Kaitiaki
NURSING NEW ZEALAND

NEWS

‘Shining star’ Bernie wins most outstanding kaiāwhina award

BY MARY LONGMORE

November 2, 2023

A long-time health-care assistant (HCA), described as a “shining star” by colleagues, has won the “most outstanding” kaiāwhina award at a new Manawatū event which throws a spotlight on caregivers.

Bernadette Casey (right) with associate charge nurse -- and nominator -- Amy Anderson.

Bernadette Casey — Bernie — has worked as an HCA for nearly 50 years in aged care residences and hospitals around the country — the past 15 at Palmerston North Hospital’s Opal rehabilitation and older person’s ward.

“She’s just a shining star for us, and I think acknowledging the work she’s put towards people and the kindness and compassion to families in everything she does makes me want to go to work,” said Opal’s associate charge nurse Amy Anderson, who nominated Casey.

‘To feel valued in your work, valued by your workmates – it just gives you a wee spark.’

Along with her vast experience and leadership skills, Casey brought “kindness and compassion” to the role, Anderson said.

“Bernie will sit down and play Connect 4 with a person who’s particularly stressed, or pull out puzzles. She’ll walk them around and get them a cup of tea – she has a natural ability to see past the delirium and connect with the person and who they are. And I think that’s beautiful,” Anderson told *Kaitiaki*.

‘Most outstanding’ kaiāwhina Bernadette Casey receives her award from Midcentral’s associate director of nursing Tim Richards and executive director of nursing Yvonne Stillwell.

‘It takes a while to get your head around being recognised for something you’ve done all your life – that’s part of who you are.’

Casey said she was pleased that her work — and that of all HCAs — had been recognised, as it was “not always” appreciated.

“I don’t like attention, but I think it’s important to be appreciated in your job,” she told *Kaitiaki*. “It takes a while to get your head around being recognised for something you’ve done all your life – that is part of who you are.”

Casey began working at age 16 in the late 1960s, as what was then called a nurse aide in rest homes. She moved from Milton, in Otago, to Hamilton, then Gisborne, before landing in Palmerston North in the 1990s.

‘Immensely’ changed role

Over the years, the role had changed "immensely", she said. "Back then, we didn't have the lifting aids so you were doing heavy lifting all the time — it was very challenging."

That included lifting residents in and out of baths at times, as showers were not always available. "It wasn't safe at all — but that's how it was back then."

Today's caregiving work was challenging in different ways, with more dementia, and physical and verbal abuse, she said. "I've been slammed into walls, had my head slammed onto a locker and held there; been punched in the mouth, pinched, scratched, strangled — when I started it was nothing like that."

> **'For the longest time we've always come under the umbrella of nursing – and we just want our voice to be heard as well.'**

Casey left aged care for the hospital role 15 years ago for better pay — a decision she remains saddened by. However her daughter drew the line at her working two caregiving jobs just to make ends meet. "I loved my rest home work. It was a tough choice to leave but I could see the sense."

At the time, her hourly rate jumped from $13.50 per hour to $17.

Casey said caregiving was about being a team player. "You're there basically to support your nurses and your colleagues."

HCA Victoria Richards (right) with nurse educator Anne Thomas

The HCA role covered "all sorts", including one-to-one supervision of high-needs patients, assisting nurses, responding to patients' call-buttons, taking them to the toilet and keeping the ward clean, tidy and stocked.

Casey had a "strong work ethic" and was rarely idle, she said.

"There's always something to do — always. I'm thorough – to a fault probably. Patients watch me and say: 'I haven't seen a bed cleaned that well before!' "

The kaiāwhina awards at Te Pae Hauora o Ruahine o Tararua Midcentral (formerly Midcentral Health) began last year, after a long campaign for recognition. But this year they "exploded" with nominations, tripling to nearly 30, says founder, Palmerston North Hospital oncology ward HCA Victoria Richards.

"It was incredible to see, and there was a lot of support from other ward staff – charge nurses, RNs, educators, DONs [directors of nursing] – it was massive and really heartwarming."

'Unseen and unheard'

Richards said she had pushed for years for the recognition of kaiāwhina — an inclusive term for HCAs and hospital aides — who often felt "unseen".

"We felt unseen, unheard, in a lot of ways," Richards said. "For the longest time we've always come under the umbrella of nursing – and we just want our voice to be heard as well, that's why these sorts of things are important."

Some of the 30 HCAs and hospital aides nominated in Te Pae Hauora o Ruahine o Tararua Midcentral's recent kaiāwhina awards.

Richards — who is part of a NZNO-Tōpūtanga Tapuhi Kaitiaki o Aotearoa working group on the role of caregivers — said it was about being appreciated.

"To feel valued in your work, valued by your workmates — it just gives you a wee spark," she said. "Because you've got some really hard days here in the hospital, and to feel valued makes it easier to come to work in the morning."

Anderson said kaiāwhina brought a "different level of companionship and time" to patients, and were embraced as part of the Opal team, including with handovers.

"We couldn't function in our ward without our beautiful team of HCAs."

Palmerston North Hospital's high dependency unit HCAs Vicki Casey and Horacio Garzan (both pictured, below, with nurse educator Mel Te Rauna) were highly commended in the awards.

Palmerston North Hospital high dependency HCA, Vicki Casey, (right) receives her highly commended kaiāwhina award from nurse educator Mel Te Rauna.

Palmerston North Hospital high dependency ward HCA, Horacio Garzan, (right) receives his highly commended kaiāwhina award from nurse educator Mel Te Rauna.

Victoria Richards (centre photo, in centre and top left with pink roses) celebrating the awards in September with her kaiāwhina colleagues at Te Pae Hauora o Ruahine o Tararua Midcentral.

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LETTERS

2024 skills and training scholarships offered to union members and families

BY SHERYL CADMAN

November 3, 2023

The Northern Drivers' Charitable Trust (NDCT) is a registered charitable trust that was established in 1987.

Since 2019, the NDCT has been offering skills and training scholarships to members of unions affiliated with the Council of Trade Unions.

The spouse or child of the union member is also eligible to apply. This initiative allows the NDCT to fulfil its education and training objectives while contributing to the trade union community.

To raise awareness of these scholarships, the NDCT requests that your union informs its members about the financial assistance available for individuals who aspire to gain training or retraining in any trade, skill or tertiary study.

Scholarship applications are now open and will be accepted until January 20, 2024. The maximum value of each scholarship is $3000 per individual per year.

This year, the trust board has reinforced the union membership requirement. To be eligible for a scholarship, the union member must have a minimum of six months of active financial union membership before submitting a scholarship application.

We invite you to visit the NDCT website at www.driverstrust.org.nz (http://www.driverstrust.org.nz/) for more information about the scholarship application process and to learn more about the Northern Drivers' Charitable Trust.

Sheryl Cadman
First Union central regional secretary

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FEATURES

Frenemies to friends? As nurses fear being edged from their profession, caregivers are demanding more respect

BY MARY LONGMORE

November 17, 2023

Nurses are feeling under threat from less qualified workers — while kaiāwhina are demanding clarity and respect for their role, leading to a challenging kōrero for NZNO-Tōpūtanga Tapuhi o Kaitiaki Aotearoa and the wider health system.

Nurse panellists at the NZNO conference (left to right): Gina Chaffey-Aupouri, Natalie Seymour, Cassandra Raj, Helen Garrick and Margaret Hand.

Nurses across different sectors are fighting to protect their role from being encroached on by other, less-qualified, health workers.

At the same time, the kaiāwhina (caregiving) workforce is demanding recognition and respect, amid claims some are being exploited as cheap labour.

Both are seeking to define their roles, for their own protection — and that of patients.

> **'At the end of the day, the last person looking after our patient in the perioperative workforce is a nurse. It is not a surgeon, it is not an anaesthetist, it is not a technician. It is me, it is you.'**

Both nurses and kaiāwhina shared an emotional kōrero over their roles at the NZNO-Tōpūtanga Tapuhi Kaitiaki o Aotearoa conference in September.

On a 'challenges for nurses' panel, NZNO's perioperative nurses college (PNC) chair Cassandra Raj told the conference members were concerned they were being driven out of operating theatres by a new perioperative practitioner role.

"We are critical to the health and wellbeing of patients and whānau — why are we directly under threat?"

Cassandra Raj. Photos NZNO/Marty Melville.

No longer "handmaidens" to doctors, she said perioperative nurses these days carried out tasks such as surgical safety checks previously led by surgeons. "We deliver. We are consistent. We are not stagnant and we are leaders," said Raj.

Yet, instead of investing in nurse training, retention and professional development, hospitals were shifting to a different workforce, she said.

> **'The focus should be on the value the unregulated team members add to the team – rather on them taking the place of nurses.'**

The Cartwright Inquiry into experimental treatments on women with cervical cancer at National Women's Hospital in the 1980s also showed nurses' crucial patient safety role. "This event included nurses' intervention and also placed New Zealand as a world leader in protecting the rights of health-care consumers."

Raj said nurses were "critical" to safe health care.

"Nurses lead, nurses protect the public and nurses have the integrity of nursing practice to uphold," she said.

"At the end of the day, the last person looking after our patient in the perioperative workforce is a nurse. It is not a surgeon, it is not an anaesthetist, it is not a technician. It is me, it is you. This is the role of the nurse."

'Evolving' profession

College of gerontology nursing chair Natalie Seymour said the nursing role was ever-evolving.

This had never been more evident than during the COVID pandemic, when nurses stepped up into leadership roles as "scientists, innovators, advocates and educators".

> **'Please can you start respecting us? We are human.'**

The key now was to figure out what was core to nursing — and how to work with the kaiāwhina workforce to provide the best and holistic care for patients, Seymour said.

In aged care, many health-care assistants (HCAs) were internationally-qualified nurses (IQNs) on the pathway to becoming registered here, so often were supported to train and give medication, she said.

"The focus should be on the value the unregulated team members add to the team — rather on them taking the place of nurses."

Natalie Seymour

'Please respect us' – caregivers

Dunedin aged care HCA Marita Ansin-Johnson spoke up to ask for "respect" from nursing colleagues.

"We are part of this workforce. I was on the campaign for equal pay with [care and support workers' 2017 pay equity settlement advocate] Kristine Bartlett. What happened? We won. Now I'm standing in front of you guys, who I respect, who I've learned a lot from — but please can you start respecting us? We are human," she said, to loud applause.

Christchurch Hospital HCA Al Dietschin told the conference HCAs and midwives wanted to see themselves reflected in NZNO's language — such as this 'challenges for nurses' panel.

Marita Ansin-Johnson

NZNO panellists (left to right) Al Dietschin, Marita Ansin-Johnson, Gina Chaffey-Aupouri, Natalie Seymour, Cassandra Raj, Helen Garrick and Margaret Hand.

> **'Every screw you put on a tyre is important – if you miss one screw, that tyre will fall off. Every person has a vital role to play.'**

"I don't see 'challenges to HCAs' written there or even 'challenges to midwives', who are also members of this union," Dietschin said. "It's our voices who need to speak about our challenges — not nurses speaking for us, about our challenges."

Gina Chaffey-Aupouri: 'Every person has a vital role to play.'

Dietschin reassured nurses HCAs wanted to complement, not threaten, them.

"It's not about dumbing down or taking away from the scope of practice, its about adding to it. We want to be a part of that — we want to be considered a part of the nursing workforce umbrella."

Dietschin later told *Kaitiaki* there was no clear scope of practice for HCAs, "just a really vague job description that varies from place to place" which left HCAs vulnerable to exploitation and overload. He knew of HCAs around the country expected to do nursing tasks such as cannulation, observation, ECG monitoring and urine analysis.

'Definition' of HCA role needed

Ansin-Johnson told *Kaitiaki* the nurse shortage was putting the kaiāwhina (caregiving) workforce under huge pressure, and a basic role definition would protect workers.

"We haven't got a scope but they were asking us to do things we've never done before – things that were the nurse's job."

Manawatū HCA Victoria Richards — who successfully lobbied for kaiāwhina awards in her region — told *Kaitiaki* clear pathways for HCAs were needed, across different sectors. This would allow bridging into nursing for those who wanted

it, but also set work boundaries.

> **‘We haven’t got a scope but they were asking us to do things we’ve never done before – things that were the nurse’s job.’**

Victoria Richards

Te Whatu Ora chief people officer Andrew Slater said there was no work underway to “fundamentally change” the role of HCAs.

“HCAs and nurses have strong existing models for working together which we want to continue building on — and we greatly value the particular skills and capabilities that both HCAs and nurses bring to our clinical team.”

HCAs could never replace nurses, who were registered health professionals under the Health Practitioners Competence Assurance Act, with a regulated scope of practice, Slater said.


Andrew Slater

However, HCAs could do a range of different tasks depending on their levels of skill, experience and comfort — “and we are committed to giving HCAs opportunities to make the most of their abilities within their scope of practice”.

Te Whatu Ora also wanted to “enable” HCAs to progress into registered roles such as nursing, should they wish. “This is not a response to shortage, but ensures that our people can grow over time, use their skills, and have pathways to develop over the course of a career in health.”

East Coast community nurse Gina Chaffey-Aupouri said respect for each other went a long way. “Every screw you put on a tyre is important — if you miss one screw, that tyre will fall off. Every person has a vital role to play.”

- *Work is underway at NZNO on both the role of the nurse and kaiāwhina.*

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FEATURES

It’s cool to kōrero – November 2023

BY KATHY STODART

November 23, 2023

Ngeru — cat

There are around 1.2 million domestic cats in Aotearoa and just over a third of Māori households own at least one cat. Photo: Adobe Stock

The traditional Māori string game displayed by these tamariki in this 1939 photo is known in te reo as whai or maui. In English it is known as the cat's cradle. (Photo: Children holding Māori string patterns. Making New Zealand :Negatives and prints from the Making New Zealand Centennial collection. Ref: MNZ-2424-1/2-F. Alexander Turnbull Library, Wellington, New Zealand. /records/22324030)

This punua ngeru (kitten) enjoys the comforts of a welcoming home. Photo: Adobe Stock

it's cool to kōrero

Haere mai and welcome to the November kōrero column. *Ngeru* is a commonly used word for cat in te reo Māori (it is also known as *poti, puihi* or *tori*).
This introduced animal is the most popular pet in Aotearoa, where we have a total population of 1.2 million domestic cats. Just over a third of Māori households have at least one cat, and Māori cat-lovers are quite fond of purebreds — Asian NZers are most likely to own a purebred, with Māori second in line, and then European NZers.

Cats are good hunters, and have been valued through history for catching pests such as rats, mice and rabbits. However the large numbers of feral cats in this country pose a serious risk to endangered birds, lizards and insects.

In terms of Māori tradition, there is a popular string game, known in te reo as *whai* or *maui*, and in English as the cat's cradle. A long circle of flax string is looped over the hands and the fingers are used to weave complicated patterns. Sometimes the pattern would be so complicated it would take two or three people to hold it, and often a chant accompanied the finger movements.

Kupu hou (new word)

- **Ngeru** (cat)– *pronounced "ne-(as in 'net')-rroo"*
- **Kua patua e te ngeru te kiore.** — The cat has killed a rat.

More words related to *ngeru*:

- **punua ngeru** — kitten
- **whai** — cat's cradle
- **pūpū** — cat's eye or winkle, a mollusc found on rocks at the seashore, much favoured for eating by Māori
- **hāmoemoe** — catnap
- **matihao** — paw

When feral cats kill rabbits, rats and mice, their hunting is welcome. But they are also a serious threat to native birds, bats, insects and lizards. Photo: iStock

Last year marked 140 years since the formation of the Society for Prevention of Cruelty to Animals (SPCA) in this country. This stamp, released in 1982, marked the 100-year anniversary. Picture: Adobe Stock

- **moenga ngeru** — cat bed
- **kaitiaki kakarehe** — vet
- **kai ma te ngeru** — cat food

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

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OPINION

Language matters – patients are not 'naughty'

BY ANJA SCHAAR

November 30, 2023

A recently graduated registered nurse shares her reflections on the power of words — and how nurses can fall in the trap of talking down to patients.

Photo: AdobeStock

"She's naughty." "We had to tell him off." "She is refusing her meds, that's so naughty."

If I could get money for every time the word "'naughty" is used in our ward, I would be able to afford a coffee out every day.

I have been a registered nurse (RN) in a rural hospital for only 10 months. I come from a background of studying psychology for many, many years, mainly part-time, while raising my two children. I never got to register as a psychologist but did end up completing a master of nursing over two years during the COVID pandemic. It's been an interesting journey. Before nursing, I worked in mental health and the disability sector.

Anja Schaar

Working in the ward with mainly elderly patients, I am amazed at the language used almost daily to describe their behaviours by staff — mainly nurses. One would think we treat children.

More than 20 years ago, during my community mental health care training, a tutor in behaviour management introduced us to seeing behaviour as a form of communication. This way of looking at behaviour has remained with me ever since.

> **Language builds us up or tears us down. It builds communities or marginalises people.**

Any behaviour, be it addictions (smoking in the room), refusing medication (I like to call it declining as "refusing" evokes that naughty child idea again), walking out of the ward without letting anyone know with a luer in their arm (because they want to see their children or satisfy their addiction), are all forms of telling us that we haven't got their trust to talk to us about their needs. It's a loud and clear sign that whanaungatanga [relationship] has not been established.[1]

Whanaungatanga is a non-negotiable expectation in nursing care — nurses should work to build a trusting relationship with the patient to enable the best outcome. Whanaungatanga is part of the duty of care in our profession as nurses.[2]

Words such as "naughty" are used very easily in our hospital. I would like to see this changed.

The way we talk about people is important and relates closely to how we treat people. Language forms our basic understanding and the world view from which we operate. It matters to people — it connects us or separates us.

The language we use reflects the power we have over others. It shows respect, or a lack of, for others. The language we use reflects our attitude toward others. Language builds us up or tears us down. It builds communities or marginalises people.

> **I certainly wouldn't be impressed if staff talked about me, my family or friends as if we were little children without much agency or decision-making skills.**

The words we choose impact others. We can choose how we influence the world around us by simply using our words carefully.

Much has been written on how much language matters, particularly that of professionals.[3,4]

How do I expect others to talk about me? If I, or my dear family and friends, are in hospital, what language would you expect from those who care for us? I certainly wouldn't be impressed if staff talked about me, my family or friends as if we were little children without much agency or decision-making skills. How would you feel?

We, as nurses, have a lot of power over patients who are vulnerable while in our care. Language is a tool we can use to minimise inequity in our nursing care and to make our nursing care patient-centred.

I don't believe patients are merely "naughty". They have a right to make their own decisions, and to be given information. Patients have a right to decline any treatments we offer (there is always a reason).

They have a right to leave the hospital for whatever reason. We all, including patients, have a right to be treated with respect.[5]

Words matter. And let's not forget we nurses might be patients later today.

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OPINION

Māori nurses must be recognised as taonga – and key to a future with equal health for all

BY DENISE WILSON

November 8, 2023

50 years after nurse education moved out of hospitals, Māori health professor and former nurse Denise Wilson reflects on the "ugly" backlash over cultural safety — and challenges the profession to make way for Māori leaders.

Denise Wilson: "I'll go to my grave remembering what an ugly time that was to be a nurse educator."

I undertook my nursing education at Tauranga Hospital in the late 1970s. While I learnt a lot, often this was by trial and error. Repeatedly — despite our junior student nurse status — we were placed in positions of great responsibility without senior leadership.

We faced unexpected and complex situations that required not only the art and skill of nursing, but essential in-depth knowledge to guide our practice – knowledge we lacked. All the while working seven and 10-day shifts, often in close succession.

> **If we truly see Māori nurses as taonga, then we need to look at how we do things differently.**

Yet, the romanticisation of hospital training prevailed for at least the first 20-30 years of nursing in the tertiary sector. Yes, in considering a move to campus-based training, there were all the arguments about lack of exposure to clinical practice. But there were flaws in the hospital training that frequently led to less-than-desirable outcomes and burnout.

When I entered nursing education in the tertiary sector in the mid-1980s, I came to fully appreciate its importance for nurses. It provided a depth of knowledge we had not previously been exposed to.

I was fortunate to work at the former Waiariki Polytechnic in Rotorua in the first year of its diploma in nursing. We had a revolutionary curriculum framework based on the late Rose Pere's Te Wheke (https://www.health.govt.nz/our-work/populations/maori-health/maori-health-models/maori-health-models-te-wheke) concept of holistic health. It was a privilege to work with forward-thinking educators like Bill Brislen, Mere Balzer and others. They understood the need to include cultural safety in nurse teaching. This was prior to its wider emergence at the beginning of the 1990s.

Māori nurse educators were — and are — strong advocates for improving opportunities for Māori to become nurses.

Whaea Rose Pere at the 2019 indigenous nurses hui. PHOTO: ERICA SINCLAIR

Later, in my post-graduate nursing education work and as education advisor for the Nursing Council, I came to fully appreciate the role of nurse educators in the tertiary sector — and the potential nurses have to make a difference for whānau across Aotearoa.

Māori nurses critical

But we cannot celebrate 50 years of nursing education in the tertiary sector without addressing the elephant in the room and thinking about what we must do moving forward. I say this in my twilight years.

The reality is that Māori are more likely to die younger than non-Māori. We live in what should be the prime of our lives with diseases of older age.

The role of the Māori nurse is critical to improving equity and outcomes for our people.

> **Having lived through that, we were ahead of our time and, socially, the country wasn't ready.**

Cultural concordance is a huge factor in health outcomes. You look like me, so you'll look after me and "get" some of my issues — people feel safe to talk and share their stories, trusting that a Māori nurse or health professional will better understand their realities.

Yet we are in the fifth decade of talking about the need to increase the Māori health workforce — especially nurses, who form the largest part of that workforce.

Māori have remained at just six to 7.5 per cent of the nursing workforce for the last four decades. No real change has been made in achieving a Māori nursing workforce that reflects the proportion of Māori in our population — 17 per cent as of August 2022. In some regions the Māori population is even higher, ranging from 20-50 per cent.

The rise of cultural safety – and its dilution

In the 1980s, Hui Whakaroranga was a historical event, gathering government officials, non-government and community health organisations and health workers to listen to the aspirations and concerns of Māori — and define what health meant to Māori. Māori articulated the need to address inequities in health care — a challenge that remains today — and the need for a health workforce to reflect the population it serves.

Equity is not about equality but rather doing things differently for some groups to achieve similar or the same outcomes as others. It is about need, not ethnicity.

> **Nurse leaders and educators . . . are complicit in the long-standing Māori health inequities, upholding systemic practices deemed to be racist.**

Working with our whānau reinforces for me that, for many, health and social needs are enormous. This is a population whose needs are not being met by a health system which is designed to serve people equally when a more tailored response is needed.

The intention may be good — but the way it plays out for Māori and Pacific populations is not working. The outcomes are not equal.

Many whānau do not trust or feel safe in the system — nor with some who work within it. Instead of having their needs met, they experience racism and discrimination. This is where Māori nurses are well-placed to make a difference.

While at the Nursing Council, I was privileged to work with cultural safety pioneer Dr Irihapeti Ramsden. She advocated for new ways of doing things and her legacy — along with that of many other Māori nurses involved in its birth and implementation — is kawa whakaruruhau, which later became known as cultural safety.

By the early 1990s, cultural safety had become part of the state exam for registered nurses. But the public of Aotearoa rebelled over "political correctness", leading to a media outcry and parliamentary committee hearings.

Having lived through that, we were ahead of our time and, socially, the country wasn't ready.

I'll go to my grave remembering what an ugly time that was to be a nurse educator — to have something that was about trying to improve quality of care and experience, not only for Māori but for everybody, become so challenging.

Irihapeti Ramsden

Some of the media headlines in the 1990s at the time cultural safety became a part of the nursing curriculum. (Source: Cultural Safety and Nursing Education in Aotearoa and Te Waipounamu — Irihapeti Ramsden's 2002 thesis).

A subsequent government-initiated review of how cultural safety was being taught resulted in the original concept of kawa whakaruruhau being diluted into a broader concept embracing age, gender and socio-economic status, alongside ethnicity.

Kawa whakaruruhau had been very focused on the safety of Māori and our whānau entering the health system, along with the safety of Māori nurses and tauira (students) as they studied nursing.

I believe its politically-driven broadening into cultural safety has allowed apathy in adopting it as a fundamental nursing concept.

> **The courage of Māori nurses who introduced kawa whakaruruhau in the late 1980s and early 1990s needs to be reflected on – as does where we go now.**

Nurse leaders and educators have languished in unfulfilled rhetoric. They are complicit in the long-standing Māori health inequities, upholding systemic practices deemed to be racist, according to the 2019 Waitangi Tribunal health services and outcomes inquiry (Wai 2575 (https://waitangitribunal.govt.nz/inquiries/kaupapa-inquiries/health-services-and-outcomes-inquiry/)) and Health and Disability System Review (https://www.health.govt.nz/publication/health-and-disability-system-review-final-report). Such discriminatory practices might include rigid clinic hours which do not recognise the realities of whānau work obligations.

Inequal health outcomes for Māori

The courage of Māori nurses who introduced kawa whakaruruhau in the late 1980s and early 1990s needs to be reflected on — as does where we go now.

All nurses have huge potential in this space and are key to a future with accessible, equitable and quality care for whānau and families who are marginalised and prone to poor outcomes due to problems accessing health care.

At the end of the day, all people — but particularly tāngata whenua who continue to endure such poor health outcomes — have the right to access the health system at its various points and come away feeling okay.

The challenge now is for nurses in relatively privileged positions to address their roles in the issues facing whānau Māori, and others marginalised by the health system.

> **Window-dressing responses, such as using kupu Māori, whakataukī, and tikanga are insufficient to effect change.**

Māori nurses are taonga – give them a voice

If we truly see Māori nurses as taonga, then we need to look at how we do things differently. That means people might have to give up something they're used to doing and give it to someone else. We need to make the space for our Māori nurses to have a voice at all tables seeking solutions to grow our workforce.

Tāonga and key to the future of Aotearoa's health system– Māori nurses at the recent NZNO-Tōpūtanga Tapuhi Kaitiaki o Aotearoa conference.

It is also time for some hard reflection on the paternalistic "we know best" attitudes and behaviours within nursing that have effectively silenced Māori nurses wanting leadership.

Window-dressing responses, such as using kupu Māori, whakataukī, and tikanga, are insufficient to effect change. Having a Māori nursing workforce that reflects the population is critical to improving equity in outcomes and whānau Māori satisfaction when they engage with health services.

Hamiora Hei (Te Whānau-a-Apanui) — the sister of Ākenehi Hei, one of the first Māori nurses registered — said in a 1897 kōrero to the Te Aute College Students Association that: *" . . . a scheme to train Māori women to tend the sick and to give advice on matters of hygiene, would strike at the root of many evils. It would work below the surface with little trumpeting of its methods . . . and would tend to the increase of the numbers of the race'* (McKegg, 1992, p. 145).

Despite a lot of rhetoric, little has changed.

> **Kawa whakaruruhau and cultural safety is about people's dignity, mana, and the essence of humanity.**

I am a strong advocate for improving the health and wellbeing of our whānau, hapū, iwi and hapori Māori, and will lay a wero (challenge) going forward. Kawa whakaruruhau and cultural safety is about people's dignity, mana, and the essence of humanity. Its absence in our people is evident in poor health status, outcomes and determinants.

All health professions need to be culturally safe. Whānau need to know they can expect high quality and culturally safe care. Māori nurses are pivotal in this — they are not nurses who happen to be Māori, they are Māori who happen to be nurses. They bring with them innate knowledge and skills such as relational care, whanaungatanga, manaakitanga and aroha, and can be tika [correct] and pono [dependable] in their practice with Māori.

I have observed a lack of understanding of the taonga status and the mana of Māori nurses and what they offer in nursing education and practice.

> **I see talented, enthusiastic, and visionary young Māori nurses around me – they are the beacons as we progress into the future.**

Space must be given to Māori nurses to lead the way in creating a korowai of kawa whakaruruhau, not only for our Māori nurse educators but, also for whānau, hapū, iwi and hapori Māori. I see talented, enthusiastic and visionary young Māori nurses around me — they are the beacons as we progress into the future.

Health practitioners and nurses are critical in safely caring for our whānau facing social and health challenges. So, while we have challenges moving into the next 50 years, I see great potential, hope, and a growing understanding among nurses in general.

My wero is for nursing education to have the courage to enable Māori leadership going into the next 50 years.

Kia hora te marino, Kia whakapapa pounamu te moana,
Kia tere te Kārohirohi I mua I tōu huarahi.
May the calm be widespread, may the ocean glisten as greenstone.
May the shimmer of light ever dance across your pathway.

Denise Wilson (Tainui, Ngāti Porou ki Harataunga, Whakatōhea, Ngāti Oneone, Ngāti Tūwharetoa) RN, MA, PhD, is associate dean Māori advancement and professor of Māori health at Auckland University of Technology.

— This article was adapted from Denise Wilson's kōrero in June, at the 50-year-celebration of nursing education in the tertiary sector and a recent interview with Kaitiaki Nursing New Zealand.

Listen to RNZ's Kim Hill interviews with Irihapeti Ramsden about cultural safety in nurse training in 1993 (https://www.ngataonga.org.nz/search-use-collection/search/242833/) and 1995 (https://www.ngataonga.org.nz/search-use-collection/search/279548/).

Kaitiaki
NURSING NEW ZEALAND

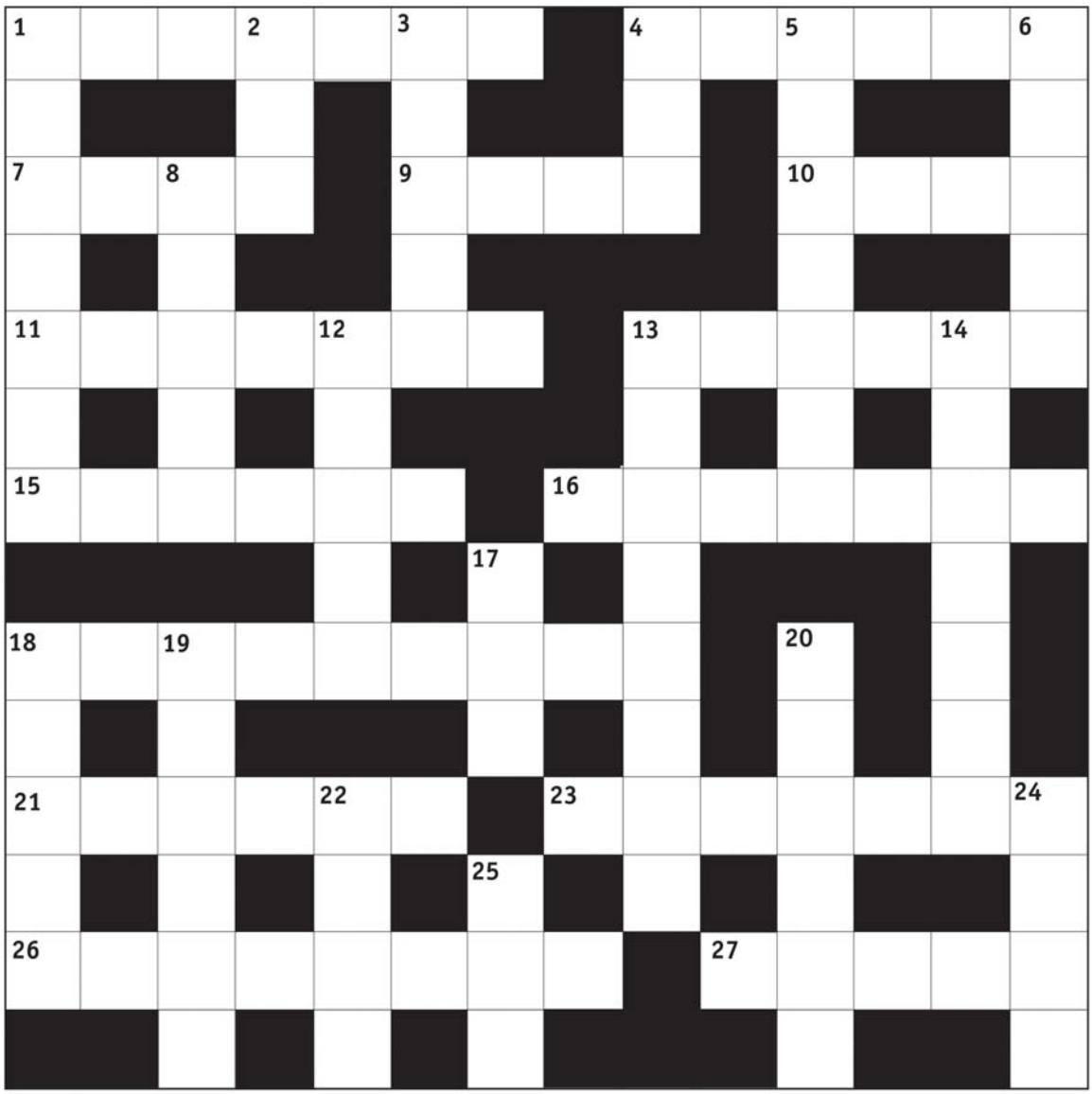
PUZZLES

NOVEMBER 2023 crossword

BY KATHY STODART

November 9, 2023

Print out the grid (using PRINT tab at the bottom right of this page) and use the clues below. October answers are below the clues.



ACROSS

1) Sign of illness.
4) Red gems.
7) Arm or leg.
9) Devoid of feeling.
10) Leather strap.
11) Beginners.
13) Outside of a pie.
15) Used to blink.
16) Nazi secret police.
18) Person's entry to hospital.
21) Doubtful.
23) Nervousness.
26) Makes bigger.
27) Of the kidneys.

DOWN

1) Absence of sound.
2) Hotel.
3) Imperial weight.
4) Bone in chest.
5) Supervise children.
6) Peanut sauce.
8) *The Godfather*, for example.
12) Weeps.
13) With child.
14) Affinity.
17) Eye twitch.
18) Mistreat.
19) Gluteus maximus is the largest.
20) Performed badly.
22) Uncommon.
24) Shout.
25) Not many.

October answers

ACROSS: 1. Inflation. 5. Kelp. 9. Feijoa. 10. Giardia. 11. Hidden. 14. Owning.
17. Carpet. 19. Cry. 20. Hōiho. 22. Naan. 24. Aorta. 25. Crisis. 26. Love. 29. Ta.
30. Noah. 31. Twigs.
DOWN: 1. Inferno. 2. Faith. 3. Avoid. 4. Organic. 6. Ends. 7. Prayer. 8. Cavalry.
12. Iwi. 13. Relapse. 15. Warfarin. 16. Global. 18. Unusual. 21. Once. 23. Arena. 27. Vow. 28. Us.

Kaitiaki
NURSING NEW ZEALAND

NEWS

Nurses celebrate 50 years of tertiary education – but fear for its future

BY MARY LONGMORE

November 3, 2023

New Zealand nurses are celebrating 50 years since nurse training began moving out of hospitals and into the education sector — but warn tertiary funding pressures and a pay gap of up to $40,000 for lecturers are putting the future of nursing education at risk.

Johanna Rhodes: 'Concerned' about the future.

"I think it's awesome that we're celebrating 50 years — we should be celebrating, nursing education has come a long way," long-time educator Johanna Rhodes told *Kaitiaki Nursing New Zealand*. "But the thing I'm most concerned about is the future of nursing education and, ultimately, the patients."

Nursing leaders spanning decades — including those who had experienced the shift such as Dame Margaret Bazley — gathered earlier this year at Parliament's Grand Hall to mark the 50 year anniversary since nurse training moved into the education sector.

The 1971 Government-commissioned Carpenter report recommended moving nurse training out of hospitals in response to high dropout rates and fears of trainee exploitation. In 1973, two pilot programmes began in Wellington and Christchurch. Today, there are 20 schools of nursing around Aotearoa, New Zealand, including universities, Te Pūkenga/polytechnics and wānanga.

'The pay parity gap between nurses in tertiary sector and industry is very marked now. What happens if you can't staff, you can't run, a proper school?'

Johanna Rhodes (right) with former director of nursing and state services commissioner Dame Margaret Bazley, who made an impromptu speech at the 50 years of nursing education in the tertiary sector celebration.

Celebration 'a piece of history'

A midwinter gathering of nursing luminaries in Parliament's Grand Hall this year was a "fabulous" event to mark the historic 1973 shift of nurse training out of hospitals and into the education sector, say attendees.

It included two dames of nursing — Margaret Bazley and Judy Kilpatrick — as well as long-time Māori nursing educator Hemaima Hughes, Māori health professor Denise Wilson and former chief nursing officer Jane

Rhodes — who has worked in nursing education for 18 years, including five as Southern Institute of Technology (SIT)'s head of nursing — said nursing schools were shedding staff to better paid jobs elsewhere.

$40,000 pay gap

Similarly skilled nurses in the clinical workforce could be paid up to $40,000 more per annum, Rhodes said.

"The pay parity gap between nurses in tertiary sector and industry is very marked now. What happens if you can't staff, you can't run a proper school? What are you going to produce at the end and what does that mean for patient safety?"

Tertiary funding pressures were also worrying schools, she said. Massey University is axing its Albany-based nursing degree from next year, while Victoria University's nursing department survived proposed cuts (although its midwifery stream is under review).

> **'It's about how do we create an environment where Māori feel they belong and do have a rightful place?'**

All this had left nursing education in an "extremely vulnerable" position, Rhodes said. "Thinking about the next 50 years of education – what does that look like?"

Nursing Education in the Tertiary Sector (NETS) network co-chair Ruth Crawford agreed the pay gap made it difficult to recruit and keep staff, especially with such high costs of living.

Ruth Crawford

"We're often offering them a drop in salary — so that's the difficulty we've got. We also have some staff leaving education to return to practice because they can get better salaries."

NETS was working with Te Pūkenga to increase staff salaries and she hoped this would happen by the end of the year.

"Increase the salary for nursing academics – that's what they've got to do and that's what we're looking for. We're expecting a positive response."

Te Pūkenga said it was "reviewing" salary rates for its nursing programmes' staff, as part of moves to attract and retain them, as well as ways of building up student numbers.

O'Malley — one of the first to complete the early nursing diploma.

"It was like a piece of history happening before us," said nurse leadership consultant Liz Manning, who helped organise the event in June.

"Dame Margaret Bazley stood up and did 20 minutes [speaking] – it was totally unexpected, as we hadn't been able to get hold of her. It was astonishing. She did a wonderful speech."

Māori nurse educator Hemaima Hughes speaks at the June celebration, with Sarah Ropati Vine (left) of Te Whare Wānanga o Awanuiārangi and Kiri Hunter (obscured) of Nelson Marlborough Institute of Technology.

Victoria University's nursing and midwifery head Kathy Holloway said despite a few challenges and last minute speaker cancellations, it had turned into a "seamless" night. "Like all good nurses, we just got on with it — made it seamless."

NETs co-chair Ruth Crawford said it was "really wonderful having people who had that history to speak up".

Wilson — who spoke of the pressing need to make cultural safety a reality after decades of rhetoric — said it was "really good to come together and reflect on that time – and also to connect with people you've lost connections with over the years".

Hughes, who was involved with designing the bachelor of nursing Māori now in its ninth year at Te Whare Wānanga o Awanuiārangi, told *Kaitiaki* it was a response to the "cry of our people needing to be cared for by Māori".

Along with the rest of the education sector, Te Pūkenga said it, too, was being impacted by the skills shortage. Of 466 nursing staff positions across its 15 institutes offering nursing programmes nationally there were currently 64 vacancies — a vacancy rate of about 14 per cent.

"We acknowledge feedback from nursing kaimahi on the challenges of remuneration compared to external market opportunities, which has had an impact on retention." a statement said.

'Crisis' point

Head of Whitireia's nursing school Carmel Haggerty has warned nursing education was reaching "crisis point".

The recent nurses' pay equity settlement alongside pay rises across the health sector had left nursing educators and the education sector behind, Haggerty wrote in an April report called *Nursing academic staff – recruitment and retention issues*. Rising living costs had compounded the problem, with many tutors unable to make ends meet, she wrote.

> **'Increase the salary for nursing academics – that's what they've got to do.'**

Nurse educators had many years' clinical experience and their salary range needed to be lifted to $90-106,000 to attract and keep them, she said. Currently, the starting salary for tutors (with allowances) was around $79-83,000, the report said.

"At Whitireia over the last 12 months, in Te Kura Hauora, we have had to re-advertise six times to fill vacant positions. Although there are interested applicants, they have often declined the position once the salary offer is made."

In August, all 20 nursing schools released a joint statement calling for urgent support and pay parity for their "at risk" workforce. It warned fewer educators would mean fewer students at a time of high need for a locally trained workforce.

They also demanded better support for Māori and Pacific nursing academics and clearer academic pathways for all RNs.

Clinical placements 'challenging'

Rhodes said short-staffing in the clinical workforce also made it hard to find good quality placements and preceptors for students.

While it was fine for students to have a "real" experience of understaffing, "I don't think they should be experiencing that consistently and not learning", she said.

"It's a real spiral of things which to me puts nursing education at risk. Because if students have bad experiences or consistently bad experiences, they're either going to withdraw, or they're going to register and probably not stay in nursing for a long period of time — because they themselves will burn out."

Māori nurses are 'taonga'

Auckland University of Technology (AUT) professor of Māori health Denise Wilson (Tainui, Ngāti Porou ki Harataunga, Whakatōhea, Ngāti Oneone, Ngāti Tūwharetoa) said more Māori nurses, including educators and students, were needed for a healthy future.

"It's about how do we create an environment where Māori feel they belong and do have a rightful place? It's about recognising that Māori nurses are Māori first, then nurses – not nurses first, then Māori"

Māori nurses were "taonga" (precious) and key to better outcomes for Māori. They must be better supported in both the education and clinical workforces, said Wilson, who spoke at the celebration.

Over the years, she had seen Māori nurses appointed into academic positions at low levels. "The glass ceiling for them for growth and opportunities is low – so how do we recognise that?"

Kaitiaki
NURSING NEW ZEALAND

LETTERS

PhD student sought for research project on elimination of tuberculosis among Māori

BY AMY JONES AND SUE MCALLISTER

November 23, 2023

Nau mai haere mai.

Join us for a three-year PhD studentship within the Centre for International Health, University of Otago.

The team is a collaboration between researchers in the Waikato region and the University of Otago. We have a Health Research Council (HRC) research project entitled "Elimination of tuberculosis (TB) for Māori in Aotearoa New Zealand (NZ)".

This is an exciting opportunity to be involved in the development of new ways of working in the health system and address inequities, working within a research project and a Māori model of care.

You will work in a collaborative team with members from Te Whatu Ora Waikato and Te Aka Whai Ora to engage in kaupapa Māori research and evaluation and link with Māori and indigenous research and networks.

TB, which is preventable, is a leading infectious disease globally. In New Zealand (NZ) the majority of people with TB are born outside this country. However, TB is a disease of colonisation and among NZ-born cases, half are Māori. The rate of TB for Māori is 3.6 per 100,000. This is over five times the 0.7 per 100,000 rate in NZ Europeans.

Māori-led targeted approaches and strategies are needed to reach Māori at risk of TB and address the determinants of TB. Engaging Māori TB contact networks should therefore take a holistic approach to health needs, seek to enhance hauora gain for whānau, and eliminate inequities, while dealing sensitively with stigma.

We propose to do this by providing access to high quality hauora services for whānau and communities that we engage with through our study, which could become part of an integrated national approach to eliminate TB in the long term.

The project, which is based in the Waikato region, will co-design an approach, and includes the following phases:

1. Situational analysis, engagement, development and input from kaupapa partners;
2. Development of a health needs assessment and hauora programme for whānau;
3. Recruitment of participants and undertaking of the hauora programme and screening for TB and latent TB infection;
4. Qualitative exploration of the experience and views of Māori whānau, and other partners regarding the approach, and analysis of data;
5. Development of the template model for a hauora-enhancing approach to TB case contact management in NZ.

This PhD studentship will work under the supervision of the study's principal investigators Professor Philip Hill and Dr Nina Scod (Ngāti Whātua, Waikato, Ngāpuhi), and alongside kaupapa partners to undertake and evaluate phases 1-3 of the project and provide input into phases 4-5.

Eligibility:
Applicants must have a master's degree in a health, or wider health-related field, with an average grade at or equivalent to at least B+.

This project is to develop a Māori model of care for control and elimination of TB, therefore it is imperative that the candidate is of Māori ethnicity and is happy to be based in the Waikato region for many months at a time, while also visiting academic supervisors at the University of Otago, Dunedin, as required.

We are looking for a candidate who:

- is willing and ready to collaborate with others in the community and in the research team to achieve optimal results
- has strong interpersonal, relational skills
- has an understanding of research or kaupapa Māori research and is willing to learn
- has strong organisational capabilities
- understands tikanga Māori, te ao Māori and mātauranga Māori and is able to engage appropriately in Māori settings.

Stipend
NZ$30,696 tax-free stipend per annum plus a domestic fees waiver for 36 months (excludes student services fee and insurance).

There may be the opportunity, depending on qualifications and need, to also work part-time on the project, and receive a salary for doing so.

Application
Applicants should submit their CV and a covering letter, including full contact details of two referees (one of whom should be a current employer), to either: Dr Amy Jones (Amy.Jones2@waikatodhb.health.nz) or Dr Sue McAllister (sue.mcallister@otago.ac.nz). University of Otago PhD entry requirements must be met and the successful applicant will subsequently need to apply online.

For further information, please contact Amy.Jones2@waikatodhb.health.nz or sue.mcallister@otago.ac.nz. **Closing date:** Friday, December 8, 2023

Amy Jones, *Te Whatu Ora Waikato*
Sue McAllister, *University of Otago*

Kaitiaki
NURSING NEW ZEALAND

NEWS

Prioritise nursing workforce – Te Whatu Ora union meetings will send strong message to new Government

BY MARY LONGMORE

November 20, 2023

As health budgets are being set, now is the time for Te Whatu Ora nurses, kaiāwhina and other workers to turn out and be heard by the new Government, say NZNO-Tōpūtanga Tapuhi Kaitiaki o Aotearoa members.

Nelson Te Whatu Ora members on their way to NZNO stopwork meetings in June.

'This is our only opportunity to get the funding that we need for the health sector over the next three years – so it's absolutely crucial.'

With health budget planning underway that will decide funding for the next three years, paid NZNO union meetings (https://maranga-mai.nzno.org.nz/nov_nzno_meetings) for Te Whatu Ora members are being held around the country next week, from November 27 to December 1.

NZNO campaigns director Tali Williams said members wanted to tell the Government what the nursing workforce expected from them — more funding for the health sector and safe staffing.

"This is our only opportunity to get the funding that we need for the health sector over the next three years — so it's absolutely crucial."

A new three-year health funding cycle — set under the Pae Ora health reforms to give more certainty — is set to begin in 2024, at the May Budget.

'Fire in the belly'

Hawke's Bay nurse Nayda Heays said while nurses on the ground were fatigued, a "fire in the belly" had been lit after the election. "If anything, it's spun around into another fight that we're ready for.

Nayda Heays

"We're just trying to hold Te Whatu Ora accountable for the things they didn't come to the party with," she said. They included actualising te Tiriti, safe staffing-patient ratios and a safe workplace.

"For Māori, our entire existence is about fighting — it's about advocacy for our patients, especially with [staff] ratios, for actualising te Tiriti o Waitangi."

Wellington Hospital lead delegate Jenny Kendall said the irony was that members felt too tired and overworked to get to meetings — but it had never been so important to turn up.

"For so long we've been promised safe staffing levels," Kendall told *Kaitiaki*. "This is what is stopping us [from turning out], we can't abandon our patients."

A nurse for 48 years, Kendall said staff throughout the hospital were regularly under pressure to work overtime and often missed meal breaks.

"If you haven't got safe staffing and a safe environment to work in, it doesn't matter how experienced you are."

2024 Te Whatu Ora bargaining was only months away and with a potentially hostile new Government, it was crucial to be heard, Kendall said. "Find a way to get to them [union meetings], because it's very important. This is our opportunity to have a say in the budget."

Auckland Hospital theatre admission/discharge nurse Mohini Lal said she would be encouraging staff across theatre and recovery departments to attend. "Fingers crossed, we'll have a big turnout."

She said staffing was the biggest issue for nurses.

> **'It's just not about work anymore, it's about mental health.'**

"People are feeling tired — it's more just about being fully staffed, I'm finding here is the biggest problem."

Jenny Kendall

When people call in sick, there was never enough cover. "Today we have two sick, and there's no bureau cover — so we're managing." But it increased everyone's workload.

Mohini Lal

The day she spoke to *Kaitiaki*, Lal herself had been called in a few hours early due to the short-staffing and was juggling a coordinating role with teaching and patient load — and a 10-hour shift.

"I've got a nurse to orientate, then on top of that we've extra patients coming — so I'm helping a couple of patients too as we go along."

Lal — who had worked at the hospital for 24 years — said this year had been one of the worst in terms of resignations. "It's the pressure — it's so busy, people are stressed — it becomes about their wellbeing. It's just not about work anymore, it's about mental health."

Support for senior nurses, too, needed to be a priority. Instead of focusing on leadership, mentoring and coordinating, they were being pulled onto the floor to plug gaps.

Te Whatu Ora 'sets the bar'

NZNO kaiwhakahaere Kerri Nuku said when people were fatigued and vulnerable, that could be used to others' advantage in bargaining.

"So now more than ever, it requires of us . . . to continue to be strong, united and to keep coming back — and this is one of those times where we have to keep going back because of the three-year long term [budget] plan."

NZNO kaiwhakahaere Kerri Nuku.

Te Whatu Ora set the bar for other sectors, she said.

"This isn't just about their cause, it's about the future of nurses who are coming into that workspace, but it's also for the future of nurses outside of that space — non-Te Whatu Ora — that this is really, critically important."

> **'. . . nurses are completely over it, they're fatigued, they're tired – and because they're professionals they'll continue to agitate for what needs to be done to fix the system'.**

'Now is the time to be heard'

Williams also noted the pre-Christmas mini-budget, or half-year economic fiscal update, was coming up, where Government worked out how to direct its spending .

With planning already underway on how much to put aside for the health workforce, salary, staffing levels, training and development, now was the time to be heard, she said.

NZNO chief executive Paul Goulter said Te Whatu Ora bargaining was one way to attain safer staffing , "so it's really important that members come along and participate in those meetings."

Timaru Te Whatu Ora members on their way to NZNO stopwork meetings in June.

"I don't think anyone can be in doubt that nurses are completely over it, they're fatigued, they're tired — and because they're professionals they'll continue to agitate for what needs to be done to fix the system."

Details including transport for all paid union meetings around the country for Te Whatu Ora members from November 27 to December 1 can be found ***here.*** *(https://maranga-mai.nzno.org.nz/nov_nzno_meetings)*

Kaitiaki
NURSING NEW ZEALAND

PRACTICE

The benefits of a bedside nursing handover

BY NICOLE SIMONSON

November 8, 2023

Nursing educators emphasise the benefits of bedside nursing handover. A final-year nursing student was surprised to find she never saw it happen during her clinical placements.

Bedside nursing handovers are associated with fewer patient injuries and errors than non-bedside handovers. Photo: iStock

The importance of person-centred care has been consistently emphasised throughout my nursing degree course.

Nicole Simonson

However, during clinical placement, I often found this focus hard to see. This was demonstrated particularly in how nurses conducted patient handovers.

In class, our lecturers emphasised the importance of participation by patients and their whānau, and we discussed what patient-centred care would look like, including the benefits of bedside nursing handovers. Despite this, I have yet to witness a bedside handover.

All handovers I observed on clinical placement occurred privately between staff members in the nurses' station, without the patient's involvement. Anecdotally, this also

appears to be the experience of many of my fellow student cohort.

In at least one emergency department, reported anecdotally, a combined handover method is used, where the co-ordinator provides an update on all patients, after which the nurse conducts a bedside handover. While this approach was effective, time constraints could lead to rushed bedside handovers, compromising their quality.

The irregularities in handover practice in New Zealand, and lack of patient involvement in non-bedside handovers, led me to investigate the literature to answer this question: Do bedside handovers achieve better patient outcomes than non-bedside handovers?

Continuity of care

The New Zealand Nurses Organisation defines patient handover as the exchange of information between health-care team members to ensure continuity of care can be provided to the patient.[1]

Patient handovers typically occur during shift changes or when a patient is transferred to a different unit, ward, or health-care facility.[1] Often, handovers occur in staffrooms or conference rooms when the next shift begins, and do not involve the patient or whānau members.[2]

During the handover process, incorrect information is frequently passed on because patient participation and perspective are often missing.[2] Many errors can be attributed to the provision of incorrect or unreliable information given during handovers.[2]

> **. . . handovers typically lack patient involvement, meaning the patient loses a valuable chance to ask questions, discuss their care and provide their input.**

In contrast, bedside handovers are a person-centred approach involving the patient, which helps prevent information-sharing errors and results in better patient outcomes and care.[2]

Working in partnership

The Nursing Council Code of Conduct sets standards for all nurses working in New Zealand to meet and apply to their practice.[3] One of the standards is to work in partnership with the health consumer, ensuring that they have the opportunity to express their views and preferences.

This can be accomplished through collaboration with the patient, showing empathy, providing sufficient information regarding their care, ensuring that communication with the patient meets their needs and is readily understood, and respecting and upholding their preferences where possible.[4]

Patient participation is a key concept underpinning person-centred care.[4] However handovers typically lack patient involvement, meaning the patient loses a valuable chance to ask questions, discuss their care and provide their input.

This is because patients' care discussions are typically conducted away from the patient in the nurses' station, and are based on information and documentation acquired during previous shifts.[4]

Using bedside handovers

One study I looked at investigated what was the best available evidence on patient involvement in, and experiences of, clinical handover conducted at the bedside.[5]

The study found that the involvement and two-way communication that occurred during bedside handover — as opposed to the traditional nurse-to-nurse-only communication that occurs at shift change — improved patient safety and increased patient satisfaction. It allowed the patient to share ideas and needs about their care which meant the patient was better prepared for discharge.[5]

The validity of information about the patient's care could also be determined, and information was less likely to be missed.

However, the use of bedside handover is affected by factors such as the need for confidentiality — which could be hard to maintain where others in the ward could hear the conversation — and staff resistance to altering existing handover procedures.

Patients were generally interested in being involved in bedside handover, but each patient should be able to determine the extent of their involvement. Photo: Adobe Stock

The use of medical jargon and patients' willingness to be involved also played a role in patients' perceptions of bedside handovers. But this study found that patients were generally interested in being involved in bedside handovers; however each patient should be able to determine the extent of their involvement.[5]

Overall, according to this research, bedside handovers have been shown to enhance the quality of care provided to patients.[5]

Does handover education help?

An Australian study, based in two geriatric and rehabilitation wards, used an education intervention — which put forward a standardised bedside nursing handover method — to investigate whether bedside handover would enhance patient safety.[6]

Nursing staff, inpatients and family members received teaching materials on bedside handover, including information on the SBAR communication method (situation, background, assessment, and recommendation), an example video, written materials, and a bedside flowchart.[6] The participants were surveyed before and after the intervention.

Before the intervention, patient handover occurred only in the staffroom through written and verbal information transfers. Despite the organisation's earlier use of SBAR, the information conveyed from nurse to nurse varied significantly.[6]

After the intervention, the study found the nurses believed bedside handover standardisation improved patient safety, and patient and nurse satisfaction with the process had improved. The intervention ensured shift handover best practices and guidelines were achieved. Some patient injuries, such as falls and pressure injuries, were reduced, and there were fewer medication errors.

However, the improvements were not substantial, due to the modest number of instances reported.6 Other limitations to the study included the fact that the sample size was small, and from a single hospital.6

Patient satisfaction

A Swedish study aimed to assess patient satisfaction two years after the introduction of person-centred handovers and to discover what patients considered to be individualised treatment.7

The participants were 90 adult patients on an inpatient oncology ward at the Karolinska University Hospital in Sweden. The survey found that two years after the introduction of person-centred handover, there was a significant improvement in the provision of information by nurses.

However, differing methodologies make it hard to draw comparisons to other studies. This study did not directly measure patient involvement in information exchange, so a higher result did not necessarily mean patients actively participated in their care.7

The survey found that two years after the introduction of person-centred handover, there was a significant improvement in the provision of information by nurses.

Overall, this study demonstrated improvements in information provision and exchange between nurses and patients. However, long-term and randomised studies are necessary for a more complete understanding. Nevertheless, this study recommended the use of person-centred handover in oncological inpatient settings because it can improve patient outcomes.7

What helps, and what hinders

Another systematic review and meta-analysis compared findings from 24 qualitative studies on bedside nursing handover and explained what facilitated its use and what were the barriers to implementing it.8

Barriers the studies found included lack of time, with some nurses feeling rushed to complete the bedside nursing handover, which patients took negatively and interpreted it to mean the nurse lacked interest in the therapeutic relationship.

Nurses worried that patient enquiries and the time needed to express and repeat information without medical terminology could lead to errors and lost information during handovers, which could be unsafe.8

However, it was found that nurses who used bedside nursing handover, used easily understood terms which allowed patients to better understand their medical condition and instilled confidence in the nurses' abilities.

Nurses were concerned about the ability to maintain confidentiality during bedside nursing handover in a shared room, and there was uncertainty around how much information nurses should provide during such handovers.8

Some nurses did not like bedside handover as they felt less free to communicate concerns with colleagues. Photo: iStock

It was found that participation in bedside handover decreased when the complexity of the patient's illness increased. Some nurses did not like bedside nursing handover as they felt less free to communicate concerns with colleagues.

The study drew no conclusions on which handover method was recommended, only emphasising facilitators and barriers that needed consideration before an organisation implemented bedside nursing handover.[8]

WHO strategies

The World Health Organization (WHO) outlined strategies to improve communication during patient handovers to guide health professionals' practice and ensure patient safety, in a guide issued in 2007.[9] It cited Australian data which said 11 percent of the 25,000 to 30,000 preventable events that caused disability in Australian hospitals in 1992 were related to communication breakdown.[9]

Among its recommendations to reduce errors and improve communication were:

- use of standardised handover approaches, such as the SBAR technique
- allowing enough time for providing the necessary information
- limiting exchanges of information to only those needed to care for the patient
- making it easy for other healthcare providers to access the patient's information and records if necessary
- communication between healthcare organisations.[9]

The WHO recommended patient and family participation in the handover process, stating that the patient and family played a crucial role in ensuring continuity of care. It was also important to ensure the patient had access to their medical records and that the patient was aware of the nurse caring for them on a particular shift, so they could ask questions or share concerns with the appropriate staff member.[9]

A crucial aspect of patient engagement was keeping patients and their families informed so they were aware of the next steps in their care and could participate more actively.

Factors standing in the way of implementing these recommendations could include staff opposition to change, lack of training and time, cost, language and cultural differences, low health literacy, staffing shortages, leadership failures, lack of technology infrastructure and insufficient accepted research or data.9

Recommendations

Current handover practices in this country usually occur away from the patient.6 Although I could not find a standardised nationwide handover policy, the Nursing Council's Code of Conduct includes the principle of participation and states that the involvement of health consumers must be facilitated.3

It could be argued that handovers that occur without the patient's presence do not adhere to the principle of participation because they fail to provide the patient the opportunity to hear and input any concerns or correct any information in the handover process.

Each health organisation must evaluate their specific bedside implementation barriers and facilitators.8 It seems many New Zealand organisations have not yet implemented bedside nursing handovers, but by not doing so, they prevent nurses from achieving an essential principle in their practice and potentially lowering the quality of care provided to patients.

Barriers to the implementation of bedside handovers include staff resistance to change, insufficient time, and insufficient research.8,9

Bedside handovers are associated with fewer patient injuries and errors than non-bedside handovers.5,6,9 Therefore, instituting this practice could save time and improve health outcomes by reducing the number of errors requiring time and staff to correct.

Based on the literature summarised above, bedside handovers are the recommended practice.7,9 However there are few studies conducted over the long-term that could assess if a change in practice offered sustained results.6,7

The findings of some of the studies could be questioned, due to the small sample size and the possibility of observation bias.6 Further randomised studies need to be undertaken that have a higher reliability, without bias.7

Each of the studies I looked at recognised there were barriers to implementing bedside handover, but they all described its positive effects on patient care.

Although the safety solutions proposed by the WHO9 are not recent, the organisation is globally recognised for its health promotion recommendations. It could be argued that its recommedations on handover practices have not been updated because the information is still applicable 16 years after the initial publication.

Each of the studies I looked at recognised there were barriers to implementing bedside handover, but they all described its positive effects on patient care. The reduced patient injuries from the use of bedside handover,6,9 could result in fewer hospitalisations, and because patients do not sustain additional illnesses or injuries, they may return to good health more quickly. This points to bedside handovers being a possible solution to improving patient outcomes.

The more involved and knowledgeable the patient and family are, the better it is for the patient because it ensures the continuity of care.5,9 Ultimately patients are better prepared for discharge.5,9

Do bedside handovers achieve better patient outcomes than non-bedside handovers? My literature search found that bedside handovers were not the most commonly used handover method.

However, the research showed that bedside handover equates to fewer patient injuries, and greater patient participation and satisfaction, despite not all studies directly concluding that it was the recommended practice.

More research needed

There is a need for further research to gain more understanding of the benefits of bedside handover. Research has shown that bedside handovers result in positive patient outcomes, provided the specific barriers and facilitators applicable to each facility or organisation are first considered.

Due to the positive aspects of bedside handover, it is possible to conclude that bedside handovers result in better patient outcomes than non-bedside handovers.

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Nicole Simonson has just completed the final year of her bachelor of nursing course, and is sitting state finals.

** This article was reviewed by Ben Ross, RN, MN(clinical), who is the charge nurse manager education, in the workforce practice and development unit, Te Whatu Ora — Capital, Coast and Hutt Valley.*

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Kaitiaki
NURSING NEW ZEALAND

NEWS

Whakarongorau's telehealth nurses finally settle pay deal

BY MARY LONGMORE

November 22, 2023

After eight months of negotiations, two strikes, nationwide rallies and mediation, frontline nurses have finally voted to accept a new offer from national telehealth service Whakarongorau — calling off two looming strikes.

Whakarongorau staff rally in Auckland.

Telehealth nurses will receive a four per cent pay rise and up to $4000 in lump sum payments, after two more payments of up to $1000 were added to an earlier $2000.

A living wage of at least $26 per hour for the lowest paid workers was also part of a revised offer from Whakarongorau, after its earlier offer was rejected in September.

> **'We've shown them that they need to take us seriously for the next lot of negotiations.'**

NZNO Tōpūtanga Tapuhi Kaitiaki o Aotearoa delegate Bruce Tomlinson said it had been a "long and drawn-out affair" but was satisfied with the deal — for now.

Bruce Tomlinson at Hokitika's rally in September.

"We've got a really good deal for our members who were taking the lowest wages — we've got a living wage and better conditions for those staff," he told *Kaitiaki*. "The other thing that's important is we've shown them that they need to take us seriously for the next lot of negotiations." These were likely to start before the proposed new deal ended on June 30, 2024.

> **'This milestone provides certainty for them and for the people of Aotearoa, who rely on the free-to-the-public 24/7 services we provide.'**

Strike action called off

Staff rallied then went on two 24-hour strikes in September and October. Two more strikes planned for this month were called off after Whakarongorau's NZNO and Public Service Association (PSA) members voted to accept the revised offer on November 9.

Whakarongorau staff on strike in Wellington last month

Whakarongorau paid out $2000 to all its telehealth nursing staff in September, and has agreed to pay members another $500-$1000, depending on their role, this month and again in June 2024.

Whakarongorau also rounded up its proposed pay rise from 3.75 to four per cent. Its initial offer was 2.5 per cent.

Some senior nurses also received wage increases of eight to nine per cent from the Government's $200 million pay parity fund back paid to July 1, 2023.

Whakarongorau chief employee experience officer Anna Campbell said they were "delighted" to have reached agreement with a "significant settlement".

With the three lump sums, pay increases ranged from 7.8 to 22.2 per cent under the deal, she said.

"This milestone provides certainty for them and for the people of Aotearoa, who rely on the free-to-the-public 24/7 services we provide."

Whakarongorau has more than 40 phone or web-based health services, including Healthline, 1737 Need to talk? along with crisis services like 111 mental health support and ambulance triaging.

Tomlinson said members would be pushing for a pay rise that better matched cost of living increases in the next bargaining round.

He said there were lots of "unanswered questions" around the profits made from the telehealth service by Whakarongorau's owners, primary health organisations Pegasus and Procare.

Anna Campbell

Campbell has said while the social enterprise did have a $7 million surplus in 2021/22 due to the Government's COVID funding, it made a loss in 2022/23 and was forecast to do so again.

Whakarongorau offer summary

- A minimum living wage of $26 per hour, from October 27, 2023.
- Pay parity wage increases of eight to nine per cent for eligible senior nurses [from the Government $200 million pay parity fund] back paid to July 1, 2023.
- A four per cent increase from October 27, 2023, for those roles not covered by pay parity or living wage increases mentioned above.
- Two lump sum payments of $500 to $1000 for all members, one now and one next June. (This follows a $2000 lump payment made during bargaining).

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NURSING NEW ZEALAND

OPINION

What is a nurse, at the core? Nurses seek to define their role in the face of threats from other workforces

BY NATALIE SEYMOUR

November 23, 2023

The profession of nursing is an ever-evolving one — and the key is to embrace a team-approach with other workers, argues aged care nurse Natalie Seymour in response to fears the role is being eroded.

Natalie Seymour

Nurses are facing changing times. Our role is being challenged by rising workforces such as physician associates (so far unregulated in New Zealand), anaesthetic technicians and perioperative practitioners — as well as health-care assistants (HCAs) and kaiāwhina with expanded duties that, at times, encroach onto nurses' territory.

When differentiating nurses from caregiving roles, we often hear the nurse saying 'I am doing the drugs'. But in aged care — where many of the kaiāwhina/caregiving staff are internationally-qualified nurses (IQNs) on a pathway to gaining registration here — many are supported by employers to complete their medication competencies.

The challenge here is to ensure the registered nurse (RN) recognises their knowledge and skills and factors them in as part of safe delegation of tasks.

> **[During Covid] nurse leaders had an opportunity and an obligation to lend their knowledge and skills as scientists, innovators, advocates and educators.**

With more complex and acute residents entering aged care, most staff have needed to widen their scope. While there is no single solution, developing interdisciplinary teams can be a great support to nurses and ensure high quality care is given.

Profession 'evolving'

Nursing is an evolving profession and its scope will likely continue to expand. As a profession, we need to decide what aspects must be protected — and what can be taken up by others. What lies at the centre of this discussion is the patient or resident and the best health outcomes.

Winding back to 2020, that year began with a celebration of nursing and was declared international year of the nurse by the World Health Organization (WHO).

It ended with the most destructive and life-altering global pandemic in modern history. Devastating disparities among marginalised groups resulted. Nurse leaders had an opportunity and an obligation to lend their knowledge and skills as

scientists, innovators, advocates and educators, as well as lead efforts to advance health equity — which means equal health outcomes for all.

Having exposed many of the health and social inequities affecting communities across the nation, the COVID-19 pandemic — along with other health crises such as rising levels of influenza, measles and obesity — has created an opportunity to take a critical look at the nursing profession, and society at large. We now have the chance to work collaboratively to allow everyone a fair and just opportunity for health and wellbeing, reflecting our social mission.

While access to health care is an important part of achieving health equity, on its own it is not enough. Health is affected by a wide range of other factors, including housing, transport, nutrition, physical activity, education, income, laws, government policies and discrimination.

Natalie Seymour speaking about the role of the nurse at the NZNO Tōpūtanga Tapuhi Kaitiaki o Aotearoa conference in September. Moderater Ruth Hill is at left.

Complementary health teams.

Kaiāwhina is an overarching term to describe non-regulated health workers such as health-care assistants (HCAs). It embodies the core essence of a workforce that is passionate, resilient, diverse, skilled and committed to supporting hauora — health — outcomes for everyone in Aotearoa.

Nurses, working in concert with other sectors and disciplines, contribute to interventions that address multiple and complex needs of people and have far-reaching effects on the health of communities.

As multiple factors influence the health of individuals and populations, a multi-discipline, multi-sector approach is needed.

The role of the nurse is characterised by collaboration and partnership with communities. As trusted professionals who spend significant time with patients and their families, nurses are well equipped to work in partnership to address an array of health-related needs.

Involving others from the kaiāwhina workforce such as HCAs helps provide holistic care and is becoming more common.

Guidelines

An NZNO-Tōpūtanga Tapuhi Kaitiaki o Aotearoa position statement (https://www.nzno.org.nz/Portals/0/publications/Fact%20sheet%20-%20Regulated%20health%20practitioners%20working%20as%20unregulated%20staff%20in%20the%20New%20Zealand%20healthcare%20setting,%20N2012.pdf) guides members who have been regulated if they take up voluntary or paid roles as unregulated members of the health workforce — for example registered or enrolled nurses working as first aid staff at events, or as caregivers in aged care.

We now have the chance to work collaboratively to allow everyone a fair and just opportunity for health and wellbeing, reflecting the concept of social mission.

There can be much satisfaction in completing unregulated nursing work and for some it can be a stepping stone to gaining further qualifications and "staircase" into a regulated nursing role.

While nurses may conduct screenings and assessments, create care plans, refer patients/residents to appropriate professionals and social services, the support roles in the kaiāwhina workforce such as HCAs can bolster this by completing tasks such as medication rounds, cultural navigation and connecting people to community providers.

The Nursing Council details its expectations (https://www.nursingcouncil.org.nz/Public/Nursing/Standards_and_guidelines/NCNZ/nursing-section/Standards_and_guidelines_for_nurses.aspx) for directing and delegating, with a series of questions to be asked as part of the process:

- Does the registered nurse (RN) have the skills and knowledge to safely delegate care in this context?
- Can this activity be routinely performed without complex observations, decision-making or nursing judgment?
- Has the consumer's health status been assessed and delegation of care determined to be appropriate?
- Is this health care activity within the level of knowledge, skill and experience of the person being delegated the activity?
- Are there organisational policies and procedures in place to support the delegation?
- Does the person who has been delegated the activity understand the delegated activity, have appropriate direction and know when and who to ask for assistance and who to report to?
- Is there ongoing monitoring and evaluation of the outcomes of care by the RN?

Focus on the value others add

As nurses, it is our responsibility to shape the support roles in response to the increasingly complex and acute patients/residents we are treating — while recognising the constraints of resourcing and the implications this potentially has for health equity.

In short, we influence the non-regulated roles and how they can play a significant part in the health sector, to deliver as good health outcomes as possible.

A 2014 paper *The use of unregulated staff: Time for regulation? (https://www.researchgate.net/publication/261408544_The_Use_of_Unregulated_Staff_Time_for_Regulation)* by Australian nursing professor Christine Duffield identifies a number of benefits from RNs and their unregulated colleagues working together.

The focus should be on the value that unregulated workers add to the team, rather than as replacements for nurses.

- *Natalie Seymour is chair of the college of gerontology nursing (https://www.nzno.org.nz/groups/colleges_sections/colleges/college_of_gerontology_nursing). This viewpoint was adapted from her presentation at the NZNO-Tōpūtanga Tapuhi Kaitiaki o Aotearoa conference panel 'challenges for nurses' in September (below).*

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NURSING NEW ZEALAND

PRACTICE

Your mission: To use antimicrobials wisely

BY HE AKO HIRINGA

November 21, 2023

There are many ways that health professionals can help prevent antimicrobial resistance, a worldwide problem which threatens the effectiveness of these important drugs.

November 18-24 is World Antimicrobial Resistance Awareness Week (WAAW)

World AMR Awareness Week aims to improve awareness and understanding of antimicrobial resistance (AMR). The New Zealand Antimicrobial Stewardship and Infection Pharmacist Expert Group (NAMSIPEG) has provided the following information to support this initiative.

About AMR

AMR is one of the top 10 global public health threats, causing over 1.3 million deaths each year. The biggest driver of AMR is use of antimicrobials, including overuse and misuse. AMR compromises routine and complex medical care, such as surgery and cancer treatment, where antimicrobials are needed to manage infection.

Learn more about AMR from the Ministry of Health Manatū Hauora (https://www.health.govt.nz/our-work/diseases-and-conditions/antimicrobial-resistance) , the World Heath Organization (https://www.who.int/news/item/06-06-2023-world-antimicrobial-awareness-week-(waaw)-will-now-be-world-amr-awareness-week), the Australian Government (https://www.amr.gov.au/) and the European Centre for Disease Prevention and Control (https://www.ecdc.europa.eu/en/antimicrobial-resistance).

About WAAW 2023

The major cause of antimicrobial resistance is overuse and misuse of antimicrobial drugs. Photo: Adobe Stock

This year's global theme is *Preventing AMR together* and our national theme is *Indications in antimicrobial prescriptions.* This means being specific about what the prescription is for, for example, write "cystitis" or "pyelonephritis" rather than "UTI" or "infection".

Eighteen organisations have joined together in Aotearoa this year to promote documenting the rationale for antimicrobial use in the prescription. This action can help improve patient care and conserve antimicrobial effectiveness (see poster below).

A range of free resources (https://www.psnz.org.nz/practicesupport/antimicrobial) (including posters, screen savers and this information as a printable bulletin) are available on the New Zealand Pharmaceutical Society website.

Prescribers need to ensure they use a precise indication on an antimicrobial prescription. Photo: Adobe Stock

What can health professionals do to help slow AMR?

Use antimicrobials wisely by:

- only using them if the benefits likely outweigh the harms
- following relevant local guidelines and having a low threshold for seeking advice
- thinking the "4**R**s" – **r**ight agent, **r**ight route, **r**ight dose and **r**ight duration
- challenging the veracity of penicillin allergies – see 2021 WAAW resources (https://www.psnz.org.nz/Category?Action=View&Category_id=654)
- documenting the indication and course duration (ie, review or stop date) in the prescription.

Prevent infections and spread of resistant microbes by:

- washing hands regularly
- following relevant infection control guidelines
- ensuring safe food handling
- keeping vaccinations up to date
- encouraging safer sex practices
- avoiding unnecessary use of invasive devices such as IV lines, and removing them promptly when no longer required.

National antimicrobial guidelines 2024

Aotearoa has much duplication in antimicrobial guideline development at district, regional and national levels. This creates inconsistencies and is inefficient.

A team of clinicians is now working collaboratively across the motu to harmonise the existing guidelines into a national standard for antimicrobial prescribing. The guidelines will be freely available in both mobile and desktop versions and will be launched in November 2024.

Getting involved

The national antimicrobial guideline development is part of a suite of projects aimed at promoting effective, safe and equitable antimicrobial use. An introductory letter (https://www.akohiringa.co.nz/document/view/national_antimicrobial_guidelines_-_introductory_letter_140923) has been widely distributed. If you are keen to contribute, or are interested in hearing about progress, contact antimicrobials@cdhb.health.nz

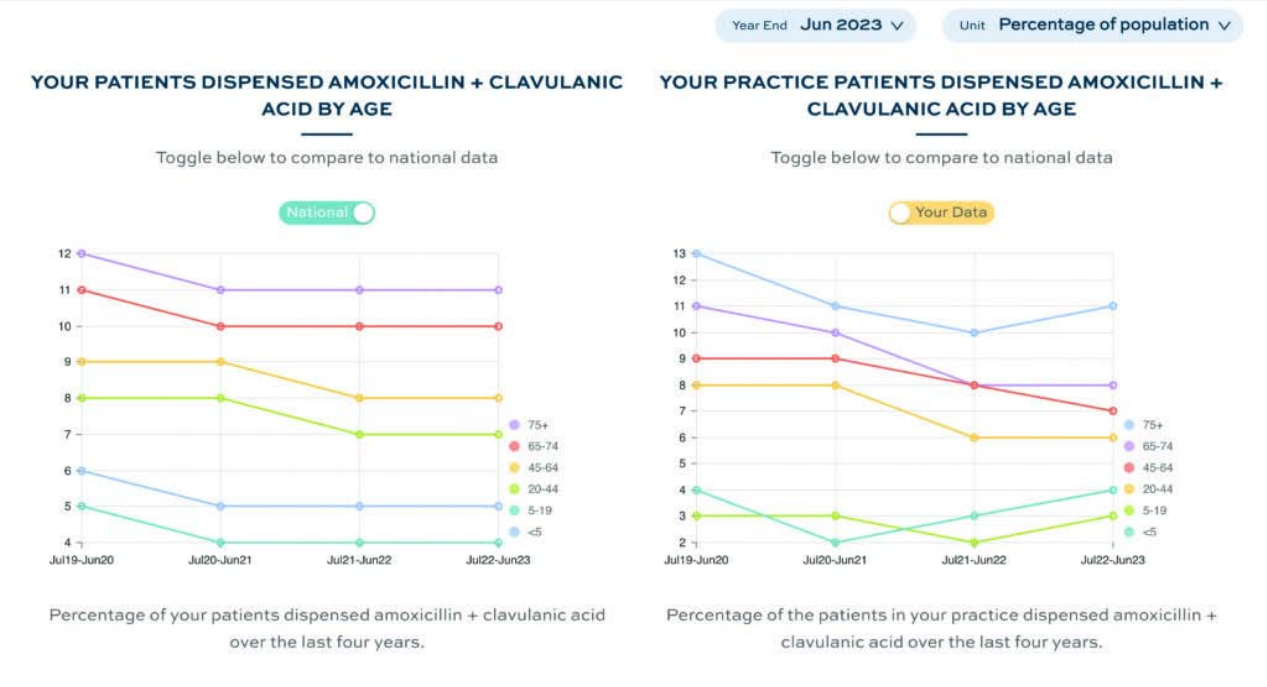
He Ako Hiringa tools to help slow AMR

EPiC dashboard

EPiC (http://www.epic.akohiringa.co.nz) is a data analytics tool that enables clinicians to compare their own prescribing with prescribing for all patients in their practice and with patients nationally, using age, gender, ethnicity and socioeconomic deprivation quintile filters.

Community dispensing of antibacterials accounts for around 95 per cent of human antibacterial consumption in Aotearoa1 so small changes to practices in primary care can have significant effects on addressing antimicrobial resistance in the community.

The EPiC antibiotics dashboard (https://epic.akohiringa.co.nz/antibiotics) helps clinicians to review their prescribing of antibiotics and consider areas where they might implement change. Data are included for urinary tract infection, seasonal variation, use of amoxicillin + clavulanic acid and use of topical antibiotics.



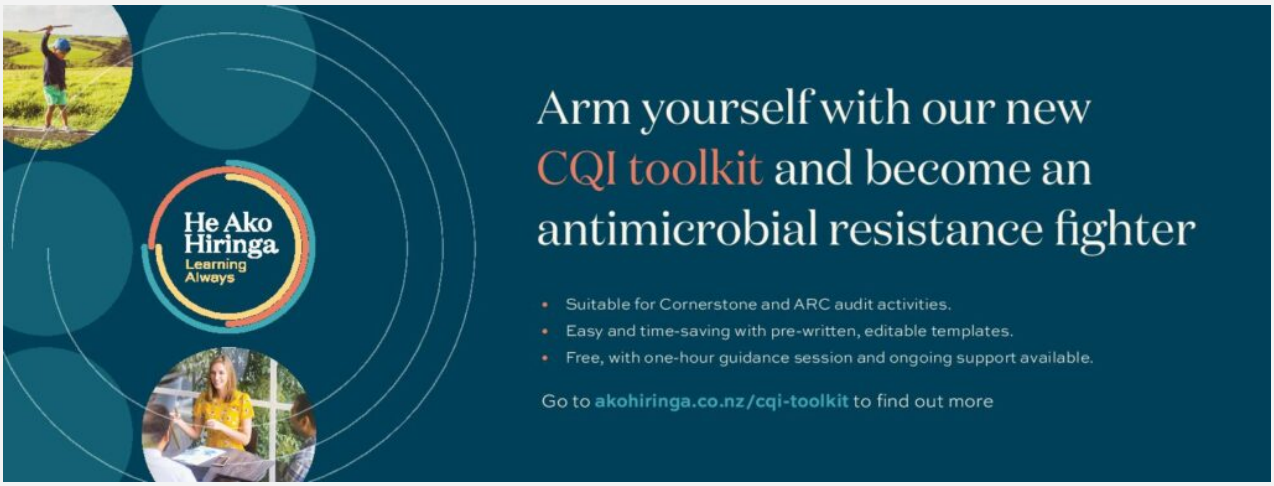
An example of the antibiotics prescribing data available on the EPiC dashboard.

The CQI Toolkit

The continuous quality improvement toolkit (http://www.akohiringa.co.nz/cqi-toolkit) consists of an activity guide, a data collection form and an information sheet. The resources guide you through identifying an area

for improvement, collecting baseline data from EPiC antibiotics, implementing a change, and collecting subsequent data to determine if the change has been beneficial.

The toolkit uses antibiotic prescribing throughout the example templates, making it an ideal aid for improving antimicrobial stewardship and reducing AMR. The toolkit is endorsed by the RNZCGP to help medical practices meet various requirements of the Foundation Standard and the Cornerstone CQI and Equity modules.



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- Kotahitanga – Uniting Aotearoa against infectious disease and antimicrobial resistance (https://cpb-ap-se2.wpmucdn.com/blogs.auckland.ac.nz/dist/f/688/files/2022/06/OPMCSA-AMR-Full-report-FINAL-V3-PDF.pdf)