Kai Tiaki NURSING NEW ZEALAND

August 2020
vol 26 no 7

Palliative care

- Equity at the end of life
- Palliative care 'not just for specialists'
- Views on the cannabis referendum

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ISSN 1173-2032

Vol. 26 No. 7 AUGUST 2020

THIS ISSUE has a focus on palliative care. There are profiles of two palliative care nurses working in vastly different spheres; and articles on preparing students to care for those who are dying; a new framework for Māori palliative care, and the impact of deprivation on access to palliative care. With the general election next month, we have an article on using NZNO's election manifesto as a guide for questioning politicians and we look at the cannabis referendum.

Kai Tiaki Nursing New Zealand is the official journal of the New Zealand Nurses' Organisation, Tôpûtanga 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*.

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

Practice article review process:
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.

This issue . . .

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Call NZNO's Membership Support Centre: **0800-28-38-48**

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Photo: Adobe Stock.

Cover design: Kathy Stodart.

Pre-press production: TBD Design.

Printers: Inkwise.

Caring for those with advanced frailty

By Michal Boyd

It may surprise many that the highest proportion of all deaths in New Zealand – 38 per cent – occur in residential aged care (RAC). This proportion increases to 45 per cent when accounting for those living in aged care but who die in hospital.[1]

For the vast majority of us, death will not come suddenly, but will follow a period of disability lasting anywhere from months to years. In the last few years there have been several initiatives focused on improving end of life for people living in RAC. However, the highest complexity is often not when the person is dying, but in the months and years before they die, as advanced frailty takes hold. It is essential we don't only focus on RAC as the place where older people die, but where they *live* as the body winds down with multi-morbidity and frailty during the last stage of life.

Fear of old age disabiity

As a society, we fear old age disability more than death itself. This has resulted in little recognition of the increasing dependency and care needs of those admitted to care homes. People living in RAC are now much older and sicker than ever before, but resources have not kept pace with the increasing complexity of this care.

The unavoidability of 24-hour specialist care for advanced physical and cognitive frailty can cause enormous distress and grief for older people and their families/whānau. It can be a devastating realisation that the need for 24-hour care is a necessity, not a choice. Yet, there are few formal emotional support mechanisms for the "bereavement" that comes with loss of independence.

We must begin to acknowledge that admission to aged care is not a failure, but a necessary component of the overall continuum of health care.

We are still staffing and resourcing RAC as if it is a "lifestyle" choice for mild frailty. Staffing levels have not changed in the last two decades. The subsidy for aged care has not kept up with inflation or increasing resident needs. Although resident acuity is often similar, the daily rate paid to care homes is between one half to one-fifth that paid to hospitals and hospices. The building of new aged-care facilities is mainly supported through the property development profits of retirement villages, and privately paid "premium charges" are now common. These additional costs are borne by the consumer, creating a two-tiered RAC system.

Traditional palliative care models developed for cancer do not fit the needs of frail older people, particularly because death prognosis is ambiguous. The trajectory to end of life in old age most often occurs slowly over a long period of time, accompanied by physical and cognitive dependence that requires a very specific set of skills that integrates gerontology and palliative care expertise.

The recently completed ELDER (End of Life with DEmentia Research) study explored the end-of-life experience for those dying in RAC.[2] Very few deaths in aged care required hospitalisation. In fact, our study showed the end-of-life experience in New Zealand aged care ranks highly compared to a similar study of six European countries.

The ELDER study showed the majority of people in aged care died of dementia (55 per cent), chronic illness (28 per cent) and a minority with cancer (17 per cent). The median length of stay for those with cancer was only one month, significantly less than those dying from dementia (15 months) or chronic disease (17 months). There was more community hospice involvement for those with cancer (30 per cent) than chronic disease (11 per cent) and dementia (five per cent).[2] Although we found no difference in the quality of death in the last week of life regardless of the diagnosis, people with dementia and chronic illness experienced significantly more physical symptoms in the last month of life, illustrating the long-term complex needs of older people dying with cognitive and physical advanced frailty.

Traditional palliative care models developed for cancer do not fit the needs of frail older people . . .

Now, and into the future, the oldest old will make up the majority of all deaths, and a significant proportion of people will die in RAC. We need a different model of end of life care for advanced frailty. Those working in aged-care facilities are recognising that palliative care philosophy and practices are an integral part of their work. It is also crucial that specialist palliative care providers become more skilled in complex geriatric syndromes and proactively work inside RAC systems. We must learn from, and support each other and share our complementary skills. It is essential that gerontology and palliative care approaches are integrated to assure high quality end-of-life care for those with advanced frailty living in the last stages of their lives. •

Michal Boyd, RN, NP, ND, is an associate professor with the School of Nursing and the Department of Geriatric Medicine, University of Auckland, and director and NP, Equinox Health Ltd.

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Tell us what you think

Co-editors taken to task over reporting of meeting

I AM a New Zealand registered nurse and financial member of NZNO and, until recently, have been working at the "coal face".

Until the district health board multi-employer collective agreement (DHB MECA) negotiations took place in 2017/2018, I eagerly anticipated receiving and reading *Kai Tiaki Nursing New Zealand* magazine.

I must say I felt betrayed by the way in which the DHB MECA negotiations were run and the settlement was reached, and felt there were events within NZNO limiting the effectiveness of those negotiations. Since that time, there has been evidence of obvious infighting and opposing factions within NZNO.

This was confirmed for me when I read the news article, *Wellington delegate quits after SGM fallout* in last month's issue (p7), featuring Erin Kennedy's account of the June 2020 meeting of the Greater Wellington Regional Council.

I am disappointed Ms Kennedy was so aggrieved by her historic attendance at such meetings. However, it is obvious to me she has little knowledge of Te Rūnanga and its partnership/participation with NZNO and of Te Tiriti o Waitangi principles. I found her assertion re residential place and "being from out of the area" of the interim chair, who was elected by Te Rūnanga, offensive and demonstrated colonialist thinking.

As an ordinary Pākehā member of NZNO, I would like NZNO to be working on my, other nurses' and members' behalf to ensure all nurses and health-care workers at the coal face have access to consistent and reliable supplies of personal protective equipment, regardless of which DHB area they work in, in these COVID-19 times. And I would also like NZNO to be attending to issues which have the potential to kill or severely disable its members in the workplace, as well as ensuring all health-care workers in this country are paid properly for the work they do.

Creating a racial divide is divisive. We are all health professionals trying to achieve the same thing for our patients while keeping ourselves and our families safe, housed and fed, no matter where we come from or where we live in Aotearoa New Zealand.

My "coal face" message to NZNO is to stop the infighting, do your job (which the members pay you to do) and employ some professional editorial integrity by labelling opinion pieces as opinions, not as news and events.

Pull yourselves together and get on with your work like the rest of us.

Marcia Ashdown, RN
Porirua

Co-editors reply: Thank you for your letter. Kai Tiaki Nursing New Zealand *is attempting to clarify the issues, and resolve the distress and offence the article has caused. Please see correction and apology below.*

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.

Supporting the right to die

AS A recently retired nurse, I dare to say what other nurses dare not: *"Legalised medical aid in dying [MAID] cannot come soon enough"*. Many of my employed colleagues, including some in palliative care, agree with me privately, but are gagged by their employers. This says much about the bullying culture of nursing that causes nurses significant distress.

In 2019, *The British Medical Journal* cited four palliative care consultants, who claimed to "risk their careers" if they discussed MAID.[1] The article provoked a flood of responses in agreement and demands for a "wake up call" to the Association of Palliative Medicine (APM).

Palliative Care Australia routinely submits clinician-assessed measurements of suffering to the University of Wollongong NSW. Their 2019 Patient Outcome Reports showed that five to six percent of patients suffer "severely" in their terminal phase.[2]

Routine reporting from Oregon in the United States, where MAID was legalised 22 years ago, shows that 90 per cent of patients requesting a hastened death are enrolled in palliative care at the time of the request.[3] Clearly, palliative care has its limitations.

There is significant public support for MAID and nurses are also "the public" when off duty. Research in 2019 found 67 per cent of nurses supported MAID legalisation,[4] almost identical to the 68

Correction and apology

IN THE news article "Wellington delegate quits after SGM fallout", published in the July 2020 issue of *Kai Tiaki Nursing New Zealand* (p7), we reported that some Te Rūnanga members attending the June 10 Greater Wellington Regional Council (GWRC) meeting were from outside the region, including the interim chair. In fact, the interim chair and the Te Rūnanga members who attended are all based in Wellington. The co-editors apologise for the error.

It is clear the article has caused great distress and offence to members of Te Rūnanga o Aotearoa NZNO. The co-editors have met the Te Rūnanga members involved and are working with chief executive Memo Musa to assess further information that is to be provided in order to resolve the queries that have been raised and restore the mana of all concerned.

per cent public support.

I do not see MAID as a "life and death" issue as sometimes described. To comply with the eligibility criteria, the patient must be already close to death, continuing to decline and continuing to suffer. It is no longer a question of life over death, but a question of what kind of death – peaceful or harrowing.

Neighbouring Australia has some practical experience of MAID implementation, although limited to date. Two voluntary assisted dying (VAD) doctors in Victoria, Nick Carr[5] and Cameron McLaren,[6] speak of the relief and serenity of patients as soon as permission is granted for an assisted death. The reassurance of choice and control alone is palliative. Why would we deny our patients that?

Patients themselves would infinitely prefer MAID over their other current choices of death-hastening. I call these "Hobson's choices" – stopping eating and drinking, violent suicide, overdose.

I will vote "yes" in the End of Life Choice Act 2019 referendum for the sake of compassion, when even the best of palliative care cannot relieve terminal suffering. Nurses should not have to walk away from the desperate call of "Nurse, please help me to die!"

Tess Nesdale, RN, (retired)
Tauranga

Disclosure: The letter writer is a member of the End of Life Choice Society NZ.

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Health literacy research

HEALTH LITERACY is key to effective partnerships between individuals and health-care professionals. I am completing a PhD in nursing and conducting a study about the health literacy strengths and challenges of New Zealand nurses and the implications for the nurse-patient relationship.

In the first phase of my study, with the help of NZNO, I am inviting a randomly selected national sample of New Zealand registered nurses to complete the Health Literacy Questionnaire online, which takes about five minutes. The questionnaire asks you to indicate the degree to which you agree with a set of statements about health literacy.

If you have been randomly selected, you will have received an email invitation including information about the study and a link to the anonymous online survey. I encourage you to look out for your email invitation to this important study, which will draw attention to the part health literacy plays in effective nurses-patient relationships.

Nurses play a key role in implementing health literacy whether they lead a movement towards a health-orientated system, or work to improve how health demands can be reduced and health equity achieved. Regardless of your role, I would appreciate your completing the online survey.

If you have completed the survey, thank you so much. If you have received the invitation and have not yet completed the survey, I would ask you to please do so, in order to progress this important work. If you would like further information, please email me at l.carrucan-wood@auckland.ac.nz

Louise Carrucan-Wood, RN,
University of Auckland,

Wound Care Awareness Week

THE NEW Zealand Wound Care Society (NZWCS) has partnered with the Accident Compensation Corporation (ACC) to present New Zealand's first Wound Awareness Week. This year's focus is skin tears.

Wound Awareness Week is an exciting opportunity to increase awareness and strategies to prevent and manage skin tears. Skin tears are a common preventable skin injury, especially in older people and can develop into a non-healing wound if not managed appropriately. Prevention can be as simple as implementing a skin moisturising regime and avoiding the use of skin closure strips, staples and sutures in fragile skin, especially in the older person.

During August, skin tear resources will be freely available. For more information, visit www.nzwcs.org.nz for a health-care poster and an educational PowerPoint on the best practice for prevention and treatment of skin tears. You will also be able to access the free patient skin tear information sheet via www.nzdoctor.co.nz/ located under "patient sheets".

Join us in celebrating this monumental week and spread the word to prevent and manage skin tears.

Maria Schollum, RN, NP, MHSc (hons),
Kate O'Dwyer, RN, PGDip (HlthSc), and
Liz Milner, RN, BHlthSc, PGDip, PGCert,
NZWCS Wound Awareness Week Team

'Thank you', Carolyn Clissold

THANK YOU so much Carolyn Clissold for your clear and practical discussion about personal protective equipment (PPE) and standard precautions. (Truths and myths about PPE, *Kai Tiaki Nursing New Zealand*, June 2020, p14.)

All organisations were struggling to some extent with their variety of settings and the necessity to tailor approaches to PPE use in the face of limited PPE access. This is a great example of the value of asking the experts. Often the appropriate expert will be a nurse.

Rose Stewart, RN, MN,
Family Planning national nursing adviser,
Wellington

Changes to dementia testing

CHANGES TO the screening tool for cognitive impairment (dementia) come into effect on September 1, this year.
The Montreal Cognitive Assessment (MoCA©) test will no longer be free to use from September 1, 2020.

Mini-Addenbrooke's Cognitive Examination – Mini-ACE – is now the recommended screening tool for cognitive impairment in New Zealand. It is a brief cognitive screening test. It's free, easy to use and takes around five minutes to complete. HealthPathways will reflect this change to the test for cognitive impairment from September 1.

Online training on Mini-ACE is available this month and, from September 1, the Mini-ACE test and guidance docu-

Notice to members: Please participate in survey

AT THE NZNO annual general meeting in 2019, NZNO's membership committee asked attendees to fill in a short survey regarding the future of NZNO. The survey asked for:

- thoughts on strategies to encourage NZNO members to participate in NZNO activities,
- how we can increase visibility of both industrial and professional arms of NZNO, and
- any further comments.

There were 109 responses from members working in a variety of settings. The answers could be broken down into broad themes:

- accessibility,
- communications,
- delegates,
- education,
- fees,
- information technology,
- marketing/campaigns,
- social media,
- website,
- support, and
- others.

Although we received many ideas through the survey, the committee recognised this was a small sample, mainly comprised of those in leadership roles in the organisation, rather than being representative of overall members.

It was proposed the survey questions be expanded to collect richer data. However, doing this would make survey analysis complicated and we want to hear from the wider membership. The membership committee would be grateful if you would complete the survey available on:

- Survey Monkey at www.surveymonkey.com/r/NZNOMCSurvey2020; or
- download a form from the NZNO website: www.nzno.org.nz /About Us/ Governance /Membership Committee /Membership Committee 2020 Survey

Completed surveys should be sent to: Sally Chapman, national administrator, NZNO, PO Box 2128, Wellington 6140 or scanned to: sally.chapman@nzno.org.nz

As your membership committee, we value your input and hope your collective feedback will foster positive change, to create a sense of ownership for NZNO members around the country. All responses would be appreciated by Sunday, September 6, 2020. If you have any questions about the survey, please email sally.chapman@nzno.org.nz

Ngā mihi maioha,
Sandra Corbett
(chair) and Andrea Reilly (vice-chair)
NZNO membership committee

ment will be available in HealthPathways.

A kaupapa Māori Assessment of Neuropsychological Abilities (MANA) tool is being developed and will be integrated in HealthPathways alongside the Mini-ACE in 2022.

For more information on this change and online training, please visit www.nzdementia.org/mini-ace

Shereen Moloney,
executive director
NZ Dementia Foundation

Correction: The article, Te Poari reviews plan's equity focus, in last month's issue of *Kai Tiaki Nusing New Zealand* (p41) stated Margaret Hand and former board members Sela Ikavuka and Katrina Hopkinson were the members of a board working group looking at the strategic plan before it went out for consultation. In fact, former board member Anne Daniels was on the group, not Katrina Hopkinson.

The co-editors apologise for this error.

Honouring the anniversary of a 'trailblazer'


Emma Hattaway

LAST MONTH we honoured our great aunt Emma Hattaway, dearest friend and sister-in-law of Mereana Tangata (featured in *Kai Tiaki's* April issue, p28). Emma died 100 years ago on July 15, 1920.

Her three great nieces, all of us nurses, believe she was a trailblazer and an outstanding nurse of her time. Born the seventh child of 17 children, she trained at Auckland Hospital with Mereana in the 1890s. They became best friends, with Emma introducing Mereana to her brother Vincent. Vincent and Mereana married in 1904.

Emma made a difference to the lives of many. A compassionate woman with strong leadership skills, she became the charge nurse on the male typhoid ward around 1896. She worked there for three years and was regarded as one of the best typhoid nurses in New Zealand.

In 1902, she cared for returned soldiers from the Boer War at the quarantine hospital on Motuihe Island in the Hauraki Gulf with Mereana. She then left to visit England, where her father Robert was from.

An enterprising woman, Emma arranged for the first maternity home and hospital to be built in Te Kuiti, where she was matron from 1908 for more than seven years. She was part of the committee that helped form the Te Kuiti Branch of St John Ambulance. Providing nursing care 24/7 at her private hospital took a toll on her health, however, and she eventually sold the hospital to recuperate.

During World War I, Emma became relieving matron at Mongonui and Tauranga Hospitals. Two years later, she returned to Te Kuiti to help organise and care for the sick during the 1918 influenza pandemic.

Her final nursing role was as matron at the Nurse Cavell Memorial Hospital in Paparoa, Northland, where she died of a heart attack in 1920. She was greatly missed by the community who erected a memorial to her at the hospital in 1924.

Until recently, Emma's story had been lost in the mists of time. Thanks to research by her nieces, her story has been recovered and her memory honoured.

Raewyn Hattaway Pukas, *Auckland,* Joy Hattaway Stafford, *Kaitaia* (granddaughters of Mereana Tangata), and Marilyn Hattaway Gendek, *Canberra*

Two constitutional review options for AGM

MEMBERS MUST consider two approaches to reviewing NZNO's constitution ahead of this year's annual general meeting (AGM), being held virtually on September 17.

They will also vote on whether a non-nurse can be appointed NZNO's chief executive; an independent professional director can be appointed to the board; and whether NZNO evaluates its safe staffing strategies.

A joint policy remit from the mental health nurses section (MHNS) and college of cancer nurses (CCN) proposes NZNO's constitution be fully reviewed by a person with no "vested interest" in NZNO. Voting opened on August 5. According to AGM documents, the reviewer must have a strong knowledge of constitutional law, preferably within bicultural organisations. Any changes proposed would then be subject to the one-person-one-vote process.

The NZNO board's terms of reference (TOR) for a review of the constitution have also been released. Voting on the board's proposed review is expected to take place at the AGM on September 17. Its scope differs to that proposed by the member groups.

In its December 2019 board meeting, the board agreed a review should be conducted biculturally by two external facilitators, both with legal expertise and prior knowledge and engagement with NZNO, with at least one nominated by te poari. It must not alter the constitution in any way which alters the te Tiriti partnership, unless ratified by Te Rūnanga.

Also excluded by the board from any review were the constitution's clauses one to five, which outline NZNO's name, definitions, vision, mission and philosophy; clause 25.2.3 on the remit committee; clause 29 on voting for constitutional and policy remits; and schedule three on the election of board members.

Both would be completed for the 2021 AGM.

NZNO's board is also seeking member endorsement of NZNO's draft strategic plan 2021-2025. The plan identifies three strategic goals: Skilled workforce; influencing improved health outcomes; and being an effective and sustainable organisation.

Policy and constitutional remits for members to vote on include:

- Giving NZNO's board the power to appoint an independent professional director to provide expertise in specific areas that may be of benefit to NZNO function.
- That the requirement for NZNO's chief executive to be a registered nurse be removed.
- Amending a range of clauses to ensure any remits "which could compromise the constitutional role of Te Rūnanga or poari" be endorsed at hui-ā-tau before being subject to a one-person-one-vote process.
- That NZNO conduct an independent evaluation of its safe staffing strategies, including care capacity demand management (CCDM). Then, NZNO presents options for additional safe staffing mechanisms, including legislated minimum nurse/patient ratios, for consideration.

Virtual conference

The NZNO conference, *Community Wellbeing in Aotearoa,* will be held, also virtually, on Wednesday, September 16. Speakers include University of Otago professor of public health Michael Baker; International Council of Nurses chief executive Howard Catton on challenges and opportunities for nurses in 2020; Otago Polytechnic associate professor of nursing Jean Ross on the impact student nurses can have on reducing health disparities; Hawke's Bay clinical nurse specialist Merryn Jones on organ donation in a Māori cultural context; and Auckland GP and cannabis prescriber Graham Gulbransen on medicinal cannabis.

Chief nursing officer Margareth Broodkoorn will discuss the relevance of the World Health Organization's *State of the World's Nursing Report 2020* in a COVID-19 context.

A college and section day is being held separately on August 18 in Wellington, and will be a mixture of Zoom and face-to-face. A decision on how and when to hold the indigenous nurses' hui is yet to be made.

www.nzno.org.nz/get_involved/conference_and_agm. •

Members, use your voice, Musa urges

TWO SOUTH Island nurses have been nominated for the role of NZNO president: Canterbury nurse manager Brenda Close – NZNO's kaiwhakahaere from 2005 to 2009 – and Christchurch forensic mental health nurse Heather Symes, a board member from 2009 to 2011.

Another six candidates are vying for three vacancies on the board. Candidate profiles can be found on page 41-43. Voting closes at noon on September 11.

Waikato practice nurse and Te Rūnanga's Midlands representative Tracey Morgan has been elected vice-president, unopposed, as the only valid nomination.

The five vacancies were created when former president Grant Brookes and three board members, Katrina Hopkinson, Anne Daniels and Sela Ikavuka, resigned in April and vice-president Cheryl Hanham resigned in March.

Chief executive Memo Musa said he was pleased to see some people had put their hands up to be elected to the board and take up a governance role, and he encouraged members to turn out to vote. "There is a lot going on and we need members to contribute to the governance of NZNO." For those members not standing, now was the time to use your vote, he said. "Use your voice, have your say."

Voter turnout at the 2019 board election was just eight per cent of NZNO's membership, about 4000 out of more than 50,000. •

PHC nurses poised to strike

FOR THE first time ever, primary health care (PHC) nurses and medical recepitonists/administrators around the country are voting on whether to go on strike for eight hours next month.

Primary health care nurses at a stopwork meeting in Te Atatū last month show their support for the pay parity campaign.

The strike ballot was to finish on August 12. If the vote is in favour, the strike will be on September 3 and involve more than 500 general practices and accident and medical centres.

NZNO's PHC industrial adviser, Chris Wilson, said the strike ballot indicated members' frustration "after nine months of fruitless PHC multi-employer collective agreement [MECA] negotiations".

PHC nurses want pay parity with their district health board (DHB) colleagues and employers support this claim. But PHC employers say they can't afford the $15 million pay parity would cost. Wilson said the 10.6 per cent pay gap between experienced PHC nurses and DHB nurses was "completely unjust" and undervalued PHC nurses' work "providing expert care in the community – demonstrated so clearly in the COVID-19 response".

Resolving the situation came down to political will. "NZNO members were seeing new funding allocated elsewhere every day. They are wondering what has to happen for the Government to value the sector as the front door of our health service. They are disappointed and angry they have been forced into considering strike action," Wilson said.

Director general of health Ashley Bloomfield has not responded to a letter from NZNO chief executive Memo Musa seeking support for pay parity funding, which would enable the MECA to be settled. This was "disappointing".

NZNO has now written to Prime Minister Jacinda Ardern and relevant ministers, outlining the funding shortfall. "They should rectify the situation as soon as possible, particularly given that the report of the major review of the health and disability system recommended pay parity for PHC nurses," Wilson said.

The strike ballot follows on from overwhelming support for an eight-hour strike expressed at two-hour stopwork meetings around the country last month. More than a third of the 3400 members covered by the PHC MECA attended the meetings. "We were very pleased with the turnout and members' commitment to keeping their pay parity campaign going," she said. • (See also p39.)

Report-back meetings start

MEMBER REPORT-BACK meetings on the NZNO/district health board multi-employer collective agreement (DHB MECA) negotiations are underway this month. During the two rounds of negotiations so far, NZNO has presented members' claims and explored the possibility of a short-term agreement, similar to that reached between the Association of Salaried Medical Specialists (ASMS) and DHBs. The ASMS agreement is for one year and delivers a 1.9 per cent pay increase.

Speaking early this month, NZNO advocate David Wait said a majority of members, in the NZNO claims survey, had supported exploring the option of a short-term agreement because of the uncertainty created by COVID-19.

"We asked members if they would support exploring an option similar to the ASMS and 71 per cent of those who responded did. With that in mind, we spent some time in the last round of negotiations trying to reach an agreement, but were unable to agree on a comparable offer." The DHB team had highlighted constraints due to the State Services Commission's expectations for minimal or no pay increases in the state sector, he said.

Because no agreement was reached, the next MECA negotiations in September would address all NZNO claims. These include the pay claim and the safe staffing claim "which seeks to encourage DHBs to staff appropriately through a mix of public reporting and penalties for DHBs that don't staff safely", Wait said.

Negotiations were still "very much in the early stages" but he hopes they will be completed "swiftly". •

DHB chief executive's resignation 'a huge loss'

THE CHIEF executive who led Canterbury District Health Board through earthquakes, the mosque terror attack and the COVID-19 pandemic, David Meates, has resigned, effective from September 4.

Christchurch-based NZNO lead organiser John Miller, said he was "a brilliant chief executive. His resignation is a huge loss. We had a good relationship with him. He was always accessbile and that was an absolute bonus for us".

NZNO chief executive Memo Musa echoed these sentiments. In the early stages of the hospital rebuild, post the 2011 earthquake, Meates sought engagement with unions and professional associations and wanted their input. "He took that approach with other major changes at the DHB. As a peer, he was a good person to work with," Musa said.

Miller said he did not know the background to the resignation. "Clearly something is going on and that's a concern."

The DHB has a ballooning deficit and a Crown monitor, Lester Levy, in place. The Ministry of Health and Levy have called for drastic funding cuts, according to *The Press*. Meates has been outspoken in his call for more funding for the DHB, particularly for mental health services. •

Racism 'not tolerable' in nursing profession

RACISM IS "simply not tolerable in our profession", according to the chief executive of the Nursing Council, Catherine Byrne. She was commenting on an interim decision of the Health Practitioners Disciplinary Tribunal (HPDT) to cancel the registration of a Taranaki nurse for racist comments about Māori she had posted on a public NZNO Facebook page in May last year.

Council chief executive Catherine Byrne

The tribunal, in its decision released late last month, found Deborah Kathryn Hugill guilty on two charges, amounting to professional misconduct. She has 21 days to appeal the decision.

The charges were brought by a professional conduct committee (PCC) of the Nursing Council and it was the first tribunal case involving a practitioner making inappropriate comments on social media. The first charge related to Hugill's racist comments posted on Facebook and the second to her continuing to work as a nurse after her practising certificate was suspended by the Nursing Council in July last year.

The tribunal found the charges established and stated it was left in no doubt the nurse's Facebook post on May 4, 2019, was highly offensive, derogatory to Māori and inappropriate for a member of the nursing profession to post on a nursing organisation social media platform.

In a statement to *Kai Tiaki Nursing New Zealand*, the Nursing Council welcomed the decision. It was as an issue of public safety, was unacceptable and the nursing profession could not tolerate racism, the statement said. The tribunal found the nurse's conduct fell below the standards expected of any registered nurse or health professional. The council's role was to protect the safety of the public by ensuring nurses upheld the standards of the profession and abided by the council's code of conduct.

Byrne later said she hoped the council's strong stand in this case would empower others in the sector to take a similar stance. "This is a very important issue. Racism is simply not tolerable in our profession,' she said. •

'Overwhelming response' to council elections

THE NURSING Council has received 31 nominations for its three board positions elected by the profession.

Council chief executive Catherine Byrne said this was "an overwhelming response. The council is heartened by the high calibre and diverse candidates and encourages all nurses to vote".

These governance roles were important, as they were elected by the profession for a three-year term, she said.

A number of the nominees have had close connections with NZNO, including former associate professional services manager Hilary Graham-Smith, former president Marion Guy, former NZNO board members Juliet Manning and Maria Armstrong (a current council board member) and a former NZNO kaiwhakahaere Brenda Close, who is also standing for NZNO president. A former council chief executive Marion Clarke is also on the list. A full list of the nominees appears on p48.

Voting closes on September 4. Once elected, the candidates will then be officially appointed by the Minister of Health, Byrne said. •

Student leader remembered

NZNO STUDENT leaders and fellow students at Nelson Marlborough Institute of Technology (NMIT) are mourning the death last month of National Student Unit (NSU) vice-chair Trudi Kent. She died in Nelson, surrounded by loved ones, having been flown home from Wellington Hospital by Life Flight, after being involved in a serious car accident.

In a tribute posted on a Givealittle Trudi Kent community fundraising page, her close friend at NMIT, Shannon Norton, described her as "a beautiful soul who had a profound impact on people's lives whether she had known them for five minutes or five years . . . Trudi was an amazing daughter, sister, friend and nurse".

Trudi Kent at the first NSU meeting of 2020 in Wellington.

NZNO chief executive Memo Musa, in a letter to Trudi's parents expressing NZNO's deepest sympathy, wrote: "Trudi was emerging as a future nursing leader. She and Shannon had worked together regionally and were doing great work together to promote NZNO and to support fellow students studying at NMIT. They approached this work with great positivity. Local NZNO staff enjoyed the contact they had with Trudi and remember her very fondly."

He also praised her as NSU vice-chair. "She approached her role with enthusiasm and passion. As a student leader, she endeavoured to make a real difference in raising concerns on behalf of other students and would no doubt have been a compassionate and caring registered nurse."

Funds raised through the Givealittle page (https://givealittle.co.nz/fundraiser/trudi-kent-fund) will be divided equally between Nelson Marlborough Rescue Helicopter, Ronald McDonald House and Life Flight. •

Nurses 'must report violence'

"LEVERS ARE being pulled" to try to tackle widespread violence and aggression against nurses, an NZNO workshop in Wellington this month was told.

New Zealand's workplace safety regulator, Worksafe, and the Australian Nursing and Midwifery Federation (ANMF) joined the August 4 workshop, intended to strategise on what steps were needed next to better protect nurses, professional nursing adviser Suzanne Rolls said. "The purpose is to define the actions needed by NZNO to address violence against nurses, midwives and health workers."

WorkSafe NZ's general manager health & technical services, Catherine Epps, said the regulator was keen to work with NZNO, other unions and district health boards to address the problem. "Levers are being pulled and we want to come with you on this journey," Epps said.

WorkSafe inspector Sharon Cox, a former nurse, emphasised the importance of documenting incidents. "If people don't report things, they become anecdotal, a bit of a whisper," she said. "We all have a duty to ensure we are reporting things." However, reporting processes must be facilitated, to encourage this.

NZNO research showed violence and aggression against nurses was "really prevalent" – particularly verbal – but significantly under-reported, principal researcher Jinny Willis said. The 2019 research suggested this was because nurses believed patients were confused, or it was just "part of the job", Willis said. "But it's still not okay, so I don't know how we change the mind set of nurses that . . . [violence and aggression] is not okay and needs to be reported."

NZNO lead organiser John Miller suggested health workers under-reported as they had "no hope" of change.

NZNO medico-legal lawyer Sophie Meares discussed how nurses' duty of care required them to provide care only in "reasonable" circumstances. A nurse's safety in potentially violent or harmful situations was a factor in determining what could reasonably be required of that nurse. "If there is an imminent risk in providing that care, then they don't have to provide that care, as it's not reasonable in the circumstances."

ANMF health and safety co-ordinator Kathy Chrisfield zoomed in from a locked-down state of Victoria, to share how the union successfully implemented its 10-point plan to end violence and aggression. NZNO is hoping to model a "New Zealandised" or "Aotearoa-ised" version of the ANMF plan, NZNO's manager of professional nursing services Mairi Lucas said at the workshop. •

Advice for working in quarantine

NZNO EXPECTS nurses to talk to their primary employers before taking on any extra shifts at managed isolation or quarantine facilities, acting associate manager of professional nursing services Kate Weston said.

Reports of nurses working extra shifts at isolation and quarantine facilities have raised fears over the risks of spreading COVID-19. But Weston said: "Somebody needs to do this work, and there is only a limited pool of sufficiently qualified nurses who are available and want to."

For those working in managed quarantine facilities, the Ministry of Health's recommended 48-hour stand-down period before returning to another workplace should be observed, and a designated workforce created, where possible, she said.

COVID-19 testing was required as protection for both staff and the public to minimise risk of community spread, Weston said. Strict protocols must be adhered to for personal protective equipment. NZNO did not support working back-to-back shifts or on days off, as it increased the risk of COVID-19 contamination and nurses' fatigue. Those working with "highly vulnerable" patients should "consider carefully" whether to take extra shifts. •

Atele Pepa and Jean Al-Daghestani

Workers' plea for safe staffing

AGED-CARE workers gathered around the country on July 21 to plead for safer staffing levels, in a joint NZNO-E Tū event.

One Lower Hutt aged care health-care assistant (HCA) Atele Pepa told *Kai Tiaki Nursing New Zealand* residents' needs were higher than 10 years ago, with many needing almost hospital-level care.

That made caring for them "very challenging", said Pepa, who has worked in aged care for 13 years. "During cares, before, we used to have a very nice chat with the residents, and we learned a lot from them. Some of them really like to tell their stories, we used to really value those conversations. But we don't have that time now."

Registered nurse (RN) Jean Al-Daghestani later said people were living longer with more complex conditions, requiring significant support when they eventually went into care. "What I see is a lot of compassionate, hard-working staff who want to sit down and have that cup of tea, but don't have the time, as they have to go and help another person."

Retired Lower Hutt caregiver and equal-pay champion Kristine Bartlett people needed "encouragement" to come forward.

An open letter from aged care workers to the Prime Minister seeking mandatory safe staffing levels can be signed here: www.together.org.nz/safestaffingnow.

NZNO organiser Laura Thomas said 15-year-old voluntary guidelines were "shockingly" out of date.

Another event is being held in Waikanae's Presbyterian church on August 18 at 7pm. •

Nurses' views mixed

By co-editor Mary Longmore

Nurses appear to hold mixed views on the possible impacts of legalising cannabis. The Cannabis Legalisation and Control Bill will be voted on in a referendum on September 19, in conjunction with the general election.

NZNO college of child and youth nurses (CCYN) acting chair Sarah Williams said there were a range of views among members on the proposed legalisation of recreational cannabis. But the committee shared a concern that young people would find it easier to access cannabis if it was legalised – even with a minimum age of 20.

The Bill has the support of the New Zealand Drug Foundation, which says prohibition has failed.

The aim of the legislation is to reduce cannabis-related harm by controlling the supply chain, raising awareness of health risks, and limiting how much individuals can grow and buy.

Nurses were aware cannabis had strong links to mental health disorders in young people, Williams said. However, members also believed that incarcerating young people for cannabis-related offences was "more harmful than beneficial".

"If the referendum outcome legalises the use of cannabis, New Zealand will need to ensure we have the capacity and resources to increase addiction support services."

Mental health nurses' section chair Helen Garrick said while the committee preferred not to comment, she personally had concerns about legalising recreational cannabis, which "undoubtedly has an effect on mental health".

Risk to young males

Evidence suggested those who began smoking cannabis earlier were at higher risk of developing mental illnesses such as schizophrenia, bipolar disorder, anxiety or depression. Young males were particularly at risk, she said. "Adolescence is when these illnesses can start to emerge – so it's not a great time to start using cannabis."

Secondly, the greater the range of drugs people used, the more likely they were to develop mental health and addiction problems, Garrick said. If cannabis were to become more available, more support services were needed for those who became addicted. "So, it's lovely to say 'it's a health issue, not a criminal one', but we are ethically obliged to increase addiction services for those who need them. "It's not as simple for some people to have a little drink or smoke sometimes – not everyone is able to do that."

Drug Foundation executive director Ross Bell told NZNO staff in June the foundation would welcome the legalisation and regulation of cannabis, as prohibition was "a system which has failed us and failed so many people". But it depended on the quality of the legislation. He hoped legalising recreational cannabis would make it "safer and easier for people with problems to get help".

Currently, a small number of people were "carrying the burden for all of us" when it came to cannabis-related punishment – mostly Māori and young people. Māori were four times as likely to be prosecuted for cannabis use than non-Māori, he said.

The foundation's policy and advocacy manager, Katie Mercier, said the current prohibition of cannabis was "basically anarchy and chaos". Most people were "pleasantly surprised" when they looked at the bill in detail. "The Bill is all about trying to reduce the harm, it's a really public health focused bill," she said. "It's a world-leading piece of legislation."

Trying to reduce harm

The foundation did not wish to see cannabis "normalised", she said. "We are dealing with a harmful substance." But "on every count" the Bill was stricter than current rules for alcohol and tobacco consumption – and she hoped any law change could lead to better controls for alcohol.

A proposed Cannabis Regulatory Authority would ensure every part of the supply chain was licensed. In Colorado, when cannabis was legalised, its use among teens dropped "sharply" by almost half, she said. The foundation wanted to focus on social equity, ensuring communities, indigenous people and small businesses benefited from cannabis sales rather than large corporates or "big cannabis".

NZNO nursing policy adviser/researcher Sue Gasquoine said NZNO will develop a position statement on the regulation and recreational use of cannabis when the referendum outcome was known.

Professional nursing adviser (PNA) Angela Clark said many colleges and sections acknowledged that individuals would vote according to their personal opinion. PNA Marg Bigsby said she had concerns about the impact of cannabis on the developing brain, which recent research suggested did not fully develop until the age of 25. "So we need to think about making the legal age limit even higher than 20, like 25."

Details of the Bill can be found at www.referendum.govt.nz. •

Race as an influencer

By Leanne Manson,
NZNO policy adviser, Māori

"Race will influence whether we survive our birth, where we are most likely to live, which schools we will attend, who our friends and partners will be, what careers we will have, how much money we will earn, how healthy we will be, and even how long we can expect to live." This quote from Robin DiAngelo's book, *White Fragility: why it's so hard for white people to talk about racism*,[1] is a stark reminder that race plays a big part in how we can be treated, educated or have our opportunities marginalised or limited.

As Martin Luther King Jr observed, *"the ultimate tragedy is not the oppression and cruelty by the bad people but the silence over that by the good people"*. Racial discrimination is alive and well in Aotearoa New Zealand. The silence of good people has perpetuated health inequities and racism. The latest research from Otago University indicates deeply entrenched inequities for Māori in terms of cannabis convictions.[2] We can no longer ignore, or be silent, on this issue.

Globally, racism is an ongoing public health crisis. There are many examples of racism and many personal stories describing poor treatment just because of the colour of their skin. Racism pervades the health and justice systems of America, from the brutal death of George Floyd, to the many black Americans infected or who have died in the COVID-19 pandemic. This was because they were more exposed, less protected and over-represented in low-paid frontline jobs as home health aides, transit drivers, postal workers, sanitation workers, hospital orderlies, grocery workers and warehouse workers.[3]

Further, the zip code (post code) is a better predictor of health than genetic make-up. This is seen in the profound differences between black and white Americans' annual income, housing, and access to healthy food, green space, clean air and clean water.

In recent testimony to the US House of Representatives Committee on Education and Labor, Camara Jones (a public health academic and past president of the American Public Health Association) raised issues about racial disparities in health outcomes arising on three levels: difference in quality of health care, differences in access to health care and differences in underlying exposures and opportunities, which make some individuals sicker than others. She believes health equity should involve an assurance of the conditions for optimal health for all people.[4] However, we know that the system fails to deliver this.

In Aotearoa New Zealand, we have our own stories of racism. The Human Rights Commission's latest campaign, "Give nothing to racism", is asking us to stop being silent on this issue.[4] Racial stereotyping and systemic racism have led to an unjust over-representation of Māori and Pacific people in the justice system. The "Give nothing to racism" website makes suggestions on how to combat this problem. They include reflecting on how you'd be affected if you were constantly suspected of being a criminal just because of your race. Read and believe the stories of those who were treated differently in the justice system. No longer should we tolerate stories about a Māori woman being refused a rental property because of assumptions that as a Māori she must "wreck houses, and have gangs and the drug life".[5]

Sentenced more harshly

As health professionals, we hope our patients and whānau have all the facts to make informed decisions. Being informed of the impacts of racism on Māori in the justice system is particularly important for voting in the cannabis referendum. For instance, rangatahi Māori (youth) are far more likely to be criminalised and sentenced more harshly for cannabis use from a young age, when compared to non-Māori youth who use cannabis the same amount.[2] This is a clear issue of race injustice.

NZNO has long supported treating cannabis use as a health issue rather than a criminal one. Further, cannabis use can negatively affect young people's wellbeing and health. I encourage you all, as health professionals and Tiriti partners, to read the latest research (it's only 17 pages),[2] and make an informed decision. Racism prevents people from achieving their full potential and causes harm that can affect families and communities for generations. Let's stand together to make change and give nothing to racism. •

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Palliative care is a specialty

All nurses should be able to provide good palliative care and all New Zealanders should have equitable access to palliative care, according to a leading academic in the field.

By co-editor Teresa O'Connor

Aileen Collier has always been intellectually curious. That curiosity has fuelled a nursing career which has included working in remote areas of her native Scotland, a "life-changing" two years supporting nurses in Laos, time as a social care worker, and senior clinical leadership positions and PhD studies in Australia.

The latest, but possibly not the last, destination on her peripatetic nursing journey is Auckland. When the opportunity arose to work in the University of Auckland's bicultural multidisciplinary Te Arai palliative and end-of-life care research group, led by Professor Merryn Gott, Collier grabbed it. She arrived in early 2017. Along with her research programme focused on safety, equity and palliative care, she teaches research methods to postgraduate students in the school of nursing and does occasional casual work as a clinical nurse specialist (CNS) with West Auckland Hospice. She's also the chair of Palliative Care Nurses New Zealand (PCNNZ), a role she's held for the last 18 months.

Her intellectual curiosity was fostered at Abertay University, Dundee, where she gained "a very high quality nursing education" in 1991. She was in one of the early cohorts to gain a nursing degree.

Specialty became her passion

She first worked in the specialty that was to become her passion in a new inpatient palliative care unit in Dunfermline, Fife. A community role as a Macmillan nurse in Morayshire, in Scotland's north east, confirmed that palliative care was where her "passion, skills and gifts" lay.

Not suited to a conformist nursing life, in 2001 Collier then "took off to Laos on a life-changing experience". There, under the auspices of Volunteer Service Overseas, she supported nurse educators in Savannkhet and Champone district. Working where there were often no toilets, poor equipment, where dengue fever was rampant and the people in very poor health, she was taken back "to the roots of what it is to be a nurse".

'Crisis of profession'

Her experiences there made her question "everything about what it meant to be a nurse. I was having a crisis of profession".

In a bid to answer those questions and resolve that crisis, Collier became a social-care worker in Scotland. She cared 24/7, week on, week off, for a man with multiple sclerosis. As the person responsible for care, with nurses visiting for just 10 minutes at a time, she gained a very different view of nursing.

In 2003, Australia's warmer climes beckoned and she took up a CNS position in south west Sydney, leading a team of community palliative care nurses in a "hugely diverse and rapidly growing community" – where 40 per cent of the community did not speak English at home as their first language". Here she was able to retain the Lao language she had learnt.

A role as a lung cancer clinical nurse consultant at the Royal Prince Alfred Hospital in Sydney followed – "a huge learning curve, bridging the gap between oncology and palliative care". From there, she returned to south-west Sydney to project-lead the implementation of the Liverpool Care Pathway at Liverpool Hospital, despite some scepticism about the pathway. "It was a tool to have end-of-life conversations, but I found it created more questions than answers."

She was concerned about the "tick-box" approach inherent in the pathway and the general "formification" of nursing. "The pathway provided a vehicle to improve care but had unintended consequences. Eventually, the funding attached to the document overrode the care."

'To provide good palliative care in generalist settings, nurses needed education and appropriate support and resources' – Aileen Collier.

These concerns and her continuing curiosity about nurses' role in palliative care drove her to begin PhD studies. Her PhD, undertaken through Sydney's University of Technology using video reflexive ethnography methodology, examined what would constitute a safe, healing space at the end of life. Her social science PhD gave her exposure to thinking outside her discipline and suited her questioning nature. Her studies concluded that bringing together clinicians' expertise with the patient's and family's knowledge, experience and expertise was what produced a safe space at the end of life.

After completing her PhD, she moved to an academic role at Flinders University in Adelaide and subsequently to Auckland. She was – and remains – impressed with the professionalism and quality of senior palliative care nurses here.

"Those working at CNS and nurse prac-

‘but not just for specialists’

titioner levels have a high level of skill, professionalism and capability.”

But there are significant challenges for both the specialist and generalist palliative care nursing workforces. “For example, nurses working in hospice in- patient units often find it very difficult to access research support and resources. While hospices generally provide experienced, high-quality nursing care, a challenge can be the isolation from what is happening in the rest of health care, resulting in what can become a skewed view of how many people with palliative care needs are cared for,” Collier observed.

The biggest challenge

The biggest challenge is equipping all nurses to provide good palliative care. “This is essential, given the context of an ageing population with multiple morbidities, increasing numbers of people with dementia and with chronic illnesses, and a Māori population which dies younger and often receives less culturally safe care. We are not building the capacity of junior nurses well enough to provide a palliative care approach.”

One of the messages she is keenest to convey is that, while palliative care nursing is a specialty, it is not just for specialists. “All nurses should be equipped and able to provide good palliative care, wherever they are practising.”

To provide good palliative care in generalist settings, nurses needed education, support and resources. Specialist palliative care services also face significant challenges, including lack of access to research, too few Māori and Pasifika nurses and an ageing nursing workforce.

Inequity of access

Inequity of access for many, including those living in aged residential care, people with cognitive impairment, for Māori and for those living rurally, was another challenge. “It’s all I bang on about,” Collier says with a rueful smile.

A significant problem is how to get nurses to value caring for older people. Aged care languishes at the bottom of new graduates’ practice preferences. Collier understands this lack of enthusiasm. “When you look at the resourcing of aged care, the number, pay and status of nurses, and the nurse-to-patient ratios in the sector, new graduates’ reluctance to work in the sector is understandable.”

She hopes COVID-19 will be a “game changer” in how we care for and value older people. “When the skills of palliative care as a specialty, are combined with those in aged care, with its focus on quality of life and rehabilitation, great care is possible.”

Reaching across disciplinary silos and focusing on what matters, what’s important and what people need, is essential to providing good palliative care, as is changing attitudes to death and dying.

“How do we face death and dying as a community? How do we talk about it in schools? We need to normalise what death is and how it looks and we have shied away from doing that. Often junior nurses have never seen someone die.”

Collier would love to see the sharing of intergenerational wisdom about death and dying. She urges nurses to “be themselves” when giving end-of-life care and to remember the person is still living.

Collier said PCNNZ was “all about building the capacity of nurses, advocacy for nurses and equitable access to quality palliative care in New Zealand”. To achieve its aims, and to ensure the voice of palliative care is integrated into all health strategies, it works in close collaboration with the other national lead organisations in Aotearoa, the Australian & New Zealand Society of Palliative Medicine, Hospice New Zealand and Hospital Palliative Care New Zealand.

Collier would rather focus her energies on closing the gaps in palliative care provision to ensure equitable access for all than on the upcoming referendum on whether the End of Life Choice Act 2019 will be enacted. (Collier’s detailed view on the Act can be found at: www.stuff.co.nz/national/health/euthanasia-debate/121961504/end-of-life-choice-comes-down-to-compassion.)

However, she says the Act will have significant implications for all nurses and urges them to read the viewpoint, “End of life choice – do nurses know what they are voting for?” published in last month’s issue of *Kai Tiaki Nursing New Zealand* (p32-33).

“All nurses need to read the Act carefully and research the evidence and make an informed decision before they vote.” •

PHOTO: ADOBE STOCK

‘When the skills of palliative care as a specialty are combined with those in aged care, with its focus on quality of life and rehabilitation, great care is possible.’

Providing palliative care in aged care

Providing palliative care in aged care poses many challenges, according to a manager of an aged residential care facility.

By co-editor Teresa O'Connor

Working in aged care has meant Kim Tayor has had to acquire "a lot of new skills sets" from those she had needed earlier in her career.

Trained at South Auckland's Middlemore Hospital in the mid '70s, for the next 20-plus years she worked at Green Lane Hospital, back at Middlemore and completed Green Lane's cardiothoracic and vascular nursing course and the advanced diploma of nursing. She also had two children during this time. In 1999, she moved to MercyAscot Hospital and worked there until moving to Wanaka in 2003.

She had a break from nursing and, with her husband, ran a small business. They sold that in 2012 and Taylor completed a return-to-nursing course. She has been working in aged care since then, first in the community and, since 2016, at Presbyterian Support Otago's Emslie House where she is currently the acting manager.

Emslie House has 31 "dual beds", with a mix of rest-home and hospital-level residents. There are around 47 staff – 13 part-time and casual registered nurses (RNs) and 22 caregivers, who are a mix of local and those on work visas.

Emslie House acting manager Kim Taylor chats with resident Margaret Adams.

Complexity of the work

As her parents aged, she became aware of the complexity of working with elderly people. "This was new to me and required a lot of new skill sets from those of nursing roles I had done in the past."

It was those new skills and the challenges of providing that complex, ongoing care that has kept Taylor in the sector. One significant aspect of that complex, ongoing care is the provision of palliative care to residents.

"Many residents are here because they are entering the last phase of their lives, so we always have a number of residents needing palliative care. They are cared for by the RNs and caregivers, with support from the multi-disciplinary team," Taylor said.

This team includes local GPs – there are two medical centres in Wanaka – a nurse practitioner (NP) from one of the general practices and another from Central Otago Community Hospice in Cromwell, and local physiotherapists and occupational therapists.

The NP from the community hospice, Louisa Ingham, visits most weeks. "We discuss the needs of our current palliative care residents and we also discuss those whose health is declining and who are likely to become palliative. We can also call Otago Hospice [in Dunedin] any time for advice."

Taylor describes the input and support from Ingham, in an initiative funded by the Southern District Health Board, as a "game changer for us" in terms of the quality of the palliative care the facility provides. "Ultimately, all our residents are palliative, not just those in the last few weeks or days of their life. With Louisa's support and guidance, we are always looking out for those who may become in need of acute palliative care."

The NP from the local general practice, Rebecca Grant, is "passionate about older people's health" and provides a good deal of support, as do the local GPs.

Avoiding hospital admissions

"When a resident is receiving palliative care, the local NP and the GP regularly review them. Ninety-nine per cent of residents want to die here at Elmslie House with their family by their side.

Most symptoms can be managed without an admission to hospital and both NPs and the GPs support this and will do all they can to ensure a resident does not have to be admitted to hospital and can die at Elmslie," Taylor said. "It's a success for us if a resident is not admitted to hospital."

Occasionally a resident will need hospital for an acute symptom, "but in reality that doesn't happen very often". The nearest hospital – Dunstan Hospital in Clyde – is 80km away.

Peaceful death 'a great comfort'

When a resident passes away peacefully at Emslie House, it is a great comfort to families and to staff, Taylor said.

Providing good palliative care often means "all hands on deck" as there is only one RN on duty per shift, and s/he also has to oversee the 31 residents and care staff. "We also have a number of level-four carers who are experienced and also provide excellent palliative care." The facility's clinical coordinator – Taylor's role before she became acting manager – and the manager also help out as needed.

"There are many resources to help us provide palliative care well. I like and regularly use the *Te Ara Whakapiri Toolkit (Principles and Guidance for the Last Days of Life*), which is an excellent resource from the Ministry of Health and the *Frailty Care Guidelines* available from the Health Quality & Safety Commission."

Some training and development for both RNs and carers is available through the Otago Community Hospice. The hospice offers courses in palliative care for caregivers and syringe driver education twice a year for RNs.

Taylor is the local convenor for, and hosts the monthly palliative care lecture series at Presbyterian Support Otago's other facility in Wanaka, the 52-bed Aspiring Lifestyle Care Centre. That facility also has a dedicated palliative suite.

Community hospice NP Louisa Ingham is available for debriefs when a resident has died and is happy to be contacted by staff for one-on-one sessions, Taylor said. These sessions can be on any subject. And being a long way from a large town or city, "we can take advantage of any webinars available as well". A lot of education and support this year has been disrupted by the COVID-19 pandemic.

Taylor said one of the major barriers to providing quality palliative care in aged-care faciities is time – "time to spend with the resident and their families without disadvantaging other residents".

One of the major barriers to providing quality palliative care in aged-care faciities is time – time to spend with the residents and their families without disadvantaging other residents.

Another issue is the loss of RNs to higher-paying jobs at the Southern DHB. "In the last six months, we've lost four RNs to the DHB, so constantly orientating and upskilling new RNs in palliative care impacts on the quality of care at the end of life."

She doesn't think the need to provide good palliative care in aged-care facilities is well understood. "People tend to think 'hospice' when they think of palliative care. Our focus is on helping our residents die well and this support can start many months before they die, not just in their last days. It involves the resident, their family, their GP and other members of the multi-disciplinary team and includes updating and adjusting advance care plans as the resident wishes."

But despite the challenges, the rewards are profound. "I would like all nurses to understand that, regardless of the practice setting, it is a privilege to be able to provide good quality palliative care and to be part of a resident's journey at the end of their life and to support their family." •

Boosting staff's skills and confidence

THREE NURSE practitioners (NPs) work with aged-care facilities in Otago to support staff provide the best possible palliative care to patients.

The Otago Community Hospice and Southland Hospice intitiative began in 2016 with Ministry of Health innovations funding, which is still funding the programme.

One of the three, Louise Ingham, is based in Cromwell and works with facilities in Central Otago, Wanaka and Queensland. "I visit the facilities regularly and review patients, provide support, suggestions and advice on care and can attend family meetings. I also provide formal and informal education sessions. There is flexibility within the role so I can be available if something changes for a patient and their needs become more acute."

Ingham said the initiative is working really well and has been mutually beneficial. "It is great to work with senior nursing staff to boost their knowledge, skills and confidence in end-of-life care. I am readily available and approachable, so it is easier for them to ask questions."

The collaboration benefits patients which is what makes the role so worthwhile, Ingham said.

And through the role, she has developed "huge respect" for aged-care workers. "The nurses and caregivers do amazing work. I didn't have that appreciation before I started this work."

Ingham works half time with aged-care facilities and half-time in the community. The aged-care role has evolved as the needs of aged care have evolved. "The hospice has the flexibility to ensure the role remains relevant to the needs of the aged-care facilities," she said. •

Preparing students for end-

How can nursing students best be prepared for end-of-life and after-death care?

By Faye Davenport

We are living in times where the proportion of older people in the total population is increasing. According to the 2018 Census, the proportion of people in New Zealand aged over 65 years was 18.3 per cent and by 2038 it is estimated it will be 25.9 per cent.[1] The cultural diversity of our nation, and hence of our health-care workers, also continues to increase. In 2019, internationally qualified nurses made up 27 per cent of nurses working in New Zealand.[2]

Nurses experience and witness the beginning and end of life. Both are privileged places to be, where life sometimes hangs in the balance. These can be times of triumph or of tragedy and nurses are in the midst of these situations. As the health professionals who spend the most time with patients, it is nurses who are most likely to be at the bedside when patients die.

Everybody has only one opportunity to die and, for those who die in hospital, hopefully the patient dies in peace, surrounded by those the patient wishes to be there. But what is it like for the nurse at the bedside?

We live in a society that does not yet comfortably and openly discuss dying and death. That is until we, or someone close to us, is dying.

We live in a society that does not yet comfortably and openly discuss dying and death. That is until we, or someone close to us, is dying. Death is something that happens to other people and we do not confront it until it confronts us. With the diversity of cultures in society and nursing, there will be differing beliefs, values and attitudes regarding palliative care and death. Palliative care may be a completely new concept in some cultures. Even using the word death can sometimes be challenging and uncomfortable. We talk about "passing away", "passing over" or "passing on". We use phrases such as "gone to sleep", "gone to a better place".

When someone has died in hospital, how do we clearly indicate the finality of what has just occurred at the bedside? How do we communicate clearly to the family members what has happened to their loved one?

Nurses will have different professional and personal experiences of caring for those who are dying and at the time of death.

This paper explores the thoughts and experiences of first-year nursing students before their first clinical placement in aged care. These thoughts and experiences were gleaned through classroom conversations and reflections, which began in 2018. I was interested to see if the themes raised in the experiences the students described were common in the literature. This led me to conduct a literature review (2004-2019).

The first-year nursing students had been in the bachelor of nursing (BN) programme at the Universal College of Learning in Palmerston North for about four months. Before starting their aged-care placement, the students had completed a professional nursing paper, a skills paper, as well as four days specifically preparing for the first clinical placement.

The professional paper explores the ethical aspects of, the boundaries and possible conflicts for nurses caring for their own family members at the end of life. In the skills paper there is a discussion of the physical and emotional aspects of nursing care of the dying. The students are asked to reflect on some key questions, discussed later in this article. Preparation for the clinical placement is four days in the week before the placement begins. This is really useful as a more intense focus on what the students may be faced with during their placement in aged care. There are whole group discussions and small group work. There is time to discuss previous experiences, both professional and personal, and emotions. This includes highlighting fears and anxieties about caring for the dying and care at the time of death.

Nurses feel unprepared

A common theme in the literature is that nurses do not feel adequately prepared to care for those who are dying and their family, or to provide care at the time of death. Nurses reported they lacked experience and knowledge, they felt incompetent and insecure and/or were not ready to provide the care.[3]

Caring for the dying is challenging, stressful and demanding, and nurses may question their ability to cope.[4] One group of researchers reported that the nurse's first experience of care of the dying was emotionally influenced by the situation but that they lacked the necessary skills to cope.[5]

These findings prompted the question: How might first-year nursing students be best prepared to care for those who are actively dying, and at the time of death? Nurses enter the BN programme with a wide variety of experiences in care of the dying or with no experience at all. Some of the experience is professional, eg a student who had worked as a health-care assistant. Other experience is of a more personal nature, such as care of a family member or friend.

Experiences of death are also varied, from sudden and unexpected death (motor accident, suicide, cardiac arrest in the community) to end-of-life care of a grandparent. Someone's age when they experienced caring at the end of life or the death of somebody close was an important factor in their ability to cope. If young at the time of the experience,

-of-life care and death

PHOTO: ADOBE STOCK

'Caring for the dying is challenging, stressful and demanding and nurses may question their ability to cope.'

the students described: *"I cried and cried . . . I wasn't prepared for the death."* If older at the time, students reported they were more prepared for later experiences of death.

When asked if their previous experience made them more or less anxious about care of the dying in their upcoming placement, the majority of the students reported feeling less prepared, even in light of that experience. Their reaction was along the lines of: *"I don't know how I will react, my previous experience comes back to the surface, I am very emotional, I am unsure of the process of dying."*

Some of the students felt both more and less prepared, depending on the circumstances of the death they had already experienced. A few students reported feeling more prepared due to their past experience. One explained: *"I know how I will react, what to expect, how it feels to wait (for death to occur), how I will handle this, how it feels to support those closest to the one who is dying."*

Previous experience does not necessarily prepare the students for their first death in clinical practice.[6] From the classroom conversations it emerged that a number of students were more anxious, while others were less so.

If the students said they felt more anxious, this anxiety was due to a number of factors; firstly, the fear of not knowing enough. These fears were related to inadequate clinical skills, not knowing what to do or say, fear of the unknown and not knowing how to manage a situation. Students fear not knowing what to say or just how to answer a question.[7]

A fear of 'messing up'

Secondly, anxiety is due to the fear of "messing up", of making a mistake, of being insensitive, or of putting a life at risk. Students may feel helpless, guilty and distressed, lack the required skills, lack someone to speak with, and experience anxiety related to care of the dying, as well as care of the deceased body.[8] The anxieties related to care of the dying and after-death care are often separate anxieties: students may be anxious about one but not the other, or about both.

Thirdly, a major theme, both in the classroom conversations and from the literature, was the fear of not being able to control their emotions and anxiety about how they would react, eg crying or panicking. Students felt emotionally unprepared,[8] feared losing control and not being able to support the patient.[7] One group of researchers found that students required more experience in how to manage their own sorrow.[7]

How to reduce students' anxiety

Our UCOL students were asked what would be most helpful in reducing their anxiety. Some of the answers were related to pre-clinical placement and some to during the placement. The responses have been captured under five "Cs".

- The importance of open **conversations**: What will happen? What do I do in the situation? What do I say to family members at the bedside? Part of this was having clear guidelines (policies and protocols) about what to do, eg how to care for the dying and after death care.[6] What students felt would help ease their anxieties included: the opportunity to talk to family, peers, and lecturers about the process of dying and death; taking time to have conversations about the end of life and not putting off such conversations due to a perceived lack of time or discomfort in relation to this.[7]
- Secondly, it was deemed important that the students felt **comfortable** with their preceptors. This was a major area of concern. *Will I be accepted into the clinical area? Will I get on with the preceptor? What if we clash?* were common concerns.

Being assured that support from the preceptor and peers would be available, and reassurance they would not be alone in the experience, were ways of easing their anxieties. A good orientation to the facility and feeling comfortable to ask for help were also discussed.

- Thirdly, having **confidence** in, or being **competent** in their clinical skills. This was the ability to carry the skills they had learnt in the skills lab into the clinical area.
- Fourthly, part of the preparation for the clinical placement was being provid-

ed with strategies to manage emotions. Part of this was keeping the pathways of **communication** open [5, 8] and being able to discuss, with their preceptor and lecturer, how they were feeling. Students felt reminders to be kind, to believe in themselves and to remember they were in a new situation would be helpful.

Therapeutic relationships

Building effective therapeutic relationships is important – relationships between the student and peers, the preceptor, other clinical agency staff, as well as the clinical lecturer. This is crucial, as it enables students to feel comfortable during the clinical placement to ask questions, to discuss their feelings and reactions to situations, and to seek support in an honest and open way. Some of the support may be one-to-one with the preceptor, group meeting with peers and/or the lecturer.

A critical part of the support offered to the student before and during the clinical placement was the preceptor's and lecturer's attitude to death.[7] What is the preceptor's and the lecturer's experience of, and comfort with discussions about societal views, as well as their own attitudes? It has been reported in the literature students have not always been able to find staff with whom to discuss death.[3,6] The mentorship role is a major influence on the nursing student.[6] It is what is said, how it is said and role modelling that stays with the student throughout the training and on into his/her nursing career. The experience and support provided during the first clinical placement and the first death will have a major and ongoing impact on the student.

Lecturers in the BN programme have a key role in preparing the students for the first clinical placement. Much of this will take place in the classroom. It is crucial that a "safe space" is created in the classroom so the students and the lecturer can comfortably share their feelings, attitudes, stories and experiences. In this space the students can ask questions with ease. Common scenarios from the lecturers' own clinical experiences may be discussed. Discussions on *"What would you do in this situation?"* take place in small and large groups. Time is allowed for reflection and discussion of possible different approaches to the scenarios. In the first year of nursing, students require basic general knowledge and, in the third year, more specific experience and training is required.[5 8]

Some lecturers may find it useful to discuss stories from their personal experience, if they are confident to do this. A degree of vulnerability and risk may be involved in this. An example could be involvement in end-of-life care for a member of their family. This approach allows discussion of appropriate boundaries and possible conflicts of interest as a nurse caring for someone close to him/her. I used an example from my own experience as part of the professional nursing paper I teach. Following one class, an older student came up to me and said: *"Thank you for what you shared because if I was an 18-year-old student sitting in this class, I would have no idea of what you have just described."*

It may be that at least some of the students in the class will find themselves caring for a family member, or indeed several members, over the course of their nursing career. I am interested in exploring this in more depth in a later research project, with a view to developing a resource for nursing students at all levels in the BN programme.

Ongoing support needed

Nursing students require end-of-life care to be threaded through the BN programme. They also require ongoing support. I have developed a wrap-around support package, POD. "P" stands for the the pre-briefing before the clinical placement begins. This includes the "what to expect" when caring for the dying and in after-death care. What to expect can be demostrated through stories, scenarios and opportunities for discussion. "O" stands for the ongoing briefing (supervision and support) during the placement. This may include writing detailed reflections or exemplars, allowing students the opportunity to reflect on, and document their reactions and feelings. "D" stands for the formal and informal debriefing, both one-to-one and in groups, after the placement has ended. This may occur immediately after the placement and/or in ongoing papers/placements throughout the BN programme.

A variety of teaching and learning approaches are required to provide opportunities for students to explore beliefs, values, attitudes and experiences related to care of the dying and after-death care. The experience of their first patient death and the initial clinical placement will leave memories that will remain throughout the student nurse's career. It is crucial the experiences are positive in terms of the care of the patient and the family, and the support and guidance the student gets before, during and after the clinical placement. The key figures in ensuring therapeutic relationships are developed and students have positive experiences are the lecturers, clinical preceptors and agency staff. •

This article was reviewed by chair of Palliative Care Nurses New Zealand and senior lecturer in the School of Nursing, University of Auckland, Aileen Collier and the co-editors of Kai Tiaki Nursing New Zealand.

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Droplets and aerosols

GRAPHIC ADOBE STOCK

Is COVID-19 being spread by tiny airborne aerosols, as well as by larger droplets?

By Georgina Casey

Speculation about the role of airborne transmission in the spread of COVID-19 has focused on the differences between droplets and aerosols (also called droplet nuclei). Whenever we exhale air from our lungs – even in normal quiet breathing – we also expel mucus, saliva and water, which exit the mouth and nose as droplets of varying sizes.

The fate of these droplets, and the way they behave in the environment, depends on their size: larger droplets, being heavier, fall rapidly out of the air, while smaller droplets (aerosols) behave differently. The main forms of transmission of SARS-CoV2 are understood to be via direct inoculation, when large droplets from an infected person (expelled through breathing, coughing, sneezing, or from aerosol-generating procedures such as intubation or suctioning) contact the mucosa of another; or via fomite transmission, when heavy droplets contaminate surrounding surfaces and are transmitted to the mucus membranes of the next person via their hands.[1]

The recommended physical distancing of 1.5 to two metres (depending on country) is determined by the maximum distance that large droplets expelled during normal breathing and talking travel before falling out of the air. Coughing and sneezing cause large droplets to travel further – two and six meters respectively – before falling. These distances are also affected by the relative humidity of the air and the presence of air currents.[1,2]

Increasingly, aerosol scientists are arguing that the SARS-CoV2 virus is transmissible via much smaller airborne aerosols.[3] Once expelled into the environment, water evaporates from droplets and the smaller the size, the more rapidly this evaporation occurs. For droplets of less than 5 micrometres (μm) evaporation is sufficiently rapid to allow the droplet to stay airborne for prolonged periods. Studies of other respiratory viruses show that these smaller aerosols are more likely to penetrate deep into the lungs, while larger droplets tend to get trapped in the upper airways.[1]

The research is unclear however, on whether virus particles can survive in aerosols and in sufficient amounts to inoculate a person who inhales them. Evaporation of the water vapour in droplets creates a capsule that appears to protect viruses from brief exposure to environmental factors such as temperature and humidity changes and air pollutants.[1,3] However, there is little evidence yet about the survival of the SARS-CoV2 virus in aerosols.

The research is unclear, however, on whether virus particles can survive in aerosols and in sufficient amounts.

In one experiment, artificially generated aerosols containing viable SARS-CoV2 virus were found in air samples in a closed room for up to 16 hours, but viable virus has not been found in air samples in health-care settings when aerosol-generating procedures are not being performed.[2,4]

Spread of the virus in indoor settings with poor ventilation and crowding has also been considered an argument supporting airborne transmission. But according to the World Health Organization, this could also be explained by droplet and fomite transmission, especially if hand hygiene and physical distancing guidelines were not adhered to, or where there is a super-spreader (a person who sheds much greater numbers of the virus from their lungs than average).[2]

Nevertheless, anecdotal evidence of unusual spread, especially in indoor settings, is being used to question conventional thinking about the role of aerosols.[3] If aerosol spread is found to be a factor in the COVID-19 pandemic, then masks, adequate indoor ventilation, restrictions on indoor gatherings and the use of ultraviolet light during air filtration will become much more important in pandemic management.[3] •

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Slow CCDM progress has worrying echoes

Progress reports show district health boards are implementing CCDM too slowly. Meanwhile nurses are reporting working conditions and management attitudes worryingly reminiscent of the notorious Mid Staffordshire scandal.

By Maree Jones
NZNO CCDM project
implemenation coordinator

In June 2010, the United Kingdom (UK) Government announced a public inquiry to investigate care provided at Stafford Hospital, which was run by a government-funded National Health Service (NHS) trust. This was in response to community and patient concerns about care provided at the hospital and high mortality rates. The inquiry was chaired by barrister Sir Robert Francis QC.

His report, the Francis Report, released in 2013, concluded that *"patients were routinely neglected by a Trust that was preoccupied with cost-cutting, targets and processes and which lost sight of its fundamental responsibility to provide safe care."*[1]

He also concluded that the Mid Staffordshire NHS Trust's structure and culture of decision-making was deeply flawed, and had allowed serious care failures to occur. His report sharply heightened awareness of the consequences of staffing failures and highlighted that past nurse staffing decisions had been made without recourse to evidence.

An analysis of the evolution of nursing staffing policies in the UK, by former New Zealand Safe Staffing Healthy Workplaces Unit director Jane Lawless and colleagues, says: *"Prior to 2010, determining nurse staffing levels for hospital wards in the NHS was almost entirely undertaken at a local level, with little national guidance. From the early 1980s, these local nurse-staffing decisions were increasingly influenced by ongoing reforms and issues of funding and supply. De-centralisation of funding and decision-making, and the absence of centrally provided standards, guidance or regulation resulted in largely uncontrolled and unmonitored experimentation with nurse staffing."*

New Zealand's methods of determining nurse staffing were very similar to those described above.

The UK Government accepted the Francis Report findings that the failings indicated systemic issues within the NHS that required fundamental review.

Some might think, on reading the Francis Report, the same could never happen in New Zealand. But can we be confident that some of the problems of Mid Staffordshire could not be found in our hospitals and health system today? I was fortunate enough to attend a presentation by Sir Robert of his findings in Wellington several years ago. He warned that the Mid Staffordshire failings could happen in any health system in any country due, in no small part, to an increasing focus and priority on meeting targets and financial outcomes.

He warned that the Mid Staffordshire failings could happen in any health system in any country due, in no small part, to an increasing focus and priority on meeting targets and financial outcomes.

NZNO members regularly voice their concern and frustration at this emphasis on cost cutting and targets, to the exclusion of other important patient-care issues.

Nurses and midwives regularly tell us they are struggling to deliver care on tighter budgets, care is being left undone and morale and motivation are very low. Our health service is now under unbearable pressure, standards of care are inevitably dropping, patient outcomes are being compromised and treatment is being delayed due to staff shortages and increased patient acuity.

The UK safe staffing solution

Following the Mid Staffordshire inquiry, the UK government set up a commission to analyse the Francis Report recommendations and advise the government and the NHS on what needed to happen.

Initially, as a result of the report's recommendations on nurse staffing, the National Institute for Health and Care Excellence (NICE) was given the task of developing evidence-based nurse staffing policy guidelines. NICE is a non-governmental organisation responsible for producing evidence-based guidance and advice for health, public health and social care practitioners.

The aim of these guidelines was to ensure staffing levels were consistent with scientific evidence on safe staffing and that these were adjusted for patient acuity and the local context across all NHS-funded providers. NHS boards and organisational leaders were told to use evidence-based acuity tools and scientific principles to determine the staffing they needed to safely meet patients' needs and be accountable to regulators. Their methods and conclusions were to be made public and easily accessible to patients and carers.

Trusts were also to put new staffing transparency systems in place, including displaying the number of staff on each shift outside all inpatient wards, publishing monthly updates on staffing and providing a staffing review every six months to the trust's board.

Then, a new development. According to Lawless's analysis: *"In an unanticipated and unprecedented development, NICE's involvement in staffing guideline development was abruptly terminated in June 2015 ostensibly to integrate the*

PHOTO: TOBY MELVILLE/REUTERS - ADOBE STOCK

Sir Robert Francis delivers his report in 2013. He has warned such failings can happen anywhere.

issue of 'safe staffing' into wider service reviews by NHS England, and to include a more multi-professional approach. Future work was transferred to a planned new entity, NHS Improvement, which would provide 'a different approach to answering those questions [of] how staffing levels are determined'. This motivation for terminating the NICE-led guidance attracted widespread criticism, including from Robert Francis.

". . . Unlike the rigorous approach taken by NICE, there was no predetermined process and no explicit framework for incorporating research-based evidence into the resulting resources, although the original reviews undertaken for NICE were utilised in the new 'resources' and new summary reviews were commissioned. Communications from central bodies to providers highlighted tensions between the goals of safe staffing and resourcing constraints.

"This tempered NICE's recommendations by reinforcing local hospital's responsibility to balance staffing investment with other obligations, specifically quality, productivity and fiscal responsibility goals."[2]

Public reporting of staffing numbers throughout the NHS has also not yet been fully implemented.

CCDM progress

In New Zealand, in 2005, a joint NZNO/district health board (DHB) committee of inquiry (COI) was formed to look at the key components of safe staffing in New Zealand. All agreed an evidence-based solution was required. This led to the establishment of the Safe Staffing Healthy Workplaces (SSHW) Unit and the development of the care capacity demand management (CCDM) programme – a validated methodology consisting of a set of coordinated tools and processes. When implemented as intended, CCDM can deliver staffing closely matched to patients' care needs, 24 hours a day, seven days a week. It provides for staffing plans based on real patient demand (ie patient acuity) based on the professional judgement of nurses and midwives who understand patients' need for care better than anybody. This New Zealand methodology is world leading.

But is the implementation of CCDM progressing sufficiently that it's making a difference to the working lives of NZNO members and the quality of the care they can provide their patients?

In the 2018 NZNO/DHB multi-employer collective agreement negotiations, members delivered to DHBs the strongest mandate to date for insisting that *all* DHBs fully implement CCDM by June 2021.

To transparently monitor DHB progress towards this goal, the Ministry of Health required all DHBs to report their implementation progress every quarter, using a detailed, standardised reporting tool. Submission of these reports includes the equal involvement and endorsement of NZNO/DHB CCDM Council representatives (including either an NZNO organiser or professional nursing adviser).

All 20 DHBs recently submitted their quarter three CCDM implementation progress reports. The results show that with, just under a year left, DHBs have made slow progress overall, with the programme 45 per cent complete nationally.

The most important component of the CCDM programme for NZNO members – and the one that has the largest impact on their daily working lives – is completion of the annual CCDM full-time equivalent (FTE) calculation process for all eligible wards. This ensures the base roster of every ward matches the base patient demand (by acuity). DHBs have been slow to implement this aspect of CCDM, which is only 12 per cent complete nationally, according to the quarter three report. This means only 60 out of 510 wards nationally have an accurate nursing/midwifery roster model and budgeted FTE, according to the CCDM FTE calculation process, to ensure base staffing is well matched to base patient demand on every shift, on every ward, every day.

So even though we have a validated methodology for safe staffing in New Zealand, DHBs' willingness to progress this seems to be a low priority.

While we wait, our members continue to report incidences of unsafe staffing. These are still occurring, despite CCDM's ability to provide a valid and accurate method of providing safe staffing.

DHBs continue their preoccupation with cost-cutting and targets. In contrast, our members continue to report their struggle to deliver more care with fewer staff, care left undone and low morale and motivation. Members report a health system that is under significant pressure, where standards of care are dropping and patient outcomes are being compromised. These were the kind of conditions also revealed in the Mid Staffordshire Inquiry report.

Unlike the UK, New Zealand has a solution based on real patient need.

How many more years do our members have to wait for DHBs to deliver the safe staffing solution we already have? CCDM needs to be fully implemented now. We need safe staffing now! •

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CCDM drives positive change in maternity

Care capacity demand management has brought improvements in maternity services at Capital & Coast District Health Board.

By Emma Williams

Capital & Coast DHB (CCDHB) has been implementing the care capacity demand management (CCDM) programme since October 2016 and has had TrendCare since 2014 in all inpatient areas, including maternity services.

At CCDHB, CCDM has been implemented in an active partnership with unions. Engagement and collaboration has been essential in the implementation of CCDM and of its success so far. Representatives from all those who use maternity services at CCDHB have been involved in all aspects of CCDM governance. This has been critical to what CCDM has achieved in maternity services over the past 18 months.

Since CCDM's implementation, maternity service representatives nationally have raised concerns about TrendCare's ability to reflect the acuity of care provided during the ante, intra and postpartum periods. CCDHB recognised these concerns and initiated TrendCare timing studies to understand the issue in more detail.

These studies were undertaken for six weeks last year and focused on antenatal and postnatal patient types. Staff were strongly engaged and committed to these studies and an excellent participation rate was achieved. Further national and international studies are required to support CCDHB's findings.

Analysis of the data identified that some reivew of the weighting for the postnatal caesarean patient type on night shift was required by TrendCare. But ultimately the timings recorded by midwives and nurses were below the weighting provided for each patient type and category.

Education plan for staff

The study resulted in an in-depth education plan to support staff to accurately record acuity to reflect the care they provided. Following the education, the data collected improved significantly and this has led to the completion of full-time equivalent (FTE) calculations for CCDHB's maternity ward and delivery suite over the past three months.

The core data set component of CCDM has been implemented using the data visualisation tool 'Qlik'. This tool has enabled an extensive "data picture" for all wards, and enables staff to access their data, creating visibility and transparency across the DHB. Understanding and using the data has been supported through a data literacy programme for all senior staff to ensure they feel comfortable reviewing and interpreting their ward data.

Local data councils

Local data councils have been established as quality improvement groups. They are made up of representatives from all ward staff, including NZNO delegates, to provide different perspectives of the ward. Local data council members spend an hour each month reviewing their ward data. Using the data, members develop and implement quality improvement projects. The success of these can be measured using the core data set. The success of this in maternity services has been driven by the local data council members with the support of the CCDM coordinator.

Maternity services are an acute service and, as such, are susceptible to periods of mismatch between capacity and demand. The service required a maternity-specific escalation plan to support staff and patients when demand exceeded the capacity to care, and to create visibility to initiate the required response at an organisational level. Over the course of six months, an escalation plan was developed and implemented, in collaboration with the maternity and CCDM teams and the union partners. The escalation plan has a set criteria for initiation and actions for each category of escalation. Staff say they feel more supported as a result of the escalation plan and recognise that maternity services are now more visible to the rest of the DHB. Staff also feel their concerns have been heard and addressed, with positive outcomes.

NZNO delegate Michelle Cotton has supported the CCDM programme in maternity services and has worked in partnership to implement the programme.

"The local data council has brought about improvements for our members. Using the data, the team identified patient flow issues that created bottle necks and consequently were increasing workloads. By altering the available space and organisation of the ward, the flow within maternity services improved and reduced pressure on staff. This had a positive impact on the work of the clinical staff," she said.

Staff say they feel more supported as a result of the escalation plan. . .

The CCDM team had been engaged in ensuring the data was accurate and available. "Accurate data has enabled us to make progress with FTE calculations. The programme is complex and takes time, but the data is clearly identifying the issues," Cotton said.

The CCDM programme is continuing at CCDHB, with the final stages of implementation of new Capacity at a Glance (CaaG) screens. Ongoing TrendCare maintenance, and support and education for staff will continue to ensure data accuracy for FTE calculations.

Partnership and collaboration are two of the keys to the success of CCDM. CCDHB has demonstrated a commitment to working in partnership to achieve all aspects of the programme for maternity services and the wider organisation. •

Emma Williams, RM, is the CCDM programme manager at CCDHB.

SAFER SICK LEAVE

Paid sick leave means that you can stay home and get better without losing income. But lots of us don't have enough sick leave. Sometimes this means having to go to work when you're sick. We need to make sure everyone has the sick leave they need to keep us all safe.

See www.together.org.nz/safer-sick-leave for more info.

My employer supported me to take the sick leave I needed. Everyone should have access to the same level of support.
Jax, PSA, delegate

Going to work at night and in the morning not knowing how you will get through the day, and not seeing your kids. It's not good.
Rose, E tū, cleaner

FAIR PAY AGREEMENTS

We can have better work lives in New Zealand with employment law that's fairer for everyone - Fair Pay Agreements.

See www.together.org.nz/make-work-fair-now for more info.

FAIR REDUNDANCY

Right now, there are employers thinking about axing thousands of working people from their jobs. Unlike many countries, New Zealand lacks a minimum legal redundancy protection. When employers choose to make people redundant, we can choose to make that fair.

See www.together.org.nz/4wks4fair for more info.

I'm 26 years old and I've been made redundant twice in two years. It takes a real toll on your mental health and self esteem.
Chrissy

We are proud that our 'go hard go early' lockdown prevented COVID-19 workplace exposure deaths. We should be taking the same attitude to all health and safety risks at work.
Richard, CTU President

MAKE WORK SAFE

COVID-19 showed us that working people need better guarantees about their health and safety at work. Too many people had no say in important decisions about their own health and safety - from whether they should stay home, to what plans were in place to protect them in the workplace.

See www.together.org.nz/make-work-safe for more info.

STRONGER PUBLIC SERVICES

Public sector unions have a range of campaigns for the 2020 General Election. They all celebate the value and power of public services to make our lives better. Together we are stronger.

See www.together.org.nz/strongerpublic for more info.

This time we've got the whole country fighting with us.
Adam, PSA, quarantine officer

If I had better pay, like the Living Wage, I would reduce my hours to 40 a week and spend more time with my kids.
Malia, E tū, cleaner

A LIVING WAGE

At the 2020 General Election the Living Wage Movement seeks a commitment from all political parties to pay the Living Wage to directly employed workers and contracted staff in the core public service, wider state sector and Crown agencies.

See www.together.org.nz/livingwage2020 for more info.

Authorised by Richard Wagstaff, NZCTU, 178 Willis Street, Wellington

The general election – raising

NZNO's election manifesto is a useful tool for raising the issues that matter most for NZNO members with political candidates.

By nursing policy adviser/researcher Sue Gasquoine and acting policy analyst Sue Russ

NZNO's ELECTION manifesto, *Nursing matters – even more in 2020*, is an important tool to help NZNO members decide who they'll vote for in next month's general election.

The manifesto sets out some of the key issues in health care which members might like to raise with election candidates. It is important to illustrate your points with personal anecdotes and experiences from your practice. These are always powerful and always have an impact on politicians. But remember to protect the privacy of others.

Nurses were at the frontline of the response to the COVID-19 pandemic – and remain integral to the ongoing response – so it is important to share with politicians and would-be politicians the nature and necessity of that work. And to ensure they understand nurses' role in containing community transmission.

Whatever party or combination of parties are in government after September 19, they will be making decisions on health funding, policy and legislation. As health workers, NZNO members want those decisions to consider: the health workforce, health funding, health equity and the social determinants of health.

The cover of NZNO's nursing manifesto, *Nursing matters – Even more in 2020*. The manifesto outlines the issues that matter to nurses and other health workers in this year's general election.

health issues with candidates

The health workforce:

- Safety and sustainability are big issues in our workforce.
- We are stretched too thin.
- Our workforce is ageing and migrant nurses are impacted by current border restrictions.
- Some of us face increasing violence and aggression at work.
- We need to hold on to the 'surge' workforce that came forward during the pandemic.
- We need a good education, before and after graduation.
- Once on the job, we need proper resourcing to reach our potential.
- We need to fully understand Te Tiriti o Waitangi so we can combat racism and deliver the right health services for Māori.
- We need a strong focus on meeting the needs of Māori and Pacific health workers, who are often doing the hardest work with the least resources.
- We need to keep learning about technological advances, eg for effective contact tracing.
- We urge the Government to make sure health training and ongoing support for graduates is available in the regions.

Health funding models:

- We are paying the price for an erosion of health funding over the last 10 years – it is increasingly difficult to do our jobs.
- We see lots of big inquiries take place such as the report of the Health and Disability System Review (*The Simpson Report*) but we know the recommendations can't be implemented without proper resourcing.
- We need an alternative care model, like the one set out in NZNO's *Strategy for Nursing*.
- We need a model that means **everyone** can access health services.
- The way funding works, Māori and iwi providers have fewer resources yet they are providing services to those with the greatest health needs.
- Big pay differences for the same job in different sectors isn't fair. An experienced primary health care nurse is paid **10.6** per cent less (about $7500 a year) than a district health board nurse with the same qualifications and experience.

Achieving health equity:

- The report from the Waitangi Tribunal (Wai 2575) backs up what we see and know about institutional racism and the structural barriers that make it so hard for Māori to access services.
- We need a major shift so that tāngata whenua provide care on their own terms. This is how we will get on top of the health issues that massively overburden Māori.
- To reinstate tino rangatiratanga and mana Māori motuhake, the articles of Te Tiriti o Waitangi must be understood and honoured.
- We need to listen to the voices of people who have barriers to accessing services, like LGBTQI people, people with disabilities, people with dementia, and those living in rural communities or remote locations.

The social determinants of health:

- Inadequate housing and homelessness have a very negative impact on people's health – particularly children's health.
- The cost of housing can result in poverty and poverty can result in poor housing and homelessness – sometimes known as the poverty cycle.
- The cycle of poverty is expected to become even more entrenched because of unemployment and under employment resulting from the impact of the COVID-19 pandemic.
- Some care is only available to people who have enough money, eg, aged care which is dominated by for-profit businesses.
- Obesity, addiction and poor oral health are examples of what some refer to as "profit-driven diseases" and they point out that these diseases affect low-income communities much more, because alcohol and fast-food outlets "target" poor communities.
- Supporting health literacy is part of nurses' "everyday" work. This has also been profiled by the COVID-19 pandemic. Nurses have been teaching hand washing and cough etiquette for generations but these critical pandemic management functions are further examples of how lack of simple resources (eg, soap, hand sanitiser, tissues) can compromise the health and wellbeing of communities. •

* We would like to acknowledge NZNO member Jane Henwood for her contribution to the development of this discussion tool.

Ensuring equity at end of life

A new palliative care framework aims to change practice to achieve equity and culturally safe care for Māori.

By co-editor Anne Manchester

Celebrating the launch of *Mauri Mate* last month are members of Te Pou Tautoko, Mary Potter Hospice's advisory group. From left, Kura Moeahu (Te Atiawa), kuia Kahuwaero Katene (representing Ngāti Toa), project sector consultant Ria Earp and Vanessa Eldridge, Rongomaiwahine, Ngāti Kahungunu.

What Māori want is culturally safe care. This was the overwhelming message at the launch of *Mauri Mate, A Māori Palliative Care Framework for Hospices* late last month.

Described as a first for Aotearoa, the framework focuses on quality, equity and compassion to improve end-of-life services for Māori, whether they are in an inpatient unit, an aged-care facility or at home. It also focuses on how to provide culturally appropriate care and grief support for whānau.

Mauri Mate was commissioned by Totara Hospice (South Auckland) and Mary Potter Hospice in Wellington, with the support of Te Ohu Rata o Aotearoa, the Māori Medical Practitioners' Association.

Helping launch the document, head of the Department of Māori Health at the University of Auckland Papaarangi Reid said providing culturally safe care to Māori depended on creating safe relationships with Māori and safe places where they could die peacefully. Referring to the care Māori received throughout the health sector, Reid said they were "underserved rather than undeserving". To prevent inequity, health professionals needed to be protestors and advocates, using the word "equity" as a verb. "We must change the preconditions that put Māori at risk," she said.

Delivering equity in health care depended on health professionals being able to have safe conversations with Māori about what they wanted, rather than believing they already knew what people wanted. "Health systems need to change. We need the resources and space for these conversations, a commitment to health equity and the ability to look at our practices."

Before the launch, Mary Potter Hospice manager and former nurse Vanessa Eldridge told *Kai Tiaki Nursing New Zealand* that more had to be done to share with Māori what services hospices offered. "People still see hospices as buildings where you go to die, rather than a service to support whānau to care for their loved ones where they want to be. We can awhi people to remain living in their communities as long as they can."

Changes in the make-up of Māori society and an increasing Māori population also meant services had to change accordingly. "As Māori families become smaller and more dispersed, more older Māori are now having to be cared for in aged-care facilities," Eldridge said.

By 2038, the older Māori population will have increased significantly, with Māori deaths expected to increase from 3500 to 5000 a year, she said.

Although Māori whānau mostly preferred to undertake end-of-life care at home, social and economic disadvantage often meant the toll on whānau supporting care at home was great. *Mauri Mate* suggests that aged residential care would need to adopt more customised approaches and develop alternative care services, eg those based on a kaupapa Māori approach, to meet future needs of older Māori.

Speaking at the launch, Eldridge said hospices and health services were at different places on the journey to reducing inequities for Māori. *Mauri Mate* was "a tool for hospices to help us do better, swiftly and boldly. Do we have the right relationships with local Māori to make our services culturally safe? Can we look at our biases and institutional racism? Doing those uncomfortable things requires leadership and courage."

Eldridge drew on the whakataukī *"Rurea, taitea, kia tū ko taikākā anake – Strip away the bark and expose the heartwood"* to reinforce her message that Māori values and traditional wisdom and practices needed to be honoured for growth and change to happen.

Room for improvement

University of Auckland research fellow in the school of nursing, Tess Moeke-Maxwell, speaking on behalf of the the framework's expert working group, said although hospices did a great job, there was room for improvement. "Cultural ignorance and racism are alive and well in Aotearoa – in our hospitals, hospices

and aged-care facilities. Māori nurses do their best for Māori whānau but some non-Māori nurses are bewildered by traditional processes and this bewilderment can cause offence.

"All staff must have access to cultural training and Māori staff need to be given the mana they deserve. Often they are doing two jobs – working as cultural bridge builders, as well as doing the job they are paid to do. Staff who are unable to change their practices and attitudes need to be moved to other jobs, for it matters how Māori whānau are treated.

"*Mauri Mate* will increase the cultural safety of the services we offer. It will magnify our Māori values to be incorporated into our services. Māori need an equal share of the palliative care pie."

Digital storytelling

Moeke-Maxwell also spoke of her work leading the Pae Herenga study, a three-year end-of-life study on traditional Māori end-of-life care customs and adaptations. This involves using digital storytelling research methods to record Māori end-of-life care customs. Face-to-face interviews were conducted with 61 Māori whānau, with 16 family representatives participating in digital storytelling weekend workshops in 2018 and 2019. Moeke-Maxwell said a collection of 25 digital stories – *Pa Te Aroha (Touch of Love)* – would be a great companion to *Mauri Mate*, as the stories showed what was important in end-of-life care for Māori.

Eldridge was involved in a weekend workshop as a community research collaborator and is one of those interviewed. Other interviewees include rongoā practitioners, kaumātua, those working with wairua, whānau and people working in palliative care. "We targeted people with knowledge of traditional practices which would help us develop appropriate services for the present," she said. "The next step is to take these stories back to the regions from which they came. New tools can then be created for whānau and the health sector in those regions.

"As people moved away from rural areas to urban centres, they became isolated from their iwi and kaumātua, and some traditional practices were forgotten. Other practices were outlawed under the Tohunga Suppression Act of 1907. Some practices are held closely and tightly within a tapu space and are not shared openly. When whānau appreciate that sharing their stories will help others, then they become more willing to share."

Eldridge, who is lead author for the sections on bereavement in the Pae Herenga study, will soon look at condensed narrative in order to describe Māori processes around grieving. "I found it an immense privilege to be involved in recording some of these stories. We then invited participants to hone them into short written narrations. The next step was to add images and waiata to create a finished product. For participants, the whole process was healing in itself. It is good to see some of the digital stories already being used as teaching tools for nurses."

Eldridge believes some health professionals will find it confronting and challenging to be forced to change their practice. "There are those who say 'we've always done things this way. Why should we change?' At Mary Potter, Māori patients make up about nine per cent of those referred to us for care, with Pacific people comprising about seven per cent. But we need to look beyond numbers to the needs of the people and whether those needs are being met equitably.

"In 2011, when I joined Mary Potter, there was only one other Māori staff person – our chief executive, Ria Earp. Today we have nine Māori staff – about 10 per cent of the total staff. These people work across the board – as nurses in the community, as health-care assistants in the inpatient unit, in IT, and in our volunteer services.

Māori advisory group

"We have always had a Māori advisory group. Our Ngāti Toa kaumātua Aunty Kahu Katene and other iwi representatives have been with us for more than 10 years and we now have representation from Te Ati Awa with Kura Moeahu as well. This group helps keep us on the straight and narrow. Some of our doctors are now learning about rongoā and we have translated our values into te reo. We have bilingual signage underway, and karakia and waiata are more common practices now. There is certainly a change in readiness among most staff, but given the current health and outcomes Wai 2575 hearings and recommendations, the subsequent parliamentary inquiry into health inequities for Māori and now *Whakamaua: Māori Health Action Plan 2020-2025* from the Ministry of Health, it is clear steeper change is ahead," Eldridge said.

Mauri Mate roadmap

Appendix 3 of *Mauri Mate* – He Ara Tohu, the roadmap – summarises the principal messages and recommendations contained in the framework.

It highlights commitment to Te Tiriti o Waitangi, the importance of having whānau at the centre of all services, of the need to connect to local Māori communities and for practitioners to increase their understanding of who Māori are and how colonisation has affected them. Also included are recommendations on how to improve the cultural competency of the workforce, how to understand the different sorts of healing Māori need, eg rongoā Māori practices and wairuatanga, to help Māori manage death and grieving appropriately.

All 33 hospices around Aotearoa have been sent a hard copy of *Mauri Mate*. Digital copies are available from www.hospice.org.nz/mauri-mate

Symposium rescheduled

Mary Potter Hospice had planned to hold the first national one-day symposium on Māori palliative care at Te Papa this month. However, the advent of COVID-19 has meant Ngā Whetū i te Rangi has been postponed till May 3, 2021.

According to Eldridge, the driving force behind the symposium, the aim is to highlight the work and research occurring in Māori palliative care across the motu. "There is so much research going on that we wish to showcase," she said. "We also want to send messages to other parts of the health sector that so much palliative care occurs outside hospices. There are very few articles about indigenous palliative care internationally. We hope the resources that will emerge from this seminar will add richness to this international body of knowledge." •

Death – a social justice issue

A research project will examine the impact of social deprivation on palliative and end-of-life care.

By Jackie Robinson and Merryn Gott

Society's responses to death and dying must be reformulated in the context of ageing populations and rapidly rising demand for palliative care.

The World Health Organization states developing new models of palliative and end-of-life care is a key public health challenge for the 21st century.[1] The United Nations has argued that sparing the terminally ill *"avoidable pain and enabling them to die with dignity"* is a basic human right.[2] Here, the Ministry of Health has identified ensuring all New Zealanders die well as a policy priority.[3]

However, many people continue to die with unmet physical, psychological and spiritual needs. There is growing evidence of significant inequities in both access to specialist palliative care services and overall end-of-life experiences. Improving palliative care provision is therefore a "social justice concern".[4] Previous research has explored inequities in end-of-life circumstance related to older age,[5,6] culture,[7,8] and diagnosis.[9]

A key limitation of current palliative care policy and related service development in addressing these inequities is that it reflects the aspirations and worldview of affluent populations. For example, current policy in most resource-rich countries emphasises supporting death at home.[10] This assumes people live in housing which can support a good end-of-life experience and have family/whānau willing and prepared (including financially) to provide care. In Aotearoa New Zealand, the links between inadequate housing and worse health outcomes are well established.[11] The economic burden of caregiving is also significant. Within an end-of-life context, it can result in not eating to save money, significant debt and bankruptcy.[12]

These challenges remain largely invisible. In policy, service development and research, *"palliative care tends to discount the needs of those who can be characterized as doubly vulnerable . . . in need of palliative care services and experiencing deficits in the social determinants of health and consequently carry complex, intersecting health and social concerns".*[4]

This is an important omission, given the well-established relationship between deprivation and health outcomes across the life-course.[13] People living in areas of deprivation die younger[14] and the inequalities they have experienced throughout life have a marked influence on their later life experience.[15]

However, there is a paucity of national and international research on how deprivation shapes where people die, their use of health services, end-of-life preferences, and overall end-of-life experience.[4]

Deprivation may be defined as: *"A state of observable and demonstrable disadvantage relative to the wider society to which a group belongs".*[16]

Focusing on deprivation in a defined geographical area, rather than individual-level deprivation or socio-economic position, reduces the stigmatising effects of a study focused on individuals. International research has identified that people living in areas of deprivation have less access to specialist palliative care services.[17] These both facilitate home dying and improve overall satisfaction with end-of-life care.[17,18,19,20,21] People living in deprivation are less likely to die at home[22] or in a hospice[21] and are more likely to die alone.[23] While existing research[17,21,24,25,26] has recorded these associations they have not been explained.

Researchers have speculated the disparity might relate to the availability, affordability, acceptability, and geographical accessibility of specialist palliative care services.[27] Hospices, for example, tend to be located in more affluent areas reflecting their charitable origins.[27] Evidence from our work indicates palliative care services are not always congruent with the needs of structurally disadvantaged populations, notably Māori.[12,28,29,30]

It has also been suggested that the "inverse care" law[31] might mean people in deprived areas not only receive less support from specialist palliative care services, but are also less likely to receive primary or generalist palliative care from their usual care providers. A study in the United Kingdom found primary care teams in deprived areas are busier than average due to the higher burden of ill-health within their community and so have less time to support palliative care provision at home.[32] Furthermore, there is evidence that people living in low socio-economic areas are more at risk of a hospital death. This may be related to inequities in access to, and use of community services.[33]

Internationally, there is limited evidence about the association between area deprivation and end-of-life health service utilisation and no comprehensive evidence for Aotearoa New Zealand. But our research has begun to point to a relationship between area deprivation and use of end-of-life health services. A survey-based investigation of hospital use for people with palliative care needs identified that those living in areas of deprivation reported more benefit from hospital admission than those living in affluent areas.[34] The Pae Herenga project has identified material resources as a key context for realising Māori aspirations at end-of-life, eg dying on ancestral lands. But there is currently no national evidence on how area deprivation influences service utilisation and other factors which determine overall end-of-life experience or place of death. There is also no information from people living in communities in areas of deprivation themselves about their experiences of, and aspirations for end-of-life care.

People living in deprivation are less likely to die at home or in a hospice and are more likely to die alone.

Adopting a public health approach to palliative care,[35] focusing solely on

health services as the determinant of end-of-life experiences, results in significant disparities in end-of-life related health outcomes. But emerging international evidence suggests improving end-of-life wellbeing involves the effective coordination of four basic components:

- specialist palliative care,
- generalist palliative care (provided by non-specialist palliative care teams, eg GPs and community nurses),
- compassionate communities (networks of support in communities); and
- civic end-of-life care (public sector and institutions, eg churches).[36,37]

Whether this holds true here remains to be examined, but this framework makes visible the resources and strengths communities themselves bring to end-of-life caregiving. Drawing on public health perspectives also helps make visible the structural determinants of end-of-life circumstance and supports a more integrated approach to policy and service development beyond just the health service.

A team of researchers, including the authors, is about to start a study, funded by the Health Research Council, which explores the impact of deprivation in palliative and end-of-life care across Auckland and Bay of Plenty District Health Boards. Working from a public health and health equity perspective, the project will:

- investigate access to, and use of end-of-life services for people living in areas of deprivation;
- explore the strengths and challenges communities located in areas of deprivation experience at end-of-life; and
- work in partnership with communities to identify strategies which could improve their end-of-life experience.

Our framework will support identifying structural determinants of end-of-life experiences and concrete actions to realise the ministry's aspirations for all New Zealanders to die well. The design of the study is congruent with our desire to foreground the views, needs and experiences of a potentially marginalised group, support real world change,[38] and acknowledge power relationships.[39] •

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Making space in education and

What is spiritual care and why is it important that educational institutes provide nursing students with the knowledge, understanding and skills to practise spiritual care?

By Linda Christian

As a nurse educator, I sit in meetings where topics such as curriculum and Nursing Council requirements and shifting student expectations are discussed: *"We need more emphasis on pharmacology and information technology."* . . *"We need a more robust research component in the curriculum."* . . . *"How can we use our ipads/Zoom/ apple TV/technology more effectively?"* . . . *"Students only want the 'need to know' information for their exams and assessments."*. . ."How can we measure competency?"

These are all valid and important, but somehow the patient-centredness of what we are trying to achieve seems to get lost. Questions arise about the fundamental essence and "art" of nursing – therapeutic relationships, communication, genuine and holistic care and how we are delivering these messages to undergraduate students. These thoughts led me towards an exploration of spirituality and spiritual care (SC) and the place of nursing education in this.

Holistic care

The International Council of Nurses does not include holistic care in its definition of nursing,[1] however holistic care is widely accepted as fundamental to nursing. Much of the contemporary literature regards holistic care, which includes spirituality and SC, as an expected professional and ethical responsibility of nurses.[2,3] Spiritual care has also been described as critical to holistic care.[4,5] Despite this, as with many nursing regulatory organisations worldwide, the Nursing Council does not expressly discuss or prescribe competencies or standards of care for SC.[6] Nor do the *Educational Programme Standards for the Registered Nurse Scope of Practice,*[7] which dictate curriculum content, discuss SC, nor, in fact, holistic or psychosocial care.[7] This is particularly notable in our country where the indigenous people regard wairua (spirituality) as the touchstone of wellbeing. In a study of wairua, as it pertains to psychology, a group of researchers stated: *". . . always remembering that for Māori – wairua is culturally defined, it is real, it is relevant, it is everything. Without wairua, there is no wellbeing."*[8]

Paying attention to the holistic needs, including spiritual needs, of all people has always been important. However, the changing face of society and health care has heightened the need for increasing awareness. We have an ageing population (often with complex health-care needs) and increasing prevalence of chronic illness and disability. This increasing longevity, due to improved and more readily available medical treatments, has changed the focus of health care from acute care and infectious disease to continuing care.

People who are ageing, those living with chronic illness or those facing their mortality often start to think about spirituality in terms of questioning the purpose in life and evaluating what is important.[5,9] To cope with long-term conditions, poor prognoses and prolonged unwellness, people need to be cared for holistically. Advanced nursing roles are developing steadily. Implicit in these roles is that nurses care for people with complex needs as a "whole", rather than just focusing on the disease or condition.[10]

The literature debates the definition of spirituality and it is a contentious topic – from clarity of definition due to its subjectivity, to whether there can ever be consensus and whether consensus matters anyway.[11,12] This lack of clarity contributes to debate over what SC is and how to, and who should deliver it.[4]

I have borrowed the definition of spirituality from a New Zealand-based study: *"Spirituality means different things to different people. It may include (a search for): one's ultimate beliefs and values; a sense of meaning and purpose in life; a sense of connectedness; identity and awareness; and for some people, a religion. It may be understood at an individual or population level."*[11]

Themes around spirituality

Themes around spirituality/SC include hope, faith, love, essence, meaning and purpose in life, beliefs, peace, connectedness and compassion. Compassion as a fundamental aspect of nursing care is discussed widely in the current literature and is possibly more meaningful to nurses than spiritual care. Perhaps in the end it is the same thing. *"Spiritual or compassionate care involves seeing the whole person – the physical, emotional, social and spiritual"*[13] and goes beyond religious affiliation.[14] Researchers have stated that helping people meet their spiritual needs can be achieved by being a "compassionate presence".[5]

In New Zealand, nurse academic Barbara Docherty has said: *"Nurses are suffering burnout because of the conflict between their desire to be compassionate and their inability to be so, partly because they are not taught how to be compassionate anymore and partly because the demands of their day-to-day jobs work against it."*[15]

When people are dying, they and their family often need to address spiritual concerns that have assumed greater importance.

It is important to discuss compassionate care alongside SC because one could argue that, if nurses attended to spiritual needs as they do to physical

practice for spiritual care

PHOTO: ADOBE STOCK

'If spiritual care is not addressed in nursing education, it is likely to be neglected in practice.'

needs, compassionate care surely occurs. Do we need to teach nurses compassion as we are now trying to teach person-centred care? Perhaps it is all a melting pot – SC, compassion, person-centred care, culturally safe care and resilience – impossible to really separate.

There are many positive outcomes of spirituality and SC. These outcomes include enabling clients to count their blessings in life and achieve inner peace,[14] and exploring coping strategies and positive adaptation to overcome obstacles during illness/crisis.[4,13,14]

When people are dying, they and their family often need to address spiritual concerns that have assumed greater importance.[16] Studies indicate spirituality has positive effects on mortality, managing pain and enhances recovery from illness and surgery.[13]

The literature indicates there is a high proportion of patients who want their spiritual needs addressed[17,18] and, quite simply, it is integral to providing whole patient care.[13,16] For Māori, having their spiritual needs addressed is a necessity for wellbeing.[8]

Spiritual care recognises, respects and meets patients' spiritual needs. Firstly, it has to be acknowledged that people have spiritual needs. When did you last reflect on your own spirituality? Spiritual care comprises spiritual assessment; facilitating access to, and participation in religious rituals; therapeutic communication with clients; being with (presence) the patient by caring, supporting and showing empathy; promoting a sense of well-being by helping people find meaning and purpose in their illness and overall life; and referrals to other professionals such as chaplains/ministers.[5,13,14]

Attending to spiritual distress

Health-care professionals need the skills to recognise and attend to spiritual distress.[5] In the context of palliative care, all involved in care have a role in SC, referring on to specialists as necessary, as would happen in any other aspect of medical care.[16]

It is important to recognise that spirituality isn't just religious affiliation. That may be part of it – and a big part of it for some – but certainly not for all. Qualitative research aimed to describe the meaning of spiritual nursing care for ill individuals who self-identified as having no religious affiliation.[19] The main theme drawn from this research was extension of self – where the nurse looked beyond physical needs and recognised the patient as a person. Patients felt they had received spiritual nursing care when the nurse cared about their personal life, was kind, used caring actions such as touch, listening, humour and helped the person maintain their independence.[19]

Initiating spiritual care

It has been proposed that asking two simple questions may initiate SC.[19] The researchers' two question model (2Q-SAM) asked: *"What's most important to you right now?"* and *"How can we help?"*[20] These interventions seem pretty fundamental but are clearly person-centred, need-led and holistic. Nurses have the heart to do this, but work realities can interfere with best intentions.

The literature tells us the spiritual dimension is often overlooked by health professionals[14,21] and barriers to SC are well documented in the international literature. There is limited New Zealand research but one recent study concurs with international findings. The first national survey of New Zealand nurses' views on spirituality and SC (despite a small response rate) concluded that although spirituality was valued as a core component of holistic nursing care, clarity was required about what constitutes SC and how professional boundaries and responsibilities fit within it. There was also reference to the need for improved resources and educational opportunities for SC and more inter-professional collaboration.[22]

Feelings of incompetence due to lack of education on SC, secularisation of contemporary society, lack of inter-professional education, work overload, lack of time, cultural differences, lack of attention to personal spirituality, ethical

issues and unwillingness to deliver SC are all noted barriers.[14,23] Other influences include the prevalence of the medical model with a focus on the illness and progress to cure[14] and the workplace itself can be a barrier.[24]

Despite many nurses not feeling comfortable delivering SC, they are often the most accessible health-care professional for ill people and therefore the person they turn to.[19] Therefore, nurses need to be somewhat prepared to deliver it.

Barriers to spiritual care

As a nurse educator, I tend to focus on the perceived barriers of discomfort and lack of confidence due to a lack of education. The literature highlights that, until recently, there was little consensus about how SC education could be integrated into the wider curriculum.[23,25,26] Students are not well prepared to undertake SC and it is not given priority within nursing education.[25,26]

Without local research, it is difficult to know how New Zealand nursing educational institutions fare in terms of educating students in SC. There may be some education but I anticipate it is similar to overseas – shallow, piecemeal and a low priority in an already over-subscribed curriculum. Also, without direction from the Nursing Council, consistency about what should be included in SC education and how it should be taught is lacking. I suspect there is widespread teaching of the seminal model, Te Whare Tapa Whā,[27] and this may be one of the principle ways in which SC is approached. Incorporating the necessity of wairuatanga for Māori health, via teaching Te Whare Tapa Whā, is, perhaps, some acknowledgement of the importance of spirituality.

Reasons for the lack of attention to spiritual needs in education include who is qualified to teach spiritual-related matters and difficulties in teaching and measuring affective skills and knowledge.[26] Where does the responsibility lie for cultivating the "right" attitudes and values that nurses purport to espouse, ie compassion, caring, holistic focus? There are attempts to teach and reinforce them within subjects such as ethics and professional practice, but in reality these fail to develop spiritual and moral competencies.[26] Holistic care values appear to be "caught rather than taught".[26] It seems extraordinary there is so little actual attention focused on SC in practice and education, with the increasing growth of pertinent literature, including in basic student texts. If SC is not addressed in nursing education, it is likely to be neglected in practice.

We may be getting closer to some consensus on SC education. Over the previous three years, a multinational European project has developed *"an evidence based gold standard matrix for spiritual care education for undergraduate nurses and midwives, educational toolkit and a website to act as a hub for international engagement and dissemination for best practice".*[28]

The Enhancing Nurses' Competence in Providing Spiritual Care through Innovative Education and Compassionate Care (EPICC) project indicates the increasing value nursing and midwifery educators worldwide place on this fundamental but largely sidelined aspect of care.[29] EPICC has developed four key competencies: i) intrapersonal spirituality; ii)interpersonal spirituality; iii)spiritual care – assessment and planning and spiritual care; and iv) spiritual care – intervention and evaluation, to guide the teaching and assessment of spiritual care.

Knowledge, skills and attitude are integral components of the competences and the authors note the competencies must be used within the appropriate cultural context.[29]

The role of competencies

A pilot study of SC competencies undertaken in a palliative care environment highlighted that competencies "ground" spiritual care, helping health professionals to measure and assess their SC practices.[18]

Spiritual care teaching must also flow into the clinical practice setting,[30] helping students to see and draw learning from their experiences with patients, – connecting their theory to practice. Difficulties arise as SC, and sometimes holistic care, is overlooked in busy practice and therefore students are not exposed to consistent role modelling of this aspect of care.[3] It could be argued that it then becomes the responsibility of clinical teachers to ensure opportunities are taken to work with students to help them see a holistic picture of patient care.

Including SC in the Nursing Council's competencies for the RN scope of practice[6] would ensure students were attending to patients' spiritual needs by the requirement to meet and provide written evidence of same. This also fits with a general student philosophy of being assessment-focused[13] and would be another incentive for students to learn about SC, even if they didn't yet see or understand its value.

Holistic care

The international nursing literature has discussed spirituality and SC in great depth and for some time as a cornerstone of holistic care. However, the actual practice of SC is limited. One of the significant barriers cited is lack of education and training. We know SC is important and why and, increasingly, the information is available about how to provide it. So, perhaps it is timely for New Zealand nurses, particularly those in education, to consider how we integrate this fundamental aspect of the true essence of nursing into our curriculums, always remembering the curriculum should reflect diverse opinions and a broad approach to spirituality. We must also always remember nurses who are compassionate and truly focused on the individual are able to provide holistic care – care most nurses want to give and was the reason they entered nursing in the first place.

Mahia i runga i te rangimarie me te ngākau māhaki – With a peaceful mind and respectful heart we will always get the best results. •

**References are available from the co-editors.*

This article has been reviewed by senior lecturer in the School of Nursing and Midwifery, Victoria University of Wellington, Helen Rook, and the co-editors of Kai Tiaki Nursing New Zealand.

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Coping with COVID-19 uncertainty

It is important nurses have ways of coping with uncertainty, including that generated by COVID-19.

By professional nursing adviser
Anne Brinkman

Anxiety, confusion, doubt and uncertainty are all conditions gripping the world as it faces the challenges of COVID-19, and they are conditions we are familiar with individually, to varying degrees. Anxiety and confusion hold us back, while doubt and uncertainty can be more positive, prompting us to question and to adapt.

We've all experienced doubt – about ourselves, what we know, our peers and aspects of life in general. It is part of being human. Uncertainty, on the other hand, is more about "not knowing" and worrying about what could happen and what might be. It is unsettling and affects our emotions and the way in which we might think, often to the point of distorting what actually is.[1] However, it can also be a catalyst for gaining understanding – if we are uncertain, we are likely to seek answers.

Impact of uncertainty

The lead-up to the COVID-19 pandemic was a perfect example of how uncertainty can exert a palpable effect on individuals and, as it turned out, populations. Uncertainty grew into fear, as the impact of the virus began to spread. Health systems, and health staff in particular, have felt the full weight of uncertainty. Above all, they depend on reliable analyses and informed responses, both of which have been in short supply.

It was appropriate for nurses to take a "no regrets" approach to preparedness, as horrifying data and images flooded in from the worst affected countries. Invariably, too, the potential risks facing frontline staff, their families and associates added another layer of fear and responsibility on them.

The context for COVID-19 uncertainty included inflated (as it transpired) estimates of its probable impact here, underpinned by the way in which the media portrayed its global emergence. There were many examples of high morbidity and mortality, fuelling fear among the public, as well as in the health sector.

Uncertainties in the sector were exacerbated by potential deficiencies in equipment, eg ventilators and personal protective equipment (PPE), and in ensuring sufficient staff able to rise to the challenges the virus might impose on them. Ventilators were invented and/or ordered from overseas; N95 masks were (inconsistently) fitted and tested across district health boards (DHB); stocks of masks were unearthed, some in an unusable state; and different interpretations of the use of PPE emerged, inciting angst. The Ministry of Health called on recently-retired health workers to volunteer so the ministry could compile a list of health professionals willing to fill staffing gaps, including in the tracing centre set up to prevent/reduce community spread. Compounding this were the border, quarantine and tracing app problems.

Against this backdrop of ongoing uncertainty, it wasn't surprising health professionals experienced responses ranging from mild to severe anxiety. And in team situations such as nursing, high anxiety can be contagious.

Uncertainty and the outward expression of our feelings and emotions appear to be closely linked to one other.[2] For example, we can't be certain about how other human beings will act in a given situation. It has been suggested that *"people have a propensity to simulate [imagine] negative outcomes, which result in a propensity toward negative affective responses".*[2] That is, we fear the worst.

How do we improve our own and others' responses to the realities of COVID-19 and future threats? What strategies can we use to tolerate or reduce uncertainty? There are several important moderators of negative responses to uncertainty. The context of the uncertainty, a person's tolerance of uncertainty, and strategies to regulate emotion can all have an effect on managing uncertainty.[2] Evidence also suggests that differences in tolerance of uncertainty are associated with various outcomes, including health-related outcomes.[3]

Perception of risk

Similarly, priority should be given to normalising the perception of risk. Nurses should have timely and reliable data that gives them a sense of proportion in the face of sensational media reporting and individual alarmism.

At the ward level, simple interventions can have a positive, grounding effect. One example of nurses learning to work within the uncertainties of COVID-19 was in a ward where staff were preoccupied with the many unknowns they might face. The charge nurse manager suggested a "masks-and-hat challenge" and invited staff to design either a fun mask or hat as a contrast to formal PPE. This brought the staff together in a positive way, helping increase their tolerance of uncertainty through discussion and levity.

In the context of COVID-19, we need to keep a sense of proportion that reduces fear, stigma and scapegoating, and gives a realistic perspective on the perceived threat of infection.[4] As health professionals, we need to make informed decisions about the focus, energy and resources required to cope with the very real demands of the pandemic. •

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Aromatherapy use in palliative care

Do nurses use aromatherapy in palliative care? A survey aimed to find out.

By Wendy Maddocks and Kate Reid

Last year we conducted an online survey on the use of aromatherapy in palliative care by New Zealand nurses. We were interested in determining how nurses were using aromatherapy in palliative care. No study on the subject had been published in New Zealand so we decided to try and fill this gap.

Palliative nursing provides care for those with a life-limiting illness and focuses on providing comfort and maintaining as good a quality of life as possible through effective symptom management.[1] Palliative care differs from end-of-life care, as a person may receive palliative care for a few days or for years.[2]

Aromatherapy is the use of aromatic plant oils applied or used in a diluted form to promote wellbeing or assist with specific health concerns such as pain, stress, anxiety or nausea. Aromatherapy has been increasingly used in nursing care since the late 1980s.[3] One of the authors (Wendy Maddocks) was instrumental in setting up aromatherapy services at a hospice in the early 2000s, providing staff training and professional services.

Sadly, there are limited training options for nurses to study aromatherapy in New Zealand and such training is not regulated. However, to join the New Zealand Register of Holistic Aromatherapists, a person must have completed 640 hours of training.[4] Some palliative care nurses can access specific training in aromatherapy techniques in some parts of the country through hands-on workshops delivered by a nurse/aromatherapist.[5] Registered nurses (RNs) studying palliative care at a postgraduate level at the University of Canterbury (UC) are also introduced to the concepts of aromatherapy, along with other complementary therapies, as part of their study.[6] Internationally, the literature continues to show evidence of increased research into the use of aromatherapy within palliative care, primarily to assist with pain relief, nausea and anxiety.[1,7,8,9,10,11]

We developed an online survey of 38 questions using Qualtrics software, hosted by the UC. Ethical approval was obtained from the UC Human Ethics Committee (HEC2019/40/LR-PS). An invitation with detailed information and a link to the survey was emailed to any nurse currently or recently enrolled in the postgraduate palliative care papers at UC. It was also sent to a range of organisations involved in palliative care who distributed the survey among their nurses. Email recipients were also invited to forward it to any other RNs working in this area.

The survey's purpose was to provide a snapshot of the knowledge and use of aromatherapy by palliative care nurses, their training, quality control measures, guiding policies and the reasons aromatherapy was being used.

Results

The survey went live for one month from early November to early December last year. There were 13 responses, a lower than expected response rate. Eleven respondents confirmed they were RNs. The survey relied on participants' honesty that they were a New Zealand RN working in palliative care. It was anonymous, so there was no way of verifying this.

The average length of time participants had worked as an RN was 24.3 years (ranging from five to 41 years), with the average time in palliative care 9.2 years (ranging from one to 23 years). Twelve respondents worked in a hospice; one worked in a community setting, visiting patients in rest homes, at home and in private hospitals; five were staff nurses and five were employed as clinical nurse specialists or an equivalent role. The remaining two were a clinical manager and an educator. The respondents lived from Northland to Otago, with nine from the North Island. Participants listed 10 different complementary therapies they had heard of:

- aromatherapy
- massage
- rongoā – Māori medicine
- homeopathy
- reiki
- diet
- acupuncture
- music therapy
- Weleda products

Aromatherapy was the most well-known, mentioned by six respondents. Ten nurses felt patients should be able to receive any complementary therapy they liked, with four providing further clarification about making sure it was the best option for the patient. Freedom to choose at this stage of life was a common theme, as long as the patient and their family were informed and the therapy provided hope and comfort.

Four disagreed, with three providing further clarification based on cost, lack of evidence of effect and that it should be on a case-by-case basis. Massage and aromatherapy were the most popular complementary therapies identified by the respondents. Trained clinical staff and/or trained volunteers provided most of the therapies, with a trained practitioner, employed by either the family or the facility, involved in three cases.

While no adverse events were reported, the informal approach to safety in some facilities was a concern.

Home use of aromatherapy by nurses was also popular, with seven using essential oils at home via a diffuser.

Eleven nurses stated aromatherapy was available in their workplaces. In five of the facilities, it had been available for more than five years.

The decision to use essential oils was evenly spread between RNs, patients

Most respondents purchased essential oils directly from commercial suppliers.

and families, with a social worker and an enrolled nurse also involved in two cases. Pre-set blends made by staff who had attended some training were used in most facilities. Six of the respondents indicated they followed a policy, which had been developed jointly by clinical staff, a clinical aromatherapist and a quality control or risk manager. The other five responses indicated there was either no policy or they followed a vague guideline. Two facilities employed a paid clinical aromatherapist and two had volunteer clinical aromatherapists, with the remainder using RNs to provide treatments.

Quality control

Most respondents (n=11) indicated they purchased essential oils directly from commercial suppliers, with two using donated products. Determining quality was predominantly left to the trained nurse or external aromatherapist. One response indicated the "quality assurance nurse" was the purchaser but whether they had aromatherapy training was unclear. Eight respondents indicated that buying from reputable suppliers was sufficient quality control. Less than half the respondents looked for other measures of quality, eg expiry dates, batch numbers, analysis, and checking botanical nomenclature before administering.

Storage of essential oils included the drug prep room (n=8), with only two stating the oils were kept in a locked drug cupboard. One facility kept the oils in an open reception area for anyone to access.

Half the respondents stated they either followed a protocol or used pre-set blends prepared for specific concerns. One noted there were no restrictions on what essential oils were used; another noted there were five pre-set blends to choose from and said nurses could choose what to blend, only if they had attended a two-day specialist course. All facilities had up to 10 oils from which to choose.

Nine nurses indicated they applied the essential oils to their patients, with the main reasons being relaxation, sleep, stress and control of malodour. None of the nurses had undergone full clinical aromatherapy training, with five indicating they'd had no training. However, they did follow their facility's policy. Aromatherapy use was documented in clinical notes in all but one facility, where no documentation occurred. There were no adverse reactions or errors recorded to any of the respondents' knowledge.

The final question asked nurses whether aromatherapy should be available and 10 agreed (three did not respond). The rationale for this included that it was part of holistic care, it gave patients options and nurses had seen its benefits for patients, including improving comfort and relieving symptoms. The perceived benefits, as stated by nine nurses, included an enhanced sense of wellbeing, comfort, pain relief, relaxation and sleep. Five felt it could help with wound healing and two felt it was of benefit in masking malodourous wounds.

Finally, half of the respondents indicated they had read an aromatherapy research article in the last six months. Two had never read a research article.

Despite the low response rate, this survey has provided valuable information as to how some palliative care nurses are using aromatherapy. There is real potential for further research to be undertaken in this area and nurses are in a prime position to lead this research. While some facilities have a clear policy with staff training protocols, there are clearly still gaps in practice. There are many issues around quality, adulteration, contraindications and potential drug and essential oil interactions. These need to be considered. These issues are all detailed in *Complementary Nursing in End of Life Care Integrative Care in Palliative Care* and this book would be a valuable addition to any palliative care environment where aromatherapy is practised.

Conclusion

This online survey gave a snapshot of some of the aromatherapy practices used in palliative care. While no adverse events were reported, the informal approach to safety in some facilities was a concern. Overall, it seems RNs have the clinical responsibility for choosing to use aromatherapy and then facilitating its provision or applying it themselves. The reasons for using aromatherapy were consistent with the evidence on symptom support and making the environment as pleasant as possible. No respondents claimed it was used to treat cancer or as an alternative to orthodox palliative care.

While this survey focused on RNs, there was no mention of medical or pharmacist input into decision making on the use of aromatherapy. The lack of training for clinical aromatherapists, as well as the lack of specific training in aromatherapy targeted to nurses, could also have an impact on how it is being used on patients. The low response rate could have been due to a number of factors: timing; a technical issue which may have prevented some respondents completing the survey; and reliance on the goodwill of organisations to send out the survey. We are considering a follow-up survey to try and gain a greater understanding of palliative care nurses' use of aromatherapy. •

* *References for this article are on p45/48*

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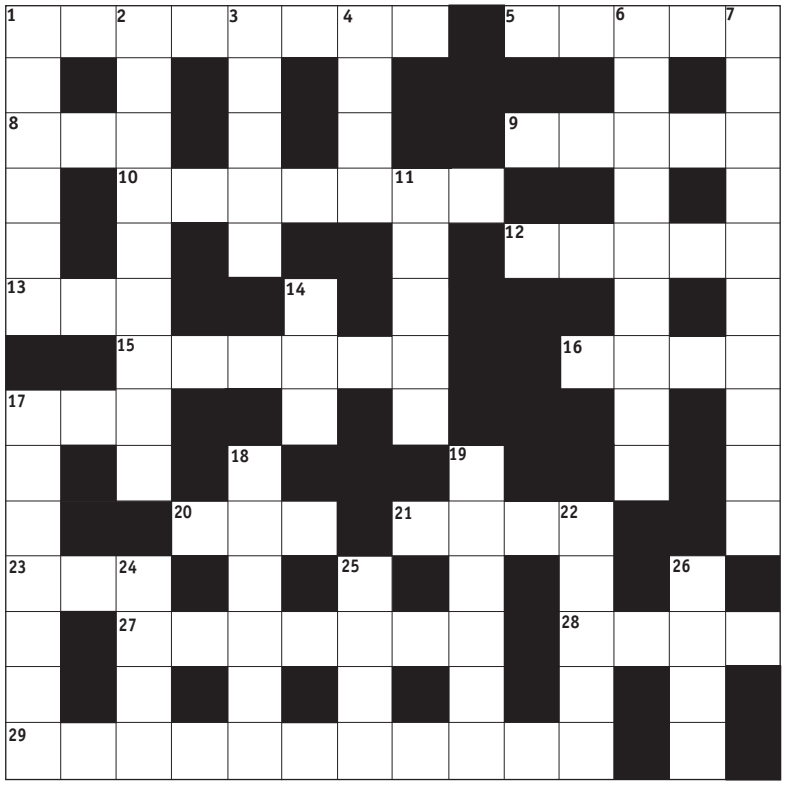
crossWORD

Completing this will be easier if you have read our July issue. Answers in September.



ACROSS

1) Severe curtailment of human activity, due to pandemic.
5) Kaumātua.
8) Purpose.
9) Standoffish.
10) Drug-buying agency.
12) Scrub vigorously.
13) Consume food.
15) Highly competent.
16) Knitting thread.
17) Possess.
20) Food (Māori).
21) Trace metal important for health.
23) Nevertheless.
27) Melancholy.
28) Money owed.
29) Science of aged care.

DOWN

1) Despise.
2) Possessing the required skills.
3) Coffee without its hit.
4) Pleasant temperature.
6) Substance used to suppress body odour.
7) National vote on single topic.
11) Major artery.
14) Edge of garment.
17) Doing as instructed.
18) Plot for flowers and vegetables.
19) Disaster.
22) One who carries golfclubs.
24) Russian ruler.
25) Nought.
26) Woodwind instrument.

July answers. ACROSS: 1. Dialysis. 5. Tangi. 8. Exodus. 10. Bubble. 11. Wahine. 14. First. 15. Unfaithful. 17. Lies. 18. Addiction. 19. Cousin. 21. Ratio. 22. Gluten. 23. Delay. **DOWN:** 1. Deep. 2. Aroha. 3. You. 4. Sob. 5. Tapu. 6. Newborn. 7. Infection. 9. Methadone. 12. Iwi. 13. Build. 14. Fluctuate. 16. Assault. 19. Cell. 20. Pita.

wiseWORDS

“In the latter months of his own long sickness the Master Herbal had taught him much of the healer’s lore, and the first lesson and the last of all that lore was this: Heal the wound and cure the illness, but let the dying spirit go.”

– Ursula K Le Guin (1929-2018), American writer, from her novel, A Wizard of Earthsea

it’s cool to kōrero

HAERE MAI and welcome to the August column. This month we look at the pūkeko, a purple swamphen. It is an adaptable and successful bird, found in most parts of Aotearoa, near water or swampy ground.

It is black with long red legs, a red bill and a deep blue neck and chest. The pūkeko often lives in extended family groups with eggs laid in a common nest.

Pūkeko can be hunted under licence and their blue feathers are popular for korowai and for fishing flies. In Māori tradition, pūkeko were known as bold schemers – they raided gardens for kūmara and taro. A stubborn, annoying person was said to have pūkeko ears (taringa pākura).

Kupu hou

New word

- **Pūkeko** – pronounced *“pu-(as in pooh)-ke-(as in kept)-ko-(as in k/paw)”*
- **Kei te wairepo a te pūkeko e noho ana.**

  The pūkeko lives in a swamp.

This issue looks at palliative care. Here are some words and phrases relevant to this type of care:

- **karakia**
  prayer, blessing
- **romiromi**
  massage
- **rongoā Māori**
  traditional medicine
- **aroha**
  compassionate care
- **wairuatanga**
  spirituality
- **whānau pani**
  bereaved family

E mihi ana ki a Titihuia Pakeho and Keelan Ransfield.

Ensuring CAs are interpreted correctly

NZNO's industrial team works hard to ensure that employers interpret collective agreement clauses correctly.

By lead organiser Andy Hipkiss

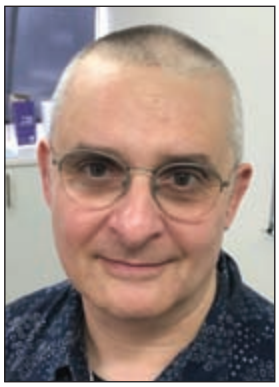
One of the jobs of a trade union is to negotiate collective agreements (CAs) and then to ensure they are applied correctly. If not, trade unions must enforce them on behalf of members.

The first step in this process is the organiser who works with the delegates to address workplace issues as they arise. Often it is the organiser who has negotiated the CA in the first place, or has been a part of a larger bargaining team for a national CA.

Often, it doesn't take long for issues with interpreting these agreements to arise, as employers interpret them one way and the union interprets the same words in a different way. More often than not, these disagreements can be sorted out by the organiser discussing the issue directly with the employer to reach an agreed interpretation. Sometimes differences can't be resolved locally and have to be addressed nationally, with resolution through the Employment Relations Authority (ERA) in the most extreme of cases. Luckily, NZNO employs industrial advisers and a team of lawyers to help when local resolutions aren't possible or the disagreement extends beyond the local level, affecting members across the country.

Holidays Act compliance

There have been a number of interpretation issues around the country NZNO has dealt with or is still working on. One example we are working on, alongside other health unions, is ensuring district health boards (DHBs) comply with the Holidays Act. One of the clauses in the Act requires the employer to make two calculations when paying annual leave to ensure the person taking leave is paid the greater of ordinary or average pay for the period. Ordinary weekly pay is calculated based on the four weeks before the leave period. Average pay is calculated across a year. These rates may not differ much for most people who work 9-5 Monday to Friday. But those who work shifts, overtime, weekends or have had periods of unpaid or Accident Compensation Corporation leave or who have penal rates for weekends or unsocial hours as part of their wage, will find there is quite a difference. NZNO caught a number of DHBs misinterpreting the Holidays Act and not applying the two calculations to holiday pay, as well as failing to properly comply with other parts of the Act.



Andy Hipkiss

Another issue of interpretation we are currently working on involves meal breaks for night staff at Tairawhiti DHB. In May 2017, NZNO became aware of a MECA interpretation issue over meal breaks for night staff at the DHB. Members in at least four different areas were not able to take meal breaks so we ran a survey of members to establish the extent of the problem. This directly relates to clause 7.2 of the DHB MECA, which states that if you are unable to remove yourself from the workplace, you are entitled to be paid for the meal break.

Different arrangements in DHB

The organiser held member meetings and sought as much information on who was affected and which wards and departments had issues. She found a number of different arrangements across the DHB, including one area where the charge nurse manager had written to staff stating the meal-on-duty allowance would no longer be paid. NZNO raised the issue through the usual channels with no change and then wrote a letter to the chief executive Jim Green requiring compliance with the MECA and inviting the DHB to mediation. It took a very persistent organiser, supported by the industrial adviser and NZNO's legal team, until this year to resolve the issue. The resolution mean members are entitled to up to six years' back pay for their unrelieved meals breaks and there must be a uniform interpretation of the MECA clause across the DHB.

Resolving issues locally

A number of interpretation issues have come to the organising team recently. These include uniform allowances not being paid where uniforms are not supplied, at what rate overtime at the end of a night shift should be paid, travel reimbursement for on-call duty call backs, access to discretionary sick leave, bereavement leave entitlements, minimum guaranteed hours per fortnight and an employer changing rosters, thus changing a member's hours of work without the member's written consent. This list could go on and on. A lot of issues are relatively simple to resolve locally but some require much more work. The Holidays Act compliance issue, for instance, has involved all 20 DHBs, their centralised resource team and many health-sector unions. Work continues on this issue, which hopefully will be resolved soon.

The NZNO organising team is constantly on the lookout for misinterpretations or inconsistencies in the application of our more than 150 CAs. Organisers work tirelessly to ensure members' terms and conditions are respected and applied correctly and consistently. •

Primary health care: Access CA gets closer

The Access bargaining team, from left:, Linda Lonsdale (enrolled nurse, Kāpiti), Emma Holland (clinical team leader, Hawke's Bay) and Julia Spencer (registered nurse, Christchurch).

NZNO ADVOCATE Danielle Davies is confident there will be a proposed collective agreement (CA) settlement for the 80 registered and enrolled nurses working for Access Healthcare to consider next month.

Negotiations for an inaugural CA for nurses working for the community health provider have been underway since late June. Two more days of negotiations were held in Christchurch late last month and Davies said progress was made on the substantive claims, notably pay and pay scales. "We made great progress, but there's one more day to go."

Those negotiations will be in Wellington on September 10. "We aim to come up with an offer to take to members and I'm confident we will."

The negotiations were being conducted in a good spirit, she said. •

Hospice negotiations to start next month

NZNO HAS initiated bargaining for the national hospice multi-employer collective agreement (MECA), with negotiations expected to get underway in Wellington early next month.

An online claims survey was held last month and one of the key claims to emerge was the removal of individual hospice exemptions from the MECA. NZNO advocate Lynley Mulrine said there was a commitment in the current MECA that the removal of these exemptions would be a focus of negotiations for the next MECA. Other significant claims are for pay equity with district health board (DHB) nurses and parity with a range of other DHB conditions.

Meetings are underway this month for members covered by the MECA to endorse the claims and to vote on who should be on the negotiating team.

The current MECA expires on August 31 and covers 520 members in 21 hospices.

Mulrine and Nelson-based organiser Daniel Marshall are the NZNO advocates. Employment relations consultant Scott Doolan is the advocate for the employers. Mulrine said 19 hospital chief executive attended the last negotiations. •

DHBs: Funding boost for Auckland and Grey Hospital opens at last

AUCKLAND CITY Hospital has received a $262 million funding boost to replace 50-year-old infrastructure. The money was allocated in Budget 2019. Announcing the funding last month, Health Minister Chris Hipkins said it was for the second stage of core infrastructure works. Initial work, such as site investigations, surveys and testing, was underway, with physical work due to begin in October, the minister said.

Any infrastructure failure could compromise the hospital and new infrastructure would mean the DHB would be better positioned to meet growing demand," he said.

Budget 2018 had allocated $275 million for Auckland District Health Board (DHB) to begin upgrading key infrastructure, including lifts, fire protection systems, boilers, electrical substations and water systems. Hipkins said that work was progressing well.

Improving infrastructure in DHBs was a government priority, he said. A recent report on the current state of their assets highlighted a number of issues with core infrastructure across the country.

New Grey Hospital finally opens

The new Te Nikau, Grey Hospital and Health Centre finally opened last month, two years overdue and millions of dollars over budget. The 8500 square metre building, adjacent to the current Grey Base Hospital, includes 56 inpatient beds, three operating theatres, four transitional care units, two negative pressure rooms, a whānau/family room and a whare karakia/chapel

The integrated family health centre is on the ground floor and a general ward with six single rooms and 13 double rooms, all with ensuites, is on the first floor.

The new hospital also has a 24/7 emergency department, critical care unit, medical and surgical services, maternity services, radiology, laboratory services, paediatrics and outpatient care.

Mental health services will remain in the old hospital building until a new unit is built next year. •

Primary health care: Nurses support action

HEALTH MINISTER Chris Hipkins should spend a day in a general practice to understand the breadth and depth of practice nurses' knowledge and skills, according to Stoke (Nelson) Medical Centre practice nurse Rosalie Adamson.

Speaking at the stopwork meeting in Nelson, attended by close to 50 primary health care (PHC) nurses, Adamson said so much health care had been devolved from hospitals to PHC. "We have a huge knowledge base but are so undervalued."

Amber Davies

Nurses expressed their frustration at the pay gap between PHC nurses and those working for district health boards; others hoped for support from DHB nurses for PHC nurses' pay equity campaign "because we supported them" and nurses were urged to tell their stories so the public understood their roles.

Medical and injury centre nurse Bridget Wild said PHC nurses had been at the frontline of the response to COVID-19 and that had been "huge for us all and we all made sacrifices".

Amber Davies, who attended one of the Wellington stopwork meetings, said the pay equity campaign was "a respect issue", that reflected the difference in skill sets now compared to earlier. "Primary health care nurses these days have a huge range of skills and are independent practitioners in their own right," said Davies, who has worked as a PHC nurse for five years. "We might see a newborn baby, then have a conversation about death-planning, all within 15 minutes."

Nelson primary health care nurses show their support for action to secure pay parity with district health board colleagues.

Wellington nurse Louise French, who has worked in PHC for 20 years, said the pay gap was "unfair. We've had to become more and more skilled, as our population has changed. With more emphasis on keeping people out of hospital we've had to expand our skill set." •

Aged care: Bupa bargaining starts

NEGOTIATIONS WITH the country's largest aged-care provider, Bupa, got underway with two days of bargaining earlier this month. Claims include:

- a one-off lump sum payment for caregivers to recognise the sacrifices all members made during the COVID-19 crisis and because the care and support workers' settlement does not provide for an increase this year;
- wage relativity with the distirct health board enrolled nurses (ENs) and a wage scale greater than that of caregivers; and
- remuneration parity with district health board (DHB) registered nurses (RNs), meaning the value of DHB nurses' conditions is added to RN base pay rates.

Other claims include paid time off for members and delegates to participate in campaign activities to make safe staffing a reality; a higher duties allowance; weekend allowances to match DHB rates; a duty leader allowance of $1/hour when performing this role; and updating the parental leave provisions to reflect recent increases.

NZNO's team is led by industrial adviser Lynley Mulrine and co-advocate Linda Boyd, with support from Dunedin-based organiser Colette Wright. The delegates on the team are caregivers Pauline Metzner, Kauri Coast, Dargaville; Jodi Thomson, Longwood Hospital, Riverton; Emily Lunam, Redwoods Retirement Home and Hospital, Rotorua; Epenesa Mutimuti, EN, Sunset Rest Home and Hospital, Auckland; and RNs Sarah Fredeluces, Tasman Care Home, Auckland, and Jacqueline Martin, Parklands, Christchurch.

NZNO will be negotiating alongside E tū, whose team is led by Alistair Duncan.

Claims endorsement is underway for NZNO members working at Oceania sites, with bargaining expected to get underway next month. Bargaining with Summerset will also start next month.

Aged-care industrial adviser Lesley Harry said individual site bargaining was also underway around the country. •

Proposed settlement at Family Planning

NZNO AND Family Planning (FP) have reached a proposed collective agreement (CA), which members are voting on this month. If ratified, it will deliver a 2.75 per cent pay increase, backdated to April 1, 2020, for nurses and health promoters. Medical receptionists will get a 3.75 per cent increase, also backdated to April 1.

Other improvements include five weeks' annual leave after six years' service, which NZNO advocate Chris Wilson said members had been seeking for a long time. And FP is committed to the principle of pay equity.

"We made it clear we will be lodging a pay equity claim during the term of the agreement," Wilson said.

If ratified, the CA will run from April 1, 2020 to September 30, 2021.

Wilson said NZNO's team had worked hard to achieve the changes in the proposed CA, particularly given FP's "clear funding shortfall". •

Colleges and sections 'active' during COVID-19

COLLEGES AND sections have remained active throughout the COVID-19 lockdown period, despite many having to defer conferences, annual general meetings (AGMs) and planned professional development opportunities until later this year, or even into 2021.

They are actively supporting members by contributing to the COVID-19 response in Aotearoa.

The efforts are too many to individually mention – so a huge vote of thanks to all college and section members who individually, or as part of a committee, assisted in the response to COVID-19.

COVID-19 response

During the lockdown period, with the support of colleges and sections, NZNO developed position papers, made submissions to the select committee on epidemic response and also made submissions to the various reviews that occurred.

They included the Ministry of Health's review of aged residential care and the Office of the Auditor-General's review of personal protective equipment.

The college of gerontology nurses was particularly active in this space.

As we emerge into a new phase of managing COVID-19 and learning to modify our lives to live with it, colleges and sections are again starting to get back into their schedules and offering forums, symposiums and other educational opportunities for members.

Keep an eye out for these events and please support the colleges and sections as we start to function in the new business-as-usual world and come to grips with what that might mean.

The college of respiratory nurses was among the first post-lockdown to hold an AGM through a mixture of Zoom and face-to-face in July. •

Report by acting manager professional nursing services Kate Weston

C&S day a 'celebration'

NZNO'S COLLEGE and section day this year would be a blend of Zoom and face-to-face in Wellington on August 18, acting associate manager of professional nursing services Kate Weston said.

Kate Weston

"The day is to celebrate with the colleges and sections the achievements and how they have risen above the adversity of the last few months.

"We are excited to bring people together to discuss the challenges of working in a COVID-19 situation. It is also an opportunity to celebrate the successes and to look ahead to the planned work for the colleges and sections going into for 2021."

College of emergency nurses New Zealand chair Sandra Richardson was scheduled to discuss violence against nurses and the college's submission to Parliament's justice select committee.

Enrolled nurses' section chair Robyn Hewlett was scheduled to talk about the section's success in achieving an enrolled nurses support into practice (ENSiPP) programme.

The college of critical care nurses chair, Steve Kirby, would be discussing COVID-19 then, now and into the future.

A presentation on the ethics of managing scarce resources in health care from the National Ethics Advisory Committee was also planned. There would also be a round table opportunity to discuss NZNO strategy, policies, the election manifesto and growing leaders. •

Members' vision for NZNO sought

A SURVEY seeking members' vision for NZNO is being extended to all members.

Last year at NZNO's annual general meeting (AGM) the membership committee surveyed 109 members about their vision for NZNO. This is now being extended to the wider membership and the committee wished to encourage all members to have their say, chair Sandra Corbett said.

The survey was intended to improve member engagement and understanding of NZNO and the committee.

The committee's work includes:

- Developing clearer guidelines for delegates dealing with workplace issues.
- Considering changes to the board such as introducing an independent director, an honorarium, ensuring governance understanding and asking the board be available for question and answer sessions.
- Creating a database of cultural competence training for NZNO members, to ensure members are culturally, as well as clinically, safe.
- Having an online membership committee charter, to support members' understanding of NZNO.
- Collating member feedback on the NZNO complaints and policy consultation.
- Encouraging regional councils and other structures to support members for whom transport is a barrier to reaching meetings.
- Engaging with and supporting local students and representatives.
- Developing an orientation package for new membership committee members, to ensure they are informed and supported.
- Extending the use of Zoom, alongside face to face meetings, to improve communications throughout the organisation.
- Making more online delegate and professional development training available.

The survey can be found here: www.surveymonkey.com/r/NZNOMCSurvey2020. •

NZNO board by-election – nominations confirmed

On the following four pages, we publish brief, supplied profiles of the two candidates standing for president and six candidates standing for the three board vacancies. The profiles have not been edited by *Kai Tiaki Nursing New Zealand's* co-editors.

Two candidates for president

Brenda Close

Professional Qualifications:
Diploma in Nursing and Master's in Nursing

Candidate Statement:
I am privileged to whakapapa to Te Ao Māori and Te Ao Pākehā. My bicultural heritage allows me to stand confidently in two worlds. I have been a nurse and NZNO member for over 30 years. I have held numerous roles and have been a serving member on committees in nursing, health and NZNO, providing professional and cultural advice and support. These opportunities have allowed me to represent nursing, Māori and membership locally, nationally and internationally.

I believe I have the skills, determination and strength to lead NZNO through its current turmoil, resetting the Kaupapa, rebuilding our organisation and uniting our membership. There is much to achieve, professionally and industrially, and I plan to represent membership and work collaboratively to ensure that our organisation brings to life our commitment to our bicultural partnership and to ensuring our members are "Freed to care, Proud to Nurse".

Previous relevant experience:
My previous nursing leadership roles in my employment and as an NZNO member demonstrate my abilities and skill in both corporate and clinical governance. My service record reflects my passion and commitment to nursing and health. I have developed strategy and translated this operationally. My cultural diversity enriches my practice.

Declaration of Conflicts of Interest:
None.

Heather Symes

Professional Qualifications:
Registered Comprehensive Nurse.
Diploma in Nursing.
Post Graduate Certificate Health Sciences – Mental Health.

Candidate Statement:
I have been a NZNO delegate for 20+ years and have previous experience on the NZNO Board of Directors. I was part of the decision-making process when the governance model was introduced to NZNO. NZNO values align with my own values of inclusiveness, social justice and concerns for the health of all New Zealanders. Te Tiriti O Waitangi is the founding document of New Zealand and must be upheld in all discussions and decision making.

I have overseas and New Zealand nursing experience in general and mental health, in private and public health systems. I am calm in a crisis and enjoy working with people with complex health needs. I pride myself in keeping up to date with what is happening nationally and internationally for nursing and healthcare. I believe in robust debate to reach a consensus. Working together is the key to developing solutions for our organisation.

Previous relevant experience:
NZNO Board of Directors 2010-2011. Women in Secure Care Environment National Committee member until 2020. Previous committee member and NZNO representative of National Council of Women of New Zealand – Christchurch Branch. NZNO Canterbury Regional Council member. NZNO delegate representative – Life Preserving Services negotiations for 2018 nurses strike.

Declaration of Conflicts of Interest:
Employee of the Canterbury District Health Board.
NZNO Member.

Six standing for three board positions

Noleen Dayal

Professional Qualifications:
Diploma in Enrolled Nursing at Unitec
Candidate Statement:
If I am elected as a board member of NZNO, I will work on bridging the gap between members and leaders of NZNO by providing members with straightforward and transparent information. I am also strongly passionate about enrolled nurses and their roles in the healthcare setting and would like to work towards implementing an education system that transitions New Zealand ENs to RNs. Whilst my time as a representative may have been short, I am strong, focussed and do not fear speaking up for myself or my colleagues. I will bring lots of passion, new energy and a fresh face to the board.
Previous relevant experience:
Enrolled Nurse at Muriwai ward, Waitakere Hospital.
(February 2016 till date)
Enrolled Nurse at Laura Ferguson Rehabilitation, Auckland.
(October 2014 – February 2016).
Enrolled Nurse at Grace Joel Retirement Village, Auckland.
(September 2014 – October 2015)
Declaration of Conflicts of Interest:
None.

Geraldine Kirkwood

Professional Qualifications:
Dip HE in Nursing Studies and PG Dip in Health Management
Candidate Statement:
I am an overseas qualified nurse working in New Zealand since 1997. I am an active NZNO delegate, member of GAR (Greater Auckland Region) council and a member of the NDC (National Delegate's Committee). I am seeking membership to the BOD to ensure our issues are escalated so that we can be "freed to care and proud to nurse". I believe in working collaboratively and compassionately to resolve issues. If I am successful I will be working to represent you all and will remain an active member of GAR. Thank you for your support and the opportunity.

Previous relevant experience:
NZNO Senior nurse delegate for Waitakere hospital
GAR (Greater Auckland Regional Council) Member
Waitematā District Health Board (WDHB) National Delegate Committee Member
DHB MECA Negotiation Team member
Declaration of Conflicts of Interest:
None.

Tina Konia

Professional Qualifications:
New Zealand Registered Nurse
PG Cert Health Sciences
BN Nursing
Candidate Statement:
My vision is to mobilise forward in a meaningful transparent way. This was realised after attending Global Nurses United forum in 2019. I heard the international struggles, and I know our own struggles I bring to the position – innovation and forward thinking. The recent changes worldwide has put a demand on nursing and it is up to us to take advantage of putting our best foot forward and mobilise together. My three year experience in governance with Te Poari has given me the insight where New Zealand nursing sits internationally. We are all born of greatness therefore we need to grow, change our collective DNA and evolve.
Previous relevant experience:
NZNO National Delegate
NZNO Workplace Delegate
NetP Recipient Renal and Respiratory
Emergency Nurse
Clinical Nurse Lecturer
Te Waireka – Rangatahi Alcohol and Drug rehabilitation residence
Family Planning Association – Medical Receptionist
Declaration of Conflicts of Interest:
Registered Nurse HBDHB
NZNO Te Matau a Māui Regional Council member
National Māori Nurses Roopu
Australasian College of Emergency Medicine ACEM – Manaaki Mana Roopu

Diane McCulloch

Professional Qualifications:
Bachelor of Health Science (Nursing)
Master of Health Science (Nursing)
Candidate Statement:
I AM YOUR VOICE
I have the confidence, desire, vitality and astuteness to be a self-motivated and active Board member, who is able to promote the profession and as a nurse in clinical practice at an advanced level. As a long time NZNO member and delegate

in the forefront of our struggle gives me the exposure to work as a board member. I have spent my professional time as a clinician and advocate for advanced nursing practice. My involvement with NZNO thus far empowers me to better serve nurses. We play a vital role in influencing health outcomes in NZ. It is our obligation as nurses to endorse ourselves as health policy advocates. NZNO has a significant role in enlightening excellence in healthcare endorsing intervention on social factors, issues like safe staffing, education, pay equity, sick leave benefits and improved working conditions. These can only be achieved when we stand strong together.

Previous relevant experience:
Winner Health Excellence Award (2010)
Waitematā DHB
Member Quality group
Member group drug profiles
Medication Standing Orders Development
Quality Documentation Development
NZNO Delegate/National Delegate/Committee 2 I C – Waitematā DHB
NZNO Committee Member Greater Auckland Region
Member CENNZ and AENN, Trustee NERF

Declaration of Conflicts of Interest:
GAR member, Trustee NERF

Clivena Ngatai

Professional Qualifications:
Dip. Bus Admin (Health Management)
BA Health Science (Nursing)

Candidate Statement:
My commitment to nursing is as strong now as it was when I first started. My vision for nursing is to promote excellence in patient care, contribute to and advocate for the development of nursing education programs and the ongoing professional development of members. Strengthening workforce planning, sustainability and leadership, and ensuring NZNO is engaged with their members and understands the issues that nurses today face.

Manaakitanga encompasses how I nurse today. Upholding the values of integrity, honesty, trust is my central focus ensuring the "mana" of both NZNO and nursing is upheld.

Previous relevant experience:
CHARGE NURSE MANAGER
My specialty is surgery. My main area is the perioperative setting; however, I have also run radiology department, district nursing and been a clinical service manager in private practice. I have worked in Christchurch, Auckland, Hamilton and now Rotorua as the Charge Nurse Manager of Operating theatres.

Declaration of Conflicts of Interest:
I hereby declare that I have no conflict of interest and will remain impartial and unbiased in my duties as a Board member of NZNO representing the nursing workforce.

Matewai Ririnui

Professional Qualifications:
Te Ara Reo Māori Certificate
Te Ara Reo Māori Diploma
Healthcare Assistant Certificate
Bachelor of Nursing
PGrd Cert Mental Health Nursing

Candidate Statement:
I am a passionate mental health nurse. My passion stems more than 20 years. I successfully graduated as a registered nurse, at Southern Institute of Technology in 2017. My love affair with my culture allows me a holistic insight into the world around us. Providing me with an indigenised world view that offers a point of difference to policy and decision making, enabling a solid foundation to facilitate growth that will be of benefit for members ensuring effective policies and management strategies with a very high standard of service delivery.

Therefore, please accept my application on behalf of Te Iwi Māori to competently influence the direction of the constitution in accordance with the relationship between the crown, and Mana whenua o Aotearoa. My divergent approach will effectively facilitate solution-based strategies and efficient policies that will enable collaborative consultation between shareholders, policy makers, and whānau within every community living in Aotearoa.

Previous relevant experience:
Te Rūnanga Tōpūtanga Tapuhi Kaitiaki O Aotearoa Tiamana O Te Tai Tonga Rohe
Te Poari NZNO Representative
He Mana Tapuhi Nursing Student Mentor
Board Chairperson for Te Wharekura O Arowhenua Kura Kaupapa Māori
Kawawhakaruruhu Tauira Representative
Vocational Service Coordinator
IHC Annual Appeal Regional Coordinator

Declaration of Conflicts of Interest:
NZNO DHB Delegate
Te Poari Representative
Te Rūnanga Te Tai Tonga Tiamana
DHB MECA Bargaining Negotiating Delegate
Te Tai Tonga Regional Council Management Member

• Board of Directors By-election

Nominations to fill the position of president and five vacancies on the NZNO board closed at 12 noon, Friday, July 17. One nomination for **vice-president** was received from **Tracey Morgan**, who was duly elected unopposed.

Voting opened on **Wednesday, August 5** and **closes at 12 noon, Friday, September 11.** Members will be able to vote for the president and board positions, constitutional and policy remits at the same time.

WELCOME

The New Zealand Nurses Organisation (NZNO) invites you to register for its 2020 online Conference.

Change is constant, and this year COVID-19 has brought a larger change than we could have anticipated. That's why we won't be meeting face-to-face in Wellington this year; instead the Conference and Annual General Meeting will be ..

.. moving online!

2020 is an especially significant year for nursing globally and in New Zealand. The World Health Organization has designated the year 2020 as "The Year of the Nurse and Midwife" and the International Council of Nurses has set the International Nurses Day theme as "Nurses: A voice to lead – Nursing the World to Health".

Our Conference theme "Community Wellbeing in Aotearoa, Nursing 2020 and beyond" acknowledges that empowered nurses play an essential role by improving the wellbeing of our communities. It's a theme which helps us focus on the need to be working within communities, and to profile the value and contribution nursing makes to achieving equity for indigenous people, universal health coverage and gender equity.

Each year we recognise and celebrate nurses who have made special contributions to the nursing profession and NZNO. This year we will acknowledge our Young Nurse of the Year, awards for Services to NZNO, and Services to Nursing and Midwifery at our AGM.

Some of our Conference presenters:

- **John Ryan**, Auditor General
- **Dr Graham Gulbransen**, Cannabis Care
- **Lizzy Kepa-Henry**, Public Health Nurse, Hutt Valley DHB
- **Margareth Broodkoorn**, Chief Nursing Officer

Moving the event online will bring our presenters to you in your space, allowing the opportunity to participate in the conference.

While we will not be meeting in person, you will have the chance to chat with colleagues, ask questions and receive all the information required to make the most of your 2020 NZNO conference.

Registrations are now open www.nzno.org.nz
Registrations close 31 August

Queries to **conference@nzno.org.nz**

Classified advertising

The use of aromatherapy in palliative care, p34-35 - references.

Follows on from page 48...

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Vote 20 Nursing Council

Notice of Confirmed Candidates

Nominations for three nurse members to be elected to the Nursing Council of New Zealand (NCNZ) Board closed at 5pm, Tuesday 30 June 2020.

Vote 20 Nursing Council (3 positions)

Thirty-one (31) nominations were received for the three (3) positions available. The candidates are:

Maureen ALLAN
Maria ARMSTRONG
Jane BOWERS
Yvonne BOYES
Jeanette BULTEEL-ADAMS
Beverley CARTER
Batool CHAGANI
Marion CLARK
Brenda CLOSE
Ann DAVIS
Ingrid FOSS
Beverley GIBSON
Hilary GRAHAM-SMITH
Heather GUNTER
Marion GUY
Karen HOARE
Elizabeth HOSKING
Hemaima HUGHES
Janice LEWIS
Juliet MANNING
Togarasei MARAHWA
Asmitha PATCHAY
Emmanuel PELAYO
Elwynne RICHARDS
Maxwell RUSERO
Mary SYLVESTER
Helen TOPIA
Shinoy VELLATTUKUDY
Anna WHEELER
Diane WILLIAMS
Deborah YARRALL

As there were more nominations received than positions available, an election will be required.

Any nurse on the register of the NCNZ with a current annual practising certificate and a New Zealand residential address as at 5pm Friday 30 June 2020 is eligible to vote.

Nurses with a valid email address recorded with NCNZ will be emailed their voting details on Monday 27 July 2020. Nurses who do not have an email address recorded with NCNZ will be posted a voting credentials letter on Monday 27 July 2020, which will take between 3-5 days to be delivered.

Voting will close at 5pm, Friday 4 September 2020.

Warwick Lampp
Deputy Returning Officer – Nursing Council of NZ
0800 666 045, iro@electionz.com

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The use of aromatherapy in palliative care, p34-35 - references

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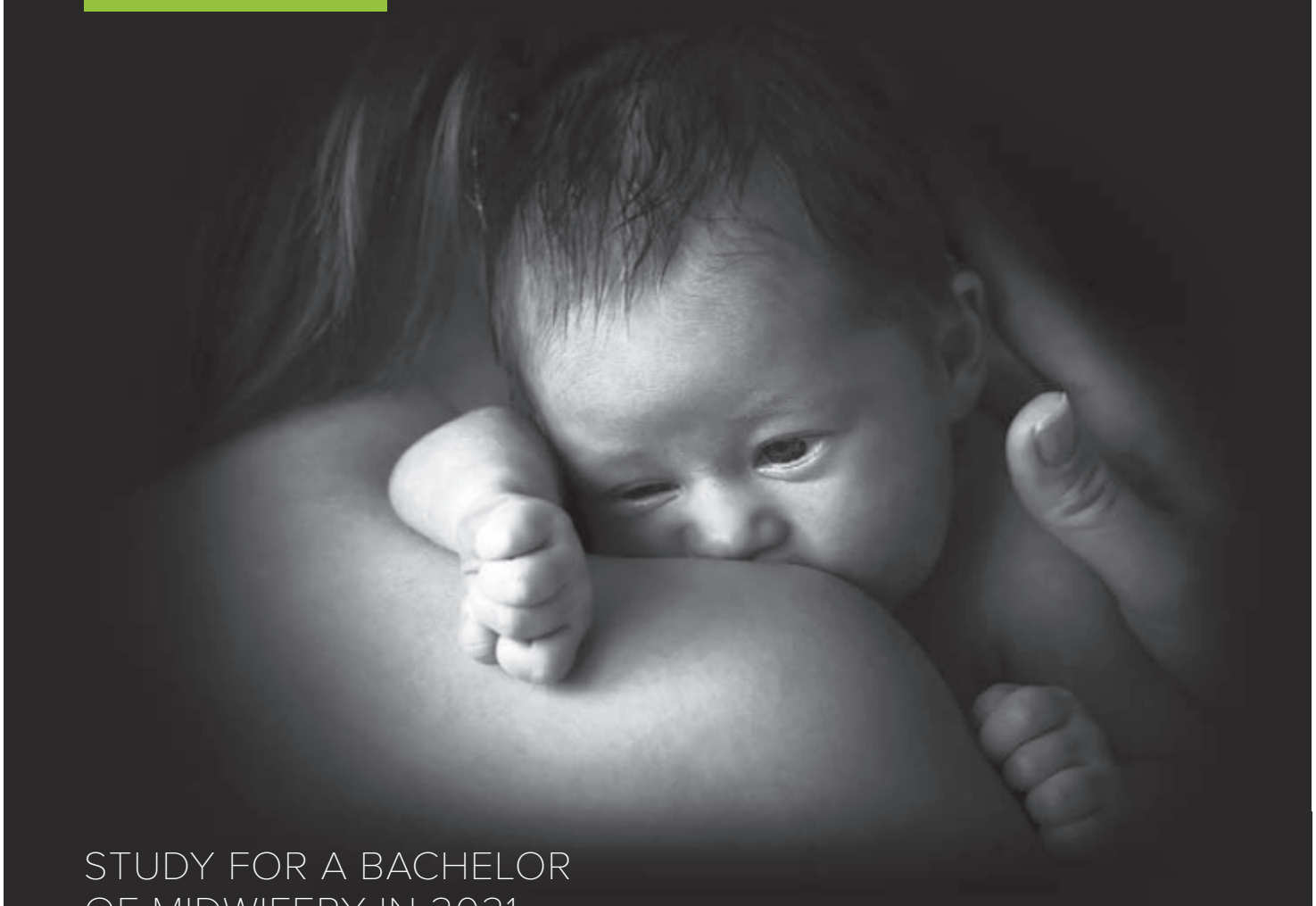

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