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NEW ZEALAND

News

Battle looms over incentive payments

By Cate Macintosh

September 22, 2022

A battle is looming over incentive payments for additional shifts to fill desperately under-staffed hospital wards. NZNO members are vowing to stop doing them completely for the week of October 3-9 in a national protest while Te Whatu Ora says there won't be any need for them after September 30 anyway.

Nicki Burns

She has 40 years of nursing experience but was brought to tears for the first time in her career this month after a frightening episode with a critically ill patient.

Christchurch Hospital RN Nicki Burns said the incident highlighted the risks of severe short staffing for patients and staff.

"I can honestly say after Saturday night, I went home on Sunday and I cried, and I've never done that before in my whole nursing career – because I was so stressed."

Burns, who works in the acute medical assessment unit, is throwing her support behind a proposed action by Te Whatu Ora (Health New Zealand) NZNO Tōpūtanga Tapuhi Kaitiaki o Aotearoa members to stop working additional shifts from October 3-9 to bring about fair pay, and highlight dangerous and chronic short staffing.

NZNO chief executive Paul Goulter wrote to Te Whatu Ora on Friday, September 16, advising of the proposed national action, unless it agrees to negotiate a fair deal for additional shifts.

But on Thursday, September 21, Te Whatu Ora lead for people and culture Rosemary Clements told *Kaitiaki* the payments were not a matter for negotiation and would not continue beyond

September 30 anyway.

"The payments were an extraordinary step in response to an extraordinary situation, namely excessive staff shortages due to Covid-19 illnesses . . ."

"We are pleased to see the need for additional hours is reducing significantly as Covid-19 and flu infections drop, and spring sees the weather start to improve."

Burns said the additional shifts incentive pay of $100 per eight-hour shift was not fair, especially in comparison with the agreement for doctors.

> **"We are pleased to see the need for additional hours is reducing significantly as Covid-19 and flu infections drop, and spring sees the weather start to improve."**

A document seen by *Kaitiaki* shows resident doctors were offered between $80-$240 per hour for additional shifts, as well as protections for wellbeing including sufficient opportunities for naps on night shifts, and supporting requests for annual leave.

"But it's so much more than the winter payment. People are burnt out . . . we've got a minister of health that does not support the people he should be looking out for, so nurses are very disillusioned."

Incentive payments debacle – how did we get here?

March 2022 – Auckland district health boards brought in additional shift incentive payments for nurses, midwives and allied staff of $500 per full night shift and $250 for day shifts, in addition to MECA overtime rates. They offered resident medical officers $60-$195 per hour, and senior medical officers $250-$350 per hour.

June 13 – Te Whatu Ora reached an agreement on incentive payments with unions representing resident doctors. Payments ranged from $80 to $220 per hour, depending on seniority and type of shift.

July 5 – TWO provided all unions draft document – which included payments. Required feedback by 9am July 8. NZNO didn't have time to consult with members and submit on it.

On a recent busy weekend nightshift, Burns was nurse in charge and the ward was short by three nurses.

She had to escalate the transfer of a young female patient, who was becoming critically unwell, to the intensive care unit.

"That was really frightening for me. It showed what can happen when our staffing levels are so low, and how easily our registration can be at risk."

In the circumstances, Burns said she was appreciative of how hard the charge nurse was working to support her team.

> **"Every day, all the time, we have gaps – 'we need three for night shift, we need this, we need that' – and you feel guilty because you feel bad for your colleagues."**

Constantly having to do more than 40 hours per week left nurses tired, stressed and more prone to illness, Burns said.

"If they pick up extra hours or an extra shift, you can guarantee somewhere down the track, in two weeks, they will be on a sick day."

Burns said not doing additional shifts would be challenging for staff because they did not want to do anything to put patients at risk.

July 18 – Te Whatu Ora chief executive Margie Apa released incentive package details for nurses for the period July 1-September 30 of $100 per each eight-hour shift, or $800 for five night shifts. The memo said "other locally arranged well-being initiatives to be put in place".

Mid-August – NZNO raised an employment relationship problem with Te Whatu Ora over the issue, industrial adviser David Wait said.

" . . they were changing the individual terms and conditions of our members and they hadn't followed the processes under the employment act that enabled them to do that."

August 25 – Te Whatu Ora agreed to a mediation with NZNO, after initially refusing to engage.

September 8 – In a written submission, NZNO told Te Whatu Ora:

- The payment programme was applied without negotiation, was a "flawed regime which treats front-line health workers differently based on existing gender and power structures" and

Christchurch ED nurses Kez Jones and Tania Thompson agreed it would be a challenge not to pick up additional shifts – but they felt it was their only option to achieve change.

"Everyone is breaking and you have your staff in tears and they just can't cope with it any more and it's not sustainable. So we have to do something and if this is what we have to do to highlight how bad it really is . . . then that is what we have to do."

Jones said there were already 96 shifts with staffing gaps in the week of October 3-9.

The flow of requests to fill staffing gaps was overwhelming, Thompson said.

"Every day, all the time, we have gaps – 'we need three for night shift, we need this, we need that' – and you feel guilty because you feel bad for your colleagues."

Te Whatu Ora's incentive offer was "a massive insult", Jones said.

was unacceptable.

- An equitable offer would be double time with no triggers required.

- A new deal for the payments would need to include backpay to June 13 and health, safety and wellbeing measures for staff.

- Members were extremely angry about the payments and 88 per cent of those surveyed (about 1500) said they would no longer work additional hours.

September 16 – Paul Goulter called on Te Whatu Ora members to work only contracted hours during the week Monday, October 3 to Sunday, October 9.

While extra pay for additional shifts would not relieve pressure, it would be an acknowledge of the extra work nurses were putting in, she said. " . . . until we get the long-term solution, which is recruiting more staff, which we all know is not going to be a simple fix."

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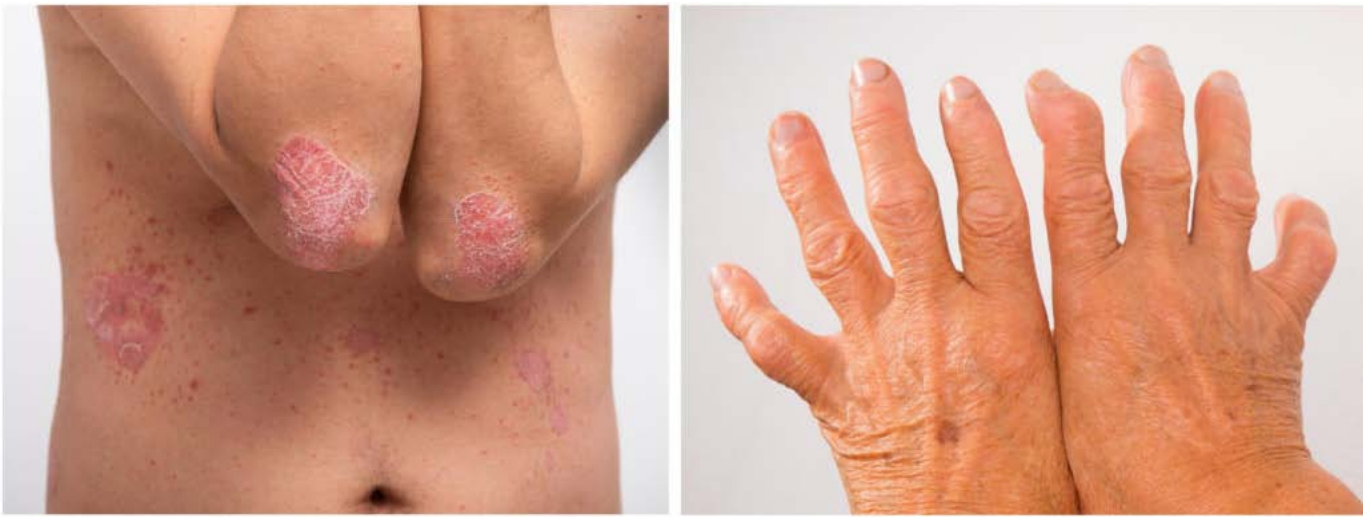
Practice

Biological medicines: Transitioning to Amgevita – a biosimilar of adalimumab

By He Ako Hiringa

September 12, 2022

Most patients taking the biological medicine adalimumab are transitioning to a "biosimilar" version of the drug called Amgevita. This article explains why this is happening, and how nurses in primary care can help smooth the transition.



Plaque psoriasis and rheumatoid arthritis are two of the autoimmune conditions that adalimumab is prescribed for. PHOTOS: iStock

Adalimumab is a biological medicine taken by thousands of New Zealanders to treat autoimmune disorders. Next month Pharmac is shifting its adalimumab funding to a cheaper biosimilar version of the drug called Amgevita.

This article summarises the changes to adalimumab funding and access. It also provides background and

KEY POINTS

resources to foster confidence in biosimilars, and outlines the supports needed to change patients from Humira to Amgevita.

Introduction

Biological medicines have markedly improved the prognoses for many chronic and disabling inflammatory and immunological conditions and cancers. Their use in New Zealand is increasing and, as patents expire on the original or "reference" biological medicines, competitor manufacturers can produce very similar versions, called biosimilars, at a fraction of the cost.[1,2]

On March 1 this year, the reference adalimumab medicine, called Humira, ceased being funded for new patients. All new patients starting adalimumab now receive a biosimilar version, called Amgevita, and this will become the primary funded option for adalimumab from October 1.[3]

This means that, with a few exceptions, patients currently on Humira (ie those who were on it before March 1) will need to be changed to Amgevita by October 1 to continue receiving funded treatment. Many patients who are stable on Humira already have repeat prescriptions and Special Authority renewals actioned in primary care. Pharmac is encouraging general practice teams to transition these patients to Amgevita.[3]

What is adalimumab?

Adalimumab is a human anti-tumour necrosis factor alpha (TNF-α inhibitor) monoclonal antibody that blocks inflammatory and immune responses often associated with chronic autoimmune conditions. It is used to treat a range of dermatological, rheumatological, gastrointestinal and ophthalmologic conditions.[4]

- A biosimilar medicine, Amgevita, is set to replace the reference biological medicine, Humira, as the main funded adalimumab option.
- From October 1, 2022, Humira will remain available to existing patients only under specific circumstances.
- Health professionals' conversations with patients about changing from Humira to Amgevita should be initiated early and framed positively; stable patients may be transitioned in primary care.
- Patients will need training on how to inject Amgevita, as the devices differ from those used to administer Humira.
- To avoid inadvertent substitution, always use brand names when dealing with biological medicines.

The reference adalimumab, Humira, has been on the New Zealand Pharmaceutical Schedule since 2009 and funded under Special Authority criteria for use in:[5,6]

- rheumatoid arthritis
- polyarticular juvenile idiopathic arthritis
- psoriatic arthritis
- ankylosing spondylitis
- Crohn disease
- plaque psoriasis
- hidradenitis suppurativa
- uveitis (ocular inflammation).

About 6400 New Zealand patients routinely self-administer adalimumab fortnightly by subcutaneous injection. Of those who are seen in primary care, most have either rheumatoid or inflammatory bowel conditions.[7]

The biosimilar agent Amgevita costs much less than the reference biological, Humira ($375 vs $1600 per month for adults). This saving has allowed Pharmac to widen the access criteria (see Panel 1), and it is anticipated that 700 more people will have access to adalimumab in the first year.[3]

Safety and efficacy of biosimilar medicines

Adalimumab biosimilars have been shown internationally to be equally effective to the reference adalimumab product. There is no evidence to indicate any specific clinical risk or harm with switching from the reference product to a biosimilar.[8] On reviewing the literature, New Zealand's Pharmacology and Therapeutics Advisory Committee (PTAC) concluded there was currently no evidence that the rate of development of immunogenicity – including the identification of treatment antibodies leading to loss of treatment effectiveness – differed between reference and biosimilar adalimumab.[8]

> **There is no evidence to indicate any specific clinical risk or harm with switching from the reference product to a biosimilar.**

Amgevita has been approved by the European Medicines Agency (EMA) for use in the European Union (EU), by the Food and Drug Administration in the United States, by the

Therapeutic Goods Administration in Australia, and by Medsafe in New Zealand for all the indications for which Humira is approved.

More than 15 years' use of biosimilars in the EU, over two billion treatment days worldwide, and reviews of more than 175 reference/biosimilar switch studies conducted up to 2018 have not revealed any safety problems.[9]

Timeline for changing from Humira to Amgevita

All existing Humira patients were issued a Special Authority number for Amgevita in March, and a seven-month transition window was put in place (to October 1, 2022).[3]

From March 1 to September 30, 2022

- Amgevita or Humira are both funded for existing patients and uses. (All prescriptions must clearly specify the brand of adalimumab — Amgevita or Humira — required.)
- Most patients using Humira should be changed to Amgevita (see exceptions below).
- Only Amgevita will be funded for new patients and uses.

From October 1, 2022

- Amgevita will be the main funded brand of adalimumab for all uses (current and new).
- Humira will remain funded (through a new initial Special Authority – see below) for patients previously treated with Humira who, following discussion with their prescriber:
    1. have Crohn disease or ocular inflammation and are considered at risk of disease destabilisation if there were to be any change to their treatment regimen.
    2. trial at least two doses of Amgevita (for less than six months after starting Amgevita) and experience clinical difficulties (intolerable side effects or loss of disease control attributed to the change) and choose to return to Humira.
- All existing Special Authorities for Humira will expire on September 30, 2022, and the appropriate prescriber will need to complete a new initial Special Authority for the above patients who require ongoing funded access to Humira.

Note that the Special Authorities for Humira and Amgevita are not interchangeable.

Panel 1: Expanded access to adalimumab via prescribing of Amgevita[10]

New funded indications from March 1, 2022, include:

- ulcerative colitis first-line
- undifferentiated spondyloarthritis
- inflammatory bowel disease-associated arthritis.

The following currently funded indications also have access widened from March 1, 2022:

- Crohn disease dose escalation
- rheumatoid arthritis: reduction in the number of swollen joints required for access to treatment, and removal of the requirement for C-reactive protein level to be >15mg/L
- Behçet disease; access to funded treatment with adalimumab as a first-line biologic
- ocular inflammation; access to funded treatment with adalimumab as a first-line biologic.

Funded access to adalumimab for all indications will be improved by the new Special Authority criteria for Amgevita. These will include:

- removal of dosage restrictions
- extension of Special Authority renewal periods to two years
- allowing any relevant practitioner to apply for Special Authority renewals
- removal of Special Authority renewals for some conditions.

Primary health care providers will be able to alert adalimumab-naive patients to the expanded access criteria and, where appropriate, refer for secondary care consultation for potential initiation of the medicine.

The full Amgevita Special Authority criteria (https://schedule.pharmac.govt.nz/ScheduleOnline.php?edition=&osq=Adalimumab+%28Amgevita%29) are available in the

Pharmaceutical Schedule.

Transitioning patients from Humira to Amgevita

Based on overseas experience, patient transition from Humira to Amgevita in primary care does not present difficulties, provided the person is given adequate support and information about the change.

Patients using Humira should only receive a first dispensing of Amgevita after having a supporting appointment or discussion with an appropriate prescriber. Other primary health care professionals involved in the care of patients using Humira should initiate a conversation about transitioning to Amgevita at the earliest opportunity.

Transitioning stable patients from Humira to Amgevita will benefit from a multi-stakeholder approach by specialists, GPs, primary care nurses and pharmacists; good communication between primary and secondary care; and knowledgeable and positive conversations with the patient about biosimilars and Amgevita.

The role of each health-care professional is to ensure that patients receive the right treatment and support. The changes to adalimumab funding provide additional flexibility in primary care management of patients while maintaining engagement with secondary care as needed.

Everyone in the health system has a role to play to deliver this change, and some specific roles may include:

Specialists: New patients (adalimumab-naive) and patients accessing Amgevita under new or expanded existing indications will continue to have treatment initiated by a specialist. During the transition of stable patients from Humira to Amgevita, specialist support may be sought for:

- patients with additional needs and/or unstable disease
- patients whose disease control has become reduced during the transition
- patients for whom the primary health care professional does not feel confident in managing the transition.

General practitioners, nurse practitioners, nurse prescribers, pharmacist prescribers: Stable patients transitioning from Humira to Amgevita may be managed in primary care, which can take responsibility for:

- Amgevita Special Authority renewals (by any relevant practitioner) – renewals will only be required every two years, reducing administrative burden
- ongoing prescribing of adalimumab in the community
- the referral of patients to relevant specialists where appropriate (eg, additional needs, evidence of disease deterioration)
- helping patients feel confident and comfortable using Amgevita
- potentially, some training of patients about how to use the Amgevita device
- monitoring for treatment efficacy and adverse effects.

Primary care nurses: Nurses in primary care will have an important role in:

- training patients in the use of the Amgevita device (previously a role performed by secondary care nurses)
- ensuring patients feel confident and comfortable using Amgevita
- monitoring for treatment efficacy and adverse effects.

Community pharmacists: Patients presenting prescriptions for Humira should be given information about the funding changes and prompted to make an appointment to discuss the transition to Amgevita with the appropriate prescriber. The pharmacist has the opportunity also to:

- support the training of patients on how to use the Amgevita device
- ensure patients have received appropriate training at first dispensing of Amgevita
- provide information to promote confidence in Amgevita at first dispensing.

Community pharmacists can initiate the conversation as Humira prescriptions are filled, recommending the patient talk with their prescriber.

See Panel 2 for resources to help with the transition.

Panel 2: Amgevita resources

Resources for primary health care providers

To support the introduction of Amgevita, resource packs for prescribers, nurses and pharmacists are available from the supplier, Amgen (http://www.amgevita.co.nz), including:

- clinical information about Amgevita, including efficacy, safety and immunogenicity data
- practical information about Amgevita, including use of the device and patient training
- reusable demonstration devices and links to online learning modules
- access to a free medical information phone line to support health-care professionals with logistical, practical and clinical queries.

Resources for patients

Patients who are prescribed Amgevita will have the following information and support from Amgen (http://www.amgevita.co.nz):

- key information about Amgevita, device instructions, a patient alert card and information about how to access support services, in a range of languages
- free access to registered nurses (based in Australia) via phone and video to assist with self-administration and medicine queries
- free replacement sharps bins posted directly to patients upon request
- a website with access to supporting documents and videos, and links for ordering sharps bins and contacting remote nursing support.

Links to additional resources can be found at the He Ako Hiringa "Biological medicines resource hub" (http://www.akohiringa.co.nz/education/biological-medicines-resource-hub).

Amgevita product characteristics

Amgevita is supplied as a citrate-free formulation in a 20mg (paediatric) dose pre-filled glass syringe and as a 40mg dose, in either a pre-filled glass syringe or pre-filled pen.[4,11] The Amgevita pen is similar to the Humira device but differs in shape and colour. Both use a clear window that fills yellow over 10 seconds as the injection is delivered.

- Before subcutaneous administration, the Amgevita device should be allowed to rest at room temperature for 15-30 minutes. It should not be warmed in any other way.[4]
- The solution should be inspected closely and not used if it is discoloured, cloudy, or if flakes or particles are present. Vigorous shaking of the product is to be avoided.[4]
- Amgevita does not contain preservatives; any unused medicine or waste material should be disposed of appropriately.[4]
- The longer shelf life of Amgevita (36 months vs 24 months for Humira) may be advantageous for pharmacists in terms of holding stock.
- Amgevita is available in the same dose and delivery options in which Humira has been available – see Table 1.[3]

Amgevita product information can be found on the Amgen (http://www.amgevita.co.nz) website.

TABLE 1. AMGEVITA DOSES AND DELIVERY

Chemical	Formulation	Brand	Pack size
Adalimumab	Inj 20mg per 0.4ml prefilled syringe	Amgevita	1
Adalimumab	Inj 40mg per 0.8ml prefilled syringe	Amgevita	2
Adalimumab	Inj 40mg per 0.8ml prefilled pen	Amgevita	2

Using brand names

In all professional and patient interactions, biological medicines should be referred to by their brand name. The New Zealand Formulary recommends to:

- prescribe by brand name, rather than generic, to avoid inadvertent substitution
- dispense the brand prescribed and record the batch number where possible to ensure the batch is traceable.[12,13]

Reporting adverse events

If a patient has a suspected adverse drug reaction to a biological medicine, a report should be submitted to the Centre for Adverse Reactions Monitoring (CARM) at the New Zealand Pharmacovigilance Centre. All reports should include the brand name and batch number of the suspected biological medicine and can be made via the website (https://nzphvc.otago.ac.nz/reporting), by email (carmnz@otago.ac.nz) or by using a pre-printed card. Electronic reporting is also possible using an adverse reaction reporting tool present in many practice management systems.[1]

Patient education and positive conversations

Successful transition of patients from Humira to Amgevita requires interdisciplinary cooperation and consistent messaging by specialists, primary care prescribers, nurses and pharmacists. As an exercise involving biosimilars, it is one that will become increasingly relevant for health-care professionals as more products come onto the market.

A smooth transition for the patient depends on health-care professionals:

- being a trusted source of knowledge on biologics and biosimilars
- explaining the reasons for, and benefits of, the change
- managing patient anxiety about change
- having positive conversations with patients about Amgevita and promoting expectations of continued disease control
- providing device training.

Good conversations with patients before initiating or changing a medicine help to reduce the likelihood of unwanted outcomes due to the nocebo effect.[14] The nocebo effect is a decrease in subjective benefit, a worsening of symptoms or onset of adverse effects due to a patient's expectation or perception of harm associated with a treatment.[14]

Patients tend to be influenced by the attitudes of health professionals so framing the transition to Amgevita in a positive light is important. PHOTO: ADOBE STOCK

Patient reporting of adverse drug effects is very much related to their expectations and may be affected by how the health-care professional talks about the medicine. In general, people are much more inclined to pick up on negative rather than positive information, both from outside and online sources, and any hesitancy or doubt conveyed to them by health professionals.[15]

> **A practitioner who is hesitant, diffident or uncertain can transfer these feelings during the consultation, affecting how the patient experiences and accepts a medicine.**

Health-care professionals are instrumental in framing medicines positively or negatively and their own beliefs can significantly influence how a patient feels about a medicine. A practitioner who is hesitant, diffident or uncertain can transfer these feelings during the consultation, affecting how the patient experiences and accepts a medicine.[15,16]

A useful approach is to create an environment where the patient can voice their beliefs, and for the prescriber to provide information – perhaps using a health literacy framework to aid the conversation:[17]

- **Ask** the patient how they feel about changing from Humira to Amgevita.
- **Build** on their existing knowledge of the medicines.
- **Check** with the patient **that you have explained things adequately** and they know the next steps to be taken.

He Ako Hiringa has produced a bulletin (http://www.akohiringa.co.nz/education/starting-a-medicine-accentuate-the-positive) and podcasts (http://www.akohiringa.co.nz/education/episode-one-initiating-new-medicines-part-1) about positive framing when initiating new medicines.

Panel 3: Terminology is important

When using the terms switching, transitioning and substitution, it pays to be clear.

SWITCHING is when the treating clinician acts *"to exchange one medicine for another with the same therapeutic intent"*.[13] Switching can refer to a change between two different medicines (eg, infliximab to adalimumab) or between a reference biological medicine and its biosimilar (eg, Humira to Amgevita) or between biosimilars of the same reference product.

Switching from a reference product to a biosimilar (or vice versa) or between biosimilars is also referred to as nonmedical switching (ie, for cost-saving purposes[18] – it has been proposed the term **TRANSITIONING** is used for this type of switching to help delineate the types of switches reported in the literature.[18,19]

AUTOMATIC SUBSTITUTION is where a medicine is dispensed in place of another equivalent medicine that is expected to have the same clinical effect, at the pharmacy level without consultation with the prescriber.[13] Note that, in New Zealand, automatic substitution of biological medicines is not permitted.[20]

Reading this article, and following the links to the bulletin and podcasts can equate to one hour of CPD time.

Nurses can use the Nursing Council's professional development activities template (https://www.nursingcouncil.org.nz/Public/Nursing/Continuing_competence/NCNZ/nursing-section/Continuing_Competence.aspx?hkey=6542ac27-9b56-4e89-b7ae-db445c5cb952) to record professional development completed via Kaitiaki, and they can then have this verified by their employer, manager or nurse educator.

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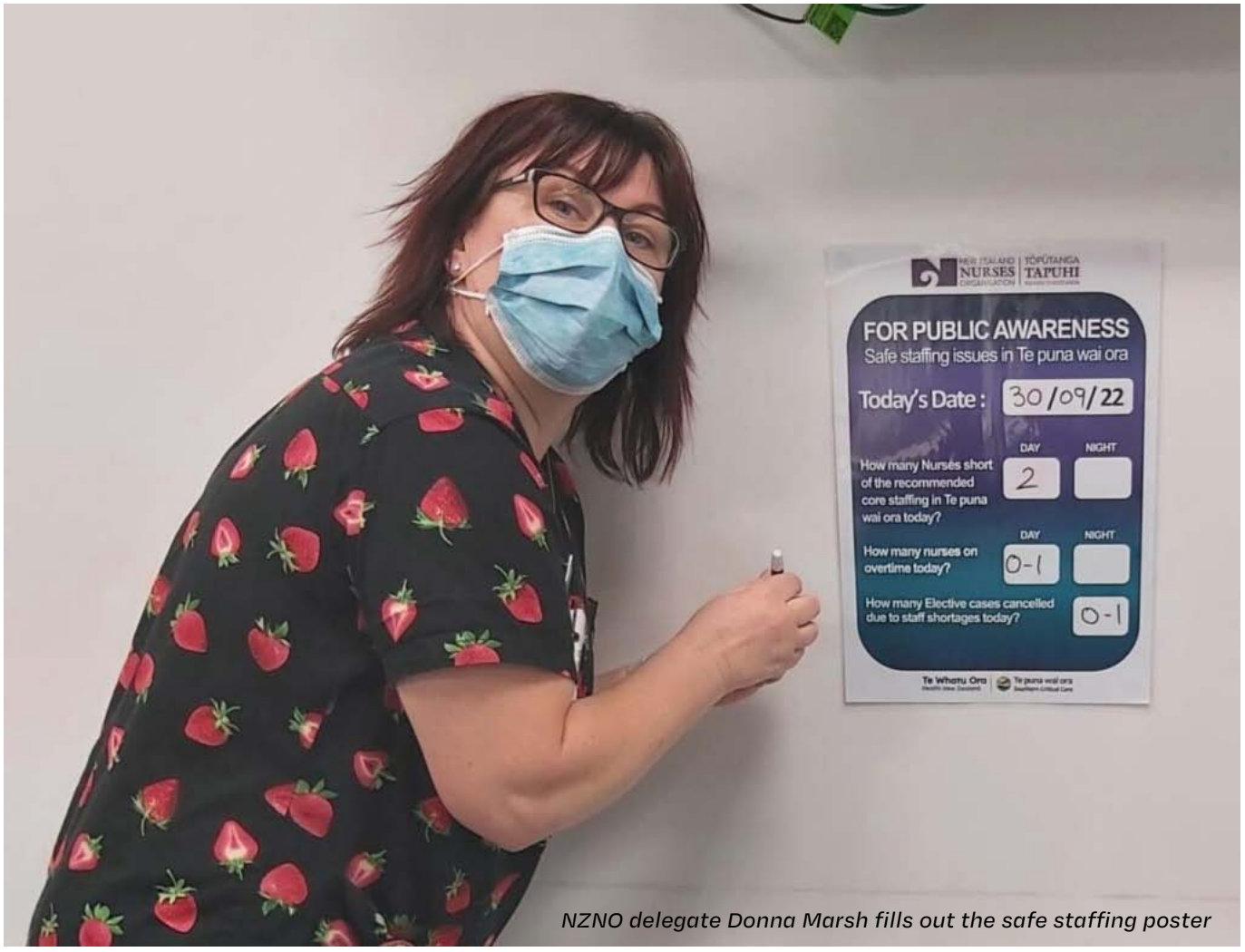
News

Dunedin nurse takes short-staffing into her own hands with home-made poster

By Mary Longmore

September 30, 2022

Tired of waiting for official unsafe staffing warning signs, Dunedin critical care nurse Debbie Robinson created her own very public display of just how dire short-staffing was in the hospital.



NZNO delegate Donna Marsh fills out the safe staffing poster

“I kept reading about the plight going on over the country on our NZNO social media pages and after the articulate way [Whangārei delegate] Rachel Thorn described their staff shortages in Whangārei ED I decided to draw a line in the sand.”

So in early September, Robinson designed an A3 laminated poster to hang in the hospital’s whānau intensive care unit (ICU) reception, and show exactly how short of staff the unit was each day — and the conseqences.

“By 11am everyday in ICU, we know how many elective cases for our unit will be cancelled due to shortages of staff (nurses and/or doctors).”

> **“I see the tiredness and the staff so much want to help their colleagues and ultimately the patients – but after this continuous pressure, goodwill is running out.”**

In ICU, the staff-patient ratio should be 1:1. For more than a year, Robinson said staff had faced a “daily barrage of texts imploring any staff. . . who can come and fill in roster gaps as our acuity and numbers have increased”.

As a delegate, she said: “I see the tiredness and the staff so much want to help their colleagues and ultimately the patients — but after this continuous pressure, goodwill is running out.”

Robinson said initially the hospital’s human resources (HR) department was “perturbed” and called a meeting. However, NZNO organiser Celeste Crawford affirmed members were entitled to put their signs up.

“It’s in the [NZNO-Te Whatu Ora collective] agreement (https://d3n8a8pro7vhmx.cloudfront.net/nzno/pages/978/attachments/original/1636941849/NZNO-DHB-MECA-2-Aug-2020-31-Oct-2022-final-signed.pdf?1636941849) and we’re entitled to do it.”

“It’s okay for them to hang their signs because family and friends of patients need to know that there aren’t enough staff in workplaces to be able to cover the workload that our members are doing,” Crawford said.

As well as highlighting “chronic understaffing”, Crawford said the signs also alerted patients that their Health & Disability Consumers’ Right (https://www.hdc.org.nz/your-rights/about-the-code/code-of-health-and-disability-services-consumers-rights/) four was being breached: “Every consumer has the right to have services provided with reasonable care and skill.”

“So because our members are working short-staffed, the consumer may not be getting that care and skill.”

Robinson said the Healthy Workplace Agreement Appendices 1(b) in the NZNO-DHB (now Te Whatu Ora) collective agreement (https://d3n8a8pro7vhmx.cloudfront.net/nzno/pages/978/attachments/original/1636941849/NZNO-DHB-MECA-2-Aug-2020-31-Oct-2022-final-signed.pdf?1636941849) allowed members to display staffing shortages to the public.

“The patients have the right to know there will be reasonable services that they expect that they’re not necessarily going to get.”

Kaitiaki
NURSING
NEW ZEALAND

News

Free NZNO membership for nursing students ‘an example for Government’

By Mary Longmore

September 13, 2022

Student members say NZNO is “leading by example” by granting free membership to nursing students.

NZNO student members celebrate the AGM vote for free union membership.

At the NZNO annual general meeting (AGM) on Tuesday September 13, chief executive Paul Goulter announced that members had voted by a 74 per cent majority — 2595 to 741 — to accept the National Student Unit (NSU)’s proposal to remove NZNO student membership fees.

The announcement was greeted by an eruption of applause from the students at the AGM.

"NZNO is leading by example and the Government needs to follow," NSU co-leader Jade Power told *Kaitiaki* later. NSU leaders have said they are keen to see fees-free nursing study in Aotearoa New Zealand, as had been implemented in Victoria, Australia recently.

Nursing students currently get their first year of membership free, but then pay just under $49 per annum. Removing the fees would reduce NZNO's membership income by around $67,000 per annum, the remit committee has said. NZNO has 2245 student members.

Power also said the result reinforced the purpose of NSU, which was to advocate for students and nursing.

NSU member Nic Brasch said part of the intent of the Maranga Mai! (https://maranga-mai.nzno.org.nz/) campaign was for members to stand up everywhere for other members, which was what NSU had done in this case.

NSU co-leader and Te Rūnanga Tauira chair Manu Reiri said the move was heading "in the right direction" for students across Aotearoa. He hoped it would see growth in NZNO student members, "bolstering NZNO" numbers, as well as the nursing workforce.

Northland student Anna Clarke, who has previously told *Kaitiaki* about the challenges facing tauira, said free union membership would definitely "make life easier for tauira on board" nursing training.

Nursing student Eli Hallam said finance had been identified as the main barrier to enrolling and staying in nursing studies.

The NSU policy remit proposed to remove fees for all individuals "studying towards certificates, diplomas and degrees which will enable them to enter the field of nursing, effective January 1, 2023."

> **"This is our opportunity to fight for better outcomes for current and future nurses and their patients"**

Reiri said he did not know when the fees would be removed, which would be a discussion for the NZNO board. The new NZNO board of directors is due to meet in October.

Students said in the remit that removing fees would remove barriers to unionism and working together on the challenges facing nursing.

“More and more we see news articles about staffing shortages, burnout and dissatisfaction. This is our opportunity to fight for better outcomes for current and future nurses and their patients. In order to improve our workforce (and ultimately patient outcomes) it is imperative that we remove barriers to unionism so that we can work together to improve our field.”

It was not yet clear whether there would be any limitations on students’ ability to participate in NZNO’s democratic processes as non-financial members — a question which was raised following the remit outcome.

Reiri said the question needed clarifying as first-year student NZNO members paid zero fees yet retained voting rights and “the same should come about from the policy remit”.

The students said they believed other members would support the “betterment of new nurses and that the overall benefits of free student membership are worth this risk”.

Kaitiaki NURSING NEW ZEALAND

News

Maranga Mai! – rise up – is our plan to save the health system

By Cate Macintosh

September 16, 2022

Maranga Mai! – rise up – is a plan to save New Zealand's health system, NZNO chief executive Paul Goulter tells conference delegates.

A full day of the annual conference was set aside to focus on the campaign (https://maranga-mai.nzno.org.nz/) and included a hikoi to Parliament to support a celebration of the 50th anniversary of the Māori language petition — te petihana reo Māori.

Maranga Mai! aimed to break down barriers to "actualising te Tiriti", kaiwhakahaere Kerri Nuku told members, " . . . as we move forward into realising rangatiritanga it's about what are our obligations to deconstruct, brick by brick, that wall".

Goulter said Maranga Mai! aimed to "win the necessary political and resourcing commitments needed to address this crisis permanently across the whole health sector".

From left: President Anne Daniels, kaiwhakahaere Kerri Nuku, chief executive Paul Goulter, professional nursing services manager Mairi Lucas and member Naomi Waipouri on the way to Parliament.

"We've got to win because this crisis and the state of the health sector says nothing else is good enough."

At the heart of the campaign was action, " . . . because I don't think just sitting around complaining about stuff wins us anything".


Kerri Nuku

Nuku said working more collectively would be key to its success.

"NZNO has existed on creating silos, colleges and sections, regional councils, rūnanga . . . if we are building a campaign based on winning as a group of nurses then the first thing we need to do is deconstruct some of those barriers that we've artificially built."

“Actualising te Tiriti” would involve rebalancing of priorities within the NZNO and holding the Crown accountable for its actions, Nuku said.

“We all know that as a registered nurse we have to show cultural competency, safety . . . when in reality there is more emphasis placed on the clinical component as opposed to the cultural part, so that is a rebalancing that has to happen.”

President Anne Daniels said the campaign would require members to become more political. “Unless we get involved politically, then nothing is going to change.”

Goals of the campaign included advocating for culturally safe and equitable patient outcomes, which she said could be challenging for some in the organisation.

“Right now, the colonialism that is within our organisation, the racism, it’s still very much present.”

Daniels said she developed a better understanding about racism through her son’s nursing study, and reading some of his course material.

“I realised I was completely ignorant in terms of what I understood racism to be and what it looked like and what it meant to me as a nurse going to work, and I realised I had a lot of work to do.”

She said everyone needed to “step up to the plate” to reflect on the issue if they wanted to prevent further harm.

“I’ve been in this job for one year and I have become extremely aware of the pain that Māori have experienced. We need to change that.”

Another goal was to ensure “every nurse has the power and resources to do the job”.

“When I go to work in ED in Dunedin and I see people in the corridors and I know that in the next eight to 10 hours there’s someone out there who might not be noticed, who will quietly fade away.”

She said the number of “near misses” was incredible.

“Unless we get involved politically, then nothing is going to change.”

“We need to have the power to stand up and say, when we go to work, we haven’t got the resources to be safe and our patients aren’t safe, and we have to use the systems that are in place to make that visible.”

Daniels said Maranga Mai! included advocating for NZNO to be at the policy decision-making table but also for individual members to be more engaged.

“This is not just the delegates’ job, or the thing I see on Facebook all the time, ‘what is NZNO doing about this’. I find that hilarious, you know, NZNO is us and I know that’s old and worn, but it’s real.”

Nuku said delegates could show solidarity with mana whenua, past and present, who had reclaimed their language, by attending the event at Parliament.

“It’s about recognising that we aren’t responsible for the failures of the past but we have an obligation and an opportunity to deconstruct the walls that have [been] built and oppressed us.”

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Maranga Mai!

Maranga Mai! Registration – what needs to change?

By Mary Longmore

September 23, 2022

As Aotearoa New Zealand faces down a nursing shortfall of thousands, changes are afoot to how overseas nurses are registered here. In the second part of a series exploring Maranga Mai! (https://maranga-mai.nzno.org.nz/), NZNO's campaign to fix the nursing crisis, *Kaitiaki* looks at what needs to change in the registration process.

Māori nurse Anamaria Watene

Clinical nurse manager at Tauranga Hospital's kaupapa ward Anamaria Watene says it's vital internationally-qualified nurses (IQNs) are competent to work with tāngata whenua when they come to work in Aotearoa. "*According to the research and evidence, caring for indigenous peoples necessitates clinical and culturally competent health-care workers,*" she says.

- **Māori involvement:** Māori must be involved in evaluating IQN cultural competence.
- **In-depth training:** Cultural competence training must be "level 5-7 and not a 101 lesson".
- **IQN support**: The IQNs, too, need support as they transition into working in Aotearoa. "*Remember, many of the IQNs are away from their families and we become their whānau.*"

Pacific nurse Mareta Pesata-Simanu

Samoan-trained senior nurse Mareta Pesata-Simanu, who has 20 years' nursing experience in the Pacific region, says the English writing test is "ridiculously" hard and the process to register in New Zealand is "long and expensive". She tried twice to pass since moving here last year to join her husband and is currently working as a public health support worker in Auckland while she figures out her next move.

- **A more relevant English test**: *"They give you something like Tesla cars to write about – I'm a nurse, I don't know anything about cars. I wish they could just take [you through] how you understand instructions and everything in English – [but] three massive essays you have to complete in 60 minutes, it's just ridiculous."*
- **Financial support**: So far she has spent nearly $1000 on the IELT English tests and is contemplating another $500 to try the OET test. Credentialling services will cost her another $500 or so.
- **A broader view:** Consider nursing experience, not just grades.

Filipino nurse Ruth Anne Cruz

Ruth Anne Cruz says the new professional and cultural education module would be invaluable to IQNs adapting to New Zealand's culture. *"I've been raised in a country where I don't get to speak up. But now I've learned it's not how it is, and I appreciate that."*

- **Lowering the written English standard** would make New Zealand "more competitive" in a global nursing market.
- **Cultural safety education**: IQNs currently "are expected to know how to practice culturally safely".
- **Financial support:** The registration process is expensive and high-risk for IQNs.

Compulsory cultural competency training for internationally-qualified nurses (IQNs) is "a step in the right direction" but long overdue, says Tauranga clinical nurse manager Anamaria Watene.

The Nursing Council announced earlier this month that cultural competency training will be part of a new pre-entry training module for all IQNs by 2024 — one of many sweeping changes to both ease and bolster the registration process for overseas nurses amid a New Zealand workforce shortage estimated at 4000-plus nurses.

Watene – who works at Tauranga Hospital's kaupapa ward, where many staff are local tāngata whenua and speak or are learning te reo Māori – said it was "critical" Māori were involved and the training was high level, "not a 101 lesson".

"This is important because they are communicating with and acting as advocates for Māori, so we have to be assured that they are culturally safe to do that."

> **"Before [in the Philippines] I just need to know if they're a Muslim or Christian, those are just my options. Here I have to consider the traditions and the cultures."**

In her kaupapa ward, patients' whānau are welcome and rongoā — traditional Māori medicine — is available alongside conventional. She says it is "critical" IQNs get "rigorous education and professional development and demonstrate cultural competency and kawa whakaruruhau".

Watene — who was re-elected this month to the NZNO board — is calling on the Nursing Council to work with NZNO's Māori nurse membership committee Te Poari on the learning module "as we represent the largest Māori nursing roopu".

Addressing inequalities

Nursing Council director of policy Nyk Huntington said while the council received "very few" complaints over lack of cultural competence, "we're also aware that addressing structural inequalities for Māori in health care requires nurses to develop a relatively deep appreciation of what concepts such as 'cultural safety' mean in our specific context. Introducing IQNs to kawa whakaruruhau is one example of that".

Nyk Huntington

Grounded in the work of Dr Irihapeti Ramsden (Ngāi Tahu, Rangitāne), the Nursing Council's definition of kawa whakaruruhau went beyond cultural safety to address equity issues across the health and disability sector, Huntington said. "At its heart is Māori patients, their whānau, hapū and iwi."

Recent research1 suggested IQNs themselves found "significant value" in learning about te Tiriti, te ao

Māori "and what that means for their practice", Huntington said.

Watene said questions remained over the new training:

- Who will evaluate competence? It must be Māori.
- Should an IQN not pass or qualify, what happens?
- Who will prove education and monitoring, and ensure there is ongoing professional development in this?

Irihapeti Ramsden

Culture shock

Wellington IQN Ruth Anne Cruz said the new pre-entry professional and cultural competency training would be incredibly helpful for IQNs preparing to work in New Zealand.

"Before [in the Philippines], I just need to know if they're a Muslim or Christian, those are just my options. Here I have to consider the traditions and the cultures. It would be nice to understand everything first, because if you don't know things it's kind of hard to work."

"It's very frustrating – I want to help people with the skills I have as a nurse."

It was also a different professional culture for some IQNs, who had been taught to follow doctors' orders. "I've been raised in a country where I don't get to speak up. That's my whole life of practice – the hierarchy, just applying what the doctor is ordering. But here I feel I have the privilege to make my own decision – it's different."

Huntington said the cultural safety education would be part of a broader orientation in New Zealand's health system and "what are some of the expectations of our nursing practice and what's distinctive about nursing in New Zealand.

"For example, if an IQN comes from a health culture where doctors have a huge amount of authority and power and you don't question them, the learning module will be explaining to them that in New Zealand we expect nurses to be relatively autonomous practitioners. And that's not just a matter of what we expect of you, it's what others will expect of you."

Prioritising Pasifika nurses

Samoan-trained nurse Mareta Pesata-Simanu has struggled to get registered since moving here to join her husband last year, despite more than 20 years' nursing experience in Samoa and Tokelau, including senior management roles. She began her credentialling verification process (CGFNS) but then gave up after failing two IELTs (international English language testing system) exams – renowned for their difficulty. The tests cost $439 each time, and the credential checking another $500 or so.

> **"According to the research and evidence, caring for indigenous peoples necessitates clinical and culturally competent health care workers."**

"It's a lot. We're renting [in Auckland] and there are other bills to pay . . . Then I started working in public health and I thought 'oh, I'll give it a rest for now'."

Pesata-Simanu said it was "frustrating" to be working as a support worker when she could be helping people as a nurse. She is saving up for a third crack at the English test – this time the OET (occupational English test), which is more expensive at $500 but health-specific.

The lost nurses

NZNO Pacific Nursing Section (PNS) chair 'Eseta Finau says Pacific-trained nurses who are not registered to work in Aotearoa are being exploited. "They know they are registered back home, so they give them the work of an RN and they get paid peanuts – that's not on."

According to Nursing Council statistics,
Pasifika make up 3.8 per cent of all RNs,

yet the Pasifika population of Aotearoa is 7.4 per cent. Only 2200 of NZNO's 55,000 or so members identify as Pasifika. The unregulated health workforce is estimated to be the largest group of Pacific health workers in New Zealand.2

Violani Wills, 'Eseta Finau and Siniva Cruickshank of the NZNO Pacific Nursing Section.

Finau said more support was needed to encourage Pacific-trained nurses into New Zealand. Many failed the "expensive, stringent" English test and gave up. "So they have had to work as cheap labour in rest homes while they pursue registering in New Zealand."

Ethics of taking away Pacific nurses?

But there was also an ethical issue at play, "taking nurses from places like Samoa and Fiji" which needed their nurses. She suggests a two-year placement or exchange, where Pacific-trained nurses can come and get experience in New Zealand.

"It would be good if they could encourage an exchange – the [NZ] students could go and learn about Tonga at the same time the Tongan students can come and experience the environment here. In that way they both learn and benefit."

Catherine Byrne

Nursing Council chair Catherine Byrne said the council would be looking at a "fair and safe" pathway into New Zealand for Pacific-trained nurses over coming months. We would think that the qualifications of some Pacific countries are very very similar to the BN qualifications here in NZ, which would means that developing a pathway to registration could actually be relatively simple for some Pacific countries."

A recent fono – hui – in July with Pacific nursing leaders helped the council understand the challenges and possible ways forward, Byrne said. "We've started those conversations, those connections, so our next steps are engaging with that group again and working out what a pathway may look like."

New bridging programme for Pacific nurses

Whitireia Community Polytech head of Pacific nursing Tania Mullane hopes some of the lost nurses will be shepherded into the workforce through a new bridging programme, specifically designed for Pacific-trained nurses who have been unable to obtain registration here.

Tania Mullane

Subject to Nursing Council approval, the 18-month post-graduate diploma in Pacific nursing is due to launch in 2023. It will be open for Pacific-trained nurses with New Zealand residency who have worked at least two years in their home countries. Te Whatu Ora scholarships will be available, Mullane said.

Unlike previously, it will not require students to pass an English test such as IELT or OET – however, they will need to pass the state exam at the end, said Mullane. It was hoped that over 18 months they would reach the English standard required, she said.

'Thousands' of IQNs working in unregulated workforce

Philippines-trained Wellington nurse Ruth Anne Cruz got her registration here last year after 10 months working as an health-care assistant, and now spends a lot of time guiding others through the process.

The drop in the written English standard – which took effect straight away – was "appreciated . . . most of the problems are with the writing" and it would help New Zealand be more competitive in the global nursing market.

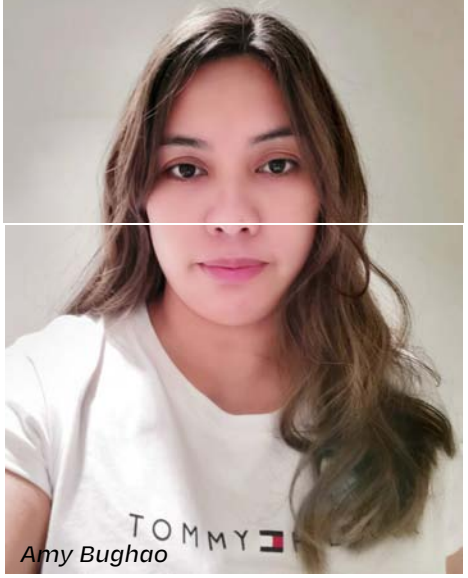
"It was the only hurdle I had. I kept procrastinating, I was like 'oh I'm so afraid to take the exam, I'm afraid to fail it, because it's expensive . . . and reviewing for that exam is kind of tedious, while working as well."

> **"I've been raised in a country where I don't get to speak up. That's my whole life of practice – the hierarchy, just applying what the doctor is ordering. But here I feel I have the privilege to make my own decision – it's different."**

Ashburton caregiver Amy Bughao – a trained nurse from the Philippines – agrees. She failed her writing test five times, before giving up in 2017, more than $1000 out of pocket. By then her time away from nursing had been too long for council requirements and she found caregiving work in aged care, working at level 4 under RN supervision.

Through a Facebook support group, Bughao estimates at least 2000 Philippines-trained nurses are in a similar position as her.

She is thinking about trying again, since Te Whatu Ora



Amy Bughao

(Health NZ) launched an IQN CAP fund (https://www.tewhatuora.govt.nz/for-the-health-sector/nursing/internationally-qualified-nurses-cap-fund/) of up to $10,000 to help IQNs with competency assessment programme costs, including English tests, in return for a two-year bonding period with an employer.

"I really wanted to help New Zealand," says Bughao — however, only those who successfully pass will be reimbursed, which makes it risky. "I'm just worried, what if I go through the process and I don't pass my English, what's going to happen?"

Te Whatu Ora's Return to nursing support fund (https://www.tewhatuora.govt.nz/for-the-health-sector/nursing/return-to-nursing-workforce-support-fund/) also provides up to $5000 for IQNs already working as care and support workers in New Zealand to practise as nurses.

Changing rules for 'fair but safe' pathways for overseas nurses

Byrne said the recent changes — announced under intense public pressure after Health Minister Andrew Little spoke of the need to "ease" (https://www.beehive.govt.nz/release/government-plan-boost-health-workers) IQN processes, will balance patient safety while dismantling "unnecessary" barriers to IQNs.

Andrew Little at the NZNO conference this month.

In August, it lowered the written standard on the English test. Then in September it announced new professional and cultural pre-entry training, alongside plans for an exam and direct clinical assessments to replace credential-checking by 2024.

IQNs will no longer be required to have practised for two years before applying, but will still need one year of post-qualifying experience.

The council was also looking at "expedited" pathways from countries with similar standards such as Canada, Ireland, Singapore, the United Kingdom and the United States.

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Kaitiaki
NURSING
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News

Members nationwide gear up for week-long boycott of extra shifts

By Cate Macintosh

September 30, 2022

Nurses across the country are preparing to take a stand against dangerous short-staffing on hospital wards.

Christchurch Hospital ED nurses and NZNO delegates Kez Jones and Tania Thompson

Christchurch emergency department (ED) delegate Kez Jones says it is clear members are saying no to additional shift requests for next week's roster.

NZNO has advised members to boycott additional shifts for the week of October 3-9 in protest over short-staffing and a lack of consultation over incentive payments.

Jones said Christchurch ED should have 112 FTE nursing staff but had just 101. The department relied on existing staff picking up additional shifts and a casual pool to fill the gaps.

Of 560 individual ED shifts required to be filled over the week of October 3-9, there were 96 shifts left unfilled — or 17 per cent — when the roster was released a few weeks ago.

Since then, about 10 of the 96 shifts had been filled, Jones said.

> **“It’s obvious that staff are not picking up as much as what they may have done previously,”**

This still left a significant staffing gap of over 15 per cent — without factoring in sick leave absences.

“It’s obvious that staff are not picking up as much as what they may have done previously,” Jones said.

The unit was planning to display staffing numbers each day in the ED waiting area, to let the public know how many staff were actually working on the shift.

Staff were nervous about how they would manage next week, but a majority were supportive of the action, Jones said.

“We want to support them so we have made sure their safety reporting is going to happen so they are backed — escalation pathways need to be put into place.”

Te Whatu Ora Canterbury warning

On Wednesday, Te Whatu Ora Canterbury warned residents Christchurch ED was under significant pressure and would be stretched into early next week.

Two of three urgent care practices in the city were forced to close to walk-in patients on Wednesday, as a result of high demand, very sick patients and a lack of staff, the media release said.

Hawke’s Bay Hospital renal unit nurse and delegate Noreen McCallum said there was overwhelming support for the action across the hospital but some nurses would opt out for different reasons.

McCallum said the staffing shortage was already a crisis in many parts of the hospital, and

next week's action could make it worse.

Dunedin Hospital ICU nurse and delegate Debbie Robinson said she was inspired to support the action of Whangārei ED nursing staff who have refused to do additional shifts in the department in protest against unsafe staffing.

"While everything happens well in my unit, I could see that's not quite the case in many, many places because of staff shortages," Robinson said.

This week Robinson's team of 110-115 members in the unit have supported the week-long action from Monday . . ."we've got it all set in motion".

She said she had been saying the unit had good staffing numbers, but this action showed that it didn't — the unit was only well-covered due to the goodwill of staff working extra shifts.

Kaitiaki
NURSING
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News

Nursing Council announces changes to competency testing for overseas nurses

By Mary Longmore

September 6, 2022

Direct competency and clinical assessments, alongside cultural safety education, are among crucial changes for internationally-qualified nurses (IQNs) coming to work in New Zealand from 2024.

AdobeStock

From 2024, an online competency test will replace a time-consuming quest for qualifications,

an in-person clinical exam will be required and all IQNs will be obliged to learn about cultural competency before they can work in Aotearoa New Zealand.

The moves are part of a raft of changes (https://www.nursingcouncil.org.nz/Public/News_Media/NCNZ/News-section/news-item/2022/9/Nursing_Council_Announces_Future_Changes_to_Assessing_IQN_Competence_.aspx) announced by the Nursing Council this week, intended to speed up registration and employment of overseas-trained nurses in New Zealand, while preserving public safety, chief executive Catherine Byrne said.

Catherine Byrne.

Byrne said the online test would test nurses' conceptual and theoretical knowledge, while the learning module would cover nursing in Aotearoa New Zealand, including te Tiriti o Waitangi, cultural safety and kawa whakaruruhau. The clinical exam would be an objective structured clinical examination (OSCE) which requires practical demonstrations in a range of scenarios.

"We must ensure that moving to a new model does not affect the current flow of IQNs into Aotearoa New Zealand."

The changes would reduce unnecessary barriers to IQNs working in New Zealand, while preserving public safety and reflecting the same modern regulatory practices as seen in Australia and the United Kingdom, Byrne said.

"Requiring all nurses to complete a learning module also helps ensure that from day one they understand the unique environment, culture and expectations of nursing in Aotearoa New Zealand — including our specific approach to concepts such as cultural safety."

Enrolled nurse pathway

A clear pathway for IQNs to register as enrolled nurses would also be introduced by 2024, she said.

The online test would be a variant of the council's current state final examination, which all New Zealand-qualified nurses are required to sit before registering, Byrne said.

Direct competence assessments meant there would be less documentation of education and employment history required. The current requirement that IQNs must have practised for at least two years, has been dropped to one — after pushback to the council's proposal to

welcome new graduates with no practical work experience.

“Rather than requiring a minimum number of recent practice hours, we will only be asking nurses to have practised for at least a year after gaining their initial qualifications,” Byrne said.

The new model would also spell an end for competency assessment programmes (CAPs) — costly 10-week courses required by about a third of IQNs.

However, recent research (https://openrepository.aut.ac.nz/handle/10292/15288) showed some of the “pastoral care and orientation” aspects of CAPs were highly valued by nurses, and the council was keen to maintain these. “We will be exploring how we can preserve these under the new model and engaging with current CAP providers about this,” she said. “This could involve supporting orientation programmes for new nurses that extend their knowledge in areas such as te ao Māori, and working . . . to develop guidance for organisations which employ IQNs.”

Fast-track entry for some countries

“Expedited” pathways for IQNs from countries with similar registration and education standards would be implemented under the new model, exempting those nurses from some assessments. That would initially involve Canada, Ireland, Singapore, the United Kingdom and the United States, but “may expand over time”. However, all IQNs would be required to complete the education module involving cultural competency, Byrne said.

The council was also talking to Pacific nursing leaders about expediting pathways for nurses from some Pacific countries.

The council would be finalising details over the next 15 months — a time-frame Byrne said was necessary to ensure minimal disruption for nurses, employers and the health system. She appreciated current workforce pressures, but warned “rushed” changes could risk the flow of IQNs into the country, patient safety and public confidence.

“We must ensure that moving to a new model does not affect the current flow of IQNs into Aotearoa New Zealand.”

A target date of the beginning of 2024 “allows us to balance all these factors while still moving at pace to the new model”.

> **“Requiring all nurses to complete a learning module also helps ensure that from day one they understand the unique environment, culture and expectations of nursing in Aotearoa New Zealand.”**

The council consulted on its proposed changes in April and May, receiving over 400 submissions — the largest response it had ever received. Of respondents, 75 per cent were in favour of the proposed changes.

IQNs in 2022 make up about 32 per cent of the nursing workforce, up from 25 per cent in 2011. Byrne said it was important to acknowledge the role of IQNs, who had always been an important part of the workforce in New Zealand. Rapid growth of the IQN workforce sparked a review of its overseas registration processes in 2017, which was interrupted by COVID, Byrne said.

Last month, the council announced it was easing its written English requirements for IQNs, in a bid to reduce unnecessary barriers amid New Zealand's nursing shortage.

Byrne told *Kaitiaki* delivery of the OSCE would likely be contracted out, while the online exam would be managed by the Nursing Council.

"We are confident this new model will preserve public safety, which is our core statutory role, and reflects modern good practice in regulation," Byrne said.

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News

NZNO board election results brings a mix of new and returning directors

By Kaitiaki co-editors

September 12, 2022

The NZNO 2022 board election results bring mixture of current, former and new board members.

Wellington mental health nurse Grant Brookes, Palmerston North mental health charge nurse Saju Cherian, Wellington perioperative nurse Simon Auty, Wairarapa emergency nurse practitioner Lucy McLaren, Waikato practice nurse Tracey Morgan, Tairawhiti clinical nurse manager Anamaria Watene and Te Tai Tokerau primary health nurse practitioner Margret Hand have been elected to the NZNO board.

Hand, Auty and Watene have been directors since 2019 and were re-elected. Morgan has previously been NZNO vice-president (2020–2021) and Brookes is a former NZNO president (2015–2020).

McLaren and Cherian are both new directors. Cherian — who migrated from India — has described himself as a voice for migrant nurses. He has said his vision for NZNO was for it to become a union "all members feel is their own, irrespective of where they work or their ethnicity or any other differences".

McLaren has stated it is a time for nurses to be "more vocal" and for NZNO to be "more open and transparent".

Hand has said she wants to see the Māori nursing workforce grow and nurses be rewarded "equitably for the care we provide, no matter where we work".

Auty has said he wants to ensure the NZNO constitutional review continues, and reflects union values rather than the current "corporate model".

Morgan has expressed commitment to "equity across systems" and "culturally responsive practices".

Brookes has said he promotes "transparency, integrity and genuine partnerships under Te Tiriti o Waitangi" as well as a stronger migrant nurse voice.

Watene has spoken of the need to keep the nursing workforce safe, across all sectors.

Returning officer Warwick Lampp, of Electionz.com, declared the results on Friday, September 9. There were 3492 votes received from 55,326 eligible voters — a turnout of 6.31 per cent. The vast majority of those who did vote — 97.16 per cent — voted online, with just 2.84 per cent votes received by post.

The vote tallies were as follows:

Grant BROOKES: 1798
Saju CHERIAN: 1531
Simon AUTY: 1502
Lucy MCLAREN: 1461
Tracey MORGAN: 1366
Anamaria WATENE: 1325
Margret HAND: 1289

Unsuccessful candidates

Lizzy KEPA-HENRY: 1272

Karen NAYLOR: 1252
Diane MCCULLOCH: 1150
Jade POWER: 1115
Geraldine KIRKWOOD: 1018

Voting closed on Friday September 9 at noon. Voting on three member remits also closed at noon on September 9, and results will be announced at the NZNO annual general meeting (https://www.nzno.org.nz/get_involved/conference_and_agm/agm_information) on Tuesday September 13.

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News

NZNO members silently protest to Andrew Little over ‘reneging’ on promised back pay

By Kaitiaki co-editors

September 15, 2022

Andrew Little faces silent NZNO protest at conference as he acknowledges “extraordinary” pressures — but warns resolving pay equity dispute could be more than a year away.

NZNO Central regional council members Victoria Richards, Kaye Johnson, Robhi-Ann Torrance, Grant Cloughley and Michael Pye.

When Minister of Health Andrew Little took to the podium at NZNO’s conference a group of five members made their own point, silently holding signs at the back of the room.

Printed in purple, each sign held by members from the NZNO Central Regional Council simply stated the start date for back pay, as agreed in the pay equity claim: “31.12.2019”.

NZNO nurse Grant Cloughley, who was on the bargaining team, said the protest was "a polite reminder to the minister of the DHB promise to pay back pay to 31st of December 2019, since he reneged on it".

Cloughley said the promised back pay was used as "leverage" in getting NZNO members to agree to the last pay deal – and now what was actually happening was "completely different" than what had been promised.

Members were "really pissed off" about it and would not be backing down, he said.

Health Minister Andrew Little

Grant Cloughley

He predicted it would be mid-2023 before it was decided on by the Employment Court.

It's unclear if the minister saw the protest, but he didn't shy away from the topic completely.

"I want to acknowledge the NZNO and the Government are in a significant disagreement over the pay equity claim."

Little said the dispute would not be resolved quickly, and he expected it to take more than one year.

While he could not comment on the matter as it was before the court, he hoped "any opportunity that might arise to discuss the issues and resolve them through mutual agreement is taken".

'Brave' minister turns up

One member, who did not want to be named, said they thought the minister was "brave" to accept the invitation to speak on the final day of the annual conference. However, the member also said; "I thought his speech really avoided a lot of what we wanted to hear."

Following the minister's speech, he addressed a summary of questions from conference delegates.

Primary health nurse Denise Moore said she was disappointed not to have an opportunity to speak directly to the minister.

"I think we can get our point across, we don't have to get angry about it, he can tell by the questions we're putting to him how upset we are."

She said her question about pay parity for primary health nurses was not answered by the minister.

"He said it was at the forefront of his mind, but he didn't really come back with an answer."

Denise Moore

'Extraordinary pressure' on nurses

Little acknowledged "the extraordinary pressure our response to the COVID-19 pandemic has put on nurses".

He said a July survey of members and their comments made "sobering reading".

Asked if the Government would offer free student fees for nursing, the minister all but ruled it out.

"I don't anticipate we will providing fees free to nurses or any other health group very shortly, so that's just the reality. We supply what support we can to nursing students."

Little said the Government had introduced a fees-free policy for all first-year tertiary students in 2018, and he had recently announced measures to support some students with particular study and placement costs. Further work to support students on placements was underway, he said.

"I've talked to student nurses – and I know about the particular burden of financial costs so we want to focus on that."

He was confident Te Whatu Ora was working to build the nursing workforce.

A "single desk" for health recruitment would be functioning from next month, he said.

"We cannot do everything that everyone would like in all circumstances."

Overseas qualified nurses have played a vital role, but this alone was not sustainable, which was why increasing the domestic training and recruitment pipeline was important, Little said.

He summarised recent action taken by the Government including an expansion of a "return to nursing fund"; doubling the number of places for nurse practitioners (from 50 to 100 by June 2024); and increasing new-entry specialist places, bursaries and scholarships.

Little said the Government's recent immigration changes had made it easier for overseas trained nurses to work here. "The facts are we made it much easier for nurses to come to New Zealand."

Andrew Little listens to kaiwhakahaere Kerri Nuku: "Unfortunately, we've felt the voices of nurses in this crisis have not been heard."

The changes, announced in May this year, were roundly criticised for not offering overseas trained nurses immediate residency, like other professions including medical specialists.

Little said work underway by Te Whatu Ora to build the New Zealand-trained workforce was focused on reducing attrition rates among nursing students, developing a nationally consistent education pathway, and improving access to clinical placements.

He said NZNO's involvement in health system decisions and changes within a limited budget, was vital.

"We cannot do everything that everyone would like in all circumstances."

The Government had increased health budgets but there were limits, he said.

"Doing more of the same won't be good enough, your voice needs to be there – not to resist change but to shape it."

Kaiwhakahaere Kerri Nuku thanked the minister for his message that "the voices of frontline workers. . . and students is really critical.

"Unfortunately, we've felt the voices of nurses in this crisis have not been heard."

Natalie Seymour

NZNO College of Gerontology Nurses chair Natalie Seymour said the minister "didn't say anything we haven't heard before and we still haven't seen action".

Aged care was losing staff, forcing the closure of beds and rest homes.

"The last 18-24 months have been horrendous for the aged care sector," Seymour said. "There is no end in sight."

NZNO student leaders Manu Reiri and Rebecca Dunn said they were keen to meet Little to discuss plans to better help students on placement.

"Any supports he's looking at should be done in consultation with students."

Rebecca Dunn and Manu Reiri

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News

NZNO rules changed to protect against racism, hate and clarity on dual membership entitlements

By Kaitiaki co-editors

September 14, 2022

NZNO's constitution will make it a disciplinary offence for members to "incite racism or hate", following a vote announced at NZNO's annual general meeting (AGM) on Tuesday.

President Anne Daniels, left, welcomes some of the new and returning board members, Lucy McLaren, Grant Brookes, Saju Cherian and Anamaria Watene at the NZNO AGM. Margaret Hand, Tracey Morgan and Simon Auty were absent.

A second proposed change to exclude members with dual union membership from being a delegate, participating in elections and holding office was also supported by a majority of voters.

NZNO's Te Matau a Māui Regional Council proposed the two changes which went to members in July.

Chief executive Paul Goulter announced the outcome of the votes at the AGM in Wellington on Tuesday, September 13.

> **"It was to ensure there is a certain level of behaviour that is acceptable, and to be very clear about what is not acceptable."**

He said there had been a low return with just 6.31 per cent of members taking part in the vote. Of 55,326 eligible voters, 3492 votes were received.

Bringing NZNO into disrepute

The full proposal for remit 1 makes it a disciplinary offence for members to: "knowingly act in a manner that is likely to either bring NZNO/NZNO officers/NZNO staff into disrepute, adversely impact the mana of NZNO/NZNO officers/NZNO staff, or incite racism or hate".

Te Matau a Māui Regional Council co-chair Sandra Corbett said the group was pleased voters had supported the remits.

She said the first remit was aimed at preventing individual members from waging personal attacks against organisational leaders and members on social media and "bringing down the mana of the organisation".

"It was to ensure there is a certain level of behaviour that is acceptable, and to be very clear about what is not acceptable."

Corbett said the remit would not prevent free and frank discussion about the organisation, which she said was necessary.

"It's about good governance and having a
culture that supports it."

Members of Te Matau a Māui Regional Council, (back, from left) Tiara Williams, Carol Pedersen, (front, from left) Noreen Mccallan, Sandra Corbett and Harata Kenny.

Dual union members excluded from NZNO office

The second remit regarding dual membership was about "recognising that if you belong to two unions you shouldn't be allowed to be office-holders in both unions", Corbett said.

"... the implication is something we have to decide at a board level, and that is a conversation we are yet to have".

That remit was passed with 75 per cent of voters in favour.

Under the change, the affiliate membership part of the constitution (https://www.nzno.org.nz/Portals/0/publications/Constitution%20-%20NZNO%20Constitution%202020-2021.pdf?ver=DAOCQHbUQ7Vgo7oWuziehw%3d%3d) (Schedule 1; clause 3) would be changed to state that: "A dual member as defined at subclause 3.4 may not hold office, be a delegate, propose nominations or motions, or have voting rights under this Constitution".

Dual membership was defined as "where a member is also a member of another union and has authorised that other union to act as the member's bargaining representative".

It meant members who belonged to another union, and had chosen that union to do their bargaining, should be subject to the same rights as affiliate members — those who had retired, resigned, or lived overseas.

NZNO's remit committee has warned such a change could impact on mental health (and some other) nurses in Auckland, Nelson and the West Coast who were NZNO members but — due to an agreement with NZNO and PSA — had no choice but to be represented by PSA in bargaining.

It is not yet clear how many members would be affected by the change.

Paul Goulter

NZNO president Anne Daniels — who is on the NZNO remit committee — told *Kaitiaki* she was aware the remit would impact on "a number" of members with dual NZNO membership.

However, members had voted to support it "and the implication is something we have to decide at a board level, and that is a conversation we are yet to have".

Goulter later told *Kaitiaki* it would be for the new board to work through the details and effects of the changes, when it met in October.

New board members welcomed

The new NZNO board members were also welcomed at the AGM.

Responding to the election of former president Grant Brookes to the board of directors, Daniels said she was "confident in my determination to ensure that the board stays on the right track".

The board would "grow from challenge", she said.

"We need to learn from history and build on it and go forward," she told *Kaitiaki*. "The board is going to focus on Maranga Mai! (https://maranga-mai.nzno.org.nz/) and work in the best interests of members."

Brookes resigned in May 2020 after five years as president, saying he could see "no way forward" after an extended legal conflict with the board. The differences emerged during contentious 2018 pay bargaining.

Brookes told *Kaitiaki* he was supportive of NZNO's member-focused approach and would be working to continue that.

About 160 NZNO members attended the AGM.

Kaitiaki NURSING NEW ZEALAND

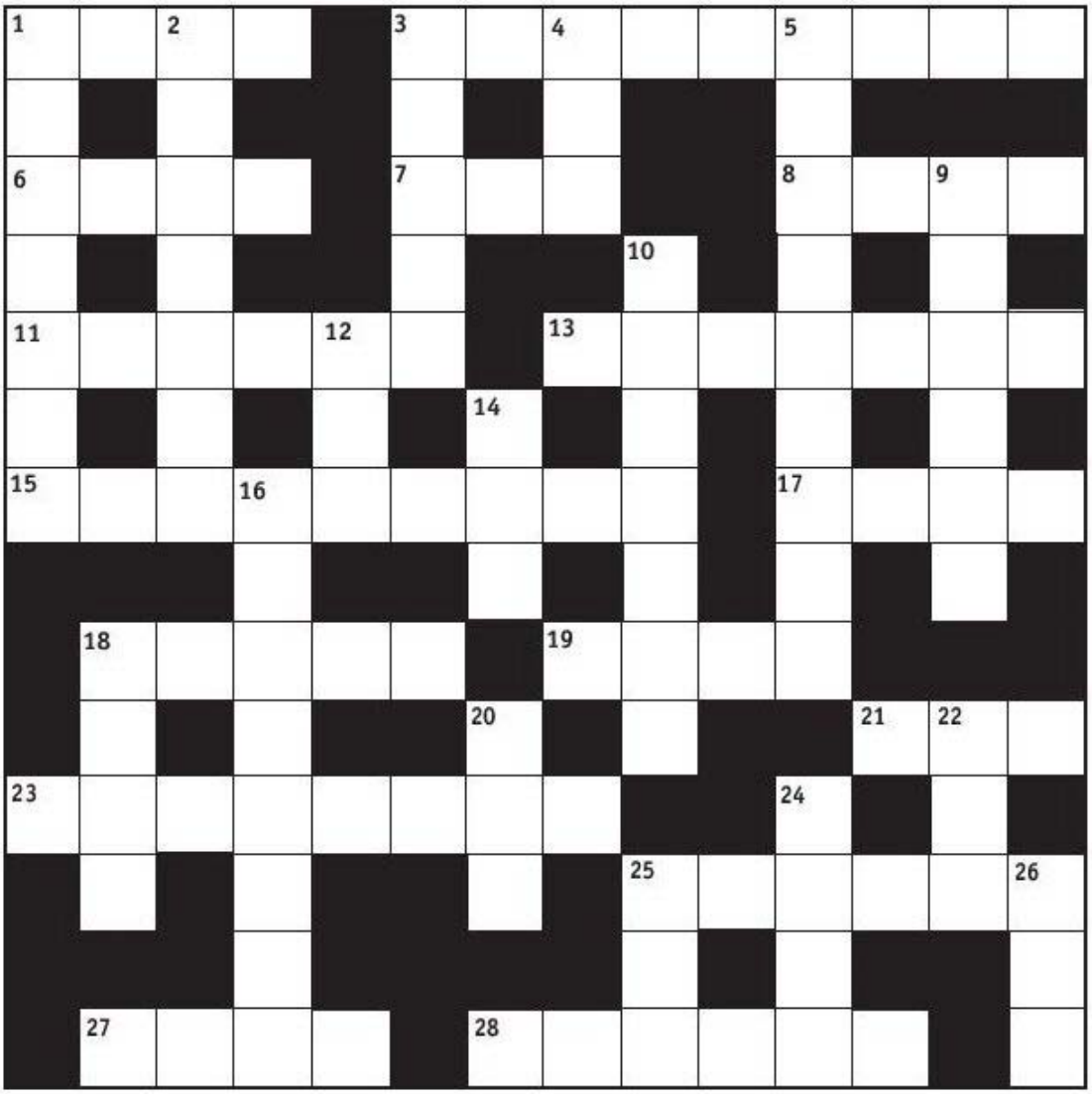
Puzzles

SEPTEMBER crossword

By Kathy Stodart

September 20, 2022

Print out this crossword grid (see PRINT tab at bottom right of page), and use the clues below.



ACROSS

1) From Monday to Sunday.
3) Emergency vehicle.
6) Lack of this causes anaemia.
7) Decompose.
8) Explosive device.
11) Toxin.
13) Female siblings.
15) Young people (Māori).
17) Possesses.
18) Exhausted.
19) Throw in the air.
21) Mother of lambs.
23) One substance dissolved in another.
25) Leg/foot (Māori).
27) Money paid for educational courses.
28) Heavy load.

DOWN

1) Speak very softly.
2) A feeling.
3) Garment worn to protect clothing.
4) Wager.
5) Wanting power or success.
9) Good morning (Māori).
10) Guest.
12) Eggs.
14) Uncooked.
16) Successfully complete education.
18) Natural fibre.
20) This animal's Latin name is *Vulpes vulpes*.
22) Four (Māori).
24) In this place.
25) *"Cry 'Havoc', and let slip the dogs of ___"* (Shakespeare's *Julius Caesar*).
26) Finish.

August answers

ACROSS: 1. Polio. 4. Aback. 8. Inflation. 11. Roar. 12. Sad. 13. Ivy. 14. Aim. 15. Nero. 18. Frail. 21. Wept. 24. Refuses. 26. Kimono. 27. Neo. 28. Increase. 29. Analgesia. 30. Sue.
DOWN: 1. Pain. 2. Ill. 3. Tūī. 5. Burden. 6. Kōrero. 9. Fever. 10. Tauira. 16. Employees. 17. Karanga. 19. Rusting. 20. Insects. 22. Skye. 23. Morale. 25. Flora.

Kaitiaki
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News

The Aussies are doing it – can we train nurses for free here?

By Mary Longmore

September 1, 2022

Nursing students say they would welcome free training in New Zealand, after the Australian state of Victoria this week announced a $270 million investment to train 10,000 nurses and midwives over the next two years.

NZNO student leaders Manu Reiri and Rebecca Dunn say free training would boost nursing numbers in Aotearoa.

Anyone taking up nurse studies in Victoria in 2023 and 2024 would receive up to $16,500 to cover the cost of the degree, Victorian Health Minister Mary-Anne Thomas and Victorian Premier Daniel Andrews announced (https://www.premier.vic.gov.au/making-it-free-study-nursing-and-midwifery) on Sunday at the Australian Nursing and Midwifery Federation offices. Anyone starting an undergraduate nursing or midwifery degree in Victoria in 2023 and 2024 will get $9000 while they study and another $7500 if they work in the Victorian public health system for two years.

Mary-Anne Thomas and Daniel Andrews

NZNO Te Rūnanga Tauira chair Manu Reiri said doing something similar here would make a huge difference to the nursing crisis.

"This is one of the ways we can actually mitigate that crisis, by supporting our students, getting them through degrees, so that we can have New Zealand-qualified nurses taking up New Zealand roles in New Zealand," Reiri said.

Financial barriers have been identified as the biggest challenge for nursing students. NZNO's National Student Unit (NSU) was lobbying for fees-free nursing education alongside paid clinical placements, Reiri said.

NSU vice-chair Rebecca Dunn said nursing students were often juggling multiple responsibilities and financial support would make a world of difference.

"Our students who are studying for a BN are often supporting whānau as well, and they're working part-time, which adds to the mental and emotional stress. So if we were able to alleviate those financial barriers, we would have a lot more successful outcomes for students."

"Paid study – that's the ultimate, that's the goal that we're looking for."

Paid clinical placements would also help retain nursing students, she said.

"Why do tradespeople get completely funded and paid to do their qualifications and not nurses?" Dunn asked.

Reiri said part of NSU's role was to lobby for better outcomes for nursing students, which included recruitment and retention of members. "We think Victoria is going in the right

direction. [Health Minister] Andrew Little said that putting ads into Shortland Street is a great platform — it's not. "

Economic hardship has been identified as the "number one issue" for nursing students, particularly Māori and Pasifika, nursing lecturer Pipi Barton has said.

AdobeStock.

NZNO manager professional and nursing services Mairi Lucas said fees-free nursing training would help, but earn-as-you-learn for registered nurses would be even better. "Paid study — that's the ultimate, that's the goal that we're looking for."

"That heavy reliance on IQNs [internationally-qualified nurses] is not sustainable for us into the future, so it's important we come up with some really strong measures right now."

Mairi Lucas

NZNO professional nursing advisor Sandra Bayliss said providing free nursing education was an example of what was possible — however, she was concerned about its bonding aspect. "I would not like to see nurses tied into working for a specific employer for a period of time as the area of practice or employment situation may not be the best fit for the nurse," she said. It was "essential" nurses maintained autonomy in where they worked and how they progressed their careers.

She was also concerned that only part of the $16,500 — $9000 — was provided to Victorian students during study, when they most needed the support. The remaining $7500 was only paid if they stayed working in the state's public health system for two years.

It was also important that nursing students were well-prepared and supported, Bayliss said.

Sandra Bayliss

"I would not like to see nurses tied into working for a specific employer for a period of time as the area of practice or employment situation may not be the best fit for the nurse."

"For some, this may be as straightforward as a pre-enrolment conversation where the requirements of the course are explained to make sure the person is fully aware of the demands of the nursing programme," she said. For others, especially those who have not been in the education system for a while, preparation courses first, such as the New Zealand certificate in study and career preparation (health pathway) would help prepare them.

Asked if such an initiative would be considered here in Aotearoa, where there is a shortage of around 4000 nurses, Health Minister Andrew Little's office referred *Kaitiaki* to Education Minister Chris Hipkins.

Hipkins said any extension of existing fees-free training would need to be part of a future Budget process "and I wouldn't pre-empt that".

Chris Hipkins

The Government already provided first-year fees-free study in nursing-related fields at level 3 and above, which included certificates, diplomas for nursing and other health qualifications, he said.

Since June 2020, the Government had also supported more than 1000 people onto a diploma in enrolled nursing through its training and apprenticeship fund.

See also: *Education – What needs to change?* and *The struggles facing nurses in today's world*

Kaitiaki
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Opinion

With assisted dying now a reality, what do nurses need?

By Margaret Sandham, Rhona Winnington and Melissa Carey

September 29, 2022

Nurses need clear policies and guidelines to give them confidence when dealing with assisted dying requests.

PHOTO: ADOBE STOCK

The End of Life Choice Act (EoLCA) 2019[1] has now offered a legal assisted death to eligible individuals in Aotearoa/New Zealand for 10 months.

Since the legislation came into effect in November 2021, there have been progressive increases in patients inquiring about assisted dying, and growing numbers are accessing this new means of dying.[2]

Margaret Sandham

As of June 2022, 400 people have applied for an assisted death. Of these, 143 people have had an assisted death, 153 did not continue the process (due to being ineligible, withdrawing the application or dying) and 101 are still being assessed or prepared for assisted dying. Most of those who have applied are NZ European/Pākeha (79 per cent), followed by Pacific and "other" ethnicities (14 per cent), Māori (5 per cent) and Asian (2 per cent).[2]

Aside from statistical reporting, we do not know what the experiences of patients and providers are in this process, nor the nuances of culture and context, eg how tikanga Māori is being supported. Research is being undertaken into the experiences of health professionals involved in assisted dying in Aotearoa/New Zealand and the perspectives of families of people who are requesting and using this service.[3]

Nurses are usually the first point of contact for patients making requests for information about assisted dying. It is imperative that nurses are aware of the legal requirements surrounding the legislation if we are to feel competent and confident in responding to these requests.[4] Furthermore, how this practice can be responsive to te Tiriti has not yet been described.[5]

Rhona Winnington

While for some nurses this new service may challenge their nursing practice and professional identity, assisted dying is here to stay in New Zealand. Evidence from overseas suggests that while there are challenges to practice, there are also positive aspects to this new means of dying.

This duality of challenge and positive experience is highlighted in a recent study[4] which analysed literature from Belgium and Canada where assisted dying is legal. These researchers noted that there are psychological and emotional impacts to being part of the assisted dying process, and the gravity of what is occurring is not lost on nurses. This is seen clearly in another study when one nurse said, "*I feel we share a sacred space at this moment, and I am moved, [I] feel the profound weight of it all*".[6]

On the one hand, there are deep professional and personal ethics involved when engaging in a practice with someone who is terminally ill to end their life. On the other hand, this can be countered by what some suggest is a beautiful death in that they are helping " . . . *somebody to die in the best way possible*".[7]

Melissa Carey

Yet the potential for positive experiences for nurses is impeded by a lack of policy and clear procedural guidelines. This places nurses at a greater risk for the negative aspects of assisted dying. Nurses have indicated they need fundamental processes and protocols to be in place to feel safe and support each other when caring for someone in the assisted dying process.[4]

This is an important point to note, given the failure to mention nurses and their roles in the EoLCA,[1] beyond that of the nurse practitioner. Such an omission from the legislation would suggest that there is no obligation for organisations to support nurses in relation to assisted dying services, and that nurses need to be fully prepared[8] to reduce their exposure to professional risk.

Here we provide a brief practical guide to what nurses can and cannot do in relation to the legislation, offering suggestions as to what nurses can ask of organisations to support them as more assisted dying requests are made. As nurses are key advocates for those in their care, this provides a brief overview of the legislation to protect nurses from potential professional risk.

Nurses' role in the EoLCA

- Nurses (or any health-care professional) cannot initiate conversations about assisted dying with patients/family/whānau under their care in a professional workplace.

- Nurses are legally obliged to respond professionally and in a culturally safe way to any request from an individual for information on the assisted dying service. For family members, nurses can direct them to the Ministry of Health website (https://www.health.govt.nz/our-work/life-stages/assisted-dying-service) and the Support and Consultation for End of Life in New Zealand (SCENZ) (https://www.health.govt.nz/our-work/life-stages/assisted-dying-service/support-and-consultation-end-life-new-zealand-scenz-group) group, as they can for everyone.

- Nurses can conscientiously object to being involved in any part of the assisted dying process. However, if a person asks them for information, they are obliged to advise of their objection and ask another staff member to provide the requested information. In doing this, nurses should not be judgmental towards the individual, as it is a legal service, nor should they be judged for taking a conscientious objector stance.

- Nurses cannot discuss assisted dying requests from people under their care with the person's family/whānau and friends without the individual's consent.[1]

Supporting nurses in practice

- Health-care organisations should provide clear policy and procedural guidelines on assisted dying services to support nurses' confidence in responding to requests.
- Communication training should be available to support nurses in conducting open conversations in response to assisted dying service requests. This should include cultural safety education specific to end-of-life care.
- Professional supervision should be offered to those involved in assisted dying services.
- Debriefing sessions should be held following an assisted death.
- Those who conscientiously object should be supported in their stance, not be judged for it, and provision should be made to ensure their professional safety.

Ultimately, nurses are at the front line in patient care and, as such, need to feel empowered to tell employers what they need, if they are to feel professionally safe and competent when exposed to assisted dying requests and services. Without this, the implementation of assisted dying will fall short of providing equitable access and outcomes for all people living in Aotearoa/New Zealand.

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Rhona Winnington, RN, MA, PhD*, is a senior lecturer in nursing at the Auckland University of Technology.*

Melissa Carey (Ngāti Raukawa), RN, PhD, *is a research fellow at the University of Auckland school of nursing, focused on ageing and end-of-life care for Māori.*

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