolled-nurses-agenda.

2) New Zealand Nurses Organisation: Enrolled Nurse Section. (2019). *Enrolled Nurses – Scope of Practice Survey*. www.nzno.org.nz/resources/nzno_publications.

# NZNO online learning taking off for members

LAST YEAR, NZNO launched an online learning platform, after members asked for a blended online/face-to-face approach to delegate training amid COVID-19 restrictions.


Angelique Walker

Since then, more than 300 delegates have completed a short online "foundations" course, receiving a certificate of completion which they can use for their professional development and recognition programme.

The online course gives members a fuller understanding of the structure of NZNO and the delegate role before they attend their introductory seminar. We have found that the pre-learning has created more discussion which is a great thing as delegates have further clarity. This online course is now available to all NZNO members, via the NZNO home page.

NZNO now has four short online courses available to all members: Foundation; social media; being an active delegate; and employment rights & relationships – a collaboration with the Youth Workers' Resource Centre.

Between them, they offer an overview of unionism, how NZNO fits together, collective agreements, bargaining, natural justice, social media guidelines, nurses' code of conduct and NetSafe guidance.

Members have showed location and shift work is not an obstacle to accessing them, whether from a hair salon, work or home. Some finish the course over time. On the rare occasion when a member has not completed the course we follow up to make sure it is not a technical issue and offer support.

Our courses are on the NZNO website and linked to our member database, so their completion is recognised. This has saved thousands of dollars by not requiring a full learning management system – yet we offer full interactive elements and capture all the completion information we need.

Every month a quick survey is sent to those members who have completed the courses.

To access, go to www.nzno.org.nz, click on the 'Resources' tab and then the 'NZNO Courses' tab. You will require your NZNO membership number, which will allow us to issue a completion certificate. •

*By NZNO educator Angelique Walker*

# Low nurse morale flagged by membership group

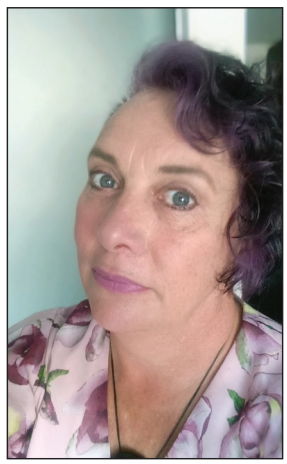
NZNO'S MEMBERSHIP committee is to ask NZNO leaders what is being done to highlight low morale and nursing stress due to short-staffing, rapid cycles of restructuring and loss of nursing leadership.

"Directors of nursing are no longer visible in most district health boards [DHBs], and there is no work support plan for suffering teams and wards, which flows onto students who meet preceptors too exhausted to provide structured and safe oversight," new chair Andrea Reilly said. "It all speaks to a culture in health, which does not recognise the need for support and recognition; education release and strong orientation and staffing processes."

However, the committee was looking forward to the new DHB-NZNO multi-employer-collective agreement (MECA) strengthening safe staffing and the tool care capacity demand management (CCDM), Reilly said. "This may further illuminate the major crisis in the New Zealand nursing workforce."

Members also discussed the need to "socialise" the one member, one vote system throughout regional councils, colleges and sections. Passed in 2018, it allows every financial member to vote on proposed changes to NZNO policies or the constitution. Previously, such votes were taken by delegates of NZNO groups, meaning individual members could have multiple votes.

A West Coast cancer nurse coordinator, Reilly has taken as membership committee chair over from Sandra Corbett, who was in the role for six years. Reilly acknowledged Corbett's work building strong relationships with the kaiwhakahaere, Te Rununga and Te Poari. The committee has vacancies in Southern, Hawke's Bay, Midlands and Canterbury regions. See: www.nzno.org.nz/about_us/governance/membership_committee. •


Andrea Reilly

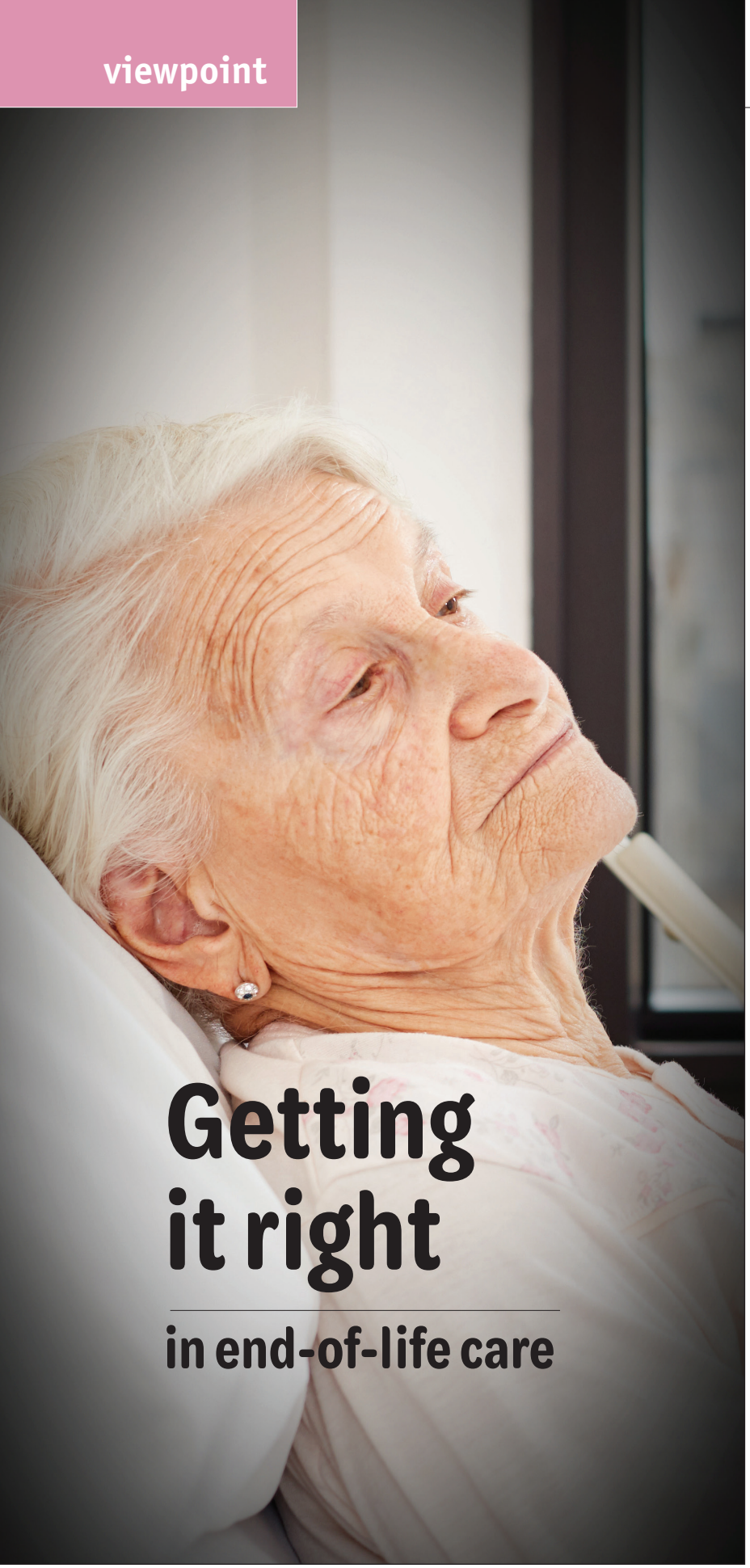


PHOTO: ADOBE STOCK

# Getting it right

## in end-of-life care

**This article was written by a palliative care nurse, about the distressing final days of her mother's life. Identifying details of the people and institutions involved have been removed as the purpose of this viewpoint is not to point the finger but to appeal for skilled palliative care for dying people and their families.**

It's been five years since my mother died and it's only now I find my voice to articulate the experience of her end-of-life care. As a family, we had planned for Mum to die at home – but sadly this didn't happen.

I am a palliative care nurse with six years' experience in the field, mainly in the community. Mum was diagnosed with bowel cancer in 2014. After her treatment options came to an end, she expressed a strong desire to stay home, with Dad, to the very end of her life.

My siblings and I provided her with 24-hour care at home for more than nine months, with support from the local hospice, community care agency and general practice (GP) team. We were a well-equipped and capable family/carer tag team and worked together like a well-oiled machine.

### Family matriarch

In later months, agency carers visited twice daily and the household 24-hour roster included several private carers.

Mum's domain as the family matriarch and household manager after 66 years of marriage was not challenged – she held that role dear to her heart and was not relinquishing it.

However, as she became increasingly frail, her ability to make good decisions diminished. Increasing narcotic pain medication affected her ability to function independently and safely and she lost sight of increasing difficulties posed by staying at

home without further support and equipment. The family was tiring and Dad's anxiety was escalating as he watched Mum's world slowly shrink, his own safety network unravel

As my siblings and I juggled work and family commitments, the increasingly complex medical and emotional needs of our parents strained our resources and resilience. We needed a break and felt that Mum and Dad's safety was increasingly at risk without a plan for special equipment and support.

Errors and accidents were marginally avoided. We needed Mum on board with any proposed additions or changes and hoped she might be more open to guidance from health professionals while taking a short break in respite care.

At a family meeting hosted by the hospice team, Mum and Dad agreed to trial a 10-day visit in a respite care home. We would regroup on their return, more equipment in place, our plan refreshed.

We knew Dad could not live alone after Mum was gone, as he had short-term memory loss and anxiety. We thought his spending time at the care facility in Mum's presence would gently introduce his proposed new living space.

Both Mum and Dad's health was stable, though complicated, and the respite admission introduction was welcoming and thorough. They had each taken activities to keep them occupied during their stay, including books and puzzles. The paper was delivered every day and Sky TV connected. Both avid sports fans, they had for years enjoyed watching many happy hours together.

Mum was engaged with a personal project – she was corresponding with present-day pupils of her beloved childhood primary school, attended 80 years earlier. She was describing to them her childhood daily school activities, explaining how different life was back then. She treasured the replies and questions from the children and teacher.

Mum and Dad went into rest-home level respite care on September 7, 2016. We set up a schedule so one family member would visit every day, sometimes twice a day, alongside other visitors.

On September 12, Mum and Dad went out for lunch with family to a café. They later did some shopping and Mum was perky, making sure Dad was okay and looking for a birthday present for my sister. She walked further than Dad did, along the main shopping street. This was not unusual.

**Mum was receiving bed cares from inexperienced staff. She was in significant pain and distress as they rolled her from side to side with minimal explanation or empathy.**

That same day, after they had returned from the outing, I had a phone call to say Mum had had a fall. I was advised she was doing well, no changes or injuries were noted and she did not need a medical review. I was reassured there was no need for me to visit.

The next morning, the 13th, Mum had another fall. I was advised by phone, and again told she did not sustain injury. Mum had been found on the floor in Dad's arms – her legs had given away and Dad had supported her to the ground. The nurses believed Mum may have had some kind of event – they said her pupils were not reacting to light and she was not speaking coherently. This was alarming.

Worried, I drove to the facility, 40 minutes from home. When I arrived, Mum was receiving bed cares from inexperienced staff. She was in significant pain and distress as they rolled her from side to side with minimal explanation or empathy.

Through the closed door I heard Mum cry out in pain, frustration and fear of falling, sounds which still haunt me. I was shocked, and requested a nurse and pain relief before they continued further. I had never seen Mum so distressed, begging to "make it stop, I can't do this anymore!"

The carers seemed unfamiliar with the needs of someone so unwell and seemed either indifferent or unaware of a gentle approach. They seemed out of their depth and had not asked for help.

As they shared a double room, Dad had been present during this event. He sat in the corner, a helpless witness, powerless to intervene.

My parents' generation is not one to challenge or question anyone medical. Dad's state of mind had eroded his confidence over recent years and he was immobilised by fear.

Mum had had a series of urinary tract infections (UTIs) before the respite admission. Symptoms would appear rapidly – each time in a different combination. (These had included dropping things, unable to hold a cup, stumbling, falling, fading cognitive skills, difficulty communicating, hallucination, smelly urine, frequency with passing urine with scant amounts passed. She required a lot more assistance and would sleep longer in the daytime.)

We learned to recognise the symptoms, and with the GP's support, commenced antibiotics and pain relief quickly. She would bounce back, the symptoms quickly resolved. She was otherwise slowly deteriorating.

On the day of her second fall, my sister and I observed familiar UTI symptoms in Mum becoming increas-

ingly evident, without treatment. Within hours we watched her suffering increasing hallucinations, delirium and confusion. This was distressing to observe, and worse, her symptoms were not acknowledged as an issue by the nursing staff. We pointed out this usually indicated a UTI – based on our previous experiences. Nothing was done.

Later that afternoon, a large bruise appeared on Mum's left forehead, likely from one of her falls. She was rapidly deteriorating before our eyes, no longer able to walk or talk, and needing full bed care. The two nurses in charge were adamant it was not a UTI, but "an event, like a stroke".

Over the following days, the infection progressed rapidly without therapeutic medication. The nursing staff refused to even consider the possibility of a UTI because the urine was difficult to test and wasn't totally indicative of UTI.

Our experience nursing and caring for our mother over previous months/years was dismissed as irrelevant. We were told to "stop being obsessed by UTI. You are stuck on that idea and unable to see past it."

I see now the nursing staff perceived we were not acknowledging our mother was dying. Yes, we knew she had a terminal disease, but this event was not being managed well, and could have been treated.

Despite considering myself an experienced and vocal advocate, I was immobilised, not heard and dismissed in one fell swoop. I felt I had let my mother down in a most significant way.

## Wearing 'daughter' hat

I had been advised to wear my "daughter" hat and try not to look from a palliative care nurse perspective. I found this increasingly difficult as I watched Mum's symptoms become more complex and her needs not met. I started asking more questions and not getting satisfactory answers, disturbed by the inaccessibility of medical care.

The facility doctor did his rounds the day after Mum's second fall. When I asked, I was told by the nurse, "He popped his head in the door, glanced in and said – there was nothing needing to be done from my perspective." And that was the end of that.

I still do not know if he was advised at that time of Mum's reason for admission (respite), the significant changes, her UTI symptoms or her falls during her admission. I was later told he believed Mum's GP and the hospice were managing her medical needs.

The GP would not visit her as the facility was too far away from his practice, and he believed her medical care was being managed by the facility doctor and the hospice team.

The hospice believed Mum's care was being managed by the facility doctor and her GP.

The hospice was unaware of Mum's change in condition until I rang them the day after her second fall and described her symptoms, her increasing rapid and unexpected deterioration. I reminded them she had been admitted for respite, not end-of-life care, that she had been relatively well on her admission.

Each of the three medical service doctors believed the other was taking care of Mum, when in fact, none of them were. She had slipped through the cracks.

We had very much hoped to provide end-of-life care at home for Mum, as had been her wish. This was looking less likely as she rapidly deteriorated.

That same afternoon, the hospice nurse and doctor visited and assessed Mum. They identified a significant deterioration, she had a bowel blockage and was not for further treatment. She was approaching end of life. The nurse asked if I would like to discuss this with Mum, which I declined. It was not my role, and Mum had always wanted professional medical opinion, before seeking mine.

Mum cried when she was told by the nurse that her end of life was rapidly approaching. She was sobbing to Dad, saying repeatedly, "It's too late . . . , its too late." I believe she was referring to it being too late to get him familiar with his future new home before she would be gone. That was what upset her the most – to be leaving him alone, without her help.

After the hospice assessment, it was decided Mum needed nil by mouth, a syringe driver for pain relief, plus intensive nursing care.

For days following this, Mum continued to express her desire to eat and drink. This was so hard for us all, as she would reach for food and beg to be fed. We gave her tastes of

**My parents' generation is not one to challenge or question anyone medical. Dad's state of mind had eroded his confidence over recent years and he was immobilised by fear.**

PHOTO: ADOBE STOCK

liquid as allowed but it was never satisfying enough for her appetite.

Both Mum and Dad were thankfully moved from rest home level to hospital level care – and were very lucky to have adjoining rooms, a very suitable arrangement for the large family presence. Two or more of us, sometimes 10 or more, stayed with them 24 hours a day from that point forward – they were never alone.

Sadly, Mum's project work and correspondence with her childhood primary school went missing during the transition to hospital care. It was never found and we believe it was inadvertently trashed, along with newspapers and other paraphernalia.

After their first night apart, in separate rooms, Mum become very distressed after waking to find Dad wasn't there. Dad was immediately brought into her room, and at the sight of him, she instantly calmed. During the day, Dad sat closely beside her, rubbing her hands and softly whistling or reading his paper.

We quickly became aware that Mum was unlikely to go home again. While the staff were welcoming of our presence, over time it became clear they were unaccustomed to large family numbers and were not entirely comfortable with it. Despite this, they accommodated us in various ways and we were grateful.

At no point were we given the option of returning Mum home – it wasn't discussed. I knew it was possible with some coordination, but everything seemed to happen so quickly and was whisked out of our hands. We were in shock and numb, no longer making the decisions.

Mum's personal cares were managed very well from that point on. However I was disappointed on a number of points.

Firstly, there was no acknowledgement of our experience of caring and nursing Mum at home over previous months/years.

Secondly, I was never hesitant to request pain relief for Mum, but the length of time she had to wait for it was cruel and her suffering unnecessary. It took 20-30 minutes to be administered, as it took time to find two hard-working and busy registered nurses to check the medications together. I know it would have been more promptly managed had she been at home.

When I asked for pain relief for Mum, there was no palliative assessment done. My word that she needed medication was enough, and she was given it. I felt an enormous responsibility to get it right and worried what might happen if I weren't there.

I had advocated for Mum, but at no point had I felt I was unreasonable in what or how I asked for what she needed. Despite this, my requests were sometimes met with sighs and comments suggesting I was being demanding.

The time came to start a more suitable pain medication delivery, in the form of a syringe driver. However it took 20 hours, from the time the syringe driver was first commenced, for staff to discover it was not delivering the medication.

This clearly indicated the staff did not have the required understanding of how a syringe driver worked – what the monitoring and recording meant and how to ensure medication was being delivered correctly.

## Breakthrough pain

Mum suffered dreadful breakthrough pain for those 20 hours. I had deliberately kept my daughter hat on and not checked the driver myself, though I was tempted several times. I now regret not doing so.

I have little respect for the nurse who, after I asked her for pain relief for Mum, flicked her hand in the air in a dismissive farewell, saying, "You'll have to get someone else love, I'm going home. Go and look in the other wings." She never even turned around – her back to me throughout as she left the building. Mum died that night, hours after this nurse flicked my request off.

Mum died in the presence of family, just 18 days after her admission for a 10-day respite visit. She put up a strong battle but finally gave up.

Providing individuals and their families professional and empathetic support in end-of-life care is significant – equally so is experience and confidence.

While the considered and thoughtful nursing care was appreciated, it was not specialised palliative care. Aged care facilities must have specialised palliative care to ensure the best outcomes for everyone's end-of-life experience.

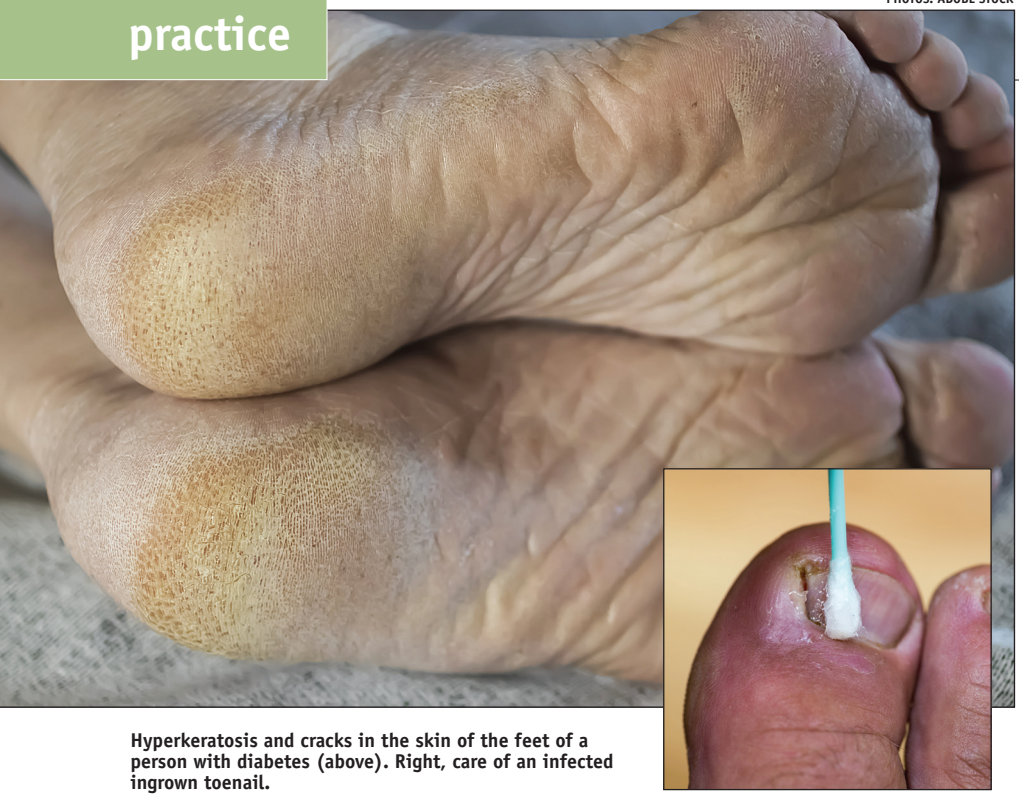
While it wasn't the planned end-of-life place for Mum, we did the best we could. Rest in peace, Mum. •

### WHAT I RECOMMENDED

I made the following recommendations to the hospice and the facility hospital:

- Ensure palliative care education is provided for all medical staff – particularly in pain management, assessment and communication.
- Ensure staffing levels are adequate for provision of timely intervention, communication and nursing cares.
- Be mindful and careful when handling anyone's personal property.
- Ensure ongoing hospice support be provided for staff, patients and families before, during and after palliative care training is delivered. •

PHOTOS: ADOBE STOCK



Hyperkeratosis and cracks in the skin of the feet of a person with diabetes (above). Right, care of an infected ingrown toenail.

# The importance of nurse-led FOOT CARE

**Nurses in primary care play an important role in managing foot care, especially for elderly, diabetic and disabled patients.**

By Heather Woods

Foot care is an important part of personal care, and registered nurses (RNs) are in a pivotal position[1,2] to help meet this care need for our ageing population.[3] As leaders in assessment and care planning, RNs are in a position to make a substantial difference to the health, wellbeing and safety of patients.

Elderly, diabetic, and/or disabled patients often present with foot conditions which they find difficult to manage and may initially look to primary health care services for information regarding how best to care for their feet. It is important that RNs recognise the importance of foot health.

*"Foot care is a very important part of personal care, especially for those who are unable to care for their own feet due to comorbidity such as diabetes, or advanced age."*[4] Anyone who has damaged their own toe will know, foot hygiene and health is important for a sense of well-being and has a significant impact on comfort and mobility.

Research makes it clear that 80 percent of people over the age of 80 find managing their toenails difficult.[2] This may be due to poor eyesight, poor balance, reduced flexibility, arthritis, obesity, shortness of breath, pain, tremor, weak hand muscles, dizziness or other chronic health conditions such as diabetes[3] or rheumatoid arthritis.[4]

They may have problems with overlapping toes, tenderness or open areas. Nails may also present problems with shape, thickness, fungal infection or edges that are prone to in-grow. Previous injury to feet, toes or nails can also make them difficult to manage.

## When foot care is lacking

When a patient doesn't get the foot care they need, these are some of the problems that may result:

**Pain:** The patient may suffer pain from long nails dragging on sheets, carpet, socks or shoes. Long toenails may be digging into the toes. Corns or calluses may be present on the toes or soles, making each step a challenge.

**Reduced mobility:** This pain can result in reduced or unstable mobility, which can negatively affect quality of life, independence, exercise, concentration, demeanour and mood.

**Injury:** Long toenails can cut either the underside of the toe if they curl under, or the side of an adjacent toe.

**Accidental injury:** People can accidentally cut their toes when they are trying to cut their toenails. These injuries can become infected, or in the case of patients with diabetes[1] extremely difficult to heal. Any changes in feet, nails and skin of patients with diabetes should be assessed

**Any changes in feet, nails and skin of patients with diabetes should be assessed and treated as soon as possible.**[6]

*continues over next page*

# Kaiapoi RN has foot in community care

By Heather Woods

I am a registered nurse (RN) based in North Canterbury, and for the past 30 years I have run my own primary health care foot clinic, Mobile Foot Care.

Referrals for affordable foot care come to me from GPs, practice nurses, carers, families and podiatrists, and I provide this service both in my clinic and in people's homes.

My journey towards setting up and managing Mobile Foot Care Ltd started when I injured my back nursing and wanted the kind of practice where I could sit down to work. I am also passionate about the importance of foot care.

I invested time and money to prepare for the role by working for a year with a podiatrist as a foot-care assistant. I learned basic foot care, including care of nails, corns and calluses. The podiatrist was enthusiastic and supportive of an RN providing a low-cost, mobile, domiciliary service. He could see the need for it and believed podiatrists would not be interested in providing such a service. I would refer clients needing advanced care back to him.

There is certainly benefit in an RN providing this service – bringing with them nursing knowledge, assessment skills and nursing philosophy. As an RN, I can also assess, plan, evaluate and understand needs or behaviours related to physical, psychiatric, neurological and sensory disabilities, and to intellectual disability or dementia.

While preparing to start my service, I also completed a person-centred counselling diploma at the then Christchurch Polytechnic. This finetuned my ability to listen and respond during the inevitable conversations which arise during home visits.[8] Broader health-related questions often arise, providing the opportunity for health education and if required, referral to a GP, nurse practitioner (NPs), or other primary health service.

## I provide home visits

A home visit by a friendly, professional RN is often as valued by the client as much as the foot care. Patients have reported a feeling of total wellbeing following the consultation, not just the fact that their feet feel much better. Older people are often lonely and a friendly regular visit can ease their isolation.

Heather Woods – passionate about foot care.


Heather Woods' foot-care clinic in Kaiapoi, North Canterbury.

## Community foot-care clinics

At the request of a rural GP, I set up four community foot-care clinics in Canterbury where basic foot/nail care is provided. I run them monthly for a minimal charge, and regular appointments are kept.

Recently I trained three RNs who have all set up their own foot care companies; set up five more community clinics; and also provide home visits. I am the central contact for anyone in Canterbury seeking foot care, and refer them to the nurse in their area. So my role has moved towards coordination and support as I age.

Foot care involves liaison between many health professionals, including GPs, practice nurses, NPs, district nurses, hospitals, occupational health, palliative care, ACC, aged and residential care facilities, podiatrists, chemists, carers, beauty therapists, emergency care workers, diabetes staff, elderly day-care staff and social services. Nurses have a pivotal role in coordinating and planning this care.[6] •

and treated as soon as possible.[6]

In extreme cases, gangrene can become established if circulation to the feet and toes is compromised, resulting in amputations that could have been avoided.

## What you can do to help

There are a number of simple, practical ways to assist with foot care. Number one is regular assessment of the feet of people with diabetes[6] (or patients who complain about painful feet, nails, or other related issues).

After assessing the patient's feet, nurses can then plan foot care, monitoring and guidance. This may include advocating regular professional foot care or referral to a specialist foot-care provider.

You should *ask* elderly and disabled patients how they manage their foot and nail care, undertake a general assessment, and discuss ongoing management options with them. Patients will usually not raise the subject themselves.

Foot-care services in the community include podiatry clinics, community foot-care clinics, beauty therapy clinics, and visiting RNs providing basic care in the home. Clients may need help from a GP or practice nurse[6] to access podiatry services or get contact details for foot-care services.

## Foot assessment

Any initial assessment by an RN[7] of feet and nails should include contact details, clinical history and expectations. Examine skin, feet, toes and legs for colour, oedema, inflammation, deformity, pain, evidence of disease or injury and skin integrity, fragility and elasticity. Examine nails for pain, thickness, brittleness, shape, contour, colour and infection. Discuss a plan of care with the client, covering immediate needs and ongoing care of their feet and nails.

All patients with diabetes should have annual foot assessment to identify changes in sensation or circulation. If either is identified then it is recommended that foot care is provided by a podiatrist. Most DHBs have subsidised podiatric care for patients with high-risk feet related to peripheral vascular disease or peripheral neuropathy.

Basic foot care incudes:

- Trimming and filing of toenails.
- Reduction of corns and calluses.
- Cleaning and dressing of any open areas/wounds.
- ,Sanitiser with moisturiser applied to feet and toes.
- Cream may be massaged into dry skin.
- Fingernails may be cut and filed alongside foot care, if requested by the client and/or offered by the service provider.

Ongoing care can include follow-up appointments at either four, six, eight or 12-week intervals, depending on what the client needs, or a client may be directed to a mobile foot-care community clinic.

## Cost

The cost of foot care may range from $55 per visit with a RN to $105 with a podiatrist, or $30 at a community clinic run by an RN. Clients with diabetes can access some conditional free foot care from a podiatrist via a GP referral. WINZ may reimburse foot-care costs using the disability allowance via receipt.

ACC (www.acc.co.nz/im-injured/injuries-we-cover/treatment-we-pay-for/) and Veterans Affairs (www.veterans.gc.ca/eng/about-us/policy/document/1239/) will provide free foot care with a GP referral.

Foot-care services are currently being reviewed in some regions,[4] though without plans to use RNs. Podiatrists have recently demonstrated their support of nurses providing basic foot care by issuing a *"Guide for providers of basic foot care who are not registered podiatrists"*. More nurses are acknowledging the importance of foot care, and becoming interested in providing it.

Podiatrists are acknowledging and discussing the value of a "second tier" foot-care provider, as their numbers dwindle, and the need for foot care increases.

## RN education

The Ontario College of Health Studies in Canada has a well-established Foot Care Nurse Association and offers online education[9] to RNs and NPs worldwide.

I am exploring options for the establishment of consistent post graduate foot-care education for nurses in New Zealand •

*This article was reviewed by Waitemata District Health Board diabetes clinical nurse specialist Lisa Sparks.*

**Heather Woods, RN, BN, DipCouns, CmtyCert PsychCare,** is a clinical nurse specialist, who has run a private practice foot clinic in North Canterbury for 30 years.

**References**

1) Daly, B., Arroll, B., Sheridan, N., Kenealy, T., Stewart, A., & Scragg, R. (2014). Foot examinations of diabetes patients by primary health care nurses in Auckland, New Zealand. *Primary Care Diabetes, 8*(2), 139-146.
2) Peterson, J. M., & Virden, M. D. (2013). Improving diabetic foot care in a nurse-managed safety-net clinic. *Journal of the American Association of Nurse Practitioners, 25*(5), 263-271.
3) University of Auckland. (2017). *Report finds our aging population will need increased levels of care.* www.auckland.ac.nz/en/about/news-events-and-notices/news/news-2017/04/aging-population-will-need-increased-care-levels.html
4) Waitemata District Health Board. (2018).
5) Harvey, I., Frankel, S., Marks, R., Shalom, D., & Morgan, M. (1997). Foot morbidity and exposure to chiropody: population based study. *BMJ, 315*(7115), 1054-1055.
6) Keller-Senn, A., Probst, S., Imhof, R. M., & Imhof, L. (2015). Nurse-led education programme enhancing foot care self-efficacy in high-risk diabetes population: pilot randomised controlled study. *International Diabetes Nursing, 12*(2), 74-78.
7) Rome, K., Gow, P. J., Dalbeth, N., & Chapman, J. M. (2009). Clinical audit of foot problems in patients with rheumatoid arthritis treated at Counties Manukau District Health Board, Auckland, New Zealand. *Journal of Foot and Ankle Research, 2*(1), 16.
8) New Zealand Nursing Review. (2014). Faith, duty and foot pampering wins nurse QSM. New Zealand Nursing Review, 14(3), 15.
9) College of Health Studies. (2018). *Basic and Advanced Nursing Foot care Competencies and Standards.* www.collegeofhealthstudies.com/footcarenurseprogram/footcarenursestandards.html


From page 4 (The president comments)

**References**

1) Herbert, F. (2006) *Dune* (opening paragraph). Orion Publishing.
2) O'Connor, M. E. (2010). *Freed to care, proud to nurse: 100 years of the New Zealand Nurses Organisation*. Steele Roberts Publishers. P11
3) O'Connor, M. E. (2010). *Freed to care, proud to nurse: 100 years of the New Zealand Nurses Organisation*. Steele Roberts Publishers. P14.
4) Pohlmann, G., Prosser, R., & Campbell, R. (1981). *Kinleith '80* [video]. YouTube. Federation of Labour. www.youtube.com/watch?v=L5KZoauwWrg.
5) Van Bewer, V., Woodgate, R. L., Martina, D., & Deerb, F. (2021). Exploring Theatre of the Oppressed and Forum Theatre as pedagogies in nursing education. *Nurse Education Today*, 103.
6) Parahi, C. (2018). Māori nurses suffer discrimination in sick health system. www.stuff.co.nz/national/health/107678008/maori-nurses-suffer-discrimination-in-sick-health-system.
7) NZNO. (2019, January 30). *Waitangi Tribunal decision just a first step towards equality for Māori women* [press release]. www.nzno.org.nz/about_us/media_releases/artmid/4731/articleid/216/waitangi-tribunal-decision-just-a-first-step-towards-equality-for-maori-women.
8) NZNO. (2020, January 22). *Nurse staffing crisis looming for primary health* [press release]. www.nzno.org.nz/about_us/media_releases/artmid/4731/articleid/1834/nurse-staffing-crisis-looming-for-primary-health.
9) NZNO. (2021, October 6). *Open letter to PM expresses nurses' disappointment at having to consider further industrial action* [press release]. www.nzno.org.nz/about_us/media_releases/artmid/4731/articleid/3101/open-letter-to-pm-expresses-nurses-disappointment-at-having-to-consider-further-industrial-action.
10) ICN. (2009). Position statement. *Evidence-based safe nurse staffing.* www.icn.ch/sites/default/files/inline-files/ICN%20PS%20Evidence%20based%20safe%20nurse%20staffing_0.pdf.
11) Nursing & Midwifery Council. (2016). *Safe staffing guidelines.* www.nmc.org.uk/about-us/policy/position-statements/safe-staffing-guidelines.
12) NZNO Board. (2020). Policy Remit 1. *Review of NZNO strategies for safe staffing*. https://unionnursegrant.files.wordpress.com/2020/08/policy-remit-1-review-of-nzno-strategies-for-safe-staffing.pdf.
13) New Zealand Herald. (2021, September 30). *Residency pathway 'welcome' for nursing workforce but more Kiwi talent needed.* www.nzherald.co.nz/nz/residency-pathway-welcome-for-nursing-workforce-but-more-kiwi-talent-needed.
14) Human Rights Commission. (2013). Article 16: *Universal Declaration of Human Rights.* In Everyone is born free and equal in dignity and rights. (pp. 13). www.hrc.co.nz/files/9914/2399/5161/UDHR-booklet-2013-reprint.pdf.

**Autoimmunity occurs where the T- and B-lymphocytes stop distinguishing 'self' from 'non-self' and begin generating antibodies and immune memory cells against the body's own tissues.**

# Autoimmune disorders – light on the horizon?

By Georgina Casey

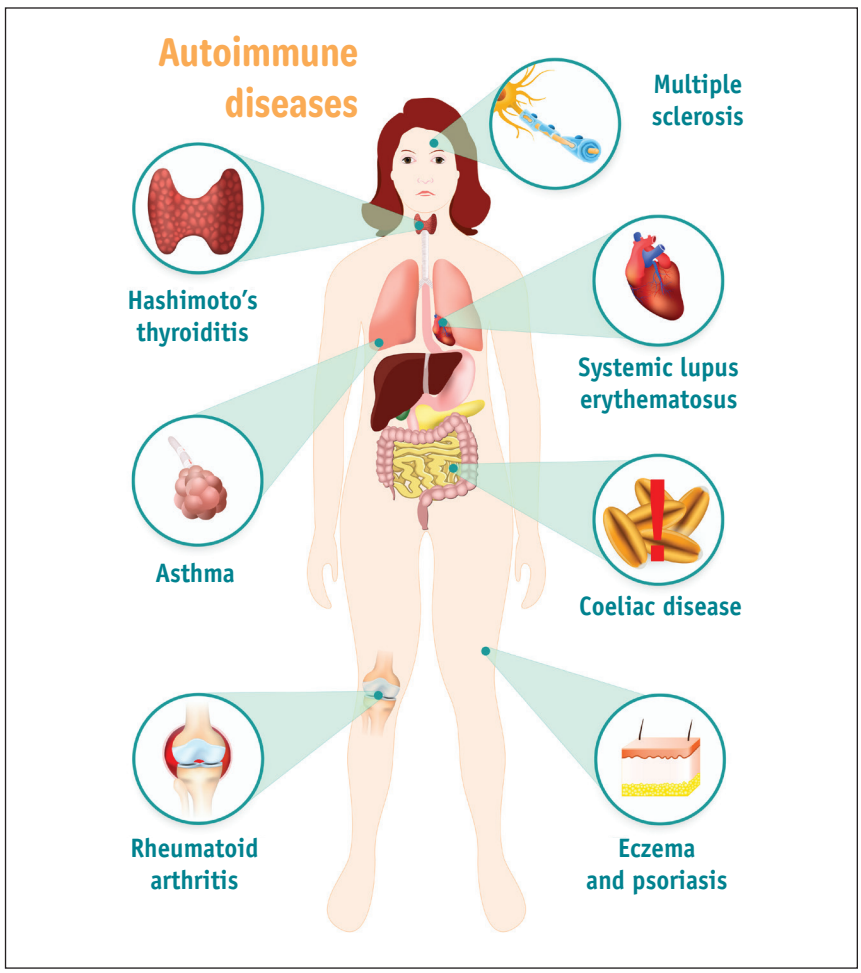



DIAGRAM AND PHOTOS: ADOBE STOCK

There are about 80 known autoimmune disorders affecting 5-8 per cent of the population worldwide.[1] These range through psoriasis, rheumatoid arthritis and coeliac disease (affecting about one in 100 people), type 1 diabetes, multiple sclerosis and rheumatic heart disease (affecting about one in 1000), and ulcerative colitis and Crohn's disease (affecting one in 10,000) and more rare diseases.[2]

Autoimmune diseases are identified by the presence of autoantibodies, which attack the body's own cells. Some autoimmune disorders are clearly linked to autoantibodies, others generate autoantibodies but the link between them and the pathology of the disease is unclear. Another group of diseases, such as psoriasis and ulcerative colitis, have no clearly identified autoantibodies but respond well to immune-modifying treatments.[2]

Autoimmunity occurs where the T- and B-lymphocytes stop distinguishing "self" from "non-self" and begin generating antibodies and immune memory cells against the body's own tissues. This can cause body-wide effects, such as systemic lupus erythematosus, or target a single organ as with type 1 diabetes.

Despite considerable understanding of the mechanisms and genetics of some autoimmune diseases, our understanding of the triggers for these diseases and their subsequent development is poor.[1] Study of the human genome has identified genes that predict inherited autoimmune risk. The greatest predictor of severe disease is found in HLA genes that code for the human leukocyte antigen – a molecule on the surface of all body cells that helps to identify them as "self".[1] Other genetic screens have identified other more disease-specific variant genes coding for different molecules. As further detail of these variant types emerges, they could potentially be treated through gene-editing technologies such as CRISPR.

## Environmental factors

Environmental factors (such as smoking, obesity, diet and infection) are known to increase risk, but the mechanisms by which they cause autoimmune disease are not understood. It is thought that they may directly damage or alter the immune system but also cause damage to body tissues that further

trigger autoimmune responses and delay healing – setting up a cycle of inflammation, tissue damage and immune attack.[1]

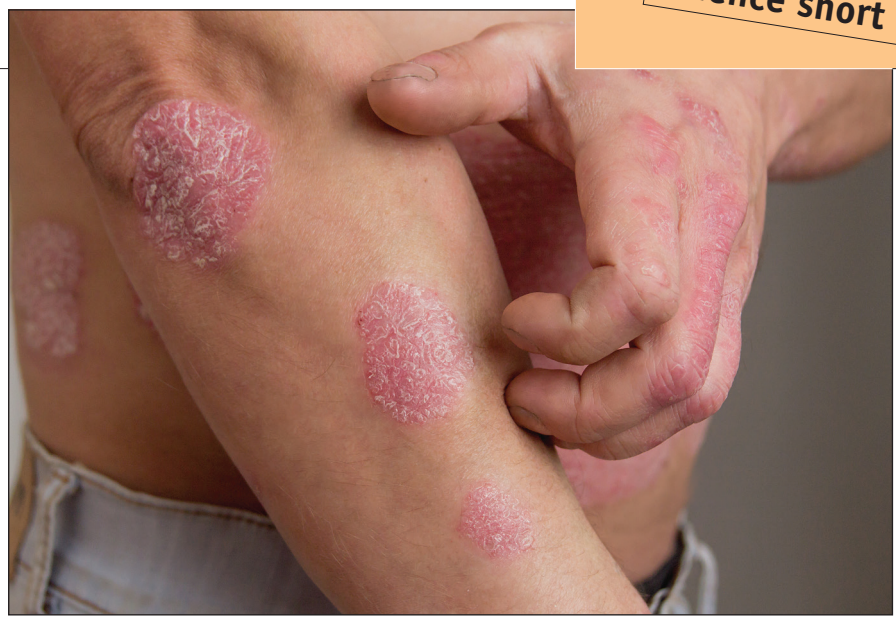
Studies have shown a link between some autoimmune disorders and the microbiome of the gut and/or skin. This may be due to changes in, or abnormal, microbiota, escape of bacteria from the gut into the body, or cross-talk between certain species of microbiota and the person's immune system. Dietary intake may affect risk of autoimmune disease via its effects on the microbiota. For example, fasting and calorie restriction in animal models affect immune cell types and their distribution in the body, reducing risk of autoimmune disorders.[1]

Current treatments for autoimmune disease involve non-specific immune-modulating drugs with limited efficacy and high risk of side effects due to immune suppression (eg infections, malignancies).[1] Generally, patients begin therapy with disease-modulating drugs such as methotrexate (for rheumatoid arthritis) or corticosteroids. The past two decades have seen huge gains in the management of autoimmune disease through the development of monoclonal antibodies – drugs that target signalling molecules in the immune pathway – eg infliximab and tocilizumab. However, these new therapies are also non-specific and have system-wide side effects.

**The past two decades have seen huge gains in the management of autoimmune disease through the development of monoclonal antibodies . . .**

There is a growing body of research directed toward therapies that target individual autoimmune conditions, are patient-centric and that address underlying causes.[1]

Ultimately, the goal for immunologists is the ability to accurately predict risk of autoimmune disease and prevent or delay its onset. This has already been seen in a small study where a monoclonal antibody against a type of T-cell that attacks insulin-producing pancreatic beta cells in susceptible people, prevented or delayed by an average of two years the onset of type 1 diabetes.[3] •



**Psoriasis (above) and rheumatoid arthritis (below) are among some 80 known autoimmune disorders.**


**References**

1) Fugger, L., Jensen, L., & Rossjohn, J. (2020). Challenges, progress and prospects of developing therapies to treat autoimmune diseases. *Cell, 181*(1), 63-80.

2) Bender, M., Christiansen, J., & Quick, M. (2021). Autoimmune Disease, by the Numbers. *Scientific American 325*(3), 31-33. doi:10.1038/scientificamerican0921-31

3) Herold, K., Bundy, B., Long, S. A., Bluestone, J., DiMeglio, L., Dufort, M., Gitelman, S., Gottlieb, P., Krischer, J., Linsley, P., Marks, J., Moore, W., Moran, A., Rodriquez, H., Russell, W., Schatz, D., Skyler, J., Tsalikian, E., Wherrett, D., Ziegler, A.-G., Greenbaum, C., & Type 1 Diabetes TrialNet Study Group. (2019). An anti-CD3 antibody, Teplizumab, in relatives at risk for type 1 diabetes. *New England Journal of Medicine. 381,* 603-613.

# No one asked us

I walk into the room. White walls, sterile.
You have put up drawings, pictures, cards.
Words jump out at me:
"Get well soon", "we miss you", "Jesus loves you".
"God will heal you".
There are religious pictures, too.
It makes it less sterile-looking, more vibrant.
But no one notices.
The professionals ignore them.

In the white bed, you look small. You are not small.
You are fourteen and big for your age.
But in the bed, in this foreign territory,
you are small and insignificant.
You have lost your mana.

We come in. We know what is happening.
You are lost, you don't understand.
Your Mum is there, she sits quietly.
I chat to her. Slowly, she opens up.
She is scared.
Very scared.
She doesn't get it, doesn't know what the doctors said.
They come in so quickly, they talk and they leave, she says.
I can't ask what they mean, she says.
So she is lost. And scared.
Just like the boy in the bed.

I am busy. I have other patients.
They are all children, they are sick.
They have no hair.
They have central lines and naso-gastric tubes.
I am so busy.

This whānau needs time. They need my attention.
I don't have time.
I have other patients. I haven't had a break and it's 12pm.
But they need time.

So I make time.
I sit. And we talk. And I listen.
I explain what chemo is, so they understand.
I explain what it looks like: black cover, IV fluids, purple gowns, purple bins.
Will it hurt? They ask.
Will I feel it? They ask.
I reassure them.

Then, I ask if they want to do anything before the chemo.
What do you mean? They ask.
Do you want to pray, karakia, or have some time to think?
They are shocked.
No one's ever asked us that.

The Mum's eyes sparkle with tears.
She is so grateful.
Yes, she wants to pray.

The time comes. Time for his first ever chemo.
I walk in, in my purple gown.
I arrive early to give them time.
The mother holds her son's hand.
Then she takes mine.
She prays for the chemo to make her son better.
She prays for her son to be strong.
Then, she prays for me, the nurse giving the chemo.
I choke back tears.

Now, when either of you see me, you greet me by name.
You ask questions.
I explain things.
You want to know how I am, what's new in my life.
I have touched your life.
And you have touched mine.

I didn't realise what an impact a small action could make.
No one asked you. – *by Anna Hickey*

AUCKLAND REGISTERED nurse and clinical nurse educator Anna Hickey wrote about a a recent experience with a patient for her post-graduate diploma in child health at Auckland University of Technology. *My poem was an attempt to describe the complexities of nursing and the impact on our patients when we become task-focused, rather than providing holistic care. . . By slowing down and taking the time to talk to my patient and his mum about their concerns, as well as to incorporate Māori tikanga such as a karakia, I not only provided holistic care but also enabled them to have more involvement in their own care. It had an impact far above what I would have imagined and this moment will stay with me forever.* •

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For information contact Jenni Scarlet at Jenni.Scarlet@waikatodhb.health.nz

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

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Since 1978, Mercy Ships has used hospital ships to deliver transformational healthcare at no charge to the world's forgotten poor. More than 2.84 million people have directly benefited from services provided, including more than 105,500 free surgical procedures.