Kaitiaki
NURSING NEW ZEALAND

NEWS

Tough new government health targets could backfire, warn nurses

BY MARY LONGMORE

April 9, 2024

Emergency nurses fear tough new targets for emergency departments (EDs) will put already-stretched staff under more pressure, risking "gaming" of wait time data.

Photo: AdobeStock (AI generated)

And perioperative nurses say they are already working "at capacity", with no spare staff to deal with accelerated elective surgery targets.

Prime Minister Christopher Luxon yesterday announced faster ED and elective treatments were in the Government's "deliberately ambitious" top nine targets (https://www.rnz.co.nz/news/political/513735/government-sets-nine-targets-in-health-crime-social-support-education-climate) to be reached in the next six years. Others were reducing child and youth offending, violent crime, beneficiaries, student absenteeism, families in emergency housing and greenhouse gas, and increasing student achievement.

The ED and elective treatment targets were first revealed last month by Health Minister Shane Reti, alongside targets for faster

New health targets

- **Faster cancer treatment —** 90 per cent of patients to receive cancer management within 31 days of the decision to treat. (Currently 84 per cent).
- **Improved immunisation rates for kids —** 95 per cent of children to be fully immunised at 24 months of age. (Currently 83 per cent).

cancer treatment and first specialist appointments, and higher childhood vaccination rates.

> **'Considerable gaming in emergency department data transpired due to a shortfall in resources and planning.'**

"Shorter stays in ED are a snapshot of how the whole health system is coping as the interface between community and hospital care," Reti said at the time.

But without resourcing, the ED targets cannot be met, say NZNO's college of emergency nurses New Zealand (CENNZ), which has written to Reti with its concerns.

- **Shorter stays in emergency departments —** 95 per cent of patients to be admitted, discharged or transferred from an ED within six hours. (Currently 66 per cent).
- **Shorter wait times for first specialist assessment –** 95 per cent of patients to wait less than four months for an FSA. (Currently 66.4 per cent).
- **Shorter wait times for treatment –** 95 per cent of patients to wait less than four months for elective treatment. (Currently 61.5 per cent).

When a National-led Government set similar targets in 2009, "considerable gaming in emergency department data transpired, due to a shortfall in resources and planning", CENNZ wrote.

PHOTO: STUFF Christopher Luxon announcing the targets this week.

Gaming could mean "clock-stopping" or admitting ED patients to short-stay units or observation beds to keep within the six-hour ED stay targets, according to research (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7182144/) into the 2009 ED targets.

"The data misrepresented the clinical reality," CENNZ wrote.

To be successful, "significant and sustained financial investment in emergency nursing is imperative", along with a hospital-wide approach".

NZNO's college of emergency nurses has written to the Minister of Health with their concerns. Chair Lauren Miller is at far left, in red.

CENNZ was "not certain that the Government's current plans are robust enough to address today's health climate" and would be seeking further detail, chair Lauren Miller said.

Perioperative nurses 'at capacity'

The perioperative nurses' college (PNC) also says new demands 95 per cent of elective patients are treated within four months would add more pressure to their stretched workforce.

"We are already working hard to train new staff and increase staff retention, [so] this will be difficult to achieve," PNC chair Cassandra Raj told *Kaitiaki.* "Perioperative units are already working at capacity with no spare operating lists."

Perioperative nurses college chair Cassandra Raj (centre) with other members Gillian Martin (left) and Emma Lineham.

One region is opening 20 more operating rooms this year — but without a staffing strategy, she said.

Raj said the college wanted to see better workplace planning for perioperative care and pathways for nurses into the perioperative environment, whether it be diagnosis, treatment, intraoperative [during surgery itself] or post-operative care.

With warnings from the International Council of Nursing (ICN) over a global nursing crisis (https://www.icn.ch/news/nurse-leaders-agree-global-nursing-crisis-built-shortages-lack-investment-and-spiraling-nurse) more government investment was urgently needed in nursing education, workforce and leadership in New Zealand, she said.

> **'We are already working hard to train new staff and increase staff retention, [so] this will be difficult to achieve.'**

The ED targets would also impact perioperative units, with late-diagnosed acute patients coming through ED likely to take priority over planned surgeries, Raj noted.

"ED does not work in isolation. All departments and resources should be working together to provide the best patient care in a timely manner."

ED and elective targets will likely be the toughest to meet, currently sitting at 66 per cent and 61 per cent respectively, according to Manatū Hauora-Ministry of Health data (https://www.health.govt.nz/new-zealand-health-system/health-targets).

Immunisation targets 'unrealistic'

Christchurch practice nurse Daana Watson, too, said 95 per cent immunisation targets were simply not realistic and would only add more pressure to an overstretched primary health sector.

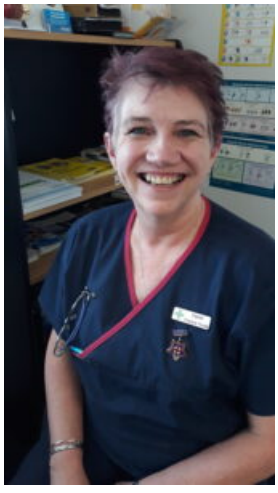
A more effective solution would be to better support primary health, to keep practices open and retain staff with pay rates equal to Te Whatu Ora's.

"It's a systemic problem. It's not just going to be solved by making vaccination rates increase."

Watson feared the targets would lead to a rise in less experienced vaccinators, which would undermine the nurse's role as a holistic carer for whānau.

Reti has said New Zealand's immunisation rates were "well behind countries like the UK, Australia and Canadia" needed to improve.

The "unapologetically" ambitious targets would be reported on quarterly by Te Whatu Ora.



Daana Watson

Health Minister Shane Reti

"Having effective targets, and reporting on them publicly, helps identify where there are problems – and how we can take action to improve them."

However, he acknowledged elective surgery, and first specialist assessment targets had been and would be "tough" to meet.

> **'We know how committed the health workforce is and how hard they are working, which is why building our workforce remains a priority.'**

"Electives – things like important hip and knee surgeries – are another sad story. COVID-19 has had an influence but wait lists were rising in the years before it even arrived."

Cassandra Raj (above) and Lauren Miller (right) speaking at last month's NZNO college and section day, where members shared their frustrations at not being consulted on major health decisions.

Reti said the health workforce would be "key" to meeting the targets.

"We know how committed the health workforce is and how hard they are working, which is why building our workforce remains a priority."

With the targets coming into effect on July 1, the first quarterly results would be available shortly after September, he said.

The nine targets follow the Government's action plan (https://www.rnz.co.nz/news/political/513735/government-sets-nine-targets-in-health-crime-social-support-education-climate) last week in what former chief executive Luxon said would "create momentum and drive focus".

Kaitiaki
NURSING NEW ZEALAND

NEWS

Health-care assistant ambitions ‘no threat’ to nurses, says new NZNO group

BY MARY LONGMORE

April 5, 2024

A new group of NZNO health-care assistants/kaiāwhina has big plans for their future — but is reassuring nurses there is no wish to encroach on their role.

Leadership HCA co-chairs Michael Deibert and Marita Ansin-Johnson.

“We do not want to make the nurse feel threatened,” co-chair Marita Ansin-Johnson told *Kaitiaki.* “This whole campaign is to be a teamwork environment. We just want clarification of where we are in the team — and how far we can go.”

> **‘We finally stood up – and this time there were more voices to be heard, and those who were speaking up can’t really be quieted.’**

They are seeking clearer definition and practice scope for the role of kaiāwhina (an inclusive term for health-care assistants/HCAs and hospital aides), along with pathways to allow training and career progression should they wish, and pay that recognises extra skills.

The "HCA leadership group" grew out of a breakfast meeting last September with NZNO — Tōpūtanga Tapuhi Kaitiaki o Aotearoa kaiwhakahaere Kerri Nuku, president Anne Daniels and chief executive Paul Goulter shortly before a fired up Ansin-Johnson unexpectedly took the NZNO conference stage with a call to respect caregivers more.

Marita Ansin-Johnson at last year's NZNO conference.

"Now I'm standing in front of you guys, who I respect, who I've learned a lot from — but please can you start respecting us? We are human," she said at the time, to loud applause.

That spontaneous kōrero to a room full of nurses was the result of frustration after years of following the rules, she said. "We went through the channels of writing letters and doing what we were supposed to do — but nobody was listening."

Co-chair, Hamilton HCA Michael Deibert, said that having found their voice after so long, caregivers would not now give up on their aims.

"We finally stood up — and this time there were more voices to be heard, and those who were speaking up can't really be quieted."

NZNO HCA leadership group (L-R): Michael Deibert (Waikato); Marita Ansin-Johnson (Dunedin); Princess Espareagoza (Upper Hutt); Alice Olynsma (Canterbury); Victoria Richards (Mid-Central); Al Dietschin (Canterbury). Carey Lord (Taranaki), Ashley Faleafa (Auckland), Donna Watson-Thoresen (Whakatane) and Mihara Taihakoa-Richards (Hawke's Bay) not pictured.

Now the group has a core committee of about 10 across sectors and is connected to dozens more kaiāwhina around the country.

The pair are interim leaders until next year, when full elections will be held for a bicultural leadership model with Te Rūnanga members.

The idea is to set up and connect local HCA groups around the country, aiming to capture as much as possible of Aotearoa's caregiving workforce — estimated at around 100,000 and growing, by Te Whatu Ora in its 2023 workforce plan (https://www.tewhatuora.govt.nz/assets/Publications/Health-Workforce-Plan/Health-Workforce-Plan-2023-2024-final.pdf).

> **'In one ward I couldn't even get an ECG off a patient – but if I went down to ED, I could do that same job.'**

"Our core goal is get every single workplace . . . to have either their own work group or a strong connection to a local or employer-based [one]. That then will connect to the bigger campaign, because that's how we'll communicate and keep together and unified," Deibert said.

The long term goals are:

- To establish a clearly-defined national kaiāwhina role, along with a pathway that aligns with the EN/RN pathways, allowing HCAs to progress, including into nursing, if they wish.
- To create a level 4 hospital HCA/kaiāwhina course with work-based learning organisation CareerForce.
- To work with the Nursing Council to establish a scope of practice and clear job description for kaiāwhina.
- To be paid for any extra tasks and training.

Purpose: *To develop and implement, within the New Zealand health sector, a complementary model of teamwork that ensures proper career pathways for HCAs and other non-nurse roles by means of recognised education and training, qualifications, reward and recognition and career pathways.*

However, the immediate priority was to push for better training and pay at Te Whatu Ora as part of upcoming 2024/25 collective bargaining, Deibert said. The group was also keen to see more support for the aged care kaiāwhina workforce, which tended to be fragmented across unions.

HCA role 'variable' and inconsistent

Deibert says caregiving work varies wildly from place to place. In aged care, HCAs can give medication, but cannot do so in hospitals. In primary care, some do vaccinations. Sometimes the role varies even within hospitals, he said.

"In one ward I couldn't even get an ECG [reading] off a patient — but if I went down to ED, I could do that same job."

> **'We didn't ask for all this extra work . . . the employer is pushing them onto us.'**

A scope would protect kaiāwhina from working beyond their skills and capabilities, which puts both them and patients at risk, he said.

"We didn't ask for all this extra work . . . the employer is pushing them onto us. We're trying to push back and say 'hold up, we don't mind learning more, but we need to be trained adequately so it's helpful to the nurses'."

This might include training for smaller jobs, such as monitoring patients' vital signs during a hospital transfer — currently limited to nurses only — which would allow kaiāwhina to relieve a team's workload more, Deibert said.

"It gives us a bit more knowledge and somewhere to go, and helps the nurses as they're not having to leave the ward to ferry that patient, who probably doesn't need full nursing care."

Last year's breakfast with NZNO leadership which eventually led to the HCA working group.

> **'I know a lot of nurses – especially the ENs – are afraid of us coming into their territory.'**

But it would not veer into the territory of enrolled nurses (ENs), whose scope was much broader, including giving medication, he said.

"I know a lot of nurses — especially the ENs — are afraid of us coming into their territory," Deibert said. But kaiāwhina only wanted to be a safe, effective and complementary member of the wider nursing team.

"We're all part of that nursing team – but right now we hit a road block when we get to a certain point and we have to start over if we want to go to the clinical side, so we're trying to bridge that gap a bit," Deibert said.

"It's some of the smaller things – defining what is our job, but a bit more than a job description, because they vary from hospital to hospital, ward to ward, sector to sector."

It would also ensure kaiāwhina were given adequate training and pay for any expanded role — unlike now, where they were asked to do extra jobs without such recognition.

> **'Naturally enough, HCAs and non-nurses feel disrespected and put-upon, nurses often feel threatened, and patient care suffers.'**

A regulated role?

Deibert says while he believed there was room for more regulation of caregiving, much of the role, such as restocking, did not require it — and he acknowledged it could be a thorny area with nurses. "Maybe a bit more [regulation] than what we have, but not the full regulation of the EN or the RN."

The group was considering something like Te Whatu Ora's HCA merit steps (https://www.ccdhb.org.nz/working-with-us/nursing/professional-development/healthcare-assistant-merit-steps/information-unregulated-healthcare-worker-pr-nzno-merit-step-information.doc) for its HCAs and theatre support assistants, which allows them to upskill and be paid accordingly.

"We don't have to push everyone, but are providing a way to advance and a career path [for those who want it]," Deibert said.

'Clear and complementary'

NZNO chief executive Paul Goulter said that, along with clear pathways, a complementary role for the kaiāwhina workforce was needed, rather than a role made up of substituting for tasks done by nurses as currently existed.

"HCAs and non-nurses often feel disrespected and put-upon, nurses often feel threatened, and patient care suffers as the overseas research also shows."

NZNO's work on the future role of the nurse was inextricably linked with defining the role of HCAs and the kaiāwhina workforce, he said. They should complement each other.

Law change?

The Nursing Council chief executive Catherine Byrne said the Health Practitioners Competence Assurance Act 2003 authorised the Council to regulate the practice of nursing only. That meant that the Council's regulatory jurisdiction extended to enrolled, registered and nurse practitioner scopes.

The Act may require amendment to allow regulation of HCAs, she said.

"The Council welcomes initiatives that support the safest care to the public, but it needs to be recognised that regulating HCAs may incur large costs to the workforce and employers."

The Council wished HCAs all the best in their endeavours, she said via email.

Any HCA/kaiāwhina leaders interested in setting up a group in their workplace can contact Michael Deibert: ***michaeljdeibert@gmail.com*****.**

Kaitiaki
NURSING NEW ZEALAND

PRACTICE

Asthma education through the eyes of your patients

CPD one hour

BY HE AKO HIRINGA

April 24, 2024

In this webinar, Asthma NZ nurse educators Bekitemba Maseko and Ann Wheat highlight the importance of asthma action plans.

This video is a recording of a live webinar hosted by Mobile Health. Asthma NZ nurse educators Bekitemba Maseko and Ann Wheat highlight the importance of asthma action plans and provide practical advice resulting from real-case scenarios.

He Ako Hiringa Learning Always

Presenters:

Bekitemba Maseko is an Asthma NZ nurse manager with 20 years' experience in hospital and residential care facilities. Holding a diploma in general nursing and applied mental health, Bekitemba has educated thousands of asthma patients. With an acute understanding of what drives behavioural change and self-management when it comes to asthma, he keeps 87 per cent of his patients out of hospital and enables them to live well with asthma.

Ann Wheat is an Asthma NZ nurse trainer and a registered general and obstetric nurse. Post-graduation, Ann worked as a practice nurse for 25 years and recently retired as nurse manager at Asthma NZ. She is a member of the Unitec nursing advisory board, GSK advisory board, and Pharmac's advisory board. She is a guest lecturer in nursing and pharmacy programmes with more than 20 years' experience in asthma education.

Options for recording your CPD activities and hours include:

- the Nursing Council's MyNC (https://www.nursingcouncil.org.nz/MyNC/MYNC/Sign_In.aspx?WebsiteKey=940918e5-df3e-4c60-9746-7312cd202474&LoginRedirect=true&returnurl=%2fMYNC) "continuing competence tab"
- the council's "professional development activities template" (you can download a PDF from this page (https://www.nursingcouncil.org.nz/Public/Nursing/Continuing_competence/NCNZ/nursing-section/Continuing_Competence.aspx?hkey=6542ac27-9b56-4e89-b7ae-db445c5cb952))
- the app "Ascribe" which can be found on Google Play (https://play.google.com/store/apps/details?id=com.ascribe.pdrp_diary) or the App Store (https://apps.apple.com/nz/app/ascribe/id1667199802).

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NURSING NEW ZEALAND

PRACTICE

What can you do to prevent the oversupply of medication?

BY HE AKO HIRINGA

April 11, 2024

Large amounts of unused medications accumulate in people's homes. Health professionals, including nurses, have an important role to play in reducing this medicinal waste and its harmful effects on the health budget, the environment and public safety.

Photo: Adobe Stock

**** Reading this article equates to 15 minutes of CPD time.***

From a consumer's perspective, the benefit of having ample stocks of medicine at home (and perhaps at work) may outweigh any wider considerations about appropriate supply.

But prescribers and dispensers do need to consider the potential consequences of oversupply. Such considerations can include the cost of wasted medicine, the effect on the environment if they are discarded into wastewater or landfills, stress on the distribution chain and family safety.

"Appropriateness" is one of the five drivers of medicines access equity in Aotearoa New Zealand, along with availability, accessibility, affordability and acceptability.[1] Appropriateness requires prescribing and dispensing in a manner that meets patient need and avoids unwarranted variation in the use of medicines.

This is achieved when clinical expertise and evidence-based practice are combined with a patient's preferences, values, experiences, culture and beliefs.[2]

How medicines accumulate in the home

A survey of 452 New Zealanders from around the country, reported in 2009, found more than 60 per cent of respondents said they had leftover or unwanted prescription medications in their home. Fewer than one in four people returned their pharmaceutical waste to pharmacies.[3]

A 2016 Australian audit of 704 tonnes of unwanted medicines found the most commonly returned medicines were unexpired opened packets of medicines for the treatment of acute conditions.[4]

Internationally, for medicines returned to pharmacies, studies have shown:

- 65 per cent of items contained greater than 65 per cent of the amount originally supplied.[5]
- 66 per cent of items were medications dispensed for greater than a one-month period.[6]

NOTES FOR NURSES

- When seeing patients, nurses and nurse prescribers should be mindful of the possibility of oversupply of medicines. They're well placed to advise on safety, use and storage.
- This article may be of interest to nurses and nurse prescribers working with patients who are on multiple medicines, eg care of the elderly
- This article raises safety issues not only for the patient but also for their family, particularly children who may be in households where medicines are stockpiled

A 2016 survey found three out of four New Zealanders did not finish their prescribed course of medication.

Overprescribing is just one reason unused medications accumulate in the home, but it magnifies the problem when other events come into play. These include:

- A patient's death.
- Change of treatment or dose.
- Adverse effects or lack of efficacy leading to treatment cessation.
- Resolution of the condition.
- Dispensing not being individualised to patient need.

- Expiry of medicines.
- Non-adherence due to, for example: poor memory; physical barriers (eg, difficult packaging); complex or asymptomatic conditions, such as hypertension, and lack of education/understanding of the reasons for taking (and consequences of not taking) the medicine.[7]

Clinical scenarios that are complex or have the potential for change (eg, multimorbidity with polypharmacy, frailty) can make appropriate prescribing difficult, and with that comes the risk of overprescribing.

Prescribing can also be challenging in the early treatment of conditions – where the need for modification is likely[8] – or where "as required" medication is prescribed in standard pack sizes, such as for as pain, nausea or vomiting.[8,9]

The impacts of medicines oversupply

Cost, stockpiling and waste

In 2016, Medicines New Zealand determined that about 76 per cent of patients did not finish their prescribed course of medicine.[7] The $40 million cost of medicines wastage represented 5 per cent of the then $800 million annual spend on pharmaceuticals, according to health IT provider SimplHealth.[7]

On top of this comes the cost of dispensing and disposal of unwanted medication, and the time taken for health professionals to sort patient medications (eg, during home intervention or hospital admission).

> **Environmentally, pharmaceutical waste can cause immediate harm to those who handle it and cumulative damage by contaminating the environment.**

Oversupply also increases stress on the supply chain, increasing the potential for shortages while reducing the predictability of demand.

Environmentally, pharmaceutical waste can cause immediate harm to those who handle it and cumulative damage by contaminating the environment.[10]

Pharmaceutical waste collected by community and hospital pharmacies in Auckland increased more than fourfold from 2016 to 2020[10] (possibly due in part to PPE contaminated with pharmaceuticals).

Regional practices for the return, handling and disposal of unwanted pharmaceuticals vary. Even when medicines are returned to pharmacies, they may still be incorrectly processed.

Flushing unwanted medication down the toilet should be avoided as sewage and water treatment systems are not designed for pharmaceutical waste. Photo: Adobe Stock

Cytotoxic waste needs to be separated for incineration and the remainder sent for autoclave processing, and then to landfill – the autoclave does not deactivate the pharmaceutical waste, and the potential for leaching into soil and groundwater remains.[11]

Inappropriate direct disposal (into the wastewater system) should be avoided because sewage and water treatment facilities are not designed for pharmaceutical waste. One New Zealand study found that less than 50 per cent of some drugs (eg, trimethoprim, metoprolol) are removed by wastewater treatment before being discharged into the environment.[10,12]

Safety

Oversupply of medicines and patient stockpiling are safety issues with negative implications for good clinical practice and professional responsibility. These include:

- **Personal safety** – intentional or inadvertent overdose; harm from inappropriate use of no-longer indicated or expired medication; excess supplies at home can lead to confusion about what needs to be taken.
- **Family safety** – risk of harm from shared medication; accidental poisoning of young children; intentional overdose.
- **Community safety** – crime, morbidity/mortality due to oversupply of medicines with potential for abuse (much of the controlled drug supply "on the street" comes from legally dispensed prescriptions).13

> **Of all the reasons to avoid oversupply of medicine, perhaps the message regarding safety will appeal the most.**

A 2017 evidence review found that 42 to 71 per cent of opioid tablets prescribed after surgery were unused.14 While it is important that excess supplies of potentially dangerous medicines such as oxycodone and tramadol are removed from households, the same applies to all unused medicines.

The New Zealand National Poisons Centre has analysed data from contacts in the period 2018 to 2020. Its report finds all age groups were frequently exposed to (ie poisoning resulting from using medicines in a way in which they are not intended to be used) paracetamol, while youth and adults were also frequently exposed to psychiatric medicines, and older adults to cardiac medicines.15

Youth and adults had more intentional exposures compared with children (often exploratory) and older adults who frequently had unintentional exposures and exposures due to therapeutic errors.

The authors commented that, "medicines no longer acutely required or already expired were often kept 'just in case,' which may lead to accumulation in the household and cause added risk if there is unintended access by children or others".15

The National Poisons Centre receives around 800 calls a year about paracetamol ingestion by children. Photo: iStock

Paracetamol supply and patient harm

Paracetamol overdose is the leading cause for contacting Poisons Information Centres in Australia and New Zealand.[15]

Almost every home in Aotearoa (87 per cent in one study) has a supply of paracetamol (median 24g, two paracetamol-containing products).[16] The problems caused by its oversupply and inappropriate use provides a useful example of the general concept of medicines safety in the home.

The safe use of paracetamol has the potential to resonate with patients because the drug is available so widely (on prescription and over-the-counter, via pharmacies and supermarkets), in numerous formulations and products (often combination products), in different paediatric liquid strengths requiring weight-based dosing, and is used frequently by so many people.

> **While the incidence of paediatric acute liver failure caused by paracetamol poisoning is low, it disproportionately affects Māori children – half of the cases in Aotearoa over a decade being tamariki Māori.**

Accidental harm from paracetamol toxicity is a concern, particularly with children and their risk of acute liver failure and (rarely) death. While the incidence of paediatric acute liver failure caused by paracetamol poisoning is low, it disproportionately affects Māori children – half of the cases in Aotearoa over a decade being tamariki Māori.[17]

The New Zealand National Poisons Centre receives an average of 804 calls per year relating to paracetamol ingestion in children.[17] The most common reasons for paracetamol exposures vary by age group. Around 53 per cent of children's paracetamol exposures are due to therapeutic errors, where a child is given a dose that is too high and/or given the medicine too often or for a prolonged duration. Child exploratory behaviours

account for 44 per cent of paracetamol exposures, showing the importance of safely storing medicines out of reach of children.

Intentional exposures, ie incidents of intentional self-harm, were the most common reasons for paracetamol exposures in those aged 13-19 and 20-64 years, and 74 per cent of older adults' exposures are due to therapeutic errors.[15]

Health professionals can promote the safe and effective use of paracetamol in many ways, such as by prescribing for individual children rather than an entire family. Patient education, dosage and administration advice can be found on the Healthify (https://healthify.nz/medicines-a-z/p/paracetamol-children) website.[18]

Health professionals can promote the safe and effective use of paracetamol in many ways, such as by prescribing for individual children rather than an entire family.

A New Zealand Drug Foundation analysis of coronial data on fatal overdoses between 2017 and 2021 found at least one prescription or over-the-counter (OTC) medicine was listed on the toxicology report in 321 of 419 (77 per cent) closed cases.[19] Sedatives (excluding opioids) were most heavily implicated, with prescription opioids second most implicated.

Fifth in the list of legally available individual medicines implicated in overdose deaths was paracetamol. The list is, in order: diazepam (97 closed cases), zopiclone (72), codeine (64), morphine (64), paracetamol (59).

Appropriate supply of paracetamol reduces waste and improves safety in the home. It requires matching the quantity to the needs of the patient and their condition, and ascertaining what supply is already on hand at home.

For analgesia, paracetamol is often prescribed "as required", for example:[20]

- *Rx Paracetamol 500mg tablets: Sig 1–2 tablets q4h prn, up to qid (mitte 3 months).*
  Written in this way, the pharmacist will dispense 720 tablets: appropriate if the intention is for the patient to take paracetamol 1g on a regular basis, four times daily, for three months (eg, for osteoarthritis). But is this quantity appropriate for the patient in front of you?

An alternative prescription might be:[20]

- *Rx Paracetamol 500 mg tablets: Sig 1–2 tablets q4h prn, up to qid (mitte 180 tablets).*
  This quantity provides the patient with enough supply to take two tablets, twice daily, for a few days a week over a three-month period (eg, for intermittent headaches or pain), or two tablets, four times daily, for approximately three weeks (eg, for injury).[20]

Pacific peoples receive paracetamol at more than 1100 items per 1000 patients per annum, whereas Māori, Asian and European/other peoples have a dispensing rate around of just below 700 items

Unsurprisingly, the He Ako Hiringa EPiC (Evaluating Prescribing to inform Care) dashboard reveals high levels of paracetamol dispensing (https://epic.akohiringa.co.nz/annual-report) in this country. What is surprising is the ethnic

breakdown, which shows Pacific peoples receive paracetamol at more than 1100 items per 1000 patients per annum, whereas Māori, Asian and European/other peoples have a dispensing rate around of just below 700 items.[21]

There is no clear reason why this difference exists, but it may prompt additional consideration by prescribers and dispensers of paracetamol.

Measures to help avoid medicines oversupply

There are a number of methods that help promote appropriate prescribing and dispensing and reduce oversupply and wastage. And at an individual level, medicines wastage is best addressed before it begins.

Patient education and shared decision-making

- Encourage shared decision-making, with the patient to choose a treatment consistent with their values and preferences.[7]
- Improve the patient's health literacy by talking with them about their condition, the effects of the medication, the reasons for taking it and the consequences of not taking it.[7] This is particularly useful in complex conditions and in the prevention or treatment of long-term conditions such as hypertension, gout, chronic pain and depression.
- Be aware of physical and/or psychological barriers a patient might have to taking their medicine as directed – for example, hand arthritis, poor memory or vision, alcohol dependency, depression.[7]

Thoughtful prescribing

- Be aware that bulk prescribing frequently leads to incomplete use of the supply.[7] Remember, this can also occur with over-the-counter products provided by prescription.
- Treatment change is one of the most common reasons for unused medications. Changes often occur during early treatment;[8] therefore, it may be prudent to prescribe a smaller amount of medication or "close control" for the first month of a three-month prescription, if a dosage change is anticipated and the patient is due to be reviewed.[9] (Absence of a co-payment now makes prescription adjustments less costly for the patient at the point of dispensing.)
- The large number of "as required" medications being returned by patients[9,15,22,23] may indicate oversupply. Specifying an appropriate quantity on prescriptions may reduce wastage and allow better monitoring of the condition (see the example in the panel on paracetamol, above). Where "as required" medicines (eg, paracetamol, asthma reliever inhalers) form part of a long-term medications plan, a simple enquiry about what quantities a patient has at home will shed light on what actually needs to be prescribed. This could also be asked by the dispensing pharmacist. Patients may be reluctant to confess they have a stockpile; it is best to ask open questions rather than make assumptions.[9]

Treatment change is one of the most common reasons for unused medications.

Adherence monitoring

- Ask patients regularly if they are using the medicines they have been prescribed.[9] The Royal College of Physicians recommends every patient contact should be taken as an opportunity to check medication compliance, to minimise the need to dispose of unused medication.[24]
- Limit the number of repeat prescriptions before an appointment for a medicines review is triggered, to check for adherence.[9]
- Consider using patient portals and other technologies to communicate with patients outside the consulting room.[7]

Helpful reminder of strategies

A 2015 BPACnz article provides a helpful reminder of strategies that may reduce medical wastage and improve safety in the home; these include:[20]

- regularly reviewing a patient's current medicines
- using trial periods for new medicines
- prescribing appropriate quantities of "as required" medicines
- putting prescriptions on hold at the pharmacy (for up to three months) where it is uncertain if a medicine will be needed
- using pharmacy long term condition services.

FURTHER READING

Achieving medicine access equity in Aotearoa New Zealand: towards a theory of change. (https://pharmac.govt.nz/assets/achieving-medicine-access-equity-in-aotearoa-new-zealand-towards-a-theory-of-change.pdf) Understanding the reasons behind inequitable access to medicines and how to address them.

Quantification and composition of pharmaceutical waste in New Zealand. An overview and up-to-date insight into the problem of pharmaceutical waste.

A retrospective analysis of therapeutic drug exposures in New Zealand National Poisons Centre data 2018–2020. (https://www.sciencedirect.com/science/article/pii/S1326020023000109) An analysis of contacts made to the New Zealand National Poisons Centre.

He Ako Hiringa EPiC (Evaluating Prescribing to inform Care) dashboard. (https://epic.akohiringa.co.nz/annual-report) A breakdown of the dispensing data for paracetamol in primary healthcare.

Contributor: *Richard French*

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Kaitiaki
NURSING NEW ZEALAND

FEATURES

It’s cool to kōrero – April 2024

BY KATHY STODART

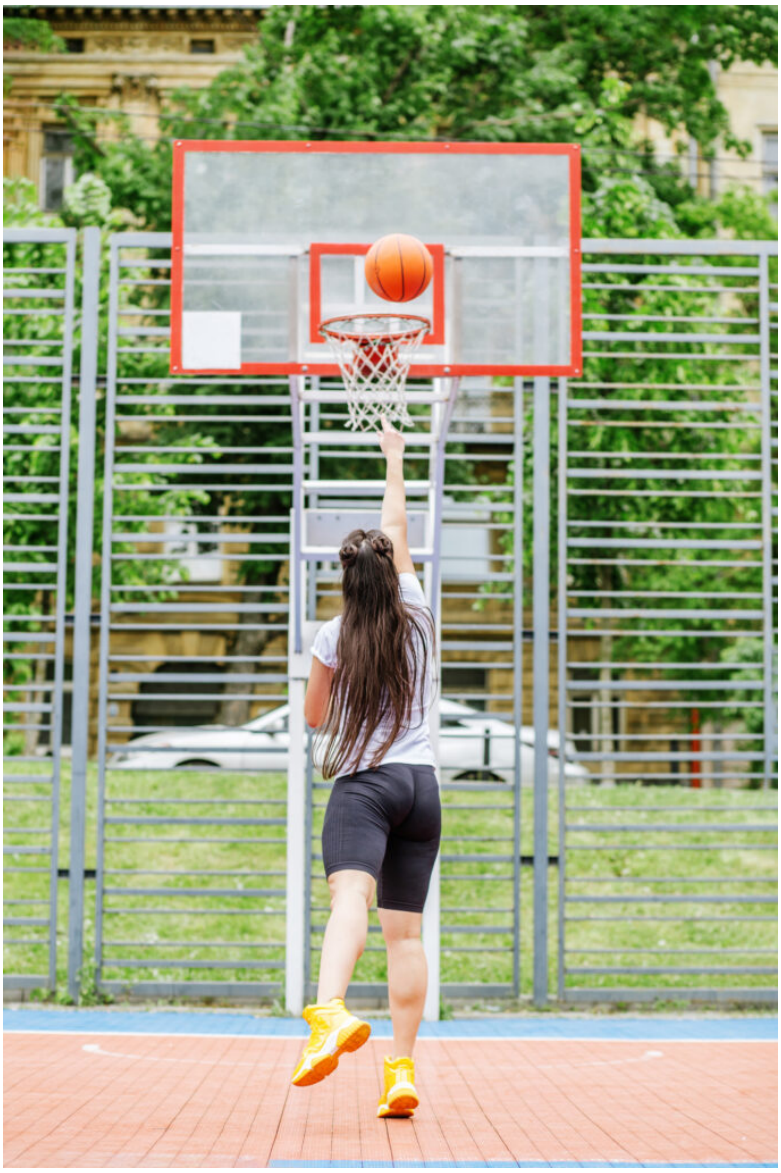
April 24, 2024

Ringa — hand

Photo: Adobe Stock

Haere mai, and welcome to the April “it’s cool to kōrero” column. This month we are

Ringa rehe means to be skilful, particularly in crafts. A carving in progress at Te Puia, Rotorua. And above, an expert weaver in action. Photo: Adobe Stock



Ringa tītere — goal shooter. Photo: Adobe Stock

looking at the word *ringa*, which means arm or hand. It can also refer to arms or weapons.

Māori culture and traditions grew in a pre-technological world, so what you could do with your hands was vitally important — be that growing food, your hunting and fighting skills, or the highly valued crafts of carving and weaving.

The whakataukī *"He kai kei aku ringa"* means to grow food with your own hands. The same words, He Kai Kei Aku Ringa, also form the name (and vision) of a Crown-Māori Economic Growth Partnership launched in 2013.

Kupu hou (new word)

- **Ringa** (hands) — *pronounced "rrrree-ngah"*
- **Kei te makariri aku ringa.** — My hands are cold.

Other words related to *ringa* include:

- **Ringa pīau** — blacksmith
- **Manawa ringa** — wrist pulse
- **Ringa kuti** — fist
- **Pūkaka ringa** — ulnar (bone)
- **Ringa tārake** — fielder (sport)
- **Ringa tītere** — goal shooter (netball)
- **Ringa rehe** — skilful, especially in crafts
- **Waiata-ā-ringa** — action song
- **Puringa** — handlebars
- **Whakatū ringa** — hand-brake

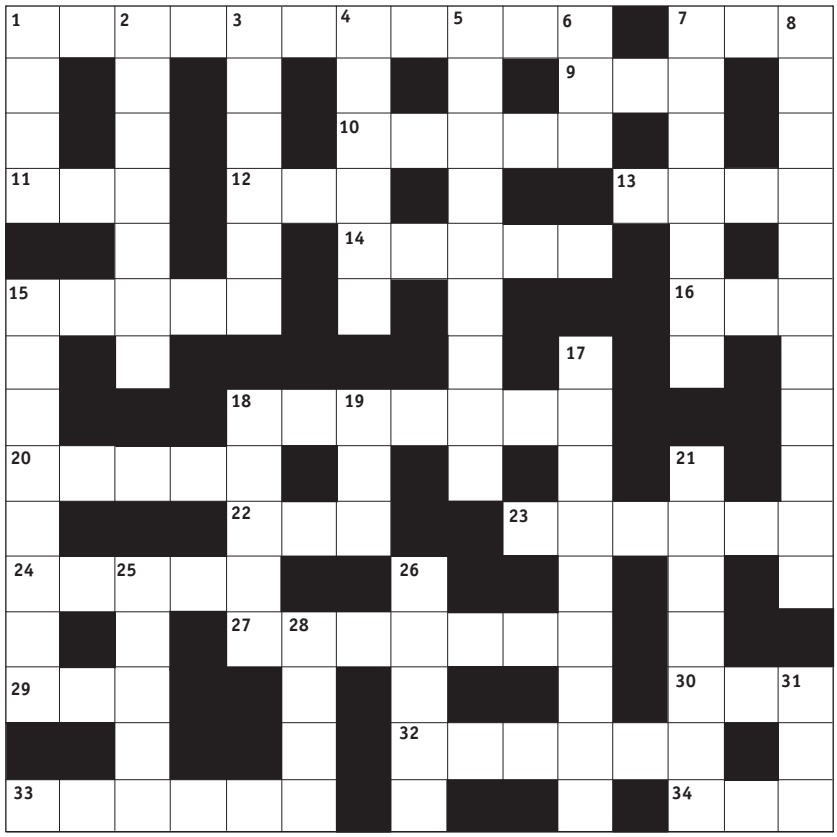
E mihi ana ki a Titihuia Pakeho rāua ko Mairi Lucas.

Source

- https://maoridictionary.co.nz (https://maoridictionary.co.nz)

Ringa pīau — blacksmith

April 2024 crossword



ACROSS

1) See-through
7) Mat
9) Fish eggs
10) War remembrance flower
11) Native songbird
12) Unwell
13) Vegetable in Pacific diet
14) Sign up
15) Whale's tail
16) Use chair
18) Memory loss
20) Head (Māori)
22) Decompose
23) Using eyes
24) Stupid person
27) Iron deficiency
29) Chicken's mother
30) Solid water
32) " ____ and gentlemen"
33) Heavy load
34) Small serve of alcohol

DOWN

1) Canvas home
2) Worried
3) Withdraw labour
4) They keep the doctor away
5) Advanced skill
6) Earns five points in rugby union
7) Get sick again
8) Aged care specialty
15)Thrive
17) Lunch room
18) Major artery
19) The new ___ goes fishing: whakataukī and Witi Ihimaera story
21) One who tickles the ivories
25) Close to the centre
26) Largest instrument in string quartet
28) Midday
31) Consume

March answers

ACROSS: 1. Competent. 6. Rabbi. 8. Fargo. 9. Hum. 11. Barrier. 12. Legal. 13. Ewe. 15. Eerie. 17. Elm. 19. Midwife. 21. Wept. 22. Pou. 23. Western. 26. Fatigue. 29. Rude. 31. Wit. 32. X-ray. 33. Bed. 34. Ethnicity. 35. Mayor.
DOWN: 1. Coffee. 2. Morale. 3. Enough. 4. Exhale. 5. Timber. 6. Rear. 7. Impromptu. 10. Liver. 14. Write. 16. Expert. 18. Swot. 20. Fir. 21. Wolf. 22. Pageboy. 23. Wae-wae. 24. Stitch. 25. Nod. 27. Alas. 28. Elder. 29. Reti. 30. Exit.

Kaitiaki
NURSING NEW ZEALAND

LETTERS

A nurse's burnout leads to hospital for carers

BY JACQUI O'CONNOR

April 9, 2024

In 1993 I graduated as a New Zealand registered nurse. Starting from university, we were never taught the importance of caring for ourselves, or other carers, to help meet the huge demands of our roles.

Jacqui O'Connor

And the personal experiences which lead many of us down this career track are never identified or supported.

As a nurse, I regularly experienced burn-out, compassion fatigue and moral injury. This would present itself as lack of motivation, feeling helpless, reduced compassion for myself and others, a low or negative outlook, a sense of failure and self-doubt.

There was no relevant wrap-around support options for carers in my position. I never witnessed examples of nursing leaders accessing support, nor did I see any understanding of how to protect and maintain our own care tanks, to remain "care-full".

I spent 26.5 years caring on the wards of Auckland's Starship Hospital, London's Great Ormond Street and St Mary's Hospitals, followed by Greenlane, Auckland, Waitakere Hospitals, and working in various other health roles in New Zealand.

For much of my career, I felt my empathy, intuition and emotions were a liability that I needed to "fix" if I wanted to be a successful health practitioner.

I didn't realise at the time that these feminine qualities are exactly what a true healer must embody to help another human being heal.

In 2016, I came face-to-face with somebody experiencing a similar health challenge as I had faced in my childhood.

This started a chain reaction of post-traumatic stress disorder (PTSD) that would take some time to heal from – psychologically and spiritually.

My usual protection mechanisms of busyness, people-pleasing and perfectionism were gone. In the still void that remained, I began to heal. And it was here that my journey to Heart Place Hospital began.

After many unsuccessful attempts to lobby the Government and hospitals, it became clear that I was going to have to be the change I wanted to see in the world of health care.

I created a safe space for the carers and empaths of the world to be uplifted and supported, and to create a network of love and compassion which extends far and wide.

Heart Place Hospital expands the definition of health to include, not just physical and mental health, but also interpersonal, professional, spiritual, creative, sexual, environmental and financial. This "whole health" model is largely missing from medicine.

Heart Place Hospital is feminising the broken, outdated, patriarchal health-care system, reclaiming love as a healing practice, bringing spirituality back to medicine, encouraging people/healer collaboration, empowering patients to heal themselves, and changing how we deliver and receive health care.

Most wellness models teach that the body is the foundation for everything in life — that without a healthy body, everything else suffers.

We've got it all backwards. The body isn't the foundation of our health. The body is the physical manifestation of our life experiences.

When our life is out of alignment, our mind gets stressed, and when our mind is under stress, our body suffers. The good news is that we can make changes that may profoundly affect our whole health.

We are our own whole health expert, who can call on others to meet us with their expertise and work in partnership to support our healing.

Heart Place Hospital offers everything I wish had been available to me when I first looked for support and felt lost and alone.

I have spent the past eight years researching what really makes people sick. Everything I've learned — everything I wish they had taught me in nursing and life but didn't — I now offer to other healers and future healers.

A New Zealand-registered charity (CC61280), Heart Place Hospital is dedicated to supporting our frontline workers in the health and education sectors with multi-faceted service providers.

They use individualised approaches to awaken and amplify the power and progress of these vital workers via satellite clinics, and workshops and accommodation at our first physical hospital in Mangawhai, Northland. We also offer online and in person personalised support in locations through New Zealand.

The ultimate flow-on effect of serving and reinvigorating our frontline caregivers is a thriving and resilient community.

(https://www.mangawhaigolf.co.nz/events)

Jacqui O'Connor, CEO
Heart Place Hospital

Kaitiaki
NURSING NEW ZEALAND

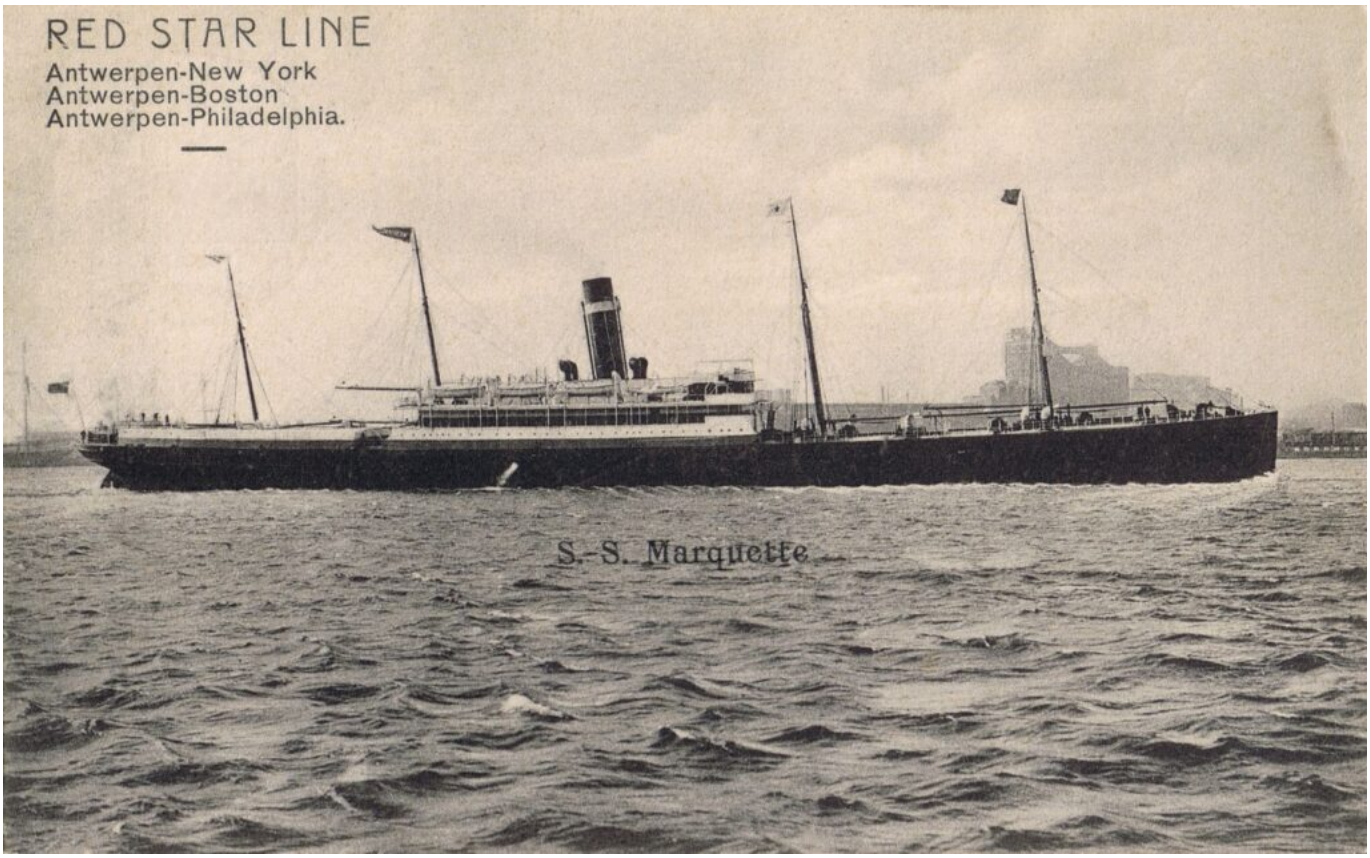
LETTERS

Nurses Memorial Fund is there to help

BY SHARYN LOVELL

April 3, 2024

In these difficult economic times, and with another wave of COVID-19, many people are experiencing financial hardship alongside the usual life events.



Ten nurses were lost in the sinking of the Marquette in 1917.

We write to highlight that financial help is available from the New Zealand Nurses Memorial Fund. It was established as a benevolent fund in 1917 in memory of the 10 nurses lost in the sinking of the *Marquette* and has supported many nurses in times of financial hardship and emergencies for more than 100 years.

The fund's philosophy is that it is there to help when social services and someone's own resources and are not enough to meet their needs. The Nurses Memorial Fund is closely allied with NZNO, though applicants do not need to be a member to apply for assistance.

We welcome applications from nurses with at least two years' full-time post-registration experience in New Zealand who are working or now retired.

Recently, recipients have been given funds for sudden unexpected illness, a house fire, urgent dental care, and for single parents struggling financially, among others. So, as managers and colleagues, we encourage you to spread the word to nurses you think might benefit from support from the fund.

The fund's income comes from interest on its investments and also from bequests, donations and membership subscription.

You can become a member or life member and support the fund to help others. We also welcome donations and bequests. The fund is a registered charity – Charity No CC28877

An annual subscription costs $10 and life membership $100.

Applications for assistance or donations can be made to the memorial fund committee by email to nznmfund@gmail.com or by post to NZNMF, PO Box 5363, Dunedin 9054.

Sharyn Lovell
Chair, NZ Nurses Memorial Fund committee