Kaitiaki
NURSING NEW ZEALAND

NEWS

# Measure RNs against six pou – not 41 competencies, say nurses

BY MARY LONGMORE

*February 29, 2024*

As consultation on new nursing competencies closes, nurses are embracing moves towards a culturally safer workforce — but say they should be measured against a handful of pou (domains) instead of dozens of new competencies:

**'Nursing will be leading the way in health care towards equity and inclusion at a time when the Government is attempting to dismantle the rights of tangata whenua.'**

NZNO — Tōpūtanga Tapuhi Kaitiaki o Aotearoa members responded in large numbers on the proposed changes, many saying the leap from 20 to 41 competencies for RNs would be a "huge amount of work".

**At a glance**

However the move towards a more te Tiriti-led, culturally-competent nursing workforce, focused on improving Māori health, was warmly welcomed.

"Nursing will be leading the way in health care towards equity and inclusion at a time when the Government is attempting to dismantle the rights of tangata whenua," one said.

#### More competencies – but no more indicators

In December, the Nursing Council released a proposed set of new competencies (https://www.nursingcouncil.org.nz/common/Uploaded%20files/NCNZ%20Competencies-Registered-Nurses.pdf) for both enrolled nurses (ENs) and registered nurses (RNs), which doubles the number of competencies required — but also ditches dozens of "indicators" (performance meaures).

> **'We never intend to complicate a system, but we can't also sit on our hands and think the system's working.'**

Council chief executive Catherine Byrne said a key focus was Te Tiriti o Waitangi and nurses' role in improving health equity for Māori. Another focus was a more collaborative relationship between RNs and ENs. Consultation ended on February 12 with the council saying it had received a "tremendous" response from nearly 3000 people.

RNs would have 41 competencies across six pou (domains), instead of 20 competencies across four domains (https://nursingcouncil.org.nz/Public/NCNZ/nursing-section/Registered_nurse.aspx) (professional responsibility, management of nursing care, interpersonal relationships and "interprofessional" health care/teamwork). But 83 indicators would be ditched.

ENs would have 29 competencies across five pou, instead of 17 competencies across four domains (https://nursingcouncil.org.nz/Public/NCNZ/nursing-section/Enrolled_nurse.aspx) (professional responsibility, provision of nursing care, interpersonal relationships and interprofessional care/teamwork). But 69 indicators would be ditched.

#### Workload concerns

Concern over the workload of providing evidence for each of the 29 or 41 competencies — and the impact on continuing competency requirements — was the number one issue for members, said NZNO researcher Sue Gasquoine, who drew together NZNO's highest member response in years for a submission.

"An alternative suggested was assessment of competence against each pou — five for ENs and six for RNs. This would be more enabling and meaningful and creates opportunity for nurses to demonstrate excellence through reflective description."

**For RNs, the proposed six pou (domains) of competence are:**

- Te Tiriti o Waitangi, ōritetanga (equality) and social justice.
- Kawa whakaruruhau and cultural safety.
- Pūkengatanga (skill) and excellence in nursing practice.
- Manaakitanga and people-centredness.
- Whakawhanaungatanga (relationships) and communication.
- Rangatiratanga and leadership.

**For ENs, the proposed five pou are:**

- Te Tiriti o Waitangi
- Cultural safety
- Knowledge-informed practice
- Professional acccountability and responsibility
- Partnership and collaboration.

See the full proposed changes, here. (https://nursingcouncil.org.nz/common/Uploaded%20files/NCNZ%20competencies%20consultation.pdf)

**Members said:**

*'I really love the new pou for the EN and RN competencies and believe they are highly relevant to being a nurse in Aotearoa New Zealand, particularly the very focused pou to actualise Te Tiriti o Waitangi, and other pou to ensure Māori and other are being safely and appropriately cared for within our health system.'*

*'There appears to be an unsubstantiated hypothesis that nurses have a sphere of influence to be effective agents of change in regard to social justice, cultural safety and leadership — where is the robust evidence of this that would underpin such assumptions?'*

## ‘How do we move some of those deeply entrenched behaviours in the system, and make nurses lift their gaze?’

*‘I’d like to be able to say that I understand the current competencies well and that I can readily apply them to practice but it is a huge amount of work to provide a single example for each of the competencies. Increasing the number of competencies will only make this more challenging.’*

*‘Where are the competencies for management, education, policy and research?’*

*‘My concern is the proposed new competencies will become a huge barrier to our aged force and our IQNs.’*

Nurses were also keen to see the environment — te taiao — and climate change given greater priority, as a key health issue, Gasquoine said.

But members overall expressed “huge respect for the emphasis the proposed changes places on Te Tiriti”, she wrote in the submission.

### Change is coming

NZNO kaiwhakahaere Kerri Nuku — who was part of the Nursing Council’s competencies design group for both ENs and RNs — said the proposal “signalled change” and a shift away from institutional racism and other barriers to culturally safe health care for Māori. These had been identified in reports such as the Waitangi Tribunal inquiry into health services for Māori Wai2575 (https://www.waitangitribunal.govt.nz/inquiries/kaupapa-inquiries/health-services-and-outcomes-inquiry/), and the 2020 health and disability system review (https://www.health.govt.nz/system/files/documents/publications/health-disability-system-review-final-report-executive-overview.pdf).

“We never intend to complicate a system, but we can’t also sit on our hands and think the system’s working,” Nuku told *Kaitiaki*.

*Kerri Nuku*

“How do we move some of those deeply entrenched behaviours in the system, and make nurses lift their gaze — understand the health sector environment, but also be better advocates for change, for the patients.”

Co-chair of the national PDRP (professional development and recognition programmes) coordinators group Diane Bos said the proposed number of competencies and duplication could be a “major barrier” for many.

“If they were going to put that many competencies in, it would take that much longer to write [a peer review].”

But generally, both ENs and RNs loved their new pou — although there were questions over a lack of a leadership pou for ENs who Bos said often showed “clear leadership” across the health sector.

All “loved” that te Tiriti and cultural safety had been given their own pou for the first time, Bos said.

### ‘Tremendous’ response

Nursing Council projects leader Jane MacGeorge said response to the consultation had been “tremendous” with feedback from 2773 people including 100 written submissions and 1429 completing the survey.

The response showed nurses’ concerns over the number of competencies, and the impact of this on meeting their continuing competency requirements — particularly professional development and recognition programmes (PDRPs), she said.

*Catherine Byrne*

The council would be considering feedback with further consultation on a revised proposal expected mid-year before new competencies were finalised later in the year, MacGeorge said.

Byrne said the council had been guided in its proposal by a range of nursing voices, including NZNO's EN section, Te Rūnanga o Aotearoa NZNO, professional groups and Māori and Pacific nursing leaders, with a series of wānanga last year.

*'[There is an] assumption that inequity in healthcare is caused by or can be relieved by nurses . . . Such requirements need to be incorporated into national and organisational policy and procedure and, where appropriate, specified in areas where a proven sphere of influence exists e.g. role descriptions for those in senior leadership positions rather than as defining competence for nurse registration.'*

*'I like that ENs can take on a leadership/coordination role.'*

*'It appears that some of the organisational responsibility for strategy planning and operational policy/procedure/protocol is being transferred into the definition of a registered nursing via the revised competency framework.'*

**NZNO members also wanted to see:**

- The collaborative team relationship of ENs and RNs better reflected.
- A better defined career pathway across the EN and RN scopes including RN prescribers.
- Inclusion of the term "whakapapa-centred care" in RN competencies, as with ENs, in order to consider physical, emotional, spiritual and cultural needs.
- Greater priority on te taiao — the enviroment — in the face of climate change and its impact on health.
- More accessible language.

**Members were concerned that:**

- Nurses' abilities to meet pou six — rangatira and leadership — might be inhibited by their organisation, if leadership opportunities were not available for nurses.
- Employers wouldn't support and pay for nurses to improve their knowledge of te reo Māori pronunciation and names as well as tikanga (as proposed in pou five).

| Pou | Registered nurses | Enrolled nurses |
|---|---|---|
| One | **Te Tiriti o Waitangi, ōritetanga and social justice**<br>This pou requires evidence of critical consciousness and nursing practice which gives effect to Te Tiriti o Waitangi and human rights advocacy. Nurses have an ethical responsibility to lead in the elimination of health inequities and the achievement of a health care system that delivers appropriate and equitable healthcare for all. | **Te Tiriti o Waitangi**<br>This domain contains competencies that gives effect to Te Tiriti o Waitangi in everyday practice, to support the right of Māori to be Māori and exercise self-determination over their lives, to improve health and wellbeing of Māori and whānau. |
| Two | **Kawa whakaruruhau and cultural safety**<br>This pou supports the provision of holistic care, and ensures the nurse reflects on their own values, biases, and beliefs, and understands the impact of these on care provision. | **Cultural safety**<br>This domain contains competencies to ensure cultural safety in practice. This requires ENs to reflect on their own values, biases, and beliefs, to ensure the rights of Māori, Pacific and diverse population groups to promote equity and inclusion. |
| Three | **Pūkengatanga and excellence in nursing practice**<br>This pou addresses critical thinking and analysis; use of evidence based and scientific knowledge to underpin practice; and being accountable and taking responsibility for own practice. This includes the use of a range of assessment tools appropriate to the practice environment and diverse populations. | **Knowledge-informed practice**<br>This domain contains competencies related to the knowledge and expertise to enable assessment, clinical decision-making, and provision of safe nursing care for individuals, whānau, and communities. |

| Pou | Registered nurses | Enrolled nurses |
|---|---|---|
| Four | **Manaakitanga and people- centredness**<br>This pou refers to building trusting, compassionate, collaborative relationships with people and whānau, facilitating holistic care focused on collective wellbeing. This includes caring for others to uphold the mana of all concerned (nurse, service, profession, organisation). | **Professional accountability and responsibility**<br>This domain contains competencies that relate to the provision of nursing care within professional, ethical, and legal boundaries, that promote safe nursing practice by ensuring the rights, confidentiality, dignity, and respect for people are upheld. |
| Five | **Whakawhanaungatanga and communication**<br>This pou focuses on establishing relationships through the use of effective and appropriate interpersonal skills and communication strategies. | **Partnership and collaboration**<br>This domain contains competencies related to working in partnership and collaboration with individuals, their whānau, communities, and the interprofessional health care team across the life span in all settings. |
| Six | **Rangatiratanga and leadership**<br>This pou focuses on leadership, professionalism, advocacy, teamwork, and nurses as change agents. Rangatiratanga in the context of nursing practice refers to the inherent potential of all nurses to act as change agents, regardless of seniority or formal leadership positions. Rangatiratanga is exercised when nurses act as independent thinkers, intervene, speak out, advocate, and follow processes to escalate concerns. Rangatiratanga is further demonstrated when nurses are proactive in offering solutions and leading innovative change for improvement. | |

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NEWS

# What can Pākeha do? Anti-racism event offers chance to 'stand up, fight back'

BY MARY LONGMORE

*February 22, 2024*

A Te Tiriti o Waitangi-focused event in March will help nurses and kaiāwhina become more culturally and politically competent at an 'alarming' time, say organisers and NZNO's kaiwhakahaere.


*Heather Came-Friar with fellow anti-racism academics Keith Tudor (left) and Tim McCreanor at Waitangi this month. Photo by Denis Came-Friar.*

Te Tiriti-based futures (https://www.tiritibasedfutures.info/) is a free 10-day online anti-racism event on March 16-25 which is open to all and will benefit nurses and health professionals at an "alarming" time for Aotearoa, says founder, public health academic and activist Heather Came-Friar.

"I'm hoping this will provoke and inspire people wanting to learn more and work out how they can contribute to racial justice in this country."

> **'If you're going to be politically and culturally competent, this is the sort of training you need to get to keep up-to-date and learn about what's going on in the world.'**

For health practitioners, she said it was "free professional development".

"As a public health practitioner, it's enormously relevant to get your head around what the issues are that a range of communities are facing," Came-Friar told *Kaitiaki Nursing New Zealand*.

"If you're going to be politically and culturally competent, this is the sort of training you need to keep up-to-date and learn about what's going on in the world."

NZNO — Tōpūtanga Tapuhi Kaitiaki o Aotearoa kaiwhakahaere Kerri Nuku, who spoke at the first Te Tiriti Futures event in 2020 about pay disparities (https://www.youtube.com/watch?v=DodbWdvJUCo) for nurses working for Māori and iwi health providers, said it was a great opportunity for the nursing/kaiāwhina workforce to upskill.

*Kerri Nuku*

"It really makes you critically look at the language you use and the impact that could have unintentionally – so almost a professional development session and cultural safety training programme, all wrapped up into one."

Came-Friar said the session on Saturday, March 23, *Fighting for racial justice in health care* (https://www.tiritibasedfutures.info/programme) would be of particular interest to the nursing and health workforce.

However, she expected nurses would pop up in "unexpected places throughout the programme — as nurses are always on the frontline".

Nurse and midwife Jean Te Huia, Starship Māori health director Toni Shepherd and GP/Te Aka Whai Ora chief medical officer Rawiri McKree Jansen will be discussing how to transform a system to better care for Māori, who endure shorter lives and worse health outcomes than non-Māori.

> **'Te Tiriti is the contract and terms and conditions by which my ancestors came to this country. It cannot be rewritten by a bunch of men in Parliament.'**

*Jean Te Huia*

*Toni Shepherd*

*Rawiri McKree Jansen*

Te Huia was one of the midwives filmed in 2019 stopping social workers uplifting a baby from a young Māori māmā in Hawke's Bay Hospital, and has continued fighting for wāhine Māori rights on the frontline and through the Waitangi Tribunal's Mana Wāhine (https://www.waitangitribunal.govt.nz/inquiries/kaupapa-inquiries/mana-wahine-kaupapa-inquiry/) inquiry into discrimination against Māori women.

Other speakers include Māori philosopher Ani Mikaere, Māori researcher Leonie Pihama, Māori sociologist Tracey McIntosh, Te Tiriti scholar David Williams and indigenous Australian activist Yin Paradies, as well as speakers from Palestine, Honduras, the Pacific region and the Black Lives Matter movement.

> **'I'm just hoping for some compassion and some considered and strategic action – and for people to get some skin in the game.'**

There will also a student-led petchakutcha (https://www.tiritibasedfutures.info/kei-te-mura-o-te-ahi-pechakucha) marathon — based on a Japanese concept of short, image-based presentations.

"We do privilege the local scene because we want to understand what's going on there – but we're also curious about the world, as there are things to learn," Came-Friar said.

"I'm just hoping for some compassion and some considered and strategic action – and for people to get some skin in the game."

Nuku said the international speakers helped share not only the challenges facing indigenous people globally — but solutions relevant for Aotearoa. "What do other groups or people put in place to combat this?"

She said it was a timely to be considering what Te Tiriti partnership looked like — and what non-tāngata whenua can do to support the kaupapa.

#### 'We need to step up'

Came-Friar — who is Pākeha — said current discourse around Te Tiriti was "somewhat alarming" but she was confident about its future.

"Te Tiriti will always endure – commonsense will prevail. Te Tiriti is the contract and terms and conditions by which my ancestors came to this country. It cannot be rewritten by a bunch of men in Parliament. It's been agreed to and we need to step up and honour it."

It was a time to listen, "open your heart" and decide how to respond, she said.

“My theme for the year is stand up, fight back – and I hope people take the opportunity for this important free education for people to learn a little bit more and then consider whether they’re standing on the right side of history.”

Held every two years, the online event was attended by 42,500 globally in 2022.

*— Te Rūnanga o Aotearoa NZNO is a partner of Te Tiriti-based Futures*

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NEWS

# Shane Reti says end goal is a NZ-trained culturally competent nursing workforce

BY MARY LONGMORE

*February 22, 2024*

More cash support for nursing students struggling with high dropout rates is "not off the table", says Minister of Health Shane Reti.

*Minister of Health Shane Reti*

In a recent NZNO survey nursing students identified financial pressure as the number one issue causing them to drop out. Overall, nearly a third drop out — with higher rates for Māori and Pasifika, who are under-represented in nursing.

Reti told *Kaitiaki Nursing New Zealand* this week he wouldn't rule out some kind of stipend or payment for nursing students on clinical placements in their third year — but it would have to include other clinical students on placements such as doctors and psychologists.

> **'At the end of the day, my end goal is to have New Zealand, homegrown, domestically culturally competent nurses.'**

"It's not off the table, but I don't have it as an active workstream — so I'm not a closed mind to it," Reti said.

"If we consider that, then we consider every other student in a clinical placement — it needs to be in that much broader context."

While he had not seen any recent costings, Reti said, for that reason, any such policy would be "very expensive".

His preferred solution has been a student loan write-off of $4500 per year for up to five years ($22,500) for nurse and midwife students who complete their training and stay in New Zealand. This had been costed at just under $230 million over four years (https://assets.nationbuilder.com/nationalparty/pages/17860/attachments/original/1684306047/Delivering_more_nurses_and_midwives.pdf?1684306047) to be funded by cutting government consultant costs — but Reti did not yet know when this would be implemented.

"It's still to be decided . . . [but] is unlikely to be this year."

Reti said he and Minister for Tertiary Education Penny Simmonds, who together developed the policy, needed to see the impact of tertiary fees-free shifting (https://www.rnz.co.nz/news/what-you-need-to-know/508677/the-new-government-is-scrapping-first-year-fees-free-what-you-need-to-know) from first to final year, before rolling out any new initiatives.

*Minister for Tertiary Education Penny Simmonds.*

And when it came to deciding any new spending, Reti said there were "surprise fiscal cliffs" the Government had to consider. For example, the need to fund Pharmac another $200 million per year to maintain its pharmaceutical budget for things like COVID vaccines and anti-virals, due to run out in July.

"This year in particular, is the [fiscal] surprises, which I guess every new incoming government gets — you lift up the hood and . . . 'oh, we didn't know that'."

The loan write-off/bonding idea was criticised when it was announced last year by students who said they needed help during — not after — training.

But Reti insisted it was intended to retain students, who could borrow enough to complete their studies, knowing a big chunk could be written off if they graduated and stayed in the country.

> **'. . . my observation over nearly 30 years of clinical practice is that if you treat people in a culturally competent context, you get a better outcome – no matter what their culture is'.**

"It was actually about student retention with the knowledge of 'we'll then address your student loan pending bonding on graduation'."

#### A workforce that 'looks like us'

Addressing health workforce shortages — estimated at around 4000 for nurses — was the "number one" priority, said Reti, who wanted to see more New Zealand-trained nurses in the face of a "huge" number of internationally-qualified nurses (IQNs) — 45 per cent of the New Zealand nurse workforce at last count (https://www.nursingcouncil.org.nz/Public/News_Media/Publications/Workforce_Statistics/NCNZ/publications-section/Workforce_statistics.aspx).

"Don't get me wrong, I'm grateful to IQNs as we wouldn't cope without them, as with other systems. But at the end of the day, my end goal is to have New Zealand, homegrown, domestically culturally competent nurses," said Reti.

"I think it [cultural competency] should be through all stages, both of teaching and when you graduate. There's responsibility for the colleges," said Reti, a GP who previously worked in Northland. "I have a certain number of cultural competency components I must do to maintain my APC [annual practising certificate] but then I think it should be at a department level, it should be at an organisational level.

> **'So it's an ambition that nurses are valued wherever they are, in any part of the health workforce. I do support pay equity and pay parity.'**

"So I'm a big fan of cultural competency."

The health workforce also needs to "look like those they serve," said Reti, who is Māori (Ngātiwai, Ngāti Maniapoto, Ngāpuhi-nui-tonu). For Māori, comprising about 17 per cent of the population, that meant more than the current level of Māori nurses — about nine per cent — was needed. But he also wanted to see migrant communities represented in New Zealand's health workforce.

". . . my observation over nearly 30 years of clinical practice is that if you treat people in a culturally competent context, you get a better outcome – no matter what their culture is. That's not epiphanous – so I have ambitions for our health workforce to look like us."

Reti offered few specifics on how to get there, but said a better understanding was needed of how to make the nursing profession more attractive. "We need to understand what is it that creates a hurdle for them to even start. Then, as they make their way through, what are the hurdles?"

He acknowledged that the biggest barrier was financial.

#### Paying all nurses the same

Reti also said he supported pay parity — nurses being paid the same no matter where they worked — but getting there was "a challenge".

"I agree with pay parity. The challenge there is severalfold. We get close and then one part of the workforce advances, and another hinders. And of course there's a fiscal component to all of that, clearly," he said.

> **'The first priority is health need – and then, surprise surprise, Māori have the highest need. Done, easy.'**

"So it's an ambition that nurses are valued wherever they are, in any part of the health workforce. I do support pay equity and pay parity. But like it's been for previous governments, it's been a challenge for them and it'll be a challenge

for me also, as to how we do that. But I do support those ambitions."

**Equitable health-care for Māori?**

Reti believed a needs-based approach to health care, rather than ethnicity-based, would still address inequities for Māori who endure shorter lives and higher disease and death rates.

"The first priority is health need — and then, surprise surprise, Māori have the highest need. Done, easy."

Considering anything else was a "slippery slope", Reti said. "The next day we'll distribute resources based on your value to society. Are you a previous mayor? You deserve to get your hip done first . . . that just does not work."

Reti was "fully committed to delivering health care as close to home and close to the hapū as possible.

"To do that, we'll be needing depth and breadth in our health workforce, and I certain value all our nurses and kaiāwhina as part of that, for what they bring."

NZNO's core strategy *Maranga Mai* (https://maranga-mai.nzno.org.nz/why_we_support_maranga_mai) outlines the need for equal access to health care for Māori, 4000 more nurses particularly Māori and Pasifika, affordable training, attractive pay and safer conditions for the nursing workforce.

Reti invited NZNO leaders kaiwhakahaere Kerri Nuku and president Anne Daniels to meet him the same day he was sworn in last year and has pledged ongoing catchups.

Shane Reti is the second Māori minister of health — the first was a century ago, Sir Māui Wiremu Pita Naera Pōmare, who was minister from 1923 to 1926.

*NZNO — Tōpūtanga Tapuhi Kaitiaki o Aotearoa student members at their hui late last year where they discussed the challenges of training as a nurse.*

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NEWS

# A bit of aroha – and coffee – goes a long way for Waikato and Auckland nurses

BY MARY LONGMORE

*February 15, 2024*

Hundreds of Waikato and Auckland nurses have been treated with free coffee and groceries in recent years, courtesy of community-minded publisher Chris Biddulph.


*Waikato Hospital emergency nurses Jacqui Bunyan (left) and Tracy Chisholm enjoy their free coffees.*

**'These little moments of appreciation are often what is needed while wading through our daily grind.'**

Waikato Hospital emergency nurse Tracy Chisholm said it was the second year running coffee vouchers had appeared "out of the blue" to acknowledge what Biddulph describes as the work, compassion and commitment of nurses.

"These little moments of appreciation are often what is needed while wading through our daily grind — and the caffeine boost always helps!" she said.

The Waikato man behind the gesture manages family-run educational publishers, the Biddulph Group. He told *Kaitiaki* one of his main purposes was to help others, and his motto was "lead with kindness".

It was in August 2021, bang in the middle of the COVID-19 pandemic and media coverage of frontline staffing pressures, that Biddulph decided hard-working nurses needed some appreciation. He contacted NZNO — Tōpūtanga Tapuhi Kaitiaki o Aotearoa offering to shout some of Auckland's frontline nurses morning tea or lunch to the tune of $1000.


*Chris Biddulph (right) with Special Olympics long-distance runner Te Huia Apaapa or 'Rocket Man'.*

Later that month, after reading about thieves targeting nurses' cars (https://www.nzherald.co.nz/nz/covid-19-coronavirus-delta-outbreak-thieves-target-nurses-cars-as-auckland-hospital-staff-work-12-hour-shifts/7CZ7DG6QIWNGRSTIYMKXKULGRQ/) at Auckland Hospital, Biddulph was again moved to help out and — with the help of NZNO staff — distributed cafe and supermarket vouchers to nurses at Middlemore Hospital emergency department (ED) and intensive care unit (ICU), as well as nurses at Waikato Hospital's ED, ICU, neo-natal intensive care unit and delivery suite.

Since then, he reckons he's donated about $15,000 to reach about 1700 nurses and midwives at Auckland and Waikato hospitals and medical centres.

### 'Seen and valued'

Waikato Hospital clinical midwife manager Heidi Strother said it was a "lovely surprise" for midwives to be acknowledged for the hard work they do.

"Here in delivery suite, we all hugely appreciated Chris's kindness and generosity in organising these vouchers for us. It made us feel seen and valued."

> **'During the pandemic, more people thought about the many essential workers, and the need for fairness, equity… recognition of their hard work, the risks they were taking'.**

The family-run Biddulph Group publishes educational material for schools and early childhood education. The sale of its literacy programmes (https://www.readingtogether.net.nz/blog/history-of-reading-together-in-new-zealand.html) *Reading Together, Te Pānui Ngātahi* and *Early Reading Together* had allowed it to support a number of organisations, including the Waikato/Bay of Plenty Cancer Society and Waikato Community Hospice Trust as well as environmental causes in recent years, he said.

#### COVID 'reaffirmed' the need for social justice

Biddulph has also been a long-time volunteer at community athletic events, supporting athletes with disabilities and guiding walks in support of mental health in the Waikato region.

For him and his family, the impact of COVID had "reaffirmed" the importance of social justice, fairness, equity and opportunities for all, said Biddulph. He wanted to recognise the hard work of nurses in a predominantly female profession.

"During the pandemic, more people thought about the many essential workers, and the need for fairness, equity (particularly where the majority of workers were female), recognition of their hard work, the risks they were taking, and so on."

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NEWS

# Nurses concerned over leap in competencies proposed by Nursing Council

BY MARY LONGMORE

*February 9, 2024*

The Nursing Council of New Zealand says it is listening, after a "strong" response from nearly 2300 nurses to its proposed new competencies for both enrolled nurses (ENs) and registered nurses (RNs).

*Photo: AdobeStock*

So far, 2225 nurses have made submissions or completed the Nursing Council survey (https://www.surveymonkey.com/r/ZYDNLTL) on the changes since they were released in December 2023, projects manager Jane MacGeorge said. Another 54 individuals or organisations had made written submissions.

The cut-off for feedback is on Monday February 12, and the new competencies are expected to be finalised by mid-2024.

Under the proposed changes (https://www.nursingcouncil.org.nz/NCNZ/News-section/news-item/2023/12/Consultation-on-competencies-for-Enrolled-and-Registered-Nurses.aspx), the number of competencies required has grown from four to 41.

They are grouped within five domains or pou (pillars) for ENs and six domains/pou for RNs.

Nursing Council chief executive Catherine Byrne says in the proposal document that the new competencies reflected the council's commitment to Te Tiriti o Waitangi and the role of nurses in improving health equity for Māori.

*Catherine Byrne*

The review was intended to ensure all nurses are competent to practise in a culturally safe and ethical manner, she says.

Current RN/EN domains/broad competencies are: Professional responsibility; management of nursing care; interpersonal relationships; interprofessional health care and quality improvement.

Within the four current domains are 20 competencies but also nearly 100 "indicators" — specific requirements within the competency. Those have been removed in the new proposal.

The proposed new RN pou/domains are:

- Te Tiriti of Waitangi, Ōritetanga (equality) and social justice
- Kawa whakaruruhau and cultural safety
- Pūkengatanga (skill) and excellence in nursing practice
- Manaakitanga and people-centredness
- Whakawhanaungatanga (relationships) and communication
- Rangatiratanga and leadership

Within the six pou are 41 competencies but no indicators.

The proposed new EN pou/domains are:

- Te Tiriti o Waitangi
- Cultural safety
- Knowledge-informed practice
- Professional accountability and responsibility
- Partnership and collaboration

Details for both can be found here: (https://www.nursingcouncil.org.nz/NCNZ/News-section/news-item/2023/12/Consultation-on-competencies-for-Enrolled-and-Registered-Nurses.aspx)

NZNO members have expressed concern too many new competencies would add to their workload — already burdened by continuing competence requirements such as professional development and recognition programmes (PDRPs).

In a statement, the Nursing Council has acknowledged the concern over the number of competencies and said it would likely be cutting them down as a result.

"The review will take this into account and the council will work with the nursing profession, educators, and employers to consider how new competencies could be implemented in practice, including the processes for maintaining continuing competence."

Nurses have until Monday February 12 to feedback via a survey or written submission, here (https://www.nursingcouncil.org.nz/NCNZ/News-section/news-item/2023/12/Consultation-on-competencies-for-Enrolled-and-Registered-Nurses.aspx).

While EN competencies were updated as part of their scope of practice review last year, RN competencies have not been updated since 2016, the Nursing Council notes in its proposal. Both needed to reflect a modern nursing

profession in a changing world.

Byrne said the council had been guided in its proposal by nursing leaders, educators, NZNO's EN section, Te Rūnanga o Aotearoa NZNO, professional groups and Māori and Pacific nursing leaders.

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NEWS

# Nurses and kaiāwhina show up to a Waitangi event ‘like no other’

BY MARY LONGMORE

*February 8, 2024*

Rhetoric from leaders of a three-headed coalition Government “taniwha” at Waitangi this year reflected ignorance and “diminished” Māori, says Tōpūtanga Tapuhi Kaitiaki o Aotearoa kaiwhakahere Kerri Nuku.

*Tāmaki Makaurau kaimahi (left to right) Marina Parata, Nirvanah Streeter, Gabrielle Husband and Aroha Sheperd at Waitangi. (Photo Rangi Blackmoore-Tufi ).*

“From people who have a lot of influence on decisions in our country, I couldn’t believe some of the ignorant thinking and disrespectful behaviour,” Nuku told *Kaitiaki Nursing New Zealand*.

Nuku attended Te Tiriti o Waitangi commemorations at the Waitangi Treaty Grounds along with NZNO’s college of primary health nurses college chair Tracey Morgan and other Te Rūnanga representatives from Te Tai Tokerau.

**‘We’re not just here as nurses – first and foremost, we’re Māori.’**

Auckland nurse manager Marina Parata, who brought her team of seven kaiārahi nāhi — clinical nurse specialists — from Auckland’s Te Whatu Ora / Te Toka Tumai planned surgery unit, said the wairua (spirit) was “amazing” at Waitangi.

> ‘He completely nullified the significance of whakapapa, of our long connection, as tāngata whenua.’

A fiery pōwhiri (https://www.rnz.co.nz/news/national/508391/waitangi-day-2024-all-the-speeches-and-action-from-the-treaty-grounds-on-5-february) greeted Prime Minister Christopher Luxon, ACT Party leader David Seymour and New Zealand First Party leader Winston Peters when they arrived on the upper Treaty grounds on Monday. The wero was met with equal intransigence by the leaders, including Peters who — after scolding the crowd for bad manners — rapidly departed for “important” appointments with overseas ambassadors.

Seymour did manage to finish his kōrero about the importance of tino rangatiratanga (self-determination) for all despite being almost drowned out by waiāta — a common technique on marae to move on those who talk too much, Nuku said.

His comments that there should be no distinction between recent immigrants and those with historical whakapapa were hurtful, Nuku said.

“He completely nullified the significance of whakapapa, of our long connection, as tāngata whenua, of this whenua [land], and diminished us with a flick of his words.”

The notion of tino rangatiratanga — a te Tiriti article in the original te reo version giving Māori continuing full chieftainship over their land and taonga in the face of British settlers — for all was “ridiculous” and made no sense, she said.

> ‘We can’t be treated as equals, our outcomes are still inequitable.’

“It gave us an absolute feeling of groundedness now we’re back at work,” she said. “The mauri [life force] was amazing.”

In a unique initiative, Parata’s team works to identify and prioritise Māori patients on surgical waiting lists.

Frontline nurses were working hard to address health disparities for Māori – shorter life spans, lack of engagement with hospitals and health services and worse health outcomes.

Many nurses felt the closer they worked with other colleagues, the better the outcome would be for Māori and more engagement was likely with health services.

Working together “with determination” with patients and their whānau, to achieve equitable outcomes was crucial.

“We can’t be treated as equals – our outcomes are still inequitable.”

Parata said it was important for Māori nurses to “immerse ourselves” in mātauranga (Māori knowledge) as part of their work.

“We’re not just here as nurses — first and foremost, we’re Māori.”

*Photo: Stuff. David Seymour, Chris Luxon and Winston Peters are welcomed onto the Waitangi Treaty Ground.*

> **'Now they've seen how quickly that can be whipped away under their feet.'**

Luxon, too, has been derided (https://www.nzherald.co.nz/nz/pm-christopher-luxon-talks-to-mike-hosking-after-criticism-for-copying-waitangi-speeches-year-on-year/S4NGKAWOUZHR7KPNMS7JU45PSM/) for repeating much of his 2022 Waitangi speech word for word — a move which signals a lack of respect for the event and "tramples on the mana" of Māori, Nuku said.

*Kerri Nuku wanted to 'look the taniwha in the eye' at Waitangi.*

Waitangi was always a time to reflect on the achievements of tīpuna — ancestors — who had declared independence from the Crown as early as 1835 with the He Whakaputanga declaration of independence (https://teara.govt.nz/en/he-whakaputanga-declaration-of-independence) — considered the parent document to te Tiriti, she said.

#### We came to 'look the taniwha in the eye'

"But this year was a physical show of unity — because of the political discourse and wanting to hear the politicians yourself — to actually look the taniwha in the eye and hear that kōrero."

She said it was crucial to attend, at a time the unique rights of tangata whenua were under attack.

> **'You could just feel the wairua, everyone was pumped up.'**

Nuku, who has attended many Waitangi Day events at the marae, said 2024's had been "like no other".

"It had a completely different feel about it. You could just feel the wairua, everyone was pumped up. Māori and non-Māori, tangata tiriti, young and old people — everybody was harmonised around the kaupapa of unity and it was really cool to see."

Walking onto the marae as part of Māori activist Tame Iti's silent dawn hikoi had been a powerful experience.

"Tame Iti and also the rangatahi [young people] with him — I've never seen a group of rangatahi so driven, so focused."

*Participants in Tame Iti's silent hikoi on Monday watch the sunrise at Waitangi.*

As the day broke, you could see the "full force" of people's passion in their eyes, she said. "It was captivating . . . just so powerful."

### 'The battle ahead'

Nuku said hearing Government leaders in person had given her a "better sense of the battle ahead" for her own whānau as well as nurses and kaiāwhina on the front lines.

"It gave me and my family more reason to organise, to unify and to be vocal against the shift to review te Tiriti. It just put the fire in our belly to carry on."

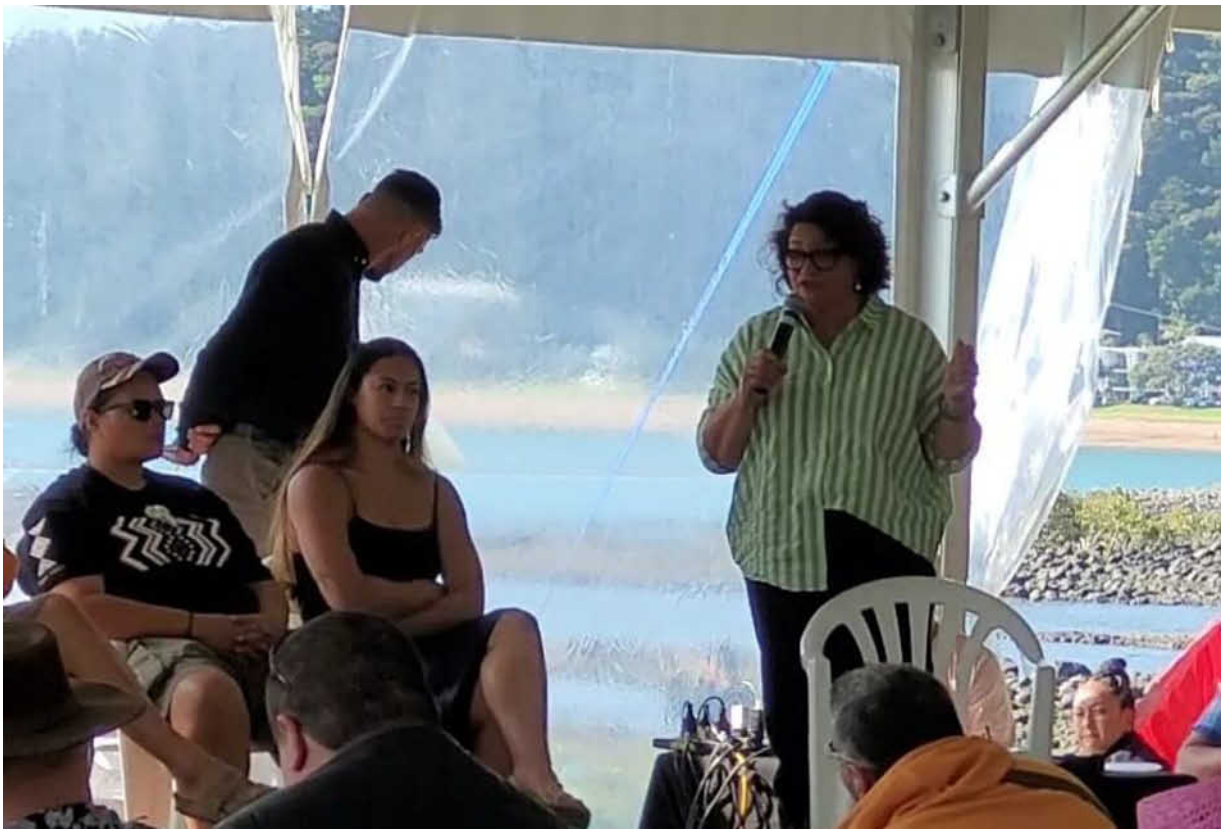
She now wanted to see nurses and kaiāwhina join the groundswell of unified opposition to Māori-hostile policies such as the dismantling of Te Aka Whai Ora, ACT's proposed te Tiriti review and other policies such as rolling back te reo Māori in government departments — along with NZ First's proposed review of the Waitangi Tribunal's powers.

> **'It gave us an absolute feeling of groundedness now we're back at work.'**

Māori nurses — many of whom had given evidence in the Waitangi Tribunal health services inquiry 2575 (https://waitangitribunal.govt.nz/inquiries/kaupapa-inquiries/health-services-and-outcomes-inquiry/) — expected more would be delivered under Te Aka Whai Ora.

"Now they've seen how quickly that can be whipped away under their feet."

With the same happening for SmokeFree Aotearoa, Nuku believed nurses were ready to "stand up and disrupt".



*NZNO kaiwhakahaere Kerri Nuku spoke at Waitangi about the need to value Māori nurses.*

Planning was underway for workshops, webinars and working groups, both within and outside NZNO, and Nuku hoped to see a growth in nurse activism — whether quietly, in the style of the late Moana Jackson, or less quietly in the vein of constitutional lawyer-activist Annette Sykes.

Sykes — who worked closely with NZNO during the Waitangi health services 2575 claim where Māori nurses gave evidence — also took the paepae (speaker's platform) at Waitangi to challenge Seymour for "tinkering" with te Tiriti via his Treaty Principles bill (https://www.rnz.co.nz/news/political/508579/act-launches-treaty-principles-bill-information-campaign). He had presented "rewritten lines in te reo Māori to the nation that don't make any sense", Sykes said.

Long-time Waitangi activist Hone Harawira also pulled no punches, accusing Seymour of trying to "gut" te Tiriti.

"You and your shitty-ass bill are going down the toilet."

### Māori-led hospitals by 2040?

Speaking on a panel at Waitangi, Nuku also called for a Māori-led health service "immersed in mātauranga [Māori knowledge] to be set up by 2040.

"Not another hospital that runs under the same governorship as the Crown — a service that is fully immersed in matauranga," she said. And it would be for Māori to decide how to staff it — "they won't hold the power and determine when we come in", she said.

"That is what 2040 looks like for our nurses."

*Auckand kaiārahi nāhi (clinical nurse specialist) and NZNO–Te Rūnanga member Rangi Blackmoore-Tufi (right) with a colleague and their tamariki at Waitangi.*

Nuku also called on the Crown to pay Māori and iwi nurses the same as other sectors.

"Our Māori nurses stood up [during COVID], they were the ones who went into communities – they were the ones who risked their lives to support whānau. And they're still now, after the crisis, putting their hand up to be recognised for the pay they deserve."

New Zealand First's Minister for Regional Development, Oceans and Fisheries and Resources Shane Jones claimed nursing had been "gentrified" in recent years as a profession beyond the reach of many working class Māori.

*As the sun rose, the passion was evident in hikoi participants, says Nuku.*

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PRACTICE

# Hepatitis C targeted for global eradication

CPD 0.25 hours

BY HE AKO HIRINGA

*February 29, 2024*

A short course of oral antivirals can cure hepatitis C, but the challenge lies in overcoming stigma and identifying those with chronic infection, as they may be asymptomatic for many years. Nurse prescribers and specialists, and those in primary care generally, have a role to play in identifying hepatitis C patients and ensuring they get the best care.

*Photo: Adobe Stock*

Hepatitis C is inflammation of the liver caused by the blood-borne hepatitis C virus (HCV). An acute illness can occur at the time of infection but, more often than not, the infection is asymptomatic and often goes unnoticed.

For acute illness with symptoms, even these are generally mild, non-specific and can present weeks or up to six months after exposure. Approximately 30 per cent of infected individuals spontaneously clear the virus within six months without treatment. This is often the case for people who present with an acute illness.

The remainder develop chronic HCV infection, which carries a 15-30 per cent risk of developing cirrhosis of the liver within 20 years.[1]

### Key points

- About 30,000 people live with chronic hepatitis C in Aotearoa, and up to 40 per cent are unaware they have it.
- Early detection and treatment can prevent serious liver damage and significantly increase life expectancy.
- Oral antivirals are well-tolerated and can provide almost a 100 per cent cure rate.
- Raising awareness and reducing stigma will help to identify people for treatment.
- "The face of hep C" may not be who you think it is — it only takes one exposure incident to contract the virus.
- Regional support is readily accessible to health providers and a comprehensive national HealthPathway is in place.

**Early detection and cure is estimated to improve life expectancy by almost 20 years.**

Early detection and cure of HCV infection, using effective short-course oral treatment, is now possible and can prevent serious liver damage, liver failure, hepatocellular carcinoma and further transmission, as well as improve long-term health.[1] Early detection and cure is estimated to improve life expectancy by almost 20 years.[2]

The World Health Organization has set a target to eliminate viral hepatitis as a major public health threat by 2030 by achieving a 90 per cent reduction in new chronic infections and a 65 per cent reduction in mortality, compared with 2015 levels.[3]

Recognising this unique opportunity, in 2021 the Ministry of Health – Manatū Hauora released its National Hepatitis C Action Plan for Aotearoa New Zealand – Māhere Mahi mō te Ate Kakā C 2020-2030. It includes a framework for achieving improved, equitable health outcomes for all New Zealanders living with hepatitis C, while also advancing the health aspirations of Māori, who are disproportionately affected.[4]

### The health burden of hepatitis C

By 2040, it is projected that viral hepatitis will kill more people worldwide than tuberculosis, malaria and HIV combined.[5] In Aotearoa, chronic hepatitis C is the leading indication for liver transplantation and is responsible for more than 200 deaths annually – all of them preventable with earlier diagnosis and treatment.[4]

Approximately 30,000 people are living with chronic hepatitis C in Aotearoa.[6] Between 35 and 40 per cent are undiagnosed due to lack of awareness of previous exposure risk and lack of symptoms, the prevailing stigma about having hepatitis C (creating a reluctance to test), and outdated knowledge about management and treatment options and success rates.[4]

Overall, Māori are considered to be at higher risk of hepatitis C and its long-term complications, compared with other population groups.[4]

About 1000 new cases of chronic hepatitis C are recorded each year,[6] with many of these people having been infectious for years but unaware.

**Overall, Māori are considered to be at higher risk of hepatitis C and its long-term complications, compared with other population groups.**

We need to treat at least 2200 individuals per year to achieve our goal of eliminating hepatitis C by 2030.[7,8] However, for a range of reasons, largely due to lack of new diagnoses, treatment uptakes have fallen from more than 500 per month in 2019 to 26–57 per month for the first nine months of 2023.[9]

The peak incidence of HCV infection was during the 1960s to 1980s, secondary to the rise in people who inject drugs (PWID). Today, the incidence is declining but the main risk factor remains injecting drug use.[4]

In Aotearoa, the risk of infection with HCV falls primarily into specific categories:[10]

- History of injecting drug use (>99 per cent of new infections).
- Recipients of blood products or organ donation in New Zealand before 1992.
- People who have been imprisoned.
- Immigrants from regions with high HCV prevalence[1] (the largest numbers of HCV-positive immigrants to New Zealand are from the Indian subcontinent, largely northern India and Pakistan, and from Egypt, and Russia and Eastern Europe).
- History of tattoos or body piercings with suboptimal infection control.
- Contacts of HCV-infected persons (eg sharing needles or razors).

- Recipients of medical or dental treatments, including vaccination, in a high-prevalence region where equipment may not have been sterile.
- People living with HIV (particularly men who have sex with men living with HIV).
- Birth to a mother with HCV – low risk (5 per cent) of transmission.

*The top risk is a history of drug injecting, while other risks include body piercing or tattooing (where infection control is less than optimum) and receiving blood products in New Zealand before 1992. Photos: Adobe Stock*

### New treatment makes elimination possible

Effective treatment of HCV infection using direct-acting antivirals (DAAs) puts the goal to eliminate the virus within reach. The latest DAA, a fully funded combination of glecaprevir 100mg and pibrentasvir 40mg (Maviret), has been available since 2019[11] and has significant advantages over earlier treatments:

1. A 98 per cent cure rate, defined as HCV not present in the blood at three months after treatment ends (in patients who complete the full course, the cure rate is 99.5 per cent).
2. Effective against HCV genotypes 1 to 6 (so genotype testing is not required).
3. Easy (oral) administration: three tablets, once-daily with food for eight weeks (12 or 16 weeks for some previously treated patients).
4. Adverse effects are generally mild (eg nausea, headache).
5. Few contraindications and – while lifestyle advice would recommend stopping – alcohol and illicit drug use are not contraindicated (a potential barrier to treatment in the past).
6. Accessible in primary health care, with many providers not charging consultation fees.

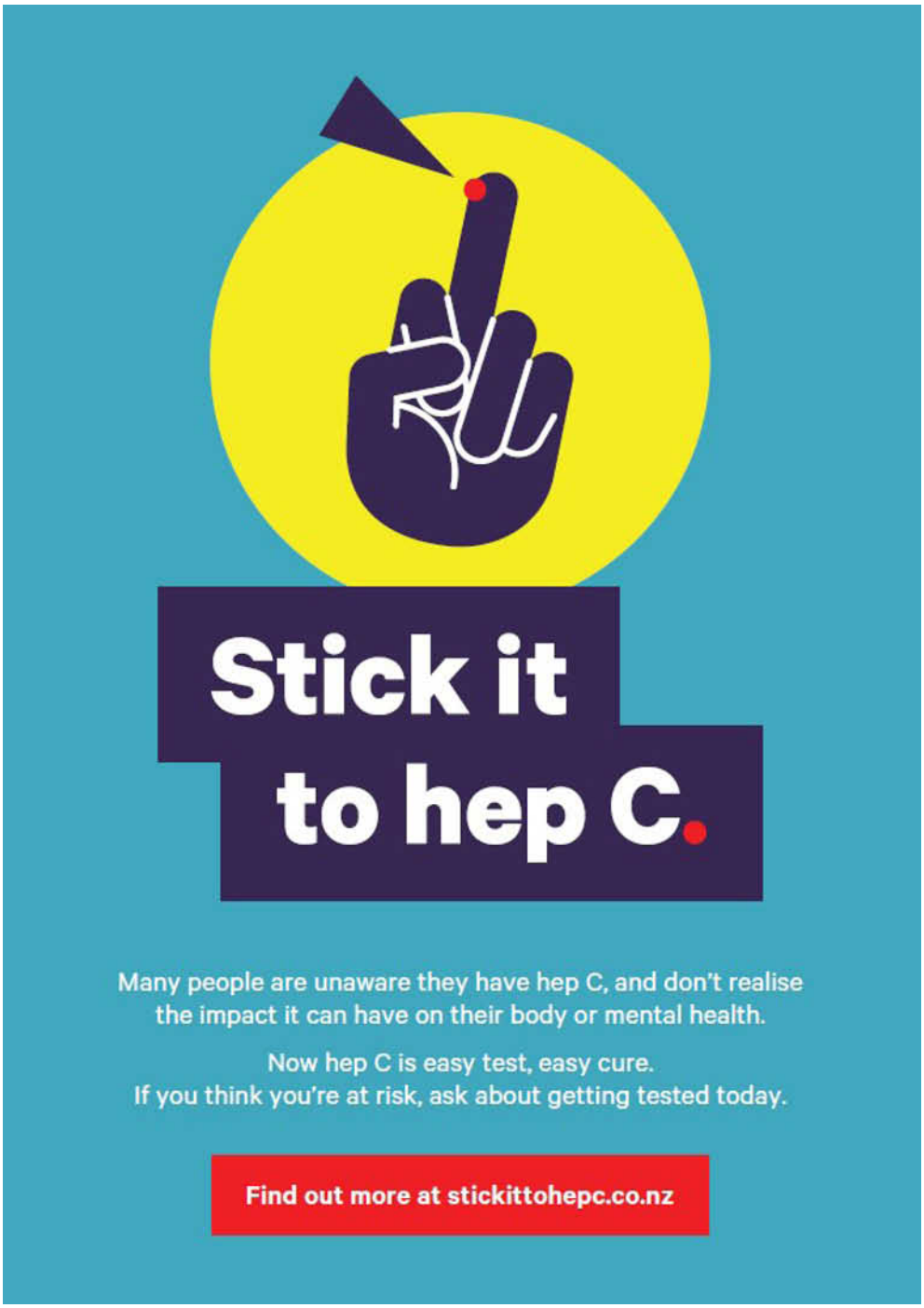
Prescribers should refer to the New Zealand Formulary,[12] product data sheet,[13] manufacturer information[14] and Community HealthPathways for full prescribing details and treatment recommendations. Maviret is a special access medicine, meaning only contracted pharmacies can dispense it.[15]

### New Zealand Action Plan

When DAAs for hepatitis C became available, treatment uptake was high. This was partially due to the large number of people already diagnosed with hepatitis C who chose to await for the new medicine rather than use the previously

available treatment, injectable interferon. A subsequent decline in treatment levels followed, reflecting a lack of new diagnoses.[8]

In 2022, Te Whatu Ora funded *Stick It To Hep C*, a successful campaign to increase public awareness, encourage people to act by seeking more information or getting tested, and to make it clear that hepatitis C could be cured.




The main challenges now are continuing to promote testing and the easily accessible oral treatment leading to cure, identifying and engaging with people at high risk of hepatitis C (many remain unaware of their risk), overcoming stigma, and providing acceptable education and support for accessing and completing treatment.

To reduce the chronic hepatitis C burden, the New Zealand Action Plan[3] overview identifies the need to focus on:

- awareness and understanding
- prevention and harm reduction
- testing and screening
- surveillance and monitoring
- integration and access to care.

Key priorities are to target populations known to have a higher prevalence of hepatitis C and also the long-term complications of chronic infection.[4]

Given the effective cure rate provided by current treatment, there is support for a pilot study to evaluate testing of the general population.[4] Universal testing occurs in some countries but to be practical in Aotearoa it needs to be linked to a registry, which has yet to be developed.[8]

Testing patients without risk factors for HCV infection is not recommended at this time.[16,17] However, testing patients with unexplained elevations of the liver enzyme alanine aminotransferase beyond three months is essential.

Anyone with a history of intravenous drug use, even with normal liver function tests, requires HCV antibody serology then a confirmatory HCV RNA (PCR) test

Active case finding within prisons and drug dependency clinics, and laboratory lookback programmes to identify people with chronic HCV infection and no record of treatment, are other targeted screening approaches being employed.[18]

There is also a regional service where community providers screen and offer testing and links to care.[19]

### Testing for HCV infection

**Screening (non-diagnostic) test for HCV antibodies**

Venepuncture at a community lab or finger-prick point-of-care serology to test for HCV exposure.

- A negative antibody test indicates no HCV infection, unless the patient is immunosuppressed or has an acute HCV infection (antibodies may take up to six months to develop*).
- A positive antibody test indicates a current or previous HCV infection.

** Consider the possibility of acute infection without antibody development in individuals with a known risk of HCV exposure, and explain why continued antibody testing may be useful.*

**Confirmatory (diagnostic) test for HCV RNA is required of all positive antibody tests‡**

Venepuncture at a community lab, or finger-prick for a "dried blood spot" test (collected in community settings and sent to a lab that performs the PCR assay for HCV RNA. Dried blood spot testing is being set up at Auckland City Hospital's LabPLUS and Wellington Hospital).

- A negative HCV RNA test indicates the person is not currently infected and does not require treatment. (Repeat after three months to confirm the negative result).
- A positive HCV RNA test result confirms chronic HCV infection.

*‡ Some laboratories perform HCV core antigen assays rather than HCV RNA assays –– both are appropriate tests for detecting current HCV infection.*

‡ HCV RNA testing may be requested as a reflex test on blood taken for HCV antibody serology at a community lab, so patients do not require another blood draw. In some regions, it is performed automatically.

**Confirmation-of-cure testing**

For patients completing treatment with Maviret, a sustained virological response (SVR) test to confirm viral clearance is required at four weeks (minimum) after treatment ends.

### Patient assessment and treatment in primary care

A person with hepatitis C confirmed by HCV RNA assay can receive treatment with Maviret once cirrhosis or complicating factors have been excluded with:[16]

- clinical examination for symptoms and signs
- laboratory tests for liver disease, hepatitis B, HIV (for those at risk of HIV) and pregnancy
- non-invasive liver assessment: APRI (https://www.hepatitisc.uw.edu/page/clinical-calculators/apri) (AST-to-platelet ratio index, see below) calculation or liver elastography (FibroScan), if available
- check for medicines interactions: New Zealand Formulary interactions checker (https://www.nzf.org.nz/nzf_9751) or University of Liverpool HCV medicines interactions checker (https://www.hepdruginteractions.org).

### APRI score

- If APRI is <1.0, the patient does not have cirrhosis and can be treated with Maviret for eight weeks.
- If APRI is ≥ 1.0, the patient has a 50 per cent chance of having cirrhosis and should be referred for a FibroScan for confirmation. FibroScans require secondary referral but are becoming increasingly accessible in the community through regional hepatitis C outreach services.

If cirrhosis cannot be excluded, discussion with a gastroenterologist or referral to secondary care is recommended. Likewise, for patients previously unsuccessfully treated with other hepatitis C medicines, who may require treatment with Maviret for longer than the standard eight weeks.

Additional sofosbuvir-based regimens, eg Harvoni (ledipasvir and sofosbuvir[20]), which can only be accessed through the HCV retreatment study at the New Zealand Liver Transplant Unit, are also used for people who remain HCV RNA positive after Maviret treatment.

Uncertain liver pathology results, an eGFR <30ml/min/1.73m $^2$, or hepatitis B or HIV co-infection should also prompt discussion with a specialist.

After four weeks of treatment with Maviret, a patient follow-up to check for adverse drug effects is recommended. This is also an important opportunity to encourage treatment adherence for the full course, increasing the chance of cure and helping avoid treatment resistance. The one to two per cent of patients who fail to clear HCV require specialist referral.[16]

Repeat liver function tests can be done at the same time as the test of cure (a minimum of four weeks after treatment ends) and again at 12 weeks post-treatment as they may take longer to normalise. Annual HCV RNA diagnostic tests are recommended for people with ongoing risk factors (eg, PWID) as previous infection does not confer immunity.

Note that HCV antibodies will remain positive for life once a person has been exposed to the virus, so repeating the antibody test will not be helpful in determining re-infection.[16,18]

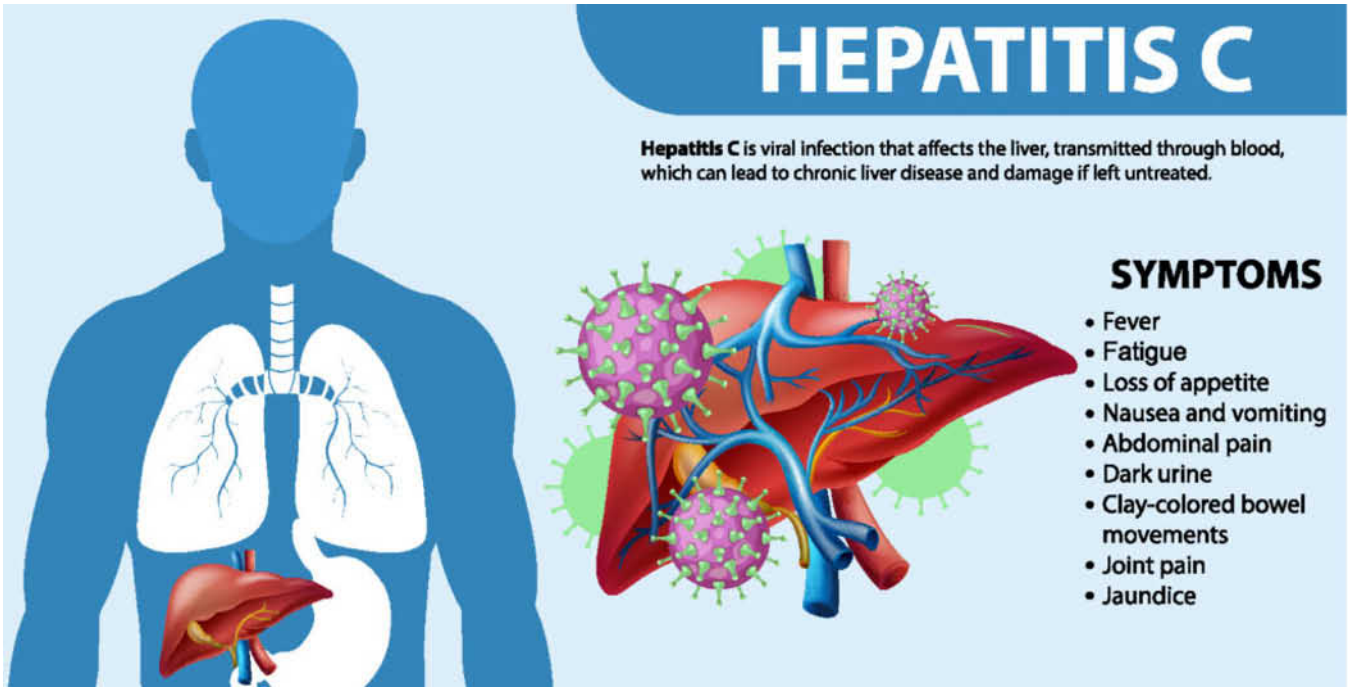
### Initiatives to increase testing and treatment uptake

It is not possible to treat patients if they cannot be identified. Supportive information and resources need to be made highly visible; displaying posters in waiting areas is an effective tool. Providing patients with written information on risk factors and the availability of curative treatment may prompt a future discussion or the direct uptake of point-of-care testing.

> **. . . some people diagnosed with hepatitis C have no firm knowledge of how it was contracted, and there is no need to feel stigma or shame.**

When discussing HCV risk or testing, it is useful to point out that some people diagnosed with hepatitis C have no firm knowledge of how it was contracted, and there is no need to feel stigma or shame.

Point-of-care finger-prick antibody testing for HCV is widely available. The "Stick It To Hep C" promotional campaign includes a website (http://stickittohepc.co.nz) with regional testing providers: GPs, pharmacies, kaupapa Māori health providers and needle exchanges.




*Hepatitis C symptoms. Graphic: Adobe Stock*

It also has FAQs on hepatitis C, testing and treatment. Results of whether a person has ever been exposed to HCV are confidential ("no questions asked") and available within minutes after a finger-prick test.

Te Whatu Ora funds the delivery of hepatitis C assessment and treatment services (https://www.tewhatuora.govt.nz/for-the-health-sector/health-sector-guidance/diseases-and-conditions/hepatitis-c/regionally-led-integrated-approach-to-the-delivery-of-hepatitis-c-services/hepatitis-c-regional-coordinators) in an integrated approach across four regions to support primary care, each region with its own coordinator.19 A mix of initiatives are employed, including:

- community clinics and free mobile services run by specialist nurses — to reduce disparity and geographical disadvantage and provide a "one-stop shop" as much as possible
- engaging with previously diagnosed patients with no record of treatment, through the Pharmac laboratory lookback programme
- organising FibroScan clinics in the community, hospitals and correctional facilities (without a specialist appointment)
- testing clinics in needle exchanges and coordinating with community alcohol and drug services, and opioid substitution treatment services
- point-of-care PCR testing (Cepheid GeneXpert; only available in some regions).

There are regional variations in how HCV point-of-care testing is supported but each follows a documented process approved by the Hepatitis C Implementation Advisory Group and its chair, Professor Ed Gane, a liver transplant specialist based at Te Toka Tumai Auckland.21 Finger-prick HCV antibody serology testing in the pharmacy or outreach service is supported by the community hepatitis C service, specialist nurses and the patient's GP.

> **Training and assessment are proposed in 2024 for selected nurses and pharmacists to become accredited providers of glecaprevir and pibrentasvir for hepatitis C, without prescription.**

Increased access to Maviret through exemption to prescription status for pharmacists and nurses with appropriate knowledge and experience22 is in the final stages of planning. Training and assessment are proposed in 2024 for

selected nurses and pharmacists to become accredited providers of glecaprevir and pibrentasvir for hepatitis C, without prescription. The two medicines have already been reclassified for this purpose.[23]

This is expected to be useful for accredited nurses and pharmacists who also perform point-of-care HCV antibody testing, so an individual is not lost to follow-up after a positive test, and, when people who were lost to follow-up present, a supply of medication can be provided on the spot.

To improve access to hepatitis C treatment in the community, in addition to low-cost access for community services card (CSC) holders, people seeking treatment from their GP who would qualify for a CSC may be eligible for a special needs grant to cover the costs of transport and up to three or four doctor visits.

This may include people recently released from prison who have already started hepatitis C treatment.[24]

### Conversations to overcome barriers

Before any of this can happen, there needs to be a level of education or a conversation that reassures a person that testing is something they should proceed with. There also needs to be communication with the wider population to reduce stigma and prompt a realisation that "the face of hep C" may not be who you think it is.

It is useful to emphasise that HCV is highly infectious and spreads when infected blood from someone with hepatitis C comes into contact with another person's blood, and that HCV can survive outside the body for days, even in tiny and unseen traces of dry blood.

**Gaining the patient's trust and being non-judgmental are equally important. People with hepatitis C come from all walks of life.**

Injecting drug use is the main route of infection but people need to know there are many other ways to contract the virus, and it only takes one exposure incident. When symptoms do emerge, it could be 20 or 30 years after the acute infection, and the risky behaviour leading to infection may have been a single occurrence, long forgotten.

Gaining the patient's trust and being non-judgmental are equally important. People with hepatitis C come from all walks of life. As a health-care professional, you can reassure the person that you do not need to know "how" they might have been exposed.

Having posters and written information in waiting areas allows the person to go away and digest the information and consider returning for testing (see resources section below).

*People with hepatitis C come from all walks of life — reassure them that they don't have to tell you how they were exposed to the disease. Photo: iStock*

Opportunistic testing is important while population-wide testing is some way off. A casual introduction of the subject can sometimes sidestep the implicit stigma: *"While you're here for xyz, we are doing free hepatitis C testing. It's curable now with a course of tablets -– have a quick read of this and let me know if it's possible you've ever been exposed to the hepatitis C virus."*

The person does not need to state how they consider themselves at risk.

Specific factors alerting a possible need for testing may be evident in a person's medical notes, eg references to health care while in prison, or immigration from or residence in a high-risk country, especially if combined with medical or dental procedures or other risk factors.

Some patients may even have had a positive diagnostic test for HCV but declined previously available treatments, been ineligible for funded treatment (due to genotype) or the treatment may have been unsuccessful or not completed.

Visit your local Community HealthPathways for further treatment recommendations.

## Resources

***For health professionals:***

- AbbVie Care pharmacy locator (https://maviret.co.nz/find-a-pharmacy)
- He Ako Hiringa website: Legendary Conversations podcast episode 7 (https://www.akohiringa.co.nz/education/episode-seven-eradicating-hepatitis-c-in-aotearoa)
- Ministry of Health Manatū Hauora website: National Hepatitis C Action Plan for Aotearoa New Zealand — Māhere Mahi mō te Ate Kakā C – read online or download the PDF (https://www.health.govt.nz/publication/national-hepatitis-c-action-plan-aotearoa-new-zealand-mahere-mahi-mo-te-ate-kaka-c)
- New Zealand Needle Exchange Programme (http://www.nznep.org.nz/outlets)
- Te Whatu Ora Health New Zealand website: Regionally led integrated approach to the delivery of hepatitis C services. (https://www.tewhatuora.govt.nz/for-the-health-sector/health-sector-guidance/diseases-and-

conditions/hepatitis-c/regionally-led-integrated-approach-to-the-delivery-of-hepatitis-c-services/hepatitis-c-regional-coordinators) Includes contact details of the regional hepatitis C coordinators.

***To provide to patients:***

- Healthify He Puna Waiora website: Hepatitis C Pokenga huaketo (https://healthify.nz/health-a-z/h/hepatitis-c) – Q&A, short videos, free brochures and help lines
- Hepatitis C website (http://www.hepcinfo.co.nz) with information for patients and a downloadable risk checklist (https://hepcinfo.co.nz/get-tested/#checklist-link)
- Ministry of Health Manatū Hauora website: Hepatitis C (https://www.health.govt.nz/your-health/conditions-and-treatments/diseases-and-illnesses/hepatitis-c)
- New Zealand Needle Exchange Programme (http://www.nznep.org.nz/outlets)
- Pharmac Te Pātaka Whaioranga website: Maviret for treating hepatitis C (https://pharmac.govt.nz/medicine-funding-and-supply/make-an-application/special-access-medicines/maviret/)
- Stick it to Hep C (http://www.stickittohepc.co.nz) – information in English and Māori

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Kaitiaki
NURSING NEW ZEALAND

FEATURES

# It's cool to kōrero – February 2024

BY KATHY STODART

*February 29, 2024*

Waewae — feet.

*Photo: iStock*


Haere mai and welcome to the February column. The new word for this month is

*Tūrangawaewae (above and below) — a place to stand, a place to belong. Photos: iStock*

*waewae* (feet). Before Europeans brought horses and other forms of transport to Aotearoa, Māori had waka to navigate the seaways and rivers, but much of the time they explored and travelled the country on foot.

Māori exploration of Aotearoa is known as *ngā waewae tapu*; the phrase *waewae tapu* (literally meaning "sacred feet") also refers to newcomers or rare visitors to a marae or other place.

Another very important Māori concept involving *waewae*, is *tūrangawaewae*. This means a place where a Māori person has the right to stand — the place where they have the right to belong and live, according to kinship ties/*whakapapa*. More generally it can mean a place a person regards as their spiritual home.

Tūrangawaewae is also the name of the main marae of the Kīngitanga, in Ngāruawāhia.

The names of some *haka* also include *waewae* — eg *whakatū waewae*, or *tūtū waewae* — indicating the importance of the actions of the feet.

**Kupu hou (new word)**

- **Waewae** (feet) — *pronounced "wai-wai"*
- **Ko te mutunga o te rā, tino mamae aku waewae.** — It's the end of the day and my feet are sore.

More words related to *waewae*:

- **kainga waewae** –- stamping ground
- **hanara waewae** –- jandal
- **takahanga waewae** — dance moves
- **rakanga waewae** — skilled footwork
- **waewae tīwhera** –- person related to two tribes, one foot in each camp
- **waewae whiri** –- cross-legged
- **waewae hao** –- bandy-legged

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

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1. maoridictionary.co.nz (http://maoridictionary.co.nz)

*The placement of the feet is vital in the haka. Photo: iStock*

Kaitiaki
NURSING NEW ZEALAND

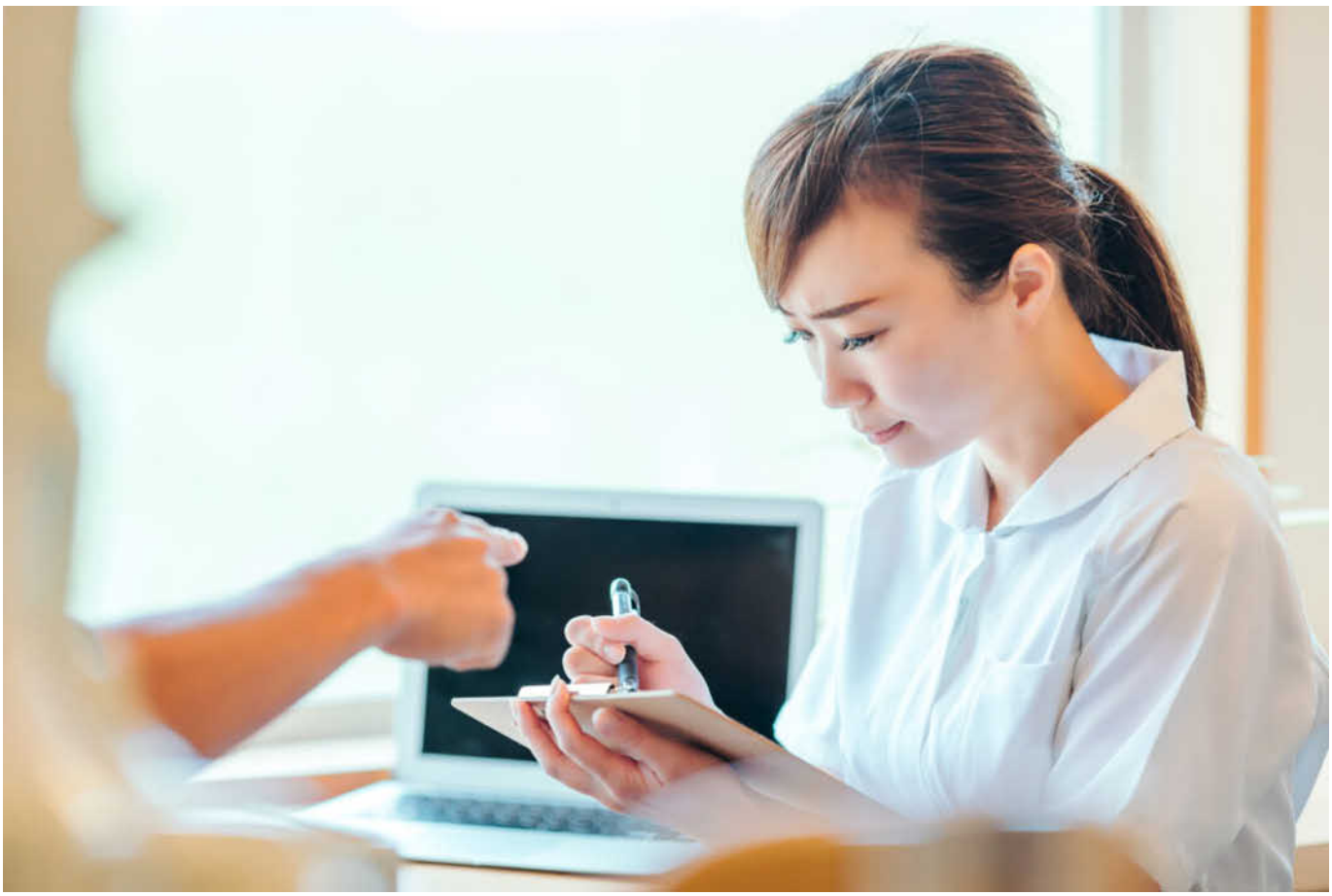
RESEARCH

# Bullying in the nursing profession: Can mentoring ameliorate the ill effects?

BY VASUDHA RAO AND BETH TOOTELL

*February 14, 2024*

Bullying can have a devastating effect on nurses, and some even leave their jobs because of it. This research study asks if mentoring can ease the problem.



## Introduction

Workplace bullying is a problem that is gaining increasing attention from practitioners and scholars alike.

Although there is no universally accepted definition of workplace bullying, with differing schools of thought on some key aspects, the characteristics that tend to be agreed on usually include that it is: *"harassing, offending, socially excluding someone or negatively affecting someone's work tasks"*.1

Workplace bullying has a number of negative consequences for those affected, as well as for organisations.2 These include:

- decreased productivity and morale and associated employee absences and high turnover;
- poor team dynamics;
- reduced trust, effort and loyalty from employees;
- poor physical and mental health;
- and financial impacts resulting from legal costs or bullying investigations.[3], [4], [5], [6].

Health-care employees are at a high risk of exposure to bullying.[7] In particular, the risk for nurses is three times that of other health-care workers.[8]

The negative outcomes of bullying for nurses have gained heightened attention in recent scholarly and non-scholarly literature.[9], [10], [11] Numerous surveys and interviews show that nurses are bullied in different ways, across different settings and to varying degrees.[12]

In New Zealand, research shows that nurses continue to be bullied.[13] Studies on workplace bullying among nurses have focused mainly on the outcomes and consequences of bullying.[14], [15] And while some instances of bullying are recorded and reported, many are not.[16]

**In particular, the risk for nurses is three times that of other health-care workers.**

Meanwhile, researchers and practitioners have suggested measures for addressing nurse bullying.[17], [18], [19] One such suggestion is mentoring.[20]

However, while the benefits that mentoring can provide for bullied nurses have been identified, there is less in terms of examining *how* mentoring can address the issue of bullying in nurses, even less so in the New Zealand context.

In our research, we sought to put the spotlight on a range of workplace bullying experiences and explored the role of mentoring in addressing bullying among nurses. In this article, we present a summary of the key findings of our research on the role of mentoring in bullying and make recommendations for an enhanced role for mentors in addressing bullying.

**What is bullying?**

Bullying is defined as *"harassing, offending, socially excluding someone or negatively affecting someone's work tasks"*.[1] It is also sometimes described as harassment, incivility and/or horizontal or vertical violence (vertical being when there is a power differential between the parties involved).[21] It is not always overt and is often described as relational aggression.[22]

Bullying is said to be entrenched in the culture of nursing and there are claims of not enough being done to address it.[23] Nurses report negative consequences of bullying such as burnout, wellbeing undermined, increased staff turnover and compromised patient care.[24]

A number of nurses cite bullying as a reason for leaving the profession.[25]

*A number of nurses cite bullying as their reason for leaving the profession. Photo: iStock*

### What is mentoring?

Mentoring has several definitions. Overall, it is understood as developmental and relational, involving phases and stages and including career and psychosocial functions.[26], [27] Mentoring can be formal or informal and can be provided by a range of people within the same or different workplaces.[27]

Nurses are commonly assigned formal mentors or preceptors. Evidence suggests that while mentoring has a positive role to play in the development of nurses,[28], [29], [30] at times formal assigned mentors or preceptors themselves can be a source of bullying,[31], [32] through dysfunctional or abusive mentoring.[33]

> **. . . mentors or preceptors themselves can be a source of bullying, through dysfunctional or abusive mentoring**

Mentors can offer support, act as a role model and provide an empathetic ear to those being bullied.[34], [35] Mentors may also have an indirect effect on workplace bullying by exhibiting authentic leadership that offers psychological safety for the bullied nurse and sets the scene for positive relationships in the workplace.[30], [32], [36], [37]

## Our research

The aim of our research was to explore bullying experiences of nurses and the influence, if any, of mentoring. A qualitative approach was deemed most appropriate, and aligned with the aims of our research.[38]

Data was gathered through open-ended semi-structured interviews, which enabled us to elicit responses to the questions we had prepared to guide the interviews, while also allowing for impromptu answers to probing and/or clarification questions.[38]

To understand what role mentors played in mitigating the ill-effects of bullying and/or preventing bullying, we sought to recruit participants who had either experienced bullying themselves or witnessed bullying in the preceding five years  and had a mentor to support them during the experience/s. There were no other exclusion criteria.

Nurses were invited to participate through an advertisement placed in *Kaitiaki Nursing New Zealand* magazine. Nineteen participants responded. They had worked in a range of settings when they had experienced or witnessed bullying – eight had been hospital nurses, seven had been district nurses, two in aged care and two in primary health care.

## Our findings suggest that bullying is culturally embedded and accepted as a given in the nursing community in New Zealand.

In terms of ethnicity, 16 described themselves as New Zealand Europeans, two as New Zealanders and one as South Asian. All were women.

This project had full ethics approval and all appropriate steps were taken to maintain anonymity of participants. Braun & Clarke's six-step thematic approach was used to generate key themes from the data.[39]

We found the participants were keen to share their experiences of bullying, and many of them keen to see these published. This emphasised not only the ongoing issue of bullying among nurses but also their desire to be "heard".

Our research findings were similar to existing evidence about bullying both internationally and in New Zealand – that nurses are bullied by colleagues, supervisors and other health professionals;[40] and that bullying has detrimental effects on the mental health and retention of nurses.[41]

We also found that nurses are subjected to a range of bullying experiences. For example, bullying can take the form of being reprimanded in front of patients, or being subjected to rude remarks about competence.

## In all the accounts of bullying shared with us, the nurses being bullied quit their jobs due to mental health issues, inaction by authorities, frustration and/or a sense of defeat

Bullying, or horizontal violence, as it was sometimes referred to by the participants of our research, was ongoing across a range of health-care organisations and settings.

In most cases it was a more senior and/or influential person bullying a more junior and/or less influential person. Often the person bullying was a direct line manager.

Mentors were in most cases informal, either from within or outside the organisation. Some victims sought out mentors while others stepped in as mentors for victims when they saw a need. A summary of the key findings is presented below.

- ***Bullying begins early in the nursing career***

There has been a focus on the bullying of student nurses in New Zealand, which has negative physical, mental and financial implications.[23] We found that student nurses often began their work life with experiences of bullying:

> *"When Dana and I did our training, we were some of the first comprehensive nurses, and we weren't treated very well by the hospital nurses. This is going back a while and you had to stand your ground and be aware that that [bullying] was out there."*

- ***It is often not reported***

Bullying was often not reported due to fear — victims themselves could be fearful and so could witnesses to bullying, as well as those told about bullying by other victims. The organisational culture and systems heightened nurses' fear to speak up:

> *"A bullying type of culture where people were afraid to speak up, and if you did speak up, then you basically had a target on your back. But it's a very subtle type of bullying where the person being bullied is shut out, so they're not part of the inner group that discusses things and then brings them as a fait accompli to meetings or they aren't told the decisions that have been made and the rationale behind them, so this is a locking out type of situation that goes on."*

In line with the unfortunate, yet popular, catchphrase "nurses eat their young",[42] often performance appraisals were a source of bullying:

> *"The hard thing is that I've heard from some people that the performance appraisal is actually a mechanism for them to be targeted, to be bullied."*

- ***The systems in place support cover-ups***

The other significant finding was that bullying was covered up and those bullied were often either overtly or covertly threatened. This meant that if a nurse overcame fear and hesitation to report instances of bullying, it did not lead to any negative outcomes or consequences for the perpetrators:

> *"So that was his way of covering those tracks. He also befriended quite a few people in his immediate area, he had a tight clique of people that he befriended, but outside of that everybody else was not included in this little sphere."*

- ***Mana-destroying and endless***

At a personal level, bullying was mana-destroying, leading to a sense of shame in those bullied as it was done in front of other nurses, colleagues and even patients:

> *"So, in front of the patients and other nurses, they basically just absolutely belittle this nurse, inferring that she'd been doing nothing in the shift."*

Further, there was no respite from bullying:

> *"I was strong enough to be able to do so, but you can't switch off because it's continual [the bullying], it's like a dripping tap."*

- ***Mental health issues***

Mental health issues were reported by all our participants:

> *"I went through [my nursing training] and got it all done and got bullied really, really badly while I studied, it was real hell."*

In all the accounts of bullying shared with us, the nurses being bullied quit their jobs due to mental health issues, inaction by authorities, frustration and/or a sense of defeat:

> *"She resigned because the bullying had basically taken her out at the knees, was her description."*

- ***Influence of ethnicity***

We sought to understand if the nurses had experienced bullying in any form due to their ethnicity. Most participants were Pākehā and were bullied by other Pākehā.

However, some reported that nurses of Māori, Pasifika and Asian ethnicities were targeted and berated for being of that ethnicity:

> *"Ethnicity, no, we're both of the same ethnic makeup, but having said that, there was a nurse before me who wasn't, she was Samoan, and she felt very much that her ethnicity was used against her and she was made to feel stupid."*

We also wanted to understand if ethnicity influenced the experience of mentoring; however this was not something that participants reported.

- ***Role of mentors***

In response to our questions about the role of mentoring in instances of bullying, nurses mainly reported mentors being empathetic listeners, or that they themselves (as mentors) were good listeners to those being bullied.

There was a high level of trust and psychological safety involved in the mentoring relationship, and it was thought to help those being bullied:

> *"You know, I think it's important to have somebody that you feel a rapport and comfort with, that you can sit down and have a gut laugh with, or, you know, get things off your chest, cry if necessary, and feel like you're not, you know, there's no lasting ill will around if you're going to see them."*

*A mentor can be a listening ear and provide a safe space, but they can also actively advocate for a bullied nurse. Photo: Adobe Stock*

- ***Is there a different more effective way of mentoring?***

A noteworthy finding was that in a few accounts of bullying, mentors demonstrated assertive behaviours, going beyond nonconfrontational behaviour such as being a good listener. They advocated for their mentees and in some cases "took on" the bullies, including their networks and those covering them up.

Others who had witnessed bullying actively ensured their mentees were not self-harming or were getting the help they needed for mental wellbeing. These were individuals who took on a mentoring role, even though they were not approached directly by the victims.

Rather they were witnesses to bullying, either as colleagues or seniors. One of these mentors expressed it this way:

> *"I thought I really have to do something about this because with being in management, I do, and I'm not afraid to have difficult conversations."*

The desire for a mentor to be an advocate was also expressed by other victims and witnesses. When asked whether their mentors did enough, nurses said they would like an advocate, someone who would speak up because they could not.

One participant, who was a victim of bullying, explained this:

> *"If I went to them with an issue, and it would be, yes, they will listen and they will do that, but they didn't advocate [completely] for you, is what I am trying to say."*

### The way forward

Our findings support the notion of extending the existing scope of nurse mentors to actively engage as advocates for mentees. Indeed, advocacy is a professional expectation of nurses, both for patients and for each other.[43]

Such mentors may be formally assigned, such as preceptors, or they may be the more informal mentoring relationships that form along the career path of nurses.

This means organisations would need to focus more on awareness of these mentor roles and functions and to provide mentor training. Further, these mentors would need to have the influence to advocate without fear of consequences and backlash. Thus, senior leadership support would be necessary.

**When asked whether their mentors did enough, nurses said they would like an advocate, someone who would speak up because they could not.**

Participants reported that victims of bullying were encouraged by human resource departments to report bullying to line managers who were sometimes the bullies themselves, or close to the perpetrators.

So, the existing institutional processes that do not lend themselves to bullying being discussed in a safe space, need attention and modification. Clear human resources policies and guidelines on reporting bullying need to be established to mitigate such issues.

The importance of having a voice was emphasised by the participants, who were keen to have their experiences published so that others were made aware of the continuing issue of bullying among nurses. Being able to complete anonymous surveys was considered positive as it enabled them to report experiences of bullying to a wide audience:

> *"The only positive thing I feel, was there was a survey from [a national nursing body], it was a questionnaire."*

However, there was also a sense of dejection and participants felt no hope for change:

> *"I'd be interested to hear the outcome of the whole survey, but really, I can't really see a resolution because I think it's just people. Certain people, they get their rocks off by putting people down."*

Thus, there is a role for organisations to provide opportunities for staff to tell their stories beyond standard employee satisfaction surveys, and the results of these surveys need to be distributed around the whole organisation.

> **Further, these mentors would need to have the influence to advocate without fear of consequences and backlash.**

External surveys provide an opportunity for victims to disseminate their experiences beyond just their organisation — this should be encouraged, and staff made aware of such opportunities. Further, victims of bullying could be invited to assist in the development of strategies for mitigating bullying, having had those experiences themselves.

### Cannot afford further loss of nurses

We set out to explore the processes involved in mentoring of nurses who have been bullied or have witnessed bullying. We uncovered further stories of bullying and some key issues with the current mentoring practices in the context of bullying.

Based on these, we have highlighted our recommendations at an individual and organisational level for addressing bullying. Our findings suggest that bullying is culturally embedded and accepted as a given in the nursing community in New Zealand.

Empowering mentors, extending the scope of their operation as advocates, and gathering ongoing senior leadership support for them could be key in mitigating nurse bullying.

With the ongoing health workforce shortages, the health system cannot afford a further loss of nurses – something that is evidently happening much too often as a result of bullying.

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43. Green

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NURSING NEW ZEALAND

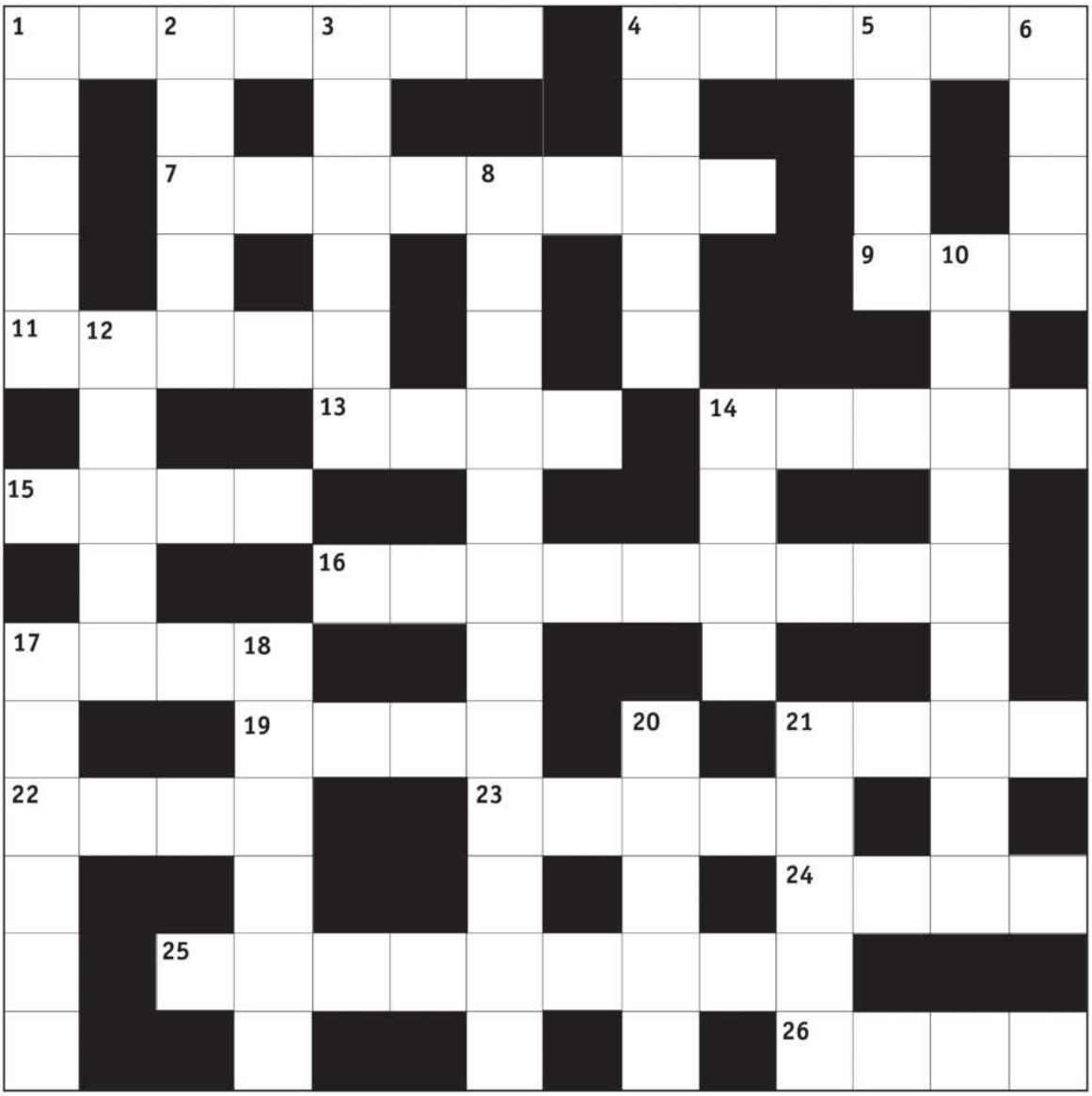
PUZZLES

# FEBRUARY 2024 crossword

BY KATHY STODART

*February 15, 2024*

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



## ACROSS

1) Plant material in cigarettes.
4) Aunt's child.
7) Elder (Māori).
9) Request.
11) Summer herb.
13) US TV award.
14) Safe place.
15) Scottish dagger.
16) Shy person.
17) Pay for.
19) *Jane* ____, by Charlotte Bronte.
21) Killer whale.
22) Type of bean sprout.
23) Baked meat meal.
24) Road charge.
25) Women's hormonal change.
26) Asian cereal crop.

## DOWN

1) Known as *pollex* in medical Latin.
2) Makes cake.
3) A romantic pair.
4) Do this to cream to make butter.
5) Long involved story.
6) Supports the head.
8) Involves use of essential oils.
10) Disbelieving.
12) Farewell (French).
14) Bees' home.
17) Whānau.
18) University qualification.
20) New Orleans culture.
21) Small swimming mammal.

**January answers**

ACROSS: 1. Nicotine. 5. Scar. 7. Aunt. 8. Cramp. 9. Exit. 10. Ennui. 12. Ruth. 13. Adonis. 16. Cud. 17. Mokopuna. 19. Tears. 20. Giraffe. 23. Vegan. 24. Deeply. 25. Continue.

DOWN: 1. Nectar. 2. Coalition. 3. Typed. 4. East. 5. Stents. 6. Retired. 11. Inmates. 14. Drummer. 15. Hopeful. 16. Cardigan. 18. Rigid. 21. Reek. 22. Knee. 23. Vat.

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NURSING NEW ZEALAND

LETTERS

# ‘Innovative’ nurse-pharmacist partnership can help with declining childhood immunisation rates

BY NICOLA METCALFE

*February 2, 2024*

I write as a registered nurse (RN) and immunisation coordinator, deeply concerned about the declining childhood immunisation rates in Aotearoa.

The recent media release (https://www.nzno.org.nz/about_us/media_releases/artmid/4731/articleid/6717/nurses-support-keeping-childhood-immunisations-in-primary-care) by NZNO on January 24 and the subsequent email (http://nzno.createsend1.com/t/r-e-tiidsjt-l-r/) dated January 27 urging members to *Help keep childhood immunisations in primary health care* caught my attention.

The Government and most health-care professionals are aware of Aotearoa’s rapidly declining childhood immunisation rates. Current ways of empowering whānau to consider and then access child immunisations are not working — this is the unfortunate reality backed by the Immunisation Taskforce Report 2022 (https://www.tewhatuora.govt.nz/publications/initial-priorities-for-the-national-immunisation-programme-in-aotearoa/).

Gatekeeping the traditional nursing skill of vaccinating in primary care contradicts RN competencies, specifically domain 4 (https://www.nursingcouncil.org.nz/Public/Nursing/Standards_and_guidelines/NCNZ/nursing-section/Standards_and_guidelines_for_nurses.aspx) — emphasising interprofessional health care and quality improvement. RNs are expected to recognise and value the roles and skills of all health-care team members, contributing to coordinated care for optimal health outcomes—a principle aligned with the principle of partnership embedded within Te Tiriti.

The apprehension regarding the decision to allow pharmacist vaccinators to vaccinate children outside of the primary-care setting simply exposes the larger issues that contribute to the present state of the primary health-care sector.

Burn-out, lack of suitably qualified staff, pay disparity with Te Whatu Ora, and the increasing complexity of patient care has affected the ability of many general practices to offer their “business as usual” appointments in a timely manner.

Whānau should not have to wait until their pēpē is nine weeks old to get an appointment for their six-week vaccinations but unfortunately, due to a combination of factors outside RNs’ or GPs’ control, this is the current reality in general practices in Aotearoa.

Yes, vaccinating pēpē and tamariki can be complex. It requires time, active listening, and careful clinical practice. However, as nurses, I believe that our role naturally extends to supporting our health-care colleagues in pharmacy to mentor and work in an innovative partnership model.

Nurses are resourceful and constantly thinking outside the square in terms of service provision and delivery, and together we can maximise this opportunity to consider innovative ways of building a combined GP and pharmacy immunisation service model.

The concerns raised about pharmacist vaccinators warrant attention, and the evidence for their impact on childhood immunisation rates remains to be seen. However, we owe it to our tamariki and mokopuna to explore this avenue. By embracing this opportunity and fostering collaboration, nurses can collectively work towards improving childhood immunisation rates in Aotearoa.

Nicola Metcalfe, RN, MHlth
*Whanganui*

Kaitiaki
NURSING NEW ZEALAND

LETTERS

# Health professionals' views sought for survey on variations in sex characteristics

BY SHAYE WOOLFORD, KATRINA ROEN AND EILEEN JOY

*February 15, 2024*

We are researchers from the University of Waikato – Te Whare Wānanga o Waikato and we are exploring health professionals' experiences of working with people with variations in sex characteristics.

People with variations in sex characteristics make up approximately 2-4 per cent of the population. Various terms are used by people with variations and the professionals they work with to describe their condition and/or their identity. These terms include intersex, differences or disorders of sex development (DSD), and variations in sex characteristics.

Little is known about the education and experiences of professionals working with people with variation in sex characteristics, especially in Aotearoa New Zealand. Understanding professionals' experiences and education in this area is likely to help improve the provision of services for people with variations.

We aim to disseminate findings from this research through journal articles and presentations. Findings may also be used to help develop continuing education and professional training.

We are interested in hearing from you if you are involved in this field and are:

1. a counsellor, midwife, nurse, occupational therapist, physiotherapist, psychologist, psychotherapist, or social worker, and/or
2. an educator involved in the training and education of any of these professions, and
3. you live and work in Aotearoa New Zealand.

We'd like you to complete our survey, which is anonymous and takes approximately 10-15 minutes. You can see the survey here. (https://waikato.qualtrics.com/jfe/form/SV_0ICPqhwQGFb0icm)

Shaye Woolford (research assistant)

Professor Katrina Roen (https://profiles.waikato.ac.nz/katrina.roen) (principal investigator)
katrina.roen@waikato.ac.nz

Dr Eileen Joy (https://profiles.waikato.ac.nz/eileen.joy/about) (associate investigator)
eileen.joy@waikato.ac.nz

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NURSING NEW ZEALAND

LETTERS

# Registered nurses considering post-graduate study sought

BY LAURA EWENS-VOLYNKINA

*February 15, 2024*

Are you a registered nurse (RN) and thinking of doing postgraduate study in health sciences?

We are undertaking a research project on behalf of one of New Zealand's leading education providers, to better understand how and why people choose further education.

Participation will involve a one-hour online video interview. You will be compensated with $250 for your time.

For more information, please contact: Dr Laura Ewens-Volynkina l.ewens.volynkina@fiftyfive5.com , 022 677 2855

Dr Laura Ewens-Volynkina