Kai Tiaki NURSING NEW ZEALAND

April 2020
vol 26 no 3

At the COVID-19 coalface

- Frontline nurses prepare for unknown
- How will the pandemic change nursing?
- NZNO fights for PPE for all
- Tips for remote assessment

Conference and AGM

Wednesday 16 & Thursday 17 September 2020
Museum of New Zealand Te Papa Tongarewa, Wellington

Call for remits: opens 16 March 2020 – closing date 16 May 2020 at 5.00 pm
Call for Abstracts: now open – closing date 5 June 2020 at 5.00pm
Call for award nominations: now open – closing date 12 June 2020 at 5.00 pm

Full details available on the website: www.nzno.org.nz/2020conference

Call for Abstracts

We invite you to share your innovations and achievements, allowing others to learn from your developments as you will learn from theirs. NZNO's annual conference is vibrant, attracting nurses, students, educators and researchers from all health sectors across the country, creating multiple opportunities for relationship building and networking.

Information: www.nzno.org.nz/2020conference
Closing Date: Friday 5 June 2020, at 5.00pm

National Awards

Nominations for *Service to NZNO* and *Service to Nursing/Midwifery* are called from Regional Councils, National Sections and Colleges, National Student Unit and Te Rūnanga.

Criteria: Service to NZNO

The nominee must be an NZNO member who has a commitment to NZNO and who has made a superior contribution to the national or regional work of NZNO.

Contribution could be made in any area of NZNO activities at a national or regional level.

- Promotion of NZNO to nurses or outside groups
- National or regional committee work
- Performed additional work for the committee
- Advanced NZNO objectives or policies

Criteria: Service to Nursing/Midwifery

The nominee must be an NZNO member:

a) Whose actions have made a difference to nursing or midwifery care in the region (may be in the area of practice, education, management of nursing/midwifery, research or support area such as QA, infection control, staff development), or

b) Whose actions have improved the occupational health, welfare or practice environment of nurses or midwives in New Zealand

Information: www.nzno.org.nz/2020conference
Applications to: awards@nzno.org.nz
Closing Date: Friday 12 June 2020 at 5.00pm

Conference Sponsorship

The New Zealand Nurses Organisation (NZNO) invites you to become a sponsor for our 2020 Conference being held at the Museum of New Zealand Te Papa Tongarewa on Wednesday 16 September 2020, giving you an opportunity to promote your services to nurses and health professionals.

A range of sponsorship options are available for your consideration. If you would like to consider other options to support our event, you are welcome to contact our Conference and AGM organisers, Paardekooper and Associates at **sponsorship@paardekooper.nz**, **04 562 8259** or view the Prospectus from our homepage at **www.nzno.org.nz/2020conference**

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THIS ISSUE has been produced in unprecedented times – New Zealand is in lockdown to contain the spread of the COVID-19 virus. Nurses – the country's largest health-care workforce – are in the frontline of that containment battle. This issue includes interviews with nurses from a range of specialties about how they are coping in these testing times. To mark International Nurses Day, we salute some nursing pioneers of Aotearoa.

Kai Tiaki Nursing New Zealand is the official journal of the New Zealand Nurses' Organisation, Tōpūtanga Tapuhi Kaitiaki o Aotearoa. Views expressed are not necessarily those of NZNO. *Kai Tiaki Nursing New Zealand*, under a variety of titles, has been published continuously since 1908.

Kai Tiaki Nursing New Zealand is a peer-reviewed journal. All clinical practice articles are independently reviewed by expert nurses/researchers (see below). It is indexed in the *Cumulative Index to Nursing and Allied Health Literature* and *International Nursing Index*.

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Kai Tiaki is the Māori term for carer or guardian and has always been incorporated in the title of the magazine.

Co-editors:
Teresa O'Connor, Anne Manchester and Mary Longmore.

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Clinical practice, education and research articles are critiqued for publication in *Kai Tiaki Nursing New Zealand* by nurses/educators/researchers with expertise in the subject area of the article, and by the co-editors.

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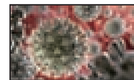

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Need information, advice, support?
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Nursing the world to health

By chief nursing officer Margareth Broodkoorn

The theme of this year's International Nurses Day – *A voice to lead, nursing the world to health* – could not be more relevant to the world right now.

In New Zealand, along with the rest of the world, nurses are either directly caring for COVID-19 patients or doing their best to prepare for a pandemic which has taken more than 50,000 lives globally to date.

Spreading with 'devastating speed'

2020 brings with it the International Year of the Nurse and Midwife, the completion of the global *Nursing Now* campaign and the 200th anniversary of the birth of Florence Nightingale. It has also brought a new virus that is spreading with devastating speed around the globe.

Nurses are indeed nursing the world right now and, together with colleagues, placing themselves in the frontline of a highly contagious virus overseas and now here in New Zealand. Here in New Zealand, we are doing everything possible to ensure our valued nurses and colleagues receive the latest information and protective equipment they need to stay safe.

Florence Nightingale led the way to a more hygienic approach to caring for wounded soldiers during the Crimean War in 1854, dramatically reducing death rates. Along with mass infections, soldiers were dying of illnesses such as typhus, typhoid and cholera in overcrowded and unsanitary conditions.

'A passionate sanitarian'

A passionate sanitarian, Nightingale promoted the benefits of cleanliness, hygiene, notably handwashing, clean air and water – all of which are as relevant today as then. She went on to promote sanitary conditions in the army, hospitals and communities after the war was over, saving countless lives in peace time also.

She professionalised nursing and nurse education, all the while advocating that high-quality patient care from dedicated nursing staff was a basic human right.

As we, along with the rest of the world, face a pandemic of unprecedented and unpredictable proportions, Florence Nightingale's approach to the profession of nursing is more relevant than ever. This is what we are trained for and, as a profession, we can and must rise to it – with evidence-based best practice, courage and determination.

Just as important as her clinical care and public health initiatives, was her holistic approach to nursing, which recognised the need to draw on the past habits and histories of indigenous people. In Aotearoa, she provided important advice in assisting and addressing the health and wellbeing of Māori.

International Nurses Day (IND) on May 12 – Florence Nightingale's birthday – is celebrated in her honour. And this May 12 marks her 200th birthday.

This year's IND is also an opportunity to honour and recognise our Māori nursing pioneers. Two early nurse leaders in particular were Akenehi Hei and Mereana Tangata, who were pioneers in every way because they paved the way for other Māori nurses.

Mereana Tangata (1869-1929), known and registered, in 1902, under her European name, Mary Ann Helena Leonard, went on to have a successful career in hospital and community nursing and stood out for her commitment to nursing. (See also p28.)

Akenehi Hei (1876-1910) was the first Māori to register as a nurse in her Māori name, which she did in 1908, and the first Māori nurse to qualify in both general nursing and midwifery. She stood out for her absolute commitment to improving health care for Māori.

Raising the profile of nursing

My hope this year, as we deal with the fear and uncertainty of COVID-19, is that our professional, compassionate and informed care provides an opportunity to raise the profile of nursing, and that this continues long into the future, as we work to grow a strong and resilient workforce.

'Nurses are in the spotlight and all around the planet this tragic pandemic is revealing the irreplaceable work of nursing for all to see.'

I look forward to seeing nurses, including our Māori nurses, develop into great leaders, setting a pathway for others to come, as those who have gone before have achieved for us today.

International Council of Nurses president Annette Kennedy has said the eyes of the world are on our profession in a way we could not have anticipated: "Nurses are in the spotlight and all around the planet this tragic pandemic is revealing the irreplaceable work of nursing for all to see."

I, too, wish to express my deep appreciation and support for all that you are doing today, in the coming days and into the future, as we all work together to combat this situation.

For the latest advice, please go to our website www.health.govt.nz. •

Tell us what you think

Health Minister praises nurses' 'vital contribution' to the COVID-19 response

TO ALL nurses in Aotearoa, including enrolled nurses, registered nurses and nurse practitioners:

I am writing to acknowledge and thank you for the vital contribution you are making in the COVID-19 response. Whether you are working in the community, aged residential care, or for Māori health providers or district health boards, the skills, service, commitment and care you are providing to our communities is invaluable at this time.

Nurses' work has always been important, but now it is more important than ever. At stake is not just the health and wellbeing of individual New Zealanders, but the health and wellbeing of entire communities.

I am heartened by the response we have seen to the call for nurses and other health professionals to register their interest in returning to work.

Health Minister David Clark

The nursing workforce is the largest it has ever been in New Zealand. Among you, nurse practitioners are playing a vital role in the pandemic with their advanced clinical and leadership skills. Nurse practitioners are working in the frontline of the COVID-19 response in primary care, in emergency departments and in secondary hospital care, with older people and others vulnerable to the COVID-19 virus.

I'd like to also acknowledge and thank the approximately 2500 nurses who work in intensive and critical care and other acute settings, who have been working hard to prepare for people with COVID-19 who require acute care.

I am aware 2020 has been sanctioned by the World Health Organization as International Year of the Nurse and the Midwife. The year has been endorsed to celebrate the role of nurses and midwives, highlight the challenging conditions they often face, and advocate for increased investments in the workforce.

I know nurses are a resilient workforce. Many of you have stepped up and are practising to the top of your scope.

In doing so, we want to keep you safe and well during this period, so have tasked the Ministry of Health to ensure resources are distributed as required. But in doing so, we also want to ensure those resources are used wisely and appropriately.

This is a stressful and uncertain time for all New Zealanders, and I acknowledge that this is exacerbated by your work as an essential frontline worker, which also impacts on your family, whānau and loved ones. Please look after yourselves. New Zealand is known for its manaakitanga and now, more than ever, we need to remember the power of kindness and uniting together.

I know all New Zealanders will want me to thank you all for your service and commitment to their health and the wellbeing of all of us in the face of adversity. I sincerely value your hard work and commitment.

The Minister of Health,
David Clark

Email your letter to:

coeditors@nzno.org.nz

We reserve the right to edit letters for sense and length. Shorter letters (under 400 words) are preferred. Please include address, nursing qualifications and phone number.

Pride in nurses' work in our country's 'hour of need'

I WRITE this letter with feelings of great pride and sadness during this uncertain and stressful COVID-19 pandemic. I am extremely proud of our members. Once again, it is nurses, midwives, health-care assistants and kaimahi hauora who are stepping into the breach, at increased personal risk, to care for the health needs of others.

You are doing your duty in the most extreme of circumstances, just as you have done in the past during world wars and earlier pandemics. And though I am sure the public will be grateful, I'm also pretty sure that few will understand the full extent of your dedication.

And that's why my heart is also heavy. I understand the fear and uncertainty members are facing – about contracting the virus themselves or bringing it home to their families and communities.

As I write, there has been the first COVID-19 death and the first nurses with confirmed cases. I can only imagine how things may have worsened by the time this is read. I can only imagine how you are feeling. I can only admire, with gratitude, your continued courage.

You are the largest health workforce in the frontline against COVID-19. You are crucial now more than ever, not just in hospitals, but across all sectors and in every community. That means you must be fully supported by the Government, the public, your employer and by staff at NZNO.

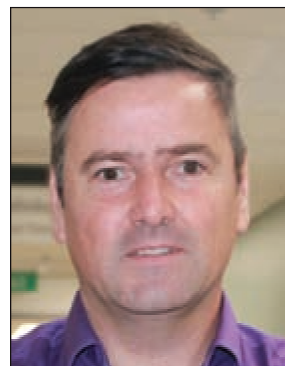
We are doing as much as we can – meeting with district health boards every single day, and with other employers regularly, to get the best we can for you in terms of additional support and protection. While we have had some successes, we will continue this fight, and also our work in the media to make the public aware of how much nurses are doing for them.

And, of course, we remain ready and available to support members with employment and professional matters as they arise.

We are proud and grateful for what you are doing in our country's hour of great need. Thank you – sincerely and from the bottom of our hearts. Together we will get through this difficult time.

NZNO chief executive,
Memo Musa

The president comments:



Grant Brookes

By Grant Brookes

OUR LIVES have changed, utterly. I write this column in the early days of the historic COVID-19 lockdown. Given the daily rate of change, I can hardly imagine what our professional and personal lives will look like when the April issue of *Kai Tiaki Nursing New Zealand* is completed. But I know this. We have the potential to create lasting, transformational change beyond this crisis – a different future for our profession and our society is possible.

The top priority for the country right now is to unite against COVID-19. Collectively and individually we're stepping up. And as we step up, the Government is mobilising the country's resources behind us. Health Minister David Clark said he's been given a blank cheque to maintain New Zealanders' wellbeing. For as long as any of us can remember, NZNO has been fighting for a fully-funded health system. Now, at last, the focus is on the value of our work, not the cost. We are being recognised for what we are – "essential". These first days of lockdown have seen seismic shifts in practical support for our essential work.

Some cities made public transport free for us. Our need to get to work became the focus for hastily re-designed timetables. Staff parking became free for most, too. Provision of free childcare began. Discretionary sick leave was suddenly available when we needed it. Constrained budgets for clinical supplies, like those which regularly forced the indignity of rationed continence pads, were gone over night. 640,000 PPE masks were shipped to district health boards in a day. None of this made the health system perfect. Parts of the sector were completely overlooked. Many inequities remained. But such resourcing was almost unthinkable just weeks earlier.

This transformation extends far beyond health. As a society, we are now embracing new values and ideas. From the Prime Minister down, the message is, "*Be kind*". We're working together so the needs of the community are prioritised above individualism. New "caremongering" groups are springing up in communities, to help more vulnerable members.

We have returned to more socialist ways of thinking – "*from each according to their ability, to each according to their needs*".

The same thing's happening internationally, too. Countries less affected by, or recovering from the pandemic are helping those suffering more – because until there's a vaccine, the only way any of us will be safe from future outbreaks is through global control.

As World Health Organization Director-General Tedros Adhanom Ghebreyesus says: *"The bottom line is solidarity, solidarity, solidarity"*.[1]

We're all in this together. He waka eke noa. As the weeks go on, we must intensify this focus on community, solidarity and kotahitanga. This is the way to keep us united against COVID-19, support essential health workers and fix the inequities still in our health system.

But let's not shelve this approach once the virus is under control.

All around the world, countries are comparing the fight against COVID-19 to a war. And like in a war, when the battle against COVID-19 is over, we will have to rebuild.

There may be hard times ahead. But with our new priorities and values, the world we rebuild can be better than before. As World War II was drawing to a close, the British Government contemplated a radical vision of post-war reconstruction. It knew the people who'd sacrificed so much for the country – especially the troops on the front line – wouldn't settle for going back to how things were before.

So, despite the war rationing and scarcity, they drew up plans to massively expand workers' rights, social housing and the welfare safety net. Out of this came what was then the world's best health system, the National Health Service.

I believe Prime Minister Jacinda Ardern when she says, "we will get through this". And when we do, today's frontline will be insisting on a better future. •

Reference

1) Ghebreyesus, T. (2020, February 11). *Research and innovation forum on novel coronavirus 2019*. Retrieved from www.who.int/dg/speeches/detail/research-and-innovation-forum-on-novel-coronavirus-2019

Notice to members:

NZNO's BOARD of directors has decided to defer membership fee increases, due to come into effect on April 1, 2020, for six months to October 1, 2020. This is in recognition of the unprecedented circumstances members are facing at this time. It is also a recognition of the stress and impact on families, whānau and communities.

Frontline staff to get PPE

ALL FRONTLINE nurses, midwives and health staff in contact with patients will be able to access personal protective equipment (PPE), including medical-grade face masks, after a deal between health unions, the Ministry of Health (MoH) and district health boards (DHBs) was agreed over the weekend of April 4-5.

NZNO associate professional services manager Kate Weston said freeing up access to PPE for nurses and staff working with patients of unknown COVID status was "hugely important".

Updated guidelines were released on April 7 on the MoH website. They include workers across community, hospital, aged-care and iwi providers, particularly in remote and rural areas.

"NZNO has been working around the clock with other unions to get universal access for health workers dealing with patients with unknown COVID status, in response to the call from our members. This has been the number one issue for them," Weston said.

Widening access would help staff – and patients – feel confident, she said. "It's not only science, it's perception – people feel safer," she said.

However, proven infection control methods, such as patient screening, hand-washing (even if using gloves) and distancing were still the priorities, she said. "PPE should be the last line of defence, not the first."

Kate Weston

The new guidelines would also cover the proper use of PPE. "If PPE is not used properly, staff can put themselves, patients, colleagues and whânau at risk," Weston said.

Director-General of Health Ashley Bloomfield has confirmed 41 million face masks 500,000 isolation gowns, 30,000 face shields and 50,000 goggles would arrive within the next six weeks. The MoH said they would be "for our health-care workers' immediate use".

Weston said PPE was already more widely available except for some "pockets" NZNO would deal with locally.

Health unions have been meeting daily with DHB and the MoH. A sub-group with Weston, Deborah Powell of APEX medical laboratory workers' union and Caroline Conroy of midwives' union MERAS have been working with chief nursing officer Margareth Broodkoorn on PPE guidelines. The guidelines would be updated as the situation evolved.•

Accommodation for nurses sought

NZNO HAS been working with the district health boards (DHBs) to find urgent accommodation for nurses and health workers shunned by house mates over COVID-19 fears.

"There have been nurses who have been evicted by their flatmates," NZNO industrial adviser David Wait said. About 15 nurses were affected around New Zealand, so this was an "incredibly rare" occurrence in the context of the size of the nursing workforce, he said.

An NZNO organiser has told *Kai Tiaki Nursing New Zealand* about one young nurse who was asked to leave a family she was boarding with. The family feared she would bring the virus into their household, which included young children. The "panicked" nurse was poised to quit her job and leave the region but, after NZNO became involved, her manager sorted out some accommodation for her.

Wait said the DHBs were also working to find accommodation in apartments or hotels for nurses and health staff who had to isolate themselves after travelling, or could not stay home because of vulnerable family members or elderly parents. "It's obviously a good thing but also a big step for our members, who have to leave their homes and live alone."

The availability of accommodation "varied" around the country, Wait said. No numbers on how many nurses or staff still needed accommodation were available by deadline. •

Daily meetings for nurses' wellbeing

NZNO and its sister unions are talking daily with district health boards (DHBs) and Ministry of Health (MoH) representatives in virtual meetings to try and keep nurses safe and protected, NZNO industrial adviser David Wait says.

Access to protective gear, childcare, accommodation, scrubs or laundry services and extra pay were all on the table. "We get to discuss these issues every day, even if we don't have solutions to them all immediately," Wait said.

"DHBs are looking for ways to make things work. We are ensuring that members' rights are protected, along with their safety and wellbeing. We're keenly aware that our members want to play their part in getting through COVID-19."

Childcare availability for essential workers had also been resolved. Where it was not available, staff could apply for special leave without affecting leave entitlements, he said. That appeared to mostly affect smaller regions at the moment.

Talks were continuing on a vast range of issues thrown up by the pandemic, such as whether nurses and health workers must launder their own uniforms or could access scrubs, rostering, and whether extra payments would be made for working in risky environments, Wait said.

The sense from members was fear but determination, he said.

"Our members put themselves in harm's way every day, but what is different about this is the level of publicity about what is happening. This means people are necessarily more careful. COVID-19 is the only thing people are talking about.

"The sense I have is that members just want to get on and get going. It's scary but they want to help."

APEX, the Association of Salaried Medical Specialists, Specialty Trainees of NZ (junior doctors), MERAS (midwives), E tû and the Public Service Association were all involved in the daily meetings. •

Hundreds of nurses re-register

THE NURSING Council has issued more than 400 interim practising certificates to nurses returning to practice to help out in the COVID-19 pandemic.

It had also received more than 1500 email queries and 600 phone calls. "This is a dynamic situation and therefore these numbers are changing all the time," council chief executive Catherine Byrne (pictured right) said.

The practising certificates were interim ones for the duration of the pandemic and were being issued in response to a pandemic workforce request from the Ministry of Health, she said. As well as being interim, some other conditions may be required on the practising certificate, depending on the individual nurse.

Nurses over the age of 70 and those whose practising certificates had lapsed for more than 10 years, were not eligible for the interim certificates.

Nurses can apply for an interim practising certificate online and the council can also be contacted by email or phone, as many nurses have questions to ask before applying for an interim certificate. Byrne said the council had diverted additional nursing and administrative staff to its phone lines and emails to enable a quick response to enquiries.

Byrne said the number of nurses who had contacted the council about getting an interim practising certificate to help with the COVID-19 effort demonstrated "amazing commitment and resolve from nurses to provide the best care to New Zealanders when they are needed the most".

Auckland public health nurse Lizzie Farrell put her hand up to re-register as "another pair of hands", after retiring in late 2018 after 30 years of nursing.

"When I heard they were looking, I thought I'd do it. I only retired 15 months ago, so I'm not that far away [from clinical practice]," she said. "I can help in primary care, I can help anywhere I have some clinical knowledge."

She said re-registering had been very simple and free.

Byrne said all council staff were working remotely but were responding to calls and emails during normal hours. The council had recently invested in a new database which improved its capacity and capability to work remotely and remain connected.

The council has deferred continuing competence requirements and audit processes for the duration of the pandemic to enable nurses to focus on clinical care to the public. It had also deferred accreditation and monitoring visits to education providers and was now conducting a number of essential panel and committee meetings electronically, Byrne said.

She thanked all nurses for their "commitment, dedication and hard work" to fight the COVID-19 pandemic.

"Never before has the work of nurses been more vital or more valued." •

DHB MECA preparations to continue

PREPARATIONS FOR the NZNO/district health board multi-employer collective agreement (DHB MECA) will continue "in the background" during the COVID-19 lockdown.

NZNO DHB industrial adviser David Wait said the national delegates' committee – made up of an elected member from each DHB in the country – had reached a consensus decision to continue with the preparations.

"Claims collection and delegate selection for the bargaining team will continue in the background and allow us to prepare for bargaining when it does occur. This will add approximately four weeks to the current process," Wait said.

Members will need to participate in an online survey for claims collection, and claims endorsement will be by online ballot.

"The claims already collected at delegate-run claims meetings will form the basis for the online claims survey," Wait said.

A broad selection of claims had been collected at the meetings, he said, but the two most "widely and deeply felt" were pay and leave, notably sick leave.

Nominations for the negotiating team have been extended until the middle of April. The dates for online voting for the 12-strong team have not yet been finalised.

Wait said local campaigning had stopped during the lockdown. "Members are overloaded with information right now and we did not want to contribute to that. National campaign preparations are continuing and the focus of the online campaigning is solidarity with nurses. It will return to the specific DHB MECA campaign when the situation allows."

Despite the lockdown, there was still time for preparations, as the DHB MECA did not expire until the end of July, Wait said. "Continuing with the preparations means we will avoid long delays, once the situation returns to normal."

The situation will be reassessed when the national COVID-19 level four alert drops or at the end of this month, whichever occurs first.

Wait said it was crucial that, despite COVID-19, member engagement and leadership of the campaigning and bargaining preparations were maintained. •

Southern DHB hopeful its hospital not COVID-19 source

AN ABSENCE of further COVID-19 infections among Queenstown's Lakes District Hospital staff "builds confidence" there has not been community transmission in the hospital workforce, Southern District Health Board (SDHB) Medical Officer of Health Susan Jack said.

Two of the hospital's nurses have COVID-19 and are in isolation. The second nurse was one of 15 close contacts of the first nurse. All those contacts were in isolation for 14 days and would be retested if symptoms developed, Jack said in a statement.

Another 21 "casual" contacts who tested clear have returned to work. All 74 staff who have worked at the hospital over the past 14 days have been tested, as the SDHB tries to discover the source of the infection. "It is noted there are a number of COVID-19 cases in the wider community in Queenstown," Jack said.

The hospital re-opened on April 2, after being extensively cleaned.

NZNO organiser Karyn Chalk said the SDHB had responded well. A COVID-19 team had been in place for "weeks" and access to personal protective equipment had not been an issue. "They have done everything they can. Not one member has called me – and if there were concerns, they're a strong bunch of people who would ring me. Their silence is a huge message."

College of critical care nurses chair Steve Kirby said, while it was not yet clear how the Queenstown nurses had picked up the virus, based on overseas evidence, it was "inevitable" more health-care workers would get infected here. "It's inevitable, but that's the sacrifice we are making, and that's what the public need to see – that we are putting ourselves on the line." •

Students 'non-essential'

NURSING STUDENTS around the country have been pulled out of clinical placements as they are considered non-essential workers.

"Currently, legally we are closed and all students' education is on hold," Auckland University of Technology head of nursing Stephen Neville said.

All nursing students, including postgraduate students, were removed from their clinical placements on March 24, a day before AUT closed to all lectures, tutorials, clinicals and assessment activities.

"For as long as the country remains at level 4, and students and academic staff are deemed non-essential workforces, we will be closed," Neville said.

Future pathways

"However, we are in the process of working out future potential pathways for students to minimise any disruption to the future pipeline of registered nurses."

AUT would offer flexible ways for its postgraduate students, including those on nurse-entry-to practice/specialist programmes, to complete their requirements, he said.

If students were called on by the Government "my preference would be that they would be placed in non-contact places like Healthline so, when the university opens, then they are ready to immediately resume clinical."

That was important to protect the future pipeline of nurses, he said.

NZNO student leaders Mikaela Hellier and RitaPearl Alexander said it was a very "uncertain" time around clinical requirements.

They would work with the advanced choice of employment committee, Nursing Council and nursing schools to help students navigate their next steps.

Many were meanwhile "gaining fabulous experience" as health-care assistants (HCAs), Alexander said.

MoH agreed students could still be employed on "essential work" such as Healthline or as HCAs. •

Concerned members swamp NZNO

NZNO MEMBERSHIP support centre (MSC) staff are being "slammed" with an average of 200 calls and 90 emails daily from worried members, lead adviser Jo Stokker says.

The main concerns are over the availability of personal protective equipment for staff, childcare, casual staff and members who are pregnant, she said.

Before the lockdown, many calls were from members over 70. However, since the government directive for them to self-isolate, those had lessened.

Organisers had stepped in to help cope with the calls, she said.

"The team is getting slammed – we're getting heaps and heaps of calls and emails every day."

Support from other staff

But with the support of NZNO's industrial and professional teams, staff were well-placed to advise members.

"The MSC staff are managing really well. They have all said to me 'we just care about our members and want to give them the best service we can'."

Members were "really stressed", Stokker said.

"Members are struggling and going through some really difficult stuff. These issues are far more complex than what normally comes through, so it takes extra time for the call advisers to deal with."

Member adviser Georgina Araboglos said members were fearful, but thankful for the advice and a sympathetic ear.

"There is a lot of fear, people are really scared. We just work through their feelings with them and break everything down, so we can give them guidance." •

Abortion law now changed

NZNO WAS "pleased" abortion was now a health service rather than a crime – but disappointed "safe zones", where women seeking abortions could avoid protestors, were removed from the Abortion Legislation Bill.

Associate professional services manager Kate Weston said NZNO's Women's Health College, along with Family Planning, had strongly advocated for abortion to be taken out of the Crimes Act and treated as a reproductive health issue.

"But we are disappointed women will still have to face a barrage of protestors because removing their place of safety somehow slipped through," said Weston.

In a late-night vote last month, MPs voted to legalise abortion by 68 to 51. They initially voted to keep safe zones, where protestors must stand 150m away from any facility. A second attempt to remove any way to enforce these zones, via a verbal vote led by ACT leader David Seymour, succeeded.

MPs, including Justice Minister Andrew Little, appeared confused by the decision, later acknowledging it was "annoying" but said he would not attempt to remedy it. Green MP Jan Logie, however, said she was looking at options to re-insert safe zones.

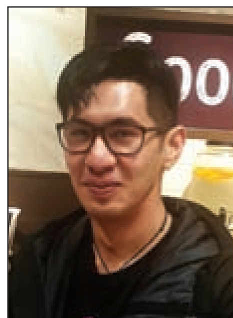
Weston said MPs appeared to have been "asleep at the wheel".

"While we at NZNO uphold freedom of expression, we also uphold the right for women to seek health care – which abortion is now – without being threatened, intimidated or harassed." •

New student leaders for Te Rūnanga Tauira

TWO students, one from Napier, the other from Southland, have been seconded to lead Te Rūnanga Tauira (TRT) until the 2020/21 election in June. "Unprecedented" pressure had led to a shortage of candidates for the 2019/20 elections, according to kaiwhakahaere Kerri Nuku. Second-year nursing student at Eastern Institute of Technology (EIT) Ritapearl Alexander, Ngāti Porou, Tainui and Te Arawa, has been appointed chair, and second-year Southland Institute of Technology (SIT) student Kimmel Manning, Ngāi Tahu, vice-chair.

Ritapearl Alexander from EIT


Kimmel Manning from SIT

Students had been unwilling to put themselves forward and take on the burdens of leadership roles last year, Nuku said, due to tensions within NZNO and experiences of racism.

In March, te poari agreed to second Alexander and Manning into the roles, as per the NZNO constitution (schedule five, clause 1.9), rather than go through "expensive and time-consuming" elections with less than six months of the term remaining, Nuku said.

Alexander said while she had not actively sought the role, she saw it as an opportunity. "I believe that leadership isn't just about leading, but providing a safe haven to ensure students can unload and be supported," she said.

Manning said they wanted to explore how to enhance the mana of tauira, so "when they make it into the workforce they will have the confidence to stand up for themselves and the people they will be caring for".

Both wanted to focus on changing attitudes to bullying. Former TRT chair Tracy Black said she would be staying on to provide tuakana (mentoring) support.

Alexander and Manning join National Student Union chair Mikaela Hellier and vice-chair Trudi Kent, as co-leaders in a bicultural model. •

UCOL honours Wenn

FORMER NURSE Janice Wenn, Kahungungu ki Wairarapa, last month received the Universal College of Learning's (UCOL) highest award – an honorary fellow for her services to Māori health.

Now in her late 80s, Wenn became a nurse in the 1950s and has worked extensively in the health sector since, focusing on Māori health issues and improving access to care. In 1998, she helped set up Whaiora Whanui, a primary health care service for Māori in the Wairarapa.

UCOL council chair Ben Vanderkolk said Wenn's work had "touched many lives".

"Her contribution to Māori health and health care in the Wairarapa has left a lasting impression."

Wenn gained a Massey University doctorate when 84, and in 2017 published an autiobiography, *Ko Mātakitaki te Tuatahi – A 'sort of life'.* Drawn from her thesis, it focused on her interviews with 40 kaumātua about Māori values that were essential to health and wellbeing.

She was awarded Te Rūnanga o Aotearoa NZNO's Te Akenehi Hei award for her services to Māori health in 2010. •

NZNO staff changes

NZNO PROFESSIONAL nursing adviser Kate Weston has been appointed to fill the associate professional services manager role for the next six months. The role was vacated by Hilary Graham-Smith, who resigned after nine years.

Nursing and professional services manager Mairi Lucas said Weston would bring new ideas and 12 years of working knowledge from her time at NZNO.

Kaiāwhina (assistant) to the kaiwhakahaere, Pirihira Toroa, has also resigned after four years. Chief executive Memo Musa said Toroa had encouraged staff to learn te reo Māori and run regular waiata, alongside her obligations to provide administrative support to te poari and members of Te Rūnanga.

NZNO board vice president Cheryl Hanham has also resigned, creating a vacancy on the board. An election would be held in due course, Musa said. •

Interviews by
Mary Longmore,
Anne Manchester and
Teresa O'Connor

PHOTO: Clinical nurse specialist in infection prevention and control Julie White at Christchurch Hospital.

Nurses at the frontline

Rising to challenge of a lifetime

Public health nurse Justine Paterson says the COVID-19 pandemic is nurses' chance to 'shine'.

In late January, Auckland public health nurse Justine Paterson was pulled off her regular work in communicable disease control onto the Auckland Regional Public Health Service (ARPHS) team responding to COVID-19 at Auckland airport.

This led to a lot of rapid up-skilling as she and colleagues tried to stay one step ahead of the rapidly-evolving virus.

While pressured – "I haven't had a 40-hour-week since the end of January" – she's not complaining. An event like this is what she and fellow health professionals had been trained for, and an opportunity for nurses to "shine".

Hot off the back of an intense measles epidemic in 2019, dealing with COVID-19 was tough on public health staff.

"To lead a team at the border was uncharted territory for me, but in many ways it's been a really positive experience," Paterson said. She believed, for all its challenges, COVID-19 could be "career-defining" for nurses, who were stepping up and demonstrating their skills and leadership. "The feedback from people has been really appreciative of the importance of our work."

She hoped the profession would gain more recognition and visibility as a result. "It's really amazing to see the nursing leadership at the moment – for us it's been really positive to be recognised as leaders. We are the experts in this – it's our chance to shine."

The ARPHS team had been observing since December the virus' emergence in China, and were aware of the pneumonia-type illness some people displayed. "We could see quite early on we could have some work to do around the border," she

said. "We knew we would get COVID here, it was just a matter of time."

Working at the airport, as well as monitoring the World Health Organization, Ministry of Health and Customs' fast-changing advice was "quite a change and quite a step up" for her professionally.

All public health nurses had to re-prioritise their workloads, which meant difficult decisions. "How can you let existing work go and what will the implications be? It's a real tension."

For her, it was tuberculosis patients, usually closely case-managed and supervised taking their medication, who now had to take it themselves. With COVID-19 accelerating so quickly, it became the priority.

The team worked out a system of case and contact management with each notification, trying to "wrap around" the patient, their family and household, while tracing their contacts on flights.

At the same time, Paterson was managing calls from the public, schools and GPs all worried about the virus. "There is a lot of fear and anxiety, so it's trying to give consistent, accurate advice to manage that."

But there were – and remain – so many unknowns. "Assisting people to make that clinical decision, in an environment that we don't have a lot to go on" was a challenge. With a background in public health, Paterson had a good understanding of how to approach infectious diseases. "But COVID is so new, fast and the science is still coming."

Health staff had to figure out quickly whether people without symptoms were infectious – still not clear – track people who had left hospital without permission, visit homes of patient contacts, while keeping safe. The team copped criticism for not wearing masks at the airport but, mostly, protection was manageable with a minimum of personal protective equipment, simply by keeping a physical distance, she said.

Hot off the back of an intense measles epidemic in 2019, dealing with COVID-19 was tough on public health staff. "Measles was long and hard work." But while hours had again been long, ARPHS had been taking good care of staff by providing meals and coffee and making sure they took breaks. Paterson has been working 10-hour days and most weekends for the past two months.

She believed the current shut-down would slow the disease, but expected continuing "small peaks" over coming months.

A parent of three teenagers, Paterson made the "difficult" decision to send them to stay with their father during the shutdown, allowing her to focus. "It's pretty challenging, but I think a good decision, given the amount of time I'm working. They will be better supported." •

ICU staff ready for challenge

Auckland critical care nurse Steve Kirby says the intensive care workforce is 'resilient' from recent disasters.

Critical care nurses – toughened and resilient from dealing with earthquakes, eruptions and shootings – say they are as prepared as they can be for the unknown effects of COVID-19.

"The nursing workforce is ready to meet this challenge – as much as anybody can meet something which could be really overwhelming," college of critical care nurses (CCCN) chair Steve Kirby said. "Recent disasters have shown how hard-working, professional and adaptable the critical care nursing workforce is."

With high health worker infection rates in Europe, protecting staff was "hugely top of mind" and the availability of personal protective equipment (PPE) a constant topic of conversation among nurse and clinical leaders, he said.

CCCN was working with the Australian-New Zealand Intensive Care Society (ANZICS) to carefully plan, especially for "high-risk" procedures like intubation and ventilation. However, there was an acceptance there would likely be infection of staff. "There is a general feeling that this is extremely infectious and there is a high risk that a lot of us will get it, even with all the protections."

> **'There is a high risk that a lot of us will get it, even with all the protections.'**

Auckland-based Kirby has been communicating with hospitals nationwide on policies and processes – trying to prepare for the unknown.

He acknowledged it was a "scary" time, but said New Zealand's nursing workforce had been through several crises in recent years – from the Christchurch mosque shootings to the Whakaari/White Island eruption, and was again preparing to put itself in harm's way. "These staff have come through those events admirably and have demonstrated such professionalism and care for each other. I think that will stand us in good stead for what is coming – whatever that might be."

Long-standing concerns about inadequate staffing and bed numbers would now be validated, he said. "But we will do our absolute best with what we have." Discussions included using operating theatres and post-anaesthesia care units for overflow patients.

Critical care nurses, in wards and higher acuity areas like high dependency units (HDU), across district health boards (DHBs) had been trained in using PPE correctly to protect both themselves and those around them. With a limited supply of the single-use items such as face masks, Kirby said the emphasis was on safe but appropriate use to avoid wastage. "So the equipment is being used appropriately and not needlessly."

The college was working closely with the infection prevention & control nurses' college on best practice guidelines across DHBs, as well as a network of intensive care clinicians.

Kirby said it was important to have clear, accurate and honest communication with health staff and the public – particularly around bed and ventilator numbers, as hospitals and intensive care units prepared for the worst. "These disaster planning preparations for dealing with a high number of pandemic victims are already in place," he said. "We're looking very carefully at how the units are staffed, managed and equipped."

Nurses felt "reassured" by the government response, support and education, he said. "They are clearly, like everybody, concerned by the speed that COVID-19 is developing, and the high number of cases around the world." Concern was focused on when the virus would "peak".

"I really hope that these measures have come in soon enough to prevent the catastrophes seen in other places. The Government has stepped in fast and hard and we really support that decision."

He urged nurses to stay socially connected with friends and colleagues in closed online groups. •

'Comradeship is strong'

Northland nurse practitioner Margaret Hand says nurses are 'in it together'.

At Te Hau Āwhiowhio ō Otangarei health care clinic in Whangārei, nurse practitioner Margaret Hand has noticed a dramatic rise in patient numbers in recent weeks, many of them with long-term and chronic health conditions. She attributes this rise to other practices in the area closing their books and people returning to the area from overseas or other parts of New Zealand.

Hand would normally spend part of each week working at the iwi provider Te Hā O Te Oranga O Ngāti Whātua clinic in Dargaville, but all community clinics have been closed due to the national emergency.

Nursing consultations at both clinics are now being done by phone, with nurses checking whānau, especially those over 60, to see how they are going mentally and physically. "While our doors are closed, patients who are unwell will still need to be seen, but with limited stocks of PPE, we have to be cautious. Full face masks are safer, but we don't have any yet," she said.

Ngāti Whātua iwi was providing support to around 400 whānau members aged 65 or more, many subject to chronic diseases, pregnant mums, and large families. Welfare packs included vouchers for GP visits, medication, transport and kai. "With the average wage in this area only around $17,000, there is not a lot of money for anything beyond the basics. We need to check children and families are safe," Hand said.

At Te Hau Āwhiwhio ō Otangarei, flu vaccinations are continuing, but they are being done in the open air – more than 200 flu vaccinations were done over seven days a couple of weeks ago. However, a lot of kaumātua had been fearful to leave their homes to get their flu injections.

"Many of our patients and whānau are experiencing a lot of fear – fear of the unknown. What they might need are messages to be given to them by local iwi and kaumātua, as well as nationally."

'Many of our patients and whānau are experiencing a lot of fear – fear of the unknown. What they might need are messages to be given to them by local iwi and kaumātua, as well as nationally.'

Instead of patients coming into clinics to collect their medications, the team was picking these up for them from the pharmacies. This relieved the pressure on pharmacies and provided access to medications for whānau.

"Patients can make appointments with us by an 0800 phone or engage with us on Facebook where up-to-date information is being posted."

Hand admires how iwi are working together across Northland to reduce barriers and provide resources for many patients/whānau, despite marae being closed. "My marae, Waikaraka, has stopped all bookings and, with the new tangihanga procedures, this is going to have a huge impact on whānau. Not being able to touch your loved one or say goodbye goes against all Māori tikanga. However, whānau understand the risks and will adhere to the rules."

Senior staff from all the clinical practices in Northland also met recently via video to discuss how they might help each other – the feeling of comradeship was strong, Hand said.

"The Ministry of Health has put a call out for nurses and doctors willing to become community testers. Like many other health professionals, I want to do my part and have registered my interest to support wherever else I'm needed."

While admitting to feelings of stress and sadness at times, she says the team at Otangarei try and have a few laughs, recognising that laughter was the best medicine. "Nurses are in this together, nationally and internationally, and I think they should be congratulated for their work at every level of the health system," she said. •

Workload heavy for IPC

Infection prevention & control leader Carolyn Clissold says other staff are turning to IPC nurses for their expertise.

Infection prevention & control nursing college of nurses (IPCNC) chair Carolyn Clissold, who works in Wellington, said its members were busy assessing patients and advising other nurses and health staff, while also trying to prepare for the pandemic.

"All of us are really feeling that we have a very heavy workload at the moment, both preparing hospitals in terms of how to take protective gear (PPE) on and off, and prepare for these patients if and when they come in . . . thinking about the best rooms for them, the best procedures for them and how to do the procedures correctly."

Other staff were turning to IPC nurses for their expertise. IPC nurses were also advising health workers in outpatient areas such as dental and anaesthetics, to ensure they were keeping themselves safe from infection.

Clissold said the college was "absolutely supportive" of the restrictions. Social distancing and screening patients was key. "Nurses need to make sure they're asking patients screening questions, like if they've travelled recently or are feeling sick."

She was working about two hours longer than normal every day at present. "Today I've gone to see two patients and talked over the phone about two patients in connection with people who have been overseas."

'It's a really hard time for everybody, we need to be compassionate . . . '

IPC nurses were spending a lot of time assessing people: "Do they need swabbing? Do they need to be in isolation?" Also ensuring that staff were screening everybody coming to the hospital – either by phone or in person.

Clissold said it was very much a team approach, "and the team is the entire hospital, coming in behind us".

Its approach was to limit visitors, use PPE when necessary, and run education sessions. But also in the current environment, "people are having to make decisions more quickly than ideal".

"We are just going to have to face each day as it comes and do the best we can, given the evidence we have and the resources we have available."

There was sufficient PPE currently, "but we are being mindful of not using too many and we are at the end of the supply chain in New Zealand."

She said it was a tough time for many people, having to isolate themselves at home, with limited visitors. "It's a really hard time for everybody, we need to be compassionate. People are lonely and sad, and fall over . . . nurses can be creative and compassionate in this situation".

IPC nurse leaders like her were involved with many more meetings and emails than normal, as people sought advice. The college had set up a forum online for members to ask questions, as well as a twitter account linking to best international practice articles, at www.infection-control.co.nz •

'Unknown territory'

Associate emergency charge nurse manager Tanya Meldrum says it feels like the 'calm before the storm'.

Dunedin associate emergency charge nurse manager Tanya Meldrum says it feels like the "calm before the storm" at Southern District Health Board.

Staff were busy trying to prepare for COVID-19, but nobody knew exactly what it would look like. "It's a funny in-between stage as we haven't got definite community-acquired illness related to COVID yet. It's like the calm before the storm, it's unknown territory," she said.

Meanwhile, camaraderie and humour was helping keep nurses' spirits up. "The nice thing about nurses is we do tend to pull together and look after each other. There is a lot of talking going on. People worry but appropriately. We're worried about our own families – are we putting them at risk? Should we be staying away from our families?

"We've been saying 'it's bigger than Ben Hur'. We have to kind of keep on going, but there're a lot of anxious people, presentations and staff right now."

Meldrum, as a designated COVID-19 planning nurse, had been working 50-plus hour weeks, holding meetings, keeping up-to-date with developments overseas and at the Ministry of Health, liaising with other services, such as St John's ambulance, medical flight services, community assessment clinics and GPs, as well as managing staff workloads.

"Emergency departments [EDs] are often the gateway between the community and the hospital. We have our feet in two camps."

Staff wellbeing is a huge priority for residential aged care nurse manager Natalie Seymour.

Caring for the vulnerable

Residential aged care nurse manager Natalie Seymour, of Christchurch, has her overnight bag packed, ready to stay should COVID-19 hit her residential aged care home, run by Nurse Maude.

"I've got my overnight bag, ready to stay if I need to, to the point where I am able to get staff comfortable and confident being here. I'm role-modelling that we're doing this together, we're all in this together."

Seymour has been working up to 16 hours a day since early March, from 6.30am to midnight in her 75-bed rest home and hospital facility. "I'm tired. But I have got some really fantastic staff around me to alleviate the situation," said the NZNO college of gerontology member. "We are all doing this, we all have to work as a team."

Staff wellbeing was a huge priority for Seymour, as she tried to maintain a sustainable workforce in the face of a potentially overwhelming pandemic situation. "I'm fully engaged with my staff, and putting my own emotions and feelings aside."

The home had totally changed all its processes for cleaning, laundry and meals, to minimise outside providers coming in.

All clinical matters had been delegated to the clinical manager, and between checking for Ministry of Health updates, "I'm constantly walking around checking if staff and residents are okay".

Her biggest challenge if COVID-19 did get into the facility would be finding enough staff to take care of residents, she said. "There is an underlying angst, because they have their own families to go home to. If it comes into the facilities, how should we handle it?"

Already several staff did not want to work or were in self-isolation. "Who's prepared to work? Who doesn't have young families?"

If COVID-19 did infect residents – as it had in Auckland and Hamilton facilities – residents would be isolated. The facility also had the ability to split into infected and non-infected areas.

Seymour hoped a clearer picture of what to expect would emerge soon – and it would look like Taiwan or Singapore, which had far slower infection rates than Italy. "We just don't know exactly what we're working with yet."

Ministry information had been "overwhelming" and not clear or concise enough, making it difficult to plan and communicate with families.

"I think we are in for a really interesting time. On the positive side, this

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Protecting staff was a key focus, with good hand hygiene reminders and guidance on personal protective equipment (PPE). "Looking after all our staff is the key to our department, and we've had good support from our nurse leadership, coming down and talking to us every day."

Human resources were looking at the spread of staff, considering age, chronic conditions and family situations, while trying to plan ahead, she said. "We're working out how we can cater for more numbers. We are planning for further escalation."

The closure of schools and childcare services had put extra pressure on nurses, many of whom were parents. Another challenge was working in an older hospital building, with no negative pressure rooms for isolation, and poor design.

ED nurses were screening arrivals on entry, from a barrier two metres away; categorising patients as "red", "green" or "orange", if their status was unclear.

Nursing staff were enjoying plenty of support and messages from friends, acquaintances and each other. "We are listening, talking, sharing, supporting each other – it's really important to feel listened to right now."

After "huge" hours over several weeks, Meldrum was now working from home due to a chronic health condition which rendered her vulnerable, but was still very busy coordinating remotely. 'It's been a struggle for me, knowing that I have the skills to help but cannot be in there." •

is an opportunity to really showcase our skill set, as nurses. We are charged with providing care to a really vulnerable population and now is our chance to really demonstrate that."

Seymour said the home had "totally" changed all its processes for cleaning, laundry and meals, to miminise outside providers coming in. "Staff are now taking full responsibility for these."

Virtual consults

GP consults were now being done virtually, through Skype, and all non-essential care cancelled. Management were meeting daily instead of weekly, to ensure things would run as smoothly as possible, including sourcing enough personal protective equipment (PPE).

Seymour was in close contact with the Nurse Maude infection prevention and control nurse coordinator. There was enough PPE to last for a couple more weeks and more on order. There were also really clear processes on its use, which was only when COVID-19 was suspected or confirmed.

Without visitors

Other than that, for most residents, it was "business as usual", except without visitors.

She predicted the level four restrictions would be "the new norm" for some time.

Residents' families had been very considerate and concerned about staff wellbeing, and staff were doing their best to reassure residents. "There is a true element of professionalism and responsibility in our work – it's humbling to see." •

Planning for the worst

Nelson Marlborough District Health Board associate director of nursing and operations manager of ambulatory services Jill Clendon says nurses' skills and knowledge are 'utterly vital' in this pandemic.

'We've been planning for the worst case scenario but because of the lockdown, we hope we won't get there. But if we do, plans are in place."

That's how Nelson Marlborough District Health Board (DHB) associate director of nursing and operations manager of ambulatory services Jill Clendon sums up how the DHB has prepared for COVID-19. Because planning began weeks before the lockdown, all those involved have had time to put the policies, procedures and protocols in place. "We have had time to think about the issues and what might emerge and put plans in place," she said. "Every DHB unit had a business continuity plan in place."

Among other things, Clendon is responsible for public health nurses (PHNs) and district nurses (DNs) and preparations have been different for each.

"Public health nurses are case managing the COVID-19 cases. Every patient [there were 19 when *Kai Tiaki Nursing New Zealand* spoke to Clendon] gets a phone call every day and the PHN does a clinical assessment. Most of the calls are straightforward but we have had some pretty sick people in Nelson," she said.

Most other public health nursing work – apart from flu vaccinations – has been put on hold. Contact tracing, which is being managed nationally, is being carried out by health protection managers, assisted by health promoters and PHNs, if needed.

Clendon said DNs, after emergency department and intensive care nurses, were among those most at risk. "They are going into people's homes and not knowing what's going on and that has created a level of anxiety. A lot of my role has been to support them," she said.

When PPE should be worn

Their anxiety has been focused on personal protective equipment (PPE) and Clendon has developed a flow chart for DNs, and other health-care workers who go into people's homes, to determine when PPE should be worn, drawing on the Ministry of Health's latest guidelines. "It is a screening tool – a home visit check list to determine whether PPE should be worn. If anyone has any symptoms at all, PPE should be worn. But 90 per cent of district nurse visits won't require PPE, as nobody in the home will be symptomatic."

Clendon is developing a model for 'swoop teams' to provide care in people's homes and to enable them to die at home safely.

She believes the education provided and the screening tool has mostly allayed nurses' anxiety.

The DHB has introduced a colour-coded triage system to decrease the patient load, based on the level of support patients need. Those identified as "green" will be educated to self manage their condition at home, with regular phone contact with their DN as needed. Those identified as "orange" have had their visits pushed out, with

video or phone consultations as needed. "Red" patients need to be seen regularly.

As with other nurse managers, Clendon has had to deal with immuno-compromised staff and those over 70. "We are using them in different ways," she said.

Clendon said the DHB was "fine in terms of staffing", with people lined up to help if needed.

She is "tentatively optimistic" that the Nelson/Marlborough region will be able to "keep the lid on" the spread of the virus. "We have had no community transmission so far – all cases have been linked to overseas travel as far as public health is aware. Most of those with COVID-19 were already self-isolating. If we can keep it at a slow rate of increase, regionally we might be okay."

Looking ahead, Clendon is developing a model for "swoop teams" to provide care in people's homes and to enable them to die at home safely. It is based on a critical care decision-making flow chart. Each team will most likely consist of a nurse and a GP.

Difficult decisions

"Some really difficult decisions about who should and shouldn't have treatment may have to be made. The swoop team will be able to provide comfort and palliative care for people in their homes."

Clendon said the skills and knowledge of nurses were "utterly vital" in this pandemic situation. Nurses were involved in much of the systems planning around COVID-19. "This situation will be a catalyst for change in our society in a way we have never seen before." •

Residents and staff scared

Health-care assistant Marita Ansin-Johnson says rest-homes are mostly well prepared for outbreaks of infectious illnesses, due to experience with norovirus.

'We've got frightened residents and we've got frightened staff. People are scared – they are afraid of the unknown."

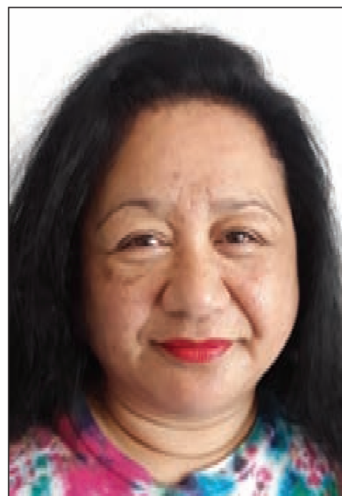
That's how Dunedin health-care assistant (HCA) Marita Ansin-Johnson describes the atmosphere in many rest-homes around the country. Ansin-Johnson, the driving force behind establishing an NZNO section for HCAs, has contact with caregivers all over the country and from a range of different care settings.

"I've heard of HCAs who can't afford to take time off work and of good and bad employment practices. But generally speaking, most rest-homes are prepared, seem to have adequate personal protective equipment, which is only to be used if the virus gets into rest-homes, and are educating their staff on what to do to prevent COVID-19 getting into rest-homes," she said.

And she said rest-homes were mostly well prepared for outbreaks of infectious illnesses, as they had had to cope with norovirus in the past. "We have knowledge and history around such situations."

But HCAs were reporting that many residents were afraid, and the lack of contact with their families because of the lockdown was compounding their stress.

"I am finding I have to ease residents' anxieties, then do the cares. We need to have people settled so we can provide care safely," Ansin-Johnson said.



HCAs were reporting that many residents were afraid, and the lack of contact with their families because of the lockdown was compounding their stress.

Mobile phones and computers had become "vital tools" for residents unable to have visits from family and friends. "The lack of contact is very difficult so phones and Skype have become vital tools to keep them communicating. It is lovely to see their faces light up when they are talking with their family on the phone or over Skype," Ansin-Johnson said.

Strong loyalty

Most HCAs felt "a strong loyalty" to their residents and she cited the staff at Bradford Manor in Dunedin who had chosen to stay at the facility during the lockdown. "They have chosen to live with their second family and leave their first family in their bubble. That demonstrates their loyalty," she said.

Ansin-Johnson had heard that Rymans, one of the country's largest aged residential care providers, was providing "care packages" to staff. "I heard from one HCA who works for Rymans that they are getting an extra $2 an hour, backdated to the start of the lockdown, a care package, meals and that there were security guards at facility entrances. She said the HCAs were feeling pampered."

By contrast, one HCA had told her that at her facility they were short staffed, had to re-use masks and that HCAs had been left out of all COVID-19 planning. Another had reported that some staff were "abandoning ship", leading to even greater staffing pressures.

The Otago Daily Times reported that Presbyterian Support Otago (PSO), the largest provider of rest-home care in Otago had asked staff over 70 or

in other high-risk categories to stay at home.

"Not all of these staff wish to stay home, but those that do are being asked to use sick leave, then annual leave to cover their time at home," chief executive Jo Rowe said.

As a charity, PSO did not meet the requirements for the Government's wage subsidy, she said. "We'll continue to support all our staff in every way we can, whether they are at work or at home, and that includes lobbying the Government for more specific wage support for charities and not-for-profit organisations working in social services and aged care during the Covid-19 crisis."

Ansin-Johnson said there was a marked contrast between providers with money, who could provide extras for staff, and those which struggled and were doing the best they could. "But most HCAs are doing a wonderful job under extreme conditions." •

Combining leadership with self-isolation has been the challenge for Waikato District Health Board chief nursing and midwifery officer Sue Hayward.

Communication and compassion

Waikato District Health Board (DHB) chief nursing and midwifery officer Sue Hayward spoke to *Kai Tiaki Nursing New Zealand* from a unique perspective – that of a nursing leader nearing the end of a period of self-isolation and having to continue managing staff via e-connections.

Hayward had returned to New Zealand from a meeting of the Global Centre for Nurse Executives in Brisbane just before the midnight deadline on March 15 for people returning from overseas. The time line changed, however, so she needed to go into self-isolation.

"We have all sorts of means of connecting using e-platforms but what I have learnt is there's nothing like face-to-face communication. However, perhaps this will have to become our new normal for a while. After the earthquakes in Christchurch, people had to get used to new ways of living and working. Now it's our turn."

Hayward said her primary focus was to ensure the nursing workforce at her DHB remained well-supported, healthy, happy and committed. The key to this was good communication and the ability to maintain compassion – for other staff members, patients and their families.

"Our nurses continue to work within their scope of practice but some are now working in other arenas to meet other immediate needs, eg staffing our community-based assessment centres. There are around seven at the moment, covering both rural and urban areas, but that number will increase. We also have registered nurses who are adding to their skills, taking refresher courses on working with ventilators, so they will be able to care for high-dependency patients when that need arises.

"We have other nurses going on leave because they are immune-compromised and we want to keep them well. There are nurses in self-isolation because they could have been exposed to the virus or they have come back from overseas recently."

'We only have so much resource. We will have to deal with this in the coming weeks. Quite how we do this, we haven't quite nailed yet.'

Some nurses were anxious about the risk of bringing the virus into their homes and families, Hayward said. The DHB had been putting out guidelines on how to manage this risk. Advice included changing clothes as soon as a staff member got home, washing work clothes separately, wiping down all hard surfaces and, of course, washing hands frequently.

Staff shortages could become an issue in the future. "We only have so much resource. We will have to deal with this in the coming weeks. Quite how we do this, we haven't quite nailed yet. As well as staffing our hospitals, nursing support will also be needed for people recovering from the virus at home or in residential care."

Reassurance and support

On March 26, the chief nursing officer Margaret Broodkoorn held a meeting, via Zoom, with all directors of nursing around the country. "This worked very well and gave us reassurance and support," Hayward said. "We can now spread the messages we received to our own teams. These meetings might well be held weekly."

Hayward recognises more personal protection equipment (PPE) will be needed in the coming weeks and this issue was being looked at. However, it was also important that nurses used PPE correctly – ie only when nursing people who were sick. "Nurses know how to use PPE – this is something we all grew up with."

Hayward fully recognises that levels of concern will escalate as the numbers of cases increase. Communication is the key, she says, and assuring staff "we will all get through this just as well as we can". •

A pandemic in action

In some people, an over-reactive immune response to COVID-19 brings on severe pneumonia.

By Georgina Casey

On March 11, the World Health Organization declared COVID-19 – the disease caused by the SRAS-CoV-2 virus – a pandemic. This means multiple countries, including New Zealand, are experiencing sustained transmission.

Most people experience mild symptoms following infection – a sore throat and rhinorrhoea, or perhaps fever, dry cough and fatigue. For some, symptoms can be severe, progressing from viral pneumonia, acute respiratory distress syndrome (ARDS) and/or cardiac injury, to multiple organ failure and death.[1] Even those surviving this more severe form of the illness may suffer from ongoing cardiac and respiratory damage.[2] Risk of death increases with age or in the presence of co-morbidities such as cardiovascular or respiratory disease, diabetes, cancer or impaired immune function.

Mortality rate unclear

Calculating the mortality rate of COVID-19 is difficult because:

- We do not have an accurate count of cases due to milder cases going unrecognised and low rates of testing in a number of countries.
- Death rates are affected by regional health-care capabilities and access to intensive care for the seriously ill.

Globally, 3 to 4 per cent of reported cases of COVID-19 have died. In the over-80s, the reported rate is currently around 15 per cent. The true overall mortality rate is likely to be less, although some experts put it as high as 5.7 per cent.[3]

The incubation period for COVID-19 is one to 14 days.[1] A person may be infectious before symptoms appear, and is particularly infectious in the early stages of symptomatic disease.[4] Very few cases appear after 14 days.[5]

Transmission is exclusively via droplets. Wet respiratory droplets are generated through coughing or sneezing. Droplets are larger and heavier than airborne transmission particles so do not remain suspended in the air for long, but a sneeze can potentially transmit droplets up to six metres indoors.[6] Infection occurs when the droplets land directly on another person's mucosal surfaces (eyes, nose, mouth) or through the person touching contaminated surfaces and then touching their own mucosal surfaces.

Coronaviruses may last on surfaces for anything from a few hours up to nine days, depending on temperature, humidity and the type of surface.[7] However, they can be inactivated with alcohol, hydrogen peroxide or sodium hypochlorite.[7]

Once transferred to a mucosal surface, the SRAS-CoV-2 virus attaches to receptors on the surface of cells, mainly the angiotensin converting enzyme-2 (ACE-2) receptor. The ACE-2 receptor is found all over the body, particularly in the alveoli. Once attached, the virus penetrates the cell and starts replicating, releasing new virus particles to infect further cells.

Clinical signs of infection are caused by the body's immune response to the presence of the virus. Inflammatory mediators called cytokines are released within the body to kill the virus or prevent its replication.

Unregulated inflammation

In some people, this system over-reacts, and a cytokine storm leads to unregulated acute inflammation in the target tissues. In COVID-19, this is mainly the lungs where it causes a severe viral pneumonia due to the inflammatory exudate entering the alveoli. This progresses to ARDS, with acute hypoxaemic respiratory failure. As yet there is no drug therapy for the SARS-CoV-2 virus.

After first exposure, the immune memory system allows a more rapid, and more controlled response to the virus. •

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Hot tips to assist virtual patient assessment in uncertain times

As the COVID-19 pandemic continues, nurses are being called to work in new ways. Connecting with patients via video-conferencing, Skype or Zoom can help keep patients safe, connected and out of hospital.

By Brigette Meehan and Michelle Honey

During these uncertain times of managing COVID-19 in New Zealand, nurses have already been, and are increasingly likely to be, called to work in new ways. This is both to protect our patients and also to limit our own exposure to COVID-19.

One option is to use technology to mediate interaction with patients. We share some ideas that have been developed when undertaking interRAI assessments, as these provide some useful hints for any setting where you need to assess a patient without being with them – so using a phone or video-conference, such as Skype or Zoom to connect with a patient.

These hints have been developed and tested for using interRAI (www.interrai.co.nz). interRAI is a collection of comprehensive clinical assessment tools developed by an international collaborative to improve the quality of life of vulnerable people. InterRAI is already used throughout New Zealand by health professionals in district health boards and aged residential care facilities. Standardised interRAI assessment tools help determine which level of support clients and residents need.

An interRAI home care assessment, either face-to-face or virtually, can keep people out of hospital. This is not only because it can identify the need for home-based supports (by a regular home-care provider) that can help a person stay out of hospital but also, in times of a pandemic, it provides indicators of clinical issues that may be reversed or maintained through intervention. It also provides good social support at times of uncertainty. For example, the assessment can identify who needs an advance care plan or who is at risk of depression.

In times of a pandemic, an interRAI home care assessment – either face-to-face or virtually – can provide indicators of clinical issues needing to be addressed. It can also provide good social support at times of uncertainty.

The hints offered here can be divided into three sections: pre-assesment; during the assessment; and general comments. Firstly, a virtual assessment is likely to take longer because all the usual cues you might pick up when face-to-face are not available. More preparation will also be needed. Both of these can be offset, however, by considering the travel time saved.

The following hints are proposed based on using video and audio so you can both see and hear the patient. We present these, bearing in mind an older person who might need support to use technology and who might have varied needs. You could adjust these hints to suit the client you need to assess.

Pre-virtual video-assessment preparation

▶ Contact the person or their family member/carer to prepare for the assessment:

▶ Check whether a mobile device capable of sharing live video between the person and the assessor is available. Preferably this will be a tablet or

portable laptop.

- Check whether the person is comfortable with this technology and how much support they may need.
- Practise with the person to see if the device can be positioned to allow both close ups and views of the whole person, to see the person in motion, and to observe the environment.
- Practise sending photos of the environment if the device is not mobile.
- Identify a third person who can attend the assessment to hold the device and liaise with the assessor if the person cannot manipulate the device adequately themselves. Ideally this is the family member/carer accompanying the person being assessed and who is alert to appropriate precautions against infection.
- Ask the person to collect all their medications together.
- Have the person's current height and weight information available, where possible.
- Ask the person to have available other documentation that is routinely collected for the assessment, such as health-care identification number or names of other health providers.
- Review the person's previous assessment (if this is not their first assessment) to highlight any issues that may require specific clinical observation or discussion.
- Arrange the opportunity for family/carer involvement in the assessment. If the family member/carer is in the home, check they will be available to participate while the person is assessed. If the family member/carer will not be in the home at the time of the assessment, try to include them via conference call, either by linking them to the video connection or via a conference call. If that is not possible, arrange for a follow-up call with the family/carer at another time.
- A family member/carer must be present if the person has any known cognitive or communication problems.

Completing the assessment and being mindful of COVID-19

- Assess the person through structured conversation, in the same way as a face-to-face assessment.
- Obtain information from family member/carer and others (such as the GP) in the same way as a face-to-face assessment.
- Use the mobile device to enable observations that are fundamental to the assessment.
- During the assessment explore:

a) cognitive or functional losses that might occur due to isolation or adverse consequences of isolation;
b) psychosocial issues that might be affected by isolation;
c) any issues related to medication and food, which may be problematic if the person doesn't have support to access them, prepare medications or make meals;
d) pay particular attention to any physical COVID-19 health symptoms related to the outbreak – fever, dyspnoea or shortness of breath, history of chronic obstructive pulmonary disease, history of heart failure;
e) Ask about new, continuing cough or sore throat. You should ask whether the person has had these symptoms in the last three days and record this.

- Ask the family member/carer for input to provide any supplementary information that is not demonstrated readily through the device.
- Because COVID-19 can lead to rapid, severe changes in the health of vulnerable people, it is important that your assessment is sensitive to changes in physical or mental health, cognition, function, and other clinical signs.
- If you notice substantial changes in the person's health and wellbeing based on the new assessment (eg change in cognitive function), ensure other health-care partners are aware of the change.
- Depending on your workplace policy, this may be an opportunity to check whether the family member/carer who is also present at the assessment has the COVID-19 symptoms listed earlier.

Extra points to think about for a phone interview assessment

- Good practice, as well as expectations of the Health and Disability Commissioner's code of rights, requires that people must be clearly advised that an assessment or reassessment is planned. Ideally this is arranged with the person by letter or, alternatively, by a phone call to confirm an appointment time for a different occasion.
- At the beginning of the telephone call, you advise the person of the purpose of the call, outline what they can expect will happen during the call, and inform them they can seek a review of the assessment findings if they wish.
- If you are interviewing an older person, it may be helpful to ask the person for the name and contact details of a family or whānau member you could also contact to discuss the assessment, if required or if desired by the older person.
- The assessment phone call should be conducted like a conversation and be finished within 20-30 minutes.
- Older people with significant hearing difficulties, visual, speech, language or cognitive difficulties such as dementia, or who have English as a second language, should be assessed face-to-face. If you think these apply, then you should stop the call and make arrangements for a face-to-face assessment.

A virtual assessment is likely to take longer because all the usual cues you might pick up when face-to-face are not available.

Nurses are the frontline health professionals who are on the scene and involved in providing care. In these uncertain times, this includes those who may be infected and in isolation due to COVID-19. Using technology to support assessment at a distance is another means to ensure we can maintain care and keep in touch with our patients. We hope these hints may assist this or give you ideas on how to better prepare and undertake virtual assessments. •

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Michelle Honey, RN, PhD, is a long-time advocate of nursing informatics. She is a senior lecturer and MNSc programme director with the School of Nursing at the University of Auckland and she serves on the interRAI NZ governance board.

Potential impacts of COVID-19 pandemic

What will happen to nursing after the pandemic? It is likely to involve new technologies and new ways of working.

By Patricia McClunie-Trust

The COVID-19 pandemic has challenged health systems world-wide, putting nurses at the forefront of efforts to slow the spread of the virus, and care for those with serious complications. The challenge for the future will be to manage the changes the experience of nursing during this pandemic will bring for both individual nurses and the profession.

While the impact of COVID-19 is still unfolding in New Zealand, the talk among nurses already indicates concern for themselves, their families, and their relationships with the patients and communities they serve. At the same time, significant numbers of nurses have chosen to return to practice in response to a call to action from the Ministry of Health,[1] just as they did during the 1918 flu epidemic.[2]

While the current pandemic may be unprecedented in living memory, historical accounts of the 1918 flu epidemic[2] provide insight into the experience of nurses at that time. Reports suggest that "the need for nurses was acutely felt", meaning the health services and nursing workforce were stretched beyond capacity, with much of the care given in the community by volunteers and family. The reports from 1918 communicate core values of nursing at that time, including duty, service and a social generosity that characterised the profession's relationship with the New Zealand people. The reports also convey a sense of the entire population being all one family that needed to pull together. However, they are also a stark reminder that nurses lost their lives in the service of their profession and their country during the 1918 epidemic.[2] How will the COVID-19 pandemic affect New Zealand nursing and shape our profession in the future?

Patricia McClunie-Trust

American infection control physician Kent Sepkowitz argues that countries with higher rates of nurses per capita seem to have lower death rates in this pandemic.[3] This suggests nurses may be the critical element in health services that enable effective patient management and survival. Nurses have demonstrated a particular kind of social generosity in their response to emergencies in our country, by returning to the workforce in times of need, and sustaining care delivery through personal sacrifice.

Social generosity

Social generosity is a kind of altruism that goes beyond contractual obligations one person may have to another.[4] It forms the core of social cohesion in any community or society, and the generosity of nurses at this time needs to be noticed and respected by New Zealanders and the Government. It means that this "gift of self" should not be interpreted as a commodity.

Knowledge of the demands this pandemic will make on our health service shows that social generosity is not sufficient to sustain our nursing workforce into the future. Greater investment is needed in public health and other services where nurses are key to population health. The World Health Organization (WHO) maintains that health workers are an investment in the infrastructure of a country, rather than a fiscal burden.[5] Unleashing the power of health workers is an opportunity we cannot afford to miss. A well-educated and skilled nursing work force is part of a country's wealth.

Nursing's professional values

Over the last week of March, some nurses have spoken to me about how public safety is currently foremost in their practice, forcing to the background the patient-centred and culturally responsive values central to their professional beliefs. For these nurses, social distancing and triaging patients via a phone comes at a cost, which is the loss of their relational practices in the midst of the pandemic. They also understand that people who are already compromised in terms of their health and access to health services may be those who are most at risk in a pandemic.[6]

Balancing potentially conflicting rights, interests and values between individuals and communities is central to pandemic planning. Human liberties and individual rights are likely to be limited for periods of time to serve broader public interests, including public safety and the wellbeing of health-care workers.[7] However, public health measures must also inform, educate and communicate with the public to ensure they understand the nature, scope and threat of a pandemic. The concern these nurses expressed to me, in wanting to uphold these values of patient-centred and culturally responsive care, indicates they will need professional support to come to terms with their experiences of practising during this pandemic. The profession will also need to research these experiences and disseminate information about how our core professional values can be nurtured and sustained into the future.

The "gift of self" inherent in the idea of social generosity has potential costs to individual nurses. The National Ethics Advisory Committee (NEAC) states that *"health professionals have obligations*

to provide care if a pandemic occurs, including when there is increased risk to themselves and their families".[8]

Nurses clearly have obligations as essential health-care workers, but community expectations of nurses should also be reasonable and not create unnecessary risks for individual nurses. NEAC acknowledges that kotahitanga, or working together in unity and solidarity, is more likely to occur if health professionals feel valued and supported by their organisations and communities. Nurses' right to refuse to perform work that is likely to cause serious harm is identified in the Health and Safety at Work (HSWA) Act 2015. However, as NZNO suggests, where there are sometimes competing obligations between personal and professional responsibilities, each nurse needs to decide where to set limits.[9]

The NZNO guideline on obligations in a pandemic or disaster also includes the importance of nurses being aware of the NEAC ethical guidelines for a pandemic and any specific contractual obligations to their employer. Nurses working on the frontline of health services will need ongoing support from their professional organisations and other nurses to manage the impact of the extraordinary responsibilities they will have while working in pandemic conditions. Those of us who are trained as professional supervisors or counsellors might want to consider how we could contribute to this support on a voluntary basis.

Nurses clearly have obligations as essential health-care workers, but community expectations of nurses should also be reasonable and not create unnecessary risks for individual nurses.

'Virtually perfect' technology

Technology and knowledge are two key enabling factors in our ability to respond to the threats COVID-19 presents, that our predecessors did not have in 1918. Technology has given us the ability to understand the virus's microbiology and patterns of transmission. Work is underway on rapid-detection methods using portable devices to screen suspected cases, which will enable early detection, isolation and treatment.[10] A point-of-care diagnostic device, whatever form that might take, would also enable earlier mapping of cases and clusters, and potentially ease the demand on laboratory services. Artificial intelligence allows mapping of outbreaks and forecasting the nature and scope of their spread.[11]

Knowledge of the means of transmission also allows governments to educate their populations about the reasons for public health strategies and how to maintain their own personal safety. The developments and discoveries arising from the pandemic have the potential to change how nurses work in the future, particularly in being able to diagnose and treat people with infectious diseases with much greater efficacy.

Learning to do things differently has been another aspect of our early experience with this pandemic. There has been a sudden upscaling of virtual-care capacity, with phone triage or self-triage tools being the first contact people have with health-care providers.[12] In the United States, telehealth has enabled social distancing, reducing the risk of infection transmission through face-to-face consultations. However, there have been lengthy waiting times due to overloaded systems and a lack of suitably trained clinicians.[12]

Some commentators see telehealth as the new opportunity arising out of the current crisis. United States physicians Judd Hollander and Brendan Carr argue that telehealth is "virtually perfect" as a first-line approach to prioritising convenient and inexpensive care.[13] While telehealth has the potential to benefit greater numbers of health consumers, there are also some people for whom it may not be a perfect fit. People who are already compromised in terms of their health and access to health services may be those who are most at risk of remaining disenfranchised in our new world. These health-care technologies, and the people who use them, will need to be clever in managing the factors that distance people from health services, particularly in maintaining person-centred and culturally-safe nursing practice.

How we live and work may have changed forever in the face of this pandemic. It is likely I will do far more teaching and research using online and videoconference approaches from the "bubble" of my home office. Nurses will use telehealth, perhaps as their first line of contact with clients and colleagues. The ethics of using health-care technologies, and concerns with who is enabled or not with new our ways of working, will be something we need to carefully consider in our future world. •

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What causes bullying and how can it

Bullying is a widespread problem in nursing. What causes it and how can it be reduced?

By co-editor Teresa O'Connor

Bullying is not a new problem in nursing; rather there is an embedded culture of bullying in nursing, according to a leading researcher in the field.

"Bullying has been a problem for a long time – we are just talking about it more now," says Massey University researcher Kate Blackwood, whose PhD thesis explored bullying in nursing.

The prevalence of bullying in nursing arises from a combination of factors.

"My thesis and other research confirms three factors – stress, frustration and conflict, and the culture of the organisation – all contribute to creating an environment in which bullying can flourish," Blackwood said. "And nursing is exposed to all three factors."

'Huge stressors' in nursing

Blackwood acknowledges the "huge stressors" in nursing – heavy workloads, staff shortages, patient acuity, double shifts, working through meal breaks, sometimes having to work in unfamiliar areas or departments and the emotional drain of nursing itself.

"All these factors can lead to frustrations and strains which manifest in bullying behaviours. And nurses now come to work with more outside responsibilities like children, ageing parents, grandchildren, community obligations and societal pressures."

Because of greater patient acuity, nurses now must have more and more diverse skills and they bear more responsibility. This leads to increased stress and pressure in their workplace, Blackwood believes.

Performance pressure from managers is also a major factor. Blackwood refers to the cascading effect of pressure. "Pressure from government means pressure on senior managers means pressure on line managers which brings pressure right down to the frontline," she said.

And often those managers in closest contact with nurses do not have the leadership skills needed for their roles.

"People are often promoted to management roles on the basis of their clinical skills but some of the so-called 'soft skills' – effective communication, empathy, being available, demonstrating trustworthiness – are missing.

"Performance pressures on everyone can also lead to mistakes/errors and these are often not dealt with in an effective or developmental way, rather in a punitive way," Blackwood said.

Another factor is that a lot of bullying behaviour has long been tolerated, even expected. Blackwood says this may be a reflection of oppressed group behaviour. "Research shows one of the lingering impacts of oppression is that those who were supposedly oppressed indulge in harmful behaviour to those less powerful than themselves. Many senior nurses are very supportive, but others display such behaviours and undergraduate nurses are at risk because they are less powerful and lack the skills and confidence to confront the behaviour," she said.

Blackwood said new graduates went through a socialisation "to harden them up. From what I understand, this is a very real culture that exists within nursing.

"The struggle new grads face to determine whether they are at fault [for the bullying behaviour] can lead to huge insecurity and have an ongoing impact on their career," Blackwood said.

Another factor in the mix is that managers often tolerate bullies. "It may be that those who bully are perceived to be those who get things done when things need to be done in a hurry, so their behaviour is tolerated. But the long-term impacts of such behaviour – patient errors, plummeting staff morale – are not considered."

The majority of bullying is senior nurses bullying nurses more junior to them, often new graduates.

Kate Blackwood

There is a real lack of awareness and understanding of what bullying is. Often bullying is a subtle build-up of behaviours over time, rather than an overt, isolated incident.

The impact of bullying on new graduates can be devastating. "New grads often feel they are responsible for the bullying behaviour – that the fault was with them. They don't have skills, confidence or experience to identify bullying behaviours, particularly when those behaviours are common place."

Bullying within nursing is longstanding, embedded and its impacts severe. So, are there ways it can be ameliorated? Just as the causes of bullying are multifactorial so, too, must be the responses to it, Blackwood believed.

"Early, low-level intervention is crucial, along with addressing the contextual fac-

t be reduced?

tors which give rise to it."

Staffing is also crucial. "If there were enough staff to cover every shift, that would likely overcome some of the contextual factors and prevent some bullying behaviours."

Awareness of bullying behaviours and how to confront them should "absolutely" be a part of undergraduate education "but that is only a small part of the solution".

More education needed

More education on what constitutes bullying (see table at right) is essential. "There is a real lack of awareness and understanding of what bullying is. Often bullying is a subtle build-up of behaviours over time rather than an overt, isolated incident," she explained.

And that means reporting it can be fraught. "Normal channels of reporting, such as incident forms, don't capture the subtle behaviour that has built up over time. Three or four months of small often covert incidents, for example being ignored in the corridor, or information being withheld, or being excluded from group conversation, each in isolation don't seem particularly serious. But the accumulated effect can amount to bullying and is what causes harm. How do you report that?"

Blackwood said often victims of bullying didn't have evidence to support their claim. "The traditional ways of dealing with conflict often don't work for bullying."

HR processes 'too difficult'

Complaining to the human resources (HR) department often wasn't helpful. "Lots of nurses I have spoken to have said that HR had told them they couldn't' do anything, for example start an investigation, unless they got a formal a written complaint. Often it is managers doing the bullying, so who else can an individual report to? There are many reasons why victims won't put a complaint in writing. They just want it to go away and to go through HR processes is too difficult for them," Blackwood said.

Bullying behaviours as listed in the *Negative Acts Questionnaire – Revised*[1]

Work-related bullying	• Someone withholding information which affects your performance • Being ordered to do work below your level of competence • Having your opinions ignored • Being given tasks with unreasonable deadlines • Excessive monitoring of your work • Pressure not to claim something to which you are entitled • Being given an unmanageable workload
Person-related bullying	• Being humiliated or ridiculed in connection with your work • Having key areas of responsibility removed or replaced with more trivial or unpleasant tasks • Spreading of gossip and rumours about you • Being ignored or excluded • Having insulting or offensive remarks made about your person, attitudes or your private life • Hints or signals from others that you should quit your job • Repeated reminders of your errors or mistakes • Being ignored or facing a hostile reaction when you approach • Persistent criticism of your errors or mistakes • Practical jokes carried out by people you don't get along with • Having allegations made against you • Being the subject of excessive teasing and sarcasm • Being shouted at or being the target of spontaneous anger
Physically intimidating bullying	• Intimidating behaviours such as finger-pointing, invasion of personal space, shoving, blocking your way • Threats of violence or physical abuse or actual abuse

Souce: Einarsen et al., 2009, p. 32

There are different ways of measuring bullying and different ways of applying this questionnaire, but the most common is that an individual is said to be a target of bullying if they are exposed to at least two of these behaviours, at least weekly, for a period of at least six months.[1]

But HR could provide support to line managers to deal with interpersonal issues in their team, such as training in coaching and mediation. Line managers were in an ideal position to provide early, low-level interventions but needed support to do so because the work took an emotional toll, she said.

Research showed that once there was an escalated case of workplace bullying, it became almost impossible to solve. "Who is going to admit they are a bully? If bullying isn't effectively addressed first time round, subsequent bullying is much less likely to be reported and in many cases the victim will eventually leave. It is very rare that an individual will have the confidence to approach the bully and address the issue. Unfortunately, it is also rare for organisations to intervene effectively to resolve the bullying," she said.

One key factor in reducing bullying was to try and bring about a culture shift within the organisation. Elements of this included very strong messaging from senior leadership – "they must be strongly on board and committed to addressing the issue".

Attempting to reduce some of the risk factors associated with a stressed, burnt out workforce was another element. "Getting those contextual factors to be more conducive to healthy work will mean we have a greater chance of tackling the issue."

"Some DHBs were taking really good steps to address bullying and all had some sort of "zero tolerance" bullying policies in place, she said.

One DHB she knew of had adapted her research on the management competencies needed to handle bullying as part of their training for managers.

Bullying behaviours should be named and not tolerated and reporting should be encouraged. "Excuses such as 'that's my style' or 'I have a blunt communication style, get over it' should not be accepted. And there has to be a focus on developing healthy relationships and strong leadership in line manager roles."

But new ways of reporting had to be developed – ways that captured the subtlety of so much bullying and which did not worsen the situation for the victim. "How to report bullying can be problematic. DHBs need to look at different ways from the traditional methods of reporting problems. There needs to be an unbiased communications channel, an independent network for those who have been bullied. Participants in my research said they found it healing to talk about their experiences, to be listened to and taken seriously."

Blackwood believes the prioritisation of patient care above and beyond looking after fellow nurses may be another contributing factor to bullying. She cites the Nursing Council's code of conduct as a document in which patient/client needs are elevated well beyond those of nurses.

"Promoting the health and wellbeing of the health workforce doesn't seem to be highly prioritised. To bring about a culture shift, organisational leaders must recognise that looking after the health workforce is beneficial in the long term. The focus can't always be totally on the patient – prioritising patients at the expense of the health workforce will have a long-term impact on the wellbeing of health workers," she said.

Nor does Blackwood think building the resilience of the workforce is the way to tackle bullying. "Enhancing the resilience of your workforce is not addressing the cause of the problem."

Organisational culture crucial

She's clear about what needs to be addressed, if bullying is to be genuinely confronted. "While there are personalities with blunt communication styles in every workplace, we need to acknowledge that bullying behaviour is the result of the workplace/organisational culture and not only attributable to individual personalities.

"As long as the contextual factors in the work environment which contribute to bullying remain and there is no concerted effort to focus on them, and the focus remains more on interpersonal issues, then we are never going to be able to address bullying." •

Reference

1) Pitama, S., Robertson, P., Cram, F., Gillies, M., Huria, T., & Dallas-Katoa, W. (2007). Meihana Model: A Clinical Assessment-Framework. *New Zealand Journal of Psychology, 36*(3), 118-125.

Horizontal violence 'alive and well' in nursing

HORIZONTAL VIOLENCE between nurses and towards new graduates is "alive and well" in the clinical environment, regardless of practice setting, according to a study by Otago Polytechnic School of Nursing academic lecturer Chelsea Wilmott.

The research study, part of Wilmott's 2019 masters dissertation, looked at 1516 new graduate nurses' experiences. It used an integrative review methodology, which captured an international perspective and was across all areas of nursing practice.

The findings were "disheartening", according to Wilmott. "I was surprised to discover that many new graduate nurses report first encountering horizontally violent behaviours from nurses while on clinical placement and also in academic institutions. It seems to happen early while student nurses are being socialised into the profession and is magnified in the first few years of nursing practice. The oppression cycle between medicine and nursing remains the strongest explanation for the prevalence."

Wilmott was surprised to find that many nurses who exhibited bullying types of behaviours were often unaware they were doing so, as they, too, had been "socialised into professional norms".

Transformational leadership and a commitment from managers and senior nurses had been effective in generating culture change. Working with managers, existing staff and new graduate and student nurses had also proved effective, she said. •

Coping with the COVID-19 virus

The level-four alert restrictions now in place nationally will have a major impact on the mental health of our community. Nurses have a crucial role to play in helping reduce their impact.

By professional nursing adviser Anne Brinkman

Mental health – our own as nurses and that of the community in general – is a very real issue with the country now in level-four lockdown to prevent the spread of COVID-19.

Last month, I was in Dunedin with the mental health nurses section national committee. Those working in district health boards (DHBs) were lamenting what might lie ahead for already understaffed areas. There simply aren't enough staff or the right skill mix in mental health wards and community settings now, nevermind in an unfolding crisis.

Role modelling needed

COVID-19, added to this already taxed and vulnerable mental health situation, becomes an incendiary device we all hope won't blow up. Anxiety is already rife in our communities, so if ever calm and reason were needed to be role modelled by health professionals, then the time is now.

What can nurses do to contain their own anxiety? How balanced are their lives already, and how effective are their own coping mechanisms? What do nurses need to reflect on to assess their own mental health strengths and weaknesses so they can effectively prepare for these new and uncertain health demands? These are questions we all must ponder. Certainly, gathering quality and evidence-based information on COVID-19 is essential. The old adage "knowledge is power" is relevant here. Knowing others and knowing yourself and how *you* respond to life's challenges are necessary, so you can maintain perspective.

Nurses are crucial in transferring useful information and skills to patients and their family/whānau to help promote health and prevent illness.

What are some of the likely mental health impacts of the restrictions we are now all living under? China has reported an increase in domestic violence since COVID-19 isolation measures were introduced. Our own rates of domestic violence are frightening in "everyday life"; these will doubtless increase significantly under added unfamiliar and threatening pressures. How can we work to prevent and reduce these looming issues? There is even a term for the reaction to major fatal epidemics – epidemic psychology.[1] It is a recognised and serious issue.

What are the measures we can all bear in mind, as we set out to role model balanced mental health approaches in containing COVID-19-generated anxieties and fears, let alone the virus itself? One of the best frameworks to keep in mind for mental health is that of awareness, acknowledgement and action. Our role modelling can make a huge difference, as people watch for our lead in these uncertain times.

To increase your awareness, assessing your strengths and weaknesses in coping with difficult situations is essential. How are you currently placed and how do you achieve balance in the four pillars of your own health – mental, emotional, physical and social?[2] What are your reliable coping mechanisms? How will the COVID-19 virus restrictions affect what you and your family/whānau can or can't do, let alone afford? Family/whānau interactions – face-to-face or by social media – will increase in intensity as people work out how they settle into new, enforced patterns of behaviour.

'Early warning signs'

Being aware of your own "early warning signs", eg feeling unbalanced and stressed, is necessary to survival – you can choose to pause and determine the best way forward. This is a time not to increase your stress through perfectionism, rescuing or victim behaviours. There is a plethora of information on the web that can help you improve your coping mechanisms and prevent yourself from tipping over. We particularly recommend the Mental Health Foundation's website: www.mentalhealth.org.nz/get-help/covid-19/

Being aware of the mental health needs of others is an integral part of effective nursing care. Think about the questions you can ask and discuss in establishing how another person is thinking and feeling. Listening is vital to ensure a person feels heard.

There is even a term for the reaction to major fatal epidemics – epidemic psychology.

Taking action demonstrates your understanding and awareness of how to manage anxieties and fears. There will be a need to be selective in what you take on board.

Professionally, you have obligations to be informed about COVID-19 and the many implications of the national containment strategy. It is changing our lives daily. Personally, you have to be selective about the amount and intensity of the information you absorb through social media and other platforms.

Wisdom comes from both knowledge and experience. Pursue both in your quest for making wise, informed decisions that will help promote the mental health of the nation.

Do ring NZNO's Member Support Centre for further advice and support. Even if NZNO staff are working remotely, we are still on the end of a phone. Kia kaha in these turbulent times. •

References

1) Strong, P. (1990). Epidemic psychology: a model. *Sociology of Health and Illness, 12*(3). doi.org/10.1111/1467-9566.ep11347150
2) Durie, M. (1994). *Whaiora: Māori Health Development.* Auckland: Oxford University Press.

International Nurses’ Day May 12

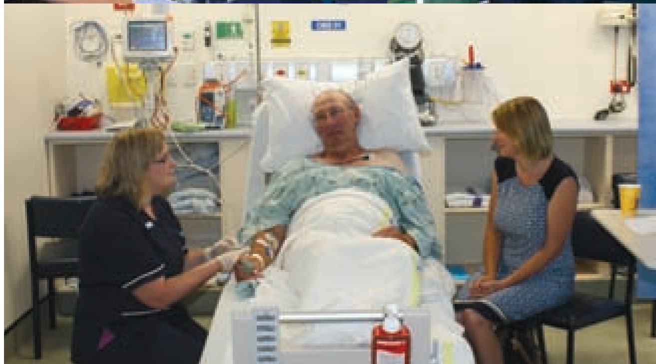
“Nursing the world to health”, with a focus on the “true value of nurses to the people of the world” is the theme for International Nurses Day 2020, celebrated on May 12.

Themes are set by the International Council of Nurses, with 2020 intended to be “extra special” because 2020 has been designated the Year of the Nurse and Midwife, coinciding with the 200th anniversary of Florence Nightingale’s birth.

With the World Health Organization declaring Covid-19 to be a pandemic on March 11, as Covid-19 has spread to more than 114 countries, the true value of nurses becomes starkly obvious.

May 12 can hardly be considered a celebration, but let us stand in solidarity with nurses throughout New Zealand and around the world – our lives depend on them and their skills and commitment, along with those of their health professional colleagues, as never before.

NZNO chief executive Memo Musa



International Midwives’ Day May 5

In the International Year of the Nurse, nothing shines a light on how important nurses are in our communities quite like the current COVID-19 pandemic.

ProCare stands alongside our talented practice nurses who are facing this crisis head-on as true professionals.

We thank all nurses across the network for placing themselves at the forefront of primary care, along with their GP colleagues, for the good of our communities.

We are proud to be on your team.

New Zealand Blood Service would like to sincerely thank our Enrolled and Registered Nurses for their significant contribution to the health and wellbeing of all our donors and patients.

The care and compassion you demonstrate to your patients and donors and your ongoing dedication and commitment to quality, ensures we continue to collect and provide safe blood products to New Zealand

THANK YOU

Capital & Coast DHB leaders acknowledge and thank all nursing and midwifery teams working across hospital services, mental health, addictions and intellectual disability, primary, community and aged residential care settings during the International Year of the Nurse and Midwife.

Your contribution to the care, health and wellbeing of the people of your community during these unprecedented times of challenge make an enormous difference. We appreciate your commitment, kindness and generosity towards the people you care for and one other.

He aha te mea nui o te ao, he tangata,
he tangata, he tangata
What is the most important thing in the world?
It is the people, it is the people,
it is the people

9068-0320

NORTHLAND DISTRICT HEALTH BOARD

THANK YOU!

¥ **Northland DHB acknowledge and thank all the amazing nurses and midwifery teams working across the sector during the COVID-19 response and throughout the year, who are committed to the well being of the people of Te Tai Tokerau**

NEW ZEALAND
NURSE OF THE YEAR
AWARD 2020

By Geneva Staffing

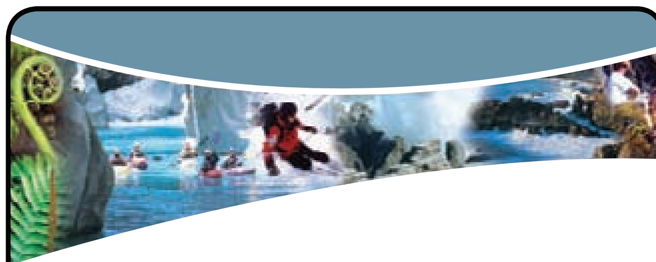
Have you ever worked with or received care from an exceptional Nurse or Midwife? Nominate them today.

The award winner will receive an Air New Zealand Deluxe Mystery Break for two*

Nominations are open from 1 April to 5 pm, 12 May 2020

Nominate someone today on:
www.genevahealth.com/nominate

*Ts & Cs apply



To our Nurses, Midwives and your whānau – we are so very proud of you;

- For selflessly serving something that is greater than us, which is our care and duty to others
- For your courage in facing an unprecedented event in both our personal and professional lives
- And for supporting each other in ways unseen to ensure we sustain our energy

You ARE making the difference.

www.westcoasthealthcareers.co.nz

Nurses a voice to lead: nursing the world to health.

International Nurses Day 2020 – celebrated as the global fight against the Covid-19 pandemic continues.

Our Family Planning nurses are working to deliver much needed sexual and reproductive health services in new ways to ensure every New Zealand can get the sexual and reproductive healthcare they need, when and where they need it – even in a time of crisis.

Jackie Edmond
Nurse
Chief Executive

Rose Stewart
Nurse
National Nurse Advisor

www.familyplanning.org.nz

Thank you practice nurses

To all nurses in general practice,

We cannot thank you enough for the strength and dedication you have shown, and sacrifices you have made to support our community through these trying times.

Please know that your work is highly valued.

We are here to support you in any way that we can.

From the team at Comprehensive Care

Waitematā District Health Board thanks all nurses and midwives working across North Shore, Waitakere and Rodney district for their contribution to the health of our community.

Now more than ever, it's great to see our team continue working together to deliver quality patient outcomes and best care for everyone.

Thank You for all that you do.

Going above and beyond... every day

Nurse Maude

Caring for the community since 1896

www.nursemaude.org.nz

HC NMA0676

Thank you

To all our nurses and midwives who work in our hospitals and communities across Auckland DHB - every day you make a difference to someone's life through kind, respectful and compassionate health care

Haere Mai Welcome | **Manaaki** Respect | **Tūhono** Together | **Angamua** Aim High

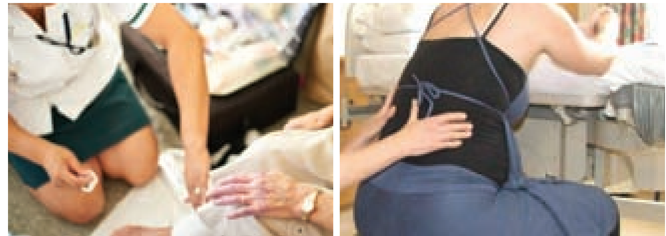
Rewarding Career, Fantastic Locations!

YOU BELONG HERE . . .

Nursing the World to Health

In these unparalled times Bay of Plenty District Health Board applauds all nurses for their contribution to providing the health and care needs of the people in our communities.

www.bopdhb.co.nz



International Nurses and Midwives Day

A chance to celebrate with nurses and midwives the care and compassion they show each day.

This is our turn to thank and acknowledge them for the work they do in Hawke's Bay everyday.

Thank you

Southern DHB and WellSouth would wholeheartedly like to thank all our dedicated nurses and midwives for the incredible job you are doing. We truly appreciate your kindness, professionalism and commitment in making sure our community is well cared for and safe in these difficult times.

INTERNATIONAL NURSES DAY 2020

Thank you

to Taranaki DHB nurses

It takes a remarkable person to be a nurse.

Thank you for the expertise, care and compassion you provide to the Taranaki community every day, especially during this unprecedented time.

Ngā Manaakitanga

NEW ZEALAND NURSES ORGANISATION | TŌPŪTANGA TAPUHI KAITIAKI O AOTEAROA

2020 INTERNATIONAL YEAR OF THE NURSE AND THE MIDWIFE

NZNO Young Nurse of the Year 2020

Nominations now open!

Purpose of award:

- To recognise and celebrate the often exemplary work of nurses in the younger age group who may still be in the early stages of their careers
- To encourage younger nurses to demonstrate their commitment to and aspirations for the nursing profession in Aotearoa New Zealand
- To provide an incentive for them to remain nursing in Aotearoa New Zealand.

Nomination criteria:

The public, colleagues or managers may nominate a young nurse for this award. Nominators are requested to specify how the nurse they are nominating demonstrates commitment and passion to nursing beyond the every day. This may include how the nurse:

- Shows compassion or courage beyond what is expected in their role as a nurse;
- Has improved care or health outcomes for their patients through their commitment to care, leadership, research or quality;
- Works to deliver care that honours the articles of Te Tiriti o Waitangi: Tina Rangatiratanga; Partnership; Active protection; Options and Equity.
- Has overcome major challenges to deliver exceptional care.

Nominees may be registered or enrolled nurses, may be new graduates, do not have to be in paid nursing work, must be under the age of 31 as at December 31st 2020, be resident in New Zealand, and a current financial member of NZNO.

There is a two phase nomination assessment process:

- Firstly, shortlisting of up to 6 nominations by a subcommittee of the YNYA assessment panel convened for that purpose and comprising NZNO staff, Te Rūnanga representation, and a previous recipient of the YNYA and using the criteria above.
- Then an opportunity for nominators and nominees on that shortlist to 'meet' the full YNYA assessment panel, by Zoom or similar, to respond verbally to set questions made available in advance. Pre-recording (filming) of nominators and nominees responses to these questions may also be an option.

Assessors will be looking for strong, detailed nominations that clearly evidence the strengths, achievements and aspirations of the nominee. In addition to giving evidence of how the nominee meets the criteria listed above, further aspects that the assessment panel will be considering are as follows:

- Is there a particular project that the nurse has been involved in or is it a general, all round nomination?
- In what way are any outcomes demonstrable e.g. has the nurse been accepted onto a programme by merit or have patient outcomes demonstrably improved?
- Has the nominee contributed in a special way to a community or culture that stands out?

The winner will receive a trophy and a cash prize (of which 50% must go toward further education / professional development). Two runners up will receive a runner-up certificate and a book voucher to the value of $200. All nominees will receive a certificate recognising their nomination.

This is an exciting opportunity for young nurses in Aotearoa New Zealand and we encourage you to submit a nomination in recognition of the work of young nurses throughout the country.

Closing date for nominations: 5.00pm, June 30, 2020

Nominations to be sent to: Heather Sander **heather.sander@nzno.org.nz**

For Nomination Form and further information / criteria go to: www.nzno.org.nz or www.nznursesstation.org

Honouring our pioneer nurses and midwives

To mark International Nurses Day, co-editor *Anne Manchester* offers a brief insight into the lives and achievements of some of our professions' trailblazers. The first are Mere Harper and Ria Tikini – the Ngāi Tahu midwives who helped found Plunket.

Mere Harper (Ngāi Tahu, Ngāti Huirapa) was a midwife, porter and wahine toa. Also known as Big Mary or Mere Hapa, she was the main informant for ethnographer William Anderson Taylor's work on Kāi Tahu history. She is credited as one of the midwives who paved the way for the creation of the Plunket Society of New Zealand in 1907.

Mere lived her whole life around the shore-whaling station established at Waikouaiti in the 1840s, situated just north of the settlement of Karitane. She was the daughter of Mata (Caroline) Punahere, of Ngāi Tahu, and William Elisha Apes, a Native American Pequot from Massachusetts.

Mere Apes (Hipi), born in 1842, was the first of their six children who survived to adulthood. With the exception of one son, Thomas, all of the Apes children lived their entire lives at Waikouaiti.

Mere was born two years after the signing of the Treaty of Waitangi and was still an infant when the first sales of Ngāi Tahu land to the British Crown took place, beginning with the Otago Deed of Purchase in 1844. Mere probably attended the mission school that had been established by Reverend Watkin in 1844, and was later run by his successor, Reverend Creed.

In 1863, Mere married an Englishman, William Harper, a former skipper of the *Alice* and the *Result*. They had one child, William (jr). In 1872, Harper was appointed the deputy harbourmaster of the port and later the light-keeper on Huriawa.

Mere, like her father, was extraordinarily tall and strong. As a young woman, she earned money by carrying passengers ashore on her back from the ships that came in at Waikouaiti. There are numerous accounts of her physical feats. One described her winning a wager that she could carry three diggers, swags and all, from the surf boat to the beach. Aged about 21, she took one under each arm while the third man was perched on her back. The account in the *Southern Cross* in 1898 says she deposited her load on the shore "as easy as if she had been carrying bags of chaff".

Mere Harper (left) and Ria Tikini. From photos by William Anderson Taylor.

By the early 20th century, Mere and her brother Thomas were among the oldest residents living at Waikouaiti. Her knowledge of wāhi tapu, place names and traditions made her a highly valued cultural informant for a number of Pākehā ethnographers.

In later years, she worked as a midwife among Māori and Pākehā in the district. Like her friend Ria Tikini ("Mrs Chicken"), 30 years her senior, she also worked closely with Frederic Truby King, the founder of the Plunket Society, who was her neighbour on Huriawa. Mere Harper and Truby King would sit together and peel potatoes from Dr King's garden, then bake them on the hot embers in his kitchen. They'd discuss families in the Karitāne area who were concerned about the health of their tamariki or other illnesses within their whānau.

In 1906, Mere and Ria delivered baby Thomas Rangiwahia Mutu Ellison (Tommy Mutu). His older brother had died in infancy, and Tommy Mutu became ill too. Mere took the sick child to Dr King, where he stayed for some months, thriving under the care of Mere, Ria, and Dr King, and becoming the first Plunket baby. The Karitane Home for Babies opened within a year. Thanks to the support and traditional knowledge held by Mere and Ria, this home soon developed into the Plunket Society.

In 2016, an interpretative panel overlooking the Waikouaiti River was updated to recognise the work of Mere and Ria

and, in 2020, Plunket rebranded its logo to acknowledge its founding Māori midwives. •

Not only was Ria Tikini (Kāi Tahu, Kāti Mamoe, Kāti Huirapa) an influential tōhuka, healer and midwife in the Karitāne community, she was also a clever businesswoman who sold poultry – hence her nickname "Mrs Chicken".

By the time she met Frederic Truby King, Ria had been working to improve the health of people in her community for many years.

Ria was born around 1810 at Ruapuke Island. She was tattooed in the tuhi style, "each side of her face being adorned with two straight lines and from mouth to ear".

In the early 1900s, just as today, some mothers had problems with breastfeeding. There were local Kāi Tahu mothers struggling with pēpi – some had trouble latching, others were allergic to breastmilk, some mothers weren't able to produce enough milk for their babies. They turned to Ria and Mere Harper, who were the first ports of call for these and other health issues in the community.

Ria and Mere encouraged healthy mothers to share milk and other supplies with mothers who were struggling. They established a network of people who both received and gave support to pēpi and whānau.

Ria was 95 years old when she and Mere helped deliver Thomas Rangiwahia Mutu Ellison (Tommy Mutu) at Puketeraki. When Tommy Mutu became ill, Ria and Mere took him to the home of Mere's friend and neighbour Dr Truby King, where he stayed for several months. Truby used the networks Ria and Mere had established, as he worked alongside them to improve the health of the community.

In the later years of her life, Ria watched as the men she had cared for as infants left her whenua for war in a foreign land. At the age of 108, she was still working and caring for her community, helping with food and entertainment at an outing for wounded soldiers arranged by her whāngai son Henry Parata. Ria Tikini was considered the "oldest person in the dominion" when she died in 1919, aged 109. Her memories are held by the uri (descendents) of those she served, and those she loved. •

• Information for these profiles has been taken from *Tāngata Ngāi Tahu: People of Ngāi Tahu*, edited by Helen Brown and Takerei Norton and published by Te Rūnanga o Ngāi Tahu with Bridget Williams Books, 2017. Additional information from the Plunket Society and Wikipedia.

Shadbolt named 'dangerously political'

René Shadbolt led the only New Zealand contingent to the Spanish Civil War. She and fellow nurse Isobel Dodds cared for wounded soldiers, particularly those from the International Brigades, from July 1937 to November 1938.

René Mary Shadbolt was born in Akaroa in 1903. She began her nursing training at St Helens maternity hospital in Auckland in 1927 and graduated in 1932. By 1936 she was head sister of Auckland Hospital's casualty ward.

Shadbolt had been "nudged leftward by the urban misery of the Depression years", though she was not a member of any particular political party. She was horrified that some doctors and nurses were reluctant to treat patients wounded by police batons during street marches and riots.

At the outbreak of the Spanish Civil War, she was among the first to volunteer for a contingent of New Zealand nurses being put together by the Spanish Medical Aid Committee (SMAC). She was appointed to lead the group, made up of Dodds, a 22-year-old staff nurse from Wellington Hospital, and Millicent Sharples, aged 46, who worked at a private hospital in Levin. Shadbolt told an Auckland newspaper that she believed the group could "be of some service to people in need".

NEW ZEALAND HISTORY ONLINE

René Shadbolt (centre), leader of the nursing contingent to Spain during the Spanish Civil War, with Isobel Dodds (left) and Millicent Sharples (right).

Prior to their departure in May 1937, the group was detained by police for a number of hours, with Shadbolt accused of being the secretary of a communist cell. Eventually the group was released in time to meet their ship. They arrived in Spain in mid-July.

Their first posting was to a large makeshift International Brigade hospital in Huete, central Spain. Shadbolt and Dodds stayed there until mid-1938, when the hospital was evacuated to Barcelona. They continued to care for wounded soldiers until November 1938.

On their return to New Zealand in January 1939, Shadbolt and Dodds worked for SMAC. In February, they embarked on

a six-week speaking tour to raise awareness of, and money for, the hundreds of thousands of Republican refugees in France. Unbeknownst to SMAC, Shadbolt had married one of her patients, Willi Remmel, a German member of the International Brigade, during her time in Spain. Despite her numerous appeals on his behalf to the New Zealand government and other agencies, Remmel was denied entry into New Zealand and the two never met again.

Like others who had served in the Spanish Civil War, Shadbolt was marked as "dangerously political" and initially found it difficult to find work. Eventually she was employed at a private hospital in Martinborough. During World War II she worked at an Auckland convalescent home for returned soldiers and again at Auckland Hospital. She remarried in 1944, but was divorced 11 years later.

In 1949, she became matron of Hokianga Hospital, where she remained until 1967. Following representations of the people of Hokianga, she was made an MBE in 1969. She was widely mourned on her death in 1977. •

• Adapted by Imelda Bargas (and abridged by Anne Manchester) from the *Dictionary of New Zealand Biography* by Maurice Shadbolt.

Mereana - the first Māori registered nurse

For many years, nurse Alenehi Hei, who trained at Napier Hospital and registered in 1908, was regarded as the first Māori to gain registration.

However, in 2001, research by former Auckland Hospital nurse educator Diana Stuart Masters showed she was predated by Auckland Hospital nurse Mereana Tangata, who registered under her European name, Mary Ann Leonard, in 1902.

Tangata came from Peria, near Kaitaia. After completing her secondary schooling at Hukarere School in Napier, she moved to Auckland, becoming a nurse probationer in 1893. After certification in 1896, she became a charge nurse – equivalent to a ward sister.

She married Vincent Hattaway in 1904 and the couple had six children. They moved to the King Country and, in 1908, nurse Hattaway helped establish a nursing home in Te Kuiti called Wharemana. According to Masters' article in *Kai Tiaki Nursing New Zealand* in September 2001, *"Family stories recount her continuing nursing in the community, and tearing up her best sheets when she needed bandages. . . .*

Mereana Tangata, known as Mary Ann Helena Leonard, photographed at Auckland Hospital c1899.

"During the influenza epidemic of 1918, Mereana was the matron of the Te Kuiti Temporary Native Hospital situated at the Māori pa, where a total of 50 patients were treated."[1]

She and her children later returned to Peria, where Hattaway continued nursing and encouraging girls from the district to become nurses.

When she was 60, she developed bowel cancer. Her surgery was unsuccessful and she died at Mangonui Hospital in Northland in 1929. She was described by the matron as being "brave and bright to the end".[1]

An obituary in *Kai Tiaki* in 1930 describes her as *"a well-known nurse who used her nursing knowledge for the benefit of her neighbours, both Pākehā and Māori"* in Te Kuiti and later in the northern district.[2] •

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Te Puea brought health to her people

Te Puea Hērangi was not a nurse or trained health professional, but she spent much of her life (1883-1952) committed to improving the health of Waikato Māori.

Te Puea was a granddaughter of Tāwhiao Te Wherowhero, the second Māori king. In later life, she was often referred to as Princess Te Puea, though it was a title she did not use herself. According to writer and historian Patricia Sargison, she was *"able to look at Māori health problems from both a Māori and a Pākehā point of view"*,[1] retaining her belief in traditional healing practices while promoting Pākehā medicine and treatment for Pākehā diseases.

These convictions arose from her experiences during the smallpox epidemic of 1913-14 and the influenza epidemic in 1918. She herself was afflicted by tuberculosis (Tb) most of her adult life and fully accepted she could not cure herself.

During the 1918 flu epidemic, Te Puea nursed many of the sick, building open-air shelters at Mangatawhiri, where she was then living, to isolate the sick. She also cared for around 100 orphans who became the founding members of her new settlement of Turangawaewae at Ngāruawāhia.

During World War I, Te Puea led an anti-conscription campaign in the Waikato. This highlighted Māori grievances against the Government over land confiscations.

After the war, Te Puea established a new settlement at Ngāruawāhia and campaigned hard to include proper medical facilities to improve health standards. She did get government support to build a meeting house – Māhina-a-Rangi opened in 1929 – but the Health Department refused to allow it to run as a private hospital, shattering one of her dreams.

In 1936, Doctor Harold Turbott became medical officer of health in Hamilton. Together he, Te Puea and district nurses worked to improve sanitation and reduce disease, getting piped and tanked water supplies for Waikato communities. She also went to Waikato Hospital for Tb checks and x-rays, setting an example for others.

She improved her people's economic base when she bought a farm near Ngāruawāhia, raising money through touring the country with a concert party made up of her kāhuipani, her flock of orphans. She continued purchasing or acquiring other plots of land, using the example of Sir Aprirana Ngata's "back-to-the-land" movement on the East Coast.

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Te Puea Herangi, c1938, wearing her Commander of the British Empire medal.

She finally did manage to establish a clinic at Māhina-a-rangi, but never achieved her dream of a full-scale hospital. Nevertheless, "*mortality from both typhoid and Tb dropped to European levels*" as Māori adopted better medical treatment for these diseases.[1]

But her greatest achievement was restoring the mana of her Tainui people and that of Kingitanga, bringing confidence and hope back to people beset by poverty and despair. She helped negotiate a compensation deal with the Government in 1946, thus paving the way for a future Deed of Settlement with Waikato-Tainui in 1995 that has restored economic viability to the iwi. •

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Bazley gives credit to nursing for success

Highly respected public servant Margaret Bazley has never forgotten her nursing roots. She credits them, in fact, with giving her the skills to achieve so much and the ability to manage teams of people so successfully.

A nurse with 27 years' experience, Bazley held a number of senior roles in mental health, her career culminating in the role of Health Department director of the division of nursing. She was a public servant for more than 60 years, filling roles as diverse as State Services Commissioner, Secretary of Transport, chair of the New Zealand Fire Service and chair of Environment Canterbury.

Now 82, she is still full of energy and has a very sharp intellect. Being chair of the economic development implementation strategy for the Wairarapa, where she lives part of each week, and serving on the Waitangi Tribunal are privileged and satisfying roles, she says. She also remains patron of a number of organisations – the Nursing Education and Research Foundation, Mental Health Nurses College, Volunteer Firemen and the Nurses Memorial Fund.

Looking back on her nursing career, she regards her eight years as matron of Sunnyside Hospital (1965-73), when she was in her 20s, as one of its pinnacles. She had earlier been charge nurse at Tokanui Hospital and assistant matron at the Seacliff group of hospitals in Dunedin.

"While at Sunnyside, I was part of a team that led the move away from the custodial care model to one based on therapy. This change was made possible by the development of psychiatric drugs. This was a huge change to the role of nurses too – they became therapeutic practitioners. Sunnyside led New Zealand and the world in this change to how mental health institutions operated.

"We developed a system of collaboration, having meetings with patients to give them a say in how they wished to be cared for. We worked with our patients so they could manage to live outside the institution. Over the eight years, we reduced our bed number from 1000 to just over 600."

It was while she was at Sunnyside, in 1972, that Bazley was elected president of the nurses association (NZNA). Psychiatric hospitals had just moved from being run by the health department to hospital board administration.

PHOTO: RADIO NEW ZEALAND

Margaret Bazley at a press conference in 2018, after releasing her report into sexual misconduct at the Russell McVeagh law firm.

"The Public Service Association had made a bid to represent all nurses, not just psychiatric nurses. I was approached to stand for president, as I understood these industrial issues. 1972 was also an election year, so this gave NZNA the chance to get members involved in political action, though not all nurses were comfortable with that idea."

In 1971, the Carpenter Report had recommended the transfer of nursing education from hospitals to educational

institutes. This gave nurses the ammunition they needed.

"NZNA had been trying for 50 years to change the way nursing was taught. Finally it had the evidence to back its campaigns," Bazley said.

"The first nursing schools approved and established within general education were in Wellington and Christchurch in 1972 – while I was still president. A third and fourth school was established in Auckland and Nelson while I was deputy matron-in-chief for the Auckland Hospital Board. I then moved to the Waikato Hospital Board as matron-in-chief and was there when the transfer was approved for this region too."

There was much opposition to these changes from hospital board administrators, the medical profession and older nurses, Bazley said. But she believed staffing hospitals with student labour was not a safe model.

"I looked back on when I was a student nurse at Thames Hospital and how, on an afternoon or night shift, I could be left looking after patients coming back from theatre on my own. The one nursing supervisor on duty could be anywhere in the hospital. It took about 15 years to get all the decisions around the transfer of nursing education in place."

Bazley also firmly believed that psychiatric, psychopaedic and general nurse training should be integrated into a comprehensive nursing curriculum, as every nurse needed to have both general and mental health nursing skills.

As NZNA president, Bazley was part of a board of health committee charged with reporting on the shape of nursing services for the future as hospital nursing schools were closed.

Without the skills she gained from nursing, Bazley believes she could never have achieved so much. "Nursing taught me how to manage hundreds of patients, to make sure everyone was bathed and fed on time. I learnt leadership and communication skills as a teenager, how to educate patients about illness prevention, and how to manage people.

"As a psychiatric nurse I learnt the powers of observation – skills I still use every day. I know how to read the signs and how to prevent problems. This is the lens I work from."

By the time Bazley had completed her six years as director of the Department of Health's division of nursing (1978-1984), she felt some in the department feared the nurse's voice had become too powerful. Later, the position was downgraded, with future incumbents struggling to have any real influence.

Bazley has sometimes been criticised for working too quickly and decisively in her later government appointments. She disagrees.

"When you work for government organisations like Social Welfare or the Ministry of Transport, you are limited by the three-year election cycle. You have to be hard-nosed and able to bulldoze ahead to get things done. No one likes change but when change is needed, it just has to be done. This is one of the cores of nursing." •

Bee Salmon – at the centre of change

Evelyn Beatrice (Bee) Salmon is remembered as a scholar, mentor, nursing leader, speaker and writer. Thanks to her influence during the 1960s and '70s, education for nurses broadened to include the humanities, as well as physical sciences. No longer based on a set of circumscribed rules and tasks, nursing began to base itself instead on social understandings, reason and analysis.

Salmon graduated in 1945 from New Plymouth Hospital, later gaining midwifery and Plunket qualifications. After a stint in 1960 as nursing inspector of hospitals in the Department of Health, she won the British Commonwealth Nurses' War Memorial Scholarship which enabled her to study at McGill University in Montreal. She was the first New Zealander to gain a bachelor of nursing degree.

Her next move was to Ghana where she worked with the World Health Organization, setting up a two-year diploma course for graduates within the university. She gained her master of science, applied, from McGill University in 1967.

Beatrice Salmon, c1980

That same year, she was appointed principal of the postgraduate school in Wellington, where she promoted a more holistic model of health education. At the same time, she campaigned vigorously for comprehensive nursing education in an academic setting.

She achieved this in 1973, when she became senior lecturer in nursing at Victoria University. At the same time, Nan Kinross developed programmes in nursing as part of a bachelor of arts degree at Massey University in Palmerston North.

Salmon struggled with enrolments and funding while working at Victoria. When she resigned in 1981, the course was suspended, though the University Council had accepted a plan to establish a bachelor of nursing degree.

Salmon was active with NZNA, serving on various national committees. She was also a consultant for the International Council of Nurses. She received the NZNA Award of Honour in 1984 and an MBE (Member of the Order of the British Empire) in the New Year Honours in 1982. •

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Building nurses' resilience

Nurses are facing increasing pressure in their workplaces. Resilience is an important factor in coping with such stress but there's no single path to building it.

By Jewel Barlow-Armstrong

Nurses face a growing number of pressures. These pressures originate from many sources, including the patients nurses care for and the organisation in which nurses are employed. And these pressures can lead to increased stress levels, increased sick leave and poor staff retention. It is, therefore, essential nurses develop and use personal resilience strategies to continue caring for the populations with which they work.[1]

In this article, several strategies are explored under four main themes identified during a search of the literature: nursing education and development; coaching and mentoring; experiential learning; and emotional attributes.

Education and development

The significance of the role nurse educators play in the development of resilience in nursing students cannot be underestimated. One group of researchers suggests nurse educators are crucial in preparing nursing students for sustained professional resilience.[2] They believe resilient nurses are more likely to be retained in the profession during times of adversity, due to their ability to challenge and improve their current roles, rather than potentially abandoning their career when the complexities seem overwhelming.[2] Teaching nursing students strategies of reflective learning and reflexive practice enables them to sustain their equilibrium during periods of adversity.[2] Through reflective learning nursing students can consider aspects of their practice, using models such as Gibbs reflective cycle[3] Students are thereby able to evaluate and develop strategies, enabling them to think critically and reflexively about their future practice.

These ideas build on the earlier work of internationally renowned nursing theorist Rosemarie Parse, who suggested building resilience could enable nurses to better deal with workplace adversity.[4] In 1992, she developed the "human becoming" theory of nursing, which highlighted the significance of focusing on quality of life and making healthy life choices. When nurses are guided by quality of life as a goal for practice, they can achieve a deeper connection with their patients, empowering them to respect each other's perspective.[4] By teaching nursing students to create meaningful connections, they will be supported to develop and sustain their own professional resilience, empowering them to challenge adversity as nurses in the future.[4]

One author noted self-care was an essential component of personal resilience.[5] Her work uncovered a distinct lack of self-care demonstrated by nurses. She highlighted the benefit of a self-care approach to building personal resilience. And she suggested that through self-care, nurses could develop and sustain their own personal resilience, enabling them to face the complex challenges of professional practice.[5]

> **The significance of the role nurse educators play in the development of resilience in nursing students cannot be underestimated.**

This view is supported by nurse author Eileen McGee, who states that "it is not possible to give patients what nurses do not themselves possess".[6] Through not caring for oneself, nurses are left feeling burned out and emotionally exhausted, therefore increasing their likelihood of leaving the profession.[6]

A 2007 literature review found that empowering nurses and nursing students enabled them to challenge their position within the nursing profession.[7] The three researchers suggested building resilience through personal growth and self-development, a key aspect of which involves developing skills to allow interpersonal problems to be identified and resolved.[7] Their research identified that many nurses faced workplace adversity during their career, such as bullying. They suggested equipping nurses and nursing students with the skills to develop positive and nurturing professional relationships, allowed them to function with increased optimism and emotional insight.[7] This positivity may lead nurses to achieve a greater feeling of work/life balance and increase their sense of professional accomplishment.[7]

Coaching and mentoring

The important role that coaching and mentoring plays in the development of personal resilience cannot be underestimated.[8,9,10] One research study identified having a resilient mind-set as a key aspect of personal resilience.[8] Resilient individuals were better able to reframe setbacks in a positive light and had effective self-care habits.[8] In this study, researchers worked with coachees to promote and develop individual resilience. To achieve this, coachees were supported through three key areas: facilitation of learning, personal growth and reflection on personal goals. Providing structured coaching sessions assisted the coachee to build resilience and enhanced their ability to deal with uncertainty and change. There was also an increase in levels of optimism and hope, and a decrease in turnover and absenteeism.[8]

This is supported by a later study, where coachees were encouraged to reflect and explore personal learning goals, with the aim of increasing self-reflection and insight.[9]

Other researchers explored the benefit of implementing a strengths-based resilience building programme.[10] They developed the promoting adult resilience programme, which supported coachees in developing and sustaining personal resilience.[10] A key aspect of the programme involved teaching coachees the value of positive self-talk. Participants reported experiencing increased levels of coping, self-efficacy and personal resilience due to their increased use of positive self-talk.[10]

Finally, several authors have identified the importance of enhancing leadership through resilience.[11,12] One researcher sought to enhance leadership resilience through guiding and supporting coachee personal growth.[11] She highlighted the significant role resilience plays and suggested the benefit of using resilience as a preventative strategy to support those working in challenging contexts. To achieve this, five key aspects of resilience coaching were identified:

- reclaiming self-belief;
- learning;
- supportive relationships;
- seeing wider perspectives; and
- thinking space.

In working with coachees to address each of these five aspects,[11] both personal resilience and leadership resilience were enhanced, and this contributed to a wider culture of organisational resilience.[11] This study acknowledges earlier research,[12] which identified the importance of developing specific core strengths to enhance personal resilience. The use of cognitive behavioural (CB) techniques enabled individuals to learn to better cope during periods of adversity.[12] Three core strengths that resilient individuals often demonstrated were an ability to tolerate high levels of frustration; self-acceptance; and an ability to keep things in perspective.[12] This research highlighted the benefit of using a CB methodology when using coaching as a technique to enhance personal resilience, suggesting that the two methods share many similarities and may assist in developing and sustaining resilient individuals.[12]

Experiential learning

Several authors have identified that experiential learning is an important strategy in the development of resilience.[13,14] Three Swedish nursing researchers noted student nurses' self-confidence improved when clinical skills and competencies were tested through practice simulation.[13] The student nurses reported decreased levels of uncertainty and worry when their clinical skills were reinforced and supported during simulation.[13] This improved self-confidence could be linked to increased resilience in these students.[13]

A pilot study used simulation and debriefing as a component of "resilience intervention" with nursing students.[14] Alongside simulation and debriefing, there were three additional modules aimed at supporting the students to develop personal resilience through professional empowerment strategies, teamwork building, and conflict management techniques.[14] The researchers were unable to demonstrate a significant change in students' resilience levels, they hypothesised that this was related to the complex nature of resilience, and that working to enhance individual resilience levels might benefit from a more personalised approach.[14]

A number of authors allude to the role that emotional attributes play in developing and sustaining resilience.

A group of Australian researchers aimed to support participants in building their personal resilience by imparting a greater understanding of workplace adversity.[15,16] They implemented a series of six resilience workshops aimed at improving participant knowledge of workplace adversity and resilience strategies, in a positive and non-threatening environment. Using techniques such as self-reflection, critical thinking and collaborative learning, participants were able to develop and practise the skills being presented. The research findings noted that participants demonstrated an increase in their levels of supportive communication, assertiveness and self-confidence. Participants commented on their increased knowledge of resilience strategies, which they felt had enabled them to develop and sustain resilience in themselves and their colleagues.[15,16] They highlighted the significant role that experiential learning plays in the development of resilience. Through the establishment of trusting relationships between group members, enhanced communication and rapport could be developed, allowing participants to experience each other's differing perspectives. In this study, participants worked collaboratively to discuss simulated workplace scenarios, resulting in an increased confidence to share their options with each other.[15,16]

Emotional attributes

A number of authors allude to the role that emotional attributes play in developing and sustaining resilience.[5,17] Two social psychology researchers suggested everybody was capable of resilience.[17] However, the level to which personal resilience could be achieved was determined by four factors: previous experiences; personal attributes and qualities; environment; and existing protective factors.[17] They used the metaphor of elasticity and malleability when describing resilience, comparing the properties of malleable metals to the psychological qualities possessed by resilient individuals.[17] These qualities allowed resilient individuals to withstand adversity, compared to those individuals who possessed more "brittle" characteristics. The importance of acknowledging these factors when supporting nurses to develop and sustain resilience is stressed.[17]

This notion is supported by three nursing researchers from Texas, who identified the attribute of "hardiness" as being important in resilient individuals.[18] They suggested 'hardiness' consisted of three main beliefs: life has a meaningful purpose; individuals are able to influence their environment and the outcome of events; and that positive and negative life experiences allowed for personal growth.[18]

When 'hardiness' is present in a resilient individual they become less 'brittle' and more able to be responsive to the situations and events around them.[17,18]

Building resilience in these testing times

DURING THESE unprecedented times of a nationwide lockdown to contain the spread of COVID-19, building and maintaining resilience can be extremely challenging. However, these are the times when being resilient is critically important. Taking small steps, such as being kind to each other, appreciating the small things, having a positive mindset and asking for help are a great place to start.

Following is a list of small ways to build your own resilience and that of others.

▶ By showing kindness to each other, we can create an environment that demonstrates "we are all in this together", allowing us to be more accepting of others.

▶ Appreciate the small things, particularly those that seem insignificant, such as the smell of freshly cut grass on your way to work. These small moments can help increase our resilience when facing daily challenges.

▶ Embracing a positive mindset can help to lower stress levels and decrease feelings of hurt, frustration or anger. When responding to a negative event, first, acknowledge the event, then pause to "breathe" and consider your response. Doing this will help you respond instead of react.

▶ Asking for help benefits not only the person asking, but also the person being asked. The person asking for help feels safe to seek assistance and reassurance; while the person being asked, feels acknowledged, appreciated and that their opinions are valued.

Finally it's important to remember you are not alone. If you would like support during these challenging times, accessing services such as the employee assistance programme, calling 1737 or speaking to a workplace support person, can all help.

Quoting two of the Waikato DHB core values seems an appropriate way to close. As we face these unprecedented times, ensure you keep people at heart – te iwi ngâkaunui – and remember that we are stronger together – kotahitanga. •

Maintaining a positive outlook by seeing the possibilities that situations and events possess is also significant, as is the value that both positive and negative experiences have on building resilience.[5] Other researchers identified the importance of being able to associate positive emotion with periods of adversity.[17] They highlighted the power of laughter, which they found decreased levels of burnout and reduced negative emotions.[17]

The importance of grit has also been highlighted as a key characteristic of resilient individuals. Demonstrating sustained, deliberate practice and conscientiousness, combined with perseverance and a sense of competency, was associated with fewer absences, decreased risk of turnover and increased ability to manage the complexities of the profession.[19, 20, 21,22,23,]

Holistic perspective

Nurse researcher Laura Polk considered resilience from a more holistic perspective.[24] She examined 26 published papers and identified four patterns of personal attributes that define resilience: dispositional; relational; situational; and philosophical. Within each pattern, attributes present in resilient individuals were identified. Resiliency could be attributed to a number of characteristics such as: a positive outlook; a sense of self-confidence; positive self-esteem; and a belief in self-efficacy.[24] When these personal characteristics were combined with additional attributes, such as being able to identify positive role models, develop close relationships and interact positively in a broader social network, the level of an individual's resiliency increased. Resiliency came from an individual's ability to assess and react positively to stressors or situations of adversity.[24] Personal values and beliefs also play an important role in the development of resilience.[24] She found that resilient individuals displayed determination and persistence, while maintaining a balanced perspective of life.[24]

Conclusion

Developing strategies to enhance resilience is an essential element of nursing practice and education, leading to improved job satisfaction, greater retention of nursing staff, and enhanced patient care.[25] The literature has revealed that resilience is a complex subject and it is not possible to identify one simple approach that will be effective for everyone. The use of a combination of strategies tailored to the individual may be a more effective approach for building resilience in nurses, empowering and enabling them to successfully navigate the challenges of workplace adversity. •

** References for this article are on the NZNO website or available on request.*

This article has been reviewed by Auckland University of Technology senior nursing lecturer Jacquie Kidd, associate professor at the University of Waikato Anthony O'Brien and the co-editors.

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Why we aren't celebrating Florence's birthday

Many nurses find Nightingale's statements on colonisation and the fate of indigenous people a dangerous legacy. For this reason, NZNO's board of directors will celebrate other nurses and models of health on International Nurses Day 2020.

President Grant Brookes and kaiwhakahaere Kerri Nuku

By NZNO president Grant Brookes and kaiwhakahaere Kerri Nuku

It's surely testament to the huge significance of Florence Nightingale in the development of our profession that 200 years after her birth, she continues to stimulate debate.

On the one hand, her contributions to raising the status of nursing, establishing formal training and applying statistical methods in sanitary reform are celebrated to this day.

But the historical figures we choose to venerate say a lot about who we are. And the legacy Florence Nightingale left for us is a mixed one – especially here in the South Pacific. It's right that her legacy should be open to scrutiny.

For decades, feminist nurses in New Zealand have been uneasy about Nightingale's insistence that "to be a good Nurse one must be a good woman".[1] Her instructions to nurses (dutifully reprinted in *Kai Tiaki,* 63 years later) told us to always display the "higher or holier" womanly virtues of forbearance and endurance, and that we must "above all" obey the male doctors.

Nurse leaders in Aotearoa have long understood how Nightingale's opposition to registration and higher education for nurses undermined our professional autonomy and fostered the eventual dominance of the medical model of health.[2]

In the end, however, it was Nightingale's troubling role in colonisation which led the NZNO board of directors to decide that on International Nurses Day 2020, we'll be celebrating our indigenous and home-grown nurses instead.

It's a little-known fact about Florence Nightingale that she was a close adviser to the Governor of New Zealand, Sir George Grey, during his second term in office from 1861-68. She also advised colonial authorities in Australia and elsewhere.

The collected letters and reports she sent to Grey and others, published in 2004, reveal a long-hidden side of her legacy.

It is now known that Nightingale supported the alienation of Māori land, in order to force migration to European settlements and to bring contact with what she termed, "the inestimable blessings of Christian civilisation".

"The object should be to draw them gradually into better habits and gradually to civilise them," she said, in her Note on the New Zealand Depopulation Question.[3]

To those who objected, and said that "provision of land should be made for the exclusive use of the existing tribes" in the colonies, she replied: "this by itself would be simply preserving their barbarism for the sake of preserving their lives".[4]

> **Nightingale supported the alienation of Māori land, in order to force migration to European settlements and to bring contact with what she termed, 'the inestimable blessings of Christian civilisation'.**

Perhaps her most disturbing advice, in the present circumstances, was her dismissal of reports about outbreaks of infectious diseases among indigenous communities, following contact with Europeans.

"People assert that they always have influenza after a boat comes to them from the mainland," she wrote, in a letter to the Colonial Office in London. "But, after all, is it a fact?

"Diseases and eclipses used to stand as effects to causes, in semi-scientific observations of the Middle Ages. It is the usual error of quarantine reasoning," she concluded.[5]

Nightingale advised that efforts to support the health of indigenous people should focus elsewhere.

Her 1863 report on Sanitary Statistics of Native Colonial Schools and Hospitals,[6] produced at the suggestion of Governor Grey, explained the high rates of child mortality using the then-discredited "miasma theory".

"Within or near the tropics the miasmatic class of diseases occasions most of the mortality at the earlier periods of life."

In her Note on the New Zealand Depopulation Question, Nightingale attributed the prevalence of "chest diseases" among Māori to "the introduction of pigs, as an article of food".

Running through all of her colonial writings is the idea that population decline was due to inherent defects of indigenous people themselves, when compared to superior Europeans.

Excessive consumption of pork was responsible for the "bad habits, filth,

laziness, skin diseases and a tendency to worms and scrofula" which, she believed, were characteristic of the Māori people (and also of the Irish).[3]

"Incivilisation, with its inherent diseases, when brought into contact with civilisation, without adopting specific precautions for preserving health, will always carry with it a large increase in mortality," she said.

"The decaying races are chiefly in Australia, New Zealand, Canada and perhaps in certain parts of South Africa. They appear to consist chiefly of tribes which have never been civilised enough or had force of character enough to form fixed settlements or to build towns."

"These aboriginal populations . . . appear to be far more susceptible to the operations of causes of disease arising out of imperfect civilisation than are civilised men (meaning by "civilised" men who can live in a city or village without cutting each other's throat)."[6]

"As for the Australians, in their present state, very few of the human race are lower in the scale of civilisation than these poor people."[7]

Faced with such frank expressions of racism, Nightingale's defenders argue that she was a product of her time and that whatever her faults, her priority was the health of indigenous people.

Yet other public figures of the time were able to see more clearly. A select committee report from the Legislative Council of Victoria in 1858-59 found that, "*The great and almost unprecedented reduction in the number of the aborigines is to be attributed to the general occupation of the country by the white population.*"[3]

Nightingale rejected this conclusion, arguing that decline is "not a universal law when savages come into contact with civilisation."

Her criticism of the report suggests where her priorities really lay: "I hope the time is not far off when such a stigma as it affixes to the empire might be wiped away."[6]

Or as she put it elsewhere, "This question of the fate of aboriginal populations is one closely concerning our national honour."[7]

Here in Aotearoa, Nightingale's upper class paternalism and her white supremacist views were inculcated in many (though not all) of our early nurses.

These attitudes were then carried across the South Pacific, as the New Zealand Department of Health assumed responsibility for nursing services firstly in the Cook Islands in 1903, then in Western Samoa and Niue in 1920, and later in Fiji and Tonga.

Nightingale's colonial legacy in the region re-surfaced in 2018, in a debate at the South Pacific Nurses Forum (SPNF) in Rarotonga. Indigenous nurses expressed their pain that the global *Nursing Now* campaign planned to celebrate the bicentenary of her birth.

A resolution, moved by NZNO and seconded by the Fiji Nursing Association, was passed unanimously, "To recommend and request that two representatives from SPNF representing indigenous nurses be appointed on to the Board of *Nursing Now* Global Campaign".

Florence Nightingale, London, c1860

On behalf of the SPNF steering committee, we wrote to the board of Nursing Now in early 2019. We explained that, "Florence Nightingale wrote about our Indigenous peoples in the South Pacific in a racist, paternalistic and patronising way.

"The continued veneration of Florence Nightingale in the Nursing Now campaign is therefore disrespectful and painful. It continues to highlight for our Indigenous nurses that their traditional knowledge and ways of being and doing are not being respected. Raising her as the beacon for nursing globally causes trauma and re-ignites the history and pain of colonisation.

"It was in order to address these issues of Eurocentrism that we had lobbied to gain two seats on the *Nursing Now* board."

Our request was declined – coincidentally, around the same time as the Waitangi Tribunal released its landmark report on the WAI 2575 claim.

"The severity and persistence of health inequity Māori continue to experience indicates the health system is institutionally racist," said the tribunal, "and that this, including the personal racism and stereotyping that occurs in the primary care sector, particularly impacts on Māori."[8]

As nursing leaders in 2020, we see Aotearoa's most pressing health issue to be health equity. The persistent and systemic health inequities have been 200 years in the making. Our health inequities will continue if we insist on being wilfully blind to their existence, or fail to acknowledge their origins.

For these reasons, the decision for us and for the NZNO board was obvious. Celebrating Florence doesn't fit with our vision. Instead, in the Year of the Nurse and the Midwife, we are choosing to celebrate those who move us forward to a bicultural future of equity for all. •

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Working for better health care for tangata whaiora

To mark International Nurses Day on May 12 – Florence Nightingale's 200th birthday – we asked two new graduates to share some of their nursing journey, their aspirations for their nursing future and whether Florence Nightingale still had any relevance to nursing in the 21st century.

By Samantha Teinakore

Ko Taupiri te maunga
Ko Waikato te awa
Ko Tainui te iwi
Ko Ngatihaua te hapu
Ko Rukumoana te marae
Ko Samantha Teinakore toku ingoa
Tēnā koutou
Tēnā loutou
Tēnā koutou katoa

My name is Samantha Teinakore and I am a proud descendant of Māori, Cook Island, Irish and Welsh ancestors, and a 2019 new graduate.

I started my degree passionate about helping people and being able to provide positive health-care experiences for people in the community. Throughout my life I have had my fair share of health difficulties, feeling and seeing the impact it had on me and my whānau. This ignited my determination to make a difference and, with the support of my parents and whānau, I knew it was possible.

Throughout my study at the University of Auckland, I was well supported by the nursing staff and other organisations, both within the university and outside. This support helped me grow as a nurse and a leader. I was able to co-facilitate a rural nursing trip, tutor and participate in activities that helped recruit the next generation of nurses. I would like to acknowledge the Māori and Pacific Admission Scheme (MAPAS), Kiaora Hauora, Whakapiki Ake and Te Kaunihera, all of which are aiming to increase and support the Māori workforce, with MAPAS also supporting Pacific people. I appreciate these organisations and the nursing staff for always supporting me and helping me get where I am today. Reflecting on my degree, it created a great foundation, allowing me to grow and go on a self-discovery journey. I strive to be a nurse working in partnership with all people, no matter their status or background, as all people are valuable.

'I strive to be a nurse working in partnership with all people ' – Samantha Teinakore

Gaining more qualifications

My plan for my nursing future is to gain further education and work my way up to completing my PhD, funnily enough to be a doctor of nursing. With this educational growth, I hope to increase my knowledge of mental health. The specialty I am working towards is adolescent community mental health. Furthermore, I hope to develop in leadership and strength, hopefully getting a manager role some time in the future, with my ultimate goal to join the Ministry of Health where I can influence future policies and procedures. However, I also have a passion for teaching and would love the privilege of giving back to future students by becoming a lecturer. While uncertain about what the future holds, I remain positive and look forward to the possibilities and opportunities that emerge.

Supporting whānau

I hope to look after my whānau and friends, supporting them to achieve their best health. Furthermore, as the oldest cousin on both sides of my whānau, I hope to be a good role model to them all and show them you can do anything you put your mind too.

Within nursing, I have come across challenges, both as a student and as a registered nurse, which I continue to try and overcome. These challenges include understanding different cultural perspectives, staffing and the difficulties of upholding person-centred care.

A common misunderstanding in Aotearoa is that we are a bicultural country when in reality we are multicultural. Our country is blessed with many beautiful cultures with different values and beliefs, which can affect the way we need to deliver care. Mason Durie's Te Whare Tapa Whā model is based on a Māori cultural perspective, which looks at four key pou (elements). These can

affect the patient's health, but might not be directly linked to how the patient is presenting to you. Being open-minded to other cultures allows us to deliver culturally appropriate care. We cannot understand the complexities of all cultures – that would be impossible – but we can always ask our patients for guidance. It could be something as simple as greeting them in their native tongue, or getting in touch with cultural support to help us as health professionals understand. As health professionals, we must continuously challenge ourselves to understand the different ways of life and values of our patients.

The challenge of short staffing

Short staffing is a long-standing challenge within nursing, affecting nurses and, most importantly, patients. It affects nurses' ability to provide effective care to patients and whānau, but unfortunately most of the factors that influence staffing levels are out of our control. As nurses, the best thing we can do is demonstrate sound time management in our work and ensure we give the best care we can, because our patients and whānau deserve the best.

Short staffing is also linked to the next challenge. Although person-centred care is the gold standard of care we strive for as nurses, sometimes the pressures we face make it hard. Time pressures can make it very easy to become task-focused, trying to get everything completed before the end of shift.

We all strive to focus our care around the person and their whānau, but the reality is that sometimes it can be hard to do that, because of the high volume of tasks and the lack of time to complete them. This situation can create an internal moral challenge for nurses – we want to spend more time with patients, but sometimes it's really hard. We try really hard to build rapport and trust within a short period of time, but sometimes it's more complex than that. As nurses, we all find our own ways to get the tasks done while also putting time aside for patients, but it's a skill that comes with experience.

Everyone defines leadership differently and there are different leadership styles and techniques. But despite these differences, all leaders are working to achieve a goal. Certain situations require different leadership styles to maximise the outcome, and being able to recognise that is essential. I define leadership as the ability to bring a group together, using people's different strengths to achieve a common goal.

I have seen the benefits of having a good leader – how it can affect the dynamics of a group and the ability to work as a unit. A good leader is someone who is empathetic, open-minded, respectful, honest, trustworthy, determined, passionate and a good listener. Positions/titles, eg charge nurse, help a team identify its leader, but anyone can display leadership, no matter what position or title they hold.

In a critical time like the COVID-19 pandemic, nurses all around the world are displaying the characteristics and courage Florence Nightingale displayed.

Every nurse can lead

Although a charge nurse manager has been appointed into an identified leadership role, their staff can display leadership qualities. Some common examples of such leadership are when student nurses voice concerns about being asked to do something outside their scope; a fellow nurse helping a colleague who is struggling; or when a nurse advocates for their patient. Leadership is displayed every day, more than some people realise. While in nursing we do have identified leadership roles, we need to appreciate that every nurse, at all levels, can display leadership qualities within the workplace.

Florence Nightingale, often described as the founder of modern nursing, was a clear example of a nursing leader. She was someone who came from a wealthy background but always put others' needs above her own, staying humble and well-grounded throughout her life. Over her years of work, she was someone who pushed boundaries, defied stereotypes and made positive changes to how nursing care was delivered. To achieve such accomplishments takes confidence, determination and passion.

In a critical time like the COVID-19 pandemic, nurses all around the world are displaying the characteristics and courage Florence Nightingale displayed. I would like to acknowledge the hard work of all health professionals at this time, in particular nurses who remain on the front line for the good of the people they serve. We pray for your safety as you continue to work for the good of others.

Personally, I strive to uphold the characteristics Florence Nightingale upheld during her career, particularly her determination for better health-care standards and to create better environments for the people she cared for. As a young nurse passionate about mental health, I hope to emulate that determination throughout my career so I can improve the environment for tangata whaiora (service users) and staff. I consider it a privilege to be part of the nursing profession and look forward to my future in it. •

By Melissa Harrington

A nursing future dedicated to diabetes care

A new graduate nurse considers her future and draws inspiration from the past.

When I started to write this article COVID-19 was an emerging threat. As I completed it, New Zealand was facing unprecedented measures to contain further spread of infection. This article will have minimal focus on COVID-19, although I acknowledge the dire impact the virus is having globally and nationally in all sectors, but particularity in health care and nursing.

It is timely that my first year as a new graduate registered nurse (RN) coincides with the International Year of the Nurse and Midwife. My mum is a primary care nurse; I have long admired her dedication and the contribution she has made to her community, spanning more than 45 years. I had wanted to be a nurse for over a decade before I started my bachelor of nursing. For me, nursing is about belonging to a widely respected profession, nurturing the vulnerable members of our societies and providing education to enhance health literacy. The ultimate goal is to create better outcomes for individuals, families and populations.

Empowering patients

I completed my degree at Ara in Christchurch and am now working for the Canterbury District Health Board as part of the nurse-entry-to-practice programme. My current role is split between two jobs: I work 2.5 days/week at the Diabetes Centre in the newly-created Christchurch Hospital outpatients facility. I work with patients who are having difficulty managing their diabetes in the community. I provide education and support to help those patients achieve realistic, collaboratively-created solutions. The aim is to assist and empower patients to be able to achieve good glycaemic control and help prevent the many serious complications associated with diabetes mellitus.

The centre has a large multidisciplinary team – I work closely with the diabetes physicians, dietitcians, clinical nurse specialists, RNs, a psychologist and a social worker. As part of my final semester at Ara, I completed an eight-week transition placement at the centre. So I was familiar with the environment before starting work as an RN and had realistic expectations of what working there would involve.

The setting allows time to establish and nurture enduring and meaningful connections with our patients. I firmly believe this is a fundamental component of facilitating engagement. It empowers people and acts as a catalyst for behaviour change. I feel well supported, welcomed and safe in my role; my preceptor and the wider team have embraced having a new graduate nurse. It can be daunting and anxiety provoking taking a patient load and being responsible for outcomes and lives, so it is paramount that wraparound support, including mentoring and preceptorship, is available for new grads.

Melissa Harrington in the endocrine test centre.

The other 2.5 days/week I work in the Endocrine Test Centre, also located in the outpatients building. I have quickly become part of this small team of highly-skilled nurses who perform specific endocrinology tests, often for the diagnosis of rare and complex illnesses. My preceptor has endless patience and has shadowed my every move for nearly eight weeks to ensure the procedures I am learning are being done with precision and care. It has been a challenge to learn two jobs simultaneously, however I believe the combination of skills will provide me with a robust foundation in nursing. It has been a privilege to have the opportunity to learn more advanced clinical skills alongside my endocrine colleagues.

I first learnt about health theories 10 years ago while I completing health promotion papers at Ara. At the time, I was working as a diploma-qualified sports massage therapist, which I did for more than a decade. The theory that resonated with me then, and still does now I am an RN, is Mason Durie's Te Whare Tapa Whā model of health. It is a renowned health model developed in 1984 as a framework for approaching health care. It was

originally orientated toward providing Māori with culturally appropriate care to improve their health outcomes.[1]

The framework consists of four dimensions of wellbeing and describes health as a wharenui, or meeting house, with four walls. These walls represent taha wairua (spirituality), taha hinengaro (mental health), taha tinana (physical health) and taha whānau (social relationships). Connection with the whenua (land) forms the foundation.[1]

I think the framework and philosophy Durie developed can be successfully translated to all cultures to shift from a disease-centred approach to a more person-centred, holistic approach.

Acknowledging that health is a multidimensional concept helps nurses formulate effective strategies of care that can be moulded to individuals', families', communities' and societies' ways of being. This is how nursing is unique. Our profession has its own sound body of knowledge and approach that is separate from medicine but which still greatly contributes to health.

My nursing future

Ultimately, my passion lies in the treatment and management of diabetes mellitus – this is the direction in which I wish to steer my future career. My professional goal is to develop further knowledge, and transition into more specialised and advanced roles. Completing postgraduate studies, specifically achieving a master's qualification with nurse prescribing, is the pathway I wish to take to enable me to fulfil my goal.

The World Health Organization states that type 2 diabetes mellitus (T2DM) can be successfully treated and its consequences delayed with timely interventions, such as physical activity, appropriate diet, hypoglycaemic medications, effective screening and early treatment of complications.[2] Despite this, national and global rates of T2DM continue to soar and the complications of diabetes are costly to governments and seriously affect an individual's quality of life. In my final semester, I conducted a comprehensive literature review, examining the barriers to achieving good glycaemic control. There are many reasons patients are not able to do this and this is what really got me interested in diabetes. I remain curious about how we, as nurses, help patients cultivate an intrinsic sense of self care and wellness and support patients to take on more responsibility for their own health.

A platform for leadership

Nursing provides a platform for leadership in health, and to change the narrative from sickness to health. In their everyday interactions, nurses can promote preventative health strategies and seize opportunities to promote and implement health interventions. Ideas that come to mind are using the skills of motivational interviewing, brief interventions, referral pathways, culturally appropriate practices and timely education tailored to patients' existing knowledge and capacity to learn.

Nurses in Aotearoa face many challenges. Issues of inequity and disparity are ongoing. The link between poverty and disadvantage and poorer health outcomes is undeniable and our most at-risk people are of Māori or Pacific descent. These populations require individualised care and ongoing support to overcome health challenges. The diabetes centre has Māori and Pacific nurses who can connect with their communities and provide the unique care required.

Another topical issue is the endemic and toxic culture of bullying. I have experienced first-hand how bullying can affect opportunities for learning and one's self-esteem and confidence. We must unite to eradicate bullying and other behaviours that sabotage our workforce. And as a newly-graduated RN, I was surprised to discover nurses are poorly paid. Nurses are significantly undervalued and under-resourced within health care. Nursing is a humanitarian profession – collectively we are a cohort who want to provide nurturing, compassion, advocacy, kindness and so much more. We get to be with people and their families in their darkest moments. It is important to acknowledge the impressive and substantial contribution nurses make to societies, and to individuals' lives, no more so than on the frontline of the fight to contain COVID-19. Those contributions are often overlooked and undervalued.

The International Year of the Nurse and Midwife is also the 200th anniversary of Florence Nightingale's birth. Florence was a pioneer of nursing. Despite her father's objection, as a young woman, she was compelled to attend the sick, injured and dying. She was called to action in the Crimean War and effectively implemented practices that still guide nursing practice and philosphy today.

Florence did what no one else had done up until that time, which was to consider how the nursing environment affected a patient's recovery and health outcomes. One of the most profound ways she was able to reduce patient mortality was to improve sanitation, which significantly reduced infection rates. She was also aware of the importance of nutritious food and adequate rest. These ideas are the foundation of the holistic approach to health we continue to endorse today.

As the COVID-19 pandemic engulfs humanity around the world, at no other time in my life has the need for nursing and all it represents been greater.

I believe Florence Nightingale is still relevant – many nurses are called into the profession in the same way as Florence, with a desire to provide comfort and care. However, nursing has evolved over the last 200 years to become an evidence-based, tertiary-educated profession, with nurses working in a vast range of practice and academic disciplines.

As the COVID-19 pandemic engulfs humanity around the world, at no other time in my life has the need for nursing and all it represents been greater. Kia kaha. •

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Māori nurses need more kindness – Nuku

Nurses working in iwi and Māori providers need "kindness" through being recognised with equal pay, NZNO kaiwhakahaere Kerri Nuku told anti-racism event, Te Tiriti-based Futures 2020, in March.

Te Tiriti-based Futures 2020 was a 10-day online "Tiriti-based, anti-racism and decolonisation" event with nearly 60 speakers, run by the Stop Institutional Racism network.

In a session on racism and pay disparity, Nuku said she was "heartened" by Prime Minister Jacinda Ardern's call for kindness during the COVID-19 pandemic – but wanted to see such an attitude shown to Māori/iwi provider nurses seeking equal pay.

"This should be a consistent value we apply every day, not just in times of crisis.

Annette Sykes

Kerri Nuku

Saunoamaali'i Karanina Sumeo

Māori nurses sleep in cars 'loaded with clothes, because they don't know where they will be sleeping that night. How is that kind?' – Nuku

Same skills

"It's so concerning to me that an essential group of health workforce – nurses working in iwi services – get paid differently," she said. "They have the same skills, they have to be clinically competent, whether working in communities, district health boards or prisons.

"Now that's not fair, that's not equitable, that's not kind, and it's been happening for many years."

The issue of the pay gap between nurses working for Maori/iwi providers and those working for other employers was raised 10 years ago by Māori nurse Ngaitia Nagel, in a petition to the Government to change the funding model. Te Rūnanga o NZNO had also raised the issue with the Human Rights Commission, the United Nations Permanent Forum for Indigenous Issues and the Waitangi Tribunal. However there had been no change – in fact the gap was widening, Nuku said. "We battle on to make sure the voice of nurses is heard."

As a consequence, many Māori nurses had to supplement their income with a second job and some slept in cars, "loaded with clothes, because they don't know where they will be sleeping that night. How is that kind?"

As a primarily female workforce, there was a gender gap also. "We are asking for kindness and recognition."

In an online discussion afterwards, Nuku said another challenge for Māori nurses was seeing how Māori patients were treated differently within the health system. Te Rūnanga wanted them supported to be able to speak up for vulnerable patients if they were being discriminated against.

Nuku's vision for New Zealand was that her kids would be able to grow up without discrimination – "that my kids will be allowed to grow up without the prejudice they currently face today, to be seen as individuals because of their character they bring, not the colour they wear.

'Empowering my kids'

"My vision is to empower my kids to be proud of who they are, the whakapapa that got them here and runs through their bones."

Her vision for health was that it would recognise wellbeing – hauora – which involves the whole person, "not just the broken bone", and a society which didn't assert the superiority of one culture over another.

Equal Employment Opportunities Commissioner Saunoamaali'i Karanina Sumeo shared the session on pay disparities, calling for people to help others. "If we have positions of privilege, it is our duty to lift people up."

Human rights and constitutional lawyer and activist Annette Sykes spoke about the experience of representing Te Rūnanga nurses at a Waitangi Tribunal hearing on inequalities in the primary health system late last year.

Fundamentally unjust

She said a funding model which paid nurses at iwi/Māori providers less than others was fundamentally unjust.

Institutional racism against Māori nurses had continued, with nurses today even being stopped from using te reo Māori in their workplace, as well as facing more barriers to professional development opportunities.

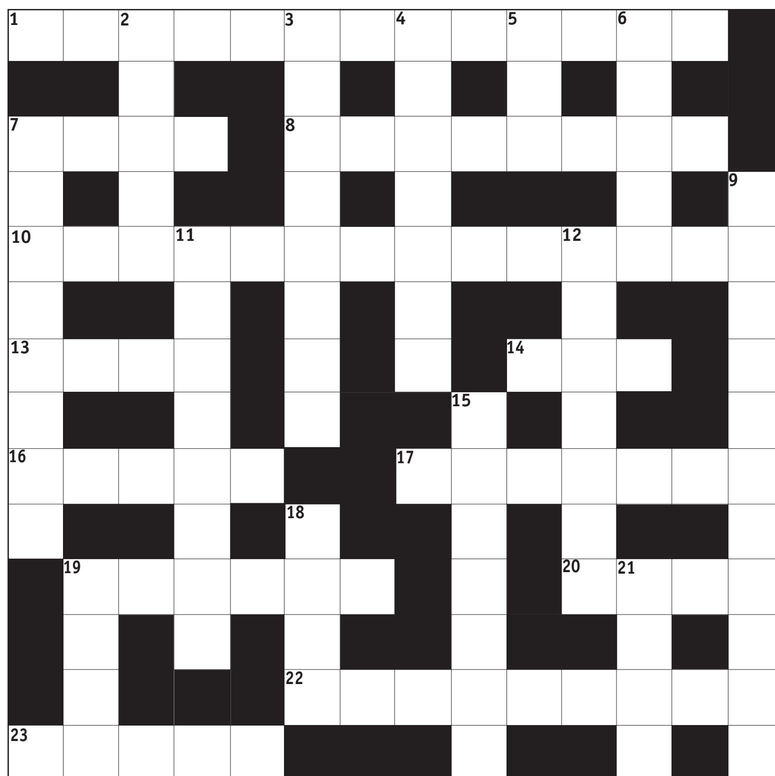
Yet a range of evidence presented to the Waitangi Tribunal suggested care by Māori nurses led to more successful outcomes for Māori. This should be recognised and acted on, she said.

At NZNO, Te Runanga wanted to co-design a funding model with the Government, as well as lobby Māori organisations for equitable funding across the board.

Māori nurses were generally "quiet activists" and needed support, Sykes said. •

crossWORD

Completing this will be easier if you have read our March issue. Answers in May.



ACROSS
1) Birth control.
7) Bend object to make smaller.
8) Worth less than they earn.
10) Sovereignty, personal automony (Māori).
13) Bright-glowing sign.
14) Wood-chopping tool.
16) Furious.
17) Powerful household cleaner, and body waste product.
19) Unconscious.
20) Breathe out, in martyred fashion.
22) Cancer therapy using high-energy waves.
23) Sandy shore.

DOWN
2) Man-made fibre which replaced silk stockings.
3) Deliberate pregnancy termination.
4) Curved line of hair on upper face.
5) Pointy end.
6) Bulb vegetable.
7) Branch of nursing which involves collecting evidence.
9) Most basic and important infection control method.
11) External sex organs.
12) Worried.
15) Put in danger.
18) An equal, in terms of profession or status.
19) Skin break-out.
21) Coloured part of eye.

March answers. ACROSS: 1. Millennial. 6. Cat. 8. Sunburn. 9. Omit. 10. Culture. 12. Flour. 13. Lagoon. 14. Taupiri. 18. Scapula. 20. Recipe. 22. Equal. 24. Bullying. 25. Preceptor. 26. Fade. **DOWN:** 1. Mask. 2. Language. 3. Eruption. 4. Nun. 5. Atom. 6. Cotton. 7. Tamariki. 11. Exit. 12. Future. 15. Ripened. 16. Asleep. 17. Rabbit. 19. Acute. 20. Ruler. 21. Coy. 23. Lie.

wiseWORDS

“. . . The COVID-19 epidemic is a dramatic reminder that we humans are both so fragile and so resilient. Be kind to one another. Avoid the pandemic panic; proceed with caution. Don’t touch your face, cover your cough and please — wash your hands.”

– Tiffany Swedeen, a critical care nurse and clinical instructor working in the first United States hospital to treat a COVID-19 patient

it’s cool to kōrero

HAERE MAI – welcome to the April kōrero column. The natural world can be a place to ground ourselves in times of peril, anxiety or distress. Taking a bush walk may not be possible right now, but the sounds of our native birds can often be heard, even in urban areas.

Pīwakawaka (fantail) is a small friendly insect-eating bird with a fan-shaped tail.

Ruru (morepork) is Aotearoa’s native owl, whose plaintive two-note call can be heard at night. Both its Māori and English names reflect the sound of its call.

Both birds have strong associations with the spirit world in Māori mythology.

Ngā kupu hou

New words

- **pīwakawaka** – pronounced *“pee-wah-kah-wah-kah”*
- **ruru** – pronounced *“rrroo-rrroo”*

Rerenga kōrero

Phrases

Two simple messages about COVID-19:

- **Horoi ō ringa. Mahia te hopi.**
Wash your hands. Use soap and water.

- **He waka eke noa.**
We are all in this together.

Karakia

Prayer

Tūtawa mai i runga, Tūtawa mai i raro
Tūtawa mai i roto, Tūtawa mai i waho
Kia tau ai, Te mauri tū, te mauri ora
Ki te katoa
Hāumi e, hui e, tāiki e

Come forth from above, below, within
and from the environment
Vitality and wellbeing for all
Strengthened in unity

(karakia by Scotty Morrison)

E mihi ana ki a Titihuia Pakeho, Keelan Ransfield and Leanne Manson.

To learn more about pīwakawaka and ruru, go to www.doc.govt.nz/nature/native-animals/birds/

Your rights and responsibilities

Nurses must be aware of their rights and responsibilites in these unprecedented times.

By NZNO staff

With New Zealand now in lockdown until at least late April in an attempt to halt the spread of the COVID-19 virus, the health-care workforce, of which nurses are the most numerous, is under immense pressure.

District health boards (DHBs) have been preparing for an onslaught of patients and the Government has pumped an extra $500 million into the health service. Despite these efforts, NZNO has has had to lobby for more personal protective equipment (PPE) for nurses and others. And it has heard of some private-sector employers trying to force staff to take sick or annual leave during the lockdown. Nurses and all health-care workers need protection and professional and practical advice at this time.

NZNO has prepared a raft of resources and information for members on how to cope in a range of different scenarios they may face in their work. These are being updated regularly and can be found at www.nzno.org.nz. This industrial focus outlines some of the key issues nurses and other members face, and their rights and responsibilities during the pandemic.

Supporting members

NZNO's role in a pandemic is to support members' access to the latest pandemic information; support members as they prepare for and practise during the pandemic and throughout the recovery phase; and support them should employment issues arise.

PPE has emerged as a major concern. DHBs and the Ministry of Health have issued guidelines in line with those of the World Health Organization. However, members remain concerned, particularly about cases which may be asymptomatic or where it not known whether a person has COVID-19, eg where district nurses or other health-care workers go into people's homes. NZNO is advising a precautionary approach be taken, as this is an entirely new situation with many questions still unanswered.

NZNO members must be part of all the planning regarding COVID-19 and to know their obligations in a pandemic.

Under the Health and Safety at Work Act (HSWA), an employer must ensure, so far as is reasonably practicable, the health and safety (H&S) of workers.

The primary duties of workers under the HSWA are: they must take reasonable care of their own H&S; they must take reasonable care that their acts and omissions do not adversely affect the H&S of others; and they must comply with reasonable instructions and cooperate with reasonable policies, eg following safe work practices, effective use of equipment, wearing protective clothing and participating in training.

The employee is responsible for highlighting to their employer any conditions or circumstances that place the worker's H&S at risk.

NZNO recommends in the case of COVID-19, that members monitor their own H&S and that of their colleagues, and report any concerns to their employers.

NZNO members will have to care for people with COVID-19. Careful planning can help reduce the impact of the pandemic, but all nurses and other members must be mindful of their rights and responsibilities.

In their information to staff, DHBs say health workers are employed to use their professional skills "to care for whomever presents for care". They are provided with knowledge, safe procedures and PPE to protect them from risk as much as possible. Those with concerns about their immediate safety should contact their line manager.

In their information to staff, DHBs say, where possible, flexible working arrangements should be explored for staff who need to be away from work for either self isolation or other matters, such as looking after dependants.

Where staff are off work due to public health advice, DHBs will waive the requirement for a medical certificate after three days, but may require a signed declaration from the staff member.

According to NZNO, if an employer requires a member to stand down, who is symptom-free and willing to work, that person will be entitled to paid special leave or some other leave.

Paid special leave

If a member is required to self-isolate or contracts the disease, they will get paid special leave. NZNO believes all health-care workers in all health-care settings should be entitled to the same provisions, protections and conditions that apply to those working in DHBs. DHBs are, ultimately, the funders of these other health-care providers and there should be a consistent approach across all sectors.

It is likely members will be asked to work more than usual. NZNO believes an open conversation with employers about what will be expected of health professionals, should demand become overwhelming, is crucial for workforce planning.

Redeployment was emerging as a big issue as *Kai Tiaki Nursing New Zealand* went to press, including redeployment to other providers. NZNO believes DHB employees redeployed outside DHBs must remain as DHB employees, with the same conditions and protections, including PPE, as they would if remaining in DHB employment.

Employers must meet all leave and consultation provisions under the terms of any collective agreement they have with NZNO. The Ministry of Health has information specifically for health professionals on its website.

NZNO is in constant communication with DHBs to ensure *all* members are supported and protected in this rapidly evolving situation. NZNO thanks its members standing at the frontline in the battle against COVID-19. Kia kaha. •

Primary health care: MECA ratification process delayed

THE NZNO team negotiating the primary health care multi-employer collective agreement (PHC MECA) has indicated that the member ratification online ballot should be delayed until April 23.

NZNO lead advocate Chris Wilson (right) said this was to give the 25 employers who had not yet ratified the MECA time to do so and to enable NZNO to hold serious negotiations with seven employers (to date) – via Zoom or phone – who had declined the MECA. The delay would also help ensure as many NZNO members as possible participated in the ballot, given the COVID-19 situation. Some 350 NZNO members work for these two groups of employers.

NZNO will also include advice to members who have been asked to reduce their hours during the lockdown.

Well over 67 per cent of employers – their threshold for ratification – have ratified the MECA.

NZNO will inform members working in general practices and accident and medical centres that have voted against ratification and suggest they email their employers expressing their disappointment. NZNO is also suggesting members ask their employers to reconsider before serious negotiations start.

Wilson said NZNO had done this in previous MECA ratifications and believed it should be done this time to ensure as many NZNO members as possible have the opportunity to be balloted. Only members in workplaces where employers have ratified the MECA can be balloted.

NZNO is advising members who have been asked to reduce hours that employers needed to abide by the management of change provisions in the MECA. Essentially, these make clear that: there is an obligation to meet the relevant employee/s and the NZNO organiser/delegate; there is the development of a plan from that point; there is a reasonable and specified timeframe for feedback; and then a final decision is made.

"These are meaningful and agreed contractual provisions and cannot be overruled in a pandemic," Wilson said.

The proposed MECA includes a 2.5 per cent pay increase for nurses and medical receptionists, backdated to September 1, 2019, and a further two per cent increase on September 1 this year, effectively a two-year term.

Before the lockdown, NZNO and the NZMA had been lobbying extensively for more funding for the PHC sector to enable pay parity. This offer was based on what employers could afford without any extra funding, and did not address pay parity with nurses in the district health board sector, Wilson said. As at May 4, 2020, an eight per cent pay gap between experienced PHC and DHB nurses would remain. •

Online ratification for new Nurse Maude offer

MEMBERS AT Nurse Maude in Christchurch have withdrawn their strike notice and this month are considering a changed offer from their employer. Online ratification takes place this month.

After a partial strike involving district nurses in Canterbury had begun, and notice of a full 24-hour strike in early April had been issued, the employer requested to meet with NZNO on March 26. During the negotiations, the Government announced the escalation to lockdown.

Nurse Maude presented a changed position but with no improvements, which NZNO primary health care industrial adviser Chris Wilson said was disappointing. But given the circumstances of the lockdown and the term of the proposed collective agreement (CA) – it will expire on August 31, 2020 – the NZNO negotiating team agreed to withdraw the strike notices and take the proposed CA out to members for ratification.

The key points are:

- A 2.3 per cent increase across all current paid and printed rates (excluding those roles covered by the care and support workers' settlement), backdated to September 1, 2019.
- The term will be from September 1, 2019 – August 31, 2020.

In addition, the Canterbury District Health Board (DHB) has agreed to a review of funding for community nursing services to create a new sustainable funding model. It will include a full review of nursing costs and also include the two other district nursing providers in Canterbury, Healthcare NZ and Access. The DHB has proposed a timeline to achieve this by September, which is when NZNO would next be in bargaining, should members ratify the proposed CA.

Wilson said this would not have been achieved were it not for the organiser Helen Kissell, and delegates' and members' determination throughout the campaign for pay parity.

"Collective activity has increased 10-fold on this site and will hold us in good stead for future bargaining in a few months, should members accept the proposed CA," Wilson said. •

COVID-19 dominates intensivists' meeting

CONCERN ABOUT COVID-19 dominated the Australian and New Zealand Intensive Care Society (ANZICS) regional annual scientific meeting held in Napier in March. The theme was "A 2020 vision for our environment: The spectrum of intensive care."

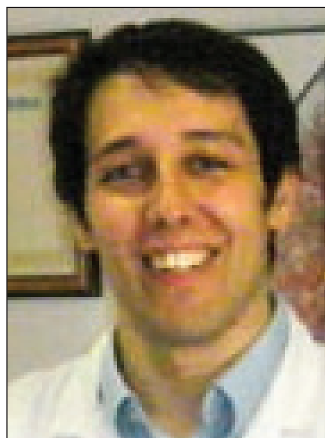
It focused on what part we health-care workers can do to sustain the intensive-care environment and respond to climate-related challenges affecting health, health equity and welfare.

Critical/intensive care nurses were among about 200 attendees at the three-day conference, which featured dozens of speakers from New Zealand and around the world.

Inspiring nursing leaders such as Massey University lecturer Alison Pirret, Counties Manukau clinical director of improvement and innovation Lynne Maher and Dunedin clinical nurse specialist Linda Grady shared their experiences. Common themes included wanting to make a difference, having a passion, challenging the system, empowering other nurses and having courage by "doing one thing that scares you".

With COVID-19 spreading so quickly, the most compelling talk came from Italian-trained, United Kingdom-based intensive care specialist Gianluigi Li Bassi on the need for global collaboration on COVID-19.

Li Bassi talked about its origins – a live animal market in China – and earlier corona viruses which could jump species, such as severe acute respiratory syndrome (SARS) which was transmitted to humans from bats. However, the number of COVID-19 cases has grown far more rapidly than SARS, with more than 70,000 cases in four months, compared to 7000 SARS cases in eight months.


Gianluigi Li Bassi

Rachel Yong

He suggested the virus would not only have health effects, but also psychological and social effects.

Climate change speakers, such as the University of Colorado's Jay Lemery and Victoria University's James Renwick, made us think about the bigger picture, and how climate change affects human health. What are our intensive care units (ICUs) doing that is increasing our carbon footprint and how can we reduce this?

Climate change affects our sense of identity, culture and environment. The spread of diseases is facilitated as temperatures increase. To slow the effects, we need good governance and health care connected with the environment.

Discussions about recent disasters such as the Australian bush fires, the mass shooting in Christchurch, the Whakaari-White Island disaster – and now COVID-19 – makes you think about how we look after ourselves, or sustain ourselves, to give better care to patients.

The reality is, our ICUs are not resourced to cope with the reality of COVID-19. •

Report by college of critical care nurses committee member Rachel Yong

Northland nurses gather to share research

ABOUT 50 nurses from mental health, community, education and acute care attended Northland's recent nursing research showcase, and discussed research initiatives for the future of nursing in Te Tai Tokerau. Hosted by NorthTec/Tai Tokerau Wānanga, the showcase was coordinated by NorthTec nursing department staff.

NorthTec's nursing pathway manager, Bev MacKay, who instigated the annual event four years ago, said it was a chance to demonstrate the work of nurses through evidence-based practice.

"We are celebrating the research nurses undertake to improve the quality of care in our communities and the network and support between nursing groups in Northland," she said. The International Year of the Nurse and Midwife was a chance to acknowledge the leadership of nurses in improving health services.

There were speakers from around Northland, including many first-timers.

The symposium was a unique chance to share the research and mahi undertaken in Northland, within a safe and supportive environment.

Topics ranged from early intervention in psychosis, barriers and enhancers for the recruitment and retention of Māori nurse educators working in undergraduate nursing programmes, to the experiences of older adults transitioning into long-term residential care.

The symposium was also an opportunity for third-year nursing students to present a range of projects they are expected to complete as part of an evidence for

Cancer nurses 'pleased' to join national cancer agency advisory group

THE CANCER nurses college (CNC) is "pleased" committee member and Waikato nurse, Mary-Ann Hamilton, has been appointed to the Cancer Control Agency board's newly-formed clinical assembly.

"It is heartening to see the Ministry of Health (MoH) and the Cancer Control Agency recognising the need for nursing representation," CNC chair Kirstin Wagteveld said.

After cancer nurses were excluded from the agency's interim board, the college lobbied to be included, meeting MoH and the cancer agency, as well as writing letters and asking medical colleagues for support, she said.

While "disappointed" not to attain a board presence, she said the college was pleased to have a member on the agency's clinical assembly, which is an advisory group of clinicians.

"As a committee, we are dedicated to continue lobbying for nursing representation at ministry level and recognition of the experience, skills and knowledge nursing and nurses bring to the care of the cancer patient."

Hamilton's ability to articulate issues of equity and the nursing perspective won her a place, Wagteveld said.

The first meeting of the assembly was held in Wellington in late January, hosted by assembly chair Christopher Jackson and agency chief executive Diana Sarfati.

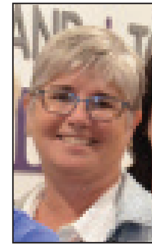
Key points included how to develop an understanding of current cancer-care structures, capacity, work programmes and priorities for the agency, as it prepares to implement the National Cancer Plan.

'It is heartening to see the Ministry of Health and the Cancer Control Agency recognising the need for nursing representation.'

The assembly also considered how to identify population-based cancer survival estimates, to benchmark how New Zealand compares on the world stage.

Māori epidemiologist Jason Gurney also highlighted the uncomfortable truth that Māori diagnosed with cancer were more likely to die – and sooner – than non-Māori with cancer, emphasising the need for a well-resourced and focused approach to eliminating inequity.

Kirstin Wagteveld


Mary-Ann Hamilton

After lobbying, the college has also succeeded in getting nursing representation on the systemic anti-cancer therapy (SACT) working group, with nursing representation in each of the current tumour streams. The SACT project is focused on national data collection and standardisation of anti-cancer treatments, including chemotherapy via electronic prescribing.

The college has ongoing representation on the following MoH working groups: medical-oncology, radiation-oncology and haematology.

Wagteveld said the college welcomed communication from members, whether concerns or ideas.

"We are here to represent cancer nursing so please feel free to contact us on cancernursesnz@gmail.com." •

Report by cancer nurses' college chair Kirstin Wagteveld

Participants at the nursing research showcase in Northland.

practice course. These presentations are always highly regarded.

Fern Astill presented on intra-muscular injection practice and Hanibrez Sipu on the importance of rongoā Māori. Both said they valued the chance to share their findings with nurses working in the field.

Hani said there was not enough knowledge about rongoā heal-health care. "It's almost like its hidden and needs to be brought to the forefront. I want to draw attention to it and plant a seed in nurses' minds to be more aware of it in their practice."

The event was worthwhile, showcasing nursing initiatives and providing a platform for networking and collaboration. •

Report by NorthTec senior nursing lecturer Linda Christian

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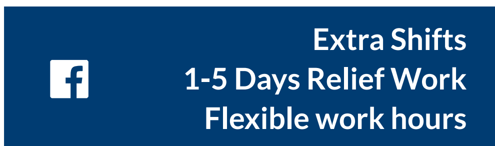

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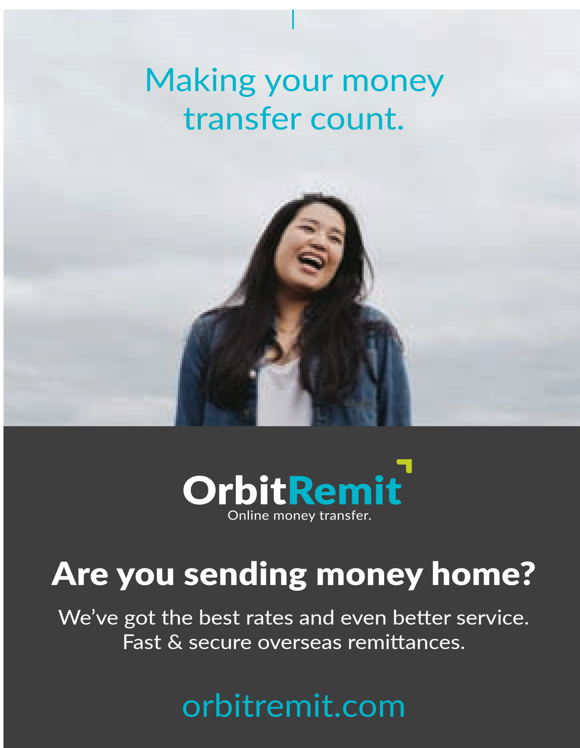

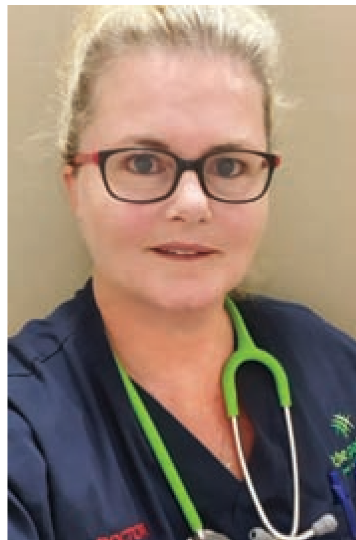

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