Kaitiaki
NURSING NEW ZEALAND

NEWS

‘I feel like s…’ – vote for three per cent wage relief leaves sour taste

BY CATE MACINTOSH

January 27, 2023

Desperate Whānau Āwhina Plunket members have voted to accept a three per cent lift in pay which they previously rejected, to stave off further financial hardship. They are now putting their hope in a pay parity top up which the Minister of Health has committed to.

For one Whānau Āwhina Plunket member – a single parent – buying everything on her children’s school stationery list is out of reach.

“I feel embarrassed about this, knowing the school will email me and ask for ‘all stationery’.”

Pleas from the children to do gymnastics after school have gone unanswered – that is “just not affordable for me”. She knows school camps and other education-related requests will be coming, and that leaves her feeling “stressed”.

“I love my job and am very grateful, however it would be extremely beneficial if I could build some savings, get my kids the basics, pay for all their schooling necessities.”

The Whānau Āwhina Plunket bargaining team:(from left) Wendy Dawson, Kathy Greenstreet, Tracey Haughey, Lauren Erdbeer, Debs Radley, Sharon Armstrong, and Hannah Cook.

The community worker, who did not want to be identified, is one of about 700 members employed by the not-for-profit organisation, who voted to accept a three per cent wage rise – an offer previously rejected – this week.

Members under the agreement include registered nurses (RNs), clinical educators, community (Karitane) workers and administrators, who support the physical, mental and social wellbeing of whānau and their young tamariki. The organisation is the largest well-child services provider in New Zealand.

The new agreement includes a wage increase of less than half the inflation rate of 7.2 per cent as at the end of January, and backpay to July 2022 (rather than March 2022 when the previous agreement expired). It expires on June 30 this year.

> **"In all my years of bargaining I have never experienced that."**

NZNO industrial advisor Danielle Davies said inflation had started to rise when the previous Whānau Āwhina Plunket agreement was signed in July 2021.

The upwards trajectory continued steadily until the agreement's expiry on March 1, 2022 when it was 6.9 per cent. By June last year, when negotiations for a new agreement were underway, the consumer price index (CPI) reached its highest point in decades at 7.3 per cent.

"This is why the members came to delegates [in December] and said: 'Can you put that back to a vote?' "

NZNO industrial advisor Danielle Davies.

Davies said the request to vote again on an unchanged offer was highly unusual and underscored the financial pain members were experiencing.

"In all my years of bargaining, I have never experienced that."

Members believe the new pay deal is not fair or adequate, but say they could not wait any longer for some financial relief.

Whānau Āwhina Plunket relies heavily on government funding and says the current levels would not cover parity rates with the NZNO/Te Whatu Ora collective agreement, which they support in principle.

"I feel like s... sometimes to be honest, I feel pretty hopeless."

In November, Minister of Health Andrew Little said the first groups to benefit from pay parity funding would be those in aged care, hospices, homecare support and Māori and Pacific health-care organisations "because there is clear evidence that that is where the biggest pay gap is".

"I expect these contract changes will happen in the first part of next year, followed by mental health and addiction facilities, organisations caring for the disabled and other types of residential care, and then other government-funded health services."

Government response

In response to an enquiry by *Kaitiaki*, Little confirmed Whānau Āwhina Plunket nurses were included in the pay parity funding.

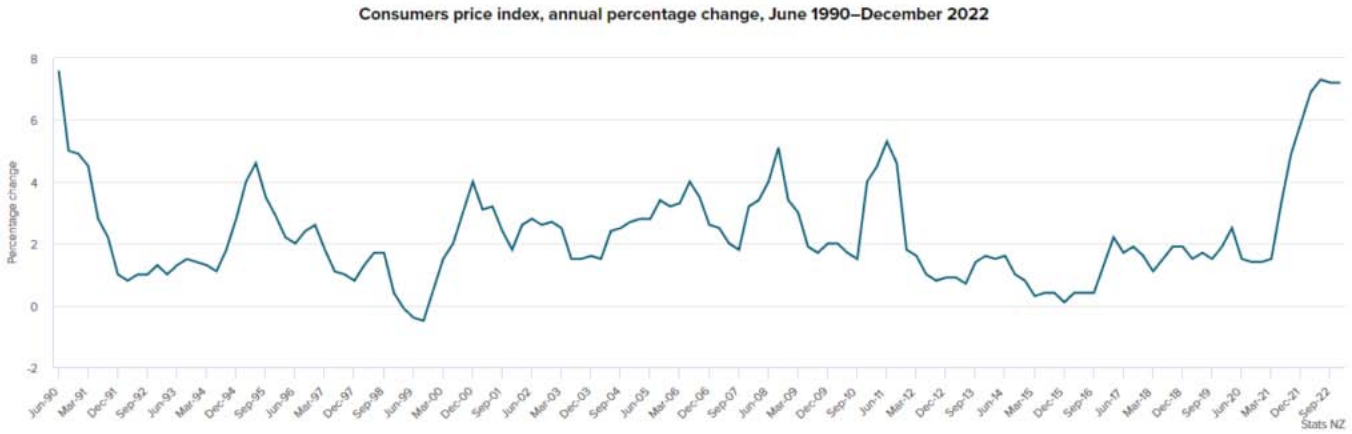
Te Whatu Ora primary, community and rural national commissioning interim director Emma Prestidge said Te Whatu Ora was "aiming for the new funding to be . . . passed on to the nurses from 1 July, 2023".

"Whānau Āwhina Plunket delivers a valued service across the motu and, whilst it was not specifically mentioned in the announcement, it was always included under the general heading of government-funded health services."

Family Start social worker and delegate Debs Radley is on the top rate for her role – $63,500. She works with a case load of 16 whānau, who have significant social, mental health and addiction problems.

Radley's pay is far less than that of peers at Oranga Tamariki, which range from $76,284 to $92,465.

Minister of Health Andrew Little said Whānau Āwhina Plunket nurses and health-care workers were to benefit from pay parity funding.



To cope with rising costs and wage stagnation, Radley sold her home to downsize her mortgage, insurance and rates payments.

She voted to ratify the three per cent offer as it was "better than a slap across the face with a wet fish".

Another member, who has more than a decade of experience as an RN including in a hospital intensive care unit, and five years at Whānau Āwhina Plunket, said she had young adult relatives who were earning at least $10 more an hour than her in banking and building jobs, despite having little experience.

She voted to ratify the three per cent offer as it was 'better than a slap across the face with a wet fish'.

When the interest rate on her mortgage increased by three per cent recently, she asked her bank if she could pay interest-only for a period. The bank declined this, and instead sent her a hardship grant application.

The member, who did not want to be named, said her financial situation made her feel really sad.

"I feel like s... sometimes, to be honest, I feel pretty hopeless. I couldn't imagine being able to visit my children who have moved overseas.

I just feel like . . . I'm less . . . you do feel like less of a person."

Whānau Awhina Plunket chief executive Fiona Kingsford.

Whānau Āwhina Plunket chief executive Fiona Kingsford said a meeting is scheduled with Te Whatu Ora to discuss funding in February.

While the organisation's nursing and health-care staff are set to benefit from the Government's $200 million pay parity funding announcement, they are in the third tranche of spending, she said.

"At this stage we still have no details on what the funding uplift will be or when this will be implemented. We are anticipating it will be aligned to our next contract term which commences in July 2023."

Kaitiaki asked Te Whatu Ora if Whānau Āwhina Plunket pay parity rates would match the new Te Whatu Ora rates, with a pay equity adjustment.

A spokesperson said: "The funding moves towards the Te Whatu Ora nurses adjusted rates, but it will not reach this level immediately."

Wage comparison – Whānau Āwhina Plunket and Te Whatu Ora

The table below sets out pay rates under the different collective agreements for three roles/steps.

	Plunket CA	DHB Meca (expired)	Difference	Plunket CA	DHB Meca	Difference	Plunket CA	Te Whatu Ora CA (interim pay equity adjustment)	Difference
	6-Jul 2021	6-Sept 2021		11-Jul 2022	6-Sept 2021		11-Jul 2022	7-March 2022	
	Per hour	*Per hour*		*Per hour*	*Per hour*		*Per hour*	*Per hour*	
Registered Nurse Step 7	$37.98	$40.65	-7%	$39.12	$40.65	-4%	$39.12	$45.70	-14%
Community worker (Karitane) Step 4	$27.43	$30.13	-9%	$28.25	$30.13	-6%	$28.25	$34.18	-17%
Clinical leader Step 3	$51.30	$53.93	-5%	$52.84	$53.93	-2%	$52.84	$56.27	-6%

Tags

Click to search for related articles: pay parity, Whānau Awhina Plunket

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FEATURES

‘My hands shake as I apologise for the millionth time’

BY AMY CLARK

January 30, 2023

An experienced nurse shares her struggles with IV cannulation.

After a long battle with herself, Amy Clark finally feels ‘moderately’ confident in her cannulation skills.

My name is Amy. I am a nurse. Sometimes I cause people pain.

My hand brushes against thick folded paper in the pocket of my crisp, neatly laid-out nursing uniform this morning. Quizzically pulling it out, my heart sinks as I remember.

Last Monday I agreed to become accredited in venipuncture. I have read the handbook and completed the quiz. I have practised inserting a cannula into a squishy blue plastic vein in a very realistic-feeling fake arm. This form commits me to complete four successful cannulations into poor unsuspecting humans over the next two months. I've been instructed not to tell my patients it is my first time.

How have I practised as a registered nurse (RN) for almost 17 years without ever inserting a needle into someone's veins?

Well, no one ever asked me directly. Until now. Nurses in my unit are now being encouraged to cannulate patients pre-procedure — a role previously carried out mostly by doctors. My complete fear and aversion to causing someone pain is slowing down our unit and letting my team down. It is time. God help me.

> **The humiliation is overwhelming. The whole room is staring at me. I am exposed as the fraud I am.**

So. Here we are.

I nervously approach patient zero, my guts churning, my heart racing. I am conscious of my capabilities, I am careful. I lean heavily on my mentor's guidance and we have success. My confidence grows with this win.

I have begun. I've made the first step on this journey.

I complete my sign-off sheet in one week, feeling a little smug that each patient only took one attempt. Maybe I am a rock star after all. I am now accredited in venipuncture. I feel bona fide now — no mentor watching over me means the patients will never know how completely inexperienced I am.

Then I miss.

The humiliation is overwhelming. The whole room is staring at me. I am exposed as the fraud I am. I know I am permitted to try up to three insertions per patient, but I won't. I will not

attempt to cannulate anyone else in this room who has witnessed my failure. I cannot stand to feel they were all judging me, holding their breaths . . . hoping I don't come near them with my wee kidney dish of supplies.

How have I practised as a registered nurse for almost 17 years without ever inserting a needle into someone's veins?

I am fallible. I get it wrong and don't actually know why, or even how, to "get it right".

I am dejected. Maybe I can't do this.

I make a deal with my highly-disciplined self to try once, every shift. I have some success but experience the same pattern of humiliation and waiting for the room to clear of all witnesses when I miss.

Others who started their IV cannulation journey at the same time as me seem to be having more success. I subtly watch their techniques and pore over my resources to try and work out what I am doing wrong.

A patient presents with amazing veins. These suckers don't even need a tourniquet . . . I've got this — too easy!

Fail.

To remove a cannula from an artery, you hold firm pressure for five minutes. I hold for 10. He is very understanding.

I am now convinced I have no idea what I am doing.

I am nervous about going to work these days. Knowing I will be expected to cannulate haunts me. I often feel anxious.

Exasperated, I announce to my team that I just can't do it and that I am giving up. My colleagues respond sympathetically.

I decide to attend another training session to watch and listen — again.

My confidence plummets further as I set out to cannulate the next patient, and a colleague gently advises that I'd better not attempt this one in case it wrecks the patient's only good vein. She has a valid point. It still stings.

I'm told: "You just need to get your confidence back up."

> **I'm feeling great – I even try a vein I hadn't tried before. Five out of five in one day. I am pumped.**

We run out of the cannulas I am familiar with. I try once with the new kind, get flashbacks, and then it tissues — ends up in the surrounding tissue instead of the vein. I won't be trying again until the other ones are back in stock.

I get one in! I don't know how I did it — I'm now more confused than ever.

'I fail 10 times in a row'

I speak to a few trusted others and discover they also have limited success. I am starting to surrender my worry about failure. I am slowly distancing my worth from how well I can cannulate. It's comforting to share camaraderie with others in the same situation.

I have a breakthrough and muster the courage to try twice on the same person. I fail the second time too. My hands shake as I apologise for the millionth time. I feel ill, but I am ok. I even stay chatting to the man afterwards.

I fail 10 times in a row.

> **It's quite likely that patients aren't judging me on my precision at cannulating their veins. Even if they are, I don't need to take that on. My job is to know my limits, do my best, practise safely, communicate authentically and care for the person in front of me.**

I am actually going to give up — it is too much stress. Cannulation is just not my jam.

Someone gently suggests doing it another way, by lifting the vein, taking my time, being aware of the anatomy, going in with the needle further than feels comfortable or safe. I try their way.

One — in. Two — in. Three — in. I'm feeling great — I even try a vein I hadn't tried before. Five out of five in one day. I'm pumped.

I guess sometimes things just take a new approach. I am so grateful for my colleague. His well-timed tips made all the difference.

I feel brave enough to try inserting a cannula into a hand this time. It goes in, I feel elated. I move on to the next patient who jumps and screams as the needle touches her skin. I freeze and hand her on to someone more experienced.

I have a new trick. I avoid veins that look tricky so as to not break my winning streak. But I know I'm not learning anything new and I'm still not really sure what I'm doing right or wrong.

I accidentally cannulate an artery. I learn to be aware that if it's pulsing, it's an artery. To remove a cannula from an artery you hold firm pressure for five minutes. I hold for 10. He is very understanding.

I make two attempts on a guy with such thick skin it won't go in. It dawns on me that it isn't hurting someone that I hate, but more that I cannot bear having them think less of me. I feel exposed by that reality. I didn't know I was quite so prideful.

I am beginning to understand the anatomy of a vein better now. I take a deep breath and manoeuvre the cannula instead of instantly giving up. My success rate skyrockets as I learn to patiently persist and troubleshoot.

Three months in, I receive my first compliment: "You're really good at this, I didn't even feel it." Ahhhhh, I've arrived! I'm validated as a person. Argh, wait, my self-worth is not tied up in my abilities.

Six months in and sometimes I get them, sometimes I miss. I still feel nervous and would often rather not try. However, when I miss, I don't feel the sting of humiliation quite so strongly.

I am coming to a place of acceptance. That I am not my cannulation record.

It's quite likely that patients aren't judging me on my precision at cannulating their veins. Even if they are, I don't need to take that on. My job is to know my limits, do my best, practiSe safely, communicate authentically and care for the person in front of me.

A year on . . .

Today marks the one-year anniversary of my cannulation journey. I am fairly comfortable around veins now, although I still miss enough to keep me humble — we all do. But I have started to think of myself as moderately capable. Maybe that's the reward for perseverance and practice.

I am thankful for the journey. Acquiring this new skill has uncovered some issues from my shadow self — fear of judgment (including my own) and fear of failure — but it has developed me as a nurse and for that I am grateful.

Amy Clark *is a registered nurse in Christchurch.*

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NURSING NEW ZEALAND

NEWS

Just one doctor at Thames Hospital – 'a huge risk'

BY CATE MACINTOSH

January 24, 2023

Thames Hospital ED normally has three day shifts for doctors, but recently this dropped to just one – a situation which left patients and staff vulnerable to serious adverse events, NZNO members say.*

Thames Hospital members were prepared to picket their employer over last weekend's roster which had no ED doctors – but the event was cancelled after a locum from Kaitaia volunteered to fill the gaps.

The action came as concerns grow over short-staffing in the department – with members left to manage without any doctors – (https://www.stuff.co.nz/national/health/300787462/paramedic-helps-cover-thames-ed-night-shift-when-doctor-unavailable)from 6pm on January 12, until 8am the following morning.

The roster requires three doctors on day shifts, and one at night, at Thames Hospital ED.

NZNO organiser Nigel Dawson said Tokoroa Hospital was also without a doctor on-site on the night of January 15.

Last Saturday, a locum doctor left his home at 4am and arrived at Thames Hospital just before 10am. He worked until midnight and then again from 8am to 6pm on Sunday. A local doctor who was rostered on for the night shift was asked to come in four hours earlier than her usual start time of 10pm.

Te Whatu Ora Waikato denies Thames or Tokoroa Hospitals were without doctors at any time in the New Year.

"Doctors were on-site at each hospital during this period," operations director, rural and

community for Waikato Jade Sewell said in a statement to *Kaitiaki*.

Asked if Te Whatu Ora could confirm the hospitals would be fully staffed in coming weeks, Sewell said: "We will continue to roster as normal."

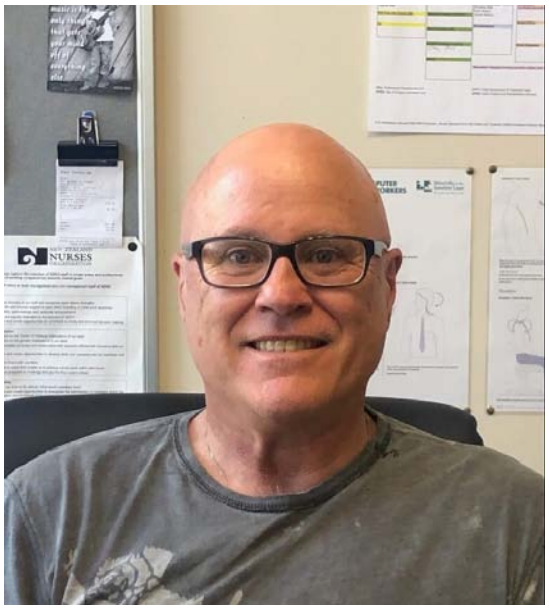
Dawson raised the alarm about the weekend roster with no doctors on Tuesday, January 17, but had no response from hospital management until Thursday.

Interim hospital and specialist service lead Chris Lowry called him to say they were working on finding someone, but hadn't been successful.

> **'We are scraping through day by day by the skin of our teeth, and at some point, something's going to happen, and it's not if, it's what and when.'**

That afternoon, delegates texted members about a protest outside the hospital at 12.30pm on Friday.

Within a few hours Dawson received a call from the hospital's director of nursing to say cover was in place as a locum had volunteered for the work.



NZNO Organiser Nigel Dawson

Members were pleased a doctor had agreed to work, but said the staffing was still woefully inadequate, leaving patients vulnerable to poor outcomes.

Dawson said this week's roster showed ED several days without doctor cover, but hospital management had assured him at least one doctor would be working.

But he says a "new normal" of just one doctor for all day shifts is not acceptable.

"We can't let that become the new normal because the nurses just aren't coping."

An RN who worked at Thames Hospital on the weekend, and did not want to be named, said "it was crazy".

"It's a huge strain, I think . . . I just want to go and work at PAK'nSAVE."

In addition to the doctor shortage, there were gaps in the nursing team due to illness.

A patient on the hospital's sole ward went into cardiac arrest, and was attended by the locum. But this meant he was not available for other patients who were being treated in ED – should he be needed.

> **'If a nurse is triaging and a patient fails to wait, and they go home and die, that comes back on that nurse.'**

"We had fail-to-waits, and we know what can potentially happen. It was pretty crazy," the nurse said.

The RN said she was very worried about what to do if one of her patients deteriorated while the doctor was attending to a critical event.

"If I know my patient needs specific medications, I need to get that doctor to do it . . . and I can't pull him out of resus. I thought I'd have to run in there with a chart and quickly try and explain the situation – but the doctor hadn't seen that patient yet. It's a huge risk."

Many patients – including some who were very elderly – waited longer than six hours, she said.

Nurses were being put in an impossible situation where they could be held responsible for a serious adverse event.

"If a nurse is triaging and a patient fails to wait, and they go home and die, that comes back on that nurse.

"That can be quite devastating for us as nurses, even though it is completely out of our control because we are so inundated. The triage nurse is trying to fill other roles, trying to help out on the floor."

Another RN who worked on the weekend said it was lucky a poor outcome had been avoided – but there were no guarantees for patient safety.

"We are scraping through day by day by the skin of our teeth, and at some point, something's going to happen, and it's not if, it's what and when. It's going to happen because we don't have the ability to deal with what potentially could walk through the door."

Senior doctor's union, the Association of Salaried Medical Specialists (ASMS), has raised

concerns on behalf of their members with Te Whatu Ora Waikato, over unsafe staffing at Thames Hospital.

Executive director Sarah Dalton said the authority would need to close the ED service at the hospital, if it could not provide safe staffing levels.

ASMS executive director Sarah Dalton

"It's an absolute pattern, particularly across smaller rural hospitals and it's something employers have been absolutely reluctant to address over a long period of time, but I think all of the other staffing pressures are just making it not only untenable but actively unsafe now.

"It's really great the nurses are being proactive at registering concern over this unsafe staffing and it's something we look forward to continuing to partnering on, to stop, because it's terrible."

Sewell said there were additional services available in Thames, "which have helped to ease demand on Thames Hospital ED such as having a GP clinic onsite for referrals, availability of the Primary Care Response Unit which provides 24/7 consultation, and additional community care resources with better coordination between services."

* This sentence was updated on January 25, 2023, to clarify the usual number of doctor shifts at the Thames Hospital ED.

Tags

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NURSING NEW ZEALAND

FEATURES

Lives transformed by Mercy Ships' surgical care

BY SHARON WALLS

January 25, 2023

An Auckland nurse has completed her fifth tour of duty with Mercy Ships, and is inspired by the resilience of her patients who come from countries often lacking basic health care.

Julie Murphy, assisted by a translator, reassures a patient about to receive facial reconstructive surgery after suffering from noma (cancrum oris).

Maggie, aged 35, had lived her whole life with a severe facial disfiguration, caused by a flesh-eating disease she contracted as a baby.

The Senegal woman has now undergone life-changing facial reconstruction surgery — rebuilding her nose and one side of her face — aboard a Mercy Ships floating hospital.

Maggie is one of the patients cared for by Auckland volunteer nurse Julie Murphy in her latest tour of duty for Mercy Ships, in Senegal, West Africa.

Murphy says she has been inspired by the resilience of her patients, who suffer from extreme conditions not often seen in New Zealand hospitals. "Maggie is an amazing lady and had obviously suffered a lot emotionally due to her appearance. Despite this, she is always smiling and always looking out for the other patients in the ward."

When Murphy embarked on her first tour of duty with the hospital ship charity in 2011, her knowledge of African geography was sketchy at best.

Eleven years on, she recently completed her fifth volunteer service on board the *Africa Mercy* in Senegal, having previously served in Sierra Leone, Guinea, Madagascar and Cameroon.

New Zealand nurses are well respected onboard Mercy Ships because they are broadly trained and flexible, they are comfortable in multicultural environments, and are able to roll with stressful work conditions where every case is extreme.

For Murphy, volunteering has always been a goal. "Ever since I started nursing, I've wanted to volunteer with a non-governmental organisation [NGO] working in a medical field to help people living in low-income countries, who have very limited access to health care.

"Mercy Ships reaches to the poorest communities, into isolated regions where there is no basic health care."

With nine out of 10 people in Africa unable to access safe surgery when they need it, Murphy says the patients who present at the hospital ships are usually complex cases.

What is Mercy Ships?

Mercy Ships is an international faith-based organisation that operates hospital ships to deliver free, world-class health-care services, medical capacity building, and health system strengthening to those with little access to safe surgical care.

Since 1978, Mercy Ships has worked in more than 55 countries, with the last three decades focused entirely on partnering with African nations.

Each year, volunteer

"I wanted to offer my nursing experience and skills to help people directly. I have seen first-hand how Mercy Ships changes a patient's life. Life-transforming — and in some cases lifesaving — surgery restores a person's place in their family.

"Many have been outcast from their family and community due to cultural beliefs, such as the tumour or sickness is a sign that the person is evil or cursed. Post-operative patients are then able to return to living and contributing to their community."

For many people in low-income countries, even basic health care is usually out of reach — either financially impossible or simply unavailable. Consequently, many live with treatable conditions because they cannot get the medications, treatments or surgeries they need.

Many have been outcast from their family and community due to cultural beliefs, such as the tumour or sickness is a sign that the person is evil or cursed.

For the last two decades, global health authorities have focused on individual diseases, while surgical care in low-income countries has not received the same attention. According to *The Lancet*, lack of surgical care results in an estimated 32 per cent of all global deaths; 16.9 million people a year lose their lives from conditions requiring surgical care.1

professionals from more than 60 countries serve on board the world's two largest non-governmental hospital ships, *Africa Mercy* and *Global Mercy*. Professionals including nurses, surgeons, dentists, health trainers, cooks, and engineers dedicate their time and skills to the cause.

Since 1978, Mercy Ships has provided more than 105,500 essential surgical procedures, and health-care services directly benefitting more than 2.84 million people living in poverty. More than 49,000 local health workers have been upskilled and trained in Mercy Ships medical-capacity building programmes.

For more information, visit the Mercy Ships (http://mercyships.org.nz) website and follow us @MercyShipsNZ on social media.

A typical year will see the Mercy Ships vessels docked at an African port city for 10 months of field service, providing direct patient care and building the capacity of local health services by training local staff in surgical care. (In the two months of down time, the ships sail for the nearby Canary Islands for maintenance and resupplying.)

Emphasis on paediatric care

Although surgical services are available for people of all ages, the emphasis is on paediatric care, particularly in orthopaedics and burn treatment. Surgical specialties offered on board Mercy Ships include ophthalmic work, maxillo-facial surgery (particularly cleft lip/palate reconstruction), removal of massive benign tumours, burns and plastic surgery reconstruction, paediatric orthopaedic surgery, obstetric fistula repair, and general surgery for hernias and goitres.

The surgical specialties and full patient rehabilitation services are scheduled consecutively during each 10-month field service.

Julie Murphy (right) discusses a patient with fellow nurse Irene Kamikazi, in the adult intensive care unit.

"I have learned so much from the people in each of the nations I've served in, and from the many health-care professionals on board," Murphy says.

"I've learned different treatments, seen unusual surgeries, and gained new ideas of nursing care and treatments from this international medical team, and have learned different approaches to pre-op and post-op care, management of pain and wound care."

Building local capacity

As well as providing direct patient care, Mercy Ships staff also focus on building the capacity of local health staff and helping develop the country's health service. Local health-care professionals attend courses and workshops to upskill and learn new techniques. Murphy worked alongside several local health-care professionals being mentored on board.

Mercy Ships also helps develop local health infrastructure, building health clinics and supplying equipment, and works with the local health ministry to develop policies, gather data and improve health service coverage.

With patients of all ages admitted from urban areas and rural or isolated villages, translators play a key role, to ensure patient consent and that they understand every stage of treatment and rehabilitation.

Africa Mercy and Global Mercy on location for the first combined surgical and training field service, in the port capital Dakar, Senegal, West Africa.

Last year, the new Mercy Ship *Global Mercy* joined the *Africa Mercy*, greatly increasing the NGO's capacity to deliver health-care services.

The hospital, on the new 36,000 gross-tonne *Global Mercy,* has six operating theatres, six wards with 199 patient beds, and an intensive care unit. All the required allied health-care services are provided by the volunteer crew for the patient journey: radiology, medical laboratory, pharmacy, physiotherapy, hand and speech therapy, and nutrition.

As there is no local capacity for post-operative follow-up, patients must be able to function independently before discharge.

Particularly for paediatric patients undergoing major orthopaedic surgery and patients undergoing burns contracture releases and plastic reconstructive surgery, physiotherapy is

essential. The most extreme cases require four or five months of rehabilitation.

> **As there is no local capacity for post-operative follow-up, patients must be able to function independently before discharge.**

Outpatients who are from outside the port city are housed at the Mercy Ships Hospital Out-Patient Extension (HOPE) Centre in the city, until their treatment is finished, ensuring they can access their appointments and are well nourished to aid healing.

Lack of safe surgery

According to the Lancet Commission on Global Surgery, more people die each year from a lack of safe surgery than from HIV/AIDS, malaria and tuberculosis combined.[2]

In the region of sub-Saharan Africa where Mercy Ships serves, the lack of proper medical attention affects more than someone's health; a severe health condition also brings disconnection.

People with conditions like large tumours, burns contractures and obstetric fistula are frequently ostracised from their families and communities. The patients coming to Mercy Ships have experienced fear, shame, and isolation because of their appearance or limitations.

Volunteer nurses on board frequently comment that nursing in the hospital ships' wards is like "nursing as it used to be," in terms of the opportunity to connect with patients on a meaningful level. "TLC" is an accepted and fulfilling part of the Mercy Ships' nursing roles.

"Even if I can just be a small part of the puzzle, even if I can just help one person — restore hope, then this is what I came for," Murphy says.

Africa Mercy and the newly deployed *Global Mercy* are crewed by health-care, maritime and operational professionals who donate their time and skills.

Find out more about the range of volunteer nursing opportunities on board at Mercy Ships (http://www.mercyships.org.nz/nurses-all-aboard/).

Murphy describes care and interactions with two of her patients:

Maggie: a severe facial deformity repaired

Admitted to Mercy Ships at the age of 35, Maggie had lived her whole life with a severely disfiguring facial deformity. She was just a baby when a wound on her face became infected with the gangrene cancrum oris.

Maggie was susceptible to this infection due to malnutrition, poor sanitation and unhealthy living conditions. She survived the flesh-eating disease, but it left her without the left side of her face and part of the left side of her nose. When this eventually healed, a facial cutaneous nasal fistula remained.

> **She is an amazing lady and had obviously suffered a lot emotionally due to her appearance.**

Her cheek was reconstructed by two volunteer plastic surgeons, with work initially done on her nose. Two months later, her nose and lip reconstruction were completed.

"I looked after Maggie post operatively," Murphy says. "There were no complications during her recovery. She is an amazing lady and had obviously suffered a lot emotionally due to her appearance. Despite this, she is always smiling and always looking out for the other patients in the ward.

"An example of Maggie's kindness is when she returned from theatre at around 7pm. At 9.30pm, a four-year-old girl was crying on the other side of the ward. I saw Maggie get up, and thought she was going to the bathroom.

"I went to accompany her, as it was only a couple of hours since her operation. But she walked to the other side of the ward to speak to the mother of the little girl. She stroked the little girl's head until she stopped crying.

"I accompanied Maggie back to her bed, and via the ward translator, thanked her for her kindness and caring for the little girl. Maggie told me that this is what she does for her own children, when they are unhappy.

"Maggie called me over to say, 'Thank you and all of Mercy Ships for my surgery,' every time that I entered the ward afterwards."

Julie Murphy takes care of a paediatric patient.

‘Sal was free from pain and fear . . . his childhood was restored’

Sal was born with a ganglio-neuroma, a tumour which can occur during foetal development, on his back and right side.

He was 12 years old when he arrived at the *Africa Mercy* with his sister; each child has a caregiver stay on board with them to ensure support and consent at every stage of treatment.

By the time he came for surgery, the neuroma had grown extensively, covering nearly 50 percent of his back. The operation to remove it took several hours to complete. Sal recovered well and was discharged to the HOPE Centre 12 days post-surgery.

Sal was readmitted to the ship’s ward 14 days later – the wound was discharging heavily, and the edge of the skin flap had become necrotic. He returned to surgery, for debridement of the wound and application of vac (vacuum-assisted) dressing.

“I cared for Sal when he arrived back from the HOPE Centre. There was quite a lot of oozing from the wound,” Murphy says. “Sal was very quiet when he and his older sister came to the ward. He was very worried about what was going to happen.

> **Sal was sometimes a little reluctant to have his blood pressure, pulse and other vital signs taken, so I asked him to use the equipment to**

take the recordings himself.

"I also looked after Sal the next afternoon, post-surgery I noticed that he loved playing games on his sister's iPad and phone. Sal was sometimes a little reluctant to have his blood pressure, pulse and other vital signs taken, so I asked him to use the equipment to take the recordings himself. He *loved* doing this, so having vital signs measured was never any problem from that point."

"Sal had a special vacuum pump [a vac dressing] attached to the wound dressing to drain any exudate from the wound site. This hastens the healing process. Again, I had Sal check the pump's suction was set correctly at 125mmHg, and that the battery wasn't getting low. Sal was in charge!"

Not only was the wound healing, but Sal was no longer withdrawn. He was often found running up and down the hospital corridor, and going into all the wards, "checking what the other patients and nurses are doing". Sal was free from pain and fear. His childhood was restored.

VIDEO: Life-transforming care on board the floating hospital (https://bit.ly/3x0csWK)

***Sharon Walls** is the communications and volunteers manager at Mercy Ships New Zealand.*

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NEWS

Pay parity, pay equity for nurses: biggest challenges for new minister of health

BY CO-EDITORS CATE MACINTOSH AND MARY LONGMORE

January 31, 2023

NZNO leadership has praised new Minister of Health Dr Ayesha Verrall for her "genuine approach", while urging her to take swift action on pay parity – and outgoing Minister Andrew Little was thanked for "keeping door open and the conversation going".

Dr Ayesha Verrall (middle) with Te Poari o Te Rūnanga o Aotearoa, NZNO co-chair Tracey Morgan (left) and NZNO

kaiwhakahaere Kerri Nuku (right) at the 2021 launch of the renaming of Whānau Awhina Plunket.

In another leadership re-set, newly appointed Prime Minister Chris Hipkins has announced Dr Ayesha Verrall is the new Minister of Health, replacing Andrew Little.

She is the first woman in the role for 17 years.

Hipkins announced the changes on Tuesday, with Little picking up the public service and defence portfolios in addition to his other roles in security, Treaty of Waitangi negotiations and the ongoing response to the 2019 Christchurch terror attacks.

Another Wellington MP, Barbara Edmonds, was appointed Associate Minister of Health, with responsibilities for Pasifika health and housing.

> **"She said 'I don't want to talk, I just want to listen'. And that's rare for a politician."**

The change marks a major promotion for Verrall — a Wellington Labour list MP — from her roles as associate health minister, COVID-19 response minister, research, science and innovation minister, and minister for seniors.

New Zealand Nurses Organisation Tōpūtanga Tapuhi Kaitiaki o Aotearoa (NZNO) chief executive Paul Goulter immediately welcomed her to the role.

"We know Ms Verrall is aware of the urgent need to lift the number of trained and qualified nurses and to ensure pay and conditions are equal across the health system."

Prime Minister Chris Hipkins announced Dr Ayesha Verrall as the new Minister of Health on Tuesday.

He said Verrall's greatest challenges in the role would be the ongoing pay equity dispute and lack of pay parity for members.

NZNO kaiwhakahaere Kerri Nuku said Verrall would bring practical knowledge of the health sector to the role and a "really genuine approach".

As a guest to the indigenous nurses Aotearoa conference and hui ā-tau in 2021, Verrall had impressed attendees, Nuku said.

"She said 'I don't want to talk, I just want to listen'. And that's rare for a politician.

"She wasn't looking for a big fanfare or acknowledgement, she just wanted to understand the issues."

Nuku said she was optimistic of positive change for members with Verrall at the helm because she is a woman, and has practical experience of the sector.

"The reality is she does bring a different, diverse world view, and I think that's a valuable thing."

NZNO leaders Kerri Nuku and Anne Daniels with Andrew Little at the NZNO 2022 conference.

NZNO president Anne Daniels said pay parity needed to be the "major priority" for Verrall.

Andrew Little said in November that nurses in aged care, iwi and Pasifika health providers and hospices would be paid the same rates as Te Whatu Ora. However primary health care nurses employed by GPs were excluded as there was no evidence of a pay gap, he said.

Daniels said: "It's just not fair or ethical for nurses, no matter where they work, to be paid differently just because they have a different employer. They are doing the same job."

Daniels thanked Little for his willingness to meet NZNO and its members. "For that, I have to give him credit — for keeping the door open and the conversation going."

After completing her medical degree at Otago University, Verrall worked as a junior doctor at Wellington Hospital, completed specialist training in Singapore and researched tuberculosis in Indonesia.

She is an expert on vaccines, tuberculosis and COVID-19, and, as health minister, follows in the footsteps of two leading Labour women. Former prime minister Helen Clark served in the role from January 1989 to November 1990, and Dame Annette King took on the role for five years from December 1999 to October 2005.

NZNO president Anne Daniels said pay parity must be the first priority for Verrall.

Announcing Verrall's promotion associate to health minister, Hipkins said she brought two decades of health sector experience to the role.

"An infectious diseases expert, she brings almost 20 years of knowledge of how our health system works and of course how it could be improved."

While Little had done a "fantastic" job at leading the health reforms, Hipkins said Verrall was "the right person to lead us through the next phase which is on health delivery".

Little – who outraged nurses last year when he denied there was a health crisis and has been mired in a back pay, and pay equity dispute with NZNO – retained his "full confidence" as a minister, Hipkins said. "He is absolutely an integral member of our team."

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