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OPINION

‘Tired but passionate’ caregiver on life inside aged residential care through the pandemic

BY A NORTHLAND HEALTH-CARE ASSISTANT

April 28, 2022

After 31 years in aged residential care, a caregiver calls for mental health support.

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I am writing this knowing that I am not alone in calling for mental health support for both residents in aged-care settings, and those of us who work there. I have been a health-care worker for more than 30 years now, and never imagined how much our lives would be turned upside down by this pandemic.

In the first lockdown, in March 2020, a skeleton staff felt abandoned, scared and unsure of what to do. We walked around, tearful, yet still doing our jobs to the best of our ability as we ran low on personal protective equipment (PPE) and sanitiser. We had to do the job of undertakers, who were not permitted inside. We learned how to place a body in a body bag, the correct way to wheel a gurney out the door — even how to place a body in the back of a hearse. All this has been a steep learning curve.

Lockdown after lockdown, red zones, a carousel of staff and patients testing positive, constant use of surgical masks, N95s and sanitiser, meals served in residents' rooms, isolation and restricted movements, appointment slots for visitors, distancing. It's all very overwhelming at times.

Staff have been pushed to exhaustion, both registered nurses (RNs) and health-care assistants (HCAs) doing 12-hour shifts at times.

We have become so much more than staff to our beloved residents, during these very tough times. And we are also mums, dads, partners, daughters/sons and grandchildren/parents ourselves.

I still have a vivid memory of walking past a man's room, seeing he was taking his last few precious breaths, and walking in to hold his hand, and him looking at me with the most grateful eyes.

Our residents are finding it so tough adjusting to this very new way of living. I hear so often their thoughts of wanting to just give up — "What's the point? I can't even see my family," they say. Spouses wave to each other and blow kisses through the glass doors.

The saddest thing is asking residents, if they had the choice, would they risk catching COVID and seeing their families, or stay away? Every single resident said they would rather take the risk. Giving up seems to become more of an option when they have to fight on their own, with only phone and video calls, when isolation feels like never-ending torture — for goodness

knows how long till one lockdown ends and another begins.

Under lockdown, residents cannot attend medical appointments, unless absolutely paramount. Nor can they enjoy simple pleasures such as getting a hair cut. Every tradie has to take a RAT (rapid antigen test) and PPE-up — so do the families of palliative care residents, who must also restrict their visiting times for the safety of others.

Staff who are symptomatic must get the PCR (nasal swab) test from RNs, effectively putting those RNs at risk every time. We have to begin shifts earlier to allow time to RAT test — testing outside in the dark and cold before we can begin a shift!

I was also asked in a previous workplace to choose between coming to work or having my children. Of course, being a solo parent I had to choose work, as I was not aware of any alternative at this time and who else was going to pay the rent? If there was one, I was certainly not aware. So I gave my children up to their Dad for what felt like the hardest time I have endured to date.

We have to begin shifts earlier to allow time to RAT test – testing outside in the dark and cold before we can begin a shift!

I still have a vivid memory of walking past a man's room, seeing he was taking his last few precious breaths, and walking in to hold his hand, while he looked at me with the most grateful eyes. A reminder of total lockdown — yet another loved father/grandfather/uncle/brother feeling totally alone in these unusual times. I'm just glad I happened to be walking past.

Other people don't realise that those of us who work in an aged-care facility not only have to think about work but whom we associate with out of work — where we go and what we do. Our residents' lives really are in our hands.

Lately, residents say they feel safe in their bubble despite feeling alone. Knowing that we test daily helps them feel safe, as well as giving us caregivers peace of mind that we are not bringing COVID into their home.

Written with love, by a tired but passionate health-care assistant.

* *The name of the author has been withheld by agreement with the co-editors.*

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PRACTICE

Cardiovascular disease – tackling medication adherence

BY JIM VAUSE

April 14, 2022

Managing patients' CVD risk, medication non-adherence, and improving communication with patients: This article has particular relevance to primary care nurses, including those specialising in long-term conditions, and to cardiac care educators.

There are a range of reasons why people with CVD aren't taking their pills properly. PHOTO: ADOBE STOCK

I remember uncle Pete fondly. Rather a good friend of my dad than a real uncle, he piqued my interest in theatre as a kid through annual trips to the pantomime in Wellington.

One year, uncle Pete missed

Key points

- Significantly more Māori die from cardiovascular disease

the panto. He was aged about 40 and smoked like a train. Dad took me to see Pete in the cardiac ward – it didn't do him any good. It was the same ward in which my dad died 18 years later, and the one I ended up in two months ago. Only one of us survived until discharge. If only we had known then what we know now.

Cardiac care may be vastly better nowadays but why are young people in New Zealand still dying of cardiovascular disease (CVD)?

We know what to do: lifestyle changes and prescription medications. Let us focus on the latter.

How effective is CVD prescribing in your practice? Are all patients at increased risk of CVD – not just those who have had a CVD event – on the preventive medications they need to stop them becoming a mortality statistic? Why are patients who end up in cardiac wards still not on triple therapy? On top of addressing what your practice is doing, what then are its patients doing?

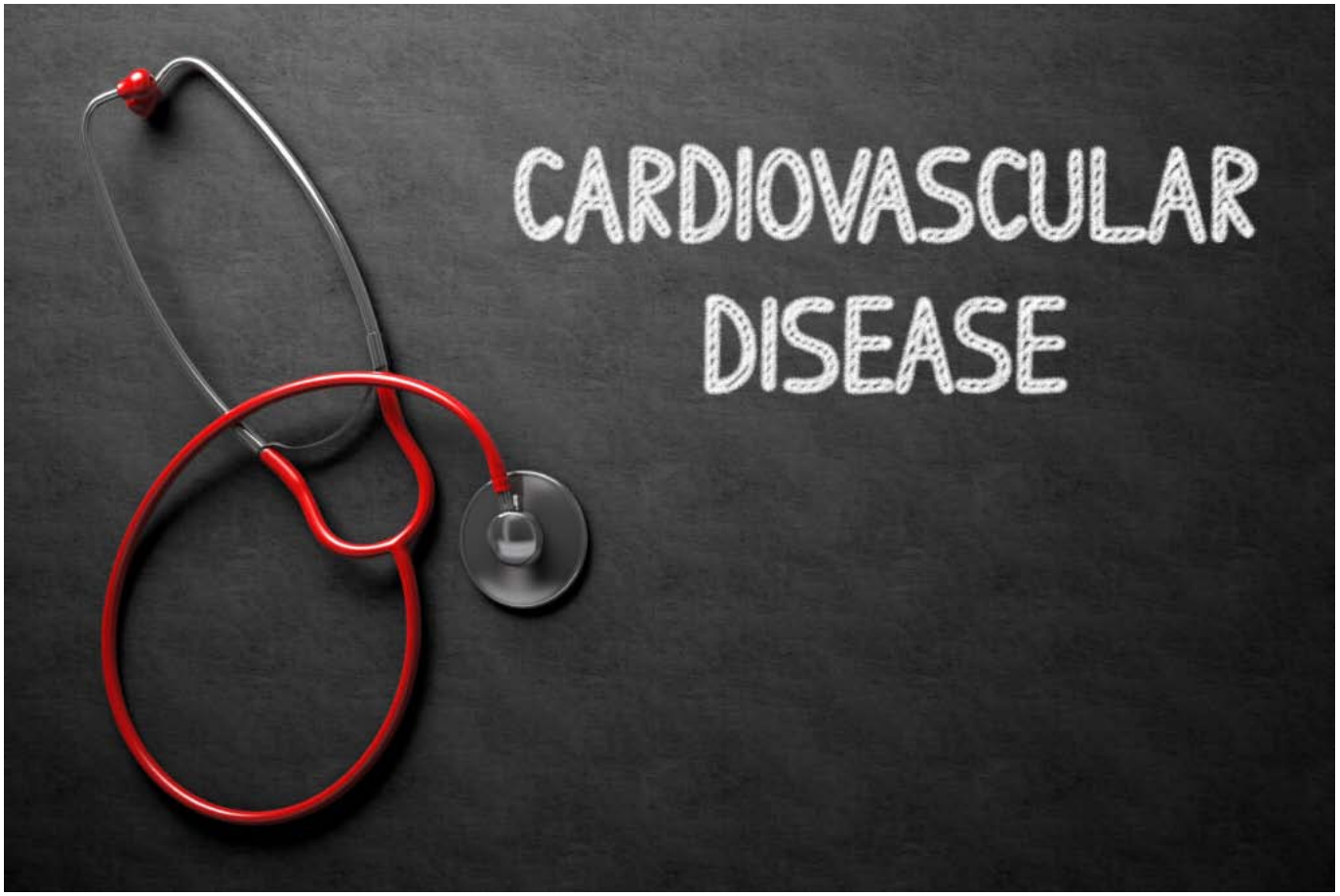
(CVD) every year than non-Māori, and at a younger age.
- Prescribing and dispensing of CVD medications is much lower for Māori than non-Māori.
- Poor adherence is a significant barrier to the management of CVD risk.
- The reasons for, and solutions to, poor adherence to medication are multifactorial.
- Patient communication and cultural safety are key to good CVD prescribing.

In people aged less than 65 years, ischaemic heart disease accounts for 40 per cent of Māori CVD deaths compared to 11 per cent of non-Māori CVD deaths.1

A study of 33,000 patients in Auckland and Northland indicated that 54 per cent of Māori, 40 per cent of Pacific and 46 per cent of non-Māori/non-Pacific peoples who were of guideline-indicated age for CVD risk assessment had no record of such assessment in the previous five years.2

How many patients in your practice who meet Ministry of Health guidance criteria have not had a recent CVD risk assessment?

Doing nothing is not an option



We are all unique – ourselves, our practices, and its patients. Add in fellow primary health professionals, the media, patient whānau, health literacy and world views, and the complex interactions between these provide some reasons why the success rates of high-level strategies to improve medicines adherence is poor.[3,4]

Therefore, when your practice is planning what to implement to improve CVD medication outcomes, the actions must be tailored to both the clinical environment and the patient's world.

Here are a few questions to provoke such planning.

The primary health care provider

1. CVD risk assessment (CVDRA):

- Are patients who need CVD preventive medication being identified?
- Are you or the GP performing computer CVD risk assessments?
- Is the assessment used accurate?
- Do you flag patients for risk assessment recalls, and are they being conducted at the correct interval?

2. Prescribing:

- Have you read the latest (2018) guidance on CVD risk management in primary care?
- Can you identify patients who may be eligible for/benefit from treatment with preventive medications?

3. Workload:

- How is your practice addressing the CVD needs of patients with higher priority morbidities, particularly when the practice is busy?
- If you are not currently doing CVDRAs, is this something your GP would appreciate your support with?

4. Communication:

- Has the need for CVD medication been explained in a way that is clear and acceptable to the patient?
- Perhaps you could use visual aids to help communicate risk, eg https://cvdcalculator.com (https://cvdcalculator.com)

Rates of prescribing of CVD medications are much higher for non-Māori than for Māori, despite Māori having a higher burden of CVD.5

The patient

1. Adherence:

- Are patients who are likely to have difficulties taking regular medications being identified?
- How many patients with poor control take "drug holidays"?
- What is your practice doing about patients who are not collecting repeats?

2. Access to health care:

- Is difficulty accessing you, your practice, or the pharmacy a cause of non-adherence?
- Is your practice's repeat prescribing policy and process an access barrier to patients, especially those with a disability, or communication or cultural differences?
- Are your practice hours a similar barrier?
- Do patients really need to be seen every three months for a new prescription?

Promoting adherence:

- If you know a patient is non-compliant, what is the practice doing to proactively address this?
- How well do you know the patient and their family?
- For patients without family, who supports them, who is close to them, and who can be contacted if the patient is not responding?
- Are reasons a patient might be non-adherent being identified?
- Is non-adherence (or the problem causing it) persistent or intermittent?
- Is their personal health a lower priority for them than that of others in their family?
- If you are not of the patient's culture, do you understand theirs?

Poor adherence is a significant barrier to the management of CVD risk, with only half of people regularly taking indicated medications.[2]

Areas for action in your practice

1. Help ensure all high-risk CVD patients in your practice have been identified and are being prescribed appropriate medications. A practice-level audit of your patient management system (PMS) should focus on Māori and Pacific peoples. Are you able to identify and flag for the GP any CVD patients potentially not being prescribed required medication?

1. Are you able to identify and flag any patients not collecting repeats from your practice or the dispensing pharmacy? Use the practice IT system indicators (eg, from ePrescribing) of when medications are dispensed, and get to know your PMS better. Communicate with your local pharmacies or ask your clinical pharmacist to alert you to such patients.

1. Identify patients at risk from medication adherence problems using factors such as:

- Co-morbidities, particularly mental health.

Patient reasons for poor medication adherence

Unintentional

- forgetfulness
- poor understanding of their CVD and the need for ongoing medicines
- misunderstanding over prescribed medicine doses or frequencies (eg complicated regimens).

Intentional reductions in dose or dose frequency

- concerns over adverse effects
- believing they have a low risk of a heart attack, stroke or leg amputation
- believing they no longer need treatment
- feeling the inconvenience and adverse effects of

- Previous non-adherence.
- Priority populations, such as Māori, Pacific peoples and younger people.
- Socioeconomic status – is the cost of repeats a likely barrier?
- Employment barriers, such as multiple workplaces, long commute times, anti-social work hours, which impede practice access and pharmacy access for repeats.

4. Suggest ways in which practice systems could become more efficient and patient-centric.

- Consider the practice's repeat prescribing policy for any barriers to patient access to repeats – put yourself in a patient's shoes.
- Review your practice's medicines reconciliation process, in conjunction with your clinical pharmacist, to target non-adherence.
- Use reminder systems for your practice and for patients, such as automated SMS text messaging.

5. Find ways to optimise health professional–patient relationships, adherence and consultations.

- Always check with patients when you see them, particularly if their CVD indicators are not to target, about medication adherence. Success with this totally depends on how comfortable your patient is with you and how well you know them and their world – connectedness is essential. It may be obvious that better communication is central to good medicines adherence but any disconnect between the health-care team and the patient is likely to impede medication effectiveness. [7]
- Delegate – identify and involve other staff or support persons, either in practice or within the community, who might provide insight into a patient's adherence issues. This is particularly important when your patient's world is of a different culture to your own. The complexity of relationships in larger families must be understood when medication treatment are not worth the benefit.

Other physical, cognitive, and psychological causes

- difficulty swallowing
- cognitive impairment, including medicine-induced
- disability, particularly affecting the hands or vision
- pill burden – the number and frequency of tablets or volume of liquid prescribed
- feelings of stigma and embarrassment
- depression.

When it comes to assessing a patient's CVD risk, factor in that medication non-adherence is a universal significant risk factor for CVD.[6]

PHOTO: ADOBE STOCK

adherence motivation is required.

- Discuss with other practice members, support staff and contacts beyond your practice, patients whom you suspect have medication adherence difficulties to identify potential ways for you to understand their world and identify motivational opportunities.
- If your time is too pressured to address any of the above questions, delegate (as above) be it within your practice or to another primary care provider.

People aged 35–44 years were up to 40 per cent less likely to be dispensed CVD medications compared to people aged 65-75.[8]

Summary

Patient communication and cultural safety are key principles to good CVD prescribing and adherence to medications. This is nicely discussed in a BPACnz article "What is Māori Patient-Centred Medicine for Pākehā GPs"[9] by Dr Trevor Walker, from his interview with Te Aroha GP Dave Colquhoun. The major lessons from Dr Walker's interview are just as relevant to relationships between Pākehā nurses and Māori patients, the key messages being:

- act with humility, warmth and respect
- establish linkages and connections
- involve the whānau
- offer to participate in some way.

Te ao Māori can teach us much wisdom for not only Māori but for all cultures.

Finally, remember, even the best patients miss their medication. I know – three times this month I forgot my perindopril and rivaroxaban. I may need that humility.

Jim Vause is an "emeritus" GP, living in Māpua, Tasman.

** This article may be useful for nurses for an hour of continuing professional development, which should include some reflection on the material contained. 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

Changes afoot on how IQN competence is assessed – Nursing Council

BY MARY LONGMORE

April 7, 2022

"Significant changes" to how the competency of internationally-qualified nurses (IQNs) is assessed are being proposed by the Nursing Council, in a bid to ease barriers and boost cultural competency.

Catherine Byrne

The proposed changes include the easing of English standards, particularly in writing, and introducing an exam and practical assessment rather than relying on credential checks, Nursing Council chief executive Catherine Byrne told *Kaitiaki Nursing New Zealand*.

"The essence of the changes is that it does align us internationally with other regulators," said Byrne, citing Australia, the United Kingdom and British Columbia (Canada) as having similar regulatory systems.

Proposed new pre-entry training would focus on Te Tiriti o Waitangi and kawa whakaruruhau (cultural safety) to ensure migrant nurses understood the history behind Aotearoa's health inequities and "understand how to work safely with tāngata whenua", consultation documents state. The proposed changes "would ensure IQNs are competent to practise in a culturally safe, competent and ethical manner" and reflected the council's commitment to Te Tiriti and the role of IQNs in improving health equity for Māori.

> **"We are absolutely cognisant of the critical workforce shortages and what we don't want to be is a barrier to nurses registering."**

Delayed by COVID, Byrne said the council had been working on the proposal since 2018, in an effort to bring Aotearoa into line with international practice and ensure the migrant nurse registration process was not unnecessarily burdensome. "The process of seeking professional registration outside one's home country can be a costly and difficult exercise, including additional barriers in terms of access and equity," her proposal introduction states.

The council was highly aware of the need to get more IQNs into Aotearoa amid a pandemic and critical nursing shortage, Byrne told *Kaitiaki.* But it must balance that against its obligation to uphold high nursing standards.

"We are absolutely cognisant of the critical workforce shortages and what we don't want to be is a barrier to nurses registering," Byrne said. "But I guess nurses do need to be able to communicate effectively with patients, with colleagues, with employers and that's the whole purpose of the English language standards."

The proposed changes would ensure "robust, equitable" processes by "shifting our focus from credentials and qualifications, to assessing and ensuring nurses are competent to practise in the context of our health system, cultures and communities", consultation documents state.

Changes ahead

Proposed Nursing Council changes (https://www.nursingcouncil.org.nz/NCNZ/publications-section/Consultation/IQN_Consultation_.aspx) would "move away from assessing our applicants' nursing qualifications and towards assessing their competence to practise nursing in Aotearoa".

NEW EXAM AND PRACTICAL ASSESSMENT:

- Instead of checking qualifications, the council would assess competence through a knowledge exam (can be done in home country) and a practical assessment (in Aotearoa).
- New pre-entry education would focus on Te Tiriti o Waitangi and kawa whakaruruhau/cultural safety.
- Competency assessment programmes (CAPs) could change to supporting pre-entry learning and practice for IQNs.
- A period of supervision is proposed to support

migrant nurses into their workplace.

ENGLISH LANGUAGE STANDARD

- The Occupational English Test (OET) would get preferred status, as a "more valid, fairer" English test. Currently, applicants must pass the more academic IELTS (International English Language Testing System).
- Lowering the writing score "will set a fairer standard that is more appropriate to the purposes of nursing practice". (No changes to the speaking, listening or reading aspects are proposed).
- Previously reluctant, the Nursing Council may recognise electronic language testing using computer-based methods, due to better security for online tests.

ALTERNATE PATHWAYS FOR SOME COUNTRIES.

- IQNs from countries with similar nursing regulatory systems, such as the United Kingdom, United States,

Canada, Ireland and Singapore, could skip the exam and competence assessments, but still complete education in areas such as cultural safety.
- The council will "in the near future" look at easing barriers specifically to Pacific-trained nurses to work in Aotearoa.

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Mostly from India and the Philippines, IQNs make up about 30 per cent of the nursing workforce in Aotearoa, council statistics show – and about half of the aged residential care nursing workforce, according to the New Zealand Aged Care Association.

Acknowledging the pressures, Byrne said it was important to remember that the council was continuing to register IQNs, with 2464 registered in the year to March 31. However, she said only about a quarter of those were known to be living in New Zealand – meaning many were potentially unable to reach New Zealand due to border closures.

Reported delays had often been due to the availability of source documents in countries such as the Philippines and India, where infrastructure had been hit hard by the pandemic, Byrne said.

The proposal (https://www.nursingcouncil.org.nz/NCNZ/publications-section/Consultation/IQN_Consultation_.aspx) will now go through a six-week consultation (https://www.surveymonkey.com/r/PN3WLP7) period until May 16 and will likely be phased in during 2023, documents suggest.

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NEWS

Fresh meetings launched ahead of May decision on pay equity deal for DHB members

BY MARY LONGMORE

April 21, 2022

NZNO has launched a fresh batch of online meetings ahead of a May 1-8 member survey on whether to accept a pay equity proposal or refer it to the Employment Relations Authority (ERA).

NZNO cancelled a vote planned for this week to ratify the proposed settlement, after its legal advice found it contrary to the Equal Pay Act 1972.

Chief executive Paul Goulter said that followed "significant member dissatisfaction" over a proposed $10,000 cap "in recognition of" back-pay, instead of the promised back-dated pay to 31 December 2019.

"This would result in many DHB employees receiving much less than their entitlement according to past promises and agreements," Goulter said in an April 19 email to Public Service Association (PSA)/NZNO members and DHB employees.

NZNO and PSA now needed a "fresh directive" from members via an online survey from May 1-8 asking whether:

- NZNO/PSA take the matter immediately to the ERA to decide on the full backdating claim. The ERA would then determine the timing and the full proposal including base pay rates.

- The existing proposal is taken to ratification for a vote. If rejected, NZNO/PSA would refer it to the ERA for a determination.

Senior nurses pay gap 'eroded'

Goulter also said NZNO was aware many senior nurses were not satisfied with their rates in the proposed settlement. "It is important to understand that, if members endorse the ERA review option, all aspects of the settlement will be up for review, including proposed base rates," he said in the email.

Employers, too, were aware the pay difference between senior nurses and registered nurses (RNs) had been "eroded" by the proposed settlement, Goulter said.

A joint working group would now be set up to

investigate whether the relative pay gap needed to be restored, and to "fully capture the breadth and depth of senior nurse practice, leadership roles and responsibilties", he said. The work would be completed by October, in time for the 2022 multi-employer collective agreement (MECA) negotiations.

Unions are legally obliged to keep non-union employees informed of the ratification process. Those who wish to opt out of the final pay equity deal must do so before it is settled.

Paul Goulter

On September 17, 2021, NZNO and the 20 DHBs signed a settlement which provided that the pay equity pay rates once settled would be back paid to December 31, 2019.

Date	Time	Zoom Link	Meeting ID	Passcode
20/4/22	11.30am – 12.30pm	Meeting link	816 5751 9134	612366
20/4/22	4.30pm – 5.30pm	Meeting link	886 0691 3485	598370
21/4/22	11.30am – 12.30pm	Meeting link	831 3713 0112	089370
21/4/22	4.30pm – 5.30pm	Meeting link	864 5504 0596	000684
22/4/22	4.30pm – 5.30pm	Meeting link	824 7714 9587	880954
26/4/22	11.30am – 12.30pm	Meeting link	891 3295 2120	130228
26/4/22	4.30pm – 5.30pm	Meeting link	880 0345 0960	269785
27/4/22	4.30pm – 5.30pm	Meeting link	817 7585 7319	504442

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NEWS

High Court upholds vaccination mandate for health workers

BY MARY LONGMORE

April 28, 2022

A High Court ruling upholding the COVID-19 vaccination mandate for health workers shows the courts view it as "justified limitation" on individuals' rights to refuse medical treatment, NZNO employment lawyer Jock Lawrie says.

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Justice Francis Cooke — who in February overturned the mandate for New Zealand Defence and Police personnel — this month rejected a claim from two groups of health workers and educators that their rights had been breached.

The groups — New Zealand Doctors Speaking Out with Science and New Zealand Teachers Speaking Out with Science — claimed the mandate was not a "demonstrably justified" breach of their right to decline medical treatment under the New Zealand Bill of Rights.

But on April 8, Justice Cooke ruled that the mandates were justified for the health/disability sector, in order to protect patients. He "did not accept" the right to refuse medical treatment was absolute, but that it was subject to "reasonable limits, prescribed by law, that are demonstrably justified in a free and democratic society".

Cooke also said it was important for schools to limit risk for students — but acknowledged those mandates had since been lifted.

Jock Lawrie

Lawrie said the decision confirmed that the courts viewed the mandate for the health and disability sector to be a "justified limitation" on individuals' right to refuse medical treatment under the New Zealand Bill of Rights Act 1990.

The essential question faced by the court was whether the right to refuse medical treatment was absolute — to which the answer was "no".

Lawrie said all rights within the New Zealand Bill of Rights were "expressly stated to be subject to reasonable limitations".

The court accepted that when the vaccination mandates were imposed, the evidence supported the view that vaccination reduced both infection and onward transmission, as well as the serious effects of the illness.

"While that evidence was somewhat more equivocal in the face of the Omicron variant, it could not be said that the adverse impacts of the mandate were more significant than the public benefits to be obtained," Lawrie told *Kaitiaki Nursing New Zealand.*

In February, Justice Cooke found the Government requirement for New Zealand police and defence staff to receive two vaccine doses by March 1 to be unlawful, after a review was sought by three unvaccinated police/defence employees. The three claimed the mandate breached their human rights.

At that time, Justice Cooke said it did not affect any other vaccine mandates as “in essence” the police/defence mandate was imposed to ensure continuity of service and public confidence in those services, rather than stop the spread of COVID-19, he said.

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NEWS

Kaitiaki Nursing New Zealand now free to all NZNO students

BY MARY LONGMORE

April 14, 2022

NZNO student leaders say they are "beyond excited" by a decision to allow free access for all student members to NZNO's online nursing journal Kaitiaki Nursing New Zealand.

Te Rūnanga Tauira chair Waiharakeke Biddle

Previously, students were not able to access *Kaitiaki* without paying a fee. But – following discussions with the National Student Unit (NSU) and Te Rūnanga Tauira (TRT) committees in early March – NZNO's board of directors approved access for all student members.

Student co-leaders Waiharakeke Biddle and Jade Power said they were "beyond excited" about the move.

"This will allow student members to be more informed, encourages students to engage and allows us to have insight into the nursing profession and our future," they said. "*Kaitiaki* is a fantastic resource for assignments as well as allowing students to publicise their work. Leadership and the NSU is very pleased with this decision from NZNO."

National student chair Jade Power

Associate professional and nursing services manager Kate Weston said the move was “great news to keep tauira connected with NZNO and be up to date with what is happening in nursing”.

Members including all students need only to register once here for *Kaitiaki Nursing New Zealand* here – then log in here to access all content.

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LETTERS

Medical exemption process for mandates 'not fair'

BY MARIA STARINK

April 14, 2022

Over the last 25-plus years, nursing has been intellectualised.

District health boards now have more middle and upper management roles and not enough nurses at the forefront of practice.

The abolishment of hospital-based training was also a significant, negative milestone as was the scrapping of the enrolled urse training for some 15 years.

Fast forward 2021... No sympathy was ever expressed or any value placed on those nurses whose autonomy was taken away by mandates.

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.

The medical exemption process was not fair, reasonable or transparent and after 45 years of dedicated service my employment was terminated a week before Christmas and I was kicked to the curb like a piece of trash that needed to be got rid of!

When I started my nursing career, I was administered a vaccine despite the doctor being aware of a contraindication and I subsequently suffered a life threatening adverse reaction event which left me with physical and mental scars. I was advised by a specialist dermatologist never to be vaccinated again.

Nursing recruitment will only be hindered by ongoing mandates.

Maria Starink (EN)
Christchurch

NZNO professional and nursing services manager Mairi Lucas replies: *NZNO supports the Government's policy of requiring health-care workers to be vaccinated. Most health-care workers are already vaccinated, and this Order (https://www.health.govt.nz/covid-19-novel-coronavirus/covid-19-response-planning/covid-19-mandatory-vaccinations) provides reassurance and certainty to both health-care workers and the public accessing health care services.*

The safety and wellbeing of health-care workers is the key to overcoming the COVID-19 crisis and high levels of community vaccination help keep NZNO members safe.

For clarity, a mandatory vaccination order simply means the Government has decided that COVID-19 vaccination is essential for people filling the affected roles. It does not mean that anyone is forced to get a vaccine.

It is NZNO's view that members who are covered by the Order and decline the vaccine are potentially putting their jobs at risk. Being vaccinated has become a legal expectation of health-care workers. Based on recent case law, NZNO does not see a wide range of options for members who choose not to be vaccinated for reasons other than any legal exemption.

NZNO will represent its members who cannot or choose not to be vaccinated to ensure their employment rights are upheld and relevant professional obligations are understood. NZNO member support can be contacted on 0800 28 38 48 or nurses@nzno.org.nz.

NZNO's full position statement on COVID vaccinations can be found here (https://www.nzno.org.nz/LinkClick.aspx?fileticket=Veo1Mf1gDX4%3d&tabid=109&portalid=0&mid=4918)

Kaitiaki
NURSING
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OPINION

Nurses must speak out on ‘sparse, inaccessible’ mental health care

BY NZNO PROFESSIONAL NURSING ADVISOR ANNE BRINKMAN, WITH CONTRIBUTIONS FROM THE MENTAL HEALTH NURSING SECTION COMMITTEE.

April 13, 2022

‘Silent epidemic’ in mental health across Aotearoa as families struggle in isolation.

AdobeStock

The mental health system in New Zealand is not working, especially for those patients needing secondary and tertiary care.

A relevant example came from a friend who recently related the horrific time their family had been having with one of their adult children who has had mental health issues over the past five years. He has been suicidal and needed intense input from the family to keep him from harming himself.

It would be nice to think that our mental health systems could provide robust support for this person but that is not what is happening. Instead, the 'care' is piecemeal, sparsely available, often inaccessible and with extraordinary waiting times for longer, more therapeutic programmes. The national paucity of long-term beds is atrocious. This patient's family is reeling in disbelief and exhaustion while he continues to suffer with severe mental health issues.

Anne Brinkman

This situation is not good enough, nor is it isolated. There is a silent epidemic happening across the country with little public profile. Families are too dismayed and exhausted to effectively collaborate with other, similarly distraught and broken, families.

It has been a hectic couple of years living through a pandemic.
There are vast health system changes being introduced this July – and it will take time for these to bed in enough to meet our diverse health needs. Disestablishing the 20 district health boards and replacing them with Health NZ and the Māori Health Authority becomes even more significant with national elections in 2023. Will we see tangible effects before a government change, or does our three-year election cycle make generational health system change near-impossible?

The NZNO Mental Health Nurse Section's (MHNS) recent submission to the Ministry of Health's consultation on transforming mental health law makes significant points. The MHNS has long been frustrated by the lack of positive change in struggling mental health units across the country – both secondary and tertiary are poorly-resourced. The evidence is there. For example, in the last week of March, the Mental Health and Wellbeing Commission released its report on mental health and addiction, Te Huringa, which found little improvement in mental health services since 2019, despite $1.9 billion allocated for mental health and wellbeing in that year's Budget.

> **. . . 'care' is piecemeal, sparsely available, often inaccessible and with extraordinary waiting times. . .**

The MHNS emphasised the potential of te Tiriti o Waitangi to underwrite mental health law change. *"Compliance with Te Tiriti would mean that such support and assurance (to ensure that patients' rights are upheld) should be provided by an agent appointed by, and accountable to, both Treaty partners,"* its submission said. With a disproportionate number of Māori suffering mental health issues, the system needs to provide kaupapa Māori models of care for all the affected tangata whaiora. Yet, the clinicians will inevitably be blamed if this model of care is not embedded in the health system.

The MHNS also stated: *"There has to be a judgement between the risks of not enforcing treatment and also the rights of the person to self-determination; and also consideration of safety and wellbeing of family/whānau/caregivers who may be detrimentally impacted if a mentally unwell person who needed treatment was to be returned to their care."* Can our society afford not to provide the quality of mental health care that is required? What are the long-term risks attached to leaving patients and their families (if still speaking to one another) to flounder in a sea of doubt, insecurity and alienation?

Since the Government's 2018 mental health and addictions report, *He Ara Oranga* (https://mentalhealth.inquiry.govt.nz/inquiry-report/he-ara-oranga/), there has been growing emphasis on primary mental health care being provided through lived-experienced peer support. The Ministry of Health's public consultation document (https://consult.health.govt.nz/mental-health/transforming-mental-health-law-in-new-zealand/supporting_documents/Transforming%20our%20Mental%20Health%20Law.pdf) states: *"New legislation can support mental health services to shift their focus from reactive risk management to proactively supporting the safety of people, with the concept of safety defined from the perspective of the person rather than the practitioner." (p15)* But how does this shift in focus and resourcing sit with acutely unwell, suicidal and/or psychotic patients? Sorely lacking is a focus on secondary and tertiary mental health care. Experience tells us that excellent care must be provided by qualified mental health practitioners to safely validate requirements imposed by

legislation – such as detaining a mentally disordered person for up to six hours to be examined. These practitioners must be appropriately resourced and staffing levels mandated.

Any significant change at secondary and tertiary level cannot happen without bolstering the workforce. This not only includes educating more staff, but also understanding the issues and other determinants that make current staff leave — and put potential staff off starting. This will not be an overnight fix and may need some thinking outside of the box to attract new staff – especially as house prices and availability become a prominent consideration for people deciding where to live and work.

There are many acute units around the country unable to provide safe staffing – February's Nursing Safe Staffing Review (p25) reported staff frequently taking on back-to-back shifts and working 14-18 hours straight. With such dire conditions, experienced staff are walking away, leaving many services already at crisis point. Violence against staff and other patients is increasing in these under-staffed and under-resourced units. Yet, post-inquiry, there is the mistaken belief that bolstering primary mental health care with unregulated personnel will be a panacea.

Listening to my friend speaking of the despair she and her family are experiencing in having to watch their adult child's mental health deteriorate is confounding. The lack of informed support imperils their family structure and is causing them to question their integrity, their own mental health, and their respect for one another. We need to strengthen our voice as nurses in to advocate for the pressing realities of mental health needs that are significantly affecting New Zealand's growth and development. Are we up to the task? How can we best influence societal support and resourcing?

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NEWS

NZNO farewells, thanks Bloomfield as a 'pro'

BY MARY LONGMORE

April 6, 2022

Outgoing director-general of health Ashley Bloomfield's "guidance and stewardship" during the pandemic reduced pressure on the public health system at a challenging time for nurses, NZNO associate manager professional and nursing services Kate Weston says.

Ashley Bloomfield

"His work through the pandemic has meant pressure on the public health system has been limited," Weston said. "With the pre-existing and ongoing staffing crisis, the system would not have coped had we had a less restrictive approach to COVID management in the early outbreaks."

The Public Service Commission announced Wednesday Bloomfield would be stepping down in at the end of July after four years in the role. He planned to take an extended break and spend time with his family.

Weston said there had been "real challenges" for nurses throughout the pandemic, from accessing PPE on day one, being redeployed (including returning to the workforce if COVID-positive but mildly or asymptomatic) and mandatory vaccination.

However, his role was to provide guidance and stewardship through the pandemic, which he had done "generally very well", she said.

“He was brand new to his director position and endured several hours of interrogation which he handled like a pro. I think he gained a lot of respect from that day”.

“The vaccinations strategy and roll-out (primarily by nurses) has been highly protective,” she said.

NZNO professional and nursing services manager Mairi Lucas said she had been impressed with how Bloomfield conducted himself at the Waitangi Tribunal 2575 health services and outcomes inquiry at Tūrangawaewae Marae in Ngāruawāhia in 2018. “He was brand new to his director position and endured several hours of interrogation which he handled like a pro. I think he gained a lot of respect from that day”.

However, NZNO did not always agree with his perspective. “We did challenge him a lot over the years on the messages he was sharing every day that were in contrast to the reality for nurses on the floor.”

Mairi Lucas

Overall, he maintained his “professionalism and decorum” under tough conditions “when no one knew what to expect next with COVID”, Lucas said.

In 2018, Bloomfield was appointed as director-general from his role as acting chief executive at Capital & Coast DHB. He replaced Chai Chuah, who resigned in 2017 following the arrival of then-new health minister David Clark.

Previously, Bloomfield’s career included stints as acting director of public health at the MOH, a role with the World Health Organization in disease prevention and control, and a spell as chief executive at Hutt Vally DHB from 2015 to 2018.

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NEWS

NZNO says proposed pay equity settlement contrary to Equal Pay Act

BY JOEL MAXWELL

April 14, 2022

NZNO says a legal review of the recently proposed nursing pay equity settlement has concluded it is contrary to the Equal Pay Act 1972.

DHB nurses will be able to have a vote on how pay equity should proceed.

On Thursday, NZNO chief executive Paul Goulter said that a planned ratification vote was

cancelled after receiving the results of a review of the settlement, and the process leading up to it, he commissioned on April 11 – undertaken by employment lawyer Peter Cranney.

Goulter said on the basis of advice, he had informed the Government, DHBs, and fellow union the PSA, that NZNO would not proceed with ratification, without a clear mandate from members.

Instead, members would be asked whether they would:

- Endorse NZNO directly approaching the Employment Relations Authority (ERA) to have pay equity rates determined and deal with the back pay issue. Or:

- Proceed to ratification on the basis of the existing proposed agreement despite that it breaches earlier agreements and is in conflict with the Equal Pay Act.

DHB members would be contacted next week with information on how the vote will proceed. "We will also be holding more online information sessions so members can learn more and ask questions next week, and beyond if necessary," Goulter said.

Goulter said he fully supported the work of the pay equity negotiation team.

"These negotiators, who include NZNO members, were operating under intense pressure in complicated circumstances. They brought to members what they believed was the best possible proposed settlement under those circumstances, and they should be congratulated for their hard work and determination to get the very best result for members after years of delay."

Goulter said the developments would delay implementation of the new rates to DHB employees but NZNO would "go hard" to make sure any eventual DHB base rates were extended to all sectors of nursing, including primary health care, aged care, and particularly Māori and iwi providers.

> **"These negotiators, who include NZNO members, were operating under intense pressure in complicated circumstances."**

Meanwhile Goulter said aside from the back pay, most members appeared satisfied with the base rate increases.

"I am aware that many senior nurses are not satisfied because the new proposed pay rates have reduced the difference between their wages and those of other nursing groups. This was largely because no suitable comparators could be found for many senior nursing roles."

He said a joint working group would be established to address these pay differences and "fully capture the breadth and depth of senior nurse practice, leadership roles and responsibilities".

Back pay was a major issue in the proposed pay equity settlement.

It would identify terms and conditions for senior nursing roles which were attractive and would encourage the development and maintenance of this workforce group.

"This work is to be completed by October 2022, in time for it to be part of the 2022 MECA negotiations."

Settlement announced

An in-principle agreement was reached in December 2021, which was eventually released to members on Friday last week. It was intended they would vote on whether to ratify the proposal.

Goulter launched the legal review this week. Feedback from members showed significant dissatisfaction with the back-pay aspect of the deal: the proposed lump sum payment

recognising past work was not what they were expecting, he said.

This was based on member understanding they would be individually back paid to December 31, 2019.

This week NZNO set up three additional members-only zoom meetings outlining the proposed settlement.

Background

In an email to DHB members, Goulter outlined the background to the pay equity proposal, as follows:

On September 17, 2021, NZNO and the 20 DHBs signed a settlement which provided that the pay equity pay rates once settled would be back paid to December 31, 2019. This back pay entitlement was an existing contractual term for each member.

The Equal Pay Act provides that a pay equity settlement that contains a term that reduces an employee's employment agreement entitlements has no effect. The proposed settlement agreement conflicts with this rule as it removes a large part of the contractual back pay entitlement previously agreed.

The purpose of the rule is to prevent settlements under which pay equity increases are offset against existing entitlements.

NZNO considers that the proposed back pay payment is contrary to the Equal Pay Act because it contains terms which reduce employees' employment agreement entitlements agreed last year.

Those entitlements require the employer to pay back pay to December 31, 2019. The proposed pay equity settlement would significantly reduce that entitlement for many members.

Kaitiaki
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NEWS

NZNO zoom meetings added for DHB members over pay equity agreement

BY MARY LONGMORE AND JOEL MAXWELL

April 12, 2022

Online meetings have launched today for NZNO district health board (DHB) members keen to find out more about a proposed pay equity settlement revealed last week.

Paul Goulter

It comes after NZNO chief executive Paul Goulter announced a full legal review into the settlement presented to members on Friday. The review would also cover the process leading up to the settlement.

Goulter said he expected to report the review outcome to members as soon as possible – preferably before the Easter break. Members would need the information before voting on the settlement and deciding next steps, he said.

Goulter said feedback from members showed there was significant dissatisfaction with the back-pay aspect of the deal: the proposed lump sum payment recognising past work was not what they were expecting. This was based on member understanding they would be individually back paid to December 31, 2019.

"These negotiations took place before my appointment as chief executive and I was not party to them. However, it appears something is not right, and I have initiated a full legal review as to whether the proposed lump sum (backdating) payment meets the conditions agreed to in our

last MECA negotiations, and whether we were legally correct in bringing the proposed settlement to members."

> **"This is a new and historic recognition that nursing has been undervalued as a workforce because it has mainly been done by women."**

Negotiations were protracted with multiple parties involved, and the NZNO and PSA negotiation teams, which included members who saw the proposed settlement as a way of settling negotiations and getting much improved base pay rates to members, Goulter said.

"The employers said individual backpay was difficult for their payroll systems and that they would have to phase increases in over at least two years, and members have already become frustrated by ongoing delays."

The new pay rates were considerable across the DHB nursing workforce and seem to have been, by and large, welcomed by members, he said.

"This is a new and historic recognition that nursing has been undervalued as a workforce because it has mainly been done by women. That has been addressed and corrected in the proposed settlement, and we will now go hard to see those base DHB rates are extended to all sectors of nursing, including primary health care, aged care, and particularly Māori and iwi providers."

Meeting dates

NZNO has added three more Zoom meetings, this time for NZNO district health board (DHB) members only, to discuss the proposed pay equity settlement, Goulter said. "I encourage you to attend one or more of these meetings so you are best equipped to help us decide the most constructive way forward after the legal review."

There are already three online meetings planned for all DHB employees on the proposal, bringing the total number of meetings planned to six. To join a meeting, just click on the links in the left hand column.

Schedule of meetings	Date	Time	Details
NZNO DHB MEMBERS ONLY	Tue 12/04/22	2.30pm-3.30pm	Meeting ID 845 4813 7820 Password

Schedule of meetings	Date	Time	Details
			491859
ALL DHB EMPLOYEES	Tue 12/04/22	4.30pm-5.30pm	Meeting ID 836 0250 8007 Password 390899
ALL DHB EMPLOYEES	Wed 13/04/22	11.30am -12.30pm	Meeting ID 890 7928 0450 Password 398250
NZNO DHB MEMBERS ONLY	Wed 13/04/22	3.30pm-4.30pm	Meeting ID 821 1224 1452 Password 574288
NZNO DHB MEMBERS ONLY	Thu 14/04/22	11.30am-12.30pm	Meeting ID 860 0195 3050 Password 136491
ALL DHB EMPLOYEES	Thu 14/04/22	4.30pm-5.30pm	Meeting ID 830 7294 4565 Password 987780

Kaitiaki
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OPINION

The invisible hand of violence that goes unreported against nurses, HCAs, midwives

BY DANA HUDSON AND SUZANNE ROLLS

April 6, 2022

A glaring discrepancy has emerged between real life nursing experiences of NZNO members and official district health board reports of workplace violence.

PHOTO: ADOBE STOCK

Despite workplace violence being recognised as a widespread problem by the International Council of Nurses (ICN) and considered an area for urgent action by the World Health Organization (WHO), it continues to be overlooked as an inevitable part of nursing.[1,2]

Last December, the NZNO project to Address Violence and Aggression against Nurses (AVAN) requested data (under the Official Information Act) from the 20 district health boards (DHBs), relating to the amount of violent incidents nurses, midwives and health care assistants (HCAs) had reported over the past five years.

We started this process to develop a picture of what the largest health staff employer of Aotearoa knew of the workplace violence (WPV) issue and how much support was being provided to the victims.

To "recognize violent incidents and identify risks of violence" is *the first preventative measure* recommended by the WHO, to address violence and harassment in the health sector.[3] Therefore, as an initial step in addressing this growing issue, the DHBs (and their soon-to-be successor Health NZ) need to be able to rapidly and accurately access the details that indicate the level of violence and aggression staff are facing each day.

From the responses we have received to date, the recording of incidents is minimal or unavailable and the figures are not reflective of the Aotearoa nursing experience.

In 2019, the NZNO Employment Survey showed that 31 per cent of members were suffering from *multiple* physical assaults annually.[4] However, from initial findings in three DHBs, the recently provided data suggests only 5 to 8 per cent of their staff had reported a *single* physical assault in 2019.

Suzanne Rolls

As the majority of NZNO members are DHB employees (approximately 35,000), it is plausible to suggest that the DHB data shows a large shortfall between what we understand to be happening and what is being reported.

This data is extremely important. Each of these numbers relates to an individual who has been hurt in the course of their work. These are people who have suffered insults, racial slurs, fractures, bruises, concussions, attempted strangulations, or worse, while simply trying to do their job.

Unfortunately, this data doesn't provide evidence of the size of the problem and without realistic figures, the need can continue to be ignored. It appears that under-reporting (due to

the multitude of issues facing nurses everyday – time and organisational restraints, structural issues, ineffectual reporting systems, etc) continues to complicate this issue.

Our initial findings also suggest that a significant proportion of harm is not reported to ACC and therefore outside of the compensation model.

Our initial findings also suggest that a significant proportion of harm is not reported to ACC and is therefore outside the compensation model. People are not seeking support for the injuries they get. Figures from one DHB show that while 2336 physical assaults were suffered by nurses, midwives, and HCAs (from 2017 to 2021), only 325 incidents "required" an ACC claim in those same five years. This would suggest that nurses are working in a system that is not highlighting the problem to the health insurer, nor is official treatment being sought.

Dana Hudson

For nurses to receive the support they deserve, ongoing documentation and support for escalation of incidents needs to be accessible and encouraged. Every incident of aggression towards a health professional needs to be documented — verbal abuse, threats, slaps, kicking and pushing. We are aware that many nurses are facing an environment of repetitive verbal and physical assaults. Working in this type of environment long-term can have enduring and complex implications.[5] The accumulative effects of violence can be both physical and psychological and yet neither can be treated if they are not first documented.

Unsafe staffing levels and inappropriate environments contribute to health sector WPV, but without oversight of the issue first, the employer can remain ignorant and claim to be uninformed. Reporting systems need to be intuitive and easily accessible. Nurses need a robust response framework for this issue, with escalation pathways that are encouraged. Health professionals must have their safety prioritised and WorkSafe needs to start investigating the health sector for breaches of the Health & Safety at Work Act.

The AVAN working group welcomes your feedback on this issue as we continue to develop a rautaki/strategy, in accordance with the member reference group directives, to address the many shortfalls leading to the inexcusable continuation of violence and aggression in nursing.

Dana Hudson works as project support for AVAN, and **Suzanne Rolls** is an NZNO professional nursing advisor.

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Kaitiaki
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OPINION

The slap that was heard around the world: when is violence acceptable?

BY JOEL MAXWELL

April 8, 2022

It was the slap heard around the world, but for some it was entirely normal.

Oscars night was struck by violence this year.

When movie star Will Smith slapped comedian Chris Rock at this year's Oscars, it forced the audience to consider questions that have plagued nurses as long as they've been around.

Is violence normal? Is it ever acceptable?

Later that evening Smith received a standing ovation after winning the best actor category for his role in the film *King Richard*. It stunned people who thought such naked violence was unacceptable.

Joel Maxwell

This week NZNO project Address Violence and Aggression Against Nurses (AVAN) released some of its initial data on violence against nurses in district health boards (DHBs).

The results can be found in stories here and here. But it appears vast swathes of violence and aggression against nurses – who *"suffered insults, racial slurs, fractures, bruises, concussions, attempted strangulations, and worse"* – has gone unreported.

Part of this is because of an unwieldy and time-consuming reporting system in DHBs.

But to my surprise, another part of the problem with underreporting is the fact that violence against nurses has been "normalised". It has become, I assume, seen as just part of the job, which has to be endured.

Instant coffee is something that should be endured in the workplace – not violence.

As two AVAN members, Dana Hudson and Suzanne Rolls, who authored the opinion piece in *Kaitiaki* say: nurses can't get the support they need if violence goes unreported. This means everything that happens needs to be shared with management.

If someone in the NZNO offices, like myself, who worked behind a desk was kicked, punched, shoved, or – yes – slapped, then it would send shockwaves through the entire organisation.

When it happens in our wards and clinics, it's just another Tuesday.

If someone in the NZNO offices, like myself, who worked behind a desk was kicked, punched, shoved, or – yes – slapped, then it would send shockwaves through the entire organisation.

The only way that the problem will get taken seriously by management in DHBs, let alone in

other health-care sectors, is when the true extent is laid bare.

Even with chronic underreporting of violence and aggression, the stats the project uncovered were still shocking.

Information obtained from 17 of the 20 DHBs has revealed from 2017 to 2021, 17 DHBs reported 26,394 assaults (physical, sexual and verbal) on nurses, midwives and health-care assistants.

As Chris Rock discovered, facing an assault is bad enough without the expectation that it was somehow acceptable. I know for many of us his crass joke might have been awful, but violence was not the answer.

Will Smith's violence might have been immortalised, but in the case of nurses, it should never be normalised.

Kaitiaki
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NEWS

Violence against nurses, HCAs, 'normalised' and left invisible in Aotearoa health system

BY JOEL MAXWELL

April 6, 2022

Normalised aggression against nurses and an unwieldy reporting system have hidden the true level of violence against district health board staff, an NZNO project has found.

Suzanne Rolls

Initial data obtained by NZNO project Address Violence and Aggression Against Nurses (AVAN) shows a gap between officially recorded violence and the real-life experiences of members.

NZNO project members Dana Hudson and Suzanne Rolls share the initial findings in an opinion piece in *Kaitiaki*, here.

In 2019 the NZNO Employment Survey showed that 31 per cent of members were suffering from multiple physical assaults annually. However, initial district health board (DHB) responses to official information requests by AVAN suggest only 5 to 8 per cent of staff had reported a single physical assault in 2019.

Project lead, Rolls supplied an outline of the group's findings – including reasons for the wide gap in member experiences and official data.

AVAD found two things were creating the under-reporting.

"The reportable event data systems are not designed for the user in mind. They can take 10 to 30 minutes to report an event electronically. The other issue is the 'normalisation', or 'its part of the job to experience violence'."

> **If no data or information is being actively reviewed by DHB executives … they will never put in strategies to eliminate the harm.**

The central theme from the data was the lack of "visibility, regulation, treatment and attention to issues affecting NZNO members regarding workplace violence", AVAD's report said.

"If no data or information is being actively reviewed by DHB executives or DHB board members, both are responsible officers under the Health and Safety At Work Act … they will never put in strategies to eliminate the harm."

By the numbers

Information obtained from 17 of the 20 DHBs has revealed from 2017 to 2021, 17 DHBs reported **26,394** assaults (physical, sexual and verbal) on nurses, midwives and health care assistants.

However, only **1815** claims to ACC were lodged for assessment and treatment (this may indicate unofficial health treatment was provided and not reported to ACC or DHBs).

Over the same five year period, only **15** individual notifications to Worksafe were disclosed to NZNO.