Kai Tiaki
NURSING NEW ZEALAND
December 2021/January 2022
VOL 27 NO 11

A farewell to print…

After 113 years in print, a Kai Tiaki era comes to an end, and the online edition takes over.

When bullying is intolerable

Page 20

Tribute to a treasured kui

Page 24

Directory

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IN THIS, the last printed issue of *Kai Tiaki*, we look back at the journal's illustrious history, and hear from four former co-editors. Two nurse practitioners explain why they want to be involved in the end-of-life choice process. Nursing students farewell a beloved kui, and we put the spotlight on gout, a debilitating chronic condition which disproportionately affects Māori and Pacific people.

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

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

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

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

This issue . . .

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Please keep reading online – for nursing


By Teresa O'Connor (left) & Anne Manchester

This final print edition of *Kai Tiaki Nursing New Zealand* is a momentous moment in the publication's 113-year history. It is, we suppose, an inevitability in this third decade of the 21st century. But it poses some interesting questions that only "readers" – or whatever the correct nomenclature for those who browse online-only publications is – will be able to answer.

While the medium/method of publication may be changing, the principles and purpose of *Kai Tiaki* remain very close to what founder and inaugural editor, the indomitable Hester Maclean, wrote in her very first editorial: *"It will be we hope a bond of union, a common interest, a means of communication, a mutual help, and a road to improvement in their professional work and knowledge, to all the nurses of the Dominion, besides forming a link between not only the nurses of New Zealand and the other parts of Australasia, but also uniting them to the members of their profession throughout the world."*[1]

It is still essential that New Zealand nurses have a journal that reflects the unique nature of the profession here – what drives it, what troubles it, what advances it, what holds it back. It is essential nurses have a publication which publishes reflections on their clinical practice – their research, their experiences, their stories, their views (whether the editors or the organisation agree with them or not). It is essential nurses have a magazine which places their work in a wider health, political and international context. And it is essential nurses have a publication which, in part at least, chronicles the work of NZNO, its staff and leaders.

And it is important that nurses remember that *Kai Tiaki* owes a debt to history to – as accurately as possible – record the events that have shaped and continue to shape the organisation and how it operates. It is said that journalists write the first draft of history, and it is important this draft is as accurate as possible. *Kai Tiaki* is not only a nursing magazine; its content also canvasses many political and social issues. We know how valuable *Kai Tiaki* has been to researchers of social history over the decades – that important resource must always be preserved.

It is essential nurses have a publication which publishes reflections on their clinical practice – their research, their experiences, their stories, their views (whether the editors or the organisation agree with them or not).

During the years we were co-editors (a combined total of nearly 55), we sometimes heard members say: *"Oh, Kai Tiaki, I never read it,"* or *"I never take it out of its plastic wrapping"*. These derisory comments reflect a worrying apathy in our profession. COVID-19, and the clinical practice and ethical issues it throws up, makes such apathy even more concerning. Nowhere else will our nurses get the comprehensive information about their profession and all that impacts on it. If nurses aren't reading the magazine which reflects their unique practice context, we can bet they won't be reading any other nursing magazines either. For all that, the last readership survey showed a very healthy readership, with nine out of 10 NZNO members reading their monthly printed *Kai Tiaki*.[2]

So, it is essential that our nurses continue to read/browse *Kai Tiaki* in its digital-only form to remain informed about their profession, its concerns and its wider context. We know the current co-editors are working extremely hard to ensure the digital version is as attractive and accessible as possible.

May *Kai Tiaki*, as an online-only publication, continue to reflect Maclean's original vision. And may its readers continue to understand the importance of their publication in reflecting the importance of their profession.

We were privileged to have contributed to the outstanding legacy that is – and will continue to be – embodied in the pages (now files) of *Kai Tiaki Nursing New Zealand* – one of Aotearoa's oldest continuously published magazines. •

Teresa O'Connor was co-editor of *Kai Tiaki Nursing New Zealand* from 1992 to 2021 and **Anne Manchester from** 1995 to 2020.

References
1) Maclean, H. (1908). The purposes of the journal. *Kai Tiaki: The Journal of the Nurses of New Zealand, 1*(1), 1-2.
2) Stodart, K. (2019). Kai Tiaki widely read, with a clear interest in an online version. *Kai Tiaki Nursing New Zealand, 25*(1), 12-13.

Tell us what you think

The importance of biculturalism

I AM surprised to see people still querying the difference between biculturalism and multiculturalism (Letters, p3, November 2021).

As registered and enrolled nurses, we are asked to complete our competency-based annual practising certificate. This requires an acknowledgment that the nurse understands and applies the cultural safety and Tiriti o Waitangi principles in practice.

An important aspect required when we "tick the box" to provide evidence of our understanding of the nursing competencies, is understanding the difference between biculturalism and multiculturalism. We are first and foremost a bicultural nation, based on the founding document of New Zealand, the Tiriti o Waitangi.

Of course we include in our nursing practice the categories of difference such as nursing people who differ to us by age, gender, sexual orientation, socioeconomic group, immigrant or refugee status and disability.

Appreciating this basic difference is vital for nurses if we are to provide culturally safe nursing care, and remain current and relevant to all the people we nurse, including those who identify as Māori.

Margaret Hughes, RN, PhD,
Canterbury

Staff contract query

IT'S GREAT all the mahi our union and members have put in to getting a satisfactory resolution to the district health board MECA (multi-employer collective agreement). It was a long campaign, with delays, strikes, anger, and a hit of COVID-19 in between. And now our wait is over.

This leads me to the next challenge. NZNO staff will automatically get the same percentage wage increase as we do. I have no qualms with that, but I am bothered by the fact that we are still are unable to access their contract, despite the fact that we pay for it.

NZNO recently appointed a new CEO – Paul Goulter. I quote from a recent email sent by NZNO: *"One of Paul's strengths is his belief that an organisation's continual existence is dependent on the confidence the members have in it, and that it must constantly improve to keep that confidence."*

To me, that means honesty, transparency and fairness between members and NZNO staff. We will not get that until we have access to the NZNO CEA (collective employment agreement). Note, I am not disputing how hard NZNO staff work, particularly with the latest MECA.

Our contract is open to the public – please make yours open to its members.

Alana Whiting, RN
New Plymouth

Industrial services manager Glenda Alexander replies: The NZNO staff collective agreement is an employment agreement entered into between the three unions that represent NZNO staff – E Tū, First Union and the Manufacturing & Construction Workers' Union – and NZNO management (the parties).

When asked in the past for this agreement to be publicly released, or released to parties not covered by it, the parties decided it was a private agreement and is confidential to those parties, unless agreed by the parties to release it. The difference between the NZNO staff collective and the district health board (DHB)/NZNO multi-employer collective agreement (MECA) is that the employees covered by the MECA are effectively paid by the public purse – as the DHBs are Crown entities – and are therefore subject to public scrutiny.

A loss for rural nurses

I UNDERSTAND why *Kai Tiaki* has gone online. But for rural nurses – with very patchy internet services, outages and no likelihood of fibre – we have now lost our valuable journal. I have read it cover to cover for many decades.

Technology is great, but not for all. I will miss my sit-down in a comfy chair to read the magazine.

Please give us an alternative.

Liz Perales, RN,
Northland

Acting nursing and professional services manager Kate Weston replies: NZNO apologises to you and other members in your situation with poor internet access. The decision to stop the print edition has been made in line with NZNO board of directors' decisions on the environmental impacts of paper and the costs of print and postage, which are considerable.

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.

Keep your info up-to-date!

IT'S IMPORTANT to keep your membership information up-to-date. Please let us know of any change of address, email, contact phone number or workplace. Ring NZNO on 0800-28-38-48, option 2, or you can log in to the members' area on our website or email membership@nzno.org.nz •

The kaiwhakahaere comments:

By Kerri Nuku

Tēnā koutou to NZNO members – as 2021 closes and 2022 arrives, it is a good time to take a broader look at social justice and how we all fit into this important kaupapa.

Major health reforms arrive next year, the biggest changes in the system in decades.

Certainly, we can change systems and processes – throw as much money as we want at something to try to make it work – but if we don't change the attitudes and behaviours behind it, then we get the same results.

Inequity is baked into the current system, and we could look no further than the COVID-19 vaccination programme as evidence of this.

As of writing this, 88 per cent of the eligible population in Aotearoa are fully vaccinated, up from 23 per cent just four months ago.

More than 90 per cent of people have received at least a single shot.

Like almost every other health measurement however, Māori were left behind.

We have the lowest full vaccination rate, at 72 per cent.

Changes on the way

With Auckland's boundary settings changing mid-December, and fully-vaccinated or tested residents heading off for holidays, Māori are left with less protection than the general population.

This is an example of how taking that broader, strategic view could have helped significantly in the vaccination rollout to Māori.

What if established Māori entities with strong community ties like Kōhanga Reo were enlisted through funding to help with the rollout?

Instead of having to go out through a mainstream, illness-based kaupapa to "deliver injections", the rollout could have embraced Māori tikanga like manaakitanga and whanaungatanga.

This could have bypassed vaccine scepticism within Māori communities, created by our people's fears of losing the right to make their own decisions.

Looking at ourselves

If we drill down further we find that perhaps we need to examine our own behaviours and biases within the system.

An example is when Māori come into emergency departments injured from what is often a one-off event.

Maybe it is drug or alcohol-related.

It might be a one-off event, but that person could end up sedated, and sectioned under the Mental Health Act, or put under observation.

This is even more likely if they come in with a police escort.

Are we buying into this rapid assessment because of the police officer sitting there by the bed, or the police that bring that person in?

What if established Māori entities with strong community ties like Kōhanga Reo were enlisted through funding to help with the rollout?

In our assessments as nurses, we were taught to make rapid judgements. But along with that comes a whole bunch of behaviours, and biases, that we don't take the time to examine.

We should always consider the power we have to make an impact on somebody's life. Not just the power at the bedside, but the power of our decisions, the power of our conversations, the power that we have in how we represent people.

NZNO kaiwhakahaere Kerri Nuku.

Our voices have struggled to be heard by successive governments, to get what we need and deserve.

But have no doubt, we are powerful in positively or negatively influencing health outcomes for our patients.

We should never forget our power, or the responsibility that comes with it – to step back and take a look at ourselves. •

Vaccination – inequity in action

As of publication, 88 per cent of the eligible population in Aotearoa was fully vaccinated.

In total, 93 per cent of people have received a single shot.

Like almost every other health measurement however, Māori were left behind.

By ethnicity, Maori had the lowest full vaccination rate, at 72 per cent.

DHBs back down after pay protest threat

THREATS OF NZNO member-led protests saw three district health boards (DHBs) back down from playing Christmas Grinch over pay increases. The action planned for the end of November came after Canterbury, West Coast and Waikato DHBs missed deadlines to pay wage increases negotiated in NZNO/DHB MECA bargaining.

Until the protest action was threatened, the DHBs had not responded to NZNO requests for new timeframes after the six-week deadline had passed.

NZNO industrial adviser David Wait said he was pleased the DHBs agreed to pay before Christmas.

"This delay was just one more blow to our DHB members who, alongside all nursing staff in all nursing sectors, have proven their value and dedication over and over again on the frontline." •

Industrial advisor David Wait.

Pay equity negotiations continue past deadline – new date set

PAY EQUITY negotiations ran over deadline with district health boards blaming the complexity of the issue. NZNO, the Public Service Association, Ministry of Health and district health boards (DHBs) met at the end of November to settle the claim.

However, DHBs said the complexity of the issue meant more time was needed. Negotiations continued on December 6 but did not settle the remaining issues. At time of publication, a new date was being set, likely on December 10.

NZNO industrial services manager and pay equity co-lead Glenda Alexander, told DHB members the negotiations were close to conclusion.

The extension meant that as agreed under the new NZNO/DHB MECA, members would receive an additional pay equity lump sum down payment of $1000 gross (pro-rated by FTE). •

Concerns remain despite boost to ICU cash

THE GOVERNMENT announcement of a $600 million-plus boost for intensive care services has come with an NZNO warning about the state of the system in the face of a COVID-19 surge.

In December, Minister of Health Andrew Little announced $544 million of "operational funding" for costs such as intensive care unit (ICU) staffing. Little said he asked district health boards (DHBs) to find ways to boost ICU capacity – such as converting unused wards.

"Cabinet has earmarked $100 million of capital funding from the COVID-19 response and recovery fund to accelerate these ICU projects."

The first hospitals to receive money were North Shore, Tauranga and Christchurch. The Government approved $65 million for a new six-bed ICU facility at Waitakere Hospital, along with two negative-pressure rooms and a new 30-bed ward.

There were about 100 ICU beds available in Auckland alone, and the ability to surge to about 550 "ICU-type" beds across the country if needed, he said.

College of Critical Care Nurses chair Tania Mitchell, part of the Ministry of Health's (MoH) critical care sector advisory group, said the group had not yet seen the cabinet paper on the proposal, so was not aware of spending details.

Tania Mitchell.

However, any investment in critical care infrastructure and staff was "definitely positive", she said.

"These are things we have been asking for, so it's good news."

Outside of Tauranga, Christchurch and Waitakere, it was not yet clear where the Government planned to invest the cash.

"But it is positive and does go towards filling some of the gaps that exist in intensive care capacity and across the workforce."

Nurses were prepared to live and work with COVID-19 in the community, with "nervous anticipation" about what that would be like.

"We are preparing for COVID being endemic, with widespread community transmission," she said. "We'll be living with COVID, rather than having surges." Building infrastructure and workforce took time, after being run down for so many years.

"There is a national shortage of nurses and intensive care nurses and the solution for that is not straightforward."

The college was also working with the MoH on making it easier for expatriate Kiwi nurses to return home from early 2022, she said.

Meanwhile nurses in Auckland DHBs were sceptical about the state of the system.

NZNO organiser Sarah Barker said the country was being told the health system was well-placed to handle a COVID-19 surge.

"That might be what DHB executives are reporting, but Auckland nurses say they're already dealing with caseloads they can't handle."

Processes to reprioritise less urgent care were not being used, and staffing shortages were unaddressed.

"I am really concerned that the Government is telling the people we can handle a COVID surge when the reality is we have 1000 health care worker vacancies across the Auckland region." •

RN ACE rules now apply for enrolled nurses

AFTER TWO years of pressure from the Enrolled Nurse Section (ENS), enrolled nurse (EN) graduates can from 2022 apply for the ACE graduate programme while undertaking or awaiting results of state exams.

The move brings them into line with their registered nurse (RN) peers, said ENS chair Robyn Hewlett.

Until now, EN graduates have had to wait until they finished state exams before applying to the supported workforce entry programme, ENSIPP (Enrolled nurse support into practice programme) via the Advanced Choice of Employment (ACE) process.

The Ministry of Health only began funding EN graduates to be part of their own supported entry programme in 2019.

Previously, only RN graduates had been eligible for ACE and nurse-entry-to-practice places.

Hewlett hoped bringing ENs into the programme would encourage more DHBs to employ them.

The ENS had been lobbying DHBs for the past two years to allow ENs to apply for ACE programmes while still sitting exams, which meant it would be easier for them to find supported graduate entry roles.

NZNO professional nursing adviser Suzanne Rolls said while it was too late for EN graduates this year, it was a "start". •

Safe staffing petition presented

NZNO AND E tū members delivered a petition (1700 signatures) and open letter (5300 signatures) to Parliament calling for mandated safe staffing levels in aged care.

NZNO industrial adviser Lesley Harry said regulations, without specified minimum levels, were unsafe and had not kept pace with the needs of senior citizens.

Nurses were run off their feet and unable to provide the safe care their residents and patients deserved. Vital care was being missed or significantly delayed because there were not enough staff on the floor, she said. COVID-19 made the problem worse in a sector that relied on overseas nurses, Harry said. •

Police send 'reassurance' patrols to vax sites

POLICE HAVE launched "community reassurance" patrols around some COVID-19 vaccination sites as nurses face abuse and threats.

In December media reported vaccination events in Taranaki were cancelled or moved indoors after abuse and physical attacks from anti-vaxxers.

The confrontations included verbal abuse, damaged equipment and in some cases physical assaults.

A police spokesman said police took any reports of intimidation or abuse of healthcare workers in any setting very seriously, "and if we get calls for assistance we will attend".

"We also undertake community reassurance patrols from time to time at sites such as vaccination centres in the area." He said police understood that the vast majority of the community were "hugely appreciative" of the work being undertaken by vaccination teams.

NZNO kaiwhakahaere Kerri Nuku said she had been told by members that it had become a problem.

"It's got to the stage now where it's obstructing them from doing the job that they need to do."

It had been "heart breaking" for nurses who were working to protect and inform patients despite being confronted by aggressive vaccination opponents.

Acting manager, professional and nursing services Kate Weston said violence and aggression towards nurses was disappointing - but an increasing trend in healthcare.

Violence in the context of vaccination was especially unacceptable, she said. "Throughout the pandemic, nurses have provided front line support, often with very little notice, which included pop-up testing stations and ongoing vaccination programmes essential for Aotearoa to maintain wellbeing in the community and to limit the aggressive spread of COVID -19 as we see in other places overseas." Nurses had provided the backbone of the COVID response across the country, she said.

Weston said the vast majority of nurses were themselves fully vaccinated: many were starting to get their booster doses.

"This will ensure their immunity carries them through what might be a very busy period with opening of borders and the spectre of Omicron across the Tasman, and any subsequent variants that may come our way in 2022."

Meanwhile the demands of the COVID-19 response has now seen proposed changes to nursing training. The Nursing Council of New Zealand proposed students would be able to use their experiences of COVID-19-related practice such as vaccination as part of their clinical learning.

These standards would allow high quality, clinical experiences in the context of the COVID-19 global pandemic. •

New pandemic lessons for nurse students

NURSING STUDENTS will be able to use their experiences of COVID-19-related practice such as swabbing, vaccination and contact-tracing as part of their clinical learning, under proposed new nursing standards from the Nursing Council.

Nursing Council chief executive Catherine Byrne said the proposed changes to nursing education standards included pandemic-related practice, to help schools provide training in what was an emergency situation. It would also allow students to contribute while allowing their experiences to be part of their clinical learning.

"Given the emergency situation and rapid response required, nursing students can learn along with contributing to meeting this urgent need, [and] paid employment could be considered in this situation."

NZNO national student unit (NSU) leaders Jade Power and Waiharakeke Biddle said students supported the changes, as a "vital way for nursing students across Aotearoa to gain their required clinical hours if they have been affected by COVID-19".

But students working as healthcare assistants in COVID red zones such as emergency departments, intensive care units and COVID wards should also benefit from the standards, NSU said. Currently, the standards only included students doing contact-tracing, case management, swabbing and testing.

NSU also sought reassurance in a meeting with the Nursing Council that students would be well-supported on placement and looked after adequately if they caught COVID-19.

They also wanted to ensure students be protected from workplace pressures "as under these standards, the students' workplace now becomes a clinical learning environment".

The supplementary registered nurse education programme standards (2021) should only be used when "normal" accredited clinical learning placements were disrupted due to pandemic restrictions, the Nursing Council states. Consultation ended on December 13.

NZNO research has found COVID-19 significantly disrupted students' clinical placements. Of 700 students surveyed in April/May, 83 per cent reported problems with their clinical placements – including 40 per cent who said the impact was major due to dropped, fewer or shorter placements. •

Global award for kaiwhakahaere celebrated

NZNO kaiwhakahaere Kerri Nuku's Human Rights and Nursing Award ceremony had a whānau flavour.

NZNO KAIWHAKAHAERE Kerri Nuku's global recognition for her human rights work has been celebrated – in a very local way – at Te Marae o Te Whare Takiura in Napier.

The Human Rights and Nursing Award 2021 was awarded to only two nurses worldwide. Nuku was recognised for her contribution to human rights and equitable care for indigenous nurses and the wider Māori community, as an advocate, activist and researcher.

In the November ceremony she said she worked for an organisation, NZNO, which was on a bicultural journey. This meant creating positive outcomes for Māori: "Not just for nurses, but for our whānau that die too young, who don't get access to services."

The audience at the Eastern Institute of Technology, and on Zoom, included distinguished academic and lawyer Moana Jackson. He said he was proud to know Nuku, and wished her and Māori nurses well during COVID-19 times.

The pandemic brought out the best and worst in people. "The institutional racism we've had to struggle against so long has reared its head again … and the sad fact that most of the deaths in this country are our people, is an indictment really."

Te Matau-a-Māui Regional Council, who hosted the event, nominated Nuku for the award. •

Now the real work begins with safe staffing tool

BOTH WELLINGTON and Hutt Valley District Health Boards are celebrating getting safe staffing programme care capacity demand management (CCDM) up and running.

But now the real work will begin – finding nursing and health staff to fill gaps identified by the tool, staff say.

"It's great to have implemented the tools and processes – now it's about achieving safe staffing," said Capital & Coast District Health Board (C&CDHB) CCDM programme manager Emma Williams. "We have a major workforce issue in New Zealand."

C&CDHB was looking at new graduates, international recruitment, those willing to return to practice and retaining existing staff. "But we really need an investment in nursing and midwifery from our Government."

It had taken four years to get CCDM up and running at C&CDHB, Williams said. Over time, she had seen growing commitment from the executive leadership to safe staffing, as well as a willingness to be open and transparent.

Getting everyone "on board the waka" had been a challenge, as the project stretched across every part of the DHB, from maternity to mental health.

"We are now able to have total transparency for the first time. Now we can see where the challenges, the problems, are and where the efforts need to go to make staffing safer."

NZNO organiser Jo Coffey said having CCDM accredited was already making a difference.

Hutt Valley District Health Board CCDM co-ordinator Sally Huntsman said there had been challenges but getting CCDM fully implemented was a "brilliant achievement".

Safe Staffing, Healthy Workplaces director Bridget Smith with C&CDHB chief nursing officer Chris Kerr and Emma Williams.

A ministerial review is currently underway to investigate why only half the country's DHBs had implemented CCDM by June 2021, a deadline set in the 2018 Safe Staffing Accord. •

Farewell to Kai Tiaki Nursing New Zealand in print

Heather Woods with the 1989/90 summer edition

AFTER NEARLY 114 years, this is the last printed edition of *Kai Tiaki Nursing New Zealand*.

NZNO librarian Heather Woods said the journal had been an essential resource for NZNO members and researchers alike, for many years. "It's the first place we go if we're looking for answers – to professional questions with regard to NZNO services, nursing practice, historic material, dates – for example when a strike occurred," said Woods. "It has recorded all NZNO's interactions. . . and is an official record of all its activities and member activities."

It also offered "sound, fact-based" opinions related to health and nursing, as well as a highly regarded continuing professional development (CPD) section, she said. NZNO always advised members seeking to boost their competency to read relevant CPD articles, she said.

Over the years, *Kai Tiaki* had helped academics, students writing theses, management, clinicians, documentary-makers and many authors, writers and researchers. It had been invaluable to NZNO college & sections committee members along with members seeking specific information.

"We always say '*Kai Tiaki* to the rescue' as people want to know dates and it's really useful to find out how long someone was president or when a member was given an award of honour."

Woods said the NZNO librarians always chose to read *Kai Tiaki* "from cover to cover" to ensure they were up-to-date with current NZNO and nursing matters, as well as things members were involved with.

Kai Tiaki Nursing New Zealand however will continue to be published online at www.kaitiaki.org.nz. •

See p12-17, A Farewell to Print

Nurse practitioners ready to

After seeing too many people die without whānau, Auckland NP Tamah Clapham (below) has trained and registered to provide care under the End of Life Choice Act.

In 20 years of nursing, I have been present at dozens of deaths.

As an undergraduate, I worked for three years as a caregiver in a rest home, so witnessed many deaths from natural causes – often without family or whānau present

In the hospital, where I started my registered nursing career in acute care such as emergency, I also saw people die, without family or whānau present.

In primary care, I have seen longer deaths, from complications of chronic or terminal illness.

All these experiences have led me to believe that there is such a thing as a good death.

While we have palliative care options that allow for a good death, for some who are terminally ill with less than six months to live, the most important thing may be to have control over when and how that death may occur – and who will be there with them.

Many experienced nurses are experts in death and dying.

I accept that some nurses, nurse practitioners (NPs) and doctors may choose to not provide this service, due to conscientious objection.

But it is important – as with last year's decriminalisation of abortion – that patients are referred appropriately to a willing practitioner.

In Aotearoa, many facing imminent death will not choose a death day, as it does not align with their values or belief system. I respect that choice too. The legislation is very clear that a clinician is not to raise the topic with a patient and this is a way of protecting against any coercion.

I have completed the Ministry of Health (MoH) training. The legislation and rollout has many processes to ensure the person seeking assisted dying is competent to do so and free from coercion. This involves up to three practitioners certifying this, two medical initially and – if not satisfied – a third opinion is sought through psychiatry colleagues.

Although this is new to us here in Aotearoa, the MoH can use experience from Australia and Canada, where similar legislation is already in place. This gives us something to base our own interpretation and practice on.

The SCENZ (support and consultation for end of life in NZ) group includes a range of practitioners and oversees the EOLCA, along with a medical officer. There is also an 0800 number for support.

But it is disappointing that the MoH only appointed one nurse representative [NP Jackie Robinson – see November *Kai Tiaki,* p16] to SCENZ.

It is top-heavy with medical practitioners, who comprise seven out of the 12. However, it does appear to have good representation for Māori.

My understanding, from listening to a colleague in Canada, is that the service is deeply valued by the patient and the community supporting them.

From what I have learned about the death day, I think it would best involve two clinicians to support the individual, their whānau and community, as well as the clinicians themselves. The range of skills needed would best be delivered through a collegial approach.

The EOLCA refers to a medical practitioner. The MoH appear to have interpreted that literally, despite 2019 amendments to the Health Practitioners Competence Assurance Act to allow qualified health practitioners to carry out activities that could previously only be done by doctors.

As things stand now, if an NP is approached by a patient about assisted dying, they must refer to a medical practitioner, who must then seek a second opinion from another medical practitioner.

Yet I believe it is entirely within an NP's competency to be able to provide a first or second opinion on a patient's eligibility and competency. It does concern me that in rural areas especially, this may increase barriers to access and create inequities.

Currently, NPs are able to administer the life-ending medication but not assess eligibility or initial consent. I find this very strange decision-making and wonder about the hegemony of the MoH decision-makers in their interpretation.

An NP/GP model, and an RN-led assisted dying service in rural areas, would be much more representative of the workforce available. It would ensure a quality and equitable service, as well as shoring up the wellbeing of practitioners. •

play a role in assisted dying

Seeing a resident effectively starve himself led a nurse practitioner working in aged care to sign up to provide assisted dying care. By co-editor Mary Longmore.

A Waikato aged care nurse practitioner (NP) registered to assist eligible people to die says she feels obligated to help after years of seeing needless suffering in aged care.

Kai Tiaki agreed not to name the NP, as she feared other nurses' reactions.

Unable to swallow, in effect he starved himself until the pneumonia took him away

One man with motor neurone disease stood out in her memory. Dependant on others for all his needs, including toileting, he had a gastronomy feeding tube in place but refused to allow anyone to feed him through it.

"Unable to swallow, in effect he starved himself until the pneumonia came and took him away," she recalled. "This was very difficult for his family and staff, as well as the man himself. All he wanted was some dignity and choice."

She is now poised to assist a patient to die for the first time, since the End of Life Choice Act (EOLCA) came into effect on November 7.

"I really don't know how I feel – apprehensive and worried, probably."

She would be accompanying a GP, who knew the patient. Under the EOLCA, NPs were not able to be part of the early process including decision-making, which would likely make it difficult to form relationships with patients, she said.

"I think the whole thing is going to be really difficult – the GP or attending practitioner can form a relationship with the patient over time, but the NP is potentially going to be coming in at the end, without any time to form a relationship."

In her 40 years working in aged residential care, she has seen many deaths – some of which took a long time and involved suffering. Some – those with terminal illness such as cancer – would likely have been eligible for assisted dying, but those with dementia would not. Yet people with dementia could have very challenging deaths, she said.

Nurses, particularly those in aged care, were often more comfortable and familiar with death than doctors, she said. "During my career as a nurse, I have been the one to administer the last [pain relief] injection to those at the end of life on numerous occasions and been present at the bedside at the time of passing."

The assisted dying process was highly structured, with many opportunities for people to change their minds, she said.

"For those who have made the decision to pursue assisted dying, this will not have been done lightly."

It was frustrating that under the current legislation, NPs were not allowed to participate fully in the process. "Will I be able to develop a relationship with the person who has received authorisation to end their life in the time between approval and date of planned death?"

Nor were NPs able to write the prescription currently, even if they were the attending practitioner.

"Very much a handmaiden role again – doing the hard bit, the actual procedure!"

However, it was a start, she said.

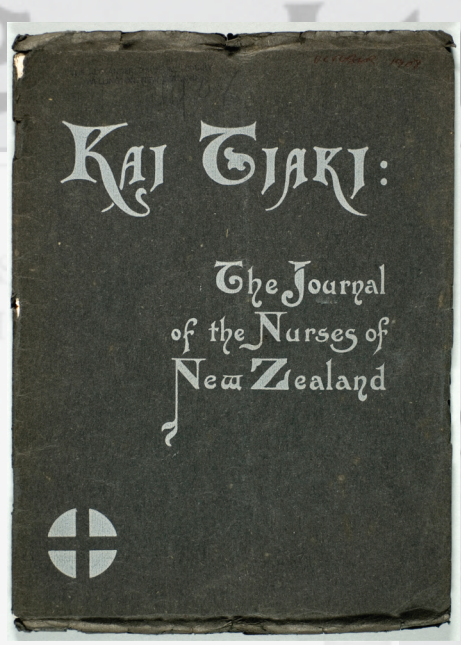
Nurse Practitioners New Zealand (NPNZ) chair Sandra Oster said the EOLCA required NPs to act under the instruction of an attending medical practitioner, even though they were authorised practitioners.

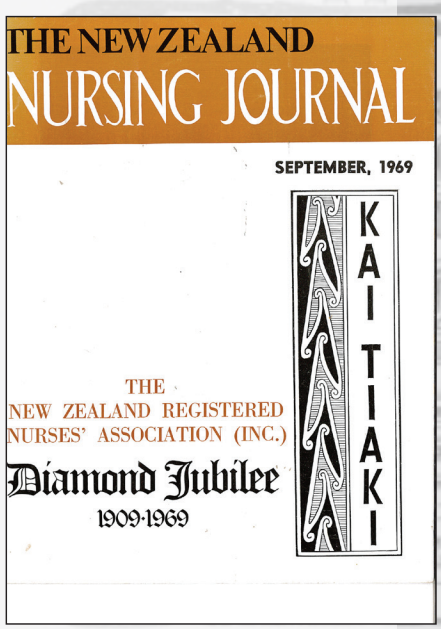
The MoH had acknowledged the error but had taken the view it could be amended when the legislation was reviewed, she said. There was no set date for a review. •

PHOTO: ADOBE STOCK

A farewell to print . . .

In this final print edition, we look back at the story of *Kai Tiaki Nursing New Zealand*. On the following pages, two former co-editors remember the highlights of their time at the journal's helm. And in the editorial on p2, Anne Manchester and Teresa O'Connor, who between them clocked up 55 years running *Kai Tiaki*, talk about why the magazine is important, and how that won't change when it is only online.





This last issue of *Kai Tiaki Nursing New Zealand* is the end of an era - 113 years of almost continuous printing since its founding by Hester Mclean in 1908 as a "bond of union" for nurses. This makes *Kai Tiaki* among the longest-running print publications in Aotearoa. It appears to have just been pipped to the post by the School Journal, which is still printing today, 114 years after its launch in May 1907.

However, both appear to have been outstripped by Auckland University's quarterly *Journal of the Polynesian Society*, which began printing in 1892 and continues today - an impressive 129 year print cycle!

Kai Tiaki – the Journal of the Nurses of New Zealand was launched in January 1908, at a cost of four shillings a year by Hester Maclean, an Australian-born nurse working as a hospital inspector in New Zealand. She became the first president of the New Zealand Trained Nurses' Association (NZTNA) when it was established in 1909.

The magazine carried many stories of nurses involved in World War I and of the sinking of the *Marquette*, as well as the 1918 influenza epidemic.

Later, in 1923, the NZTNA purchased *Kai Tiaki* from Maclean, although she remained editor. The NZTNA became the NZ Registered Nurses Association (NZRNA) in 1934.

Over the years the journal has campaigned for equal pay for equal work, publishing a paper on the topic in 1957 – even though the NZRNA was then opposed to any political activism.

Beginning as a quarterly magazine, *Kai Tiaki's* frequency has varied over the years, but since 1988 it has been published 11 times a year. Its only gaps were in the 1940s, when two issues were cancelled in 1942 and 1947 because its sole editor, Agnes Donner, was on leave. In 1942, during World War II, regulations controlling the use of newsprint meant page numbers dropped to just 24 for the next five years.

Blending the professional and the industrial, like the organisation itself, *Kai Tiaki* includes news, opinion and features, as well as member interviews,

and practice, clinical and professional development articles.

Unlike some of its sister union publications, *Kai Tiaki* has enjoyed a high degree of editorial autonomy which allowed the co-editors – generally trained journalists since the early 1970s – to make decisions over content.

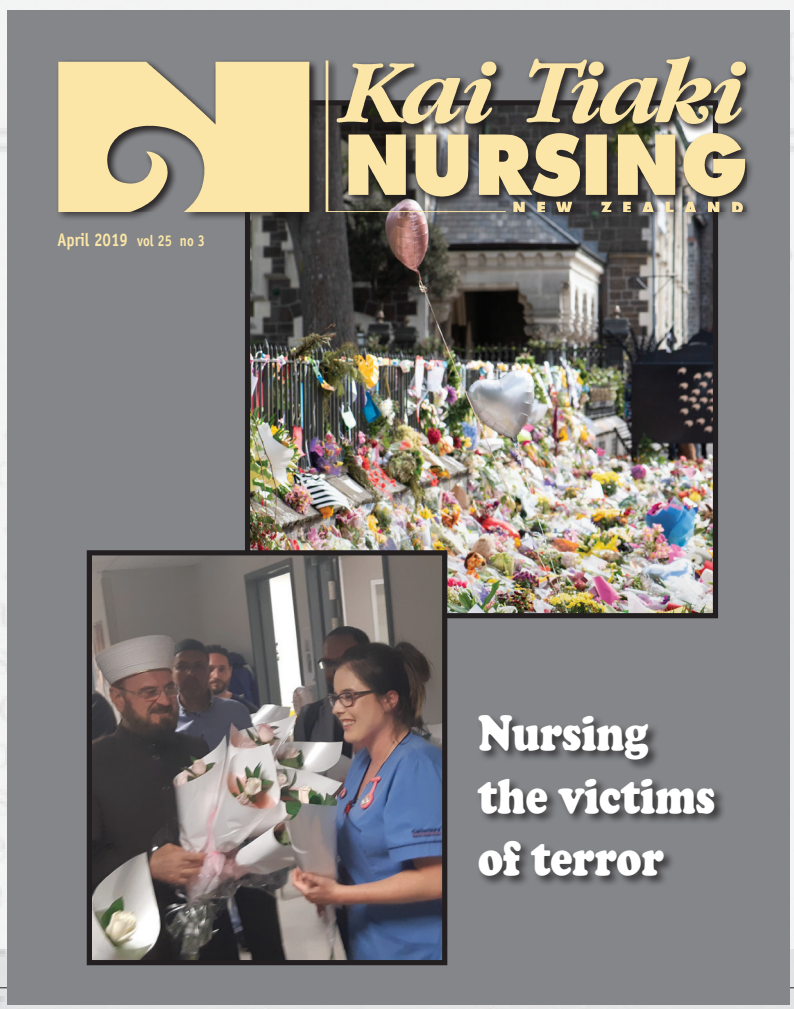
It is a unique and challenging position for journalists, to be both part of and reporting on their employer. Co-editors over the years have written for members with integrity and honesty, even as NZNO passed through its own internal challenges, member unrest and strike action – a delicate task at times.

Kai Tiaki has enjoyed enviable readership rates among the 45,000 or so members who receive a copy in the post each month. 2019 research showed nearly 90 per cent of the 1128 members surveyed read *Kai Tiaki* either all or some of the time.[1]

Members asked for an online option in 2015, to allow more sharing of material and to save costs and trees. It has taken a few years but www.kaitiaki.org.nz was finally launched this year.

With NZNO facing a $1 million operating deficit, at September's annual general meeting, a series of cost-cutting measures were announced, including ceasing of a printed *Kai Tiaki*.

But online, we plan to continue delivering the same trusted, and at times challenging, content, along with your views and news – including the debates and dissenting voices. •



Reference

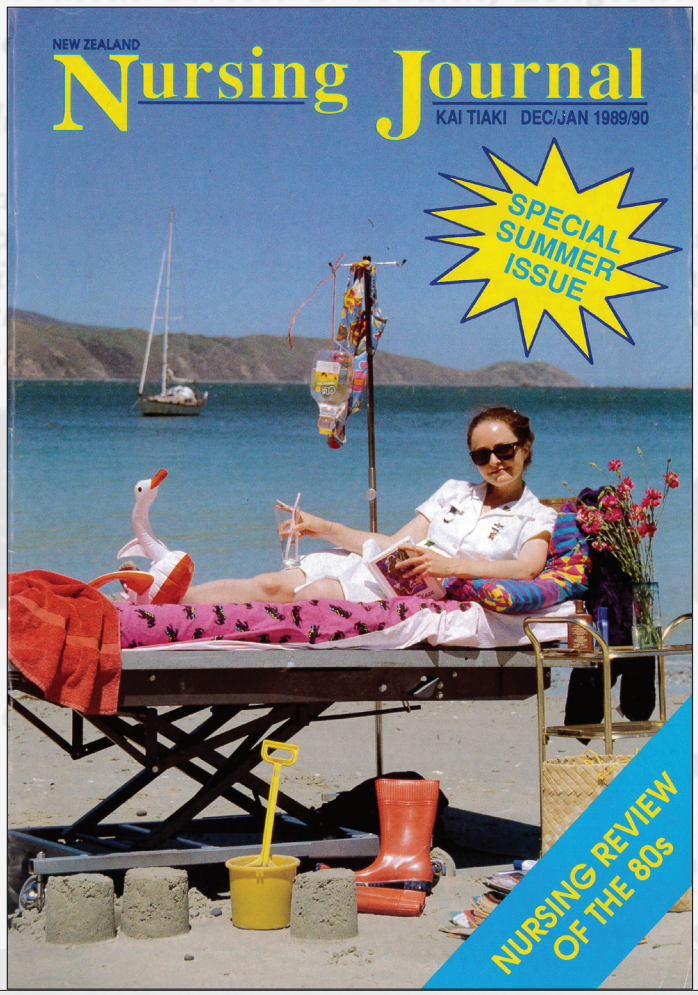
1) Stodart, K. (2019). *Kai Tiaki* widely read, with a clear interest in an online version. *Kai Tiaki Nursing New Zealand, 25*(1), 12-13.

Keep reading *Kai Tiaki* and fight the good fight

By Claire O'Brien

It's a bit of a jolt to write this (three decades – really?), but a little over 30 years ago I became co-editor of *Kai Tiaki Nursing New Zealand,* working (very happily) alongside Lyndon Keene, and later Glenda McCallum, then Kathy Stodart. We edited in interesting times – just before the New Zealand Nurses' Association (NZNA) amalgamated with the NZ Nurses' Union and not long after the "Nurses are worth more" strike. I'd been both a print and a radio journalist and editor, and returning to print was an especial pleasure; working for a union, a great privilege; and working with a female-dominated, hugely skilled profession, kind of fabulous.

The people at NZNA were amazing – passionate, hard-working, mightily able and frequently hilarious.



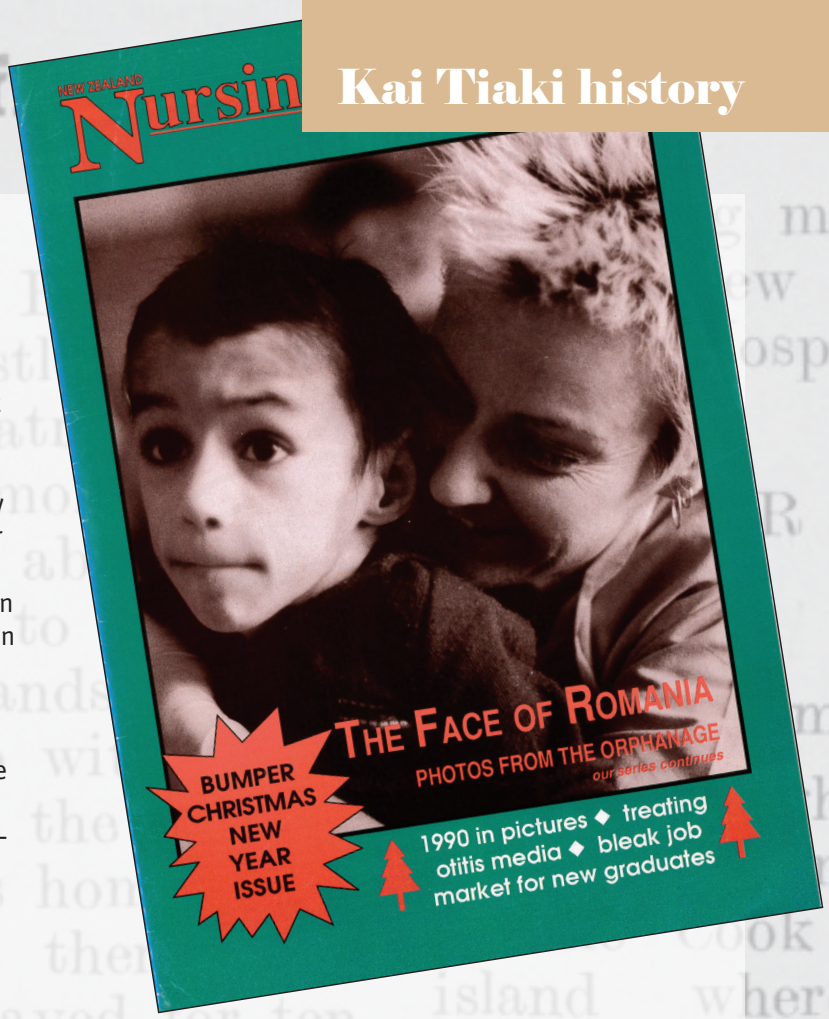
My recollections of the journal are a little lost in the mists of time, but a few things stand out. The people at NZNA were amazing – passionate, hard-working, mightily able and frequently hilarious. Not only the professional-facing industrial, advocacy and education staff (Fiona, Raewyn, Donna, Philippa, Chris et al), but the support and back office teams running the organisation's New Zealand-wide activities were brilliant, with chief executive Gay Williams' PA Jan Solloway the star; president Helen MacKenzie and the union's organisers, officers and delegates across the country – legendary and inspiring.

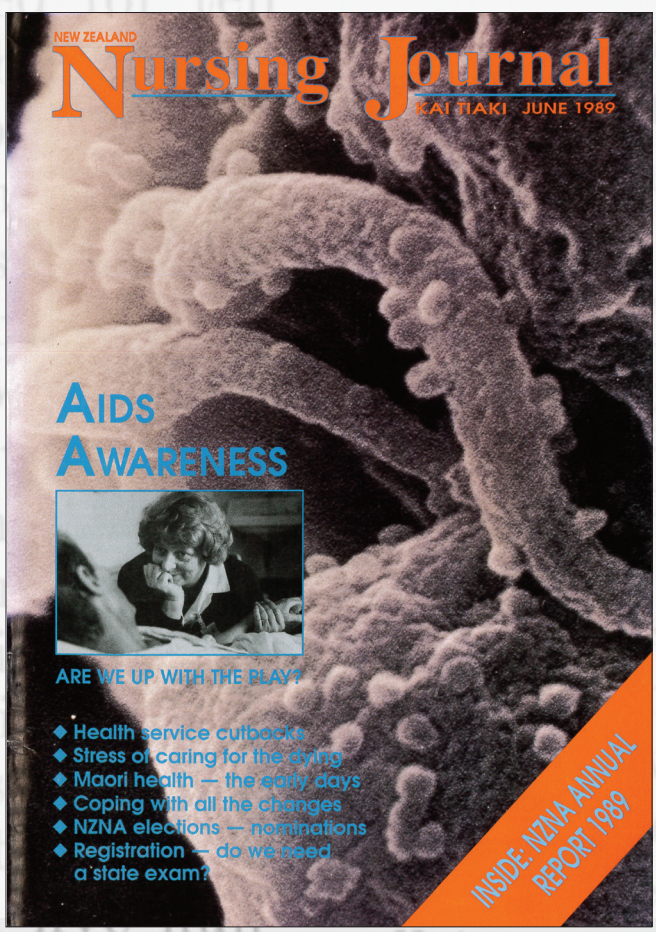
Our members were remarkable – as any

group of workers organising themselves around professional principles of best practice, fairness, justice and a strong and stable health service generally are. Getting them in the magazine, hearing their stories, campaigning on issues, providing useful content and essential information were part and parcel of the *Kai Tiaki* mix. Finding something to put on the front cover was never quite so easy. For one summer issue, we raided my daughter's toy box and bedding supplies, borrowed press manager Ann's truck, nabbed a hospital bed and created an al fresco ward on a Te Whanganui a Tara/Wellington beach with a nursing friend reclining resplendent in her uniform, drinking cocktails from an IV drip.

Two editions I clearly remember, and stood in awe of the contributors: an HIV/Aids issue leading with the resonant testimony of an HIV-positive nurse; and the letters home from a nurse working in Romania as the plight of children in the orphanages and institutions was exposed. They embodied the spirit of *Kai Tiaki*, its breadth of interests, its freedom to explore and investigate (occasionally hard argued for), as well as its essential practical function as purposeful organ of the rights of the worker!

The mists of 30 years may be a little rose tinted, but NZNA, and *Kai Tiaki* in particular, were a great place to work. I used to argue that one of the most tangible benefits of belonging to a membership organisation was receiving a hard copy of their in-house magazine. Two professional magazines I've previously edited, both in the United Kingdom, where I returned to live some time ago, and in Aotearoa, are now fully digital. I read my newspaper online, along with most of my books. I have a single monthly subscription for a print magazine and those copies accumulate in stacks, accusing and unread. We are all different in how we want to read. I don't know the full story leading to this being the final print copy of *Kai Tiaki* that you are holding in your hands right now. If you will miss it, and the process has been alienating, I am sorry for your loss. But please keep reading it, spreading the word, fighting the good fight. •





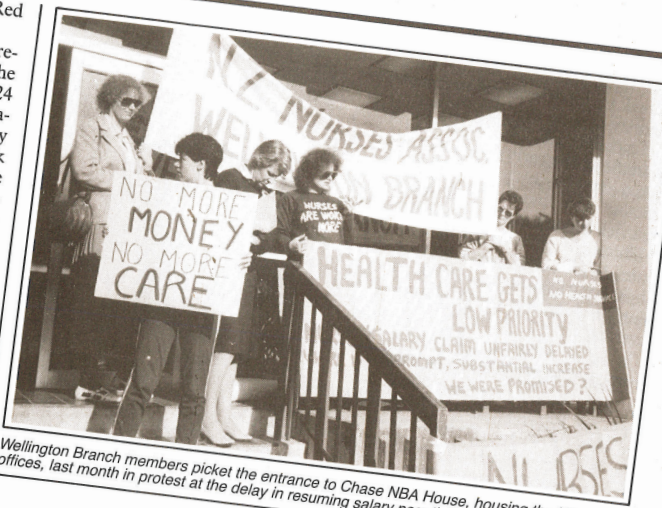
Co-editor of *Kai Tiaki* from 1990-92, **Claire O'Brien** lived in Aotearoa/New Zealand for 19 years, before returning home to live in the UK in 2002. She is a communications manager for the British Film Institute. Although London-based, she retains a strong connection to this country, where her daughter still lives. Thanks to the ending of MIQ, she will be paying her a visit early in the new year.

NEWS AND EVENTS

International Committee of the Red Cross (ICRC).

After receiving the telephoned request from the ICRC, Geneva, the nurses were assembled within 24 hours. According to the New Zealand Red Cross ...

...ecretary ...s quick ...because ...of ex- ...rve to ...d be- ...s co- ...ne of ... for ...t of ...stan ...un- ...ties ...pi- ...ng- ...nd ...as ...in ...r



Wellington Branch members picket the entrance to Chase NBA House, housing the HSPC offices, last month in protest at the delay in resuming salary negotiations.

created on the new board, and Dr Bassett said he would be discussing ... raised by the Director of Mental Health

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MARCH 1985

KAI TIAKI

The New Zealand Nursing Journal

Negotiations continue inside

200-250 Wellington nurses protest outside

CONFERENCE '85

Diary of the Bus People from North of the Bombay Hills

Day 1; Monday 15th April 1985. 1915 hrs.

TWENTY EIGHT concerned, committed, and enthusiastic nurses boarded a bus in Auckland for the N.Z.N.A. Conference in Wellington. What a night! Such a night!

After a supper of chicken supplied by Miss Perkinson, and white wine, we set off for our first scheduled stop at Taupo. Near non-existent night life: — 24 hr takeaway bar had to have top rating (no competition).

Back aboard the bus, after chorus of "Good Night Leader" we all settled down to sleep. 5 kilometres later, settled down to sleep. 100 kilometres later, some lucky ones were actually asleep!

THE busload of observers from the Auckland region

Day 2; — 0600 hrs.

Dawn tour of Wellington sites. Sun rising behind Wellington Railway station was beautiful, but unappreciated due to locked ...

NURSES ARE WORTH MORE

...; — Conference ...nued.

... End of Conference at 1700 hrs. ...n the dreaded bus again, but not for ...his time. Stopped just north of ...gton for dinner before facing the ...ng overnight journey to Auckland. ...a little sing-song then "fight for ...ons", we settled down to sleep and one ...dreamed.

...really was wonderful — the way we had been accepted at Conference. The way our questions from the floor had been answered so succinctly by the panel." Reality surfaced with, "Next stop Papatoetoe!"

Neville destroyed the short-lived dream of how it could have gone at Conference.

Was it all worth it, Mia Carrol, Gill Coombes, Uncle Tom Cobbley and all? Of course, who knows, this year's fantasy will be next year's reality — roll on '86, '87,...

Les Tomlinson
Elizabeth Dale

...ay 1985

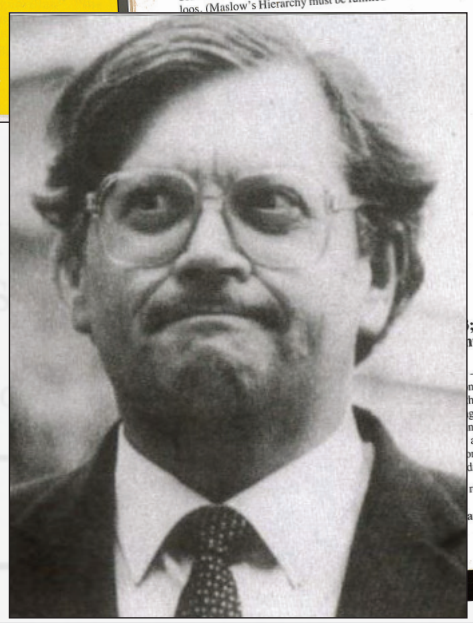
ISSN 0028-8535

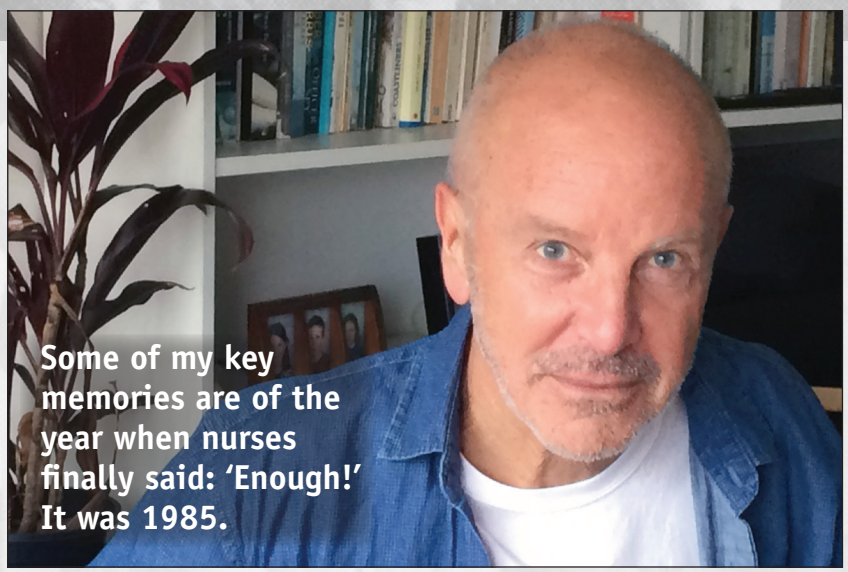
JANUARY 1983

KAI TIAKI

The New Zealand Nursing Journal

75th Jubilee Issue





Some of my key memories are of the year when nurses finally said: 'Enough!' It was 1985.

'My computer responded to instructions unpredictably'

By Lyndon Keene

I was an editorial assistant when, in 1985, *Kai Tiaki* took on a new look, coinciding with a switch to in-house computerised production. Up until then, the journal page designs were made up for the printer through a laborious process of cutting out columns of type-set script and taping them onto blank pages, leaving spaces for photos. Any editing or amendments at that stage involved calculating the number of lines of type you were going to end up with, so the columns fitted on the page properly.

The introduction of the new desk-top publishing system put an end to all that. All the typesetting, design, editing and alterations could be done instantly on screen. The computer sales people gushed about how everything would become much faster. Certainly, if speed is good, then computerisation had a very positive impact on my ageing process.

I soon learned that the computer brain is far from logical. My computer responded to instructions unpredictably. At times it would react differently to the exact-same instructions I'd given it the day before. Occasionally, most often as the deadline approached, it could get quite obtuse and even switch itself off in the middle of a conversation.

The computer customer support people (who got to know me well) put it down to software design hitches (this was the early days of desk-top publishing), but I never felt they were being completely up-front. That didn't explain, for example, why my colleague, editor Ann Cherrington's computer worked perfectly well, using the same programme (which my computer insisted I spelt incorrectly!) It was thanks to Ann the journal ever got printed in those days.

Computer challenges aside, some of my key memories from my time with the NZNA (NZ Nurses Association, which merged with the Nurses' Union in 1993 to become NZNO) are of the year when nurses finally said: "Enough!" It was 1985. Nurses across the country were gearing up for unprecedented industrial action. Health Minister Michael Bassett was not happy; he was not budging. Nor were nurses, and nurses had strong support from the public.

Prime Minister David Lange made an unannounced visit to NZNA's national office. As it happened, most of the staff were out. Chief executive Pat Carroll's PA, Jan Solloway, was holding the fort. Jan was a polite, savvy, no-nonsense person. She would have offered the PM a cup of tea, and probably a bit of advice, which I'm sure would have been far more sensible than that being offered by his Health Minister at the time. In the end, of course, the Government did see sense. If only the political memory lasted more than three years, maybe nurses would have been spared having to go through it all again later.

Nurses had a just cause, but that's not the only reason they won through – there are plenty of just causes that haven't. Another important factor has been nurses' unity, their organisation and strength of voice. *Kai Tiaki* has been a key part of that. And I'm really proud to have been a small part of it. Here's to you, *Kai Tiaki*, and all you nurses and members who make it what it is! •

Lyndon Keene was a *Kai Tiaki* subeditor, acting editor and finally co-editor, from 1985 to the early '90s. He also worked in public relations for NZNA and NZNO. He now lives in New South Wales, where he paints and works part-time as a policy and research adviser for the Association of Salaried Medical Specialists.

Bridging the digital divide: nurses a

By co-editor Joel Maxwell

It was the news that for some, brought a foreboding sense of the rapid change besetting the world – after more than a century of print publication, *Kai Tiaki Nursing New Zealand* would publish exclusively on its website from February 2022.

It seems the only certainties of modern life are change, ageing and taxes. (Death was cut from the list – it no longer qualifies thanks to our lingering Facebook accounts.)

From paper to digital notes, from mercury to electronic thermometers, from face-to-face to Facetime: health is changing. With some readers voicing understandable concerns about the digital divide, *Kai Tiaki* set out to discover if we're really ever too old to keep learning,

Firstly, the nursing world is indeed changing. Its workforce is getting a little grey around the edges.

The Nursing Council's *New Zealand Nursing Workforce 2018-2019* profiles say the average age of the workforce was about 46 at the time of publication. The number of people aged more than 50 was nudging half of the workforce – about 43 per cent.

So, are these people over 50 fazed by digital challenges, and change? But perhaps more importantly, can Aotearoa afford to leave them behind if they are?

Age Concern chief executive Stephanie Clare has been a registered nurse for 35 years – and is still actively learning every day in the job.

She said older nurses would "hold the system together" as the demands to meet workforce needs increased.

Clare was confident older nurses could keep up with digital change – and had already been adjusting to this new world. In fact she was upbeat about the digital future.

PHOTO: ADOBE STOCK

Age doesn't stop digital learning.

"When we started nursing many years ago we might have used paper notes, but now we use digital notes."

The number of people aged more than 50 was nudging half of the workforce – about 43 per cent.

The Nursing Council had itself adopted change – the "little red cards" for annual practising certificates were gone, she said. "To even get our … certificate we have to use digital."

Change might be difficult, she said, but it came with "communications and digital connections that haven't happened before".

Nurses were already digitally savvy, she said, because they worked in a changed health system.

"I remember when a thermometer had mercury in the middle – now we've got digital thermometers; blood pressure cuffs that are automated … there are no industries

nd the truth about learning

that haven't changed over the past decades, and nursing is no different."

However, older nurses were probably still keen to get more training and support, she said.

It was a case of helping older workers continue working for as long as they wanted. "Both contributing to their own wellbeing, but [also] for that of the … health system, primary practice, hospitals. We're all holding this together."

Clare had just attended an online gerontology conference offering multiple speakers, which had undoubtedly drawn gerontology nurses who were NZNO members.

"That ability to be connected with those of like minds without having to leave your home or workplace, would only be more beneficial for the people that we look after."

The good news was that Age Concern offered assistance and advice for people of all ages – not just those over 65. So if members wanted to find out more about its digital assistance resources they could visit a local office, found in the phonebook, or online at ageconcern.org.nz.

Never too late to learn

Meanwhile the question of whether digital upskilling is possible once we enter the misty realms of ages 50-plus was something to which University of Waikato education lecturer Diana Amundsen had a simple answer: yes, and COVID-19.

The pandemic, with quarantine and lockdown containment measures, was a "sink or swim" moment for people to use digital technology.

"Rapidly, it became vital to order groceries online, conduct banking online, connect with family and friends through technology, and communicate with health-care providers, often online. Online vaccine passports are another example of these 'sink or swim' moments."

Age Concern chief executive Stephanie Clare.

Fortunately, she said learning never stops in our lives.

"When we reach adulthood and leave schooling behind, all our learning is voluntary. We are self-motivated because we need or want knowledge for personal and professional reasons."

Amundsen said psychologists understood that technology would never be a replacement for human interaction.

The pandemic, with quarantine and lockdown containment measures, was a 'sink or swim' moment.

"But learning a new type of digital technology, which may be uncomfortable at times, is ultimately positive for our health and wellbeing, especially in this new-normal, COVID-19 context for enhanced connection."

Inga Hunter, health services management programme director at Massey University, said learning never stopped.

In fact, linking age with problems using digital tools might not even be entirely correct.

She said research showed older people had adopted new technology very well: "Use is extensive and age is not an indicator of use."

Some people need support, she said – but then again, so do some younger people.

Hunter said people seeking to upskill might want to keep their own learning style in mind. People learn in different ways, whether that's via text, audio, or visually.

Short videos were often popular for helping people learn new skills, as was recruiting help from within the whānau.

"Local technology champions is a developing concept in communities – [which means] ringing the local 'champion' for help."

So, in the end those new modern certainties that include change might have some real benefits.

Learning is often difficult, and challenging, but ultimately we grow from our newfound knowledge – and the journey itself.

As we age, it might be that it is not just the world transforming, but us transforming with it. On taxes, there's nothing to be done. •

Age Concern offers assistance and advice for people of all ages – not just those over 65. So if members wanted to find out more about its digital assistance resources they could visit a local office, found in the phonebook, or at ageconcern.org.nz.

‘Intolerable’ bullying drives nurse out

Auckland nurse Petra Aukino has quit the profession after bullying early in her career ‘shattered’ her confidence. She shares her story here.

I pursued nursing as I had a desire to relieve others’ suffering and provide a caring and safe environment for people dealing with health problems.

Working in the nursing sector for nearly 20 years has provided me with both positive and negative experiences. I met some wonderful nurses and have made lifelong friends – but also experienced and witnessed negativity which left me feeling disenchanted.

An older student, I graduated in my 40s. My first placement post-registration, in 2002, was in a paediatric setting. I was very eager to work in this area as I loved children.

But early on, I heard a couple of experienced nurses make derogatory remarks about one of the young patients at handover, stating that they did not want to be allocated to the care of that baby as he was too ugly.

These comments were made on more than one occasion. I was horrified but rather than raise it with the nurse manager, I decided to ask them directly if they were aware of how upsetting their remarks were. They both told me to “f…k off” and claimed they were using their coping mechanisms before walking away.

From that day on I was ignored and ostracised by these two nurses.

My next hospital placement was in an adult surgical setting where I, along with several others, had several bad experiences involving a couple of senior nurses who contributed to a very negative work environment.

Sarcastic comments

They would not even attempt to downplay some of their sarcastic comments directed to some of the junior nurses, in particular agency staff, as well as making fun of them behind their backs.

Once, as I was doing a verbal handover, one of the senior nurses responded by rolling her eyes, commenting “la la la la”, then walking away before I had finished.

She then insisted I do a blood transfusion for a patient and when I tried to explain I was not yet signed off for my blood transfusion competency, she glared at me, saying “for f…k’s sake”, before walking away.

When handing over to me on her way to lunch, she did not mention that one of her patients (a very large woman) had been sitting in her wet gown for over

PHOTO: ADOBE STOCK

an hour, despite asking for help. The patient was very distressed and upset. I asked another nurse to assist me with a complete change and advised the senior nurse when she returned of what had been needed. She replied, "I knew that."

Patient abuse

Another time, the other senior nurse had been caring for an elderly Japanese gentleman with limited English.

She tried to explain to him how to record his own fluid balance chart by documenting his intake, but when he did not understand, she shouted at him to "go back to where the bloody hell he came from". Shocked, I checked if the patient was okay. Such abuse – while not directed at me on this occasion – added to the overall toxic environment.

On an afternoon shift, I was looking after a very sick 16-year-old boy who had been admitted post-appendicitis surgery. He was very scared and his mother, who was also a nurse, stayed at his bedside most of the shift.

She was very worried for him and asked if she could stay a little bit longer after visiting hours. I said that was okay with me, but after my shift ended at 11pm, the next nurse might not allow it. She understood this.

Towards the end of my shift, I handed over to the same senior nurse.

After checking on the patients, she approached me as I was writing up my clinical notes and loudly asked what the hell was I thinking and how dare I allow the mother to stay with her son. This was in front of all the other staff.

Shocked, I did not respond immediately, but finally summoned the courage to suggest if she had something to say to me, we could go into office for some privacy. However, she simply walked off.

On my next shift, the mother thanked me for being kind and said her experience with the senior nurse had been terrible and she had never been spoken to so rudely and aggressively.

Another time, a male patient in a four-bed room, took off his pyjamas saying he preferred to sleep just in his underpants.

Later, investigating noises from the room, I found the senior nurse and another nurse holding him down and forcing on his pyjamas. They asked for my help but I did not want to participate. The two left and I comforted the patient who was upset and asked what he had done wrong.

I lost total confidence in myself and every day became a challenge. I felt I had no choice but to leave the ward as I not longer felt safe.

This ward was diabolical. In my 14 months there, I witnessed the pair of senior nurses put down bureau staff, other nursing staff and even cleaning staff.

I am aware that a few of my colleagues have been reduced to tears by their actions. Staff turnover was high, as many transferred or quit the profession altogether.

The charge nurse manager must have been aware of what was happening on her ward – if not, she should have been. Either way, she ignored the behaviour of the two senior nurses.

'Too nice'

At my assessment, she criticised me for being "too nice" and not assertive enough to get patients to do what they needed to do. I responded by saying one can be nice and assertive at the same time for in my experience people respond much better to a nurse who was caring and took time to explain things, rather than being harsh. This did not go down well and she said I was not accepting of her feedback.

Work life 'intolerable'

My working life became increasingly intolerable. They double-checked my work constantly and my questions were often greeted with eye-rolling. I lost total confidence in myself and every day became a challenge. I felt I had no choice but to leave the ward, as I no longer felt safe. I no longer had confidence in my ability and decision-making, as I was feeling anxious, stressed and disrespected.

I started making mistakes and became frightened of making a serious one. I could not live with that fear of harming someone and quit the ward, and nursing.

But I missed nursing and after four years I completed a return to nursing paper and worked in a range of nursing roles over the next six years in the community – but never again on a ward.

Each time I entered into a new role I did try to feel confident but I am sure I was experiencing post-trauma from the early days, which made it extremely challenging.

In 2018, I decided to leave the profession, for good. •

See also: Bullying – what should you do? p22

If you're concerned about bullying, please contact NZNO's member support centre on 0800 28 38 48 or nurses@nzno.org.nz.

Bullying – what should you do?

By lead organiser Christina Couling, (Ngāti Porou, Te Whānau-ā-Apanui)

Nobody, not even the boss, has the right to direct bullying behaviour at you.

Workplace bullying is insidious, harmful, and very common. It can vary, but is often present in organisations that condone bullying as part of a so-called tough management style.

It may be helpful to outline what constitutes bullying and, possibly more importantly, what doesn't, according to WorkSafe.

Workplace bullying is: Repeated and unreasonable behaviour directed towards a worker or a group of workers that can lead to physical or psychological harm. That behaviour is persistent and can involve a range of actions over time. It includes victimising, humiliating, intimidating or threatening a person.

It is not: One-off or occasional instances of forgetfulness, rudeness or tactlessness, setting high performance standards, constructive feedback and legitimate advice or peer review, a manager requiring reasonable work instructions to be carried out, warning or disciplining workers in line with workplace policies, differences in opinion or personality clashes that do not escalate.

Under the law, workplace bullying is considered a hazard which harms workers. As such, leaders/managers must minimise its likelihood by implementing such things as a code of conduct, reporting procedures and manager training.

Health and safety processes, as outlined in the Health & Safety at Work Act, mean bullying can be added to risk registers and be the subject of Provisional Improvement Notices (PINs) and complaints to management.

A collective response?

While employers are legally obliged to mitigate bullying, a collective response is going to yield the best outcomes for workers. It is workers who can set the tone and acceptable workplace behaviours. In this regard, we would encourage workers to get together to discuss the issue of bullying and set rules around what is acceptable in their workplace. There is strength in numbers after all.

Workers can designate "safe zones" where no bullying behaviours are tolerated. An easy place to start is wherever you do your handovers, where staff must stick to discussing the patients. The zones can then be expanded throughout.

Safe zone principles might include:

- Critique actions and ideas, not people.
- Support others, rather than undermining them.
- Set realistic and attainable goals (for self and others).
- Act assertively, not passively or aggressively.

It is best to nip bullying behaviours in the bud immediately. If you are on your own with someone exhibiting bullying behaviour you could raise your hand as if indicating someone to stop and state calmly that you will not tolerate having that behaviour directed at you. This small physical barrier is often enough to stop someone in their tracks. If that doesn't work, you are more than entitled to leave the immediate area. Nobody, not even the boss, has the right to direct bullying behaviour at you**.** We would suggest incident reporting as well, as this will back you up if anything arises from the situation.

If you witness someone else having bullying behaviour directed at them and you don't feel able to directly stop it, it can be helpful to simply stand beside the person who is being bullied. Bullies generally don't like witnesses, so again this can be helpful.

Of course, this is all easy to say and more difficult to do. However, if we continue to do what we've always done we can expect more of the same. NZNO staff and delegates can support bullying-free workplaces, so please get in touch with NZNO's member support centre (0800 28 38 48 or nurses@nzno.org.nz) if you are interested in doing this.

NZNO's role

When bullying complaints are made against someone who is an NZNO member, NZNO's role is also to ensure that the person is dealt with fairly and as per the relevant workplace policies.

We often hear that "NZNO is supporting the bully". However, every worker deserves to be treated with fair processes and afforded the opportunity to adjust their behaviour. That is what we would all expect if allegations are made against us. •

A life in public health: 'I didn't know you didn't talk about gay rights in Taranaki'

A career that began on the fringes for Heather Came, has now been recognised at the very heart of public health.

Came has been named Kāhui Hauora Tāmatanui Public Health Champion for 2021.

A contributor to *Kai Tiaki Nursing New Zealand*, and leader of equity workshops within NZNO, Came received the award from the Public Health Association of NZ. Last year's recipient was epidemiologist Michael Baker.

Came began her career in health promotion in Taranaki in the 1990s, co-designing community sexual and mental health promotion programmes that challenged stigma and fostered connection.

In 1993, Came was appointed HIV/AIDS co-ordinator and sexuality educator at Taranaki Area Heath Board.

"I was interviewed by media on arrival and talked about gay rights. I didn't know that you didn't talk about gay rights in Taranaki, so it ended up on the front page of the newspaper."

She said she started her public health career on the fringe, "because I didn't realise that indeed my life as a bisexual feminist was on the margins".

She told *Kai Tiaki* the award was about a body of work to which many people contributed, that many people had "shaped on the way".

"People don't win these [awards] out of nowhere. It comes from people having mentors, who open doors for them."

Times had changed since she started back in the '90s working with the rainbow community, she said.

Back then people could send vile hate letters, and sign them with their own name.

Heather Came, Kāhui Hauora Tāmatanui Public Health Champion for 2021.

"You could write a letter of hate to a colleague [signed]… and there were no consequences."

After a decade in Taranaki she worked with the Health Promotion Forum before leading a health promotion team in Waikato. Eventually she moved into Māori health and witnessed institutional racism, before making the transition to academic life.

'There were hundreds of Māori claimants telling their stories of racism.'

Came is now head of the public health department at AUT's School of Public Health and Interdisciplinary Studies, where she continues to publish on institutional racism, anti-racism, critical policy analysis, and the application of Te Tiriti o Waitangi; as well as delivering practical teaching and training.

She was still a little surprised at being recognised through the award in the mainstream of public health.

"Āe! How odd is that? I've always said if you're not on the edge you're taking up too much room. So I'm obviously in the wrong spot."

Came said the importance of the Waitangi Tribunal inquiry into health services and outcomes, Wai 2575, could not be underestimated in helping highlight Māori health inequities.

"There were hundreds of Māori claimants telling their stories of the racism within the health sector," she said. Making change couldn't be left to others, or to someone riding in on a white horse "to save the day".

People needed to recognise their personal agency and power, Came said, even though inequity seemed to be too big a problem to solve.

"I don't want to walk into a room of health practitioners, or academics, and they say 'oh we can't do anything'. Excuse me? You've got a PHD … [or] you're a health practitioner, you're powerful people, you can do things, you can change things." •

Kui Jamesina Kett.

Be confident, be br leaves behind insp

By Naomi Waipouri, Desiree Hawkins and Teana Davey
(On behalf of Bachelor of Nursing Māori tauira and nēhi Māori)

Kui Jamesina Kett was born and raised on D'urville Island in late 1935. She is of Ngāti Koata, Ngāti Toa Rangatira, Ngāti Kahungunu and Rongomaiwahine descent.

Kui and her whānau moved to Porirua, where she found her passion and followed in the footsteps of her older sisters Olive, Te Rangikauia and Huia who were nurses. She completed her psychiatric nursing training between Porirua, Ngawhatu and Tokanui Hospitals.

In the 1970s, she was the charge nurse of the psychopaedic ward at Tokanui Hospital. While she was there, she was involved in Te Roopu Awhina o Tokanui who were instrumental in the development of Whaiora. Kui was one of the founding members of Te Kaunihera o ngā Nēhi Māori who were motivated by a challenge to nēhi Māori to do more from Minister Matiu Rata at the Hui Taumata, Auckland in 1984. During deinstitutionalisation of Tokanui Hospital, Kui helped transition people into the community. She also supported the development of Hauora Waikato – an inspirational "one-stop shop" health service for Māori. In 2012, Kui Jamesina received the Whetū Kanapa Award from Te Ao Māramatanga for her extensive contribution to Māori mental health nursing. When hospital-based nursing training transitioned into polytechnics, Kui became involved in the Tihei Mauri Ora Māori nursing programme at Waikato Polytechnic. She then became a founding

E te Mareikura, Kui Jamesina
Takoto mai i roto i ngā ringa o te Atua i runga rawa.
Takoto mai i runga i te rangimarie me te aroha.
Haere atu rā koe ki ō tātou tūpuna.
Haere rā kei tua o te arai.
Haere, haere, haere oti atu rā.
Sunrise 19.12.36 – Sunset 22.11.21

rave, be educated: Kui Jamesina Kett
iration for nēhi Māori after her passing

member of Whārangi Ruamano Māori Nurses National Educators Group. Kui continued to contribute to Māori nursing for the remainder of her journey as the Kui for our Whitireia Bachelor of Nursing Māori programme in Wellington. Kui held the mana of Kaitiaki Rangatira. Her knowledge diversified with her experiences as a nēhi Māori, educator, nurse leader and Kui. The knowledge and experience she developed over the years provided the understanding and desire to improve the state of nursing for iwi Māori hapu and whanau. This led to the commitment of embracing her role as Kui at Whitireia.

A prerequisite to the Whitireia Bachelor of Nursing Māori (BNM) is that all tauira must whakapapa Māori. Kui emphasised the saying that "every Māori whānau deserves a nēhi Māori". That is, not just a nurse who can whakapapa Māori, but a nurse who gains knowledge and can work from a Māori wellness framework. Thus, enabling whānau to grow their potential and provide quality care and respect for all. Many tauira were well versed in their whakapapa, and many were not. Kui helped transition those who lacked connection by encouraging them to develop self-awareness and personal development through wānanga. This is where many of us identified we come from the same communities we are trying to serve. Kui helped transform us from untapped potential to leaders. Her wisdom came from a place of whānau, hapū and iwi. She helped us nurture and care for each other through her own kindness and care for us. It can be rough in the world of nursing. There is a saying, "nurses eat their young". Kui provided us with the knowledge and strength through a Māori lens to overcome such difficulties. From a Māori perspective, we have a tuakana-teina model. Our old don't eat their young, we nurture and grow them so they may blossom into tomorrow's leaders – poipoia te kākano, kia puawai. As a duo, Kui and Shayola [Koperu] nurtured us through the notion of kawa whakaruruhau under the tuakana-teina and whakamana processes that strengthen and empower relationships of trust and integrity.

Kawa whakaruruhau emerged from the experiences of Māori nursing students and Maori nurse educators at Hui Waimanawa in Christchurch, 1988. Kui taught us knowledge of how kawa whakaruruhau truly works. Kawa Whakaruruhau is more than cultural awareness, cultural safety, cultural sensitivity, and cultural respect. It is about guiding, developing and caring for people: not from an illness framework but from a wellness framework by implementing kaitiakitanga, rangatiratanga, manaakitanga, pūkengatanga and whanaungatanga. It is about supporting and growing tauira, remembering your whānau, hapū, iwi.

Under Kui's guidance, 10 cohorts graduated from Whitireia BNM. Kui's vision was to have nēhi Māori throughout health and education. She encouraged graduates to gain skills and knowledge, to have courage, to further untap our potential as leaders. We have graduates in Aotearoa, Australia, Bermuda, Europe and the Pacific Islands working as nēhi Māori, Whānau Ora practitioners, nurse managers, NETP educators, researchers, health policy analysts, PDRP coordinators and many returning to Whitireia as kaiako to give back. For Māori to succeed, we need to determine our own direction – tino rangatiratanga. It's not just about having many graduates but having quality nēhi Māori helping people become change makers. Kui always spoke about courage and being agents of change – education being key. Kui developed and gifted a mantra to Whitireia BNM that enhances nursing senses and observation, and instils the confidence and bravery to be rangatira and kaitiaki o ināianei. This is the korowai and legacy that Kui has blanketed over our programme and nēhi Māori. •

Kui Jamesina Kett has left a korowai of knowledge for tauira.

BNM Mantra nā Jamesina Kett
Nurses are never late, they are cool, calm, collective and supportive.
Whakarongo: Attentive - I listen. I hear what is being said.
Titiro: Observant - I look and see.
Kōrero mai: Articulate - I talk confidently.
He puku tēnei: Intuitive - I acknowledge my puku power.
Ngāmahi: Competent - I work effectively.
E tū: Grounded - I stand tall.
Hīkoi: Authentic - I walk tall.
Nurses are cool, calm and collective.
Nurses are cool because nurses have the knowledge.
Nurses are calm because nurses have the skills.
Nurses are collective because nurses can work as a team to benefit...he tangata, he tangata, he tangata!
Mauriora.

Farewell to a challenging year, as we

By acting manager, professional and nursing services, Kate Weston

It is that time where we reflect on the year, and 2021 has certainly been a challenging one. We have seen everything from large-scale industrial action, a national pandemic response and now mandatory vaccination for the vast majority of health and disability services staff.

Decades of disinvestment and serious staffing shortages led to strike action in the district health board sector in June. Efforts by the entire NZNO team and members to ensure the strike was well-planned and went ahead successfully was an event we can now look back on with a real sense of achievement – it was massive and ultimately did reach the needed outcome.

Effective implementation of the safe staffing tool, care capacity demand management (CCDM), however, remains a major challenge, with the announcement of a ministerial review in September into why only half the country's DHBs had implemented it by the June deadline. NZNO members and staff have been interviewed as part of the review and a report is expected by the end of 2021.

Our work has been done in an environment of chronic and serious understaffing across all sectors, with closed borders and the usual flow of internationally qualified staff . . . suddenly severely limited.

Since COVID-19 management strategies commenced in 2020, nurses have been at the forefront of the response. Our work has been done in an environment of chronic and serious understaffing across all sectors, with closed borders and the usual flow of internationally qualified staff on whom the health-care system is so reliant, suddenly severely limited. Nurses across all sectors and around Aotearoa have been mobilised to protect borders and communities, and to test, vaccinate and care for people with COVID-19 symptoms, both in the community and in hospital. Reaching the 90 per cent vaccination goal in greater Auckland, Tāmaki Makaurau, and getting so close nationally has been a huge achievement.

It is imperative that where nurses do have the ability to influence or be involved in the changing face of health-care delivery, that we do so.

The lack of preparedness in the health sector has emerged as a major concern. Plans for a surge workforce have been hampered by underlying staff vacancies which have meant that staff could not, in many cases, be released to undertake the practical component of the intensive care unit (ICU) training. And these nurses are no substitute for experienced ICU nurses but rather a crisis management workforce.

Unlike other jurisdictions, New Zealand has not thus far seen the overwhelming numbers of people requiring critical support, including ventilation. The admission rates to hospital for COVID-related infections have not been as high as some predictions.

Community quarantine

However, there are an ever-increasing number of people requiring isolation or quarantine in their homes – community-supported isolation/quarantine (CIQ).

In October the number of those isolating in their home was in the thousands. Nurses are providing care remotely to this large and potentially very vulnerable group of patients.

This is separate to the virtual ward – a hospital in the home – set up to manage those patients with COVID-19 who are below the threshold for hospital admission but may still be very unwell.

The high vaccination rates in the community have been protective against high numbers of hospital admissions, but the capacity and capability of community/primary care to manage growing numbers is a new challenge to navigate.

brace for more COVID in the community

Nurses and health staff at Malaeola pop-up community testing centre in Māngere, Auckland, earlier this year. The Malaeola pop-up was set up late August to get testing numbers up.

PHOTO SUPPLIED BY SOUTH SEAS HEALTHCARE

What is in the Healthy Futures Bill?

- Establishing a Māori Health Authority.
- Moving parts of the Ministry of Health (MoH) to Health New Zealand (HNZ), which will take over management of all health services.
- HNZ will replace the Health Promotion Agency and all 20 district health boards.
- A new policy on the overall direction, priorities and objectives for the health system.
- A health strategy for the next five-10 years and
- A health plan on how to implement it agreed by HNZ and the Māori Health Authority.
- A locality plan to assess health needs in communities, a charter for organisations and workers in the health system and a code to encourage consumer voice.
- A new public health agency within the MoH to provide leadership and advice.

Such challenges may be seen on a national level as community cases are identified throughout the country.

There is growing use of technologies to support this remote care, such as telehealth and remote monitoring. This is a rapidly growing area of practice, being acknowledged by the Nursing Council in its future competencies around emerging nursing skills.

With whole new areas of nursing expertise emerging, such changes in practice will be lasting, as we contemplate how we manage patients in the future, post-pandemic.

Health reforms

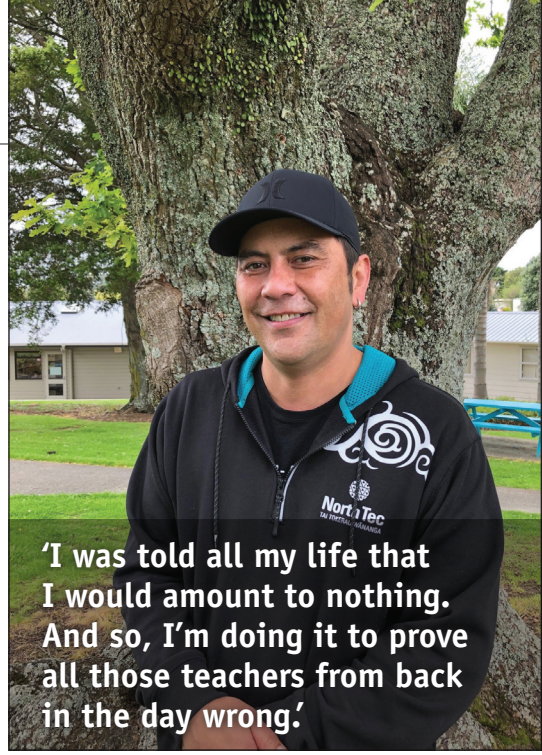
Against this backdrop of what has now become endemic COVID-19 in the community, the most significant health reforms Aotearoa has seen in decades are unfolding. The Pae Ora (Healthy Futures) Bill was introduced in October and has had its first reading. It takes effect in July 2022, replacing the NZ Health and Disability Act 2000.

The changes are huge, of a magnitude not seen since crown health enterprises and regional health authorities were set up in the 1990s. Lessons need to be taken from that period, as the changes at that time were detrimental to nursing leadership.

Disappointingly, there are no nurses on either the Transition Unit or the Maori Health Authority. It is imperative that where nurses do have the ability to influence or be involved in the changing face of health-care delivery, that we do so – whether it is being part of a working group or in submissions to the Bill as it goes through its various stages over coming months.

In a year that has been so challenging, it is important to reflect on those things that have been achieved, whether at a local or national level, and to take time to celebrate successes – no matter how small. Thank you to all NZNO members, wherever you are working, for all that you have done this year in support of better health outcomes. •

Security guard switches to nursing



FOR DANIEL Manihera, rejecting the lessons of a lifetime means he can finally start to learn again.

Manihera, in his second year of a Bachelor of Nursing, has shared the story of his journey after beginning the course at NorthTec aged 42.

"I was told all my life that I would amount to nothing. And so, I'm doing it to prove all those teachers from back in the day wrong."

He started his degree after 11 years working in the mental health sector for Northland District Health Board (NDHB). His work there eventually saw him become team leader of the mental health auxiliary workers.

"I started off as hospital security and then got poached by mental health services. I had just taken this role on and my passion for caring for people really grew."

Manihera said he turned to nursing because of the lack of control he had in helping Māori and other less-represented communities in his old job.

He "wanted and needed" to remove disparities and inequalities between Māori and non-Māori in the health system.

His children and wider whānau were another factor behind the decision to become a mature student – and educational role-model.

"I tell my kids, 'get a good education'. Otherwise, you're going to be 44, like Dad and having to return to school."

Despite his commitment, the shift to nursing was a big change for Manihera. He was concerned that at 42 he was too old to start academic learning again.

However, he said he was encouraged by his colleagues and management at NDHB, and NorthTec tutor Joanna Davidson when she visited the mental health unit to check in on nursing students on placement.

"It was 10 years before I jumped into it, although my NDHB whānau started to push me about two years into the job. No regrets so far."

Manihera said his plans for what type of nursing he might end up doing were still wide open.

"I want to choose a place where I feel competent, I feel confident, and where I can have an influence in health pertaining to Māori." •

Screening tech frees ARC nurses to care

A NURSE has helped develop a self check-in kiosk to screen visitors and staff at aged residential care (ARC) facilities for COVID-19 symptoms.

The "Florence" technology – named after health and safety pioneer Florence Nightingale – has been installed at 23 Radius Care ARC facilities around the country.

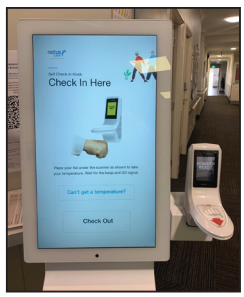
Visitors and staff must sign in and out and have their temperature scanned as well as answer a series COVID-19 screening questions.

Radius Care registered nurse and quality manager Corrie Bronkhorst – who helped design the kiosk – said "overnight" the pandemic created the need to ensure nobody was bringing in the virus. This heaped more administration on nurses, taking them way from their "real work.

"Essentially there was a full-time nurse checking people in – it was a necessary but poor use of limited nursing resources," Bronkhorst said. "They had to ask about close contacts, locations of interest and they had to do it again if the person came the next day."

Florence now did all those tasks, she said.

Bronkhorst helped inform the design of the technology, to ensure it integrated new thermal scanning and contact-tracing requirements. Florence maps contacts, locations of interest and family members, as well as handling sign in and outs, asking relevant health questions and checking temperatures. If an alert is triggered, the visitor will be denied entry and be referred to a staff member. Visitors are given QR codes and it will soon integrate vaccine passports also, she said.



Florence


Corrie Bronkhorst

Freed from the administration, nursing staff were "really happy getting back to the floor so they can look after our residents". •

ENs take lead in primary mental health care

By Sue Adams, Josephine Davis, Coral Wiapo and Beth Cooper

About 40 new enrolled nurse (EN) positions are being established in primary health care (PHC) over the next four years, to try and improve access to mental health and addiction (MH&A) services, particularly for Māori and Pacific people.

The EN workforce model – a Ministry of Health (MoH)– funded initiative – also aims to build the Māori and Pacific EN workforce.

ENs working in primary health care are relatively few and far between. Just 300 ENs work in PHC settings compared with 8500 registered nurses (RNs).[1]

The scope of EN practice[2] sees them well-placed to work with community providers to offer a range of health services and promote equity.

However, misunderstandings and confusion around their scope, including the requirement for direction and delegation from an RN,[3] together with the growth of the unregulated workforce (such as health-care assistants and health coaches), has seen PHC health providers often reluctant to employ an EN.

Within the programme, three approaches are emerging to increase the number of ENs working in PHC to provide integrated and holistic health care and take a key role in providing MH&A services.

The first is to develop the role of an existing EN, or create a new EN position, to focus on MH&A work.

One provider in Northland has employed a Māori EN to work with whānau who either underuse or overuse health (including secondary) services. A rural health provider in the South Island is developing the EN role to provide services for those isolated and disconnected from health services, after noticing an increase in drug and alcohol use and more complex mental health needs. In rural Northland, an EN is improving access to health care for wāhine Māori through the outreach cervical screening programme.

In all these cases, the ENs will be working with individuals and whānau to screen for MH&A concerns, assess and promote health, provide brief interventions and connect people with local services and resources.

The second approach is to develop clinical placements for EN students with health providers.

NorthTec's EN programme leader Beth Cooper has worked closely with the EN workforce programme's regional coordinator, Coral Wiapo, on matching students to ensure a good fit, including location and model of care – and the potential to employ the newly registered EN.

Student placements take place in the rehabilitation and community module of the 18-month EN diploma. From the first cohort of 10, three are now employed with community providers.

One new EN graduate, using a strength and resilience-based approach, will be providing free appointments to young people turning 16 to undertake both a HEEADSS (home, education, eating, activities, drugs and alcohol, suicide and depression, sexuality and safety) and general health assessment, promoting a positive health experience and behaviours, and connecting young people with community networks and services.

The third model is an apprenticeship model to support Māori and Pacific kaimahi at health providers to undertake EN training while continuing to work with, and be supported by, their employer. Given 71 per cent of the Māori workforce are unregulated,[4] this model ensures that local priority communities receive care from appropriately trained health professionals. Additionally, there is the unquantifiable ripple effect of building the capability of whānau living and working in their community.

The programme is timely given the increasing complexity of people living with MH&A issues. Exciting models of care are emerging through this programme, which will showcase the significant scope of practice and different roles ENs can play in the community.

The initiative is a collaboration with health and education providers, as well as professional organisations such as NZNO, from across Aotearoa.

For further information, please contact Sue Adams: s.adams@auckland.ac.nz. •

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Josephine Davis, **NP** is national NP/EN workforce programme co-leader, school of nursing, University of Auckland. josephine.davis@auckland.ac.nz.
Coral Wiapo, **RN PGDip**, is regional coordinator at Northland's Mahitahi Hauora Primary Health Entity.
Beth Cooper, **RN, MMgt (Health)**, **PGCertTTL**, is EN diploma programme leader at NorthTec.

References
1) Nursing Council of New Zealand. (2019). *The New Zealand Nursing Workforce: A profile of Nurse Practitioners, Registered Nurses and Enrolled Nurses 2018-2019*. Te Kaunihera Tapuhi o Aotearoa/Nursing Council of New Zealand. www.nursingcouncil.org.nz/Public/Publications/Workforce_Statistics/NCNZ/publications-section/Workforce_statistics.aspx?hkey=3f3f39c4-c909-4d1d-b87f-e6270b531145.
2) Nursing Council of New Zealand. (n.d.). *Tapuhi Kua Whakauru: Enrolled Nurse*. Author. www.nursingcouncil.org.nz/Public/Nursing/Scopes_of_practice/Enrolled_nurse/NCNZ/nursing-section/Enrolled_nurse.aspx?hkey=963854c0-246c-4bb1-800c-920a19b022dc.
3) Hughes, M., Kirk, R., & Dixon, A. (2018). New Zealand nurses' storied experiences of direction and delegation. *Nursing Praxis in New Zealand, 34*(3), 32-45. https://doi.org/10.36951/NgPxNZ.2018.012.
4) Sewell, J. (2017). *Profiling the Māori health workforce 2017*. Te Rau Matatini. https://terauora.com/wp-content/uploads/2019/05/Profiling-of-the-Ma%CC%84ori-Health-Workforce-2017_Te-Rau-Matatini.pdf.

Digital organising accelerates in 2021

By associate industrial services manager Iain Lees-Galloway

Iain Lees-Galloway.

It has become trite to say but nevertheless true that we live in extraordinary times. We all thought 2020 was a challenging year. But, as Christmas beckons, we will look back on another extraordinary 12 months filled with challenges and triumphs for NZNO, for each of us individually, our country and the world.

Staffing issues were exacerbated by the border closure and the additional nursing work that comes with managed isolation, quarantine, vaccinations and testing. Workplace health and safety was tested by the psychological strain of nearly two years of pandemic. Primary health and DHB strikes saw delegates, members and staff put an incredible effort into organising actions and arranging life preserving services. The necessary and evidence-based vaccine mandate has caused unavoidable disruption.

All of this happened against fundamental changes to the way we go about our work. Our use of digital technology has grown steadily in recent times but, like so many other organisations, we've had no choice but to accelerate that use over the last two years. It's not just meeting by Zoom. We now have online voting and online surveys. We gather in social media groups to discuss our projects.

Many staff work from home, travel less and learn how to collaborate on digital platforms rather than in person. This all raises questions about how we operate as an organising union.

Nothing can replace face-to-face, human interaction for building the relationships we need to achieve results. However, we can't ignore the reality that, for now, many of our interactions have to be online and, in the future, we may be better off doing more online if we have the right plans and structures in place. One example we have seen this year is more of our delegates supporting members with individual employment matters.

Often, the delegate will be in the room with the member while an organiser joins the meeting by video call. This is a good example of the organising model in action where our trained delegates can assume more responsibility and strengthen their role in the workplace. For this to work, our delegates need to feel confident as advocates.

Our delegate education and development pathways are designed to provide the skills and experience they need to have that confidence. It would be good to hear from delegates if there is more we could be doing.

Education delivery itself has undergone changes with more content delivered online. Our educators adjusted delivery with sessions run by video call and modules developed that delegates can access when it suits them. Hopefully, over the next couple of years, the restrictions to fight the pandemic will be lifted. We will be able to see each other in person more often and that can only be a good thing. We should use this time to consider what aspects of organising are better done in person and what aspects can be enhanced by using digital technology. We've had the push to try new things. Let's hold on to the ones that work better.

I want to thank everyone who contributed to our industrial success in 2021. Members were courageous and resilient in the face of challenges. Thank you for being united and using your collective power to settle collective agreements and fight for pay equity and safe workplaces. Our delegates work incredibly hard, often in their own time, to organise members, provide information and implement our plans on the ground. Our staff go above and beyond to empower our delegates and support our members when needed. Our leaders have superbly represented us in the media and advocated to politicians to make sure there is support for our ambitions. Our collective strength and unity of purpose has made 2021 a success for NZNO. Let's take that momentum into 2022 and achieve even more.

Kia kaha! •

Wins, progress and challenges across multiple industrial sectors as 2021 draws to close

The year was a challenging one across the industrial sectors as COVID-19 hit workplaces around Aotearoa.

However, 2021 saw a series of solid wins, and ongoing work for members from DHBs to aged care facilities.

The most prominent victory for NZNO was settling the latest district health board (DHB) MECA negotiations.

With a new process in place for negotiations following the 2018 MECA, members stuck together – with strikes and marches showing the Government nurses were serious about improvements to staffing and pay.

The result came after an important Employment Court win for NZNO over life preserving service provision during industrial action.

Unfortunately, even once the deal was struck with DHBs, members had to threaten protests in Canterbury, West Coast and Waikato to ensure wage increases were paid before Christmas.

NZNO DHB members on strike in June in Wellington.

By time of publication, all DHBs had confirmed pre-Christmas dates for payments, although Bay of Plenty was still dealing with an issue around back pay.

The DHB MECA bargaining was resolved after united action by members.

In hospice bargaining, all but two single employer collective agreements (SECAs), Arohanui and North Haven, were in ratification processes.

Meanwhile, with the year coming to a close, the future was uncertain for residents of an aged care facility in Porirua, north of Wellington.

In November, NZNO and E tū unions appealed to care home provider BUPA to reconsider its proposal to close Harbourview Home.

NZNO organiser Laura Thomas said she questioned the proposed closure of a facility meeting community needs. However, despite the efforts of the community and unions, BUPA announced it would close the facility in 2022.

It came after the owner found weather-tightness problems with the buildings, which would require extensive repairs.

BUPA would work with residents to find alternative rest homes. •

Move from hospital to homes sets community nurse on path to creating work security app

A change from hospital nursing to community work at a hospice has seen one health–care professional branch out into security technology.

From left, Tōtara Hospice staff, Andrea Lawrence, charge nurse manager, Neekita Narayan, associate charge nurse, Emma Beard clinical nurse educator, Hayley Colmore-Williams, nursing director, and Cecilia Sovincet, associate charge nurse.

An Auckland hospice has turned the humble cellphone app into a piece of modern workplace security for its community nurses.

The change in technology came after a change of nursing pace for one of its staff.

Tōtara Hospice has launched a safety app for all of its community workers, with the help of one of its nurses.

Clinical nurse educator Emma Beard, said after working in an acute hospital setting, she shifted into community nursing to make a difference for people living with palliative conditions.

Novel experiences in job

In her role at the hospice, Beard found herself visiting patients in their own home – a novel experience after her hospital work.

"I was concerned about being in different environments with so many unknowns – meeting a patient for the first time, not knowing who else might be in the home and the impact of this on the clinical interaction."

Tōtara had already developed an alert system that could be used if staff felt their personal safety was at risk.

Beard thought the system could be improved.

She said her charge nurse was "incredibly supportive" and encouraged her to investigate what options there were out in the community for isolated workers.

'I was concerned about being in different environments with so many unknowns – meeting a patient for the first time, not knowing who else might be in the home.'

"I wanted to set out some assurance that my charge nurse knew when I entered and exited a house. I wanted to feel confident that if I needed support urgently, I could activate an alarm that would get my manager's attention straight away."

Works starts on app

She said she worked with management to research, buy, and then implement a safety app for all of the hospice's community workers. "Among the many improvements this process resulted in, we were able to develop a new technology to support the safety app."

Beard said they also partnered with the police community prevention team to support staff as well.

The change from a hospital to working in the community with the hospice had been a complete contrast, she said. •

'New thinking needed' on aged care RN crisis

Margaret Crozier – 'no quick fix'.

Better status and remuneration are needed to ease the nursing crisis in aged care, says a major recruiter.

By Margaret Crozier

Since the crisis in nurse staffing in 2006, we have failed as a health industry to review what we needed to do domestically to ease the long-term pain of nursing shortages.

The shortage of registered nurses (RNs) is not going to be a quick fix. We need to turn our heads and efforts to how we can build a more sustainable workforce.

We have allowed the mana of the RN to erode in society over the last 30 years. As more professions evolve, the competition to attract individuals to carve out a career as an RN has become harder. But what have we done to compete with those new careers being established?

Becoming an RN has many attractive features, including flexible working hours and shifts, global demand, ease of employment following domestic relocation, great career progression and continued learning and development opportunities, to name just a few. So why are people not seeing becoming an RN as a viable career option?

RNs' salaries pale in comparison to other careers that allow you to achieve that same passion for helping others. Why is that?

What is even more perplexing is that the aged-care industry is further disadvantaged. Current government funding for aged-care RNs is approximately $25,000 less per year than that of other government-funded nursing positions. Why?

As a nurse in aged care, you are the most senior clinical expert on site, with a huge skillset. The opportunity to grow and develop is enormous.

We have allowed the mana of the RN to erode in society over the last 30 years.

Perhaps the greatest benefit of working in this sector is the ability to form long-term relationships with patients, getting to know each resident's health issues, behaviours, histories and personalities, which all inform their care requirements.

Education institutes are not promoting or encouraging aged-care nursing, which is, in my view, because of an institutional "superiority complex" around nursing in other sectors.

There is an incorrect perception that an aged-care nurse is pretty much a glorified caregiver. This couldn't be more wrong.

So I call for RNs to be recognised and valued:

- Let's grow the mana of RNs in society. The current global pandemic is clear evidence that we can't live without RNs, so start respecting them and promoting the importance of them in our society.
- Let's increase RNs' remuneration to truly reflect their importance, starting with aged care.
- Let's align RNs' remuneration across all sectors of the health service.
- Let's change perceptions about aged-care nurses, starting with education institutes reviewing their curriculum. Don't use aged-care placements for caregiving skills. Teach students the importance of building a relationship and understanding the resident's routine to identify when they are more confused than normal, which may signify an infection.
- Let's pull together as a health industry to promote registered nursing as a career. Ask the Government to develop scholarships for those working in the health service who want to become RNs, and provide free education and further financial asistance to those studying to be an RN.

This shortage is not just a health industry crisis – it is yours and mine as members of society. Because we all know, at some point, every one of us will need an RN's help. •

Margaret Crozier, BPsych, MBA, is the general manager of human resources for Heritage Lifecare, with a strong focus on nurse recruitment. Heritage Lifecare is among the largest providers of aged residential care in New Zealand.

Recent acquisitions to the NZNO library

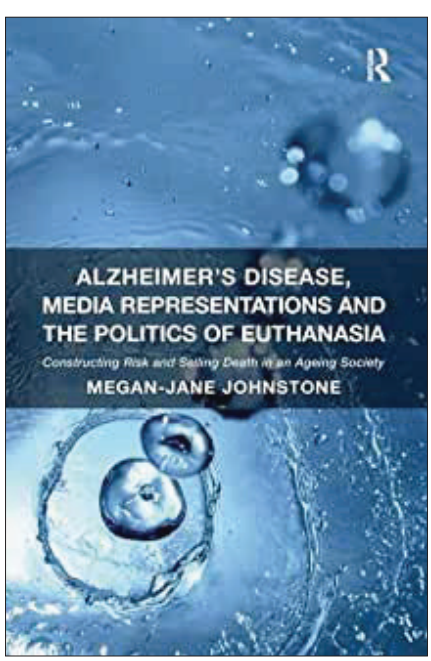
By Heather Woods, NZNO librarian and records manager, and Amanda Otzen, NZNO library

The following is a selection of books that have been added to the NZNO library during the past year. Members may borrow these from the library by using the NZNO library enquiry form on the library's web-page. The loan period is four weeks, and all books are couriered to you, so we request that you please provide your street address when requesting them. We also ask that you bear the cost of returning the books to the library by courier.

• Alzheimer's disease, media representations and the politics of euthanasia: Constructing risk and selling death in an ageing society

Johnstone, M.-J. (2013). Routledge, 223p.

REVEALS the "Alzheimerisation"'of the euthanasia debate, whereby euthanasia is seen as a solution for people living with the disease. Sheds light on the processes contributing to these changes in public opinion.



• Bioethics: A Nursing Perspective (7th ed)

Johnstone, M.-J. (2019). Elsevier, 483p.

ADDRESSES the ethical challenges, obligations and responsibilities nurses will encounter in practice. This edition examines the bioethical issues in health care with a focus on patients' rights, cross-cultural ethics, vulnerability ethics, mental health ethics, professional conduct, patient safety and end-of-life ethics.

• Critical care nursing (4th ed)

Aitken, L., Marshall, A., & Chaboyer, W. (2020). Elsevier, 1084p.

ENDORSED by the Australian College of Critical Care Nurses (ACCCN), this text addresses all aspects of critical care nursing. Divided into three main sections: scope of practice, core components and specialty practice.

• Hamric and Hanson's advanced practice nursing: An integrative approach

Tracy, M.R., & O'Grady, E.T. (2019). Elsevier, 671p.

EXPLORES how advanced practice registered nurses (APRN) are prepared, collating the latest trends and evidence of APRN competencies and roles. Stresses the benefit of APRNs as direct care providers and leaders.

• Health advocacy: A communication approach

Mattson, M., & Chervin, L. (2016). Peter Lang, 189p.

EXPLAINS the processes and strategies involved in creating a health advocacy campaign to guide current advocates in how to work for policy change.

• Helen Kelly: Her life

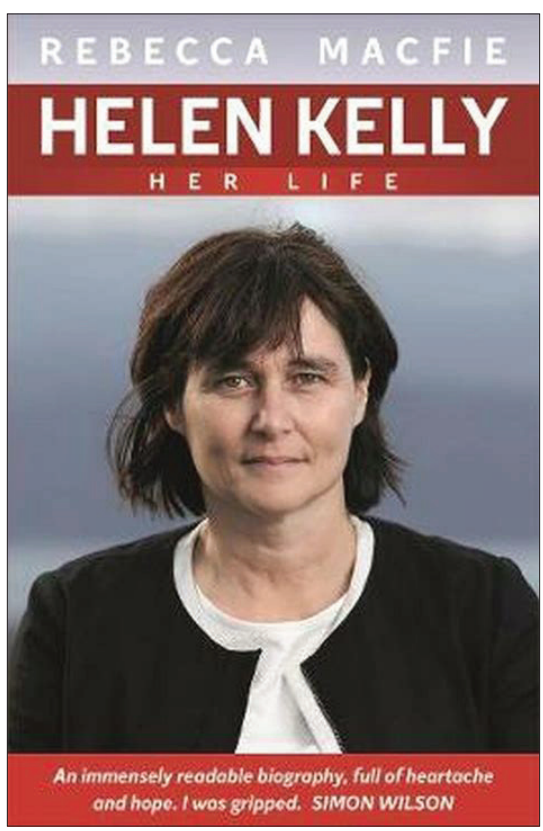
Macfie, R. (2021). Awa Press, 410p.

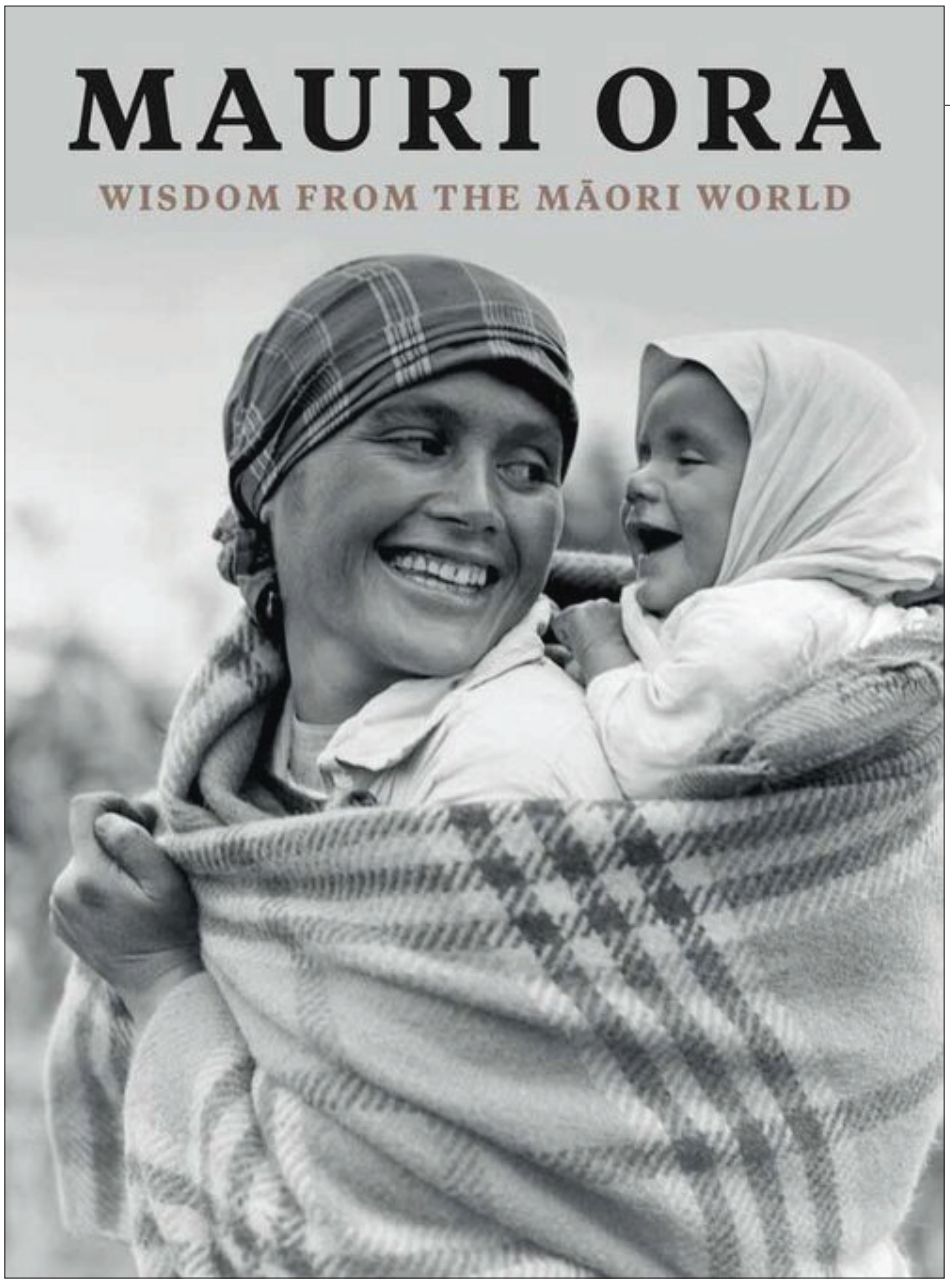
RECOUNTS the life of the first female president of the Council of Trade Unions, intertwining her life with the history of the trade union movement in New Zealand.

• Mauri ora: Wisdom from the Māori world

Alsop, P., & Kupenga, T. R. (2016). Potton & Burton, 160p.

SETS out the six Māori virtues: wisdom, courage, compassion, integrity, self-mastery and belief, each followed by proverbs, or whakataukī, pertaining to





that virtue. Each proverb is illustrated with a photo of a Māori individual from the past.

• Nice racism: How progressive white people perpetuate racial harm

Diangelo, R. (2021). Beacon Press, 201p.
CHALLENGES the ideology of individualism and explains how the author justifies generalising about groups in order to challenge racist attitudes.

• Nurses' recognition and response to unsafe practice by their peers

Blair, W. (2021). (PhD Thesis). University of Newcastle, 336p.
USES a mixed-methods approach to identify the behaviours and cues that nurses recognise as indicators of unsafe practice. Details those factors that influence such practice, and reports the actions and responses taken by nurses who encounter unsafe practice by their peers. Conducts surveys of nurses about their perceptions of unsafe practice and the organisational practices and policies for its prevention. http://hdl.handle.net/1959.13/1422832

• Roth's companion to the Privacy Act 2020

Roth, P., & Stewart, B. (2021). LexisNexis NZ Ltd., 1224p.
PROVIDES an all-in-one resource explaining the key concepts, processes, and obligations in the Privacy Act 2020.

• Tikanga: Living with the traditions of te ao Māori

Tipene, F., & Tipene, K. (2021). HarperCollins, 310p.
SHARES how the authors bring the traditional values of tikanga Māori into day-to-day living.

• Workplace bullying : A costly business phenomenon

Needham, A.W. (2019). Mary Egan Publishing, 278p.
TAKES a hard look at corporate abuse, which leads to staff demoralisation, loss of trust and confidence in organisations, and resignation.

NEW ZEALAND NURSES ORGANISATION
LIBRARY

AMONG the many services the NZNO library offers members is online access to articles from *Kai Tiaki Nursing New Zealand* from 2003 onwards. These can be accessed, as can a variety of member-only databases, via the online databases page on the library webpage.

- **Go to:** https://www.nzno.org.nz/ Click: 'Login' at the top of the page
- **Go to:** www.nzno.org.nz/resources/library/online_databases
- **Contact your library:**
Website: https://www.nzno.org.nz/resources/library
Phone: 0800-28-38-48
Email: library@nzno.org.nz

Beyond medicines for gout

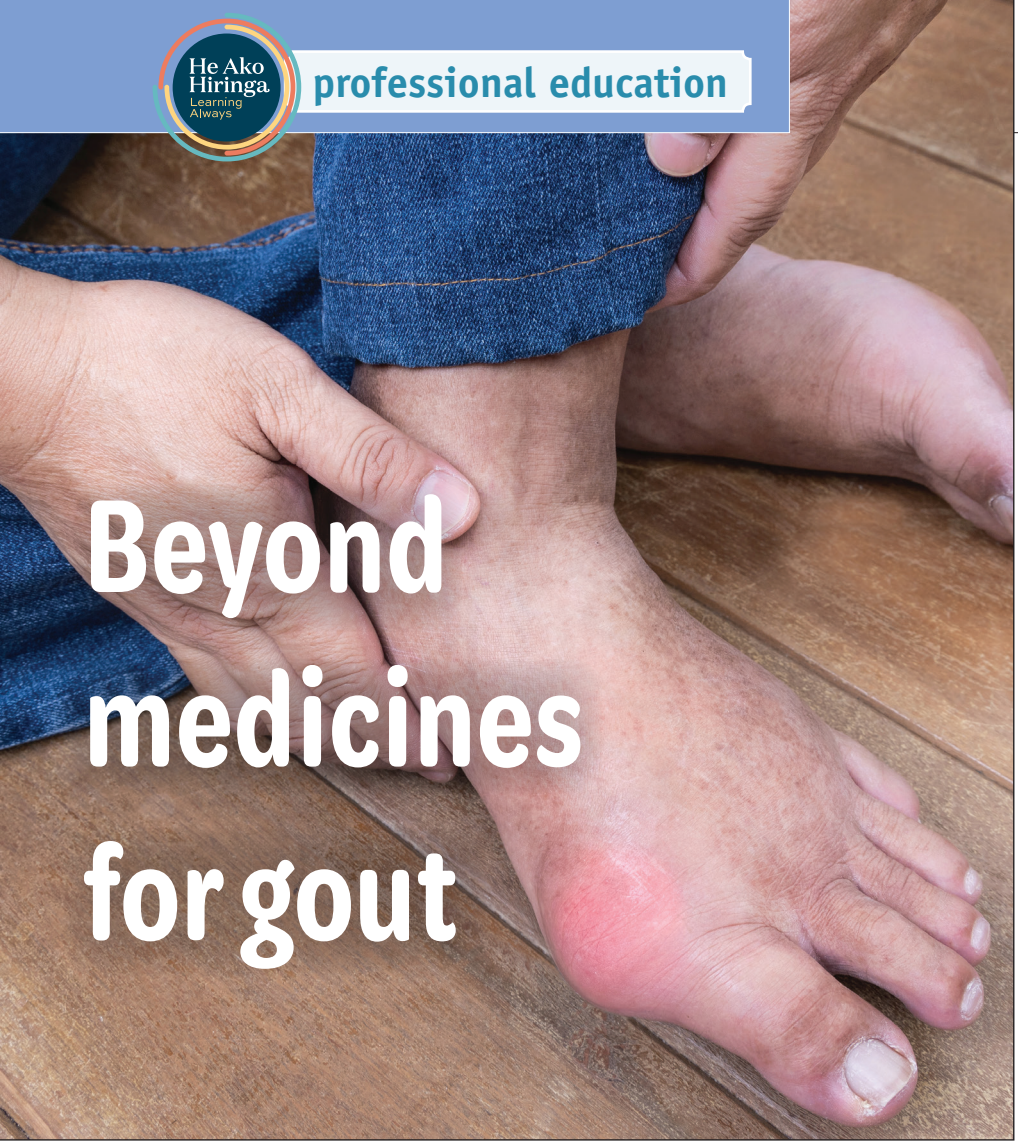


PHOTO: ADOBE STOCK

Gout is a chronic and debilitating long-term condition that disproportionately affects Māori and Pacific people. It needs to be addressed with holistic care, and patient, ongoing relationships with whānau.

By Linda Bryant

Gout – a form of inflammatory arthritis – is not a benign medical condition. Not only does it cause debilitating pain and potential long-term erosion of the joint, and is associated with cardiovascular and renal comorbidities, it also has a large impact on the social, psychological and spiritual wellbeing of the affected person and their whānau. Furthermore, there are persistent inequities because of poorly-managed gout in populations that have higher prevalence of this serious condition.

New Zealand has one of the highest prevalences of gout internationally. About 208,000 people, or 5.7 per cent of people aged 20 or older, are identified as having gout, according to 2019 New Zealand data. Gout was identified in 8.5 per cent of Māori, close to twice that of non-Māori, non-Pacific peoples (4.7 per cent) and in 14.8 per cent of Pacific peoples, nearly three times that of non-Māori, non-Pacific peoples. Notably, fewer women than men experience gout, but Māori and Pacific women remain disproportionately affected, compared with non-Māori, non-Pacific women.[1]

Gout prevalence increases with age. Eighteen per cent of non-Māori, non-Pacific men aged 65 or over are estimated to have gout; however, this proportion increases to 35 per cent for Māori and 50 per cent for Pacific peoples in this age group.[1]

Belief – "Gout is just an old person's disease."

Rates of regular dispensing of preventive gout medicines are very low across all ethnicities – only 36 to 43 per cent of people with gout in 2019 – and worse in young people.[1] Māori and Pacific peoples are more likely to be affected by severe gout, early onset gout, tophaceous disease and accelerated joint damage than non-Māori, non-Pacific peoples.[2] Additionally, over 2016–2020, they started preventive gout medicine, on average, 10 to 13 years earlier than non-Māori, non-Pacific peoples did.[3] However, given their much higher gout disease burden, this time gap may be too narrow, and Māori and Pacific peoples should perhaps be starting their gout preventive treatments even earlier to achieve equitable care.

Gout flare symptoms can be improved with non-steroidal anti-inflammatory drugs (NSAIDs), but repeated courses of these without urate-lowering therapy can indicate poor care, especially because of the potential for kidney disease and development of tophi (lumpy deposits of uric acid crystals that form around the joint).[4] NSAID dispensing without any urate-lowering therapy has consistently decreased over time for Māori and Pacific peoples, while rates for non-Māori, non-Pacific populations have not changed.

However, overall, 41 per cent of Māori and 46 per cent of Pacific peoples with gout were dispensed an NSAID, compared with 35 per cent

of non-Māori/non-Pacific peoples diagnosed with gout. Younger people, particularly Māori and Pacific peoples, were dispensed NSAIDs at significantly higher rates.[1] Treatment with repeated prescriptions of NSAIDs can be a poor and potentially dangerous stopgap.[4]

We still have not achieved optimal gout care. Although hospital admissions for gout for the general population have reduced over time, Māori and Pacific peoples are about five and 10 times, respectively, more likely to be hospitalised with a primary diagnosis of gout, relative to non-Māori, non-Pacific people.[1]

Pathophysiology – it's not lifestyle

The first strong community belief to dispel is that having gout is the person's fault because they have been eating the wrong food or drinking a little alcohol. There is a very strong genetic basis for hyperuricaemia (a high level of uric acid in the blood), which is the cause or driver for gout. Māori and Pacific peoples typically have a genetic predisposition for gout, and when discussing the diagnosis, most Māori or Pacific men with gout will say they have relatives with gout.

Belief – "It's my fault because I eat the wrong stuff."

It is vital to dispel beliefs about certain foods being the cause of gout and explain that some foods may be a trigger. If someone restricts foods that are culturally important, such as seafood, and still gets gout, they may feel frustrated and guilty, as though it is their fault for not being "good". Changing diet alone rarely prevents gout flares.

The genetic predisposition to gout is complex, with different polymorphisms, but the end result is that, for some people, high serum urate levels result in precipitation of uric acid crystals in cartilage, tendons, ligaments and, in the longer term, larger joints.

KEY POINTS

- Acceptance of the need for long-term treatment with allopurinol is important, so patients do not depend on short-term NSAIDs.
- Allopurinol should be discussed at the first gout flare, and strongly recommended at the second; there is no need for two gout flares annually.
- A primary risk factor for gout is genetics – diet only plays a minor role.
- Gout and variation in its treatment contributes to inequity.
- Gout occurs earlier and is more severe in Māori and Pacific peoples, so more prescribing of urate-lowering therapy, earlier, is needed to achieve equitable care.

Gout is a chronic inflammatory disease and inadequate treatment to reduce serum urate levels can lead to tophi, chronic gouty arthritis and joint destruction. Tophi indicates poor control of serum urate for more than 10 years.

Urate-lowering treatment (eg, allopurinol) initiated early and used regularly and consistently, rather than lifestyle and dietary changes, will help patients achieve long-term symptom control.

Although the principles for treating and preventing gout appear relatively simple, we are not doing at all well in this country. The answer is not as simple as "we need to prescribe more", and it is not helpful to hear the rationale for poor control being "patients just don't take their allopurinol". We can do better, though it may require a different approach.

Interventions promoting patient education and follow-up appear successful. University of Auckland investigators conducted a systematic review of international studies that looked at 18 interventions to improve urate-lowering treatment uptake in patients with gout.[5] These interventions went beyond the usual care provided in primary care and included nurse-led, pharmacist-led and multidisciplinary, multifaceted interventions.

Improvement in serum urate levels was seen for all interventions, but nurse-led interventions appeared most effective. These included investigating beliefs and perceptions about gout and its management, patient education, reminders for urate-level tests and prescription refills, and monitoring until target urate levels were achieved. Patient education encouraged shared decision-making and provided information on the nature of gout, its causes and consequences.

Access is an issue, but it is broader than this, and a holistic model of care is required that involves the community, greater co-design and perhaps social marketing (eg, sporting heroes advocating for taking allopurinol). Māori and Pacific men

may benefit from messaging that enhances mana, empowering them to continue taking allopurinol regularly to prevent recurrent gout attacks.

Emphasis is needed on the important role of whānau in encouraging and helping their men to engage with the health system about screening for, or managing, gout. Healthcare professionals can actively encourage and answer questions from whānau. Involvement of whānau and health promotion in the community both contribute greatly to improved health literacy.

Triggers for gout

Genetics and ethnicity are key risk factors for gout, along with increasing age, and male gender (see Panel 1, above). Dietary triggers for acute gout flares include foods containing high levels of purine, such as shellfish and red meat, and also alcohol.

Recently, fructose has been shown to inhibit renal excretion of urate. Men who daily consumed two or more servings of sugar-sweetened drinks increased their risk of gout by 85 per cent, compared with those who consumed less than one serving monthly. Compare this with the 49 per cent increase in risk from ingesting 15-30g/day of alcohol.[6]

Minor trauma and emotional or medical stress may also trigger gout. Some people may think they incurred an injury such as a sprained ankle, but it is important to remember that injury can trigger gout.

There is debate about the significance of potential diuretic-induced gout, due to possible confounders.[7] Diuretics are not contraindicated in people with gout but would not usually be first-line blood pressure-lowering agents in people with, or at high risk of, gout. Individual benefit–risk implications should be considered.

Low-dose aspirin can cause changes in renal excretion of urate, but this effect is variable and usually small.[8] An adjustment of urate-lowering therapy may be required, but discontinuation or avoidance of low-dose aspirin is usually not necessary.

Allopurinol may be less effective in people on furosemide,[9] but this is usually overcome by increasing the allopurinol dose.

Panel 1. Risk factors and triggers for gout

Risk factors	Triggers
Genetics: • Male gender • Ethnicity • Genetic polymorphisms (eg SLC2A9, ABCG2, GCKR, SLC17A1/A3)	**Dietary:** • Sugar (fructose)-sweetened drinks • Shellfish • Red meat • Alcohol
Other: • Increasing age • Chronic renal disease • Metabolic syndrome • Heart failure	**Drugs:** • Diuretics • Cyclosporin, tacrolimus **Other:** • Injury, trauma

Diagnosis

The symptoms of gout are usually clear – severe throbbing or burning pain, swelling, redness and a warming of the area affected. Touching or weight-bearing can result in excruciating pain. Flares classically occur in the big toe, but ankles, knees, elbows and fingers may be affected over time. These symptoms, coupled with ethnicity and/or family history, usually provide a good basis for a clinical diagnosis.

Forms of arthritis may mimic gout (eg, septic arthritis, psoriatic arthritis and osteoarthritis among others), so care is required to determine that gout that has "moved to the knee" is not osteoarthritis.

Joint aspiration is usually only performed when there is doubt about the diagnosis. For some people, if there is uncertainty about the diagnosis, a dual-energy CT scan detecting urate in the joints will confirm a diagnosis of gout.

A high serum urate level will help confirm gout, but a lower level does not discount it.

Gout is associated with comorbidities, including metabolic syndrome, which is estimated to be present in 63 per cent of people with gout, compared with 25 per cent of people without gout.[12]

Also, 40–74 per cent of people with gout will have high blood pressure.[13] Approximately one-quarter of people with gout have diabetes, and approximately 70 per cent have a creatinine clearance lower than 90ml/min. People with gout have an increased risk of death from cardiovascular disease.[14]

The multifaceted nature of gout, and the fact it rarely exists in isolation of comorbidity, are reasons why care for people with gout needs to be holistic rather than fragmented and siloed. A person presenting

Advantages and disadvantages of medicines for acute gout flares

Medicine	Advantages	Disadvantages	Dosage
Prednisone	As effective as naproxen 500mg twice daily. Suitable for people with impaired renal function.	Short-term increase in blood glucose for people with diabetes. Potential for short-term fluid retention and increased appetite.	0.5mg/kg for 5-10 days. 40mg every morning for 5 days, then 20mg daily for 5 days is usually considered the "standard" dosage.
NSAIDs	Effective	Adverse effects such as gastrointestinal bleeding, renal impairment and increased cardiovascular risk. Avoid in renal impairment (eGFR <60ml/min/1.73m^2); use a lower dose if eGFR 45-60ml/min/1.73m^2. Avoid in people with heart failure or high cardiovascular risk, and 12-24 months after myocardial infarction. There is a tendency for patients to exceed the prescribed dosages due to severe gout pain.	Use at full dosage (eg, naproxen 500mg twice daily). In people with creatinine clearance <60ml/min, reduce dose and use with caution due to risk of renal failure, especially in Māori and Pacific peoples. Minimise use to ≤5 days if possible. Only prescribe or dispense small amounts (eg ≤20 tablets) – diclofenac tablets are frequently shared, hence there is risk of adverse effects in vulnerable people.
Colchicine	Specific for gout. Effective when started early.	Preferable to start within 12-24 hours. Toxic in overdose, which occurs with a small number of tablets. Dose reduction in renal impairment. Potential interactions with cytochrome P450 3A4 inhibitors (diltiazem, macrolides, itraconazole, cyclosporin) and take care with statins. Do not use in pregnancy.	1mg stat followed by 0.5mg every 6 hours; maximum of 2.5mg on the first day, 1.5 mg on subsequent days (dosing reduced to 3 times daily), no more than 6mg in 4 days. Low-dose alternative: 1mg stat, followed by 0.5mg 1 hour later; a further 0.5mg may be taken once or twice daily for 2-3 days more. Dosage is reduced for people ≤50kg, or with a creatinine clearance ≤50ml/min; maximum dosage is 1mg in 24 hours, and no more than 3mg over 4 days. Once the maximum cumulative dose is reached, colchicine should not be used again for at least 3 days.

with gout needs to be screened and have other potential comorbidities managed. There is currently no clear recommendation to treat asymptomatic hyperuricaemia.

Acute treatments

Belief – "I just need something to get rid of the pain when I have an attack, and then it's all okay."

The choice of acute medicines therapy – prednisone, NSAIDs or colchicine – is influenced by comorbidities as there is little difference in effectiveness between the medicines (see table above).[15,16]

The maximal dosage and hazards of excessive colchicine need to be stressed to avoid the acute toxicity likely to result from a "more is better" perception. In Auckland, a case series found eight people died of a colchicine overdose over 15 years, with doses between 18mg and 24mg.[17]

Belief – "The Voltaren tablets don't hurt me – they get rid of the pain."

A 2020 New Zealand study found that, after adjusting for other risk factors, Māori and Pacific peoples were significantly more likely than European patients to be hospitalised with serious complications – upper gastrointestinal bleed, heart failure – after being dispensed NSAIDs.[18] Furthermore, the risk of acute kidney injury for Māori was significantly

higher compared with Europeans. This highlights the need to be especially wary of prescribing NSAIDs in Māori and Pacific peoples who have a lower estimated glomerular filtration rate (eGFR) than would be expected for their age.

Preventive medicines

Preventive medicines include allopurinol, febuxostat and probenecid, and two biologics not readily available in New Zealand, rasburicase and pegloticase. Allopurinol remains the first-line preventive urate-lowering medicine in New Zealand and internationally.

Belief – "You need two gout flares a year before you consider allopurinol."

In our high-risk population of Māori and Pacific peoples, preventive urate-lowering therapy should be discussed when someone presents with their first gout flare, and strongly recommended after the second flare. Studies have found urate-lowering therapy, although indicated, is often delayed, sometimes for a period of several years.[19] For most, and especially Māori and Pacific people with a family history, gout is not going to go away, and every flare will be causing joint damage. Māori and Pacific people also require a full assessment for comorbidities.

The resistance to taking a lifelong tablet is understandable. Patients often stop and restart allopurinol. Patience is required, especially as the process requires slow titration with each restart if the patient stops allopurinol for more than one month.

Belief – "Taking tablets every day means I am sick and weak."

If stopped for less than one month, the previous dose can be restarted.

Understanding factors that result in stopping preventive therapy is important. These include:

- difficulty developing a medicines-taking habit
- beliefs and attitudes about medicines
- misunderstanding of the need for lifelong therapy
- wanting to "test" if allopurinol is still needed
- confusing preventive therapy with acute therapy.

Studies indicate that people take allopurinol only about 62 per cent of the time.[20] Younger people and those not taking other regular medicines are less likely to take their allopurinol.

This emphasises that it is not necessarily the prescribing of allopurinol that is the issue. It is imperative that ongoing, consistent advice and education is given, addressing the individual's concerns. Ensure medicine and lifestyle conversations/interventions happen at distinct times in the patient/whānau journey: at initiation, flare occurrences, and when working towards stabilisation on long-term treatment.

It is also important to develop a relationship with the person – determine their beliefs, values and understanding, and the factors that may reduce the likelihood of taking allopurinol continuously. The Ask Build Check tool (smstoolkit.nz/ask-build-check-model) may also be helpful. This model comprises three steps: ask what the person knows, thinks, believes or does; build new information on to what is already known, and check how clearly and effectively you have communicated.

Allopurinol

Initiation

Traditionally, allopurinol has been started once an acute flare has resolved. This required the person to remember not only to start the allopurinol but also the instructions for titration. This requirement plus the need to take prophylactic medicine, such as a low-dose NSAID or colchicine, for at least three months could be seen as confusing and inconvenient.

Belief – "You can't start allopurinol during an acute gout flare."

However, there is scant evidence that initiation of urate-lowering therapy should be delayed until a flare is no longer painful. Rather, studies have found initiating a urate-lowering treatment during a flare has no significant impact on the duration of the flare or its severity.[21]

Initiating allopurinol along with prophylactic medicine increases complexity, but using blister packaging is helpful for managing acute treatment, titration of allopurinol and short-term use of prophylactic medicine. The importance of education and advice, even with blister packaging, cannot be underestimated. For starter pack regimens, see two PDFs: *For health professionals – Treating and preventing gout in 7 minutes* at tinyurl.com/25un74kv.

It is imperative patients accept the need for long-term treatment with allopurinol and not depend on short-term NSAIDs. Accepting this takes time and can be challenging for all. Multiple health professionals and community care workers can support interventions that involve patient engagement. These must empower patients to share decisions about their care and make the sustained behavioural changes required.

Dosing

Gout flare reduction is on a continuum of serum urate levels, but the target that provides a good balance between gout flares and pill burden is <0.36mmol/L (<0.30mmol/L if

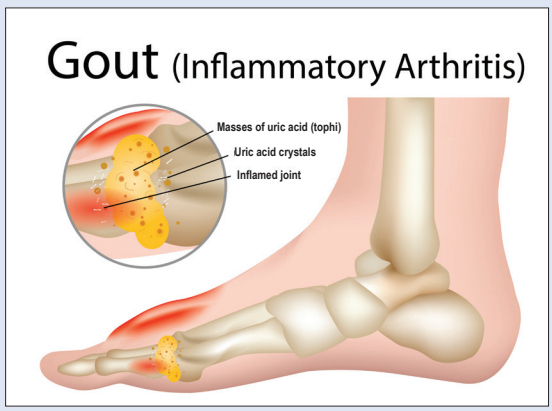
Panel 2. What to consider for practice

Keep in front of mind:

- Try to improve access to regular dispensing of preventive gout medicine (persistence and adherence).
- Help people to accept and stick with allopurinol.
- Look for inappropriate use of NSAIDs.
- Earlier detection and initiation of preventive treatment is important, particularly for Māori and Pacific peoples.
- Women are also affected by gout.
- Gout may present as a traumatic injury.

Provide consistent advice:

- Gout is caused by genetics. Dispel beliefs about food and alcohol being a major cause. Food is just a trigger.
  – Once on allopurinol and at serum urate level target, small amounts of trigger foods may be eaten.
  – Even if gout is controlled, do not drink sugar-sweetened drinks, fizzy drinks or high-fructose drinks.
- Do *not* take more than the maximum doses of tablets prescribed, even where there is a gout flare.
  – Explain about the risks of excessive doses of NSAIDs and colchicine.
  – Do not give or lend medicines for gout to anyone.
- Allopurinol titration takes three to six months, and extra medicine is needed initially.
  – Confirm what the target serum urate level is and how this is monitored.
  – Explain that flares may still occur in the first year of treatment, but these reduce over time and are less severe.
  – Advise not to stop allopurinol, even during an acute flare.
  – Explain that treatment with a preventive therapy is lifelong – stopping the medicine will cause the serum urate level to increase again.
- Describe allopurinol hypersensitivity syndrome symptoms, especially the rash, and the importance of stopping the allopurinol and seeing a doctor immediately.
- Provide written information plus website links for further information:
  – gouthappyfeet.com or www.goodfellowunit.org/gout-how-it-effects-you
  – healthnavigator.org.nz/health-a-z/g/gout



Free support and advice are available to people who want to talk about their gout. Call 0800-663-463 or fill out an online form to request a call back at www.arthritis.org.nz/0800-arthritis-educator-call-back-form/

the patient has tophi). Ideally, the main clinical outcome of urate-lowering therapy is no gout flares, although if gout does occur, it is less frequent and less severe.

Renal function is used to establish the starting dose of allopurinol: patients with reduced renal function initially start on lower doses.

Traditionally, the dosage of allopurinol was considered to be 300mg daily. However, in New Zealand, to achieve a target serum urate level of less than 0.36mmol/L, a mean dosage of 360mg daily, or median dosage of 450mg daily, is required.

Prophylactic cover

If someone starts allopurinol and a gout flare is precipitated, it is difficult to convince them to restart allopurinol as, in their mind, it becomes associated with causing gout. Therefore, prophylactic cover is needed when initiating allopurinol (eg colchicine, NSAID). This is an off-label (unlicensed) use of colchicine, but for people in whom NSAIDs should be used cautiously, it is effective cover. One colchicine tablet daily is preferred, and two tablets daily should not be exceeded.

Prophylactic cover needs to be continued for at least six months, or for three months after achieving target serum urate levels.

Adverse effects

Allopurinol is usually well tolerated. Allopurinol hypersensitivity syndrome (AHS) is the most concerning adverse effect, due to a mortality of about 25 per cent. AHS is a delayed hypersensitivity reaction, estimated to occur in 0.1 per cent of people, usually within 30 days.[22] It presents as a toxic epidermal necrolysis or Stevens–Johnson syndrome-type rash, with fever, eosinophilia, leucocytosis and possibly hepatic and renal dysfunction. Anyone with a rash should seek immediate advice.

Belief – "Allopurinol dose is limited by renal function."

Starting at a high dose, or titrating too quickly, can increase the risk of both gout flares and AHS.[19,22] The final dose of allopurinol is now the dose that achieves a serum urate level of less than 0.36mmol/L, rather than a maximum dose according to renal function. Once the optimal allopurinol dose is obtained, there is no need to reduce the dose if renal function declines.

The potential for drug–drug interactions should always be checked before starting gout medications. Azathioprine, mercaptopurine, ACE inhibitors, warfarin, diuretics and penicillins are among drugs potentially interacting with allopurinol.[23]

Other urate-lowering medicines

Febuxostat is similar to allopurinol in its mechanism of action. Avoid for patients with pre-existing major cardiovascular diseases.[24]

Losartan is not a specific urate-lowering agent but may reduce serum urate levels slightly. If an ACE inhibitor or angiotensin II receptor blocker is being considered for a patient with gout, then losartan may be preferable. Similarly, atorvastatin and empagliflozin may be helpful adjuncts. Other preventive therapies are available through specialist consultation.

How can we do better?

Gout is a health condition for which inequity pervades. Māori and Pacific peoples are much more likely to get gout, and earlier detection and initiation of preventive treatment is needed. Māori and Pacific peoples are also less likely to be able to access care, to be prescribed appropriate medicines, to be followed up and to be provided with understandable education.[4,18]

Initial explanation about gout and the long-term nature of complications and treatments is important, plus the emphasis that allopurinol treatment is lifelong. Practices with health improvement practitioners and health coaches may find these people can get patients engaged and provide good understandable information.

Work by Leanne Te Karu (Muaūpoko/Whanganui), from the University of Auckland, and colleagues has identified systemic barriers. A multifaceted, multidisciplinary and culturally-driven model of care is being investigated to improve the delivery of care for gout.

Health-care providers need to be proactive and talk about gout and its impact on work, recreation and relationships. All members of the team can contribute, including GPs, pharmacists, nurses, physiotherapists, podiatrists and kaiāwhina. We all need to give consistent advice (see Panel 2) and recognise barriers to access – often not a lack of prescribing but the ongoing, patient and whānau-centred encouragement and reinforcement that is required. •

• This article has been endorsed by the College of Nurses Aotearoa for 60 minutes professional development (CNA084). Test your learning after reading this by completing the assessment at www.akohiringa.co.nz/education/beyond-medicines-for-gout

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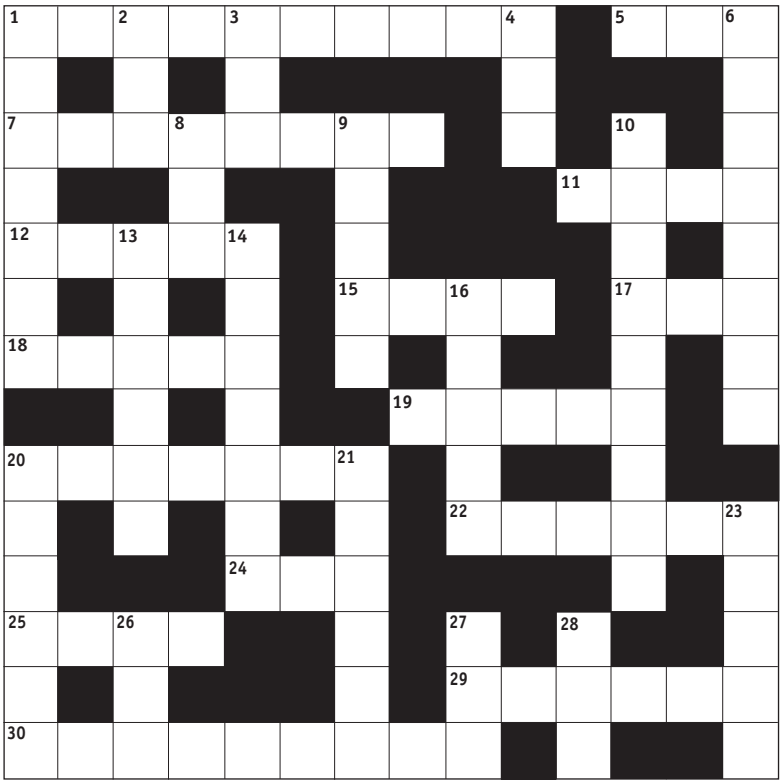
References

1) Health Quality & Safety Commission New Zealand. (2021). *Atlas of Healthcare Variation: Gout*. https://tinyurl.com/HQSCgout
2) Dalbeth, N., House, M. E., Horne, A., Te Karu, L., Petrie, K. J., McQueen, F. M., & Taylor, W. J. (2013). The experience and impact of gout in Māori and Pacific people: a prospective observational study. *Clinical Rheumatology, 32*(2), 247–51.
3) Ministry of Health. (2020). Pharmaceutical data web tool version 03. (Data extracted from Pharmaceutical Collection on March 5, 2020.) https://minhealthnz.shinyapps.io/pharmaceutical_data_web_tool/
4) Dalbeth, N., Dowell, T., Gerard, C., Gow, P., Jackson, G., Shuker, C., & Te Karu, L. (2018). Gout in Aotearoa New Zealand: the equity crisis continues in plain sight. *New Zealand Medical Journal, 131*(1485), 8-12.
5) Gill, I., Dalbeth, N., 'Ofanoa, M., & Goodyear-Smith, F. (2020). Interventions to improve uptake of urate-lowering therapy in patients with gout: A systematic review. *BJGP Open, 4*(3), bjgpopen20X101051.
6) Choi, H. K., & Curhan, G. (2008). Soft drinks, fructose consumption, and the risk of gout in men: prospective cohort study. *BMJ, 336*(7639), 309-12.
7) Hueskes, B., Roovers, E., Mantel-Teeuwisse, A., Janssens, H., van de Lisdonk, E., & Janssen, M. (2012). Use of diuretics and the risk of gouty arthritis: a systematic review. *Seminars in Arthritis & Rheumatism, 41*(6), 879-89.
8) Zhang, Y., Neogi, T., Chen, C., Chaisson, C., Hunter, D., & Choi, H. (2014). Low-dose aspirin use and recurrent gout attacks. *Annals of the Rheumatic Diseases, 73*(2), 385-90.
9) Stamp, L. K., Barclay, M. L., O'Donnell, J. L., Zhang, M., Drake, J., Frampton, C., & Chapman, P. (2012). Furosemide increases plasma oxypurinol without lowering serum urate – a complex drug interaction: implications for clinical practice. *Rheumatology (Oxford), 51*(9), 1670-76.
10) Newberry, S. J., FitzGerald, J. D., Motala, A., Booth, M., Maglione, M., Han, D., Tariq, A., O'Hanlon, C., Shanman, R., Dudley, W., & Shekelle, P. (2017). Diagnosis of gout: A systematic review in support of an American College of Physicians clinical practice guideline. *Annals of Internal Medicine, 166*(1), 27-36.
11) Janssens, H. J., Fransen, J., van de Lisdonk, E. H., van Riel, P., van Weel, C., & Janssen, M. (2010). A diagnostic rule for acute gouty arthritis in primary care without joint fluid analysis. *Archives of Internal Medicine, 170*(13), 1120-26.
12) Choi, H. K., Ford, E. S., Li, C., & Curhan, G. (2007). Prevalence of the metabolic syndrome in patients with gout: the Third National Health and Nutrition Examination Survey. *Arthritis & Rheumatology, 57*(1), 109-15.
13) Stamp, L. K., & Chapman, P. T. (2013). Gout and its comorbidities: implications for therapy. *Rheumatology (Oxford), 52*(1), 34-44.
14) Choi, H. K., & Curhan, G. (2007). Independent impact of gout on mortality and risk for coronary heart disease. *Circulation, 116*(8), 894-900.
15) Liu, X., Sun, D., Ma, X., Li, C., Ying, J., & Yan, Y. (2017). Benefit-risk of corticosteroids in acute gout patients: An updated meta-analysis and economic evaluation. *Steroids, 128*, 89-94.
16) Roddy, E., Clarkson, K., Blagojevic-Bucknall, M., Mehta, R., Oppong, Avery, A., Hay, E., Heneghan, C., Hartshorne, L., Hooper, J., Hughes, G., Jowett, S., Lewis, M., Little, P., McCartney, K., Mahtani, K., Nunan, D., Santer, M., Williams, S., & Mallen, C. (2020). Open-label randomised pragmatic trial (CONTACT) comparing naproxen and low-dose colchicine for the treatment of gout flares in primary care. *Annals of the Rheumatic Diseases, 79*(2), 276-84.
17) Jayaprakash, V., Ansell, G., & Galler, D. (2007). Colchicine overdose: the devil is in the detail. *New Zealand Medical Journal, 120*, U2402.
18) Tomlin, A., Woods, D. J., Lambie, A., Eskildsen, L., Ng, J., & Tilyard, M. (2020). Ethnic inequality in non-steroidal anti-inflammatory drug-associated harm in New Zealand: A national population-based cohort study. *Pharmacoepidemiology & Drug Safety, 29*(8), 881-89.
19) BPACnz. (2021). *Managing gout in primary care.* https://bpac.org.nz/2021/docs/gout2021.pdf
20) Harrold, L. R., Andrade, S. E., Briesacher, B. A., Raebel, M., Fouayzi, H., Yood, R., & Ockene, I. (2009). Adherence with urate-lowering therapies for the treatment of gout. *Arthritis Research & Therapy, 11*(2), R46.
21) FitzGerald, J., Dalbeth, N., Mikuls, T., Brignardello-Petersen, R., Guyatt, G., Abeles, A., Gelber, A., Harrold, L., Khanna, D., King, C., Levy, G., Libbey, C., Mount, D., Pillinger, M., Rosenthal, A., Singh, J., Sims, J., Smith, B., Wenger, N., Bae, S., Danve, A., Khanna, P., Kim, S., Lenert, A., Poon, S., Qasim, A., Sehra, S., Sharma, T., Toprover, M., Turgunbaev, M., Zeng, L., Zhang, M., Turner, A., & Neogi, T. (2020). 2020 American College of Rheumatology guideline for the management of gout. *Arthritis Care & Research (Hoboken), 72*(6), 744-60.
22) Stamp, L., Taylor, W., Jones, P., Dockerty, J., Drake, J., Frampton, C., & Dalbeth, N. (2012). Starting dose is a risk factor for allopurinol hypersensitivity syndrome: a proposed safe starting dose of allopurinol. *Arthritis & Rheumatology, 64*(8), 2529-36.
23) New Zealand Formulary. (2021). *Allopurinol.* https://nzf.org.nz/nzf_5681
24) A. Menarini New Zealand Pty Ltd. (2021). *New Zealand Datasheet: Adenuric 80 mg, 120 mg film coated tablets.* https://www.medsafe.govt.nz/profs/datasheet/a/adenurictab.pdf

crossWORD

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



ACROSS

1) Care for end-of-life patients.
5) English rock band who made the rock opera *Tommy*.
7) Dusk.
11) Work (Māori).
12) Mistake.
15) Danger.
17) Me (French).
18) Day before tomorrow.
19) Of the countryside.
20) Crept on hands and knees.
22) Lethal.
24) Affirmative.
25) Newborn horse.
29) Number in soccer team.
30) Extremely tired.

DOWN

1) Recipient of care.
2) Pacific garland.
3) Tribe (Māori).
4) Organ of hearing and equilibrium.
6) Positive attitude.
8) The lion star sign.
9) Vital muscular body organ.
10) Citrus toast spread.
13) Punch numbers in again.
14) The Queen and her family.
16) Fiord.
20) Morning beverage.
21) Arid region.
23) Of tender years.
26) Fire residue.
27) Can be single, queen or king.
28) Moisture that forms overnight.

November answers. ACROSS: 1. Needle. 5. Nephews. 8. Death. 9. Whānau. 10. Pepe. 13. Note. 14. Hospices. 16. Your. 17. Oasis. 19. Thirst. 20. Toxic. 22. Leech. 23. Leap. 25. Gun. 26. Osteoporosis. **DOWN:** 2. Ended. Diary. 4. Echo. 6. Heaven. 7. Whakatauki. 9. Wee. 10. Pressure. 11. Confident. 12. Pinot. 15. Fatal. 18. Stop. 21. Canal. 24. Ado. 25. Gas.

wiseWORDS

"The very first requirement in a hospital is that it should do the sick no harm."

– Florence Nightingale (from *Notes on Nursing: What It Is, and What It Is Not)*, 1820-1910,nursing pioneer, statistician, social reformer.

it's cool to kōrero

HAERE MAI – welcome to the December kōrero column. The haka is well known around the world, because the All Blacks perform it at the start of their matches. It shows their aggressive intent for the contest ahead, reflecting the haka's origins as a war dance to intimidate the enemy. But the haka has broader use and meaning in Māori culture. It can be performed by men and women, and can be used, through its vigorous actions and chanting, to welcome guests, and honour great achievements and special occasions.

Kupu hou

New word

- **Haka** – *pronounced "hah-kah"*
- **I te nehu ō tō rātou kaiako, i haka ngā tamariki tāne.**

The boys did a haka at their teacher's funeral.

E Ihowā Atua

NZ national anthem – Māori

Another feature of our international sporting matches is the singing of the national anthem. The te reo Māori version has a slightly different meaning to the English one:

E Ihowā Atua,
Oh Lord, God

O ngā iwi mātou rā,
Of nations and of us too

Āta whakarongona;
Listen to us

Me aroha noa
Cherish us

Kia hua ko te pai;
Let goodness flourish,

Kia tau tō atawhai;
May your blessings flow

Manaakitia mai
Defend

Aotearoa.

E mihi ana ki a Titihuia Pakeho rāua ko Joel Maxwell, rātou ko Belinda Tuari-Toma.

NZNO subscriptions 2022

On October 12, 2021, the NZNO board of directors considered options for membership fee increases presented by the acting chief executive.

The board chose to approve an increase of 2.3 per cent across all member fee categories. This is in accordance with the NZNO Constitution (Schedule two: Subscriptions and levies clause 1.2) which limits fee increases to be no more than the CPI (Consumers Price Index). In dollar terms, these increases for full fee categories will range from $7.82 to $13.20 per year.

In deciding this, the board noted: NZNO's ongoing cost pressures; the budgeted deficits of prior years; the major programme of technology work; and the impending challenges of the new health sector structures.

The board acknowledged the costs incurred by internationally qualified nurses coming to work in Aotearoa New Zealand and the ongoing shortage of nurses. It asked the NZNO management team to find further ways to increase membership numbers.

Fee increases are effective from 1 April 2022.

David Woltman,
manager corporate services

MEMBERSHIP FEE EFFECTIVE FROM 1 APRIL 2022

	Annual	Half yearly	Quarterly	Monthly (20th)	Twice monthly (14th & 28th)	Fortnightly
Nurse practitioners, registered nurses and midwives, Health Professionals New Zealand members not affiliated to their professional bodies and not mentioned elsewhere	$587.76	$293.88	$146.94	$48.98	$24.49	$22.61
Enrolled nurses, registered obstetric nurses and College of Midwives members, Health Professionals New Zealand members with affiliations to their own professional bodies	$469.44	$234.72	$117.36	$39.12	$19.56	$18.06
Caregivers, health care assistants, aides, Karitane nurses, clerical, non-clerical support workers and all other support workers	$350.64	$175.32	$87.66	$29.22	$14.61	$13.49

REDUCED FEE CATEGORIES

Caregivers, health care assistants, aides, Karitane nurses, clerical, non-clerical support workers and all other support workers who have declared their income to be **less than $26,000 gross per annum.**	$273.12	$136.56	$68.28	$22.76	$11.38	$10.50
DOES NOT INCLUDE RNs/RMs and ENs.						
Low income earners (if approved by NZNO), members who have declared their income less than $19,000 gross per annum.	$218.40	$109.20	$54.60	$18.20	$9.10	$8.40
DOES NOT INCLUDE RNs/RMs and ENs.						
Reduced fee earners (if approved by NZNO), those on parental and full-time postgraduate study leave, members not in nursing practice/unwaged, enrolled bridging students working part-time, members of another union affiliated to CTU.	$218.40	$109.20	$54.60	$18.20	$9.10	$8.40

Students in their first year of study in the BN, midwifery or enrolled nurse programme.	Free
Students in their first year of study in the BN, midwifery or enrolled nurse programme who wish to have online access to Kaitiaki Nursing New Zealand.	$46.71
Students of nursing, midwifery or enrolled nursing in second, third and subsequent years of study and those retired from nursing but wishing to retain membership.	$48.38
Students of nursing, midwifery or enrolled nursing in second, third and subsequent years of study and those retired from nursing but wishing to retain membership with online access to Kaitiaki Nursing New Zealand.	$95.08
Student vaccinators	$122.76

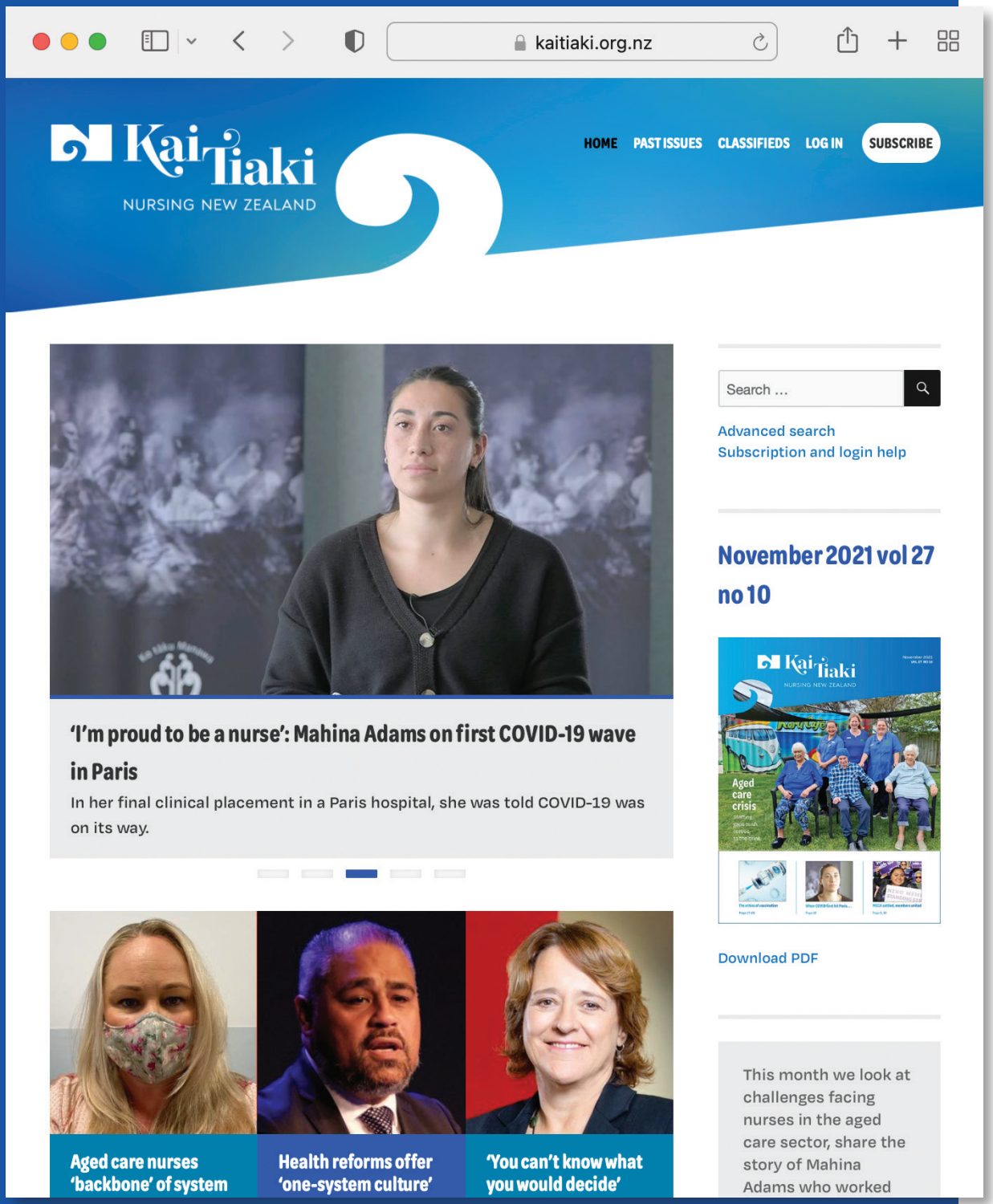
*** REDUCED FEES: At AGM in September 2009, a remit was passed excluding RNs/RMs and ENs from the REDUCED FEE subsidy.**

A new reduced fee rate for those earning less than $26,000 gross per annum was introduced. See rate chart above.
Members earning less than $19,000 gross per annum qualify for the low income subsidy.
A declaration of income needs to be made each year of membership.

The board of directors has set criteria for special consideration of a reduced fee option for RNs and ENs. Details on www.nzno.org.nz

Kai Tiaki online

www.kaitiaki.org.nz



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

Classified advertising

Events

4-5 March 2022 Christchurch
College of Emergency Nurses NZ Conference
https://au.eventscloud.com/website/1024/

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

13 May 2022 Hamilton
Breast Cancer Conference Day
For information contact Jenni Scarlet at
Jenni.Scarlet@waikatodhb.health.nz

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

26-28 May 2022 Christchurch
Women's Health College Conference/Life Goes On
For more information contact janice.grant@cdhb.health.nz

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

Bidwill Trust Hospital

Private Surgical Hospital – Timaru, South Canterbury

Bidwill Trust HOSPITAL

Registered Nurse positions – Operating Theatre and Surgical Ward

Permanent positions 0.5-0.9 FTE

Enviable lifestyle choice

- Central South Island location
- Affordable housing
- Excellent health, education, cultural and recreational facilities
- Great beach and close to mountains, lakes and rivers
- Commute times – average is 7 minutes

Bidwill Trust Hospital is modern, well equipped private surgical hospital in Timaru. Specialties include Orthopaedics, General, Gynaecological, ENT and Ophthalmology.

Our team benefit from:

- A close and supportive team that is family friendly – winner of the 2021 Business Culture and Wellbeing Award at the South Canterbury Health Awards.
- Working directly with experienced surgeons and anaesthetists
- Time to focus on quality patient care
- Hourly rates above the public sector
- Excellent training and development

If you are keen to work for a progressive private surgical hospital providing outstanding patient care while having a great lifestyle please apply now or contact us for a no obligation chat.

Visit **www.bidwillhospital.co.nz** or phone us on **03 6871230**

TIMARU welovetimaru.nz

Are you a nurse looking for *new opportunites?*

Hear why Nav loves the Heritage Lifecare family.

Nav comes from a family of five nurses including her siblings and parents.

She joined Heritage Lifecare in 2019 as a Clinical Manager. In just two years she has been promoted the role of Assistant Care Home Manager at Palms Lifecare in Auckland.

She had a few options available before starting at Heritage Lifecare, but was swayed by friends who also work within the organisation. *"Working for a larger, supportive organisation works in your favour as another Clinical Manager or Manager is always a phone call away for advice or support. You also all follow the same processes and procedures so you're never on your own",* she says.

Nav's promotion was due to that fact that Heritage Lifecare actively look for your potential and will see you through to finding the position you strive for. *"Everybody's there to listen and help with any concerns",* she says

Nav now lives in Manurewa, 25 mins from Palms Lifecare with her children and parents. *"I have a good life balance, working from Monday to Friday and occasionally on call on weekends."*

Be You, Live your Purpose and be part of a Better Everyday.

Apply now at **heritagelifecare.co.nz/careers** or call us on **0800 141 491**

HERITAGE LIFECARE *A Better Everyday*

Registered Nurse

What you will do

Working for the New Zealand Defence Force, you will find yourself based in the Central Plateau, the gateway to the world heritage Tongariro National Park. Premier snow sports in the winter, mountain biking, tramping and fishing in the summer- you will find it all here and more.

Coupled with the added bonus of a very unique working environment and the opportunity for Full Time or Part time - Permanent or Fixed Term employment - you choose what works for your lifestyle!

As a 24/7 medical facility, we require Nurses who can provide care on a rostered rotating shift basis, as part of our emergency response team and to a small number of lower acuity patients admitted to our extended care facility. Our nurses are well compensated for working rostered shifts.

This is a great opportunity to give back to those who serve and protect our country. The role is based at Waiouru Military Camp. The location is perfect to maximise your work life balance by being at nature's back door.

If you're relocating for this role, there may be an option to rent a Defence house for up to 6 months, depending on availability at the time.

What we need

We are seeking Registered Nurses to join our team in providing high quality, comprehensive health care to our service personnel within a multidisciplinary team of committed health professionals and wellbeing providers.

Our roles are best suited to experienced Nurses with post-graduate experience who are competent to practice autonomously/sole charge in a Ward like setting and who also come with sufficient nursing experience to bolster our response team during medical emergencies. In this role our Nurses are supported by a dedicated health care team during week days and by an On Call Medical Officer and Medic afterhours and weekends.

Who we are

The Defence Health Centre in Waiouru provides occupational, primary health, 24/7 urgent afterhours care, along with emergency response to military personnel working and living within the Waiouru Military Training Facility. Our relative isolation from metropolitan health providers means we need skilled competent practitioners in our team who are comfortable providing medical care to others in a rural health care setting.

How to Apply

To apply, send your applications to kerri.sterling@nzdf.mil.nz by Monday, 17 January 2022.

Please note

- Applicants will be required to undergo a pre-employment drug screening test prior to any offer of employment being made.
- Applicants must be legally entitled to work in New Zealand (NZ) and be able to obtain and maintain the required level of NZ Government security clearance for the position applied for.
- If selected for interview, you will be required to provide certified copies of your medical qualifications including your practicing/ registration certificate and a statement of good standing.

New Zealand DEFENCE FORCE
Te Ope Kātua O Aotearoa

A FORCE FOR NEW ZEALAND

DOCTORALLY PREPARED NURSE/NP PARTICIPANTS NEEDED

I am an AUT Doctor of Health Science student and a registered nurse. I'm inviting doctorally-prepared nurses/ nurse practitioners who work in clinical practice to be part of my research examining how a doctoral qualification impacts practice. This will involve a confidential interview of around one hour.

- Do you have a doctoral degree from a NZ or Australian university in a health or related field?
- Do you have 12 months post-doctoral clinical experience?
- Have you been working clinically in the last 5 years, after obtaining your doctorate?

If you are interested and would like to participate:

Please contact the researcher :

GRAINNE MCANNALLEY
Email: **gramca85@autuni.ac.nz**
ph/txt **021 178 9971**

AUT
TE WĀNANGA ARONUI O TĀMAKI MAKAU RAU

The Nursing Education and Research Foundation (NERF) have the following scholarships available:

THE NEW ZEALAND NURSING EDUCATION AND RESEARCH FOUNDATION

- **Short Course/Conference Attendance Grant**
- **Undergraduate Study Grant**
- **Conference Organisers/Speakers Grant**
- **Effie Redwood Endowment Fund**
- **Postgraduate Study Grant**

Eligibility:

- Must be a current financial member of NZNO
- One NERF grant per year
- Grant application forms specify criteria

Applications close on 18 February 2022 at 4.00pm

Apply online:

https://www.nzno.org.nz/support/scholarships_and_grants
Questions should be directed to: **grants@nzno.org.nz**

Make the move to Melbourne

Alfred Health seeking Registered Nurses

Alfred Health is a trusted major provider of state-wide services, including:

- **Largest ICU in Australia**
- **State emergency and trauma centre**
- **High level speciality operating suite services**

Critical care experience ICU/ED or theatre nurses highly regarded, however a variety of positions across all areas are available

Relocation packages available

For more information visit
careers.alfredhealth.org.au

Celebrating 150 years of extraordinary nursing care

AlfredHealth