Kaitiaki
NURSING NEW ZEALAND

RESEARCH

`Kōrero I wish I could've had with the Well Child nurse'

BY CHRISTINA SEVERINSEN, FELICITY WARE, MARY BREHENY AND SARAH AITKEN

December 20, 2022

Wāhi Kōrero is a unique research project where patients share their stories of care that did not meet their needs, via an online story-sharing platform. In the first part of this project, young mothers share challenging accounts of their experiences with Well Child nurses.

'Our previous research with young mothers highlighted how surveillance by health services undermined their confidence and limited their autonomy as mothers.' PHOTO: ADOBE STOCK

Introduction

Timely access to and effective use of health care leads to better health outcomes. Unmet need for health care is a key indicator of health system performance and is a significant driver of persistent health inequities.[1,2]

Unmet need is typically explored in terms of practical barriers to accessing services.[1,3] However, barriers to health-care access are complex; they include difficulties in making appointments, transport barriers, cost, as well as perceptions of unfair treatment.[4] Dissatisfaction with health services can lead to low rates of engagement.

There have been numerous government initiatives to reduce barriers to care, with little change to rates of unmet need.[2,4] Health-system reviews tend to focus on difficulties in navigating the system to reduce rates of unmet need. This view of access overlooks how interactions within health services are shaped by macro-economic, political, social and cultural structures. Taking a broader perspective of health service access will increase understanding of how people experience health care.

Barriers to health care access are complex; they include difficulties in making appointments, transport barriers, cost, as well as perceptions of unfair treatment.

Certain groups are particularly poorly served in health interactions, such as young mothers, whānau on welfare, and Māori parents.[5,6,7]

While surveillance — the systematic collection of personal data by government agencies — may be an important part of monitoring health systems in some circumstances, there are links between surveillance and stigma.

Collection of information about women's lives, personalities and behaviours puts their private lives under scrutiny, which can lead to a sense of being controlled and stigmatised, and feelings of fear and anxiety. Surveillance is experienced as particularly intrusive by marginalised populations, such as poor families and Māori whānau.

This can lead to non-disclosure — ie patients not disclosing personal health information or practices — and their disengagement from health services.[6]

Our previous research with young mothers highlighted how surveillance by health services undermined their confidence and limited their autonomy as mothers.[6,7] Understanding these

complex relationships between patients and health services can improve health-care provision, leading to more effective service engagement and better outcomes.

> **Certain groups are particularly poorly served in health interactions, such as young mothers, whānau on welfare, and Māori parents.**

Unmet need is not due simply to the characteristics of patients or the actions of health professionals. It is located within the social system that produces the health interaction.[8]

Understood in this way, addressing unmet need is about identifying issues that shape the health system, rather than pointing to deficits of particular patients or health professionals. Identifying the social setting that produces these health interactions has profound implications for addressing unmet need.

Nurses can play a pivotal role in engaging patients, families and whānau. The relationships established by nurses providing the Well Child service can support mothers to maintain the health of their child.

Nurses can play a pivotal role in engaging patients, families and whānau. PHOTO: ADOBE STOCK

This article identifies barriers experienced by participants in their relationship with their Well Child nurse. It provides recommendations to better address these unmet needs at a training and practice level, service provision and organisational culture level, and contracting and funding level.

The Wāhi Kōrero project

Addressing unmet need requires that we listen to challenging accounts of service provision. In our research programme, we aim to understand the drivers of unmet need by seeking and listening to accounts of health experiences where people feel that they have not received the care they needed.

To achieve this, we developed our novel online story-sharing platform Wāhi Kōrero (http://www.wahikorero.co.nz). This platform enables people to anonymously share their stories of unmet need, including challenges in accessing care, missing care, and suitability of care.

Importantly, we hear about situations where care was not sought. This information is often absent from health surveys and consumer experience surveys.[1]

In 2021, we launched the first Wāhi Kōrero project with the storyline prompt, "*Kōrero I wish I could've had with the Well Child nurse.*" This prompt invited people to share their stories of nondisclosure to their Well Child nurse.

Importantly, we hear about situations where care was not sought. This information is often absent from health surveys and consumer experience surveys.

We focused on the relationship with the Well Child nurse as one of the key health supports available for children under five years of age. Understanding why people might not tell health services the full story helps to improve how health services are delivered.

In this article, we present initial findings from this project, and discuss the implications for person-centred and whānau-led primary health care in Aotearoa New Zealand.

The project received ethics approval from the Massey University Human Ethics Committee, and was launched on August 29, 2021, remaining open for nine weeks. Through our social media campaign, word of mouth and emails sent out as part of our partnership with community campaigning organisation Action Station, we received 420 stories.

Most stories were submitted by women and the average age of those submitting stories was 34 years. Of those who indicated ethnicity (61 per cent), 19 per cent indicated Māori, 3 per cent Pacific, 81 per cent NZ European Pākehā, and 6 per cent other.

Many participants felt judged about their babies' sleeping and feeding. PHOTO: ADOBE STOCK

Wāhi Kōrero was monitored and moderated to ensure safety, anonymity and proper use. The identities of participants posting stories and of other people and organisations mentioned in the stories were protected through the removal of identifying information.

All the stories submitted as part of the project can be viewed on our website (https://wahikorero.co.nz/projects/korero-i-wish-i-couldve-had-with-the-wellchild-nurse/). We approached the kaupapa from a Māori perspective and sought to make visible Māori experiences.

Many participants had questions they would have liked to ask and things they felt they couldn't share. Several topics were commonly referred to in the stories: sleep, feeding, mental health, and relationships with the Well Child nurse.

Sometimes participants talked in the same way about different topics. For example, many felt judged about their baby's sleeping and feeding.

To go beyond a topic-based approach, we conducted a thematic analysis of *how* people talked about the services they received. We identified the following six themes that we see as representing both tensions in the way the service is provided and possibilities for change.

Excitement

The participants spoke of anticipation and eagerness to engage in the Well Child programme, and of high expectations of the service. Participants saw Well Child services as a key part of their parenting journey in acknowledging and supporting the growth and development of their child.

"When I got to see my Well Child nurse, I was always super excited & had so many milestones to share. One day when I went into the office I was left alone with my daughter in the room. My file was on the desk and I peeped over to see what lovely things were written about my gorgeous little girl . . . The nurse has said I talk too fast & excessively and was possibly on DRUGS!?! What the actual? I wish I had of been brave enough in myself to say something. I didn't & I just went home and cried my heart out. I couldn't believe being a young enthusiastic first time mum could be perceived so wrong. Really put a damper on the whole system for me and shut me down from ever wanting to open up at any other appointments."

Engaging with families and whānau

Participants organised their households for their Well Child visits, which felt futile when appointments were cancelled. Often the visits did not meet their expectations. Participants felt that the nurses were not always well-prepared for their visits.

Relationships with the nurses were often hampered by a lack of whanaungatanga and failure to build reciprocal relationships with patients.

They wished for a continuum of care or handover from their midwives, in which the Well Child nurse received information before meeting with them. Relationships with the nurses were often hampered by a lack of whanaungatanga and failure to build reciprocal relationships with patients.

Although the participants acknowledged the difficulties of funding and staff resources within the Well Child programme, they felt that the service as provided did not support mothers:

"My son is nearly 2, and I've only seen Plunket 3 (maybe 4) times, each for maybe 15 mins. One appointment was double-booked and I had to come back another time. Another appointment they asked to push out a few months as they couldn't keep up with the workload in the region. While I'm sympathetic to these lovely people, they would be the last people I go to for any concerns regarding my child, especially one that I feel society may judge or shame me for. While I have no doubt they do their best with 15 mins every few months, it's simply not enough time for someone in the vulnerable position of being a new mother – as well as any other challenges people face like race, socio economic factors etc."

Centring family and whānau understandings and priorities

Many participants referred to the "tick box" approach of visits. Assessment approaches from

initial visits through to the B4 School Check were experienced as superficial questioning, based on a physiological framework, and in some cases irrelevant.

There was little recognition of what is normal for their families and whānau. Many of the concerns participants did express were dismissed or overlooked. Participants wanted services that recognised their experiences and perspectives and upheld their own ways of knowing. They felt that the service was designed to meet institutional needs, as opposed to improving the wellbeing of their family.

> *"It was after her second visit I realised something wasn't right. She was asking questions and replying with answers that were totally unrelated to what I had just said. She was on her mission to tick the boxes in the Well Child book. And boxes she ticked. All of them!! Even the ones that didn't apply to my son."*

Partnering for hauora

Participants desired a relationship where they could work together to find a set of solutions that would work for their families and whānau. Often they spoke of advice provided that was generic, narrow or misguided. They felt they could not talk openly, particularly about safe sleeping, feeding and the mother's mental health.

Participants also questioned the advice given by Well Child nurses. They spoke of knowing their child best, and how they wished the Well Child nurses would acknowledge this expertise. They wanted to develop ways forward with Well Child nurses in whānau-led relationships.

> *"An anxious new Mum that had severe PND but my WellChild provider kept telling me I was 'fine' and 'having a baby is hard'. She literally wrote in my Plunket book 'does not enjoy motherhood' — THEN HELP ME!"*

> *"It was too difficult to have a real conversation about these things so I felt left on my own with getting information and making decisions. I felt that if I did not follow the standard advice and pathways to the letter, I would be judged as a bad parent or over-anxious or something else negative and dismissive. What I really needed was a real conversation about the needs and my concerns and the possible benefits and risks."*

Feeling fear and judgment

Interactions with their Well Child nurse led some participants feeling judged, shamed and angered. Where they experienced a sense of surveillance, they felt fearful and compelled to withhold information from the Well Child nurse.

> *"My daughter's Plunket nurse was extremely judgmental and I was always left feeling like a failure as a parent after one of her visits. My house was not warm enough. I HAD*

to make it warmer for the baby. My next two power bills added up to $1100."

"I had developed a fear of her coming back and taking my baby. As she had written falls risk all over our Well Child book with no explaining as to what it meant. I kept wondering what I had done wrong. What did it mean??"

Disengagement

Ultimately, the lack of relationship and feelings of shame led to non-disclosure of parenting practices and in some cases disengagement from Well Child services. Participants spoke of actively deciding to withdraw from the service when their needs were not being met. Their experiences lowered their expectations and trust in health-care relationships.

"I told my Plunket nurse we were struggling with sleep. She referred me on to their 'sleep expert' who advocated for stopping overnight feeding and sleep training. When I said I wasn't prepared to let him cry and what else could I do, she literally had no advice. I felt let down and cried. After that, I never told my nurse we started bed sharing. I never got the safe bed sharing advice I needed. I never used their crap service with my second child."

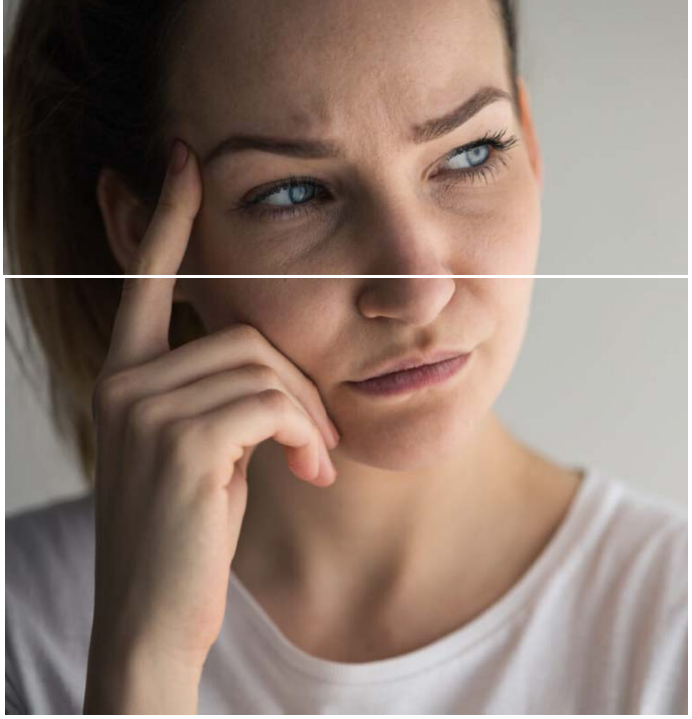
"Despite following up numerous times, we heard nothing until the B4 School check for our eldest. When the nurse asked her to count to 10, and she replied in Māori to be told "No, in English". My heart melted and we walked out, never to return. I wish I could tell them how my heart broke for the pepi of whānau who don't have the courage to walk out, who fear their babies will be taken from them if they don't comply. I wish I could tell them they need to change, because right now, they do far more harm than help."

Discussion

Hearing these stories can be challenging for Well Child nurses, but they help us to understand how current services are provided and how to create services that better respond to the needs of families and whānau.

Treating these accounts as legitimate and worthy of serious consideration is the first step in acknowledging the ways that health professionals and their patients can differ in their experiences of health services.

These specific and personal experiences arise out of the wider context of service provision. They help us to understand the limitations of current strategies to improve the health-care system.[9]



Hearing these stories can be challenging for Well Child nurses. PHOTO: ADOBE STOCK

Improving patients' experiences with the health service requires an understanding that health-service access is shaped by the processes and practices of unequal distribution of privilege, resources and power that is deeply embedded within society.

These processes and practices play out within health and social services, and can produce harmful power relations within these settings. An important step in improving equity is for health professionals to use a relational approach to the service they provide, ie building relationships with patients and whānau based on respect, empathy, kindness and cultural responsiveness.[10] Without this we cannot hope to improve unmet need.

At the interpersonal level, nurses have a key role in partnering with and advocating for families. They are well-placed to develop effective relationships through their provision of face-to-face Well Child services in homes.

Treating these accounts as legitimate and worthy of serious consideration is the first step in acknowledging the ways that health professionals and their patients can differ in their experiences of health services.

Our research shows that family and whānau priorities, ways of being and knowing, and preferences, were often unheard in their relationships with Well Child nurses. These experiences highlight power imbalances between health professionals and patients in these health interactions.

Using person-centred care, nurses can build partnerships through collaborative decision-making, respectful communication, and compassionate and culturally responsive care to empower and uphold the self-determination of those they are working with.[11,12] Whānau-centred care makes whānau active negotiators of their health information and relationships.

At the organisational level, our findings question whether Well Child services prioritise the needs and aspirations of families and whānau. Models of practice and service schedules across the early years of a child's life need to enable information-sharing, continuity of care

and partnership.

In Aotearoa New Zealand, practice models must consider both culture and clinical aspects and be evidence-based. Te Puni Kōkiri[13] states that it is essential that health-care practice adopts an holistic approach to supporting whānau aspirations and needs.

> **Creating better experiences for families and whānau will lead to more meaningful engagement and care, and improved outcomes.**

The stories also challenge the wider health system, highlighting concern with surveillance and data collection. This suggests that contracting and reporting structures, funding, resources, training, and workloads have not been designed to centre family and whānau needs and aspirations.

Narrow biomedical understandings of health and child development fail to account for the child in their family/whānau context, which can negatively affect the experiences of those receiving Well Child services.

Conclusion

The stories shared on the Wāhi Kōrero platform demonstrate the subtleties of unmet need and what drives patients to disengage from health services. Lack of connection meant that some needs were unmet. Feelings of distrust — and sometimes shame — lead to non-disclosure to Well Child nurses about parenting practices and health behaviours.

These stories provoke us to reflect on the primary health care provision environment and how current health system reform can advance us further towards an understanding of the importance of relational care. This approach is key to prevent patients distancing and withholding information, and to promote the wellbeing of all.

Instead of increasing surveillance to improve health outcomes, health services can enact culturally responsive, relationship-based, mana-enhancing solutions to unmet need. Creating better experiences for families and whānau will lead to more meaningful engagement and care, and improved outcomes.

** This article was reviewed by **Carmen Timu-Parata, MA App(nursing), MN, (Ngāti Kahungunu),** who is a former Well Child/Tamariki Ora nurse, and is now a research fellow in the Department of Public Health, University of Otago, Wellington, leading a research project on Māori breastfeeding aspirations in te Tai Tokerau.*

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NEWS

‘I just wouldn’t let them rattle me’ – NZNO wins three-year battle over public holiday pay

BY CATE MACINTOSH

December 7, 2022

After a three-and-a-half-year battle, including a grilling on the witness stand, delegate and hospice nurse Rachel Clarke is thrilled to the Employment Court found she and her colleagues at Arohanui Hospice Palmerston North, were entitled to be paid for public holidays not worked.

Clarke said she was thrilled with the result, and had no regrets.

“If you asked me if I would do it again, I would.”

Even though it’s been three and a half years of a really long slog, I most definitely would, because I stood up for what I believe in.”

In her ruling on November 22, Judge Joanna Holden said a challenge by Arohanui Hospice of an Employment Relations Authority (ERA) decision supporting NZNO’s position, had failed.

“Part-time employees employed by Arohanui who work different days each week, and are covered by the terms of the Multi-Employer Collective Agreement/Single Employer Collective Agreement, are entitled to public holiday provisions in accordance with the formula provided under the second paragraph of clause 12.5.”

In April 2019, Clarke was turned down for payment for the Easter public holiday Good Friday.

Arohanui Hospice nurse Rachel Clarke took to the witness stand in an Employment Court appeal by her employer over public holiday pay.

The hospice had previously provided staff not rostered on for a public holiday, an alternative leave day, or payment, if requested – which was also not a correct interpretation of the clause, Clarke said.

But from early 2019, they changed their policy, and declined requests for pay entirely – a move which put them in breach of the collective agreement.

According to the relevant clause, part-time staff who were not on a fixed roster, were to be paid for unworked public holidays if they had worked on that day for at least 40 per cent of the previous three-month period.

"The idea is that, yes, it's over and above the holidays act but it means that those of us who do shift work get a fair entitlement for public holidays," Clarke said.

The employer argued that "an employee's days of work may be fixed by way of a pattern (eg three days on and three days off)", and not specific days of the week, and therefore, they would not be eligible for the payment.

Clarke challenged her employer's position on the payment and sought support from an NZNO organiser Manny Downs.

They asked the Ministry of Business, Innovation and Employment labour inspectorate to review the employer's decision – but the office said there was no breach of the agreement.

NZNO lodged an application for a determination with the Employment Relations Authority (ERA) in 2020 and, following a delay due to illness, a determination – in favour of NZNO – was released in April this year.

In a move that surprised NZNO lawyers, Arohanui Hospice Trust appealed the ERA decision in the Employment Court.

NZNO employment lawyer Christine Hickey.

"We thought the clause, had been around for many, many years in health collective agreements, was really clear and had been understood and applied by most employers consistently with what we thought it would be," NZNO lawyer Christine Hickey said.

The case was significant, as many collective agreements included the clause, and losing the case could have put the entitlement at risk.

Hickey said she was "ecstatic and relieved" to hear the court's verdict in NZNO's favour.

The employer's decision to stop applying the clause properly, and appealing the ERA decision to the court had eroded the good will of their employees, and came at a financial cost, she said.

Clarke appeared as a witness for NZNO, presenting evidence and responding to a barrage of questions by her employer's lawyer for about an hour and a half.

"I was very strong on my knowledge, and very passionate about my cause – and I just wouldn't let them rattle me," she said of the experience.

NZNO fought and won a legal battle over a public holiday pay entitlement for hospice members.

Hickey said a delegate's role as a witness in disputes over interpretation of collective agreements was important because they have detailed experience with the issue, and can provide strong rebuttals to the employer's evidence.

She said it was always NZNO's preference to resolve issues without having to go down a legal path, but the organisation would go to court "if we know what is happening to our members in their workplace is unjust".

"And, of course, it's even more important to have it dealt with by way of an Authority or Employment Court decision if the issue has a wider impact for other workplaces like this one did."

NZNO's legal team helped to prepare delegates in advance, and supported them through the process on the day, Hickey said.

"If it does need to go all the way, NZNO is there with you the whole time."

Clarke said it had been a long hard slog since she first raised the issue in April 2019, but she had no regrets.

"At times it's been challenging, but I guess for me, I felt that I was right, so I had nothing to feel bad about. I felt I was doing the right thing, standing up for the little people."

Arohanui Hospice members will be entitled to backpay for unpaid public holidays for the past three-and-a-half years.

Tags

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NEWS

‘This is my way of giving back to nursing’ – union powerhouse starts role at NZNO

BY CATE MACINTOSH

December 22, 2022

Karene Walton, NZNO’s recently appointed director of organising, says there’s never been a better, or more important, time for NZNO members to take collective action.

Despite wide-spread and unprecedented staffing shortages, and the toll this continues to take on NZNO members, Walton insists they are up for the challenge.

“The thing that moves people, for organising, to get involved, to campaign around, is when we’re angry enough about an issue that impacts not just me but our community – and as nurses we care deeply about that.”

NZNO director of organising Karene Walton has 29 years experience in unions behind her. She recently took up the newly created role, based in Wellington.

Born in Scotland, Walton has spent most of her life in Australia, and recently finished a role as director of the global organising academy at the International Trade Union Confederation (ITUC), based in Brussels, Belgium.

The three-year stint included the unexpected challenge of the COVID-19 pandemic. In 2020, while on a visit to family in Perth, she was unable to leave due to a lockdown and the closing of borders for international travel. She spent the time converting face-to-face training programmes for union organisers around the world, into online modules.

Prior to the ITUC role, Walton spent 26 years working for Australian unions including the Health Services Union, the Australian Council of Trade Unions and most recently as national operations manager of the Media, Entertainment and Arts Alliance (MEAA).

In this role, from 2015-2019 Walton says she helped turn the tide on a significant membership downturn in the years prior to her appointment, and achieve growth of 1.6 per cent by October 2018.

Walton said she had huge respect for nurses and was excited to work for Tōpūtanga Tupuhi Kaitiaki o Aotearoa New Zealand Nurses Organisation (NZNO).

"My mum's been a nurse, my dad's been a nurse, my sister's a nurse. This is my way of giving back to nursing."

The role was also a fantastic opportunity to work with former colleague, chief executive Paul Goulter again – the pair worked briefly together at the ACTU – and be closer to her son, who lives in Australia, Walton said.

Asked what she wants to achieve in the role, Walton got straight to the point.

"I want to make NZNO the best organising union in New Zealand. And in doing that, we actually build power for nurses."

Karene Walton (right) with Lynley Mulrine, lead organiser – southern, at a welcome for Walton in the NZNO Christchurch office in November.

While NZNO had achieved high density, with over 55,000 members, Walton said she wants to continue work under the Maranga Mai! campaign, to increase engagement and build member power.

"High density doesn't equal power – you need to have high density and you need to have your members willing to take action over the issues that are important to them."

Walton said the work of organising and organisers was about empowering workers, "to make sure they are front and centre of being union" rather than being "in the union".

"If you're thinking an organiser is the union, and is going to save the world then that's not the union, that's an organiser – and when an organiser walks out the door, so does the union.

"So this is actually putting the power back into members and giving them power to stand up for themselves – we're here to facilitate it."

Success in the role would mean that the community and government hear what nurses have to say, Walton said.

Tags

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FEATURES

Academia, activism and nursing – the key drivers for Grant Brookes

BY CATE MACINTOSH

December 8, 2022

An unexpected period of living rough while on his OE, gave Grant Brookes a taste of "how the other half lives" and deepened his drive to advocate for human rights. As part of a series on the NZNO board of directors, Brookes spoke to *Kaitiaki* about his story.

Caring for his Scottish grandmother in her final months was a turning point for Grant Brookes and opened his mind to a nursing career.

"My grandmother, who I was very close to, became very sick and over the course of six to 12 months it became clear she wasn't going to survive and the family cared for her, and I was part of that roster," he said.

During this period, Brookes, now 54, decided to volunteer at a local hospice to get a closer look at nursing, before deciding the profession was his calling.

Grant Brookes receives a scholarship to private boys school

In 1992, and in his mid-20s, Brookes began a bachelor of nursing at Otago Polytechnic – one of the first degree programmes to be offered in New Zealand.

He had spent six years as a university student, completing an honors degree in physics, before turning to the arts, studying comparative literature, philosophy and religion.

Scottish reformer heritage shows through

Brookes says his passion for education and activism connects him with his ancestors, who, as part of a breakaway protestant movement, left Scotland for the colonies, to establish new communities founded on democracy, education and egalitarianism.

The Brookes clan arrived in Dunedin on the *Cornwall* in 1849.

"I can see how these historical forces have shaped who I am."

Fast forward to the late 1960s, and 1970s, Brookes describes a happy, middle-class upbringing in which academic achievement was highly valued – and quite a bit of tennis.

Grant Brookes got involved in the student protest movement in the late 1980s.

His mother pursued tertiary education in adulthood, eventually completing a doctorate in philosophy and becoming an academic.

Brookes' father spent summers working full-time as a professional tennis coach. "His claim to fame was being the tennis coach for the New Zealand Davis Cup team," Brookes said.

But in 1980, things changed dramatically when his father died suddenly. Brookes was just 12-years-old.

A teenaged Brookes gained a scholarship to attend John McGlashan College, a private boys high school where he thrived on academic success, debate and public speaking.

At university, Brookes got involved with the student protest movement, which ramped up in the late 1980s, in opposition to the introduction of student fees.

Academic to nurse

As a student nurse at Otago Polytechnic, Brookes admits his academic experience and love of debate didn't go down very well.

"I was debating all sorts of moot points and they were saying: just get on and bloody well do it. In the end we met somewhere in the middle."

During his nursing degree, Brookes came into contact with, and embraced, the Treaty of Waitangi "in a serious way" for the first time, he says.

"Growing up in Dunedin, going to a private school, I think I can only remember one Māori student in my school in the time I was there – it wasn't in my world until I went nursing."

Grant Brookes at a protest in support of returning land to Māori ownership.

Grant Brookes said he became aware of te Tiriti "in a serious way" during his nursing studies.
A gap year in London which didn't go as planned resulted in him living rough for several months, Brookes says.

After being robbed, he was declined a social welfare grant as he didn't have British citizenship. Unable to pay rent, he lived on the streets.

"I experienced what life is like for migrants who don't have the right residency or citizenship."

Eventually he "clawed his way back" and got a job in a cafe, where accommodation was provided.

In New Zealand, Brookes faced a barren employment landscape after graduating in 1996.

"This was a time of dramatic health spending cuts, privatisation of health services, staff retrenchments, de-unionisation."

From textbooks to nursing life

Brookes had decided to specialise in mental health nursing as there were "mental health issues in my family background", but with no jobs available in Dunedin, he moved to Auckland.

During a new graduate programme, he gained experience in the different areas of mental health and came to terms with a system he felt was overly controlling of patients' behaviour.

Despite his misgivings, Brookes said he was inspired to stay in the sector and work for improvements and "make it more respectful of human rights".

For the past 20 years, Brookes has worked at Te Whare O Matairangi, an adult acute inpatient unit in Wellington as an employee of the former Capital and Coast DHB – now Te Whatu Ora.

NZNO board member Grant Brookes became a delegate while working as a mental health nurse in Wellington in the early 2000s.

While in this role, Brookes joined Tōpūtanga Tapuhi Kaitiaki o Aotearoa, New Zealand Nurses Organisation (NZNO), and became a delegate.

During his first year on the ward, there were three serious adverse events, which sparked numerous investigations and, eventually improvements, he said.

"There used to be three acute adult inpatient wards for the greater Wellington region and the powers-that-be decided to shut one of them, and we went down to two. The pressure on our ward went through the roof and we were not able to cope."

He said the ward is safer than when he started, but the issue of violence – against patients and staff – had not been "solved".

Brookes said he was fortunate to have avoided serious injuries from assaults. In his early days on the ward, a patient knocked him out with a punch.

NZNO board member Grant Brookes with his wife Linda and children Tama and Rosa-Marama in 2012.

"I found myself flat on my back on the concrete and I came to and I thought that wasn't supposed to happen."

But he says this was the only serious assault he has suffered in the role, " . . . that's pretty good going as far as the averages go".

Over the past two years staffing levels had decreased and the ward was often short-staffed, he said.

"Things got really bad after I started [working on the ward], because many people left, and then we built that back up – but things have deteriorated. We're not back where we started, but it's the worst it's been in quite a few years."

Time for activism

Having a stable job had allowed Brookes to focus on activism for various causes, including worker rights, the landbank movement for Māori, justice for migrants and refugees, climate justice, and peace, he says.

Grant Brookes was elected on to the NZNO board this year.

This year Brookes has taken on a role as national coordinator for a group of health professionals advocating for climate change action, Ora Taiao – the NZ climate and health council (https://www.orataiao.org.nz/), and is motivated to see the NZNO board achieve more in this area.

His recent election to the board as a director will be Brookes' second experience in NZNO governance, following a period as president from 2018-2020.

He believes NZNO was in a "painful transition" period during that time " . . . from being a fairly conservative professional association which did collective bargaining, into a progressive, member-driven, industrial union for professional nurses."

The experience on the current board, which met for the first time since the elections in October, was very different to his previous experience, Brookes said.

He was certain NZNO leadership and governance would work together to achieve the aims of Maranga Mai!

Tags

Click to search for related articles: NZNO board

Kaitiaki
NURSING NEW ZEALAND

NEWS

Black Ferns take time out from celebrations to tautoko nurses

BY MARY LONGMORE

December 23, 2022

World Cup Rugby-winners, the Black Ferns, took time out from their public celebrations to warmly champion the cause of nurses in Wellington this month.

Black Ferns Kennedy Simon & Sarah Hirini.

Wellington nurse Naomi Waipouri said a handful of nurses from Hutt, Wellington and Wakefield hospitals turned up to greet Black Ferns at their Parliamentary lawn celebration on December 13.

Nurses quietly held their signs about pay rates and safe staffing, while congratulating the Ferns, she said.

“It was their event that we kind of crashed, but we were respectful about it,” Waipouri said. “Instead of being loud and waving our picket signs around, we went up to the front and just laid them by our legs.

“And they were like ‘oh, the nurses are here!’,” she said.

Naomi Waipouri (in yellow) with fellow nurses at Parliament.

"It was good to hear some of their kōrero, their talk, because it was all about gender equity. The Black Ferns said 'thank you for all that you've done, women-power, we've got to be strong as women'."

Waipouri said the group originally planned to focus on pay equity for all nurses, wherever they worked, "but as people made their own boards they just brought whatever their own concern was at the time – staffing, pay parity. It was just a whole lot of everything".

The Black Ferns made history when they won the Women's Rugby World Cup in November, beating England 34-31.

Black Fern Ariana Bayler

Black Ferns Liana Mikaele-Tu'u and Amy Rule.

Waipouri said history had shown that wāhine "can and will achieve" through collective strength and action — from the 1893 suffrage movement in Aotearoa, to the 1880s "match girls" strikes in London — where a mainly female and young workforce went on strike over low pay and dangerous conditions.

"More recently, the Black Ferns are shining a light on the recognition of women in sport," Waipouri said.

> **'It was good to hear some of their kōrero, their talk, because it was all about gender equity.'**

"As a female-dominated profession, we nurses must continue to look at such a past to encourage, empower and inform us of our future — to, ultimately, close the gender disparity and achieve equity."

After the Black Ferns victory, Prime Minister Jacinda Ardern had announced the December 13 celebration on Parliament's lawn, in conjunction with Wellington City Council and NZ Rugby, encouraging people to "come along and make it a special day".

Tags

Click to search for related articles: pay equity, pay parity

Kaitiaki
NURSING NEW ZEALAND

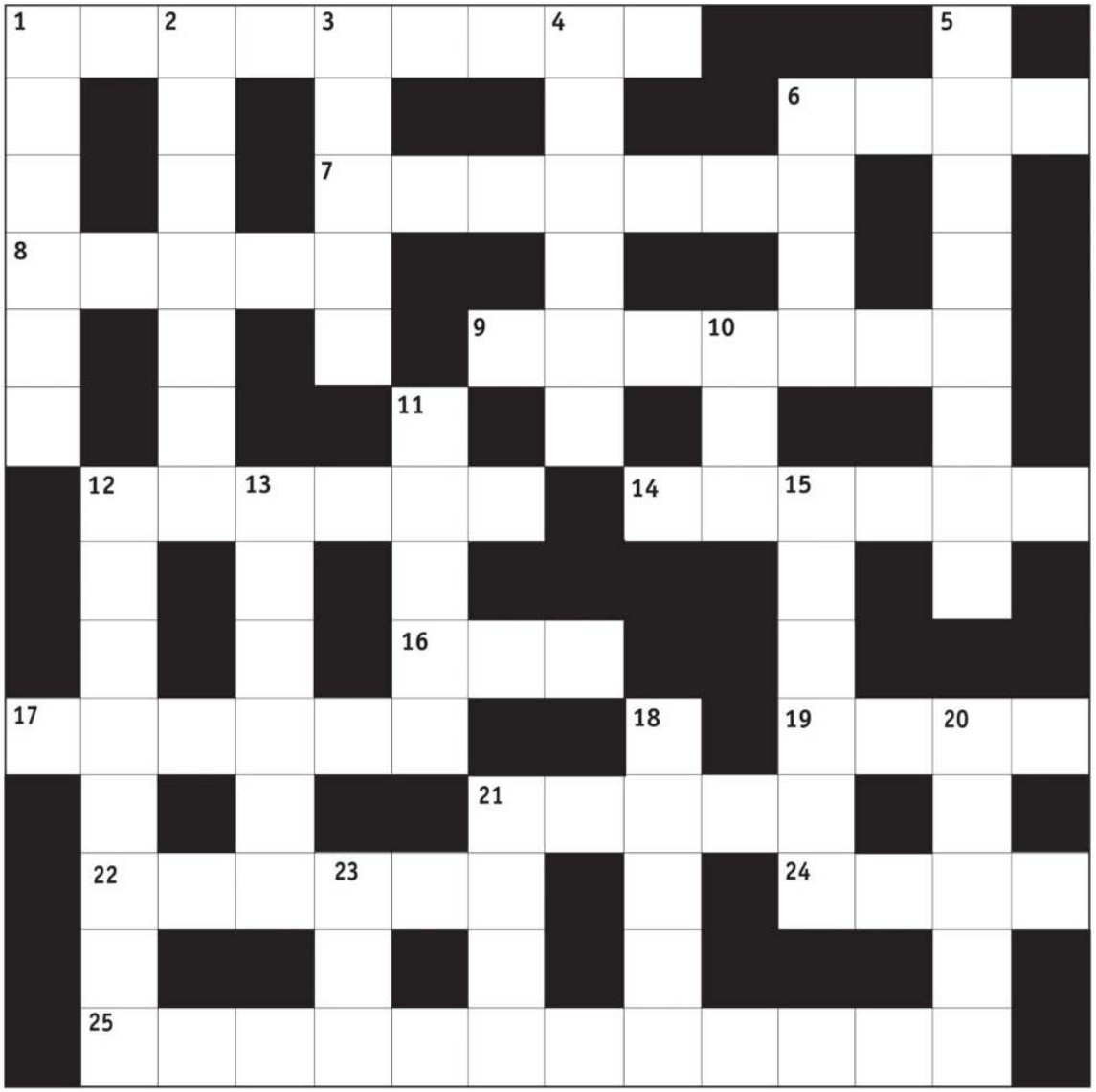
PUZZLES

DECEMBER crossword

BY KATHY STODART

December 7, 2022

Here's our new crossword for December. Print out the grid (using print tab at the bottom right of this page) and use the clues below. Last month's answers are below the clues.



ACROSS

1) Unfair difference, eg in pay rates.
6) Warm outer garment.
7) Knife or fork.
8) Study of a health service to check it is meeting required standards.
9) You can't drive without one.
12) Withdrawal of labour.
14) Top South American football nation.
16) Tolkein's tree creature.
17) Sense of fun.
19) Educational test.
21) Small mischievous fairy.
22) The car stays here.
24) Fruit of the desert.
25) Very keen.

DOWN

1) Discussion.
2) One who is learning.
3) Patient who needs urgent care.
4) Sport with a net and racquets.
5) Antibiotics fight these.
6) Scottish tribe.
10) Part of the body containing a drum.
11) One who slides down mountains.
12) Fight hard against difficult opposition.
13) Gossip.
15) Had the same opinion.
18) Additional.
20) Room up under the roof.
21) Like two ___ in a pod.
23) Smokers had trays for this.

November answers

ACROSS: 3. Chlorine. 6. Nurse. 8. Tic. 9. Chowder. 11. Wary. 12. Tired. 16. Unsafe. 17. Blister. 19. Beehive. 22. Medication. 25. Aqua. 26. Organiser. 27. Hour.

DOWN: 1. Enema. 2. Practitioner. 3. Caddy. 4. Liar. 5. Noisy. 7. Elope.
10. Kaiāwhina. 13. Diet. 14. Knee. 15. Abba. 18. Centaur. 20. Vixen. 21. Ua. 23. Tide. 24. Two.

Kaitiaki
NURSING NEW ZEALAND

FEATURES

Grisly experiences drove history graduate into nursing

BY MARY LONGMORE

December 9, 2022

In the final of our NZNO board member profiles, Wellington perioperative nurse Simon Auty describes the grisly experiences that drove him to become a nurse.

Simon Auty (centre, in black batman t-shirt) in Turkey with fellow travellers in 1990.

As a freshly minted history graduate in his early 20s, Simon Auty was backpacking in Turkey some 30 years ago when he witnessed two horrific deaths within days of each other.

“We were just walking along a street and this guy was walking in front of us, and this other guy was walking in the opposite direction, and he pulled out a gun and shot the guy in front of us,” Auty recalls. “You’re just kind of going ‘what the hell is going on, are we in danger?’ The guy who pulled the trigger just turned a corner and walked away.” Shot point blank in the chest, the victim was unlikely to have survived, he says.

‘Her mum was absolutely distraught, and I thought – I can do something about this, I can help people’

At the time, he was in eastern Turkey, close to what was then the USSR-border, where there was unrest with the ethnic Kurdish population seeking an independent state. The next day, they saw a village burn and police told them it had been an attack by a Kurdish guerrilla group – “so it was all tied into that, it was an assassination”.

Just a few days earlier, Auty had witnessed a four-year-old girl fall from a train in front of her mother. She was fatally injured and died before his eyes. “Her mum was absolutely distraught, and I thought ‘I can do something about this, I can help people’,” Auty said. “I remember thinking: ‘If I knew something more, I could do something rather than just standing there like a spare prick at a wedding.

“I trained as soon as I got back basically.”

Nursing also ran in his family, with an aunt, great aunt and several cousins who were nurses. Auty’s mother also trained as a nurse but got married before she completed it — students weren’t allowed to marry at the time.

Simon Auty (second from right) in 1990 with his great aunt, Tante Anna (in pink, right of gate), a nurse, at Fantoft Stavkirke, Bergen, Norway, one of the late Viking era "Stave" (dragon) churches. In reference to his Viking heritage, Auty describes the region as "my spiritual home". His Norwegian grandfather jumped ship in Dunedin 1940.

But it was hard to find work when he graduated from Nelson Polytechnic in 1993. Hospitals — run then by crown health enterprises (CHEs) — were reluctant to take on inexperienced new graduates and there were no supported entry-to-practice programmes for them, as there are today.

"We had only 60 of us graduated in my year and about a third went overseas, because there was no work — they went to America or Australia."

‘I had some hope that we could actually achieve something, we could advocate for members.’

At the time, when nursing jobs were scarce, then-minister of health Jenny Shipley said market forces would dictate nurses’ wages. “Well okay . . . let market forces dictate now, amid a worldwide massive shortage of nurses,” says Auty. “So, the chickens have come home to roost.”

He went on to apply for a job at Blenheim’s Wairau Hospital, where managers said they had no jobs but suggested he volunteer instead.

“I made my feelings known that I was not prepared to do volunteer work as a nurse,” says Auty, who was raised by unionists. His grandfather was a watersider, involved in the extensive 1951 waterfront strikes. Originally from Bergen, Norway, the seafarer had “jumped ship” in Dunedin in 1940 when Germany invaded Norway during WWII. But it was his teacher father who Auty said “probably unionised me as much as anybody else”.

NZNO board member Simon Auty (centre) flanked by his sons Angus (second from left) and Alex (second from right). His nephew Aidan is on the far left and brother Blair is at far right – “aka the hairy Vikings” says Auty, referring to their Norwegian Viking heritage.

Instead, Auty found a caregiving role looking after a woman who had endured multiple strokes. "She was in a wheelchair and would have epileptic fits and go into status epilepticus [seizures]. So I would have to sedate her when she crashed, as she would fall out of her chair, and get her in an ambulance and send her to hospital."

Auty was paid $119 per week by the Department of Social Welfare – equivalent to the domestic purposes benefit. "It was all you could get and that was what you did."

In the deep end

After six months, he landed a job at Whānganui Hospital as a theatre transport nurse. "I was literally taking people to and from theatre, that was my job," said Auty, who was keen to get into perioperative nursing. He also found himself the only male nurse living in the Whānganui nurses' home — the only other men being a couple of anaesthetic technicians.

One day Auty was in sole charge of maintaining an airway for a unconscious patient in the post-anaesthetic care unit (PACU). "No-one had taught me how to recover a patient or anything, I'd be holding an airway and not knowing what the hell to do . . . it seemed half an hour but was probably only five minutes."

A senior nurse noticed, and later "bailed up the charge nurse" to ask for better on-the-job teaching. "So then they taught me how to be a PACU nurse."

Auty in theatre at Bowen Hospital

A year later, he landed a theatre nursing role at Rotorua Hospital, which was "fantastic", before heading to Waikato Hospital where he learned "heaps". Waikato did "everything — plastics, cardiac, thoracic, vascular. The only thing they didn't have was neuro, but at least once a month we had to do a burr hole [hole drilled in skull] on somebody in the middle of the night if Auckland couldn't take them".

One unforgettable operation he was involved with was a hemicorporectomy – "basically cutting off the lower half of [a patient's] body". Run over by a motorbike, a man had instantly become a paraplegic, his lower body gradually deteriorating, requiring repeated surgery to remove "a little bit off and a little bit more off" every few months until they reached his pelvis. It was such an unusual procedure, that the 60-year-old surgeon had last seen one when he was a registrar many decades earlier in the United Kingdom. The patient survived, but later died in hospital.

‘I made my feelings known that I was not prepared to do volunteer work as a nurse.’

Another unusually complicated surgery involved an eight-year-old boy who received a serious electric shock after climbing a power pole. “The electricity enters through his armpit and comes out through his bum – so you have to track that . . . taking out all the dead tissue all the way through.”

The child fully recovered.

After a stint in Invercargill, by 2005 Auty was in Wellington, working in the private Bowen Hospital’s ophthalmology department — where he stayed for the next 17 years. Then owned by New Zealand’s Wakefield Group, it has since moved into the hands of Australian corporate Evolution Healthcare – currently embroiled in a bargaining dispute with NZNO.

“Employers should never stop talking to their employees if they want to prevent industrial action,” says Auty, who has been out on the picket lines lately.

Nowadays, he is charge nurse of ophthalmology, ear, nose and throat and oral maxilla-facial surgery at Bowen, but still keeps his hand in public health once a week at the Wellington Hospital’s eye clinic.

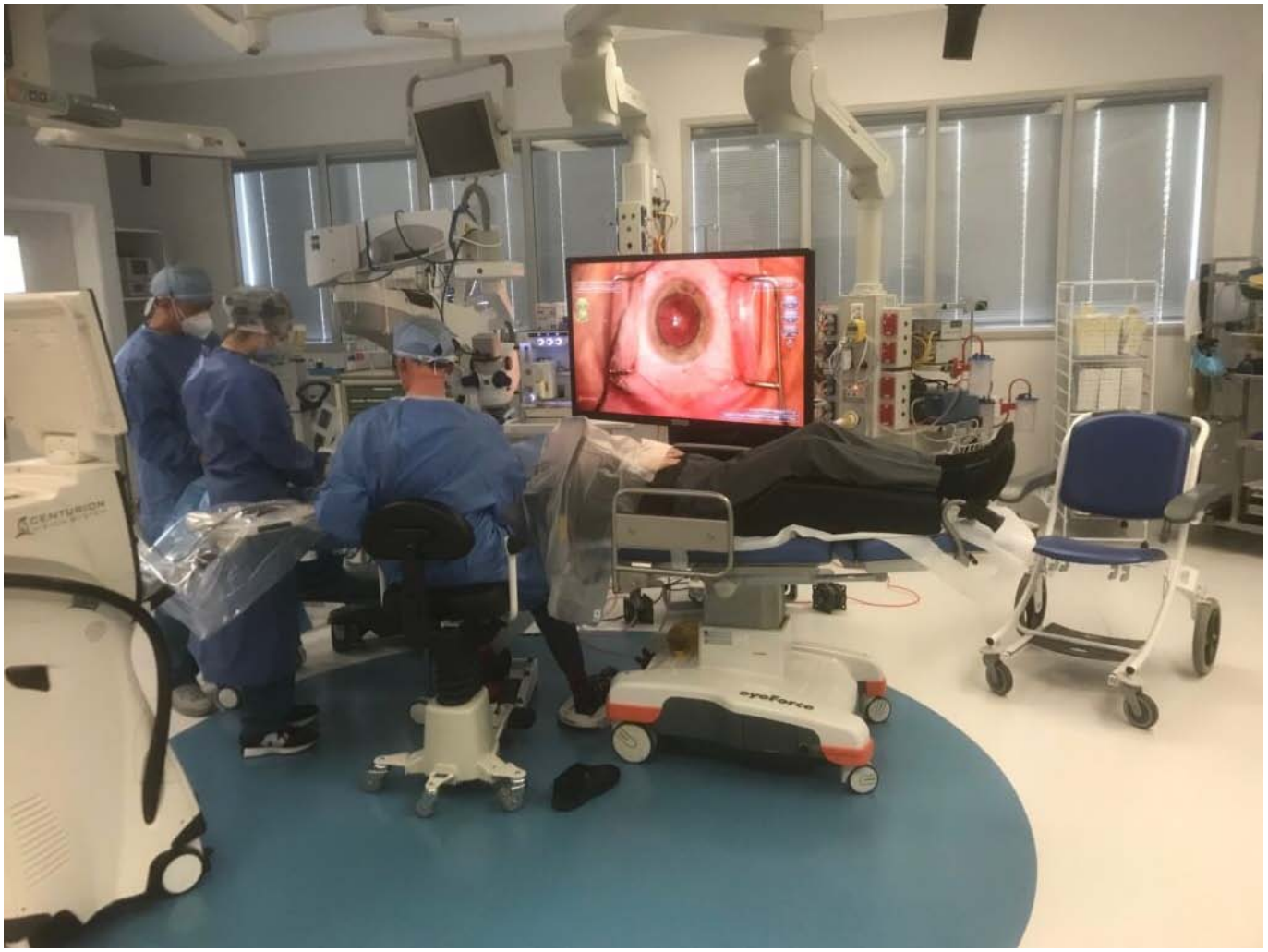
Auty first ran for the NZNO board in 2019 as part of the “MAG 5”, a member action group campaigning for a more member-led organisation, which included Katrina Hopkinson, Sela Ikavuka and Anne Daniels (now president) — who all later resigned on the heels of then-president Grant Brookes, amid a leadership stoush.

Auty, however, stayed on. He wanted to push NZNO to become “a bit more active and a bit more vocal and representative of

Auty on strike outside Wellington’s Wakefield Hospital in November.

nurses and taking on the issues nurses want taking on". At the time, he said, he felt NZNO was "kind of drifting".

He was a keen architect of the 2020 remit to allow a non-nurse to be eligible to become NZNO's chief executive – a change which has led to Paul Goulter's appointment this year.



Auty in cataract surgery: "Probably what I'm most proud of is this team of nurses and that we give people their sight back."

So why a second run? "It's unfinished business," says Auty, who ran on continuity and moving NZNO away from a corporate model. "We've now got to solidify those changes and keep the momentum going."

Auty hopes the current constitutional review will lead to NZNO "becoming the organisation that nurses want it to be".

He saw, in NZNO's response to the COVID lockdown, how effective a unified NZNO could be. "I had some hope that we could actually achieve something, we could advocate for members."

Rocket man

To unwind in between eye surgery and NZNO board work, Auty is an amateur rocket enthusiast – making and launching them since childhood.

“I get to launch rockets every now and then . . . not into space, but if we can get up a kilometre or so, that’d be great!”

Auty (right) with fellow rocket enthusiasts recently, returning the launch tower to its vertical position after launch in Pahiatua. “This rocket went 4.5km high at about mach 1.5 [1.5 times the speed of sound] . . . And took about an hour to find afterwards”.

Tags

Click to search for related articles: NZNO board

Kaitiaki
NURSING NEW ZEALAND

PRACTICE

How primary care can improve antimicrobial stewardship

BY HE AKO HIRINGA

December 9, 2022

Antimicrobial resistance — when pathogens develop resistance to drugs used to fight them — is a serious threat to health care in New Zealand and around the world. Antimicrobial stewardship — ie careful and appropriate use of antimicrobial drugs (including antibiotics) — is vital to preserving the effectiveness of these medicines.

This article explains the key role of primary care in antimicrobial stewardship. There is a clear role for prescribers, but nonprescribers such as primary health care nurses also have an important part to play in supporting the appropriate use of antimicrobials.

PHOTO: ADOBE STOCK

Antimicrobial drugs — including antibiotics, antivirals, antifungals and antiparasitics — are used to fight pathogens in humans, and also in animals, plants and the environment.

However, any use of antimicrobial medicines produces selection pressure, where the most susceptible microbes are killed, promoting the surviving microbes to flourish and pass their resistant features to new generations. This antimicrobial resistance is accelerated by inappropriate use of antimicrobials and inadequate infection prevention and control.1

Antimicrobial resistance (AMR) presents an imminent threat to the future of New Zealanders' wellbeing and access to effective, safe health care. This was comprehensively laid out in a December 2021 report from the prime minister's chief science advisor, Juliet Gerrard.2

The report's expert panel makes recommendations that have their roots in the 2017 New Zealand National AMR Action Plan as well as in the local and international evidence.1 In the words of Dame Juliet, "The time for action is now."2

Use of antimicrobials in human health is high in Aotearoa New Zealand compared with many other countries.2,3 In recent years, there have been encouragingly positive trends that show our antimicrobial use does not need to be so high. During COVID-19 lockdown in 2020, it decreased by a significant 36 per cent with no evidence of harm4 (much of this reduction would be due to less use of antibiotics for viral respiratory tract infections in general).

Before that, a modest 14 per cent decrease in use was recorded across 2015 to 2018 (an average reduction of 3.5 per cent per year), mainly due to reductions in antimicrobial use in under five-year-olds.5

The reduction between 2015 and 2018 may reflect changing attitudes due to sustained efforts, led by clinicians, to discourage inappropriate antimicrobial use.6 Through our collective experience with COVID-19, it is hoped there is now greater public awareness that antibiotics do not help viral illnesses.

KEY POINTS

- Antimicrobial stewardship (AMS) is about optimally managing infections and minimising antimicrobial-related harms, including antimicrobial resistance (AMR),

The task is to build on these gains, particularly in primary health care. What limited resources there are to support appropriate antimicrobial use focus on public hospitals rather than community health care.[6] Ironically, 95 per cent of our antimicrobial use is in the community[7] and up to half of this may be inappropriate.[8]

The purpose of this article is to provide an overview of the ongoing high-level initiatives for improving antimicrobial stewardship and the New Zealand antimicrobial prescribing landscape as it stands. It also outlines actions that can immediately improve in primary health care:

- ensuring good antimicrobial handling and prescribing practice, including the addition of a meaningful indication on every antimicrobial prescription
- addressing penicillin allergy.

toxicity and cost.

- Good AMS practice includes putting a meaningful indication for antimicrobial use on prescriptions, ie stating what specific condition the drug is for.
- Incorrectly labelling patients as having a penicillin allergy can cause harm as this often leads to them being prescribed second-line antibiotics that are less effective, broader spectrum and/or more toxic than penicillins.
- There is a push for national leadership and coordinated efforts to improve AMS.

Initiatives and leadership in Aotearoa New Zealand

The Government, health-care system and population of New Zealand have received international praise for their collective response to the COVID-19 pandemic. It is urgent that an equally commendable strategy be implemented to counter the gradually developing – but also likely as catastrophic – pandemic of antimicrobial resistance.

"AMR is the developed resistance of a microorganism (bacterium, virus, fungus or parasite) to an antimicrobial agent that it was originally susceptible to. AMR occurs naturally, but is facilitated by antimicrobial use, and inadequate infection prevention and control." [6]

The core required strategy of antimicrobial stewardship is an established concept, which has

been implemented with greater success in many other countries, including Australia.

"AMS aims to optimise the use of antimicrobial agents in the prevention and treatment of infections, and minimise the potential harms that may result from their use including AMR, adverse drug reactions and excessive health-care costs. An AMS programme includes governance, surveillance of the quantity and quality of antimicrobial use, education and training, and implementation of quality improvement initiatives."[6]

In New Zealand, the development of an AMS strategy to be implemented across the health sector has been slow, siloed, often conflicting and, in areas of primary care, lacking. The new Ngā Paerewa Health and Disability Services Standard sets minimum AMS requirements that some service providers (eg residential care and public hospitals) must meet to be certified under the Health and Disability Services (Safety) Act 2001.[9]

Not all primary care is included in this standard, but this could be rectified by developing a separate clinical care standard for antimicrobial stewardship that applies to all who prescribe, dispense or administer antimicrobials.[6]

AMS and infection prevention and control (IPC) are two human-health components within a wider New Zealand AMR action plan. This plan sets out a One Health approach to addressing AMR that acknowledges relationships between human health, animal health, agriculture and the environment.[2]

Nearing the end of this five-year action plan, progress in human health has been poor.[6] Despite the science and solutions being clear (New Zealand is a member of the Global Health Assembly and is aligned with The Tripartite Global Action Plan on Antimicrobial Resistance 2015),[10] implementation has fallen short. Almost none of the recommendations in the 2017 action plan have been put into place, even though the "bar was set low" to see what could be achieved without additional investment.[2]

What nurses can do

Nurse prescribers have a clear role in ensuring good antimicrobial stewardship. Non-prescribing nurses in primary care can also support the appropriate use of antimicrobials by:

- communicating with patients and prescribers
- explaining to patients that antibiotics are not useful for viral infections
- understanding that they shouldn't be used "just in case"
- reviewing patients' penicillin "allergy"
- encouraging documentation of indication on the script and ensuring short courses where appropriate.

Opinion leaders – including Te Whatu Ora Health New Zealand AMS pharmacists, infectious disease physicians, clinical microbiologists, IPC nursing specialists and other experts – continue to push for national leadership and coordinated efforts on AMS, most recently in a 2021 *New Zealand Medical Journal* viewpoint.[6]

A key stakeholder group, the New Zealand Antimicrobial Stewardship and Infection Pharmacist Expert Group (NAMSIPEG), has also led promotion of good AMS practices and activities for World Antimicrobial Awareness Week (WAAW).[11] For 2020, it led a national initiative to improve indication documentation on antimicrobial prescriptions, and for 2021 a national initiative focusing on penicillin allergy.[12,13,14] These are component parts to AMS and are applicable in primary care.

For WAAW 2022 (November 18-24), NAMSIPEG promoted best practice for the disposal of antimicrobials.

Prescribing landscape for antimicrobials in Aotearoa New Zealand

The implications of AMR for New Zealanders and the imminent threat it represents have been made plain by the Royal Society Te Apārangi in 2017[15] and the Office of the Prime Minister's Chief Science Advisor in 2021.[2]

Estimates suggest, without urgent action, infections due to resistant microorganisms could kill 10 million people globally each year by 2050.[16] Using a predictive model, a systematic analysis published this year in *The Lancet* has already estimated that approximately 6.3 million deaths globally in 2019 were attributable to, or associated with, bacterial AMR.[17]

The consequences of increases in AMR for New Zealand will be enormous, given the reliance we have on effective antimicrobial therapy throughout medicine. What is certain is that AMR will disproportionately impact the most socioeconomically disadvantaged New Zealanders.[2]

Rates of some infections, including sepsis, in Māori and Pacific peoples are about twice those in people of European descent and other ethnic groups, and rates are significantly above average in the youngest, oldest and most deprived population groups.[18]

One of the biggest drivers for AMR is antimicrobial use. Antimicrobial use in New Zealand human populations is high compared with many developed countries.[7,19] New Zealand has:

- the fourth highest level of antibiotic prescribing (measured in defined daily dose per 1000 people) in 2017, surpassed only by Greece, Italy, and Korea[2,3]

- a community antibacterial consumption rate that increased 49 per cent between 2006 and 2014[19]

- near-universal (97 per cent) antibiotic exposure by school age[20]

- 95 per cent of human antibiotic use in the community.[7]

Small positive trends can be found. Over three years (2015 to 2018), community antibiotic use reduced by 14 per cent, mainly due to reductions in children under five years old.[5] And during the 2020 lockdown, antimicrobial use decreased considerably, by 36 per cent, without evidence of harm.[4] Thus, much of the previous "usual" antibiotic use may have been for viral respiratory tract infections, and unnecessary.

Antimicrobials are the only class of medicine where the treatment decisions made for an individual have broader ramifications for their whānau and the wider community.

The consequence of antimicrobial use is that it produces selection pressure on the microbial environment and promotes a proliferation of resistant strains with the potential for harm.[1] Some bacteria have become multi-resistant, ie they are resistant to more than one antibiotic. These include methicillin-resistant *Staphylococcus aureus* (MRSA) and ciprofloxacin-resistant *Neisseria gonorrhoeae* which already challenge clinical care in this country.

However, the steadily increasing incidence of infections caused by multi-resistant Enterobacterales, such as *Escherichia coli* and *Klebsiella pneumoniae*, in hospitalised and community patients, is of greatest concern.[20,21,22]

- Extended spectrum β-lactamase-producing Enterobacterales (ESBL-E) are resistant to most penicillins and cephalosporins, and often also to other unrelated agents like trimethoprim and ciprofloxacin.

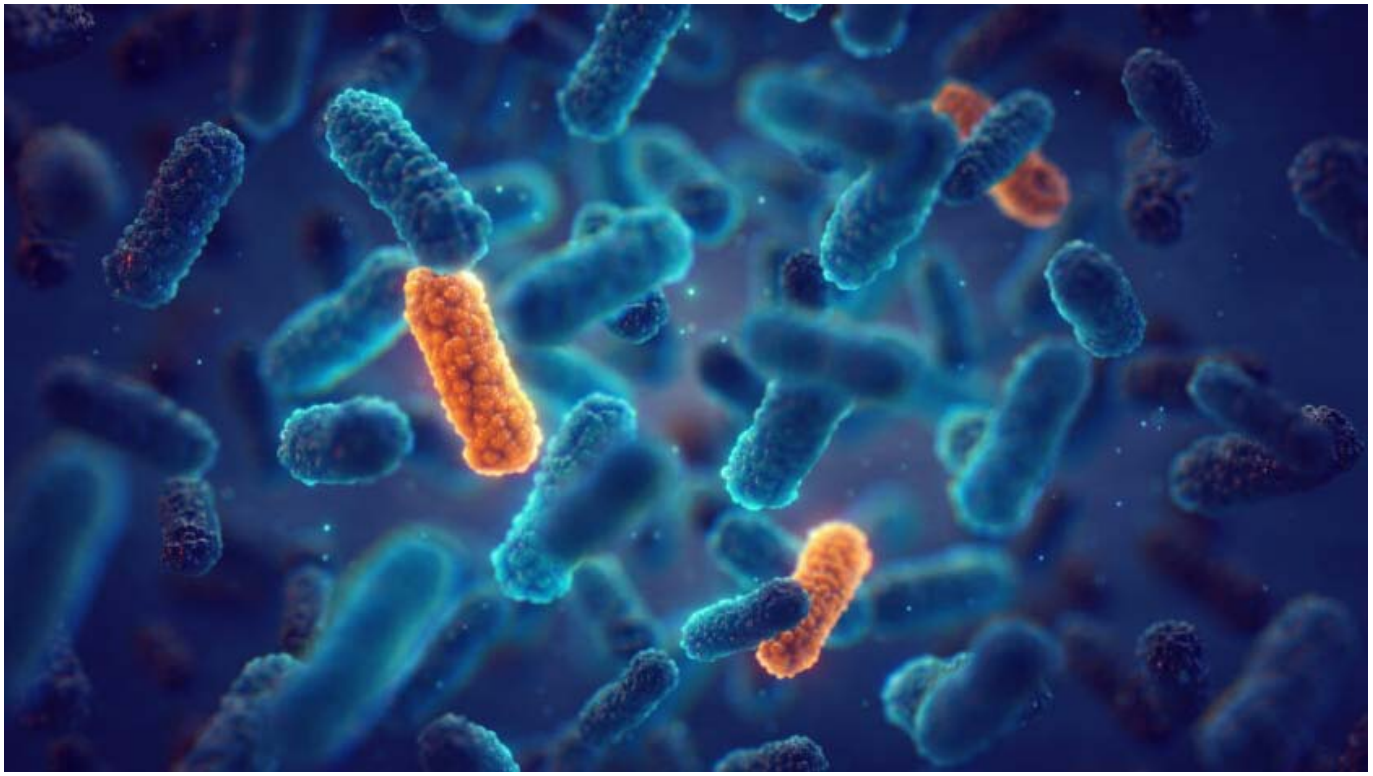
- Carbapenemase-producing Enterobacterales (CPE) are resistant to almost all antimicrobial agents, including "ultra-broad-spectrum" carbapenems (a sub family of β-lactams mainly used in hospitals), and have 30 to 50 per cent mortality when they cause invasive infections.[23] The Institute of Environmental Science and Research (ESR) recorded a greater than 10-fold increase in identified CPE isolates during 2010–2019.[22]

At the patient–clinician level, the impact of an infection due to a multi-resistant pathogen

means:

- reduced, and in some cases no, effective funded oral antimicrobials (this is increasingly seen with cystitis due to ESBL-E in the community)
- reduced efficacy when using second-line antimicrobials
- higher toxicity and rates of adverse effects from the use of second-line agents
- increased costs and inconvenience for patients who need hospital visits for antimicrobial therapy (affecting rural/low socioeconomic groups disproportionately)
- longer hospital stays
- poorer outcomes from surgery (eg, joint replacement), cancer care and other interventions
- increased mortality
- elevated health-care costs.[6]

In addition to the selection pressure for AMR caused by antimicrobial use, adverse drug events (ADE) are also common when antimicrobials are used. A 2017 study found 20 per cent of hospitalised patients in the United States receiving at least 24 hours of antibiotic therapy developed an antibiotic-associated ADE. Moreover, 20 per cent of ADEs were attributable to antibiotics prescribed for conditions for which antibiotics were not indicated.[24]



Use of antimicrobial drugs kills susceptible organisms (those in blue in the diagram) but leaves resistant organisms (in orange) free to proliferate. GRAPHIC: ADOBE STOCK

The overarching goal of AMS is wider than counteracting AMR alone – it is to improve patient outcomes as well. Prescribing a first-line antibiotic choice, where one is indicated and appropriate, helps to improve patient outcomes, partly by reducing the risk of ADEs.

Non-β-lactam antibiotics are commonly used as second-choice agents, but they carry a raised ADE risk, eg, hyperkalaemia with trimethoprim + sulfamethoxazole. Adverse effects with quinolone antibiotic use are numerous and they have led to US Food and Drug Administration[25] and European Medicines Agency[26] warnings regarding their use. First-line antibiotic prescribing helps to avoid this risk.

Patient outcome is also impacted by the effect of antibiotic use on the microbiome, which can result in greater risk for infection associated with *Clostridioides difficile* (formerly named *Clostridium difficile*) or candida.

Antimicrobials are the only class of medicine where the treatment decisions made for an individual have broader ramifications for their whānau and the wider community. This means that decisions about treating infections affect the outcomes for patients in general, not just the one sitting in front of you.

Good prescribing practice and defined indications

Antimicrobial stewardship involves coordinated strategies designed to measure and support appropriate antimicrobial use. The overarching aims are to improve patient outcomes by

managing infections optimally while minimising antimicrobial-related harms, including AMR, toxicity and cost.

Among the strategies for AMS lies a central principle – one that can be applied as well by all prescribers in primary health care as it can in the hospital setting. That is, understanding the indication for antimicrobial use underpins all assessments of the quality (appropriateness) of antimicrobial prescribing, including guidelines compliance.

Inclusion of a meaningful indication for antimicrobial use on the prescription is a key quality indicator for AMS as it promotes good practice and outcomes (see panel). There is no nationally set target for this indicator, but NAMSIPEG recommends aiming for ≥95 per cent of prescriptions being annotated with a meaningful indication (this aligns with the equivalent quality indicator used in Australia).[13]

The importance of a meaningful indication

Prescriptions for antimicrobials should include a meaningful indication — ie, they should clearly specify what condition the drug is intended to treat. This will:

- promote thoughtful antimicrobial prescribing
- facilitate communication between health-care providers, and with patients
- support timely reassessment of the ongoing appropriateness of antimicrobial use
- provide justification for non-guideline-compliant prescribing
- reduce patient harm from inappropriate antimicrobial use and errors from prescription misinterpretation
- assist quality improvement initiatives and auditing.

A meaningful indication for antimicrobial use on the prescription means being specific. For a urinary tract infection for example, rather than using a very general term like “for infection”, examples of meaningful terms include “cystitis”, “lower UTI” or “pyelonephritis”.

The following further considerations can help make sure both the antimicrobial and the patient are “handled with care”:

- Only use the antimicrobial if the benefits outweigh the harms – never “just in case” or to

alleviate "worry".

- If the antimicrobial is warranted, use it optimally – the "right" agent, dose, route and duration.

- Use the prescription to justify antimicrobial use – document a meaningful indication (see panel above).

- Determine and document the treatment duration or a review date – most courses should be short and sharp (check local guidelines and engage with specialty services if needed).

- If the patient has a documented "penicillin allergy", consider a review of how this was determined (see the following section on penicillin allergy to decide whether a challenge to its veracity is appropriate).

De-labelling penicillin allergy

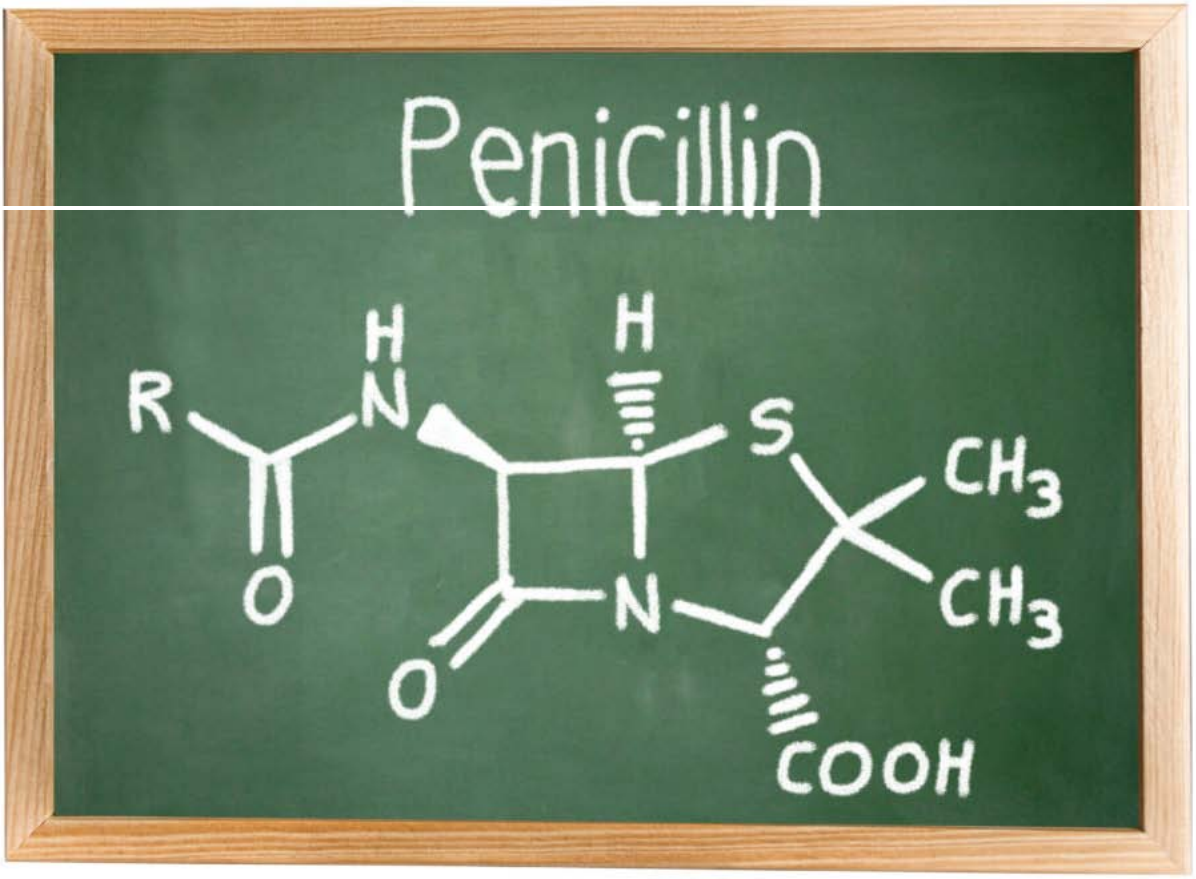
Penicillins are a group of antibiotics that are often a first-choice treatment for infection because they tend to be more effective and cause fewer problems such as side effects.

Nevertheless, penicillin allergy is the most common adverse drug reaction to be reported. However, our understanding of this has evolved in recent years.

While approximately 10 per cent of adults believe they are allergic to penicillin, about 90 per cent of these people do not have a true immune-mediated allergy. Reactions such as nausea, diarrhoea or thrush often occur with antibiotics but are side effects, not allergies.

If the patient has a documented 'penicillin allergy', consider a review of how this was determined.

A further point to consider is that antibiotic allergies will often resolve over time – approximately 50 per cent of skin-prick test-positive penicillin allergies are lost over five years, and about 85 per cent over 10 years.[14] Consequently, a reaction to penicillin during a childhood infection is unlikely to be a true allergy in adulthood.



A childhood reaction to penicillin may often be outgrown in adulthood. GRAPHIC: ADOBE STOCK

However, with any history of presumed immune-mediated reaction (eg, a delayed non-severe reaction or mild rash), an oral rechallenge with low-dose penicillin (usually amoxicillin) can be used to confirm safety before prescribing a therapeutic course. This is usually done in hospital.27

Incorrect "penicillin allergy" labels on patients' records cause harm as they often lead to the use of second-line antibiotics that are less effective, broader spectrum and/or more toxic.14

Having a penicillin allergy label has been associated with:

- an increased risk of *Clostridioides difficile*, methicillin-resistant *Staphylococcus aureus* (MRSA), and vancomycin-resistant enterococci infections and colonisation
- increased use of broad-spectrum antibiotics, contributing to AMR
- lengthier hospital stays
- higher hospital readmission rates
- surgical site infections
- admissions to intensive care units.27

A study of 2.3 million general practice adult patients in the United Kingdom found penicillin allergy labels are associated with a significantly increased risk of death in the following year

(relative risk 1.08), re-prescription of a new antibiotic class within 28 days (RR 1.32), and MRSA infection or colonisation (RR 1.90), when compared with patients with no penicillin allergy label.[27]

Based on the numbers, most patient penicillin-allergy labels can be removed, but the heart of the matter for primary health care is — which ones can be safely removed with a patient interview and notes review alone?

> **Only use an antimicrobial if the benefits outweigh the harms – never 'just in case' or to alleviate 'worry'.**

Formal referral pathways for oral challenges are not yet established for primary care. Thus, a focus on patients in the "negligible risk" category is needed; they may be de-labelled following an interview and notes review alone (with no need for oral amoxicillin challenge or engagement with specialty services). Check, however, for local policies or guidelines.

The medical records for patients at "negligible risk" for removing the penicillin allergy label will reflect the penicillin having caused one or more of the following:

- expected gastrointestinal side effects (eg, nausea, vomiting, diarrhoea)
- thrush (any kind)
- mild, reversible kidney, liver or neurological dysfunction
- allergy reported but the same antibiotic tolerated subsequently
- family history of penicillin allergy only.

Patients can be reminded why penicillins are useful and effective — this and many other helpful patient messages can be found in a resource (http://tinyurl.com/pen-allergy) produced by NAMSIPEG.[28]

Where a true immune-mediated penicillin allergy is reasonably considered to exist, this does not mean other β-lactam antibiotics cannot be used –

Reading this article and reflecting on its content can equate to one hour of CPD time. *Nurses can use the Nursing Council's professional development activities template (https://www.nursingcouncil.org*

sometimes, they can be. Cross-reactivity is less than 2 per cent with cephalosporins and less than 1 per cent with carbapenems but this varies with chemical structure. Advice from infectious diseases and/orimmunology specialists should be sought.

It is also worth noting that the blood-testing laboratory can sometimes offer additional antibiotic choices for a patient with severe penicillin allergy as they may notrelease all susceptibility results initially. NPS Medicinewise provides a practical approach (https://www.nps.org.au/australian-prescriber/articles/penicillin-allergy-a-practical-approach-to-assessment-and-prescribing) to assessment and prescribing with penicillin allergy.29

.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.

This article was reviewed for He Ako Hiringa (https://www.akohiringa.co.nz/) by ***Sharon Gardiner, BPharm(Hons), MClinPharm, PhD,*** *who is the antimicrobial stewardship pharmacist at Te Whatu Ora Waitaha Canterbury and co-leadof the New Zealand Antimicrobial Stewardship and Infection Pharmacist Expert Group (NAMSIPEG).*

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Tags

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Kaitiaki
NURSING NEW ZEALAND

NEWS

Interim pay equity lift brings celebration, relief and disbelief

BY CATE MACINTOSH

December 16, 2022

Nurses employed by Te Whatu Ora are welcoming a lift to their pay rates as an interim measure to recognise gender-pay discrimination — but many remain sceptical.

"I had two feelings, one was delight, and the second one was 'yeah, but . . . what am I going to lose'," Hawkes Bay registered nurse (RN) Gail Hussey said.

A lack of trust in Te Whatu Ora would remain as a result of previous broken promises to ensure pay equity and safe staffing, Hussey said.

"At every negotiation for many years, we've said 'we're being undervalued' and they've gone 'yeah, we really respect and value our workforce', but they don't put anything into action."

Registered nurses Gail Hussey and her daughter Samantha

On Monday, Te Whatu Ora applied to the Employment Relations Authority (ERA) for interim orders to increase pay to rates it had offered in late 2021.

Two days later, ERA member Helen Doyle made the orders and said NZNO's case about the correct pay equity rates would continue to be heard.

The increased interim rates and a lump-sum payment of $3000 will be backdated to March 7, 2022.

Te Whatu Ora chief executive Fepulea'i Margie Apa said it would aim to make the payments "early in the first quarter of 2023".

"Paying out these rates would address a legitimate claim for a key part of the health workforce that has been undervalued for too long."

Te Whatu Ora chief executive Fepulea'i Margie Apa said pay equity rate increases would be a priority.

Te Whatu Ora's offer was not ratified by Tōpūtanga Tupuhi Kaitiaki o Aotearoa New Zealand Nurses Organisation (NZNO), as the rates failed to meet pay equity requirements and back pay to December 2019 was not included.

NZNO members voted to take the issue to the ERA in April, and made a claim for back pay to December 2019 in the Employment Court.

NZNO's lawyer Peter Cranney said at various points, NZNO asked Te Whatu Ora to make the interim pay increases, while the legal processes were carried out to determine the final pay equity rates.

MEMBER REACTIONS TO INTERIM PAY EQUITY UPLIFT

"Never look a gift horse in the mouth . . . But watch it very closely in case it bites!! [Te Whatu Ora] could have done this way earlier – it's election year bribery, desperation and a failure to acknowledge they were wrong." **Tracy Chisholm, RN Waikato Hospital emergency department**

"NZNO said to them, 'Look, we've had a disagreement here, but you yourselves are saying that the agreement-in-principle rates are equal to pay equity. Now, we don't agree with that, but why don't you just pay that amount first then we'll work out the difference later?

Employment lawyer Peter Cranney is representing NZNO in the pay equity cases in the Employment Relations Authority and the Employment Court.

"Eventually, they decided to do it."

The interim pay rate increases vary across nursing roles from 4.5 per cent for senior nurses, to 14.6 per cent for RNs on step 7.

NZNO's Te Whatu Ora bargaining team has a claim for health care assistants who work in mental health to be paid as mental health care assistants.

For health-care assistants on the highest pay step (5), pay rates will increase from $53,803 to $61,540 — a lift of 14.4 per cent.

RNs on the highest pay step (7) will gain a 14.6 per cent lift in pay from $83,186 to $95,340.

Hussey, who is an NZNO delegate and on step 7, said the pay increase would mean she could save more for her retirement. She is also hoping to be able to take out private medical insurance . . . "because I don't really want to be a patient in our public health system".

"Members are frustrated that our employer is now playing [the] hero after 'punishing us' for a year, but most just need the increase and no longer care how we get it." **Anonymous**

"I'm in a senior position so the increase is only minimal. At the same time, I'm really happy for other people. I see colleagues who are really struggling, children at home, rising costs, mortgage, interest rate rises, groceries, fuel, everything is going up, up, up so hopefully it will be a help for those people." **Jane Swift, specialist clinical nurse, Te Whatu Ora MidCentral community mental health and addiction service**

"Excuse me while I say f$&# yeah! . . . Made my day." **Trish Sangster, RN, Christchurch Hospital, Facebook post.**

"I thought it's good news, but straight away the thought that follows is there's an election next year . . . so, I don't think it was out of any respect for nurses. In any case it's a good move but it really has to be accompanied

The pay lift would be more significant for her daughter, an emergency nurse, currently on maternity leave.

"I'm really pleased for her, because when she goes back next year she will have that little bit more money."

NZNO chief executive Paul Goulter said the interim pay equity increases were a step in the right direction.

NZNO chief executive Paul Goulter said the interim orders were a "step in the right direction towards the goal of just wages for the 36,000 or so NZNO members who work for Te Whatu Ora, and who have been unjustly denied equality for a long time".

by the back pay to December 2019, and a further increase [in the final ERA decision]."
Sam Mojel, RN, critical care team, Auckland City Hospital

"Just want to see it in our bank account. We have been promised so much that has not been delivered in the past four years by this health employer and government."
Anonymous member, Facebook post

Asked by *Kaitiaki* why the pay adjustment had not been made earlier, Te Whatu Ora board chair Rob Campbell said the agency didn't think it was possible "without impacting" on the legal proceedings.

"More recently we got some advice that this was an avenue we could use and that really rose out of discussions before the ERA that this was an option."

Carolyn Watson, an intensive care unit RN at Palmerston North Hospital, who is the sole earner for her family, said the interim rates and lump sum were very welcome.

As an RN on step 7, Watson's pay will increase by 14.6 per cent from $83,186 to $95,340.

"This would make a very real difference to my family – and that is why I voted to accept the offer originally and not go to the ERA, even

Te Whatu Ora board chair Rob Campbell said the agency received advice recently that it could apply

though it was unjust."

for the interim pay changes to be made.

"Life has become very difficult financially,
especially recently, and every fortnight I manage to pay all the bills but am always down to my last $20 before my pay goes in and I often have to dip into the account I try to save into, in order to make ends meet."

Watson said while she was thankful for the increase, it was "a real shame" the legal action was necessary and that Te Whatu Ora had not dealt with nurses fairly in the first instance.

Pay equity rates in NZNO's claim, submitted to the ERA, are significantly higher than those offered by Te Whatu Ora. Senior nurse and nurse practitioner rates were based on the pay equity process, and maintaining their seniority in relation to RNs.

Cranney said the process used by the Crown to determine the rates didn't comply with the Equal Pay Act and the Crown had also used out-of-date comparator salaries.

He said Te Whatu Ora was making the interim pay increases to avoid further damage to a frail and desperately understaffed health system.

"They can see the damage that it's causing – people are leaving, people aren't getting enough money to live on, people can't afford to live and work in a hospital, and they're seeing the damage that it's causing."

Current, interim, proposed (NZNO) pay equity rates

The table below shows the top rates for different nursing pay scales to be paid as an interim measure towards pay equity.

Role	Current rate	Interim rate	% increase on current rate	NZNO proposed rate (to ERA)	% increase on current rate
Health Care Assistant Step 5	$53,803	$61,540	14.4%	$79,622	48%
Mental Health Care Assistant Step 5 (this role is not specified in current NZNO collective agreement)*	$60,610	$65,334	7.8%	$94,441	55.8%
Enrolled Nurse Step 5	$62,847	$73,609	17.1%	$95,375	51.7%

Role	Current rate	Interim rate	% increase on current rate	NZNO proposed rate (to ERA)	% increase on current rate
Registered Nurse Step 7	$83,186	$95,340	14.6%	$110,917	33%
Senior Nurse roles, Grade 6 – top step	$115,946	$121,161	4.5%	$151,167	30%
Senior Nurse Grade 8 and Nurse Practitioner- top step	$136,453	$143,718	5.3%	$169,440	24%

Sources: Te Whatu Ora examples of agreement in principle pay rates (https://www.tewhatuora.govt.nz/whats-happening/what-to-expect/for-the-health-workforce/employment-relations/nurses-pay-equity/#examples-of-agreement-in-principle-pay-rates), and NZNO pay equity update 22-09-2022 (https://nzno.createsend.com/campaigns/reports/viewCampaign.aspx?d=r&c=89CAB931C3EC7887&ID=02A31700175F7C7B2540EF23F30FEDED), new nursing pay equity base rates filed with the ERA.

* A previous version of this story first published on Monday December 19 did not include the explanation in brackets. Amended on Wednesday December 21, 2022.

Tags

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Kaitiaki
NURSING NEW ZEALAND

FEATURES

It’s cool to kōrero – December

BY KATHY STODART

December 14, 2022

Kei te whiti mai a Tama-nui-te-rā. – The sun is shining.

The dawn light touches Aotearoa, taking it from te pō (the world of darkness) to te ao marama (the world of light).
IMAGE: ADOBE STOCK

it's cool to
kōrero

Haere mai, and welcome to the "kōrero" column for Hakihea (December). The sun, with its light and warmth, brings life, and has a powerful presence in Māori culture and mythology.

The story goes that the sun used to travel very rapidly across the sky, in its haste to get to bed, leaving a scant few hours of daylight for the tasks of daily life.

The hero Maui and his brothers used flax ropes to catch the sun and beat him with a magic jawbone to make him submit. From then on, the sun travelled slowly across the sky.

One of NZ Post's 2021 Matariki stamps depicts Maui and his brothers harnessing Tama-nui-te-rā.

Māori musician and academic Te Ahukaramū Charles Royal says that because traditional Māori saw the sun's birth, its journey across the sky, and its death repeated every day, they saw it as a basic principle of the world. The sun represented the birth

and growth of mana.

He says that on the marae, a speaker will often announce themselves in this way:

Tihē mauriora
Ki te whaiao, ki Te Ao Mārama

The breath, the energy of life
To the dawnlight, to the world of light

"If the orator's words offer guidance and wisdom, he brings his audience out of the 'night' of conflict and into the 'day' of peace and resolution," Royal says.

Kopu hou (new word)

- **Te rā** (the sun, the day) — *pronounced te (as in ten) rrraa*
- **Kei te whiti mai a Tama-nui-te-rā.** – The sun is shining.

More words related to the sun:

- **Tama-nui-te-rā** — the Māori sun god
- **Hineraumati** — one of the sun's two wives, with whom the sun spends the summer
- **Hinetakurua** — the sun's winter wife
- **Te ao mārama** — the world of light, the world of understanding, the natural world
- **pūhihi/hunu** — a ray of the sun
- **rerenga** — the sun's journey, rising or setting
- **whitinga o te rā** — sunrise
- **tōnga o te rā** — sunset
- **tūhoehoe** — high (of the sun's position)
- **uranga** — the glowing, rising or setting of the sun
- **te ao** — the light
- **te pō** — the darkness

E mihi ana ki a Titihuia Pakeho rāua ko Mairi Lucas.

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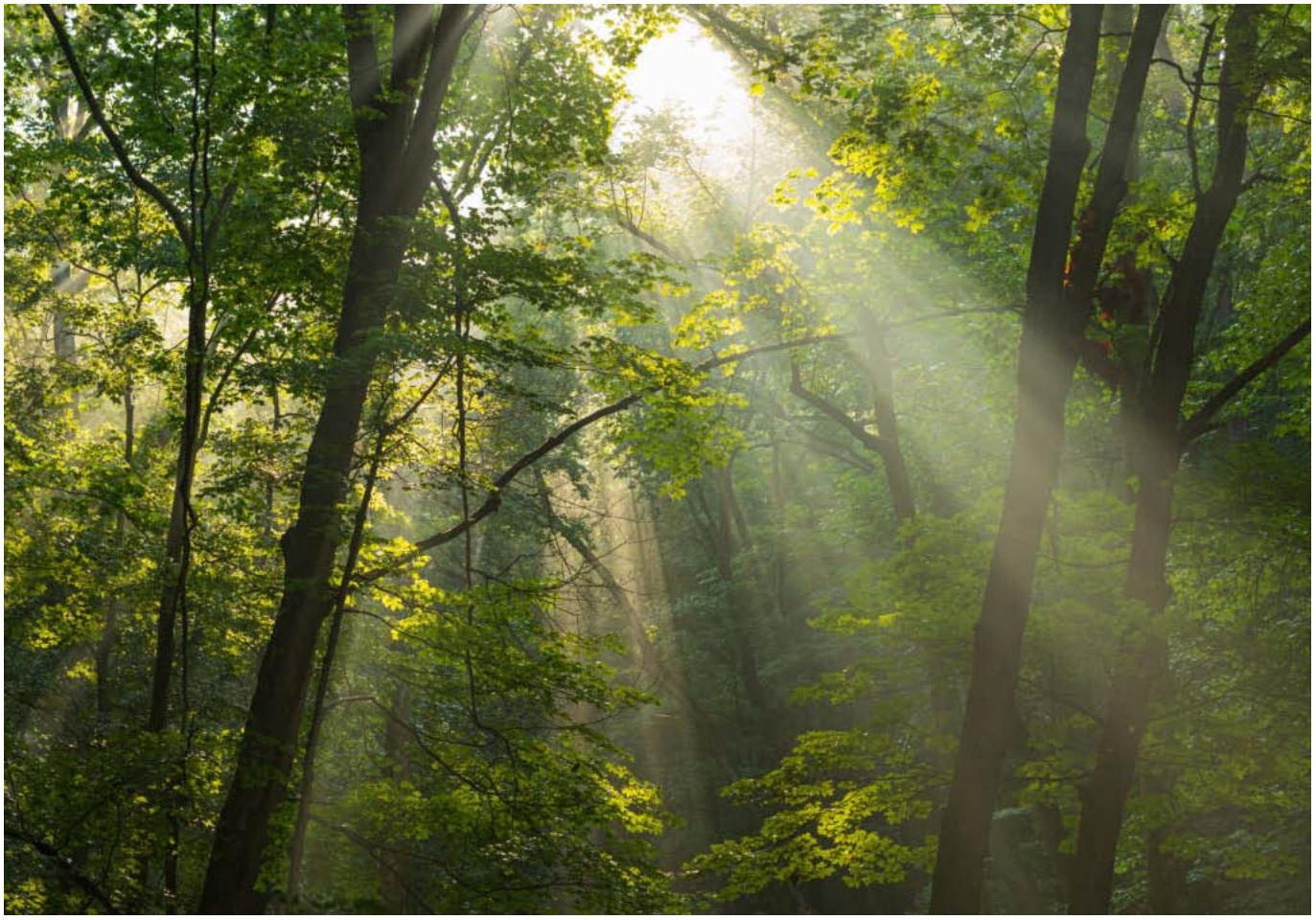

Pūhihi, a ray of sunlight, breaks through the bush. PHOTO: ADOBE STOCK

Sunrise in rural Waikato. PHOTO: ADOBE STOCK

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Kaitiaki
NURSING NEW ZEALAND

MARANGA MAI!

Maranga Mai! Rowing towards change on the same waka

BY CATE MACINTOSH

December 8, 2022

At the heart of Maranga Mai! – NZNO's campaign to fix the nursing crisis – are individual members who are empowered to act collectively for change. The goal is "building member power" by growing the membership, and increasing member support for each other, to gain permanent solutions to the health care crisis.

Health care assistant Leah Baterbonia

Aged care centre health care assistant Leah Baterbonia and two colleagues took their concerns about short staffing to their local MP.

- Baterbonia said it was important members understood what their rights are.
- Visiting an MP to raise their concerns was empowering for members, and encouraging for those who couldn't participate.
- Talking to one another regularly was key to gather information and ideas for collective action.

Crisis resolution mental health nurse Jayne Daly

Staffing in a Christchurch crisis resolution mental health team is 25 per cent down on required staff. On a recent shift there was only four staff rostered on. It was the tipping point for Daly, who initiated a meeting with senior management.

- Taking part in a collective action, including attending meetings, helped team members feel their concerns were shared.
- The action was taken by members from NZNO and the PSA, and this increased the impact when they met with management.
- Getting support from an NZNO organiser helped the busy members through the process, and to keep the momentum going.

Health care assistant Dave Dawson

Dave and his fellow delegates and members at Summerset by the Sea in Katikati, took their grave concerns about staffing and culture to the company's chief executive.

- Building the confidence of members to take or support an action takes time, as some need reassurance they will be safe from serious negative consequences.
- An NZNO organiser and professional nursing advisor supported members to take action, and this had been a huge help.
- Members who were fearful of taking action were ab le to participate by signing a group letter to the chief executive, and were further comforted by having the support of NZNO, who sent the letter on their behalf.

On an overcast Friday afternoon in November, about nine crisis resolution staff gathered in a

meeting room on the Hillmorton Hospital specialist mental health service campus in Christchurch.

NZNO delegate and RN Jayne Daly summed up the wider goal of the meeting.

"I'd like to see staff that are happy to come to work and not staff that are distressed and just quitting."

It's a familiar lament, and one that is driving a surge of collective action in diverse nursing workplaces around the motu.

Members face unprecedented staffing shortages – in some cases with managers who refuse to acknowledge or act on the situation.

> **"We are all in the same waka, rowing against the tide of disrespect, low wages, health and safety risks and being taken for granted."**

Actions include visiting a local MP, writing a letter to senior management, requesting a meeting with senior management, boycotting additional shift requests, posting public updates on staff numbers in hospitals, and holding rallies and strikes.

Under the banner of Maranga Mai! Rise Up! members are being encouraged to join together to take action in their workplaces, and support those in other sectors, who are fighting for the same things.

Daly said she organised a member meeting after learning, on a recent shift handover, she would be one of just four staff for that shift. Staff numbers per shift have dropped consistently – from up to 12 per shift, to just six – over the past two years. But Daly was incensed the number had dropped even lower on that night, to four.

"I said we can't carry on like this."

The team managed the workload without incident, with extra staff from other areas filling in until 8pm, Daly said.

But the staff shortage created huge stress, and was not safe or sustainable.

"There's a genuine fear of an adverse event," Daly

Crisis resolution mental health nurse and NZNO delegate Jayne Daly said members worked together to escalate their concerns to senior management.

said.

The crisis resolution team works with those suffering acute levels of mental distress and illness and operates 24/7 over three shifts. Staff provide in-person assessments, treatment in the community, and referrals to other services, with patients under care for several weeks.

Patient numbers for the service should, ideally, be capped at 80, but at times have exceeded 120, Daly said.

With the support of NZNO and organiser John Miller Daly called an urgent meeting of members.

> **"I'd like to see staff that are happy to come to work and not staff that are distressed and just quitting."**

About 22 turned up, with many expressing their distress and concern over the situation.

Members of the Public Service Association (PSA) also joined the meeting, and together they agreed to request a meeting with senior management.

A sub-group of several members attended and asked for a review of the service and changes to reduce demand, without compromising patient safety, and clarification over steps to take when staff were overwhelmed by demand.

Since then there had been two positive meetings with senior management, Daly said.

Management has committed to weekly meetings, in recognition of the severity of the problems faced by members.

"It's good that the problems are being openly discussed now, and there are attempts to address them."

All in the same waka

"Building member power" was a key component of the Maranga Mai! campaign, Tōpūtanga

Topuhi Kaitiaki o Aotearoa New Zealand Nurses Organisation (NZNO) chief executive Paul Goulter said.

The goal was to increase membership, engagement, participation and cross-sector support to build leverage for change, locally and nationally.

"We are all in the same waka, rowing against the tide of disrespect, low wages, health and safety risks and being taken for granted," Goulter said.

He's confident members will participate, even as they face extreme workplace stress.

"Yes, they are tired and fatigued, but they're passionate about doing their jobs properly, and being supported to do that, and that's not happening at the moment, so they will go out and fight for it."

Tōpūtanga Tapuhi Kaitiaki o Aotearoa – New Zealand Nursing Organisation chief executive Paul Goulter.

Towards member-driven action

NZNO (acting) associate industrial services team manager Lynley Mulrine agreed, saying building member power was a "long game".

"Once you participate and get a win, it encourages everyone to keep the pressure on the employer."

Demonstrating and building member power did not always mean going on strike, or organising a big event, Mulrine said.

NZNO (Acting) associate industrial services manager Lynley Mulrine said building collective power was a "long game".

NZNO industrial services manager Glenda Alexander said NZNO was shifting focus towards a more member-driven model.

Restrictions on union activity that flowed from the Employment Contracts Act in 1991, contributed to a focus on "getting the bargaining for collective contracts done, rather than building up member power behind the issues", she said.

Alexander said collective action needed to be led by members.

"So, it's inverting that model to say we're [staff] here to support you guys, doing what you need to do."

Think local, act national

In Hawkes Bay, members and caregivers at Oceania care home, Eversley, took their concerns to Tukituki Labour MP Anna Lorck, with support from organiser Stephanie Thomas in early November.

Staff at the small aged-care facility have become increasingly despondent over poor management and unsafe staffing.

Health care assistant (HCA) Leah Baterbonia, who has worked at the home part-time for 13 years, said things had changed for the worse this year.

She felt efforts to raise the issue of short-staffing at the facility had been ignored.

With the issue impacting the whole aged-care sector, Baterbonia, Thomas and two other Eversley HCA members decided to pay Lorck a visit.

Lorck told the group she would "see what she could do", but defended the Government's record on health care, pointing to funding approved for a new hospital in the region, Thomas said.

Health care assistants and NZNO members Josiah Lam, Nicky Tong and Leah Baterbonia with Labour MP for Tukituki Anna Lorck (second from left).

Baterbonia said the visit gave her and the other members confidence they could go to their local representative and was a good demonstration of solidarity for their colleagues.

On November 28, the Government announced it would provide $200 million per year towards a pay rise for workers in aged care, hospices and Māori and Pacific health care organisations.

Baterbonia said things had become desperate with staff unable to take leave and expected to care for up to 15 patients each on some occasions.

She said 15 staff had quit in the past five months, and some described their workplace as "a living hell".

"One said, 'I don't want to come to work any more. Every time I walk in the door, I want to go home'. "

Lorck said she hadn't raised the issue of short staffing in aged care directly with the minister following the meeting with the members. But she said MPs discussed issues in health and were "aware of all the issues raised", including staff shortages.

"I think [the Eversley members'] presentation represented what they were seeing on the front line and how we need to continue to value the work that they do. As the local MP, I'm continuing to talk to them, that's what I should do."

Lorck said it was important workers were represented by unions to address issues arising in individual workplaces.

"As an MP I don't get involved in those issues."

Health care assistant Leah Baterbonia visited her local MP with two colleagues to advocate for urgent improvements.

‘I’ve never seen morale so low’

Another group of members, who work at Summerset by the Sea in Katikati, a small town in the Bay of Plenty, have been plagued by staffing issues and what they say is poor management.

In some cases staff were getting less hours than they were contracted for, with management under utilising casuals – a situation that resulted in unsafe staffing, and a strained workplace culture, delegate Dave Dawson said.

“There was a culture of toxicity and people were getting really fed up.”

After unsuccessful attempts to raise the issue with local managers, the members wrote to NZNO Veronica Luca for support. Of 33 staff, 28 signed a letter outlining the issues they wanted addressed, Dawson said.

Health care assistant Dave Dawson on the job at Summerset by the Sea, Katikati. The NZNO delegate has been supporting members to take collective action for change.

“That’s a phenomenal result. I didn’t coerce anyone, I said if you want to move forward, we’ve got to do something, and this is what we can do.”

Some staff had been reluctant to get involved, fearing there would be negative consequences, Dawson said.

Luca arranged a meeting in early July, at which delegates presented their concerns to local and national management.

Summerset committed to agreed actions to address the issues including health and safety training, rosters created in line with contract commitments, minimum staff to patient ratios, respectful communications, an open door policy for staff concerns, an increase in advertising for staff, and education sessions from a NZNO professional nursing advisor.

Advertising and education commitments were delivered – but other commitments were ignored, Luca said.

As a result, members wrote directly to the CEO with their concerns in late July.

But the company took an approach of "delay, delay, delay, defend, deny", Luca said.

> **"It's good that the problems are being openly discussed now, and there are attempts to address them."**

"There was ongoing resistance from Summerset to carry out the agreed changes and improve the workplace. In fact conditions worsened."

Instead of addressing the issues in a constructive way, management initiated disciplinary action against staff, based on false allegations, Luca said.

In October, she sent an email with a formal complaint from a member, and all the correspondence between the union and the company in the previous months.

Dawson said members were surprised, and heartened when the company initiated a workplace culture review in November.

He hoped real change would eventuate as staff morale was the worst he'd seen in his seven years at the care home.

Dawson and Luca said if changes failed to materialise, members planned to escalate collective and individual actions, including an approach to media and taking personal grievances in the new year.

Tags

Click to search for related articles: membership, collective action, Maranga Mai!

Kaitiaki
NURSING NEW ZEALAND

NEWS

New Zealand ‘preferred destination’ for overseas nurses after visa changes

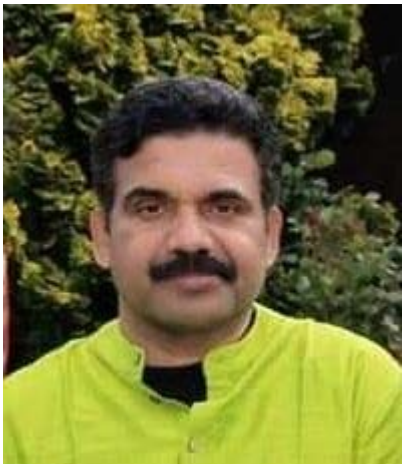
BY MARY LONGMORE

December 22, 2022

Migrant nurses are welcoming the Government’s move to put them on the straight-to-residency visa – but say they should have been included from the start.

ADOBESTOCK

Manawātu nurse and NZNO board member Saju Cherian, who is



Saju Cherian

from India, said New Zealand was now the "preferred destination" for overseas nurses thanks to the visa change — alongside recent pay parity and pay equity commitments.

However, the New Zealand nursing workforce crisis "would have been eased if nurses were in the green list from the beginning", he said.

Immigration Minister Michael Wood announced this month (https://www.rnz.co.nz/news/political/480579/nurses-eligible-for-immediate-residency-under-immigration-changes) that from December 15 nurses and midwives would be eligible for the straight-to-residency green list, alongside their doctor colleagues. This would allow them to apply for residency immediately, rather than wait two years as previously required – a decision tagged "sexist" (https://www.stuff.co.nz/national/health/128611289/midwives-and-nurses-flabbergasted-over-sexist-immigration-changes) at the time by NZNO and midwifery leaders.

Cherian said the Indian community was "very happy" with the move, which would allow many families to reunite and stay in New Zealand. One nurse had already dropped plans to move to Australia now she would be able to move her family over here as a resident. Another said it was a great relief as gaining residency status meant her husband could now resign from his job in the Middle East and join her, he said.

Tania Mullane

Whitireia's head of Pacific nursing Tania Mullane said the news was "fantastic".

"It's definitely a positive for Pacific Island-trained nurses which gives them opportunities to come to New Zealand to live and work."

Auckland-based nurse Melody Opanes-Kircher, who administers an 84,000-strong Facebook group for Filipino nurses, said it was "big news", sparking huge interest amongst members.

"There is a global shortage and New Zealand needs to be competitive," she said. "This news will certainly attract nurses to stay and settle here."

Japan, the United Kingdom and Germany had all made it easier for internationally-qualified nurses (IQNs) to work there, with fast processing, guaranteed jobs and

work visas. New Zealand still did not yet offer all they did, but the latest move made it more attractive, Opanes-Kircher said.

Melody Opanes-Kircher

NZNO chief executive Paul Goulter said he was "pleased" with the move, which followed NZNO's campaign, Maranga Mai!, to resolve nursing shortages.

"It was a key part of Maranga Mai! and we're pleased to see the Government finally listening and putting nurses on the fast track to residency."

But it was essential the IQNs were given cultural competency training and paid the same as their peers, he said.

"Wherever they end up working, we need to make sure there is pay parity being achieved as soon as possible for them, following Andrew [Little]'s announcement."


Andrew Little

Minister of Health Andrew Little said in November he will invest $200 million per year to bring in pay parity for nurses working in aged care, hospices, community and Pacific and Māori health providers, so they would be paid the same as Te Whatu Ora nurses. Practice nurses were not included in the deal at this stage, as Little said there was not the same evidence of pay disparity.

Cultural competency training

In response to high numbers of IQNs applying for Kiwi nurse registration, Nursing Council was bringing in interim cultural competency training in 2023, and this would likely be online, chief executive Catherine Byrne said.

New permanent introductory training to nursing in Aotearoa, including te Tiriti and cultural safety, is due to be launched in 2024. The Council was still looking at a range of options, Byrne said.

More than 4000 IQNs had applied for New Zealand registration over the past six months – nearly double that of the first half of the year and "... given the Government's recent immigration announcements it is likely that the Council will continue to receive high numbers of applications through 2023".

To compare, in 2019/2020, the Council registered 2768 IQNs over the entire year, 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," Byrne said in September.

Te Whatu Ora chair Rob Campbell said while the new setting would not be a "magic pill" for short-staffing, it would make New Zealand more attractive for internationally trained nurses. "We think it will be very helpful and it's something we wanted to see."

Catherine Byrne

Cherian said he believed the change had been helped by NZNO's "strong advocacy". However, concerns remained over a lack of timeframes on the Immigration NZ website and the cost of a residency application – which had doubled to $4290.

Nurses have generally welcomed a move by Te Whatu Ora earlier this month to give them interim pay equity rates while the battle for higher rates and two years' of back pay continues between NZNO and Te Whatu Ora in the Employment Relations Authority and Employment Court, consecutively.

See also: Maranga Mai! Immigration — What needs to change?

Tags

Click to search for related articles: internationally-qualified-nurses

Kaitiaki
NURSING NEW ZEALAND

NEWS

Pay equity battle: ‘There are people in need at the end of this process’

BY CATE MACINTOSH

December 8, 2022

Australian union lawyer and researcher Lisa Heap is lending her experience in the battle for pay equity, alongside employment lawyer Peter Cranney. Heap spoke to *Kaitiaki* about her trans-Tasman work to achieve pay justice for caring professions.

Heap, 54, has been at the coal-face representing female-dominated sectors in the battle to gain equal pay on both sides of the Tasman.

Melbourne-based Heap is working with Wellington employment lawyer Peter Cranney on the NZNO Tōpūtanga Tupuhi Kaitiaki o Aotearoa and Public Service Association (PSA) pay equity case (https://www.nzno.org.nz/dhbpayequity#updates).

Heap couldn't speak in detail about the NZNO/PSA case for legal reasons but acknowledged frustrations over slow processes, saying work was needed in both countries to make them more efficient.

" . . . no one should be glib about this. I get somewhat frustrated when people labour the point about needing to dot all our 'i's and cross all our 't's and . . . make sure it's a robust process, and yes to all that, but let's not forget there are people in need at the end of this process."

In a video update to members in September (https://www.youtube.com/watch?v=kCkTCNS328Q&list=PLUw2YayYode9Q9JzU6DerSklKegvg7N_L&index=2), Cranney said new rates and a review mechanism could be determined by the authority in January or February next year – but only if the employer agreed to retain previous work completed by the parties.

The dispute over new equitable pay rates is before the Employment Relations Authority (ERA), which will decide the new rates after hearing from both parties.

Meanwhile a dispute over the agreed implementation date for any settlement and backpay, is before the Employment Court.

Next week (November 22-24) the ERA will hear evidence from lead witness, NZNO industrial adviser David Wait, outlining the union's case for its proposed rates.

Born and raised in Perth, Western Australia, Heap says her upbringing in a "very working-class" family came with a strong understanding of the important role unions played in the lives of working people.

She recently celebrated 30 years as a union official in various roles and across multiple unions.

Melbourne-based union lawyer and researcher Lisa Heap.

Heap was introduced to Cranney by the PSA in 2015. They have become allies in the pay equity movement since then.

Heap's first foray into pay equity was a long legal campaign for members of the Australian Services Union in community services roles. The ASU won pay increases in Queensland of 23-45 per cent in 2009, and nationally in 2012. She argued the members had been underpaid because they were a predominantly female workforce, subject to historical undervaluation because of the caring nature of their work.

Cranney, who led the Kristine Bartlett case on behalf of New Zealand unions, cited Heap's work in his arguments during that case. In 2017, the New Zealand Supreme Court found gender bias was the cause of Barlett's low wages as a carer in the aged care sector. The Government intervened to negotiate a settlement which lifted the pay of all care and support workers in aged care by 15-50 per cent.

Heap was principal advisor for the PSA for a pay equity claim by administration workers employed by district health boards settled last year. That resulted in pay rises of 13-40 per cent for those workers.

This year, for the first time, nurses on both sides of the Tasman have launched legal action to achieve pay equity.

The Australian Nurses and Midwifery Federation applied to the Australian employment regulator, the Fair Work Commission (FWC), for a 25 per cent increase in wages for aged-care nurses.

"It's no coincidence that this work, predominantly done by women, has been historically undervalued," ANMF federal secretary Annie Butler said in a media statement at the time of the first hearings in April.

Last week the FWC announced an interim pay increase for some aged-care nursing roles of 15 per cent, in recognition they had been undervalued.

Wellington-based employment lawyer Peter Cranney is representing NZNO and PSA members in pay equity proceedings.

The final outcome from the case is likely to be known next year.

Heap said a crisis in staffing for care work, including nursing, around the world in the wake of the COVID-19 pandemic has brought its undervaluation into the spotlight.

Protestors at the July, 2021 strike rally in Wellington.

"The fact that the union movement in both countries is taking hold of that question, and pushing forward on it, can only be seen as beneficial to that global conversation around what are we going to do to make it a more attractive place to work."

Heap said in cases where pay equity had been achieved, the results were often life-changing.

She encouraged NZNO members to "keep fighting for what should have been there all along".

"I would say, for all women who are in this situation where their work is undervalued, to hold true to the belief that your work is worth more and that it needs to be addressed, and there are mechanisms to address that . . . and to keep the pressure on so they can't be ignored."

Tags

Click to search for related articles: pay equity

Kaitiaki
NURSING NEW ZEALAND

NEWS

Report shows funding gap of nine per cent for general practices

BY CATE MACINTOSH

December 23, 2022

As primary health care nurses grit their teeth to hold out for a better pay deal in the new year, a report commissioned by the interim health transition unit shows their employers are woefully underfunded.

"A future capitation funding approach" (https://dpmc.govt.nz/sites/default/files/2022-11/HTU-future-capitation-funding-approach.pdf) by research company Sapere found that to provide the current level of service, the average general practice needs nine per cent more revenue (including funding and patient fee) just to break even.

If general practices were to provide a higher level of service — an option needed to address unmet need and inequity — most would need a median funding lift of between 10 and 20 per cent.

Primary health services not fit for purpose – for Māori

NZNO kaiwhakahaere Kerri Nuku

Tōpūtanga Tupuhi Kaitiaki o Aotearoa NZNO kaiwhakahaere Kerri Nuku said the Sapere report was a step in the right direction as the capitation funding model

for primary health-care (PHC) services was inadequate.

However, she said it didn't take into account cultural/tikanga or hauora measures of wellbeing, and only considered medical models.

Nuku questioned the ability of the general practice system to deliver more innovative models to respond to community needs including culturally appropriate services for Māori.

She fully supported all nurses receiving pay parity, but was not sure about where the funding should come from to achieve this, due to a lack of transparency.

"[GPs] are a private business so they don't have the same level of transparency as you do in the public domain."

The WAI 2575 claim against te Tiriti breaches, in which NZNO was a claimant, clearly established that funding for the PHC system disadvantaged providers "that predominantly serve high-needs populations, particularly Māori primary health organisations and

providers".

The system had advantaged general practice owners, who were not required to demonstrate the adequacy of services and outcomes for Māori.

A WAI 2575 stage one report in 2019 recommended the Government conduct "an urgent and thorough review of funding for primary health care, to align it more closely with the aim of achieving equitable health outcomes for Māori".

Nuku said she hoped this would look at the wider issues of improved service provision, and not just increasing funding for the same providers and services.

"Yes, [the capitation] funding model is not fit-for-purpose — however, neither is the primary health care model fit for consumers."

Primary Health Care nurses went on strike for four hours in October to call for the Government to fund their employers for pay parity.

An increase of between 34 and 231 per cent in revenue would be needed for practices serving communities with very high health needs.

> **"We find that total status quo general practice revenue lies below the likely true cost of delivering care at current levels."**

Minister of Health Andrew Little said GPs were excluded from a $200 million pay parity announcement as there was not enough evidence of a pay disparity with hospital peers.

General practices have repeatedly said they cannot support a pay parity deal with nurses under the Primary Health Care (PHC) MECA as they don't receive enough Government funding, and their ability to increase fees is constrained by legislation.

A three per cent lift to capitation funding this year was passed on to PHC members in bargaining for a new MECA. The offer was rejected.

Despite a strike and rallies calling for pay parity, a $200m annual funding package for primary care to receive pay parity on November 28 excluded nurses who work for general practices.

Minister of Health Andrew Little said there wasn't "any real evidence of pay difference at this point".

The Sapere report was submitted on July 5 this year — but wasn't released for another four-and-a half months later by Little.

What's wrong with general practice funding?

The report addressed "a number of fundamental problems with the existing formula", its authors said. "The Wai 2575 claim (https://forms.justice.govt.nz/search/Documents/WT/wt_DOC_152801817/Hauora%20W.pdf) has established clearly that the current funding mechanism for primary health care is inequitable."

Sapere's approach factored in age, sex, ethnicity, deprivation and morbidity of patients, and the time clinicians spend with a patient, rather than the number of consultations. It uses a higher level of care and cost for Māori, Pacific people and those with the highest level of socio-economic deprivation — as a form of redress for the inequity.

The results were stark.

"We find that total status quo general practice revenue lies below the likely true cost of delivering care at current levels.

"This is consistent with widespread anecdotal evidence of constraint in general practice services, with difficulty recruiting and retaining the workforce, and rising barriers for access to care (such as delays in being able to make appointments and practices declining to enrol new patients)."

Christchurch PHC members attend a rally for pay parity.

Calls for change ignored

Health officials continued defending the existing funding formula, official information provided to *Kaitiaki* shows.

Groups representing general practices lobbied the Government to ditch the funding model for an alternative they had developed which better reflected financial realities, and would support pay parity — but this was ignored.

In an April memo to the Ministry of Health, GPs said parties to the contract for general practice services (providers and district health boards) had already agreed the existing funding formula was "not fit-for-purpose".

Christchurch PHC members vote to strike at a stop work meeting in October.

Use of the flawed system resulted in cost pressures being unfunded for six to 18 months and vastly underestimated the true workforce costs, they said.

In May this year the group tried again, this time writing to the interim Māori Health Authority and Health NZ.

Despite this, Te Whatu Ora used the current model and advised of the capitation funding increase on May 30. It was confirmed at a meeting on June 1.

GPs profiting?

GenPro, which represents a group of GP owners, and is party to the PHC MECA, continued its advocacy for pay parity in a letter to Little on October 17.

In response, Te Whatu Ora advised the Minister "there is sufficient funding in the system to settle the current PHC MECA bargaining", documents show.

> **"...it is anticipated that this funding has generated a healthy rate of return for general practice owners."**

Advisors pointed to anecdotal feedback that some GPs were already paying at or above hospital MECA rates, "and can afford to do so".

They said funding of over $8m in immunisation services this year, was provided to fund nursing workforce cost pressures.

A three per cent lift in capitation funding provided an additional $86.3 million, of which $52.6 million would be available for pay parity, estimated to cost $7.7 million.

On top of that, they argued, over $460 million had been made available for COVID-19 services (excluding testing and vaccinations) since 2019/2020.

" . . . it is anticipated that this funding has generated a healthy rate of return for general practice owners."

When will the Government review PHC services and funding?

The Government has committed to an overhaul of the way general practice is funded, following a recommendation that came out of the WAI 2575 claim in 2019, but Te Whatu Ora has not provided a timeline for this, to date.

Te Whatu Ora board chair Rob Campbell said the Sapere report findings were not a priority, and producing a conclusion about a new funding model was still "months away" at a media briefing after the report was released, *Business Desk* reported. (https://businessdesk.co.nz/article/business-of-health/gps-need-funding-increase-of-up-to-231-to-be-viable-review-finds)

Te Whatu Ora board chair Rob Campbell said

What's next for PHC pay parity?

"producing a conclusion" on primary care funding was still months away.

On December 12, NZNO PHC MECA representatives met with employers, but were unable to make further progress on pay negotiations without a commitment from the Government for extra funding, NZNO industrial advocate Danielle Davies said.

The Minister's decision to exclude general practice and Whānau Awhina Plunket from the $200m funding for pay parity, "left us all with a bitter taste, as we know that some of our members are paid more than 10 per cent less than their Te Whatu Ora colleagues".

A new pay survey of PHC members drew more than 1000 responses, and the information will be used to show a definitive pay disparity with Te Whatu Ora members, Davies said.

NZNO president Anne Daniels said the Sapere report was very clear about the funding problems, and what changes needed to occur.

"It's not rocket science and needs to be done, it's just that simple."

She said the report did not include rural and after hours services, so more work was needed to address those.

It also highlighted the critical need to improve the supply of PHC workers, and the distribution of services both geographically and demographically.

"I believe this is a real opportunity for the Government — for student nurses to be bonded to rural or after-hours services so that they can recruit and retain nurses to those areas, and to incentivise nurse practitioner, GP, rural and after-hours services."

Tags

Click to search for related articles: pay parity, PHC MECA, General practice

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NEWS

Strength ‘tinged with sadness’ – Lesley Elliott remembered by nursing colleagues

BY MARY LONGMORE

December 13, 2022

Kind, caring – and incredibly strong. That is how colleagues from the close-knit neonatal intensive care (NICU) at Dunedin Hospital remember Lesley Elliott.

Lesley Elliott in Sophie's bedroom, with the quilt made by her neonatal nursing colleagues. PHOTO: STUFF.

Elliott died on November 20, aged 76, after enduring Parkinson's disease and dementia in her final years.

She had been a neonatal nurse for 33 years, continuing to work at the NICU after her daughter, Sophie Elliott, was murdered by ex-boyfriend and former tutor Clayton Weatherston in 2008.

Elliott drew much comfort and strength from her nursing colleagues and friends – many of whom had worked together since the 1970s.

"I remember her saying that that's a stable part of her life and she took a lot of comfort from staying on and working there as well as venturing out on her new ventures," Elliott's former charge nurse at the NICU, Jan Seuseu, told *Kaitiaki Nursing New Zealand*. "We were all a very close-knit group, so we all did keep in touch. In early years, all our families grew up [together] and we got to know each others' families.

Jan Seuseu

"Sophie, of course, was the apple of her eye, and her two older brothers. And we used to hear all the details day-to-day about them."

Barbara Findlay

Retired NICU nurse Barbara Findlay said Sophie's death deeply affected the whole team.

"It was hard – we were all in shock, as Lesley was, for a long time. But I think, if anything, it pulled us closer together, and we all supported each other."

NICU staff did everything they could for Elliott in the wake of her daughter's death. "People came forward and asked if they could donate some of their leave to her, to support her, which was a lovely thing, which we did allow to happen," Seuseu said.

Staff also made a patchwork quilt for Elliott – "everyone did a patch" – and spent a few days sewing it together, which was a healing experience, Findlay said.

'She stood up for what she believed in'

A very strong person, Elliott had always been prepared to stand up for her beliefs, colleagues said.

In the 2000s, she fought to ensure obstetric nurses' scope of practice was recognised. Current NICU charge nurse Juliet Manning said Elliott campaigned against a 2003 Nursing Council proposal that obstetric nurses (ONs) be scoped as enrolled nurses. "The end result was the ability of ONs to apply to Nursing Council for a change of condition to their scope of practice."

Elliott herself applied in 2005, and was scoped as a registered nurse.

"She went to Nursing Council, she went to Government over it – she's always been the type of person who stood up for what she believed in," Seuseu said.

NICU course graduation, 1990. Lesley Elliott is front row, at left. Jan Seuseu is also in the centre at very back. (Photo courtesy of Dunedin NICU)

"So she got all that settled and then they [then-Otago Health Board] came out and said that obstetric nurses couldn't work in neonatal intensive care units, which is where she was working," Seuseu recalls. "So once again she went into battle."

Eventually, Elliott and colleagues successfully argued on the basis of their experience they should be able to remain working in NICU, Manning said.

‘Sophie, of course, was the apple of her eye, and her two older brothers. And we used to hear all the details day-to-day about them.’

Sophie and Lesley Elliott, as pictured in Lesley’s book ‘Sophie’s Legacy’ about her daughter’s death and the challenges of dealing with the justice system.

Elliott came to NICU in the late 1970s, from the Queen Mary Hospital obstetric unit, later becoming a lactation consultant to both. “Once again, she gave all she had to that, keeping her role in NICU at the same time,” Seuseu recalls.

Granted honorary NZNO membership after her retirement in 2016, Elliott had been an NZNO delegate and involved with the former NZNO obstetric section for many years. She had also been on NZNO’s Southern Regional Council on the NZNO board as a director and vice-president. She had also been the recipient of two NZNO awards, for national services to nursing and midwifery and services to NZNO.

Lesley Elliott circa 2010, from the NICU staff noticeboard. ‘She faced things, she faced it all,’ say colleagues.

Strength ‘tinged with sadness’

Seuseu said Elliott always had “huge” amounts of energy and fortitude, even after the death of her daughter.

“She certainly did still have that strength and determination but it was very much tinged with sadness,” Seuseu said.

Findlay said Elliott still wanted to have conversations about her workmates’ children, despite the pain it must have caused her.

“It was hard as a lot of us had children the same age as Sophie – [my son] was the same age and there were one or two others as well,” she said. “When she asked what they were doing and the achievements that our children had, and you think ‘oh, Sophie would have been doing this’.”

But Elliott was always willing to talk about it, "she never shied away from it", Findlay said. "She faced things, she faced it all."

NICU conference organising committee in 2004. Lesley is on the far right and Jan Seuseu third from left.

For the next eight years before she retired, she juggled nursing work with domestic violence advocacy, ploughing her energy into the Sophie Elliott Foundation she set up to raise awareness of abusive relationships, and colleagues saw less of her, Seuseu said. Elliot travelled around the country talking to young people about the signs of abuse and how to have healthy, safe relationships.

'She wasn't dwelling on what had happened any longer, she was back in the early days, which we thought was a real blessing.'

With author Bill O'Brien, Elliott also wrote the books '*Sophie's Legacy (https://www.penguin.co.nz/books/sophies-legacy-9781869795962)*', about her experience, and '*Loves Me Not* (https://www.penguin.co.nz/books/loves-me-not-9781775536017)', about safe vs abusive relationships. While the Foundation closed in 2019 as Parkinson's disease took its toll on her, the ensuing Loves-Me-Not school programme (https://www.police.govt.nz/advice-services/personal-community-safety/school-portal/resources/successful-relationships/loves-me) to prevent abusive relationships continues, now run by New Zealand Police.

Elliott also invited people over to see Sophie's room, which many couldn't cope with – and where the NICU quilt lay. But says Findlay, "it was a very healing thing to do."

"It was a remembrance of Sophie and a shrine to her life. She was very keen for as many people to go to the house and, after I'd been, I thought 'I'm pleased I did that'."

NICU dinner, likely late 1980s (Lesley at front on right). Photo courtesy Dunedin NICU.

Elliott was exceptionally kind and caring, "she was a fabulous person," Seuseu said. "The parents loved her, they enjoyed it when she was looking after the babies."

Findlay also remembers Elliott as "meticulous and very organised . . . Whenever she went to a conference or study day, the next day there would be written up in our communication book a very detailed account."

Elliott retired from nursing in 2016, aged 70, and had been in care in recent years as her Parkinson's disease worsened and dementia set in.

Friends who visited said that in recent weeks, Elliott did not always recognise people, and was living in a past where Sophie was still with her, Seuseu said.

"She remembers Sophie as a little girl, and she says 'I'll go and tell Sophie this or Sophie that', so she obviously wasn't dwelling on what had happened any longer, she was back in the early days, which we thought was a real blessing."

Kaitiaki
NURSING NEW ZEALAND

FEATURES

Working at a local meat works, getting pregnant – or nursing

BY CATE MACINTOSH

December 12, 2022

Nursing was an escape route from rural poverty and boredom into a world of service for Margaret Hand. She spoke to *Kaitiaki* about her passion to help vulnerable whānau for a series on the board directors.

Margaret Hand, 56, doesn't sugar coat her explanation of why she studied nursing.

"To get out of Dargaville, really. There weren't many jobs and if you stayed there you'd just get pregnant."

But nearly four decades later, she has a slow-burning plan to call the Te Tai Tokorau township home again.

Margaret Hand said her whānau became disconnected with their cultural connections through the upheavals of displacement and poverty.

NZNO board director Margaret Hand is a practice nurse in Whanagarei and Dargaville.

Every Monday the nurse practitioner travels south-west from her home in Whangārei, to Dargaville to work for iwi health provider Te Ha Oranga.

She and her husband are in the process of building a house in the district, where they have bought some land.

At 13, Hand moved to Dargaville from Auckland

with her two brothers, and cousins when her grandfather retired from his job with the railways.

The family didn't own a car and lived at Omarari Beach, about 40km from the township so she rode a horse part of the way to school.

Hand was born in Auckland – the second of three children and only daughter – but began her life in Timaru, her Pākeha father's home town.

Things changed abruptly when her mother died after falling from a moving car when Hand was just two years old.

Her nan – who had probably never been on a plane before" – arrived from Auckland to take the three children into her care, despite already having two of her own children and three grand-children to care for.

Hand says her childhood was marked by poverty, illness and the early death of three family members including her mother, by the time she was 18.

Her uncle, a promising rugby player, died from a brain haemorrhage at age 17, after suffering concussion in a game.

In her first year of nursing studies, Hand's younger brother died at 16. He had battled with an enlarged heart since birth, and had spent countless hours in Greenlane Hospital, Hand said.

She remembers feeding his leftover hospital food to the seagulls on the way home.

Her grandparent's youngest child was severely disabled and suffered a brain injury in a hit and run accident and required full-time care.

Hand's maternal grandparents had moved to Auckland from Dargaville after the war, for her grandfather's job.

Despite her grandparents being fluent in te reo Maori, Hand rarely heard them speak the language growing up.

NZNO board member Margaret Hand pictured here (right) with her two brothers.

" ... all of that generation had been stopped from speaking Māori.

"It affected our whole generation, my grandparents only spoke it when they went back to the marae."

Poverty marked her whanau apart from others in the neighbourhood, and was the dominant factor in Hand's sense of identity, she says.

Margaret Hand was raised by her Nan, pictured here with Hand's son.

"It was more like the haves and the have nots, we were pretty poor, and Newmarket is quite an affluent area, so there was a good education there but some days you didn't have lunch, or there were days when you'd go without dinner."

In her younger years, Hand and her brothers moved between their aunt and uncle's home in Wellington, and the grandparents in Auckland.

Nursing – a way out of poverty and boredom

After finishing school, Hand says there were many offers of work in factories in Auckland, where cousins and friends were making good money.

"But I thought I just don't see myself working in a factory, I was a bit of a snob I guess."

Hand signed up to study nursing and began the bachelor's degree at NorthTech in Whangārei in 1986. She was one of six Māori students in the course.

"It was just great, we had a fantastic time, probably drank too much, and I enjoyed the three years of training because I had really amazing friends."

NZNO board member Margaret Hand (far right) with fellow nursing students in Whangārei.

After graduating, Hand worked at Whangārei Hospital, starting in medical and surgical wards before moving to the Intensive Care Unit (ICU). She took up a public health nursing role in Dargaville for a couple of years, before returning to ICU.

Tragedy struck in her mid-30s when her ex-partner and the father of their children died in the ICU ward Hand was working in.

The couple had separated two years earlier but remained close.

"He had a bowel transplant, and he got pneumonia, and then septicemia and went into cardiac arrest."

Hand was with him in the ambulance and when he passed away in the ward.

Time on the thin blue line

Left to raise their children alone, Hand continued with a plan to switch careers and enrolled for training in the police force.

She worked as a police officer for the next four years while keeping up her nursing registration with casual hospital and ambulance shifts.

Despite the radical career change, Hand says both roles were about serving the community and making a difference to people's lives.

Hand said she was looking for a new challenge at that stage of her life.

But as she progressed in the police, the lack of flexibility while juggling "a house, a mortgage and kids" became unworkable and she returned to nursing.

Margaret Hand switched careers from nursing to the police force. She later moved back to nursing.

Hand took up a role with an iwi provider, in cardiac rehabilitation for two years, while continuing with casual hospital work.

In 2008 she took up a role at Maori/iwi nurse-led health clinic, Hau Awhiowhio ō Otangarei Trust, where she works today.

What has changed, what has stayed the same?

Hand said it was disappointing more had not been achieved to reduce poverty since she was a child.

"It's sad to say, but I don't think, with the families that I work with, it's any different to when I was growing up."

She welcomed the health reforms, but said there was still no concrete plan to address inequities.

"Rurally we're suffering because they haven't thought about the life-long planning of the workforce, not just for nurses but for all health providers.

"I can boldly say that with the low representation of Maori healthcare workers in Northland, a lot of our people have died early as a result.

"I've got aunties and uncles that have died in their 40s, that should be living in their 70s now."

NZNO board director Margaret Hand (centre) with her children, Joshua and Italy.

Hand said she hoped a cultural resurgence among Maori would bring equal rights for health services and outcomes, following the example of Dame Whina Cooper in the area of land rights.

As an NZNO Toputanga Tupuhi Kaitiaki O Aotearoa board director. Hand said she would be advocating for the Government to address child poverty and health inequities.

"As a board, if we can hold people accountable, we're a force to be reckoned with. We need to rattle the cages to get some traction."

She has seen the impact holistic nursing can make on individuals, and their whole whānau, when they are treated with respect and dignity.

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