Kai Tiaki NURSING NEW ZEALAND

July 2020 vol 26 no 6

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ISSN 1173-2032

Vol. 26 No. 6 JULY 2020

THIS ISSUE focuses on primary health care. There's a range of articles, from a news focus on the comprehensive review of the health and disability system to maintaining diabetes care during the COVID-19 lockdown. There's a profile of a community nurse and an article on the benefits of community gardens. Nurses are asked to consider what the End of Life Choice Act could mean for their practice and professional education looks at self management of long-term conditions.

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

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

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

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

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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Photo: NZNO stock shot.

Cover design: Kathy Stodart.

Pre-press production: TBD Design.

Printers: Inkwise.

Taking the step into leadership

By Kelly Robertson

As nurses working across various health systems, at times we all demonstrate a level of leadership which contributes to patient safety and quality of care. Yet we often do not recognise ourselves as "leaders". We believe it is part of our everyday practice to provide care, advocate for patients, support colleagues and mentor new staff. We are organised, we direct and delegate, we use our inter-personal skills to help others within our clinical practice – these are all aspects of leadership.

Many of us do not aspire to top-level positions, or to work in governance and political roles. Not all of us wish to become directors of nursing or charge nurses. However, there are several levels of leadership within our profession. It is important to acknowledge nurses who make the shift from direct patient care to roles that support and influence our workforce to provide quality care – our nursing educators, advisers, facilitators, coordinators and so forth. These nurses combine their clinical knowledge and experience to play a pivotal role in strengthening our workforce, while providing the leadership needed to implement evidence-based practice.

So, as nurses, when in our career do we decide to make this transition and what support do we need? There is limited research that measures nurses' interest in seeking formal leadership roles. However, anecdotally, we know that, for many, it is the years of clinical experience and knowledge that guide them to explore these roles. For others, it is study that encourages aspirations of leadership.

As more services are devolved to the ever-changing primary health sector, effective nursing leadership is particularly important. I am encouraged that, over the past 20-plus years, we have seen the growth of several primary health-care (PHC) nursing leadership models, which support the development of our PHC workforce.

These have emerged, not only from district health boards, but from a growing number of primary health organisations, non-governmental organisations and other community providers, all of which have invested in nursing leadership. They have included new career pathways to identify and support those nurses ready to take up leadership opportunities or promote change and support the development of new roles and models of practice.

Our response to COVID-19 showed how well nurse leadership in PHC works. Across the country we had nurses not only working at the frontline in general practice, community assessment centres and triage centres, but also contributing around the table in emergency operations centres to ensure a coordinated response.

Moving from the bedside

For myself, never did I imagine as a registered nurse (RN), I would move from bedside nursing. However, throughout my career, I have been provided with many opportunities to take on new challenges and advance in new directions.

New York-based health-care consultant Harriet Forman (EdD, RN), has clearly described how I have felt during my career in primary health and moving from direct patient care to a formal leadership position.

As a practising clinical nurse, she cared for a relatively small number of patients. Her patients felt cared for, her supervisors were confident in her skills, and she felt fulfilled and loved being a nurse. But as the years flew by, she needed more money to support her family than was available to bedside nurses. So, with some reluctance, Forman became a nurse administrator.

But it was in that role, despite rarely having the opportunity to "lay on hands", she discovered she could facilitate nursing care for many more patients than before. Rather than reaching eight to 10 patients as a bedside nurse, as an administrator she could influence the care provided to 50 times that. And, later, as a chief nurse, she was able to reach 80 times that number.

The roles I have held throughout my career have allowed me the privilege of nurturing, mentoring, educating, influencing, leading and sharing humour and grief with so many nurses.

The roles I have held throughout my career have allowed me the privilege of nurturing, mentoring, educating, influencing, leading and sharing humour and grief with so many nurses. From working in partnership with other primary health nursing leaders, past and present, I know that the work we have undertaken and continue to do has, in turn, shaped the direction of our current and future nursing workforce.

For me, as I continue my nursing journey, I appreciate the importance of being able to empower and inspire others in leading change to meet the current and future demands of our PHC system. •

Kelly Robertson, RN, PG Cert (HealSc), is chair of the professional practice committee, New Zealand College of Primary Health Care Nurses, NZNO.

Tell us what you think

Columnist Damien Grant is 'dangerously wrong'

IT'S OFTEN stated that while everyone has an opinion, not everyone's opinion is of equal value. *Stuff* columnist Damien Grant proved this with his June 21 piece, "New Zealand will be left behind with 'Covid-hysteria' ".

The essence of Grant's article is that "elimination" of the SARS-CoV-2 virus is impossible, so we should be aiming for "herd immunity". While Grant is correct on the first point, he is dangerously wrong on the second.

To achieve "herd immunity" (where enough of the population has been exposed and can generate an immune response to the virus that it cannot continue to spread), 70 per cent of New Zealanders would have to have caught the virus. That's 3.5 million people.

In New Zealand, we have so far had about 1500 cases (an overestimate to allow for some untraced community spread), 89 hospitalised, nine admitted to intensive care and 22 deaths.

This translates to a hospitalisation rate of 5.9 per cent, with 0.6 per cent requiring intensive care unit (ICU) care, while 1.5 per cent of those infected died. What does that mean for those 3.5 million New Zealanders Grant wants infected?

A total of 206,500 would need hospitalisation, yet there are only about 13,000 hospital beds in the country; and 21,000 would require ICU-level care. Using every resource available in New Zealand, we could manage close to 800 ICU beds (but we don't have anywhere near that number of ICU nurses); 51,333 would die.

New Zealand's health-care system would collapse, even assuming the best-case scenario. Many people wouldn't get admitted, so deaths would actually be far higher due to prioritisation of resources. And let's not forget the cancer, cardiac and road accident patients – and people with other life or limb-threatening conditions – who wouldn't get essential treatment.

And here's where Grant's argument really falls down – as yet we aren't even sure if surviving infection confers long-term immunity. (Abridged)

Simon Auty, RN, BN, PGDipHlth, *Wellington*

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.

Rebuilding aged care

THE MAY issue of *Kai Tiaki Nursing New Zealand* gave an overview of weaknesses in the aged residential care (ARC) sector, which arose during the COVID-19 lockdown (see p12-13).

The ARC sector amalgamates three levels of care – rest home, dementia and hospital. Regardless of care levels, it is not unusual to have one registered nurse (RN) on duty, nursing 40-50 residents and supervising a substantial number of health-care assistants (HCAs). Some facilities employ more than one RN. However, new-graduate RNs continue to feel isolated as they are "left" without leadership or supervision, yet are responsible for high-acuity residents and expected to manage and supervise a team of unregulated workers.

Staff in ARC are expected to be proficient, confident and competent practitioners, skilled in leadership and able to support and mentor staff. Challenges around RN employment and retention highlighted in the article are all too true. But what is available for a nurse in this sector? There is no clinical pathway, there are few nurse practitioners. Ask RNs about professional development, and you are met with the belief that professional development is sourced solely in courses. A lot of the problem comes back to the lack of nursing leadership.

NZNO industrial adviser Lesley Harry says "the value of older adults is re-

NOTICE TO MEMBERS

NEW ZEALAND NURSES ORGANISATION | TŌPŪTANGA TAPUHI KAITIAKI O AOTEAROA

• 2020 NZNO board by-elections

STAND UP and make a difference! Nominations for the NZNO board of directors by-elections closed on Friday, July 17.

This is a time when real change is possible. For example, plans are underway for a constitutional review and if you have governance skills and experience for that sort of change, I hope you have put yourself forward and been nominated and endorsed.

This is your organisation and this is your challenge and opportunity. Step up and vote on the remits when you receive them and please also vote for your preferred board candidate(s) when voting opens on August 5. We have vacancies for the president, the vice-president and three board members.

Our member voting numbers have been as low as less than 10 percent in the past and that concerns me. How we are governed and who governs us is important, so please don't let this opportunity to have your say pass you by.

Find out more at www.nzno.org.nz.

Memo Musa, NZNO chief executive

flected in the value of the people who care for them". That care is neither achievable nor safe when running facilities and implementing nursing practice is the responsibility of an unregulated, untrained workforce.

The article suggests the system is broken. I suggest the sector has always been fragmented and it is all these factors that restricted staff's ability to respond to this virus.

HCAs are hardworking, dedicated people. I also acknowledge the work and dedication of Rosewood and St Margaret's ARC staff. The issue lies far deeper than shared bathrooms or inadequate equipment. COVID-19 only made the wrong-doings and inadequacies surface.

ARC is a specialised area where not only generalist nurses should be employed, but nurses with gerontological expertise and leadership skills. The support of nursing and nursing education is crucial. I suggest staffing in the sector should exist solely of enrolled nurses and RNs. (Abridged)

Molly Page, RN, MN,
Horowhenua

'A sad state of affairs'

SO KAIWHAKAHAERE Kerri Nuku is "disgusted", describing the resignation of former president Grant Brookes as the result of a "personal agenda to take the organisation down" (p7, May issue).

The blame has started. I was saddened that a member of NZNO's board would stoop to such measures. I agree with letter writer Alana Whiting, on p3 of the same issue, that it's time to "remove the dead wood". It's unlikely that transparency and democracy will prevail with the remaining board members.

I was also shocked to read that $250,000 has been squandered on legal fees (p8, May issue). This money has been spent to bolster fragile egos. And this is our money! No wonder so many members have cancelled their membership. It's a sad state of affairs, showing immaturity and a lack of leadership.

Alistair Buchanan, RN,
Wellington

Face-to-face AGM important

NZNO's BOARD of directors has decided not to hold an annual general meeting (AGM) in Wellington this September, and instead to prepare for a shorter, smaller meeting via Zoom. The reason given is "uncertainty around COVID-19 alert levels and travel restrictions" ('NZNO plans for online AGM', June issue).

But if those concerns really were the decisive factors, then surely they would apply to all large NZNO gatherings held in the next few months.

In August, Te Rūnanga's hui ā-tau and indigenous nurses conference are going ahead face-to-face in Tāmaki Makaurau. Meeting kanohi ki te kanohi is important for tauira, kaimahi hauora and tapuhi kaitiaki.

However the face-to-face NZNO AGM is also important. Under the terms of NZNO's flawed constitution, the AGM represents a very limited form of democratic control by the NZNO membership.

AGM delegates get to vote on just a handful of matters. They typically do so without consulting the members they represent, and the ballots are cast in

Minutes confidential when 'in committee'

THE CO-EDITORS would like to clarify that NZNO board minutes are only confidential for a meeting or parts of a meeting that have been held "in committee". We reported in June that the minutes of four board meetings which took place in April following the resignation of former president Grant Brookes were not available for reasons of confidentiality.

This is correct, but the co-editors wish to be clear that only the minutes of a meeting or parts of a meeting held "in committee" are confidential. The four meetings referred to above were all entirely "in committee", thus their minutes remain confidential.

Kai Tiaki Nursing New Zealand has been advised that discussions at board meetings involving personal or staffing issues or financial and commercially sensitive matters, are held in committee to comply with the Privacy Act and NZNO's governance manual.

With the exception of in-committee minutes, NZNO board meeting minutes are available to members here: www.nzno.org.nz/about_us/governance.

Some who signed petitions were not members

IN JUNE's printed edition of *Kai Tiaki Nursing New Zealand*, we reported that a petition to remove NZNO's remaining six board members and hold fresh elections for all 11 places had been signed by 1745 NZNO members. In fact, only 1038 of those who signed the petition were financial members of NZNO.

We also reported that 719 members had signed a second petition, calling on members to reject any special general meeting called under the constitution "where members had not been fully informed from both parties' official representatives". In fact, only 512 of those who signed were financial members.

The co-editors apologise for these errors.

Clarification on kaiwhakahaere's term

THE CO-EDITORS also reported in our print edition that kaiwhakahaere Kerri Nuku had an "unlimited term", subject to a vote of confidence.

In fact, the term for both kaiwhakahaere and tumu whakarae is three years, with a right of re-election after each three-year term. There is no limit on the number of terms, but the kaiwhakahaere must still be nominated. Anyone else from Te Rūnanga o Aotearoa NZNO can also be nominated to stand for election.

Other directors, including the president and vice-president, have a limit of two consecutive three-year terms.

Te poari proposed the change, which was accepted at NZNO's annual general meeting in 2017, for equity because the kaiwhakahaere needed both exceptional governance and tikanga skills yet had a smaller pool of members to draw on.

secret so no-one ever knows how their "representative" voted. But on paper, at least, it is still "the highest decision-making authority of NZNO". It's where the board can theoretically be held to account.

More importantly, the mingling and talking at AGM allows delegates from different regions and professional groups to share information and perspectives about what's really going on in our union at the national level.

Why is the board not allowing it to go ahead, given the certainty around COVID-19 alert levels and travel restrictions which were provided by the Government a week before the last board meeting? (Abridged) Grant Brookes, RN, *Wellington*

The co-editors reply: At its April meeting, the board was presented with five options for holding the annual general meeting and conference, given the COVID-19 restrictions then in place and the uncertainty about how long the restrictions would last, particularly those relating to numbers able to attend events. Chief executive Memo Musa's paper, which contained the five options, also canvassed other considerations, such as penalties incurred when cancelling the venue, flights and accommodation after a certain date. After discussion, the board, including Grant Brookes, endorsed the option to move the AGM and conference online as a basis for planning. (See also Kai Tiaki Nursing New Zealand, *June 2020, p6.)*

As to the indigenous nurses' conference and hui ā-tau, the co-editors understand the planned venue for the August event, the Millennium Hotel in Auckland, is being used as a quarantine facility and the conference and hui ā-tau will not be held at this venue. Decisions are pending as to alternative options for the conference and hui ā-tau format and venue.

From the kaiwhakahaere: Our truth, our stories

By Kerri Nuku

CAN YOU imagine, travelling to a foreign land, nursing the falling soldiers and risking your own life for your country, but never having your services acknowledged, medals never presented and your stories never told? This is what our Māori nurses went through, and in many ways its a situation they still face today.

Anna Rogers, author of With them through hell (2018) recounts the response of the New Zealand medical services to the enormously horrific impact of the First World War and the deadly 1918 influenza. Through Rogers' quality storytelling you can almost smell the stench from trenches, the pain, distress and sadness as the ravages of war and diseases took its toll.

I want to 'mihi' and acknowledge the claimants of the Waitangi Tribunal 2500. Their stories have been lost and written out of history; who determines their value and who is silent? I am calling for those Māori nurses to be recognized and to be awarded their medals for their service to this country just as their peers were.

Hester Maclean was a powerful and influential nurse and in her role as the assistant Inspector of Hospitals was in charge of nursing services. Her views on Māori women as nurses were not always correct or acknowledged Māori nurses authority and mana within Māori communities. She had incorrect assumptions about gender relations within Māori society, believing that women were unable to wield sufficient authority to inculcate new health techniques. Further, she believed that Māori women may have been less inclined to challenge the tapu in place in the communities and be more likely to give Māori agency over how the health care was delivered.

Many of us also remember her as the inaugural editor of Kaitiaki whose purpose was 'a bond of union, a common interest, a means of communication, a mutual help, and a road to improvement in their professional work and knowledge, to all nurses of the Dominion . . .'

I have often wondered about the origin of the name Kaitiaki and the reason for choosing such a name and in the 1900s. It is understood that some of the decision to use the name was because of its distinctive connection to the journal's origin. Kaitiaki in Te reo means to give full effect to protection and guardianship, and this was the intent of the inaugural edition. Kaitiaki became an integral means for soldiers and nurses during war time to write to Kaitiaki lodging some of their most intimate thoughts, fears and aspirations. In Rogers' book the intimate and heartfelt writings are priceless.

I admire the foresight to use Kaitiaki as a 'journal of history from their writings' for nurses to use the power of their words to tell their truth through their eyes. However, to try to capture someone else's "story" is never the same as writing our own. Their language, thoughts or position can distort the story and often a story that is far from the reality. Yet, while the journal has been a crucial part of our history as nurses, there are many instances in Aotearoa New Zealand nursing history where Māori nurses' voices have been silenced and not captured in our history. We are only really starting to regain our voice after the Waitangi 2575 Tribunal recommendations.

In the 2020 Year of the Nurses and Midwife the journal of history is imperative to capture, for so long as nurses we have felt that the voices of nurses have been silenced and we have learnt to be silenced. It is Kaitiaki's obligation to give full effect to the protection and guardianship of Māori nurses to hear Māori nurse's voices, their truth and their stories.

Many of the stories of Māori Nurses remain "untold" but I also want to join with and acknowledge the nurses for their efforts during the wars. •

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1) Rogers, A. (2018). *With Them Through Hell.* Massey University Press.

2) Maclean, H. (1908). The Purposes of the Journal. *Kai Tiaki: the Journal of the Nurses of New Zealand, 1*(1). https://paperspast.natlib.govt.nz/periodicals/

Co-editors' note: This column has not gone through our normal editing process. and is published as submitted to us.

Ex-directors reluctant to break confidentiality

THREE BOARD members, who resigned together in April, are reluctant to speak of their experiences on, and decision to quit the NZNO board.

Anne Daniels, Katrina Hopkinson and Sela Ikavuka were elected last September after campaigning for transparency, unity and action on behalf of the NZNO members action group (MAG).

Anne Daniels

Sela Ikavuka

Katrina Hopkinson

They took up the roles in the aftermath of a rancorous special general meeting (SGM) over a board attempt to remove former president Grant Brookes.

But seven months later, on April 28, all three resigned, claiming they were unable to fulfil their campaign promises. "We believe NZNO and the board should be a safe place to be. However, right from the start, we were required to sign a confidentiality agreement before the first meeting," their joint statement said at the time.

Brookes had resigned earlier that month and vice-president Cheryl Hanham in March.

Daniels, Hopkinson and Ikavuka have declined *Kai Tiaki Nursing New Zealand's* request for an interview, citing the confidentiality agreement they signed at the start of their board term.

However, in a short statement, they said "events following [Brookes' resignation] were the catalyst for our resignation". They would not specify those events but said they remained "traumatised" by their experiences.

Three confidential board meetings were held after Brookes' resignation – two on April 23 and one on April 24. After Hopkinson, Daniels and Ikavuka resigned on April 28, a fourth took place on April 29 with the remaining six directors.

All were "in-committee" and the minutes are confidential.

In an interview in the May issue of *Kai Tiaki Nursing New Zealand* (p7), Nuku said the three had shown "a lack of governance understanding and responsibility to members". Responding to this, the trio said it was "disrespectful", failed to recognise their experience and had "tarnished our reputations".

Despite their difficulties on the board, they were involved in adding kindness to board values, setting up a district health board multi-employment collective agreement subcommittee to ensure members' voices were heard, launching regional board meetings and, with Brookes, developing a remit to start the journey towards nurse-patient ratios.

Simon Auty is the sole MAG member remaining on the board, alongside Andrew Cunningham and Te Rūnanga members Anamaria Watene, Margaret Hand, kaiwhakahaere Kerri Nuku and tumu whakarae Titihuia Pakeho. •

Second petition rejected by Musa

A SECOND petition, signed by 521 members, has been rejected by NZNO chief executive Memo Musa.

Lodged by Naomi Waipouri and Awa Love in May, the petition called on Musa to call a special general meeting (SGM) where members could vote to reject any SGM "where members have not been fully informed from both parties' officials prior to signing a petition . . ."

It also proposed members reject any SGM called outside of the constitution.

But Musa said in June the resolution "was not sufficiently defined". To accept it would have required an amendment to the constitution and there was ambiguity about whether or not the petition was calling for that, he said.

"As a result, I have decided that, as it is currently drafted, the resolution is not able to be voted on at an SGM," he said. "As with the first petition, I have not taken this decision lightly."

The petition came on the heels of an earlier one which sought removal of the NZNO board, and fresh full-board elections. Signed by 1038 financial members, that was also rejected by Musa in June, as "unconstitutional".

Musa, who sought two legal opinions, advised democratically-elected board members could not be removed without specific grounds identified in the constitution such as misconduct, neglect of duty or theft.

Both petitions followed the resignations of vice-president Cheryl Hanham in March, and president Grant Brookes and directors Katrina Hopkinson, Sela Ikavuka and Anne Daniels in April, leaving just six of 11 NZNO board members.

Musa said he hoped he could now focus on advocating for members in their workplaces, as "dealing with these two petitions has taken up an enormous amount of time". •

Wellington delegate quits after SGM fallout

LONG-TIME NZNO delegate Erin Kennedy has resigned as a Capital & Coast District Health Board (C&CDHB) delegate after 14 years, and quit NZNO's greater Wellington regional council (GWRC), amid bullying and racism complaints.

"I can't see the point in belonging to a council if we can't come to rational decisions," Kennedy told *Kai Tiaki Nursing New Zealand*. "It's difficult to engage in a meaningful discussion when any difference in point of view is viewed as bullying."

Kennedy said problems at the council began on September 11 last year, at a meeting discussing whether or not to support then-president Grant Brookes in an upcoming special general meeting (SGM).

Brookes was fighting a resolution by the board to remove him for misconduct after a dispute over the union's approach to the 2017/18 district health board (DHB) multi-employer collective agreement (MECA) negotiations. Brookes survived by a nine per cent majority, after voting by NZNO member groups including regional councils. A second SGM in December failed to support him. He has since resigned.

'Heated' meeting

Previously, GWRC generally made decisions by consensus, Kennedy said. But after a "heated" meeting in September, where, according to Kennedy, eventually, 17 voted to support Brookes and three voted against, several complaints of bullying and racism were lodged against Kennedy and other council members.

Kennedy, in October, lodged her own complaint to NZNO chief executive Memo Musa about "abusive messages" from Te Rūnanga members since the meeting. She received an apology from the board in April.

Erin Kennedy

'It's difficult to engage in a meaningful discussion when any difference in point of view is viewed as bullying."

Feeling "unsafe" to attend the next two GWRC meetings, she returned on June 10. That meeting, she described as "farcical" and "undemocratic".

An NZNO membership committee and Te Rūnanga member facilitated in place of GWRC chair Rerehau Bakker, who was not present. About a dozen Te Rūnanga members, who were not councillors, were present, some from outside the region, Kennedy said.

A Te Rūnanga member who Kennedy had not previously seen at GWRC meetings ended up being elected chair. "It was farcial. Members of Te Rūnanga who are not regional councillors were allowed to vote for the Rūnanga member who was also not a regional councillor."

Under the NZNO constitution, Te Rūnanga within the region can decide their own representation at regional councils.

Anyone seeking election to the NZNO board or presidency must be endorsed by their regional council, as must remits. "Regional councils hold a lot of power and having a small group in power is not right," Kennedy said. "It's a pretty poor regional council that can't talk to each other politely and come to consensus."

Kennedy said she hoped a restorative process could be organised, both regionally and nationally, to respond to what appeared to be a deepening bicultural rift within the organisation. "Without a restorative process, the GWRC will not continue to exist in any form useful to our members," she said. "The only way forward for NZNO is to find a way for people to talk together, and a way for all members to have a voice."

GWRC chair Rerehau Bakker wished Kennedy well. "GWRC is looking forward to and excited about re-building and restoring relationships within our membership," she said. "We would also like to wish Erin all the best and thank her for the amazing work she has done over the years."

Kai Tiaki Nursing New Zealand also sought comment from GWRC's Te Rūnanga representative but had not received a response at press time. •

Community response to mental health urged

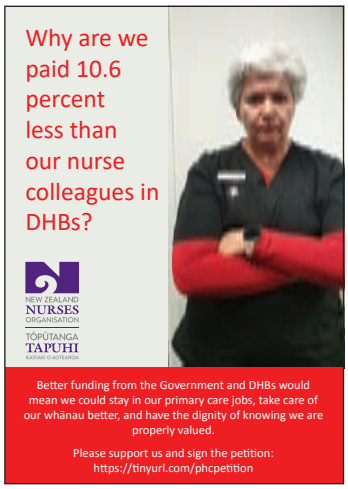
MENTAL HEALTH commissioner Kevin Allan has this month released *Aotearoa New Zealand's mental health and addiction services: The monitoring and advocacy report of the Mental Health Commissioner.* It recommends a shift away from a mainly service-based response to mental distress and addiction, to a whole-of-community response focused on wellbeing and recovery.

He Ara Oranga set the direction, said Allan, referring to the Government's 2018 report into mental health and addiction, "but much more needs to be done to get us there."

While there had been progress in early support, there was still a "pressing need" to improve services for people with complex and ongoing need. Government needed to partner with Māori, whānau and communities, Allan said. Ensuring all mental health and addiction services worked for Māori and were culturally safe was an urgent need. •

Primary health nurses to take national action

PRIMARY HEALTH care (PHC) nurses throughout the country will walk off the job for two hours on July 23 as they ramp up their efforts to squeeze money out of the Government for pay parity. The 3400 nurses and other workers covered by the PHC multi-employer agreement (PHC MECA) are taking the unprecedented action as part of their long-running campaign for pay equity with their district health board (DHB) colleagues. (See p39.)



The current pay gap between an experienced PHC nurse and their DHB counterpart is 10.6 per cent or around $7500 a year. And with DHB MECA negotiations now underway, it could widen considerably. PHC sector leaders have said repeatedly that unless the pay gap is bridged, nurses will leave the sector for better pay elsewhere. And 70 per cent of nurse respondents to an NZNO survey late last year signalled their intention to do so.

NZNO PHC industrial adviser and lead advocate for the PHC MECA negotiations Chris Wilson said the action was a clear indication of nurses' and other workers' frustration "after eight months of fruitless negotiations".

In May, members rejected the latest employer offer and mediation last month failed to achieve a resolution. Wilson pointed out that the situation was "not your usual union versus employer dispute", with general practice leaders supporting the campaign for pay parity.

In advice to its members on the meetings, the NZMA stated that while they were "likely to cause some disruption to the practice team and to your patients, it will also raise the public and political awareness of this issue and the wider issue of funding for general practice".

GPNZ also supports the campaign. Its chair, Jeff Lowe, said more needed to be done at a national level "to value and incentivise the nursing workforce, starting with fair pay".

Practice nurses delivered much of the care and support for people with complex long-term conditions and were the lynchpin of efforts to improve population health. But many practices were already struggling financially, having lost revenue during the COVID-19 lockdown. "They want to be able to pay their nurses more, but the money isn't there," he said.

Wilson said the pay gap was unjust and undervalued "the amazing work these nurses do in providing expert care in the community, demonstrated so clearly in the COVID-19 response".

The recently-released report of the health and disability system review emphasised the importance of primary care and that PHC nurses should expect pay parity.

"Resolving this really comes down to political will and our members' patience has just about run out. Budget 2020 put an extra $3.92 billion into DHBs over the next four years, whereas pay parity for PHC nurses would cost a mere $15 million," Wilson said.

All parties involved would ensure new Minister of Health Chris Hipkins was fully briefed and would be seeking his support for a resolution.

Organising the two-hour meetings, some via Zoom, for staff from more than 500 workplaces, and ensuring as many nurses as possible could attend, while maintaining safe staffing, was a huge logistical exercise, Wilson said. "We are expecting high participation because of the depth of nurses' frustration and the feedback we have already received." •

NZNO presents its claims to DHB team

MEMBER MEETINGS to discuss progress on the NZNO/district health board multi-employer collective agreement (NZNO/DHB MECA) negotiations are scheduled for late this month and next month. The meetings, which will be run by organisers and delegates, will be held throughout the country from July 29 to August 12.

NZNO lead advocate David Wait said the meetings would be an opportunity for members to hear about progress to date and to provide guidance to the bargaining team. Bargaining team delegates – there are 12 – will attend some of the meetings.

As *Kai Tiaki Nursing New Zealand* went to press, the second lot of negotiations was underway. The first three days last month had gone well, Wait said. "We opened the bargaining by presenting the claims endorsed by members. What is apparent from the breadth of members' claims is that the impact of a decade of under investment is still being felt. While we have seen some additional funding for the health system, much more is needed," he said.

The DHB team is led by Andrew Wilson, representing TAS (Technical Advisory Services), which manages the 20 DHBs' employment relations. It asked a number of questions aimed at clarifying NZNO's claims. The team tabled a letter from the State Services Commission calling for pay restraint in the public sector and members said they were listening to members' expectations, valued NZNO members and were only seeking to improve MECA conditions.

NZNO's pay claim is 17 per cent over two years. Other major claims are for more sick leave and better access to it (see p35), and more and better professional development leave, along with the time to undertake it. •

Ex-health minister left 'significant legacy'

NZNO HAD a constructive and at times challenging relationship, with former Health Minister David Clark. Responding to Clark's resignation earlier this month, chief executive Memo Musa said it was challenging at times because NZNO wanted significant nursing workforce planning and staffing issues fixed, and funding for nurse-led models of care.

Musa said Clark had inherited a health and disability system that had been "massively underfunded and under resourced" for more than nine years, during which time there had been inadequate attention to workforce and infrastructure investment.

During Clark's tenure there had been significant funding to mental health and addictions services following the government inquiry, to district health boards and to Pharmac. He also needed to be recognised for establishing the review of the health and disability system and his leadership and drive to fix safe staffing issues for nurses. "This included driving the funding to ensure 100 per cent employment of nursing graduates in a nurse-entry-to-practice programme within six months of graduation. It also included funding for an enrolled nurses' entry--to-practice programme. This came into effect this month after more than 15 years of lobbying."

David Clark

Musa said while his tenure had been marked by controversy during the COVID-19 lockdown, he had left a significant legacy.

"Health is a complex portfolio, with a lot of challenges The minister appeared to have put in time, resourcing and funding to begin to turn things round."

And he had always been willing to engage with NZNO members and answer their questions.

Musa said NZNO was looking forward to working with new Health Minister Chris Hipkins. "We, look forward to working with Minister Hipkins and talking to him, so he can get up to speed on what needs to be done to improve the health and disability system and on what our members contribute to the wellbeing of people and the recognition they deserve for that." •

Nurses' views not 'adequately heard' in review

NZNO MUST be involved in any changes to the residential aged care (ARC) sector following a review of the sector's response to COVID-19, NZNO has told the Ministry of Health (MoH).

The Director-General of Health Ashley Bloomfield commissioned the review in April after five COVID-19 clusters were linked to ARC facilities, but NZNO was only invited to comment on the findings. NZNO professional nursing adviser (PNA) Marg Bigsby said, in feedback, that nurses employed in ARC and those from district health boards (DHBs) who helped with the response "were not adequately heard".

Outbreak management policy

In late May, the panel recommended ARC, DHBs and public health units (PHUs) develop a national outbreak management policy, including leadership roles, reporting processes, staff and resident support, and supply and use of personal protective equipment (PPE).

It also acknowledged the ARC sector's "substantive" work in response to the outbreak. A total of 10 recommendations included developing an incident management team (IMT), "psycho-social" support for staff and residents, an ARC infection prevention and control strategy and a pandemic management "workbook".

But NZNO feedback from Bigsby and NZNO aged-care industrial adviser Lesley Harry said NZNO's involvement in any ARC review was "critical" in ensuring any future outbreaks had "less catastrophic" results for residents and staff.

The focus must be on the whole sector, not just 12 ARC facilities. Also, the NZNO college of gerontology nursing must be included in any national outbreak policy "as a way of ensuring worker representation", NZNO feedback stated.

Ties between ARC, DHBs and PHUs must be strengthened in normal times, to be able to work in when crises occured. "For DHBs to successfully work with ARCs and their staff, the relationships must already be in place."

NZNO also wanted industrial and professional representation on any new regional management team representing ARC, DHBs and PHUs. "Both NZNO organisers and professional nursing advisers contributed to raising issues during the pandemic."

Lack of a direct connection to an IMT had delayed managing health and safety risks, caused frustration to members and unnecessary exposure of some health-care workers to COVID-19, according to NZNO.

Union engagement would also help better support staff. Nurses in "cluster" facilities were "clearly distressed" at their inability to provide the right care. "The ethical dilemma of leaving a dying person alone to ensure others received the right care was one such concern," the feedback said.

NZNO wanted better access to professional support during such times, the opportunity to debrief after shifts and ongoing advice and support.

NZNO "clearly" needed to be involved in any national ARC IPC strategy. "Systemic, sector-wide responses are required to address the pervasive staffing and workload issues plaguing the sector."

NZNO's college of gerontology nursing must be involved in developing a pandemic management workbook.

The New Zealand Aged Care Association, a geriatrician, public health, infection prevention and control and hauora representatives comprised the review panel. •

NZNO welcomes review report

NZNO AGREES with the direction proposed in the health system review report released last month, and says the changes it suggests have been much anticipated.

Kaiwhakahaere Kerri Nuku says NZNO members have long advocated for the population health approach which the report rightly emphasises. "We especially welcome the proposed structural changes, particularly the Māori Health Authority. These changes echo the recommendations of the Wai 2575 Health Services and Outcomes Inquiry and will better reflect Te Tiriti. They will also ensure obligations under Te Tiriti are reflected across the whole health system."

Chief executive Memo Musa said nurses are the largest regulated body of health workers in Aotearoa New Zealand, so it was good to see the centrality of the health workforce reflected. However, attention must be given to making sure the proposed changes served the population and workforce well.

"The emphasis on strategic employment relations at tripartite level will be fundamental to sustained and sustainable health system change.

"We also agree with the proposed new governance arrangements because they could provide the strong leadership the system needs. They will also be an opportunity for nurses to step up and become more involved in high-level policy and funding."

But Musa said the devil was always in the detail. "We look forward to the changes and will be watching very closely. We very much encourage nurses to be involved in implementation and change, because this is where we have the most value to add."

For more on the proposed reforms – from NZNO policy staff and from a primary care nursing director – see p12-15.

NZNO staff changes

FINDLAY BIGGS has been appointed to NZNO as a medico-legal lawyer, replacing Anne McGill. He starts next month as part of the Auckland legal team but will be based in Hamilton.

Announcing his appointment, manager, nursing and professional services Mairi Lucas said Biggs had experience in dispute resolution and litigation, and a wide variety of other legal experience.

Wellington-based research and policy assistant Di Cookson has left NZNO after four years. Principal researcher Jinny Willis expressed regret at her resignation.

"Di has a passion for public health and soon progressed beyond her role. She contributed greatly to the preparation of NZNO policy submissions and went on to produce policy submissions independently," she said.

Cookson left in June to become a policy analyst with the New Zealand College of Public Health Medicine.

Pay equity process nears completion

THE HISTORIC undervaluation of nursing work may be officially established late next month. NZNO acting industrial services manager Glenda Alexander, who has led NZNO's work on pay equity, believes "we are on track" to have the analysis required to establish the undervaluation completed by the end of August.

Interviews with people in roles from the comparator occupations are underway. Data collected from these interviews will be assessed against the data collected from interviews with those in a range of nursing roles. Union and district health board (DHB) assessors are being trained to undertake this analysis. That assessment will include analysis of pay differentials, which Alexander is sure will establish the undervaluation of nursing work.

Once that has been established, negotiaions on how the pay equity settlement is applied will begin. Alexander stressed that both the pay equity process and implementation of its outcomes are separate from DHB multi-employer collective agreement negotiations.

Manifesto focuses on equity

NZNO's ELECTION manifesto is being finalised and is due for publication later this month. It now references the report of the Health and Disability System Review (HDSR) released last month.

The 2020 manifesto highlights health issues for NZNO members and other health professionals to consider, including COVID-19 in an election year and as they prepare to vote.

The manifesto, *Nursing Matters – even more in 2020,* will focus on the importance of equity in health, and primary health care services, both of which are addressed by the HDSR.

"Our manifesto, as it has developed, aligns nicely with the recommendations in the review, so really the next step is to see which of the HDSR recommendations a new government might adopt and follow through on," said NZNO nursing policy adviser/researcher Sue Gasquoine.

At the September 19 general election, New Zealanders will also be able to vote in referenda on whether to legalise recreational cannabis and enact the End of Life Choice Act (2019) in 2021.

NZNO was considering developing a position statement on the regulation and recreational use of cannabis, she said.

The 2019 End of Life Choice Act, which will come into force in 2021 if there is a majority "yes" vote in that referendum, would allow nurses to opt out of any involvement with patients using the Act to end their life. NZNO is also developing a position statement on assisted dying.

NZNO is planning research from nurses' perspectives on care at the end of life, in partnership with Te Rūnanga o Aotearoa NZNO. It is hoped the research, still in the early planning stages, will be conducted in several phases and result in a framework to support nurses in Aotearoa New Zealand when they care for people at the end of life and their whānau.

Further information can be found at: www.referendums.govt.nz

Board Māori nurse of the year

WAITEMATĀ DISTRICT Health Board named mental health nurse Chloe Maeva (below) its Māori Nurse of the Year early this month.

Maeva was presented with a korowai during a special ceremony where she was named the latest winner of the Te Kauae Raro Māori nursing and midwifery award.

"It was very surreal to receive this award. I see it as an award for my whole team and the work we do together," she said.

Of Te Rarawa, Ngai Takato and Ngāti Kurī descent, Maeva initially pursued physiotherapy, but was then given the opportunity to transfer to nursing at Unitec. She has been with the DHB for nearly four years and currently works in a specialist adult community mental health team (Moko Services) in the Waitakere area.

"It's seeing the positive outcomes for people in our community that keeps me going. It's the hope they get once they're connected to the support systems we offer."

Now part way through her masters of nursing and about to have her second child, Maeva plans to become a nurse practitioner to widen the scope of what she can offer and achieve with tāngata whai ora.

Learning te reo Māori for the past few years with Te Wānanga o Aotearoa has also deepened her connection to her Māori heritage and given her the confidence to speak te reo daily with her team.

"I grew up with an awareness and knowledge of tikanga and my heritage, but the thing that was missing for me was te reo. Everything was really solidified during those classes."

Maeva has always had a passion for sport and is the clinical lead and facilitator of Waitematā DHB's award-winning Te Rau Kamehameha Sports and Tikanga Programme. The programme uses a mixture of physical activity, social connection, and cultural education to help reconnect tangata whai ora with whānau, work and training.

"Coming into health has opened my eyes to the inequality that still exists for Māori across the whole sector. I see people come to our services who distrust the system and are disconnected from their culture. We're a unique team in that we offer cultural support and we see huge results from reconnecting what is often a complete loss of identity."

Maeva is a passionate advocate for Māori and works toward reducing inequities in health – particularly in the workforce. She's been recognised by her team as a role model to nurses entering the workforce, a support to her colleagues and an inspiration to tāngata whai ora. •

Coroner appointed Health & Disability Commissioner

AUCKLAND CORONER Morag McDowell has been appointed the new Health and Disability Commissioner (HDC), taking over from Anthony Hill.

McDowell (right) has been a coroner in the Auckland region since 2007. She has worked as a law lecturer and crown prosecutor, and as an adviser to the Health Quality & Safety Commission.

Making the announcement last month, the now former Health Minister David Clark said he was delighted McDowell had accepted "what is a crucial role, promoting and protecting the rights of New Zealanders when they access our health and disability services". She will be the country's fourth HDC, and takes up her new role on September 7. Clark thanked Hill for his 10 years in the job.

• Clark also announced last month the appointments to the inaugural Paramedic Council which will oversee regulation of New Zealand's more than 1000 paramedics. The council's first task will be to establish the new standards and processes required before all paramedics have to be registered. •

Course offers training in refugee and migrant health

A POSTGRADUATE course on refugee and migrant health, run by the University of Otago, Wellington, is offering primary health care professionals the opportunity to improve their training in the area. This is in anticipation of a likely increase in the number of refugees coming to the country.

The Government has announced an increase in the refugee quota from 1000 to 1500 from July this year, although the programme is on hold until borders reopen. The number of refugees able to enter the country through the family reunification category increases from 300 to 600 people. New refugee resettlement areas are to be established in Ashburton, Whanganui, Timaru, Blenheim, Masterton and Levin.

Course convenor Serena Moran says the paper offers nurses, doctors, pharmacists, physiotherapists, paramedics and others the chance to increase their skills in cross-cultural care. The course is primarily focused on caring for people from refugee backgrounds and looks beyond the specifics of health screening and mental health assessments.

"We look at the broader concepts of health, so we also look at people's journeys and how they came to be refugees because that impacts on their health and wellbeing," she said.

The paper is run by the university every second year, with the 2020 course starting early this month. •

A major review of the country's health and disability system was commissioned by then Health Minister David Clark in 2018. The review report was released this June. Over the following four pages are three different perspectives on the proposed reforms.

Population health will be the 'driver'

By NZNO nursing policy adviser/researcher Sue Gasquoine and policy analyst Leanne Rahman

The Health and Disability System Review recommends significant structural changes to the health system, while focusing on people for whom the current system is not working. While this change will be costly and disruptive, the focus on equity, te Tiriti o Waitangi articles and the workforce promotes hope in a failing system.

An overview of the review indicates that population health will be the "driver" of the change towards a new health and disability system. This is defined as "taking a proactive approach to promoting and protecting health, keeping individuals and populations as healthy as possible and reducing threats to health".[1]

The proposed new structure will disestablish the Health Promotion Agency (HPA) and set up a Māori Health Authority (MHA), and Health NZ, which will lead health and delivery services. The number of district health boards (DHBs) will be reduced to between eight and 12, and their focus will change. The nature of the relationships and associated accountabilities between the Minister of Health, the Ministry of Health and the new structure are represented in the figure at right. All new entities are expected to be governed by representatives split 50:50 between Māori and the Crown – all appointed by the minister.

A new planning process will see the development of a legislated charter for Health NZ, committing to a system of shared values and the development of a framework in the New Zealand Health Outcomes and Services Plan (the NZ Health Plan). DHBs will be responsible for regional strategic plans, locality plans and annual plans for implementing the NZ Health Plan.

Tier 1 services will represent the "entry point" to the restructured health and disability system and will encompass "what most people need most of the time" in homes and communities, marae and schools.[1] This will include mental health, GP services, Māori and iwi health providers, district nursing, oral health, Tamariki Ora, pharmacy services, aged residential care, rehabilitation and palliative care. Funding for tier 1 services will be ring-fenced and may not be reallocated to tier 2 services.

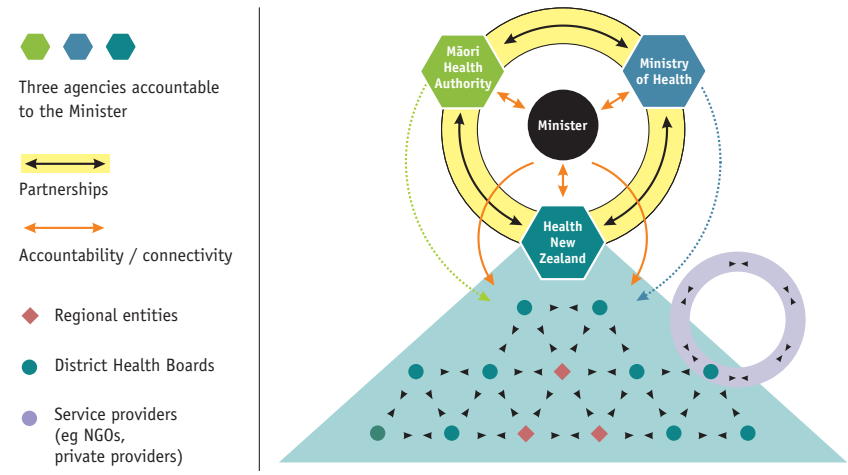
Tier 2 services will integrate with Tier 1 services, and include care currently referred to as secondary and tertiary services, such as public and private hospitals, specialist treatment and diagnostic services. The review report anticipates continued growth in demand driven by individuals living longer but with more co-morbidities. Until now, this has been accommodated by higher occupancy, using planned "surge" capacity and continuing to use existing facilities that are no longer fit for purpose. The report promotes greater use of technology and national, regional and local planning to develop a cohesive system that can deliver according to need.

Implications for NZNO members

The Government will need to decide which of the recommendations it accepts and will act on. This will dictate the timeframe of the reforms, with the report itself suggesting they be implemented over five years. Members working for DHBs that are dis-established or amalgamated are likely to experience greater disruption. But the impact is much more likely to be on non-clinical staff, given the report acknowledges how acutely problematic shortages in the clinical workforce have become.

There are clear expectations that all tier 1 services should be experienced as if they were a single service, and services should be located where they best suit

Figure 4.1: Integrated system overview



the community. These services will be open longer, including at weekends, and different aspects of a service co-located and co-ordinated, so the single service experience is achieved. Members may find their hours and location of work change as a result.

Productivity of the health and disability system, currently measured by things such as the number of procedures completed, average hospital stay in days and immunisation rates, would instead be evaluated and reported on by how well the needs of those requiring health care are assessed and met. We see this as a positive reflection of cultural safety in practice, with consumers validating the impacts of culturally appropriate services they receive.

The report characterises the health workforce as a key enabler of health services. A health workforce plan that aligns with the NZ Health Plan will draw on data from across the sector and work on a 10 to 15-year timeframe. This work will include:

- collaboration with the new New Zealand Institute of Skills and Technology (NZIST) to develop a greater variety of courses offered online and in rural locations, learn-as-you-earn pathways, leadership development and specific support for Māori, Pacific and disabled students.
- a re-invigorated tripartite accord that achieves system objectives, and includes effective dispute resolution, and strategies for developing salary scales and employment terms and conditions.
- strategies to build a workforce that represents the Māori, Pacific and disabled communities they serve.
- best-practice recruitment, onboarding, professional development and retention practices by employers in the system.

Time will tell, particularly in an election year, which of the review recommendations will be implemented. NZNO's policy and research team will keep a watching brief on this kaupapa to ensure fairness, transparency, te Tiriti o Waitangi articles and equity remain on the agenda. •

Reference
1) Health and Disability System Review. (2020). *Health and Disability System Review – Final Report/Pūrongo Whakamutunga*. Wellington: Author.

Persistence of Māori nurses pays off

By NZNO policy analyst, Māori, Leanne Manson

Leanne Manson

It is not often I can say that someone has actually listened to Māori feedback. But the health and disability system reviewers have done so. They have incorporated the recommendations of the Wai 2575 stage 1 Hauora report and articulated the faults of the Primary Health Care Strategy in not adequately implementing or pursuing equity in health outcomes for Māori.

This review will have its critics and its challenges, as not everyone will be pleased with changes to the status quo. There is a lot to contemplate, especially in the final report of 270-plus pages, which will be daunting for many. However, I would strongly recommend anyone who works in health, requires health care, or is reviewing election-year party options, to read the 33-page executive overview.

Changing the Aotearoa New Zealand health system is a tall order. Many have tried and failed.

Changing the Aotearoa New Zealand health system is a tall order. Many have tried and failed. However, the three months of COVID-19 rāhui, and the consequent spotlight on a health system that fails both users and the health workforce, make change imperative. I believe COVID-19 is the catalyst for change – no longer will systemic barriers such as racism, marginalisation and bias be tolerated in this new system and way of life.

I want to mihi the reviewers, for their courage to challenge the status quo, and to promote change in a health system that has failed to address either health equity or te Tiriti o Waitangi articles, and that has shown a lack of vision, planning and strategy for the health workforce.

Change is never easy. I have reviewed hundreds of government documents that sideline Māori to one chapter, or where the intent or commitment to te Tiriti o Waitangi principles is relegated to three words – partnership, participation and protection. I am pleased to say that the review report does make a commitment to equity and to the articles of te Tiriti o Waitangi, and focuses on Māori health and wellbeing.

The report also acknowledges the alternative views of Māori health expert advisers, who proposed another view of power-sharing, which includes a "for Māori, by Māori" structure for funding and governance. The advisers said this option "aims to push the envelope to fulfil the promise of te Tiriti o Waitangi, rather than marginalise

or revert back to the system we have been seeing".[1]

I agree with the advisory members – Māori cannot be marginalised in this new system. We must always look to the horizon and push for equity for the moko of our mokopuna. Power – in terms of funding and control – needs to be shared equally between Māori and the Crown. The review report proposes such 50:50 power-sharing in the governance structures for Health NZ, the district health boards, independent commissions and other entities across the health and disability system. I believe this proposed 50:50 governance must reach further, to include all crown entities, regulatory bodies and committees.

As in any good marae debate, there are many views and perspectives on these health reforms which need to be acknowledged. As tāngata whenua, we must remember that the end game must always be to uphold tikanga Māori, and the health and wellbeing of whānau, hapū and iwi. Further debate is required to get consensus on whether a fully-funded and empowered Māori Health Authority is the only option, or whether this just shifts the deck chairs at the Ministry of Health, or if an independent Māori commissioner advising the Minister of Health would hold accountability and transparency.

It gives me heart that Aotearoa New Zealand demographics predict significant changes in our diversity, indicated by the proportion of each ethnicity now under the age of 25: New Zealand European (32 per cent), Māori (51 per cent), Pacific (53 per cent), Asian (34 per cent), and Middle Eastern, Latin American and African (41 per cent).[2]

I am also drawn to the whakatauakī of the late Ngāti Hine elder and leader Sir James Henare:

"Kua tawhiti kê to haerenga mai, kia kore e haere tonu. He nui rawa o mahi, kia kore e mahi tonu.

"You have come too far not to go further, you have done too much not to do more."

This whakatauakī also resonates with Māori nurses as claimants in Waitangi Tribunal 2575 inquiry. A special mihi must extend to these courageous Māori nurses who, like their tupuna whaea Princess Te Puea, advocated for something better for our whānau, hapū and iwi, believing that Māori deserved better outcomes. This acknowledgement also includes those brave wāhine and tane who have challenged the health system and confirmed what they always knew that tāngata whenua are treated differently by the system. NZNO kaiwhakahaere Kerri Nuku believes all nurses have been on an equity journey, as have other health professionals across the whole sector.

Anti-racism training

We must be in a position to validate Māori nurses' truths and acknowledge their voices have been heard. Further work is needed on the impacts of institutional racism on the health outcomes of whānau, hapū and iwi. One glaring omission from the review is the lack of any provision of anti-racism training for all health-care workers so they are culturally safe to work with tāngata whenua.

I am pleased to see the Prime Minister will lead a group of ministers to drive change, and the department of prime minister and cabinet (DPMC) will manage this direction. Further questions must be raised about who is appointed to the ministerial national advisory committee under section 11 of the New Zealand Public Health and Disability Act 2000. I hope whoever they appoint, along with DPMC staff, can lead and engage with te ao Māori, using the concepts of whakawhanaungatanga, tika, pono and aroha. •

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Review gives

Philippa Jones – 'nurses are more ready to embrace collaboration and integration'.

By Philippa Jones

The recently released Health and Disability Services Review provides the perfect platform from which to advance nurses' vital role in transforming health care. Primary care nurses have the potential to be at the forefront of this important mahi.

An important recommendation of the review is that district health boards (DHBs) should hold the funding for tier 1 services, which integrate primary and community services. Many DHBs have already started this journey, with increasing degrees of integration with primary care. Many primary-care services are providing an increasing amount of care previously managed by DHBs, including some ambulatory care and district nursing. Much of this work is led by nurses. As care moves closer to home, and services such as complex wound care become part of a whole health-care package, the impact on patient outcomes is likely to be positive.

Integration and collaboration appear to be more readily embraced by nurses, perhaps because of less conflict of interest and fewer business imperatives to consider. However, nurses' holistic approach to care cannot succeed in isolation. Collaborating will bring greater pa-

'perfect platform' to advance nursing

tient benefits more quickly. Nurses know this, but have not been able to easily collaborate, despite increased responsibilities and autonomy. Growing numbers of nurse practitioners, designated nurse prescribers and, more recently, registered nurse prescribing in community health, are helping transform the health system and allowing nurses to work to the top of their scope. This erosion of professional hierarchies is likely to benefit patients, as these hierarchies sometimes service the need of the profession rather than the patient.

To support role advancement and improve access to comprehensive care, a collaboration of five DHBs and eight primary health organisations (PHOs), called the Midland Regional Collaborative, is leading RN community prescribing across Taranaki, Taupō, Bay of Plenty, Waikato and Tairawhiti. This collaborative journey has been valuable on many levels. When we gain accreditation, we will do so for the whole region, bringing access and efficiency gains. Priority training will be given to nurses working in isolation and supporting high-need populations. Many are eagerly awaiting access to the training, including nurses in schools, hauora, sexual health clinics, and primary health practices, as well as outreach rheumatic fever/public health nurses.

An unexpected benefit of the collaboration has been the strength of the relationships developed and the intent to explore other collaborative opportunities. The individuals involved – Pinnacle Midlands Health Network nurse Hilde Mullins; Waikato DHB nurse manager Lin Marriott; Hauraki PHO workforce development lead Michelle Rohleder; Waikato DHB chief nursing and midwifery officer Sue Hayward; and National Hauora Coalition practice support nurse Robyn Finucane – deserve recognition for their achievements.

The review recommends we change to a population health approach, particularly within tier 1 services. If we are to truly focus on wellness, we need to address the social determinants of health. Working closely with iwi and government departments – Corrections, Housing, Education and Social Development – will result in long-term sustainable benefits for our most vulnerable populations. The localities model identified in the review has the greatest opportunities to form multi-agency alliances. Primary care nurse representation on these alliances will be invaluable.

Health literacy

At a practice level, focusing on wellness requires additional skills. Many nurses are using "teach back" to find out what the patient has understood. With poor health literacy a barrier to good outcomes, such tools should be used routinely.

A truly patient-centred health system would work with, rather than for, the patient and their whānau to determine what they would find helpful and how this should be delivered. My years of experience working for the National Health Service (NHS) in the United Kingdom (UK), in both hospital and primary care, has convinced me the most challenging problem is time. The value of prevention and early intervention is not well understood. The model of care in both the NHS and New Zealand is mainly illness-focused and demand-driven. The system is overburdened, resulting in reduced consultation times, which only allow a response to acute need.

Low health literacy is a key reason patients delay seeking care, and time is needed to support the patient's self-management and preventative care. Self-management of non-communicable diseases needs to be a fundamental aspect of the patient's treatment plan, rather than a nice-to-have extra, if inequities are to be removed.

We also need to embrace kaupapa Māori approaches to health care, with the involvement of whānau, and using karakia, korero, koha and kai. What could this look like in general practice? We would need larger rooms for whānau, longer consultation times, more staff studying te Tiriti, tikanga and te reo Māori, and cultural advisers and Whānau Ora navigators in clinics.

Longer after-hours appointment times will be challenging. Many primary care nurses are attracted to more social hours and, like GPs, often work part-time and are due to retire in the next 10 years. This already fragile workforce must be protected. Primary care pay parity with DHB staff would be most welcome – I do not believe the integration of primary and community services can occur without it. •

The five district health boards which, along with eight primary health organisations, form the Midland Regional Collaborative.

The views expressed in this article are personal to the author and do not necessarily reflect the views of employing organisations.

Philippa Jones, RN, MA, PGCert(hlthsci), is director of nursing and workforce at Western BoP PHO and a guest lecturer teaching long-term conditions at the University of Auckland.

Diabetes and COVID-19 – a collaborative response

Over the last few months, nurses across the Midlands region have banded together to provide the best support possible for patients with diabetes. It is hoped that lessons learnt can continue beyond the pandemic.

By Anne Waterman

In response to the COVID-19 pandemic, New Zealand moved into alert level 4 on March 25, 2020. This was essentially a national lockdown. The health sector had to respond quickly to this rapid change to try to contain and eliminate the virus.

As a clinical nurse specialist (CNS) in diabetes for Pinnacle Midlands Health Network, my role is supporting practice teams in primary care to manage people with diabetes. Under the lockdown, this role was escalated to focus on a rapid response to ensure there were no adverse effects on people with this long-term condition.

This group of patients had already been identified as being at risk.[1] The national executive of the New Zealand Society for the Study of Diabetes (NZSSD) reported in the *New Zealand Medical Journal* that COVID-19 in patients with diabetes was a major health-care challenge.[2] The executive acknowledged that people with diabetes and infected with the virus had an increased risk of hospitalisation and death.

My focus during the COVID-19 response was in three areas – collaboration, communication and clarity. This continued as health care adapted to the changing alert levels.

Collaboration

The Waikato region has three primary health organisations (PHOs) – Pinnacle, Hauraki and National Hauora Coalition (NHC). The diabetes nurse specialists affiliated with each PHO have developed long-standing working relationships, which enabled us to work as a team.

Clinical nurse specialist Anne Waterman has worked hard to support practice nurses across the region.

In the initial stages of level 4, we collaborated to quickly produce sick-day advice. This advice guides the management of diabetes when the patient is experiencing any illness, diabetes-related or not.

I would like to acknowedge my colleagues Suzanne Moorhouse (Hauraki) and Elizabeth Johnson (NHC), who helped develop this. We also worked alongside the diabetes team at the Waikato Regional Diabetes Service (WRDS) – part of the district health board.

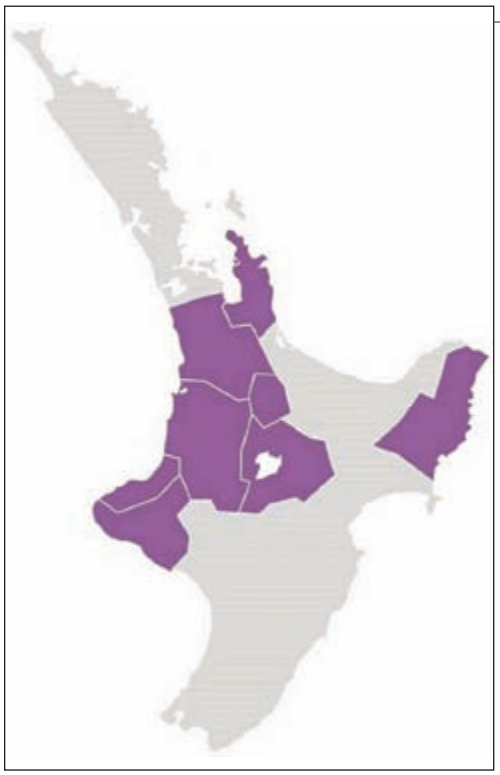
In the Waikato, people with type-2 diabetes are predominantly cared for in primary care, apart from those requiring specialist services, such as diabetes in pregnancy or the high-risk foot clinic. However, the WRDS team was willing to work with their primary care colleagues to help look after those with type-2 diabetes and complex health conditions during this time. The aim was to lighten the load, while primary care dealt with the ever-changing health environment. This included an increased workload delivering flu vaccinations to high-needs people. This collaboration had the additional benefit of ensuring these patients avoided unnecessary presentations to secondary care.

The WRDS has a 24/7 on-call helpline for people with type-1 diabetes, managed by CNSs. Patients and all health professionals supporting them are able to access this helpline. During the pandemic, the helpline agreed to take calls from primary health care (PHC) professionals supporting people with type-2 diabetes who might need after-hours assistance. The PHO diabetes nurses provided clear guidelines on the use of this service for the primary care team, along with reminders on how to manage type-1 and type-2 diabetes during times of illness.

The WRDS provided sick-day information for people with diabetes and the PHO diabetes nurses also developed material for those with limited health literacy.

Patients most at risk

At the end of March, Pinnacle advised the practice teams on identifying the most at-risk patients if they contracted COVID-19. The British Medical Association had suggested that people with diabetes with an HbA1c greater than 75mmol, recent diabetic ketoacidosis or poor medication adherence were in this vulnerable category.[1] This data was sent to all practices, so the information could be used to check on this high-risk group and support them as necessary. Some practices used the information to call and triage these patients, using a well-



The area covered by the Pinnacle Midlands Health Network. Head office is in Hamilton, with smaller offices in Gisborne, New Plymouth and Taupō.

ness checklist developed by the practice nurses. Practices were happy for practice nurse colleagues in other areas to use this checklist.

All the pharmaceutical companies were willing to share their virtual resources, along with developing new ones. The PHO diabetes nurses used Zoom meetings to comment on and discuss with their pharmaceutical colleagues the different resources available. This information was then shared with the primary-care teams.

Communication

Pinnacle's nurse lead already had an established Pinnacle nurses' Facebook page used by the wider nursing team for communication and links to practice nurses across the region. During lockdown and beyond, all practice nurses were encouraged to join the page, which became a vital tool for communicating updated information, providing self-care resources and sharing ideas. Membership increased significantly at this time.

Weekly Zoom meetings were also started for practice nurses, facilitated by the senior Pinnacle nurses. The platform was available to nurses across the four Pinnacle localities. In her role as incident controller, Pinnacle nursing director Jan Adams was able to provide updates on the management of COVID-19. The clinical services manager also reported on the funding available to practices for COVID-19 assessments.

Clear communication was essential, with alert levels and clinical guidance changing frequently, and primary care needing to respond accordingly. The regular Zoom meetings also provided a platform for the nurses to share how their practices were doing and what changes they had to make during this time. This proved to be really helpful, as this shared knowedge was able to be adapted for use in other practices.

Of equal importance was the level of support these meetings provided for those practice nurses, whether they worked in urban or rural areas. To know they "were not alone" during this stressful time was comforting.

The topics covered were many and varied, but included the use of personal protective equipment, splitting practice teams into on-site and virtual teams, immunisations (the "where" and "how"), following up on high-risk/vulnerable patients, diabetes virtual resources, and insulin starts and screening.

We also focused on mental health needs, individual wellness and the importance of self care. Pinnacle continued to advertise the services of the employee assistance programme, a confidential service available to all staff.

In my role as CNS-diabetes, I regularly provide clinical mentorship and supervision for the practices that have diabetes nurse-led clinics. During this time, I provided support to practice nurses, either by phone or via Zoom consultation.

I also shared phone consultations with the GP or nurse, with the patient present. We would have a clinical discussion, discuss blood-glucose results, then reach a collaborative decision on how to move forward with a diabetes care plan. This was very effective and I always followed up this discussion with a summarised version of the consultation in an email, which provided written documentation. This email was de-identified to protect the patient's privacy.

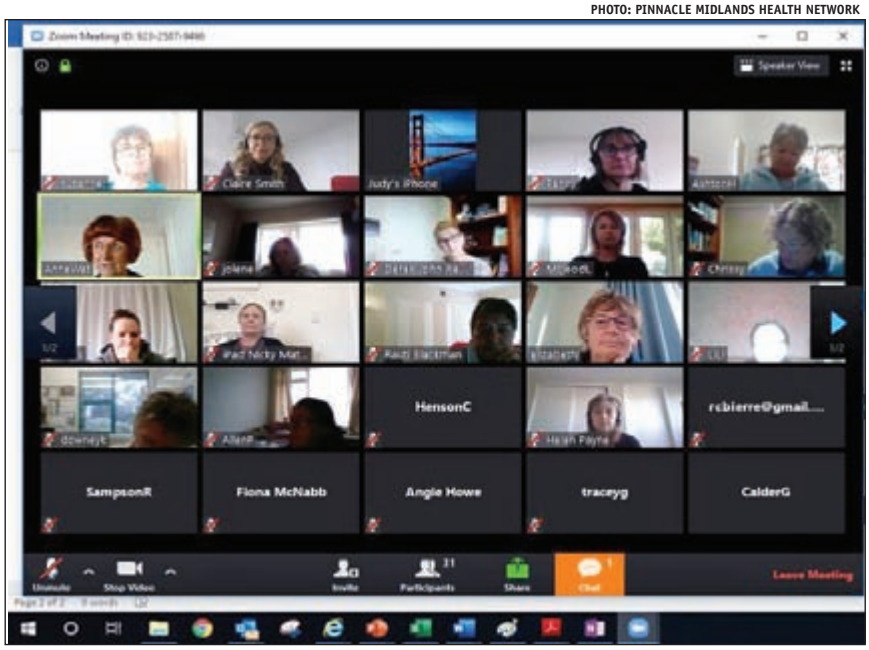
Another important source of communication for Pinnacle practices are our newsletters and website. These provide PHC news, information, educational resources and fact sheets. Over the last few months, I used the newsletter and website to provide information on doing annual diabetes reviews when access to primary care was limited

Also on the website were diabetes resources that could be used for insulin starts via video, or by patients before an arranged appointment at the practice. In this way, the time spent at the practice was reduced, as the patient had already received educational materials relating to the insulin start.

In the Waikato, we have an advanced PHC education session, facilitated by the CNS-diabetes at the WRDS. This is a breakfast forum held every two to three months for practice nurses working at a proficient level of diabetes knowledge. Topics are guided by the 2018 National Diabetes Nursing Knowledge and Skills Framework[3] and supported by Sanofi Pharmaceutical. During the COVID-19 lockdown, we were still able to have a session, facilitated by Pinnacle, with the Zoom meeting organised by Sanofi. Three presenters covered a range of topics including complex case studies, revisiting sick-day managment related to COVID-19, and local diabetes education resources available for virtual insulin starts and/or for supporting further education in patients' home. This was

Clear communication was essential with alert levels and clinical guidance changing frequently, and primary care needing to respond accordingly.

PHOTO: PINNACLE MIDLANDS HEALTH NETWORK



Regular Zoom meetings enabled practice nurses to share their experiences and the changes they had made to their practice.

attended by people in rural areas as well. It was agreed the Zoom option should be made available for future sessions, given its success.

Clarity

The COVID-19 outbreak resulted in rapid changes in health-care services and how primary care was delivered. It was important the referral guidelines for diabetes review in secondary health-care services were updated and then communicated clearly and concisely. These changes were acknowledged at DHB level and posted on our Facebook page and website for clarity of use for the practice teams.

I was able to be a link between primary and secondary health-care services on a number of occasions during discussions on referral of people with type-2 diabetes and complex health issues. This proved very helpful for the nurses in primary care who were very busy with COVID-19 management issues.

During the different alert levels, NZSSD issued several statements and publications.[4] These included research articles on COVID-19 and diabetes, screening for gestational diabetes during COVID-19 restrictions, availability of supplies from pharmaceutical companies and information for families living with type-1 diabetes.

Equally important was the publication on occupational health for health-care workers living with diabetes.[4] A categorisation scheme for workforces was developed and those with poor glycaemic control working in high-risk settings were advised not to go to work. A statement issued by NZSSD noted:

"NZSSD recognises that these employment recommendations will impact Māori staff disproportionately due to the disparate underlying rates of type-2 diabetes in the Māori workforce. We encourage occupational health services and employers to consider pro-actively the impact of this on the decisions they make, and ensure that the mana motuhake of Māori staff is considered at all levels of decision making."[4]

I was able to bring this to the attention of our Māori health manager, Rawiri Blundell, so he could discuss the impact of the advice on Māori health providers and on special projects aligned with Pinnacle. This occupational health workforce publication was also posted on our Facebook page, along with all other NZSSD recommendations for nursing staff to see.

Diabetes New Zealand (DNZ) is a national organisation that represents and supports people with diabetes. It produced advice for people with diabetes and COVID-19 which was linked to the NZSSD home page.[5] DNZ is a well-known resource used by PHC professionals and consumers in the community.

By the time the country moved to alert level 2 at the end of May, there were clear and robust diabetes resources available, specifically targeted to the COVID-19 outbreak.

Many of these had already been available, but had been moved to a virtual platform to accommodate the changing health environment PHC professionals and their patients had to adapt to. Achieving this was a joint effort with my nursing colleagues in other PHOs, within Pinnacle, the DHB diabetes services and PHC. All these nurses made generous contributions to the development and sharing of resources and banded together to support each other and provide educational materials for patients with diabetes.

This approach of collaboration, communication and clarity is a fine example of nurses pulling together in record time to provide the best possible care for people with diabetes in the community. While this was a reactive response to an unprecedented situation, some great lessons have been learnt. Many of these can now be continued and will enhance PHC delivery, even after the pandemic response has ended. •

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Lockdown challenges

Delivering immunisation services during a lockdown saw nurses adopt a range of flexible and creative ways of working.

By Anna Smith

With New Zealand going into lockdown on March 25 due to COVID-19, health providers had to get creative if they were to continue delivering immunisation services. From general practice to outreach services, whether providing flu clinics or continuing to immunise young babies and children, immunisation providers showed great flexibility in achieving this.

More than one practice implemented a colour-coding system as a way to manage patients. One used three separate colours within their premises, including a "double green" zone accessed via a back entrance and leading to three consulting rooms upstairs. Here staff saw vulnerable patients and delivered flu and childhood immunisations.

The main clinic downstairs was considered the "green" zone, where any medical, non-respiratory patients were seen. A security person at the front door helped with this and asked any necessary questions.

All patients with respiratory or suspected COVID-19 symptoms were seen in the "red" zone – a portacabin in the carpark. Here staff wore personal protective equipment (PPE) and a strict hygiene policy was implemented to reduce any risk of transmission.

Another practice created a temporary corridor for the "red" area and kept the rest of the surgery "green", with one specific room for childhood immunisations. Allocating separate waiting rooms, keeping well patients away from those who were sick, was a popular approach. Colour coding appeared to be a simple but effective way of managing risk and keeping vulnerable patients safe, while continuing to provide essential immunisation services.

A clinic in South Canterbury used a side verandah and set up a screen so they could see patients. The staff wore PPE and assessed patients at a little table on the verandah and then vaccinated behind the screen. Patients would wait for five minutes, then continued waiting in their car where the staff could see them.

A flu clinic in the car park at Te Awhina Marae, Motueka.

A lot of practices ran flu clinics in car parks, sometimes known as "drive-through clinics". Staff would obtain consent and perform pre-vaccination checks by phone. Patients would be vaccinated later that day at a specific time in the car park clinics. These proved a convenient way to vaccinate large numbers.

Outreach services

Outreach services also found new ways to vaccinate young children during the lockdown. As with general practice, many screening and consent processes were done over the phone before the immunisation visits. The outreach nurse would often vaccinate on the family's porch steps if the day was fine, or just inside the door if wet, with the nurse then waiting for 20 minutes in her car before returning to check the baby and reinforce post-vaccination messages.

In the Nelson Marlborough area, outreach nurses ran a successful vaccination programme for their refugee community. The influenza vaccine was delivered at the homes of several newly-arrived refugee families, with the aim of protecting them during the lockdown and before they were allowed out of their bubbles. They were able to ascertain whether any other immunisations were needed, eg for children, and they could identify those who should be swabbed due to COVID-19 symptoms.

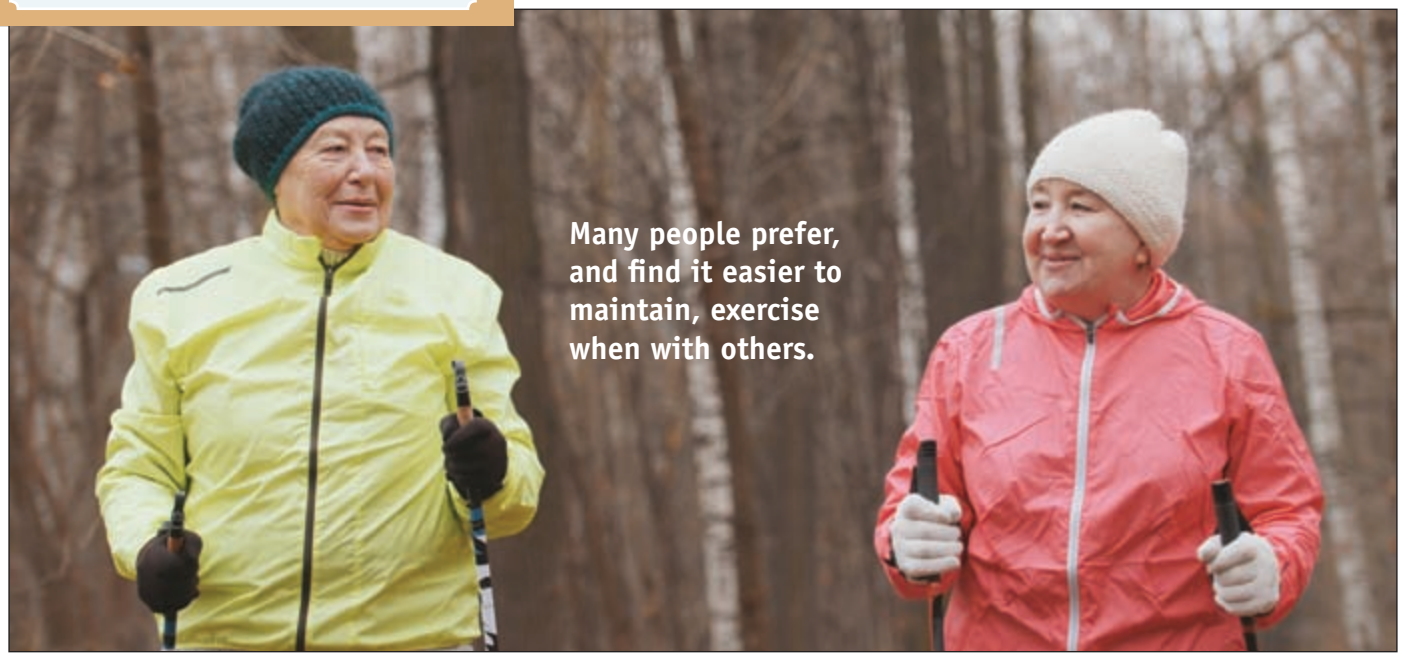
In some regions, families are forced to travel two hours or more to see a general practice. In the Nelson Marlborough area, a team of two vaccinators and two community-based assessment centre staff took services to these isolated areas, thus avoiding 50 or so people having to travel outside their bubbles to receive their vaccinations.

During the lockdown, health professionals continued to train as vaccinators. Part of this process involves completing a clinical assessment by vaccinating two people. This assessment is usually done face-to-face with the local immunisation coordinator.

Some immunisation coordinators, facing lockdown restrictions, found technology a great way to overcome this hurdle. One Southland coordinator completed her assessments via Zoom. This involved having virtual tours assessing practices' fridges, cold chain processes and emergency equipment, before asking the nurse all the pre-assessment questions by video call. She then watched the nurse administer the two vaccinations required and viewed the whole consent process. The coordinator felt safe to do this, as there was another authorised vaccinator on site and emergency services nearby. The process worked well, she said.

Working during a time of increased pressure, both professionally and individually, has shown how resilient nurses and other health professionals are and how dedicated to their work and their communities. Despite the country being in lockdown, they continued to provide essential health services and protected vulnerable patients. They have much to be proud of. •

Anna Smith, RN, is the South Island regional immunisation adviser for the University of Auckland's Immunisation Advisory Centre.



PHOTOS: ADOBE STOCK

Self-management of long-term conditions

Reasons given for positive and negative changes

In the third of a series of professional education articles based on the results of the *Talking about Health* study, the authors look at how participants were handling self-management of their long-term conditions.

By Melanie Taylor and Claire Budge

Introduction

Each year we asked the *Talking about Health* participants[1] about lifestyle/behaviour changes they had made to improve their health and wellbeing. Specifically, we asked whether the way in which they look after themselves (by monitoring symptoms, taking medication, doing "healthy" or "unhealthy" things) had changed during the previous year. The response options provided were: "no, it is the same"; "yes, I am better at looking after myself"; and "yes, I am not so good at looking after myself". A small number of people each year ticked both the positive and negative change boxes, as they were doing better in some respects and worse in others.

Those who indicated there had been a change – better or worse – were invited to explain how and why a change had occurred. The results are presented in Figure 1 (see p21). Figure 1 shows that most people indicated their self-care behaviour had stayed the same from year to year, and that this number increased slightly over time. Most of the changes that had been made were positive, but this number decreased slightly throughout the study period. Of the 297 people answering the question in all three years, 41 per cent said their behaviour had stayed the same each time, 49 per cent had made more positive than negative changes and 10 per cent had made more negative than positive changes.

What follows is a summary of the positive and negative change responses. The main themes are presented in bold type and quotes in italics.

Positive changes

Having a better understanding of conditions and accepting them and their associated limitations was described as being positive: *"I am getting to understand my health and what it involves more"*, *"have come to terms better with managing what I can do and what I can't, though we are still trying to find the right medications to help with symptoms"*. The advantage of greater knowledge was evident: *"knowing more about my condition helps me adjust to the new lifestyle I now have"*. For some people, this resulted in them **being kinder to themselves,** eg *"becoming selfish looking after myself instead of everyone else"*.

Associated with this was **improved self-awareness,** which related to knowing your own limits and **doing less,** or pacing activities by *"taking more time to do things"*, *"I try not to overdo things because I usually pay if I do"*, *"when preparing/doing jobs around the home I take breaks or sit and do things more so I'm not standing all the time"*, and

protecting yourself: *"I am trying not to take on others' dramas, I don't need the extra stress"* and *"I am more actively aware of how I am feeling and take action accordingly"*.

Many observations related to **diet**. Better eating habits included becoming vegan, cutting back on alcohol, watching amounts eaten, taking health supplements and eating less fat and sugar. One person said they recorded their daily meals. Education had evidently played a part: *"after seeing the dietitian, I follow healthier eating habits and read labels when food shopping to avoid overloading with sugar, salt etc","I am aware caution is needed with food intake, try to adhere to doctor's advice"* and *"LTC nurse has given me really good advice"*.

Following advice and getting self-management support from a range of practitioners was mentioned positively: *"a lot has changed and I have the chemist. We meet every six weeks to discuss any changes and I also see the nurse on a regular basis to keep up to date"*. Practitioners included nurses, dietitians, pharmacists, mental health team, alcohol and drug services and doctors. Attending classes and using counselling services also featured, for example, *"I attend a regular counselling session to manage anxiety"* and *"I'm taking part in personal awareness/mentoring to review where I am in my life"*.

Exercise featured prominently, with people describing doing more structured exercise or building exercise into daily activities, such as walking children to school, or increasing time spent on housework and gardening. Referrals to physiotherapy, green prescription, U-Kinetics (a clinical exercise physiology programme now called OraKinetics) and personal trainers were also mentioned.

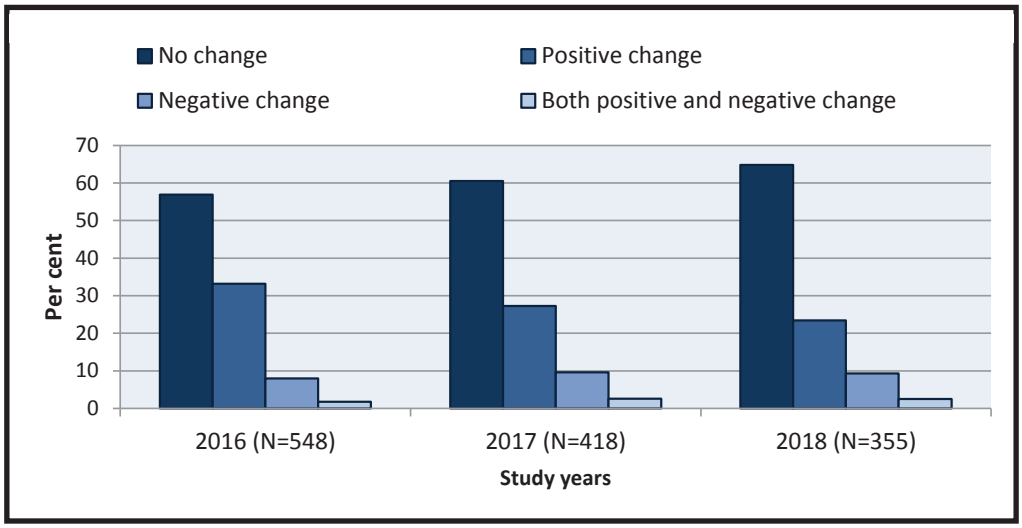


Figure 1: Percentage of people indicating they had made no change, a positive change or a negative change in the way they looked after themselves during the previous year.

Personal growth in self-management was evident in some comments, for example, *"I'm not afraid to ask if I don't understand"* and *"I got help and medication for depression and with counselling started to see ways to gain control of my diabetes and weight"*. One person now sets their own exercise goals and records their progress in a log book.

Medication was mentioned frequently, with better adherence, medication changes and use of blister packs to aid memory being described. *"Better with the blister packs, medication is all organised for me"*. Better pain management due to a change in drug or regime was also mentioned.

Some people had experienced a **wake-up call** which had brought home to them the severity of their condition: *"the shock of blood glucose hitting 30.4 woke me up"*; or made them think about life: *"I had a heart attack, this changes one's thinking. It is very confronting"*.

Positive changes do not always work alone. There was ample evidence of improvement in one aspect of life positively affecting another. For example, feeling better mentally was associated with positive behaviour change: *"better state of mind, more exercise and greater/healthier food awareness"* and *"I've undertaken 4-5*

Those who were doing better . . .

A comparison between the positive and negative change groups in 2018 found no apparent differences in sex, ethnicity, age, living situation or ratings of support from the general practice team. However, those who were doing better:

- Were more likely to have had input from a specialist nurse or LTC nurse (51.4 per cent cf 44.8 per cent).
- Had fewer of the more commonly experienced LTCs (M=2.8 cf 3.6).
- Had notably higher income adequacy (54.1 per cent cf 25.0 per cent had enough or more than enough income to meet daily needs).
- Were more likely to have health goals (75.8 per cent cf 63.0 per cent) and say that a health practitioner checked up on how they were doing with their goals.
- Were *less* likely to have a care plan (14.3 per cent cf 25.0 per cent).

gym sessions a week, walk daily and am eating much more healthily than ever before. I've lost quite a lot of weight and become much more fit. This has helped my feelings of depression".

Negative changes

The **importance of exercise** was highlighted in many comments, where people acknowledged that not being able to exercise was having a negative impact on their overall wellbeing. *"I was more disabled so gave up gym and cardio then had weight and diet problems. Less exercise means more weight, 14kg plus – less motivation and willpower, less sleep, disillusionment and depression". "I've had to cut back on my exercise which has been very difficult for me. I used to go to the gym every morning but haven't been able to due to fatigue and stiffness in the morning".*

In some cases, a **specific incident** triggered a negative cycle: *"I had a fall. My exercise program could not continue. Increased pain and disability. Now I need two knee replacements"* and *"have torn a calf muscle and have had a back injury which has caused a lot of pain and stopped physical activity".*

A **lack of finances** was also held responsible for poorer management by several people. One said they found the cold in winter demotivating but couldn't afford to turn the heater on; another had worsening symptoms but had postponed going to the doctor due to cost. Others could no longer afford a gym subscription and were finding exercising differently too difficult to establish. Income influenced food choices as well, one person saying: *"I'm finding it hard to budget for good food – it takes planning and I haven't been diligent about it".*

Symptom exacerbation – pain, tiredness, poor sleep and breathing were mentioned – was responsible for a number of people looking after themselves less well.

General deterioration with ageing also featured: *"Need more assistance from partner with medications as I find my eyesight is fading a bit and I am not so switched on about times and doses", "movement is a bit more difficult as life goes on, breathless, need a bit more help".*

Lack of motivation was a common theme, people saying they found it hard to get out and do things, or had lost motivation due to something changing. *"I have a problem with motivating myself to do planned exercise. Sometimes this is because of the weather, sometimes I am just too tired to be bothered, or I am physically uncomfortable. I do try my best!"* A person with diabetes felt disillusioned by the demands of the condition: *"I've gained weight and know my blood sugars have been high at times. I've increased my insulin which I feel makes it difficult to lose weight. I get down and frustrated when I know my levels are high. Have felt discouraged that no matter what I do, it feels like it doesn't make a difference".*

The **role of others in motivating people** to remain active was evident in some comments: *"I have stopped going to the gym and not so many visits to the nurse. They were motivating me to diet and exercise". "I need to programme myself for exercise. When I was on a regular programme to go to health clinic for exercise I attended twice a week. Since the free sessions have finished I haven't continued with the exercises as much as I could have at home."*

More serious **depression** was mentioned by several people: *"my depression has got worse and sometimes it is a struggle to leave the house"* and *"due to my depression, sleep apnoea and insomnia I tend to shut myself off from everyone when I am home. Do not sleep at right times therefore do not eat at appropriate times. Tend to sleep a lot during the day".*

The **role of caregiver** took its toll on many people, as other people's needs took priority. Examples included: *"my husband has been very ill over the last 18 months and sometimes that overrides myself",* and *"I am carer for my husband who is terminally ill and tend to put my own needs last. Therefore I tend to suffer slightly from not looking after myself better. I understand my needs but the time to exercise does not always fit in with the regime".*

The **loss of a loved one** through death or divorce increased stress, loneliness and social isolation. This resulted in problems with motivation to exercise and eat well: *"Marriage break up, just not coping"* and *"My husband passed away this year and for the last 6 months I haven't looked after myself".* One person said it had taken two years for him to get back on track after the death of his wife, for whom he had been the main carer for many years. As he said, *"perhaps sadness and loneliness should be classed as an illness?"*

Memory problems created issues for a few people, specifically in relation to medication: *"I find I am forgetting to take my insulin at meal times, then when I do a blood test the reading is really high", "Sometimes I forget taking my medication or inject insulin".*

Earlier we noted that sets of positive changes in self-care behaviour appeared to be inter-related, and the same was true of negative changes. A downward spiral was apparent in several of the descriptions: *"Because of breathing problems I no longer walk 40 minutes*

Practice points

- Ask about people's self-care challenges, eg pain or sleeping problems, and get them to share with you *how* they affect their mental/physical health or lifestyle. You may find a single problem has developed into multiple problems, but there may be a way of addressing at least some of them and stopping a negative consequence spiral.
- Many people prefer, and find it easier to maintain, exercise when with others. A gym membership, green prescription or class enrolment might help, as might encouragement to find a friend to walk with. You could phone them to check how they are doing in sticking to an exercise plan and brainstorm some different ideas if things are not going well.
- Consider options for people who can only exercise a little, or who need to improve their strength and balance. Seated exercise (such as a pedal exerciser available from mobility stores), in-home programmes, or the 9am Saturday morning show on TV One, *Healthy for Life*, hosted by Bernice Mene, may be suitable.
- When making suggestions about healthy living, consider how much income people might have to put goals into practice. Find out what programmes or group activities are available free or cheaply in the community to encourage people to exercise. Remember to accommodate people's own preferences based on their personal lifestyle.
- Be aware of the difficulties people face when caring for whānau and how it might affect their own health. Encourage them to make some time for themselves and learn how to ask for help from family members/neighbours when they need it. For example, they could ask a neighbour to come and have a cup of tea with their spouse while they have a walk. Many people are happy to help out if they know what is wanted.
- Although the caring role is one many people adopt willingly, and it has its rewards, it can also be demanding, limiting and emotionally difficult as a loved one deteriorates and loses independence. There can also be feelings of guilt about having negative thoughts about the role, or feeling that you are not coping or doing enough, which adds to the burden. Encourage people to talk about how caregiving makes them feel, and support them in finding ways of dealing with frustration, irritability or sadness. They may need practical help or respite care, but not know what they are entitled to.
- Provide help with meal planning by referring people to the Health Navigator page "Budgeting and healthy eating" (www.healthnavigator.org.nz/healthy-living/b/budgeting-and-healthy-eating) to enable people to eat healthily without blowing the budget. Suggest some ideas for planning ahead for bad days when energy levels might be down, eg cooking a larger amount and freezing a portion or two for another day, or having some healthy snacks on hand for times when appetites might be poor. We know from other parts of the study that some people struggle with reading and understanding nutritional information on food labels, so helping with this might be useful too.

Be aware of the difficulties people face when caring for whānau and how it might affect their own health. Encourage them to make some time for themselves and learn how to ask for help.

- Health Navigator also has some great consumer videos to support people on lifestyle or behaviour change (www.healthnavigator.org.nz/videos/b/behaviour-change/).
- Practitioners need to remember that change is not easy and that, for many, conversations to help them become more ready, willing or able are a necessary component of effective self-management support.
- People may benefit from attending The Chronic Disease Self-Management Programme (often called the Stanford Programme) available in most parts of New Zealand. This six-week self-management programme covers healthy eating, exercise and the symptom cycle, among other things. Some regions run programmes targeting specific conditions, such as diabetes or chronic pain.
- The importance/confidence ruler is a good way to help patients fine tune goals. See www.smstoolkit.nz/goal-setting-and-action-planning on how to use these tools. A high score on both rulers suggests the person is more likely to be successful with behaviour change.
- Life changes, such as death, serious illness in the family or divorce, can have a major impact on people's self-management behaviour. Extra self-management support at this time may help people maintain healthy lifestyles.

every day. This has caused more problems for me – less socialisation, depression etc" and *"I find I get out of breath just walking to the shower so don't shower regularly. I don't eat properly because of pain and breathing, no exercise."*

Positive and negative changes

A few people described both positive and negative changes, and that probably reflects reality for many more people. One person wrote in the positive box, *"I try to follow healthy eating, but sometimes go off the rails and have sweet thing or chippies as get craving for them and also carbs. Also make sure I have my veges, fruit, go for walks with my pup"* and in the negative box, *"when feeling tired or in pain, things are let go eg do not cook dinner or sometimes miss meals and exercise as well".*

Discussion

Most people said the way they had looked after themselves during the previous year had stayed the same, but the descriptions provided by those who indicated it had changed shed some light on how people define good self-care. Examples included exercise, diet, medication, independence, use of mobility aids and putting themselves first. What patients and practitioners define as good self-care may differ. One study found that people with diabetes defined self-management in relation to diet, non-medical approaches and managing symptoms of comorbidities, whereas practitioners focused on medication and were frustrated by their inability to influence patients' self-management.[2]

Despite 29 per cent of participants saying they had no health goals,[3] many described ways in which they were doing better or worse, suggesting they did have some sense of what they were working towards or trying to maintain. What represents "looking after yourself" clearly differs depending on who you are and what you want to achieve. For example, increased exercise was a positive achievement for some, whereas for others learning to do less, or to approach tasks more gently represented a positive change.

Overall, it appears that when things had changed for the better, it was framed as the individual putting more effort in, eg following advice, doing more exercise, cooking and eating more healthily or taking medications more regularly. However, negative changes were often a result of something out of the individual's control, like general ageing and concomitant deterioration, exacerbation of symptoms or an event such as a fall or emotional loss. The negative impact of caregiving responsibilities should also be noted.

The self-care behaviours we identified were similar to those found in a study of barriers to self-care for people with long-term conditions. These included physical limitations, lack of knowledge, financial constraints, need for social/emotional support and medication concerns. The authors concluded that many of the identified barriers stemmed from self-care being more complex in the context of comorbidity.[4]

This appeared to be so for our participants, a change in one condition triggering a change in another. Also evident in both the positive and negative comments was the complexity of the interplay between symptoms and reactions. Having a symptom such as breathing get out of control can lead to decreased activity and more pain. Conversely, an improvement in mood or more effective pain relief can result in increased activity and more investment in eating well. Consequently, it is worth putting effort into supporting people even if they are only able to work on one aspect of their lives, as it may have a ripple effect on other aspects. •

Key points

- PARTICIPANTS described a broad range of self-care behaviours which represented how they were looking after themselves better. These differed from person to person.
- BEHAVIOURS included: developing better understanding of self, conditions and associated limitations; increased exercise; better diet; attending classes/education; weight loss; having counselling; accepting help; using mobility aids; maintaining independence and knowing when to stop doing things.
- THE ways negative changes to self-care, such as less exercise or a less healthy diet, were described often suggested there was a specific trigger – limited finances, a specific event/experience, exacerbation of existing symptoms or general deterioration due to disease progression or ageing.
- THE role of caring for others and putting others' needs first was also seen as having a negative impact on people's ability to look after themselves.

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Claire Budge, PhD, is a health researcher for THINK Hauora. Since completing her PhD in psychology in 1996, she has conducted a wide range of health-related research projects, more recently on self-management issues for people with LTCs.

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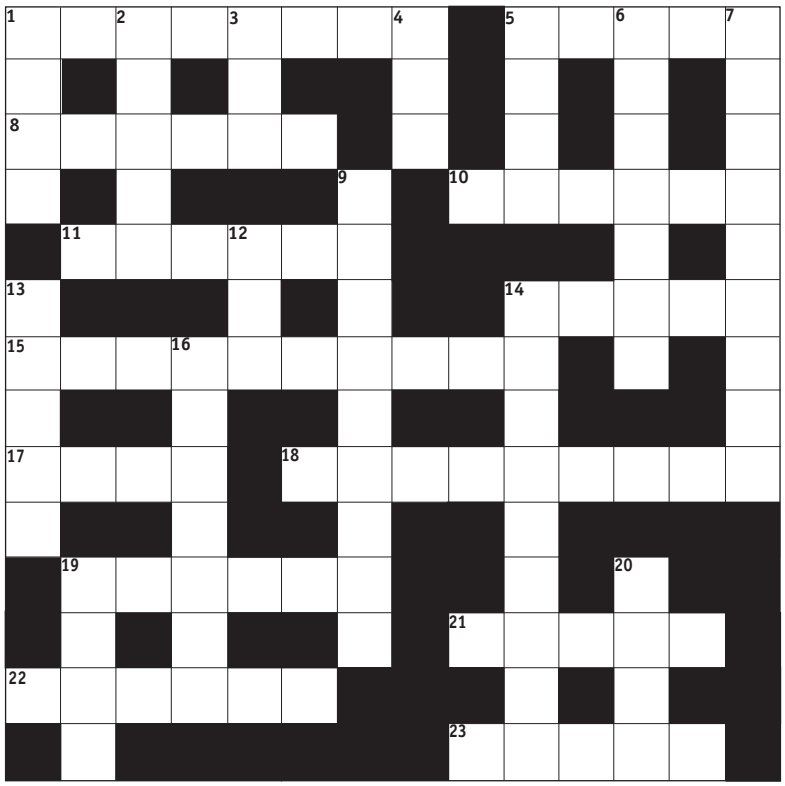
crossWORD

Completing this will be easier if you have read our June issue. Answers in August.



ACROSS
1) Renal replacement therapy.
5) Funeral (Māori).
8) Mass departure.
10) Small group isolated to prevent infection.
11) Woman (Māori).
14) In top place.
15) Disloyal.
17) Tells untruths.
18) Pathologically compulsive behaviour.
19) Relative.
21) Nurse/patient proportion.
22) Sticky protein found in grains.
23) Postpone.

DOWN
1) Not shallow.
2) Love, compassion (Māori).
3) Second person pronoun.
4) Weep.
5) Sacred, forbidden (Māori).
6) Just out of the womb.
7) Microbe invasion.
9) Opioid prescribed for addiction therapy.
12) Tribe (Māori).
13) Construct.
14) Shift back and forth.
16) Attack.
19) Building block of living things.
20) Middle Eastern bread.

June answers. ACROSS: 1. Democratic. 6. Aloe. 7. Robust. 9. Erases. 10. Ethics. 11. Intend. 13. Age. 16. Pain. 17. Aorta. 20. Eighteen. 21. Virus. 23. Office. 24. Sleep. 25. Gym. 26. Assist. **DOWN:** 2. Earplug. 3. Cluster. 4. Glasses. 5. Weds. 8. Resign. 12. Disinfect. 13. Adapting. 14. Wages. 15. Stairs. 18. Chafes. 19. Jedi. 22. User.

wiseWORDS

“Nurses everywhere will be glad when we have health targets that measure how well we meet health needs, rather than how many people we do something to.”

– Rosemary Minto, nurse practitioner in primary health care

it’s cool to kōrero

HAERE MAI and welcome to the July column. This month we look at the tūī, a honeyeater which loves the nectar from the flowers of the kōwhai, pūriri, rewarewa, kahikatea, pōhutukawa, rātā and harakeke. It is found in most parts of Aotearoa, and is distinctive for the white tufts of feathers at its throat, and the beautiful bronze, green and blue sheen on its feathers.

Tūī have great vocal abilities – their complicated song combines tuneful notes with chuckles, clicks, grunts and wheezes. They are also skilled mimics and were once trained by Māori to imitate human speech.

Kupu hou

New word

- **tūī** – *pronounced “too-ee”*
- **Ka kō ngā tūī e whakarongo ana e au.**

I can hear the tūī singing.

Rerenga kōrero

Phrases

This issue features primary health care. Here are some phrases useful for a patient assessment.

- **Kei whea koe e noho ana?**
Where do you live?
- **Kua whai tamariki koe?**
Do you have children?
- **Kei te ora tonu ō mātua?**
Are your parents alive?
- **Kore rawa koe i kai hikareti?**
Have you ever smoked?
- **Kia hohonu te hā.**
Take a deep breath.
- **Whātero mai i tō arero.**
Stick out your tongue.

E mihi ana ki a Titihuia Pakeho and Keelan Ransfield, and He Pukapuka Reo Hauora Māori by Rawiri Jansen.

Delivering NEtP education during a pandemic

Because of COVID-19, nurse educators at one North Island district health board were forced to find new ways to deliver essential study days to new graduate nurses.

By Pauline Scott

As with all things in health over the last few months, nurses and other health-care professionals have had to find new ways of practising. This has particularly been the case with providing essential education for all nurse-entry-to-practice (NEtP) nurses at Waitemata District Health Board (DHB).

Waitemata DHB's NEtP programme is supported by two nurse educators – myself and Sharon Fisher. In turn, we are supported by two clinical coaches.

During the first six months of the graduates' transition year, we deliver 12 face-to-face study days to each graduate. Twelve study days actually becomes 60, as the February cohort is divided into three sub-groups and the September cohort into two groups.

Study days cancelled

At the start of level-4 lockdown, it was decided all study days would be cancelled and reviewed on a monthly basis, depending on how COVID-19 developed. All the teaching spaces that would normally be available were being used for other essential business. Social distancing and the number of people allowed in these spaces meant any face-to-face teaching would not happen for quite some time. A greater focus for the whole NEtP team would be coaching at the bedside. This was particularly important for the NEtP nurses in the February cohort, as they were so new to practice and the levels of anxiety were understandably high, as we all faced the uncertainty of COVID-19.

During the lockdown, I wanted to explore how we could deliver the programme differently, as many of the graduates were asking when the study days would restart. The face-to-face study days normally involve small group work, simulation activities and group reflection, with an emphasis on participation and enquiry-based learning. Universities had moved to online teaching – we would need to think differently too.

On moving to level-3, an opportunity presented itself, as charge nurse managers had not removed the study days from their rosters. This meant the graduates were still available and we were given the go-ahead to deliver essential education to them.

My vision was to run a virtual or remote study day, using Zoom. We had already been using Zoom for some meetings, so this was just a further step. I sought the advice of close friend and senior learning designer Miranda Verswijvelen. As luck would have it, she was already working on developing an e-learning package on how to set up a virtual classroom.[1]

She asked me to consider several questions. What type of learning did we want? Should it be synchronous, ie where the facilitator is online at the same time as the participants and can interact directly? Or should we try asynchronous learning, ie where participants complete online activities, such as reading and watching videos, in their own time, and the facilitator is available, but not necessarily at the same time as participants?[2,3] The other option was an approach blending synchronous and asynchronous delivery. This would require a careful balancing of the learning design.[1] The blended learning approach seemed to fit with our current teaching style.

We had to consider if everyone had access to the internet from home, as you can't assume everyone has a device they can Zoom on. There was the possibility of individuals having a space at the hospital site and using a work computer.

Another question was how to work with a large group online, where we wanted to encourage participants to ask questions but not talk over each other. This highlighted the importance of setting up good housekeeping at the start, ensuring everyone knew how to use the Zoom icons to ask questions and the chat function.[1] Having two facilitators meant one could monitor the questions and chats, while the other delivered the presentation.[1] Miranda asked if I realised how much work I was taking on. Perhaps being naïve was an advantage – with only two and a half weeks to pull this together, I had every confidence the two of us would be able to do it.

Determining essential learning

The first step was to sit down as a team and decide what would be the most valuable and essential learning at this point in time. The second step was to find out what was already available on our Ko Awatea Learn site that we could use, rather than reinventing the wheel.

The third step, after we had decided on the content, was to contact one of our e-learning experts, Miriam Laidlaw, a design guru for learning and development at Waitemata DHB. Miriam had helped me set up our NEtP platform on Ko Awatea in 2016, so I was confident she would have all the answers. I explained what we were trying to do and, within half an hour, she had created a virtual study day page with all the sub headings requested – sepsis, acute care training, wound care and a quiz. She gave us both editing rights, so we could add further content. Miriam also linked this page to our NEtP platform, so only the NEtP nurses were able to access the content.

Another valuable tool incorporated

Time	Task	Participants
0800-0830	Zoom Introduction	All
0930-1000	Group Reflection	Group 1
1030-1100	Group Reflection	Group 2
1230-1300	Group Reflection	Group 3
Throughout the day	Log on to Ko Awatea. Open the NEtP Virtual study day 1. Complete all the modules within the following sections: • Sepsis • Acute Care Training • Wound Care • CPR during COVID-19	All
1400-1430	Zoom Q&A session for wound products	Optional
1430-1500	Complete Quiz	All
1500	Zoom and feedback	All

Table of suggested time line. Apart from Zoom sessions, participants were free to complete the modules in any order and time throughout the day.

into the set-up was a way of tracking individuals' progress throughout the study day.

Part of the presentation on sepsis and wound care products is normally delivered interactively and usually generates lots of questions. We decided we would video the presentations. One drawback is that we are used to getting feedback and questions from the audience, but with no audience, the delivery needed to be modified. It is one thing to film a presentation, but quite another to edit and then upload it. This required a bit of practice and new learning for me. We then exploited Miriam's expertise to embed the presentations on the study day page.

Miriam was also able to create links to our patient experience videos so participants could access the story on sepsis. The rest of the information was relatively straightforward to upload, as Sharon and I are used to editing our NEtP platform.

After checking the graduates all had access to the internet, it was wonderful to see it all come together in the middle of May. Apart from Zoom sessions, participants were free to complete the modules in any order and time throughout the day.

One advantage of running a study day this way was no one had to fight their way through the Auckland traffic. This meant everyone logged onto Zoom at exactly 8am. There were some minor technical issues for some graduates around wifi connections but they managed, using the chat to send messages or texting if they totally lost the connection. Sharon created an anonymous feedback section on the bottom of the study day page so we could improve delivery. We were pleased the responses were so positive.

"I think the number and ratio of videos to reading to interaction was just right." "I enjoyed being able to go at my own pace through the day." "The e-learning sessions allowed me to go over the content a few times and absorb the information better." "The layout of the modules was very easy to navigate and the content was delivered in a really engaging way."

This experience has inspired us to look at other study days that may be able to be delivered in this way. Some of the graduates commented that using Zoom was not the same as face-to-face connection, which they really enjoyed and missed, so there are pros and cons to delivering education virtually. While Zoom is a valuable tool, it shouldn't necessarily replace face-to-face teaching.

By the end of the third study day, we felt quite expert in our delivery and ability to run this type of virtual event. I feel excited by how far we came in two and half weeks and want to explore further options using Zoom. We can create virtual breakout rooms, so the NEtP nurses can do group work on small projects. As facilitators, we can duck in and out to answer questions and monitor progress, something we didn't investigate given the time constraints.

Since running these study days, the Awhina Waitemata learning and development team have started returning to work and are offering workshops on using Zoom for education purposes. I look forward to attending one of the sessions to expand my knowledge of how we can deliver education in this different way.

Our three study days would not have been possible without the amazing team I work with, including Miriam, our e-learning expert. As a NEtP team, we all had a part to play in developing different aspects of the day. Sharon worked tirelessly on the wound care section, a big piece of work, and she sent out the Zoom invitations. The whole experience has been a massive learning curve and has opened doors to new ways of delivering education which will influence how we plan our NEtP education in the future. •

Pauline Scott, RN, MsHP, is a clinical nurse educator, nurse entry to practice, Waitemata DHB.

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Navigating health in Nelson's hard-to-reach communities

Victory Community Centre in Nelson serves an ethnically diverse community, including those living in a nearby hostel and refugees from South East Asia.

By Steph Anderson

PHOTO: MARTIN DE RUYTER/STUFF

Steph Anderson, with primary alcohol and other drug clinician Sabien Blazek (left) and GP Debbie Harrison, ready to test people for COVID-19 at the Toi Toi Community-based Assessment Centre in May.

Victory Community Centre (VCC) sits in the heart of Nelson's Victory suburb, a vibrant and ethnically diverse community. The centre is located on the fringe of the local primary school campus and is close to local services such as the community pharmacy and the district hospital.

The Victory population is more ethnically diverse than the wider Nelson community, and there has been a rise in the number of people from South East Asia settling here. This is primarily due to settlement of former refugees with the help of the Red Cross. Families from Myanmar have been arriving since 2005, and, more recently, people from Nepal, Bhutan and Colombia have also been resettled here. VCC works closely with the Red Cross to support these new residents, many of whom have complex physical and mental health needs.

The VCC team consists of a manager (who is a registered social worker), a primary alcohol and drug clinician (trained as an occupational therapist), community navigator for former refugees, activities co-ordinator, receptionist, volunteers and community nurse.

The community nurse role has been in place since the beginning of the centre in 2007 and, until 2019, was a part-time position wholly funded by the Nelson Bays primary health organisation with a focus on navigating people towards GP care. In 2019, further funding was acquired through a contract with the Nelson Marlborough District Health Board's Māori and vulnerable populations team, which meant the nursing role could be advertised as a full-time clinical nurse specialist (CNS) position.

The focus of this contract is to provide health navigation to harder-to-reach communities. This includes the residents of Franklyn Village, a local hostel housing around 200 people, many of whom suffer from chronic, untreated health conditions.

An assessment tool called Hauora Direct has been produced. This covers a range of screening for chronic conditions, as well as mental health and addiction problems, and questions on such things as living situation and child safety.

In May 2019, I was fortunate to be appointed as the new community nurse at VCC. I had worked for 20 years as a CNS in mental health and addiction services in Nelson and, before this, in London. I was hoping my background of hospital-based general nurse training, and a keen interest in co-existing physical and mental health issues would help me adjust to this new and varied role.

As a member of Te Ao Maramatanga (College of Mental Health Nurses) I had been involved in the credentialling programme for primary-health nurses, so already had some good links with local practice nurses. This became very important in establishing good working relationships with the five practices in the Victory area.

The role is varied and can encompass anything from a B4 school check on a four-year-old to helping an isolated 80-year-old connect with others to help their mood. When the nursing service started, the price of visiting a GP was much higher, so there was a need to provide services, such as ear syringing, dressing wounds or giving B12 injections. As costs for community service card holders have fallen, the focus now

Victory Community Centre was opened in 2007.

is on engaging people with their primary providers and actively navigating them to whatever service is appropriate.

VCC's philosophy is based on the belief that community and connection are powerful. Alongside specific health interventions, visitors to the service are encouraged to join in activities, some as simple as sitting down for a cup of tea and a slice of cake. We encourage people to be active in making changes to their lives rather than expecting problems to be fixed for them.

Basic needs are important and VCC is part of the local kai rescue programme. This was established in 2017 with the aim of minimising food waste in the community. The team collects food from supermarkets, growers, manufacturers and other food outlets that is good enough to eat but is surplus or non-saleable. It is then sorted by volunteers and given to more than 40 recipient organisations within the Nelson area which distribute the food to those in need.

At VCC, kai is distributed in individual parcels (an average of 14 per day) and there is also a kai shed on the edge of the carpark where leftover food is put out twice a day for the community to help themselves. It is common to see locals dropping off their excess fruit and vegies to the kai shed to share with others.

Food is a basic necessity for us all and, as a nurse working in an environment where food is distributed to those in need, this gives me a valuable opportunity to open up those tricky conversations about health and stressors.

It's hard to estimate how many times a simple conversation as someone picks up a food parcel, has turned into a health assessment and treatment or onward referral.

Over the past year, it has been interesting to notice that the majority of those seeking help may present with a straightforward physical health issue, but during assessment it becomes evident there are often untreated psychological issues. These issues have increased markedly following the recent lockdown and fear of COVID-19 spreading in the community. VCC was heavily involved with the COVID-19 response, hosting a community-based assessment centre in partnership with Toi Toi Medical, a local general practice, and Victory Pharmacy. Some people coped reasonably well during lockdown and beyond, while others struggled, especially those who lost their jobs.

It was a scary time for all of us, as we had no idea how many cases we would find. What was encouraging was the way health professionals from a range of providers worked together so closely and supportively. I hope these new relationships will continue.

There are challenges involved in this area of work. One of the most significant is the risk of working beyond your scope of practice or competence, as it's easy to get carried away and do whatever is needed when you meet people. It is important for me to have good supervision. Currently I have one-to-one supervision with another senior nurse in a community role, as well as peer supervision with a group of local practice nurses.

The rewards of this work are huge. It is satisfying to be in a position where I am able to respond to a person's need and offer them appropriate, and often immediate, help.

Shared lunch for staff and clients at the Victory Community Centre.

For me, nursing is about having time to listen to people and building relationships, and then being able to respond immediately and appropriately to their needs. This is a job where I am able to do this, which is immensely rewarding. •

Steph Anderson, RN, PGDip (Hlth), works as a clinical nurse specialist at the Victory Community Centre in Nelson. This article, now updated, was first published in *Logic*, the College of Primary Health Care Nurses' journal, in December 2019.

The health benefits of community gardening

Community gardens can provide many benefits – improved health literacy and nutrition, physical exercise and social connection. Primary health care nurses are well placed to champion such initiatives.

By Kerry Ruck

The group endeavour of gardening can provide a different platform to increase health literacy. Other health benefits include exercise, better diet, psychological harmony, communication, caring and social contact.

Health literacy is becoming an increasing focus for organisations wishing to instigate change and improvements in the health of their patient communities.[1] A patient who is considered health literate has the ability to access and understand information which they can use to improve their health and wellbeing. In contrast, low health literacy, where a patient lacks perception and understanding relating to their condition, is the most likely predictor of poor health outcomes.[2]

The ability of all people across genders, age groups, cultures and ethnicities to live with purpose and flourish in society depends on the strength of their health and wellbeing.[3] Engaging with vulnerable patients to help them manage their health positively means health providers must deliver support and health care in new ways.[4]

One way of doing this is starting a community garden. The aim is to promote, encourage and build health literacy skills through creative endeavour and collective caring.[4] A community garden has the potential to increase patients' self-efficacy and decrease their social isolation. It is attuned to the natural environment and can provide a nurturing space for all participants to enjoy the shared activity of gardening.[5] Associated benefits include good nutrition, physical exercise[6] and social connection. A community garden can enhance holistic, person-centred care where the clinician is a co-contributor rather than simply a health-care provider.[7]

At an individual level, health promotion is more effective when interaction and communication occur within a community setting.[8] Interventions that enhance health-care communication and offer new approaches to health information and knowledge can lead to better health outcomes, particularly for those managing long-term conditions.[9]

On a global scale, the World Health Organization (WHO) states that, as climate change continues to affect the environment, health inequity will increase unless a country's national and local policies support sustainable initiatives.[10] The WHO argues that if sustainability interventions for the environment are well resourced, then the health of the whole population will benefit.[11]

It is also important to remember that urban areas will increasingly suffer from heat waves due to the heating up of the planet caused by climate change. This highlights the importance of creating more green spaces in urban areas where shady trees and plants will help negate the ill effects of overheating.[10]

Te Pae Mahutonga health model

Te Tiriti o Waitangi principles assert that "health and wellbeing is a human right" and that these rights are taonga to Māori. Māori academic Mason Durie is a strong advocate for Māori health and set up the framework Te Pae Mahutonga to guide community health goals.[12] These incorporate the wisdoms of mauri ora, waiora, toiora and te oranga with ngā manukura. The framework places equal value on culture, the natural environment, healthy living, social connection and community leadership.[12]

A community garden can provide a nurturing space where partic benefits.

The Government's PHC strategy envisions best practice centred on evidence-based care and promotion of independence, ultimately seeking to improve health equity and social justice for all.[13] Community gardens have a role to play in helping achieve this vision. Māori as a group have lower socioeconomic status and more health deprivation, and encounter many barriers to improving their health. Nurses are in an ideal position to facilitate positive change for Māori health because they provide the majority of care to the patient.[15]

Māori wellbeing is closely aligned with the natural environment.[16] Evidence reveals that where there is a higher density of green spaces in a suburban area, the people there are more physically active than those who live in areas with fewer green spaces.[17] When people have access to common green areas, there are benefits to the health and wellbeing of individuals and the community. Greenspace Scotland says policy makers should

ipants can enjoy a shared activity, along with other health

champion the allocation of green areas which should be recognised as a significant contributor to health and equity in communities.[17]

Health policy analyst Margaret Earle developed a thesis from her 2010 qualitative study investigating community gardening as a health intervention in New Zealand.[7] The study set out to assess if community gardens helped improve health behaviours and lessen health inequalities. She established that communal gardening was an integral part of the Māori way of life before the arrival of Europeans.[7] The study highlighted MoH data that estimated that if everyone ate a half portion more of fruit and vegetables per day for five years, the overall yearly death rate would decrease by 300. Moderate physical activity such as gardening is known to increase longevity and modify the impact of long-term conditions.[6]

Addressing health inequities

Current predictions forecast that inequities in health will continue to widen and that obesity and behaviours influencing obesity will increase, particularly in disadvantaged populations. The incidence of diabetes, coronary heart and respiratory diseases, and obesity are rising significantly, alongside poor nutrition, lack of exercise and social dislocation.[11] National and local policies supporting interventions to combat these issues need to take into account the social determinants of health. These have to be addressed because they directly affect health behaviours.[18] A national policy that funds its communities to provide easy access to healthy food will enable opportunities to improve health and wellbeing and decrease inequalities.[19]

Establishing a community garden can provide a platform to promote key health messages. It can showcase sustainable living, help achieve good nutrition through growing and eating vegetables and fruit, and promote the benefits of exercise. It can provide a safe outdoor environment which can aid healing through the power of community collaboration.[20] Nurses are ideally placed to influence health behaviour change and can offer enthusiastic stewardship of creative endeavours such as a community garden.[20]

Creative health messages

The idea behind community gardens is to overcome isolation for vulnerable patients and promote health messages in a creative, less demanding way. When vulnerable patients get the opportunity to improve their understanding of health messages, they are more likely to take responsibility for their own care.[22]

Most often, disadvantaged patients are often from a low socio-economic background. Nurses can wrongly assume this affects their ability to understand health information and, more critically, to act on it. A community garden can provide a way of building rapport and trust, enabling better health-care relationships and adherence and motivation to self-care.[22] A community garden is a resource for everyone to share, a safe space which facilitates communication.

The MoH's publication *Rauemi Atawhai* is a guide for developing health education resources in New Zealand.[23] It is useful to reflect on the principles in this guide when setting out the intentions behind a community garden. These principles include openness, accountability, inclusivity and the recommendation to invite all stakeholders to share their knowledge and expertise.[23] The opportunities are endless when all participants have the chance to advocate for what they wish to learn.[5] According to Earle, potential limitations are likely to be funding and resources, and unrealistic expectations of stakeholders of getting the project established within a certain timeframe. Reliance on a core group of people is key to keeping the project viable, sustainable and economical.[7]

Nurses as leaders

The primary health sector has the potential to lead the way for innovative change in how health care is delivered. PHC nurses can become leaders and devise sustainable models that champion collaboration, inclusion, connection and responsibility; partnering with their patient community to ensure the protection of health now and into the future. Strategic planning that involves a cross section of the community to prioritise the development of holistic initiatives, centred around diversity and sustainability, will provide ongoing benefits for the individual and their community.

There is growing evidence that being part of the development of a community garden has numerous health benefits. This endeavour can be preventative health care in action, enabling participants to reach optimal health and wellbeing. From such a platform of collective strength, the possibilities to improve health literacy are limitless. •

Acknowledgement: With thanks to University of Auckland professional teaching fellow Louise Carrucan-Wood for her advice and encouragement on this article.

** References for this article are on p44.*

Kerry Ruck, RN, PGDip(HSci), is a practice nurse at the Ellerslie Medical Centre. This article is based on an assignment she wrote last year on health literacy innovation in a primary health care setting. She is hoping to establish a community garden in Ellerslie in the near future.

End of life choice – do nurses know what they are voting for?

The End of Life Choice Act, the subject of a referendum in this year's election, could fundamentally change nursing practice. How well are nurses informed about its implications?

By Louisa Ingham and Bridget Marshall

If the End of Life Choice Act 2019 (the Act) passes into law following the referendum in September, it will mean a fundamental change to the role of the nurse in caring for people with life-limiting illnesses.

Yet the implications of the Act for nurses and nursing are not straightforward and remain, to a large extent, unclear. Regardless, it is important nurses consider these implications, should the Act be passed into law.

The Act outlines that a person, if they meet certain criteria, can choose the time, place and method that will end their life. There are two method options in the Act :

1) Self-administration, whereby the patient takes medication prescribed to them by a medical doctor or nurse practitioner (NP) to end their life. This is commonly known as medically-assisted suicide or physician-assisted suicide. In assisted suicide, the individual is provided with the knowledge and means to end their life, but is not physically assisted to do so.

2) The person may elect that the medication that will end their life be injected by a medical doctor or NP. This method is known as euthanasia, whereby the health professional knowingly undertakes an action that will end the patient's life.[1]

Not all people who are dying will have these choices. The Act outlines criteria for those who will or will not be able to end their lives under the Act. Debate continues concerning assessment of competence, definitions of terminal illness, ability to assess life expectancy and whether the presence of coercion can be evaluated.

In addition, there are a series of misconceptions that cloud the debate. People, including clinicians, often hold the falsely-held belief that doctors and nurses are already undertaking "assisted dying" through existing practices. Likewise, confusion remains around what practices are already permissible within the current law. We will try to address some of the more commonly-held myths in this article.

Opioids and syringe drivers

One of the most common myths in relation to end-of-life care is that doctors and nurses administer medications, such as opioids, to hasten death. Opioids are a common group of drugs used for people requiring palliative care to manage symptoms such as pain and breathlessness. Opioids, when used according to World Health Organization guidelines and in line with clinical evidence, do not hasten death.[2] Another commonly-held belief is that a syringe driver is started to expedite death. Again, it is not. A syringe driver is indicated when a person is no longer able to safely swallow their medications or when they can no longer effectively absorb oral medications. Syringe driver use is not related to the closeness (or not) of death.

De-prescribing

There is often a perception that discontinuation of medications at the end of life can hasten death. De-prescribing or stopping medications is often undertaken in the final days or weeks and sometimes months of life. This is never done to expedite death, but rather to recognise that a particular medication is no longer indicated, or that a medication may become a burden rather than a benefit. This needs to be done carefully, in discussion with patients and families/whānau and in line with accepted de-prescribing protocols.[3]

Louisa Ingham

The 'last dose'

There is often a fear among nurses that they are responsible if a patient dies shortly after administering a dose of medication such as an opioid.[4] However, there will always be a "last dose". If the dose given was the same as previous doses given, was previously tolerated and within the timing window prescribed, then it was not the medication that ended the patient's life. Rather, it was their time to die. Patients requiring palliative care have often been taking opioids and other strong medications for a long period of time and are not naive as to their effects. A single dose will not end a person's life in this context.

Stopping food and fluids

We often come across families and clinicians who are concerned that patients will be starved to death. In reality, a dying person's appetite will diminish in the final weeks of life, as does the

Bridget Marshall

swallowing reflex. This is a normal part of the dying process. This can be hard for family/whānau to witness, as food is so central to caring in most cultures.[5] Artificial hydration, such as subcutaneous fluids, and nutrition are not commonly given to people requiring palliative care. This is because parenteral fluids cannot be utilised or excreted by a person in their last days of life in the same way a healthy person can. There is no evidence that artificial hydration or nutrition helps a dying person live longer or improves quality of life.[6]

Palliative sedation

Palliative sedation is one of the most misunderstood practices within a palliative care setting. It is rarely needed and undertaken only as a very last resort in the last days of life to relieve severe and refractory symptoms unresponsive to all other forms of treatment. In the hospice setting, terminal sedation is only performed by a specialist and is usually a team decision. It is aimed at inducing unconsciousness, with the sole intent to alleviate intolerable suffering in the last days of life. It is not to hasten death.[7] Indeed, multiple studies have attempted to measure the influence of terminal sedation on patient survival, and have found survival times to be the same when compared to non-sedated patients.[8]

Implications of the Act

We are unable to anticipate all of the implications for nurses if the Act is passed. We anticipate, however, and drawing from the experience of colleagues in Australia and Canada, that there will be a significant impact on nurses and nursing. Experiences of our Canadian colleagues after euthanasia became legal in Canada in 2016 showed that, while some felt it was a natural extension to the work they did, others experienced heightened levels of responsibility, distress and anxiety.[9] An important consideration for nurses is what their moral position is and what aspects of the Act they will be comfortable (or not) to engage in.

Nursing involvement

The NP role is recognised in the Act as aligning with medical practitioners. This means NPs, unless recognised as conscientious objectors, will be expected to be involved with euthanasia. Although registered nurses are not explicitly mentioned in the Act, nurses are often the first to have conversations with patients expressing a desire to end their lives. It is imperative, therefore, that nurses are fully aware of their role and responsibilities under the law.

Communication skills and confidence in talking about end-of-life care issues will be essential for all nurses. Despite this, palliative care, including effective communication skills, are not necessarily included in all undergraduate nursing school curricula.[10] Thus the potential burden imposed on nurses by the Act represents a fundamental change in nursing in Aotearoa New Zealand.

Although nurses have a right to conscientious objection under the Act, how this will work in practice is not entirely clear. A High Court judgement has recently clarified some issues relating to current statute – including whether or not an organisation such as a hospice can conscientiously object, and the relationship between the Act and The Code of Health and Disability Services Consumers' Rights.[11] We encourage you to read the full report.[11]

However, it remains unclear what organisations will expect from nurses as regards their level of participation and nursing practice. In Canada, for instance, nurses who are conscientious objectors are still expected to prepare the patient for euthanasia and undertake after-death care.[12]

We suggest all nurses voting in the upcoming referendum take time to read, understand and reflect on the Act, and the implications for their practice. We believe this Act will fundamentally change nursing practice. As a nurse, are you ready? •

Acknowledgement: We thank University of Auckland senior nursing lecturer and chair of Palliative Care Nurses New Zealand (PCNNZ) Aileen Collier for her helpful comments on earlier drafts of this article.

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Nurses' voices essential in COVID-19 reviews

Nurses were pivotal in planning for and responding to COVID-19. Their voices and views must inform any national review.

By acting associate professional services manager Kate Weston

The past few months have been extraordinary. The world has been in the grip of the COVID-19 pandemic and pressure on health services has been immense. And, with the acceleration in the pandemic in many parts of the globe in the last month, no end is in sight.

In March, we braced ourselves for similar pressures in Aotearoa. Thankfully, we have had success – due in no small part to the work of nurses and other health-care workers, who were on the frontline in the COVID-19 response. Aotearoa did not see overwhelming numbers of critically unwell people needing intensive support. Our battles have been largely fought in the community – in primary care, aged residential care (ARC) and community and disability services.

Evidence indicates the pivotal role of nurses in meeting and managing this crisis. The role of nursing leadership in policy making and co-ordination between government and hospitals is critical to effective management of a pandemic. Yet their input has too often been sidelined. *"Nursing has barely been included in relevant strategy documents, and nurses largely absent from such expert advisory committees. The prominence of such 'expert–based' policy making may accentuate the invisibility of nurses."*[1]

Significant gaps have emerged in the planning and management of the pandemic here. While we had planned for acute services to meet the challenge, COVID-19 was always a public health issue. The previous Government dismantled many public health supports that should have been able to respond immediately, rather than playing catch-up in a rapidly changing situation. Nurses were called on to rescue the situation, often in the absence of adequate planning and support.

Adequate personal protective equipment (PPE), appropriate staffing and nurses leading education for staff and the public on infection control measures, through a variety of platforms, were advocated by the Taiwan Nurses Association.[2]

The Auditor-General's audit of PPE and the results of the PPE survey undertaken by the McGuinness Foundation in partnership with NZNO,[3,4] vindicated members' concerns. NZNO escalated these concerns on members' behalf through media, meetings with chief nursing officer Margareth Broodkoorn and the national district health board (DHB) health union group.

Nurses and other health workers have been unnecessarily exposed to COVID-19 in the workplace. How many health workers contracted COVID-19 in the workplace remains unknown. Initially, infection of health workers was blamed on contact with an infected household member or overseas travel. This wore thin pretty early on, when workplace exposure became clear. Some nurses and other health workers became very unwell. The hospitalisation of one nurse made clear that health-care incidents are reviewed through a patient-centric lens, rather than a health and safety framework focused on risk and harm to workers. NZNO and other health unions are now actively pursuing a robust health and safety framework to ensure nurses and other health workers are protected and that when serious workplace harm occurs, there is a truly independent review.

The hospitalisation of one nurse made clear health-care incidents are reviewed through a patient-centric lens . . .

Winter is upon us, meaning increased demands on primary health care and DHBs and nurses are already fatigued. As efforts ramp up to return to business as usual, adequate resources from the COVID-19 recovery budget must be directed at the nursing workforce, which was, and will continue to be pivotal in the pandemic response.

There have been a number of reviews into aspects of the COVID-19 crisis but nurses' voices have not been well represented – or even sought in some cases. NZNO made direct approaches to ensure we contributed to the Auditor General's PPE review. A detailed submission was made on behalf of members requesting to appear before the epidemic response select committee but we did not get the opportunity to speak to the submission. NZNO was not explicitly included in the review of ARC facilities, despite providing the primary response when significant, ultimately fatal, clusters emerged. We were only able to respond once the draft report had been circulated.

What is yet to occur is a comprehensive, truly independent, national review of all aspects of the COVID-19 response, across the whole health system. As a "team of five million", we have done well, but there are many lessons to be learnt. These lessons need to inform the management of any possible second wave or other similar emergency. Let's do this – and ensure nurses help lead the national review from the outset, rather than being an after-thought or an add-on. •

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A short history of sick leave

It's important to know how current sick leave provisions for public sector nurses came about, to counter inaccuracies oft repeated on social media.

By acting industrial services manager Glenda Alexander

This industrial focus is inspired by a discussion taking place on various Facebook pages. Sick leave is a topical issue, given "safer sick leave" is part of the Council of Trade Unions' election campaign, improved sick leave is a claim in the NZNO/district health board multi-employer collective agreement (DHB MECA) negotiations and we have just come through COVID-19, during which the health and wellbeing of our health workforce was pivotal to the recovery of individuals and our nation.

It is interesting to see "the retrospectoscope" in action on Facebook. The retrospectoscope is a means of looking at a situation after the fact, when it's easy to "predict" the outcome because it has already happened. It is currently being used to evaluate how the current sick leave provisions in the NZNO/DHB MECA were agreed. This historical evaluation is somewhat disingenuous, with a degree of selectivity in the information provided.

Destruction of national award

So, to set the record straight: in 2003, NZNO set about planning for the first national NZNO/DHB MECA. This had been enabled through the Employment Relations Act (ERA) 2000. Its predecessor, the Employment Contracts Act 1990, had enabled the destruction of national awards. During the 1990s, the ECA was used to dismantle nurses' national award and create regional awards. This saw members' terms and conditions reach an all-time low. This was happening in the context of major health reforms that saw many public services removed or reduced, hospitals closed and a huge number of nursing jobs disestablished.

The ERA provided the opportunity to regain what, to all intents and purposes, was the previous national nurses award.

The first phase of rebuilding our national agreement was to consolidate, on a regional basis, the more than 20 nursing collective employment contracts (CECs). Senior nurses had been taken out of the CECs and were either on senior nurse regional CECs or individual employment contracts. In preparation for the second phase of working towards a national MECA, the terms and conditions of all the collective and individual contracts were analysed and collated by the common provisions and where they differed. Moving to the 2004 bargaining itself, we took the best-of-the-best clauses into the negotiations. By the end of the bargaining for the 2004-2006 NZNO/DHB MECA, most conditions had been agreed to the best-of-the-best standard, with the exception of long-service leave, retiring gratuities and sick leave.

A standard sick-leave clause was negotiated. This was, effectively, what had been an existing and common clause in most of the collective and individual agreements we were consolidating. Where the provisions differed, they were set out in the Appendix 1 (a) of the MECA. The differences related to what was called "unspecified" (NB not *unlimited*) sick-leave provisions. In 2004, five DHBs had unspecified sick leave and four had a mix of specified for the first 12 months' work and unspecified thereafter.

Ability to end employment

A notable and concerning theme of unspecified sick leave was the express ability for an employer to terminate an employee's employment, if they did not return to work within six months due to "longer-term" illnesses.

MECA negotiations in 2007 aimed to further consolidate and improve the terms and conditions of the first MECA, particularly the long-service and sick-leave provisions. During the negotiations, delegates gave passionate presentations on sick leave. Some had seen the positive outcomes of unspecified sick leave. There were also stories of members not being treated fairly. I vividly remember hearing about a member who tried desperately to return to work immediately following cancer treatment because her manager would not exercise the discretionary provisions of the unspecified sick-leave clause. The decisions of panels put in place to review the unspecified provisions were often overturned.

Caring for family

During these negotiations, we became aware most members took sick leave to care for their families or dependants. At that time, the average sick leave taken was 8.5 days per annum. This information was the genesis of the sick/domestic leave provision (clause 14.0) of that 2007-2010 MECA. The preamble to the clause set out the intentions of the parties at that time, which were honourable and signalled a change of attitude, which we hoped would support members.

This same agreement introduced the much maligned "discretionary" sick leave. This provided an additional 10 days' leave per annum, with further discretionary leave available in extenuating circumstances. Unfortunately, this clause has never been applied in the spirit in which it was intended. It is also worth noting that the 2007–2010 MECA also included pay increases of around seven per cent for each year of the term and had one of the highest ratifications – 94.37 per cent of those who voted were in favour.

Close to 15 years on, these sick-leave provisions should be improved. It is time for the New Zealand statutory minimum five days' sick leave to be increased and for public-sector employers to model their care and support for their nursing workforces by providing enhanced and safer sick-leave provisions. •

Independent review sought

THE MENTAL health nurses' section (MHNS) and cancer nurses' college (CNC) have jointly requested by remit an independent review of the NZNO constitution.

"It is our hope that an independent constitutional review will result in a less divisive environment in which the board and NZNO leadership are given the opportunity to work together for the benefit of members without the distractions that have occurred over the past 18 months," MHNS chair Helen Garrick told *Kai Tiaki Nursing New Zealand*.

A draft strategic plan for the next five years is being finalised, after feedback from members and staff for NZNO's annual general meeting (AGM) later this year. Terms of reference for a review of the NZNO constitution are also being finalised, for the AGM.

Garrick said the section wanted NZNO's strategic plan to align with a revised constitution, and ensure two-way communication between the board and members and clearer measures of NZNO's achievements.

Membership engagement and communication, strong and cohesive leadership, and member health and safety, particularly in relation to workplace violence, should be priorities, she said.

Ensuring democratic processes

CNC vice-chair Kirstin Wagteveld said the aim of the joint remit was to ensure that the constitution has a "careful and thorough independent review" to ensure democratic processes, and the one-member-one-vote process was adhered to.

"At present, it would seem there are grey areas, particularly with regards to how voting occurs, at special general meetings in particular."

Any constitution undergoing periodic change can become difficult to understand, "which doesn't help with member engagement or understanding of the remit and voting process within NZNO".

Improved access to electronic voting should improve member engagement and a "full and independent review will reassure members that NZNO is a robust and transparent organisation moving forward", Wagteveld said. •

AGMs put off

THE NZNO board is supporting colleges and sections (C&S) forced to defer their 2020 conferences and annual general meetings (AGMs) during COVID-19.

Decisions had to be made quickly to avoid penalties, pushing some C&S outside rules for AGM frequency, NZNO chief executive Memo Musa said in his June report to the board. Some, but not all, had avoided financial penalties. In the "extreme" circumstances, NZNO had to cover C&S decisions retrospectively "to avoid the organisational risk of being outside the NZNO constitution and audit requirements".

C&S must communicate a new AGM date to members and financial, chairs' and treasurers' reports must be circulated electronically to members as close to the original date as practicable, he said. The deferral decision must be formally recorded as soon as possible when the committees meet. Any approvals outside AGMs must be formally presented and passed at the next AGM. AGMs could be conducted via Zoom. •

Virtual diabetes care works well for youth

MANY DIABETES clinics went virtual over lockdown – a move particularly successful for paediatric services, the Aotearoa College of Diabetes Nurses (ACDN) says.

Wellington diabetes nurse Pip Cresswell said young adult clinics in Wellington had a 100 per cent attendance rate, "which is exciting in this sometimes difficult-to-reach age".

The Nelson-Marlborough District Health Board (NMDHB) had been gearing up to pilot virtual health consultations before lockdown, so was well-placed to take clinics online, diabetes clinical nurse specialist Pauline Tout said. Using Zoom, paediatricians, diabetes nurse specialists and dietitians consulted patients and their families.

"The hospital team was thrilled with the process and the outcome," Tout said. Rural families in particular benefited.

Screen consultations seemed to encourage "better sharing than in the face-to-face meetings". It was also great to view the patient's information and results at the same time, and whānau felt involved, she said.

Bobby Milne

Gathering information for virtual consultations took longer but was worthwhile, said Tout, who believed virtual consults would continue to be part of the health system.

College chair Bobby Milne said at Middlemore Hospital over lockdown, most diabetes consultations were virtual or by phone. Staff did see some patients face-to-face with appropriate precautions and the Manukau superclinic remained open throughout. While some diabetes staff, who had potentially been exposed to the virus, no-one caught COVID-19.

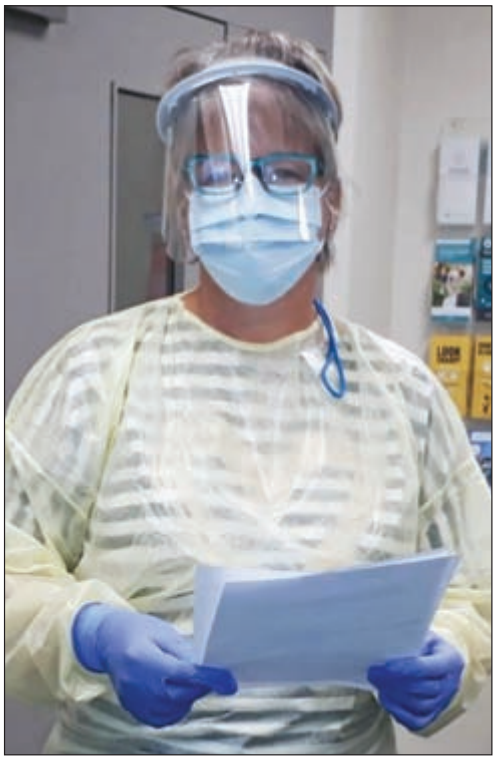
Under level 4, it was easier to contact patients, but as levels descended through 3, 2 then 1, it was "back to normal trying to contact patients who do not attend their appointments.

"Obviously in a virtual clinic, you could not do all that you would normally when seeing patients face-to-face, but mostly it worked well," she said.

Some patients preferred virtual consults. "I think we were lucky the situation here did not become like other countries. We had clear messages from the hospital and head of department. We were clear on what we were doing and who we would be seeing," Milne said. "As a team, we fed back on how things were going."The college has postponed its annual general meeting until next year but will hold a regional study day in Christchurch on November 7. •

Nurse reflects on COVID-19 experience

Waikato Regional Diabetes Service nurse Helen Ashton shares her reflections of the rāhui.



Helen Ashton in PPE for an essential consultation

It started with red tape on the floor and cordoning off reception staff from visitors. Day by day there was more tape, re-arranging of seats in the waiting room, in offices, in the staff room. Hand sanitiser and wipes became more visible at times, at others sadly disappearing. The conversion of one of our labs into an isolation room, the arrival of personal protective equipement (PPE) and compulsory training on it made the situation real and serious.

One moment we were talking about "what ifs" and the next we were packing our bags and desks to work from home. Clinics were reduced and changed to phone consults before we hit rahui level 3. Staffing on site was cut to below 50 per cent during level 4 and only urgent cases such as podiatry, diabetes and pregnant patients were seen face-to-face, along with one urgent retinal photo screening clinic. We rotated in "pods" so others would still be available if anyone went into isolation or became unwell due to potential exposure.

Planning and directing were clearly communicated by our management team. We were encouraged to check in daily with our nurse manager. This was really important to help stay connected with the service. We had daily, then weekly, meetings to check in and share resources and our experiences of working differently. We found Zoom the best platform for both sound and visual quality.

The screening process at the clinic intensified to include temperature checking. I greatly admire nurses working in acute areas where PPE needs to be worn for long periods. On my first day, I was hot, sweaty, anxious and struggling to regulate my breathing and stop my glasses fogging up, as I assessed an essential podiatry patient who arrived with a cough.

Support to our primary health care colleagues increased and we extended our 0800 type 1 diabetes on-call nurse service to type-2 diabetes patients during this period, to try to minimise hospital admissions.

Telephone consults were the norm during rahui level 4 and 3. Mostly patients were very receptive and pleased to have someone to talk to. There were fewer excuses from patients about not having time to check glucose levels. But trying to explain how to get previous results from their glucose meter was challenging and time-consuming. How great it would be to have every patient able to upload their glucose meters, libre glucose data, insulin pump data and – while on the ideal – for patients on antihypertensives to have a home blood pressure monitor, oh, and scales for weight measurement.

The majority of contacts for our on-call nurse service were about prescriptions, but would end up as a full consult. In addition to checking there wasn't serious hypo or hyperglycaemia, most calls involved checking on patients' mental health, ensuring they had enough insulin and adequate sick-day management knowledge. After two weeks in rahui level 4, more staff had to come back to provide day cover as the work increased.

Working from home has forced us to accelerate becoming "paper light" but generating prescriptions and getting them to pharmacies was problematic. Over time, our IT department managed to sort emailing prescriptions. Working from home also forced us to look at resources and teaching tools for patients and how these could be uploaded electronically. Ongoing virtual consults are likely to become the norm – easing space issues for clinics, offices and parking.

My teaching work at Wintec went quickly online, as did a breakfast diabetes educational forum for nurses. It was well-attended and requests have been made for it to continue on Zoom. Diabetes registrar teaching sessions have changed to Zoom permanently.

But I have missed the real-life connection with colleagues. I cannot wait to get together and celebrate getting through what is hopefully the worst of COVID-19, to reconnect, share our experiences and change the way we work and support our patients with diabetes, and our communities. •

I cannot wait to get together and celebrate getting through what is hopefully the worst of COVID-19, to reconnect, share our experiences and change the way we work and support our patients with diabetes, and our communities.

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Iwi health trust celebrates site collective agreement

NGĀTI HINE Health Trust (NHHT), the largest Māori health provider in Tai Tokerau and one of the largest in the country, last month celebrated signing a site collective agreement (CA). The CA, agreed late last year, delivered pay scales for the trust's approximately 30 tapuhi/registered nurses and one nurse practitioner, which reflect those of DHB nurses.

Trust chief executive Geoff Milner was pleased with the CA. However, he said the trust was commmitted to pay equity and "there is work to be done by the health system to allow us to pay our nurses at higher steps on the pay scales".

And he said funding per full-time equivalent (FTE) roles needed to be addressed. "Many nursing FTE funding rates paid to Māori providers are less than $100k per FTE."

Under the CA, the trust's kaiāwhina, community health and support workers and kaimahi get the pay rates in the care and support workers' equal pay deal.

The agreement – Ki Arahanga ki Tawhiti, The Bridge to the Future – was signed late last year, but celebrations to mark it were delayed due to COVID-19.

Milner said the trust was founded in 1992 "off the back of nurses". Its first service was a mobile community nursing service. "The nursing profession is in the DNA of the trust. Now, nearly 30 years after it began, we have 330 staff but have never lost sight of the importance of nursing and its place in the trust's foundation."

Ngāti Hine Health Trust staff celebrate a new site agreement. Chief executive Geoff Milner is in the centre of the back row.

Milner said the lack of pay equity for nurses working for Māori health providers was unacceptable and the trust had looked to rectify that through the CA. "We've stepped up to do something about the lack of pay equity. And it is attracting nurses to work for us because they feel valued," Milner said.

The trust is wanting to be a living wage employer. The minimum hourly rate paid by the trust since January 1 this year is $20.50. Milner hopes what the trust has done would inspire other Māori health providers to follow suit for their nurses and other workers.

NZNO organiser Julie Governor, who led the negotiations for NZNO, said the CA had been "a long time coming" and she was delighted with the agreement, as were trust staff. "We have come full circle. From 2003 to 2005 there was a site agreement here. The trust was then part of the primary health care multi-employer agreement and Te Rau Kōkiri, and now we are back to a site agreement."

The core terms and conditions of the CA, including annual and sick leave, long-service leave (LSL) – an extra two weeks LSL after 10 years was included in the new CA – and professional development apply to all staff. Over the coming years, the aim is to strengthen the CA and build on the salary scales for all occupational groups covered by the agreement. These include alcohol and other drug counsellors and clinicians, social workers and administration, IT and quality assurance staff. The CA expired on June 30 and bargaining for the next one has been initiated.

NHHT serves a population of around 20,000 from Kaitaia to Whangarei. •

Updates on negotiations underway or about to start

▶ NEGOTIATIONS FOR an inaugural national collective agremment (CA) for 80 registered and enrolled nurses working for community health provider Access Healthcare began late last month, with another two days early this month. NZNO advocate Danielle Davies said steady progress was made and they have started working on the main content of a proposed CA. There was also progress on the substantive claims and the team would focus on these at the next scheduled negotiations on July 29 and 30.

▶ Negotiations for the 100 or so NZNO members working for Family Planning got underway via Zoom last month. NZNO advocate Chris Wilson said Family Planning presented its financial position in terms of its current funding and the constraints this presented.

Face-to-face negotiations were scheduled for July 14 in Wellington.

▶ Negotiations with the country's largest aged-care provider, Bupa, will start next month. A claims survey closed earlier this month and claims endorsement meetings are being held this month. •

Changes in industrial services team

INDUSTRIAL ADVISER (IA) Mike Yeats retired last month after 16 years working for NZNO, based in Dunedin. He began work as an organiser in 2004, worked as a relief lead organiser (LO) and was appointed as the half-time private hospitals and hospices IA in 2015. This year he also took on a 0.3 position, suporting Lesley Harry in the aged-care IA role.

Acting industrial services manager Glenda Alexander said Yeats was a "quiet get-on-with-the-job person, who had a wealth of knowledge and great people skills, including the ability to be an active listener". His strengths included a calm, considered manner, being a supportive colleague and team member and excellent proofreading skills, she said.

Christchurch-based LO for the Nelson and Dunedin offices Lynley Mulrine has been seconded to Yeats' IA roles for six months. Mulrine has also been working with the Canterbury District Health Board on the care capacity demand management roll-out. Her LO roles will be filled by organiser John Miller, who has been working as LO for the Christchurch office.

Alexander said the IA vacancy would be covered by a six-month secondment to allow NZNO time to recover from the impact of the COVID-19 crisis and to provide an opportunity to take a good look at how best to support NZNO's work.

Tauranga-based organiser Sharon Andrews has resigned for family reasons. She began with NZNO in May last year. Alexander said she would be missed as a valuable member of the Tauranga and NZNO whānau. Recruitment for her replacement is underway, as is recruitment for an Auckland-based organiser. •

Primary health care: Seeing red and taking action

Nurses and doctors at Kawau Bay Health's Warkworth Clinic see red last month. The Seeing Red Day on June 19 was part of primary health care nurses' campaign for pay parity. NZNO members in PHC MECA worksites wore something red to work and dressed up their workplaces in red.

IN AN unprecedented move, the more than 3000 members covered by the the primary health care multi-employer agreement (PHC MECA) are to hold two-hour stopwork meetings this month. The meetings will involve all workplaces covered by the MECA – more than 500 – and will be held on the same day and at the same time across the country. They are part of an escalating campaign to get more money out of the Government for pay parity. (See news p7.)

Mediation late last month, after members had roundly rejected an employer offer, failed to achieve a resolution.

NZNO PHC industrial adviser Chris Wilson, who is the NZNO advocate for the negotiations, said the two-hour meetings were the first such action taken by members covered by the MECA and "this does make a very clear statement".

The objective was for as many NZNO members as possible to leave every workplace for two hours to attend a meeting, she said. These would be offsite meetings in as many centres as possible and Zoom meetings would also be available.

Wilson said NZNO would be pointing out the uniqueness of these meetings in letters to Prime Minister Jacinda Ardern, other relevant ministers, chief nursing officer Margareth Broodkoorn and director-general of health Ashley Bloomfield.

Members are supported in their pay parity fight by their employers. In a rare move, chair of the New Zealand Medical Association (NZMA) and the General Practice Leaders Forum, Kate Baddock, has sent a "red letter" to members urging them to support the nurses' pay parity campaign. In the letter, Baddock said unless the pay gap – an average of 10.6 per cent – was closed, "this gap will only get larger. Unaddressed, this will impact on recruitment and retention, the wellbeing of our general practice teams and the wellbeing and outcomes for patients".

An estimated $15 million was required to achieve pay parity and this could "not be accommodated within current funding", the letter said.

"When DHBs were unable to meet their MECA obligations to nurses, there was a single funding injection to meet that shortfall from the Minister [of Health]. General practice is now in the same position – we need the Minister to meet the MECA shortfall of $15 million in order for general practice to remain sustainable," Baddock said in the letter.

NZMA represents around 500 employers who are parties to the MECA and Baddock urged them to sign the petition, which calls for the money needed for pay parity. At press time, the petition was heading towards 10,000 signatures. •

NZNO proposes 'no-holds-barred' COVID review

If NZNO is not invited to be part of any Ministry of Health-led review of the response to COVID-19, NZNO will approach other health unions to seek their support on establishing a "no-holds-barred" review of planning and response to the pandemic.

Board member Simon Auty said it was "inevitable" another pandemic would strike – "the only unknowns are when and what".

It was clear, from a recent McGuiness-NZNO survey, infections of staff in Christchurch and Waitakere, as well as stand downs in Queenstown and Greymouth hospitals, that – despite early warnings from China's Hubei province and the Italian and Spanish experiences – New Zealand had been "unprepared" for such an event.

"New Zealand escaped the worse ravages (up to now) of a thoroughly preventable disaster more by good luck and timing and cannot count on that happening again," Auty said in a paper, included with chief executive Memo Musa's report on NZNO's response to COVID-19.

It was important the combined health unions contributed a "robust and 'no-holds-barred' review" to inform members and the public how such an emergency could be better planned for and managed.

It was vital health unions contributed to any review, as representatives of the workforces most exposed to a pandemic, Auty said. The board agreed to support the proposal and begin approaching health unions.

Kaiwhakahaere Kerri Nuku said any review must include an equity lens.

Musa also said NZNO's response to COVID-19 continued to be a challenge, due to changing alert levels. However, calls to the member support centre about COVID-19 had dropped "substantially" from late April to early May.

Inconsistent access and advice around personal protective equipment (PPE) continued to be the biggest issue for members, followed by laundering uniforms, sick and other leave, vulnerable worker assessments, travel, accommodation, childcare, work flexibility, job security particularly around speaking up about health and safety, income retention and extra payments.

NZNO was also investigating why workplace incidents resulting in nurses and other health-care workers contracting a serious infection like COVID-19 was not considered a health and safety matter and excluded from WorkSafe investigations. Seven nurses contracted COVID-19 at Waitemata District Health Board but WorkSafe declined to investigate.

Nuku said NZNO's unrelenting pressure through the media on COVID-19 issues such as PPE helped make a difference and "got us to where we are". •

Membership dips over year

NZNO MEMBERSHIP has declined by 0.9 per cent from 52,093 to 51,643 over the year to March 31, 2020.

The decline was led by students, who dropped by 299; then midwives, who dropped by 67, according to chief executive Memo Musa's report to the board in June.

Registered nurses (RNs) had decreased by 0.1 percent, or 49, over the year, from 40,054 to 40,005. Most left for unknown reasons (27 per cent), retiring or leaving the profession (24.8 percent), dissatisfaction with NZNO (15 per cent), to travel overseas (14.2 per cent), hardship or ill health (9.8 per cent) or maternity leave (nine per cent).

Decline means less income

The decline had meant $515,000 less income over the full year than the budgeted levels based on a membership of 52,288.

Spending on temporary staff, travel and accommodation were also higher than budgeted for, bringing NZNO's budget deficit to $1 million.

Recent feedback suggested higher levels of dissatisfaction with NZNO, following the resignation of the president and three other board members in April, Musa noted.

In the two months to May 31, there was a net membership decrease of 693, including 680 new members and 1033 resignations. That was similar to the same time last year, he said. Indian and Filipino membership continues to be the fastest growing at 8.8 and 9.2 per cent respectively, making up the second and third largest ethnic groups behind New Zealand European. Māori membership grew slightly to 7.6 per cent, to make up the fourth largest ethnic group. •

The articles on these two pages have been written from decisions taken at the June 16, 2020, board of directors' meeting.

Board mulls mana restoration

KAIWHAKAHAERE KERRI Nuku has suggested NZNO's internal reconciliation process focuses more on "mana restoration" when the NZNO board is finalised later this year.

Former Council of Trade Unions (CTU) president Ross Wilson last September recommended a reconciliation process for NZNO staff "with the objective or restoring respect, communication and cooperation" after the tensions of 2017/18's district health board multi-employer collective agreement (MECA) campaign.

Nuku told the board meeting in June she would prefer a "mana-restoration" process, to reconciliation, after NZNO elections for a new president and three new board members were completed.

Mana restoration could follow governance training, then be followed by team-building, she suggested.

No decision was made. •

NZNO plugs costs gap

NZNO HAS agreed to cover costs of up to $175,000 an individual member could be liable for, if found guilty of criminal misconduct, after its lawyers found a gap in its indemnity insurance.

NZNO medico-legal lawyer Sophie Meares told the board in June a nurse accused of criminal misconduct risked being liable for costs of up to $175,000, if they lost the case. So, if one was accused of sexual assault while inserting a catheter, for example, they might choose to plead guilty even if they had not committed sexual assault "instead of risking losing their house".

Chief executive Memo Musa said in his report that another example was medication errors resulting in death.

The current policy covered legal defence costs of up to $200,000 for criminal investigation and prosecution, unless the member was found guilty, his report said. NZNO paid the $25,000 excess. The medico-legal team recommended that NZNO acted as the default insurer in the event a member must repay criminal defence costs. Musa said a key reason members joined NZNO was to obtain indemnity cover – an exclusion obligating repayment for members if found guilty may lead them to question their membership.

There have been no such cases to date where a member has had to repay their legal costs but, since 2017, there had been 11 involving criminal investigations and prosecutions, including five current cases.

"Nurses are particularly vulnerable to sexual and physical assault allegations, which often occur in the context of . . . nursing care (eg washing patient genitals or inserting a suppository or catheter)," Musa said in his report. "Often it is accepted that the conduct occurred, but it is argued whether the conduct constitutes a criminal offence (eg a nurse restrains a patient who is about to harm themselves or others, and the patient alleges that they have been assaulted)." Often complainants were mentally unwell, suffered from dementia or were experiencing side effects from prescribed medicine, he said.

The board agreed NZNO would meet any such costs. •

ACC 'inconsistent'

THE ACCIDENT Compensation Corporation (ACC) is looking into NZNO claims that ACC has an inconsistent approach to nurses with workplace injuries affecting their return to work.

At the June board meeting, NZNO chief executive Memo Musa said there appeared to be an inconsistent approach by ACC to such cases, whether they involved returning to work or entitlements. ACC clinical manager Adele Knowles, who attended the meeting via Zoom, said she would look into it, and it should not matter who or where the provider was, as ACC's requirements were the same.

Knowles also acknowledged cultural considerations should form part of ACC's support, in response to a query from kaiwhakahaere Kerri Nuku. Currently, ACC could only act on information from the provider, which made it difficult to know whether cultural support was needed, Knowles said. •

Legal spending 'miscommunicated'

THE NZNO board wants to "change the narrative" around legal spending and dysfunctionality, kaiwhakahaere Kerri Nuku said at the meeting.

She was discussing two complaints from members, suggesting "high levels of dysfunctionality" following the resignations of five elected board members, including the president.

Nuku said there was a "huge misunderstanding" about the board's spending decisions, following a special general meeting (SGM) last December where a petition to support Brookes was voted down by member groups.

Nuku said the board never took legal action, but was seeking advice due to a "lack of clarity" about the SGM results. This had been "miscommunicated", she said.

Board member Andrew Cunningham agreed, saying the board had needed to respond to repeated Employment Relations Authority action by Brookes.

Nuku suggested the board talk face-to-face with members around the country. •

Te Poari reviews plan's equity focus

TE POARI o Te Rūnanga o Aotearoa NZNO is reviewing NZNO's 2021-25 strategic plan before it is finalised, after kaiwhakahaere Kerri Nuku expressed concern its equity focus was "gone".

Nuku told the board biculturalism is gone from the intent of the strategy". It was also DHB-centric and focused too much on numbers, instead of outcomes, she said. "So I'm not sure if we are where we need to be."

Musa said the board had signed it off for consultation. Te Poari members, including Nuku, had provided feedback, some of which was included by the board working group in the draft document before it was signed off in February for consultation.

Management consultant Margaret Hanson said it was "more qualitative than quantative" to "pin down" outcomes.

Board member Margaret Hand, together with former board members Sela Ikavuka and Katrina Hopkinson, had worked with Hanson to redraft the plan before it went out for consultation in February.

Much of the feedback was too detailed for a strategic plan, but might be useful in developing business plans to support it, Musa said. There had been 16 responses from member groups and staff, after consultation was extended because of the lockdown for a month to May 18, Musa told *Kai Tiaki Nursing New Zealand*. The board was working to finalise the draft by July 17, for the annual general meeting (AGM).

The board was also finalising the terms of reference for the constitutional review in time for the AGM. •

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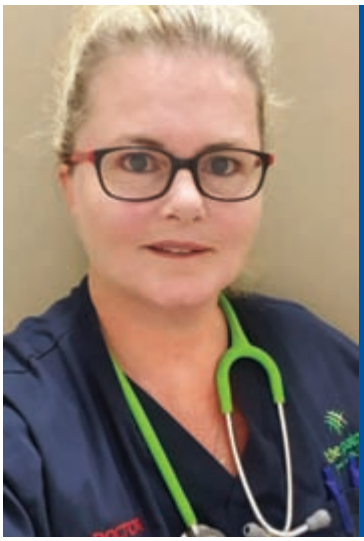

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2020 is an especially significant year for nursing globally and in New Zealand. The World Health Organization has designated the year 2020 as "The Year of the Nurse and Midwife" and the International Council of Nurses has set the International Nurses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

- **Professor Michael Baker**, Professor of Public Health, University of Otago, Wellington
- **Howard Catton**, Chief Executive, International Council of Nurses (ICN)
- **Fay Selby-Law**, Hapai Te Hauora
- **Professor Jean Ross**, Otago Polytechnic

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 will open early July www.nzno.org.nz

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

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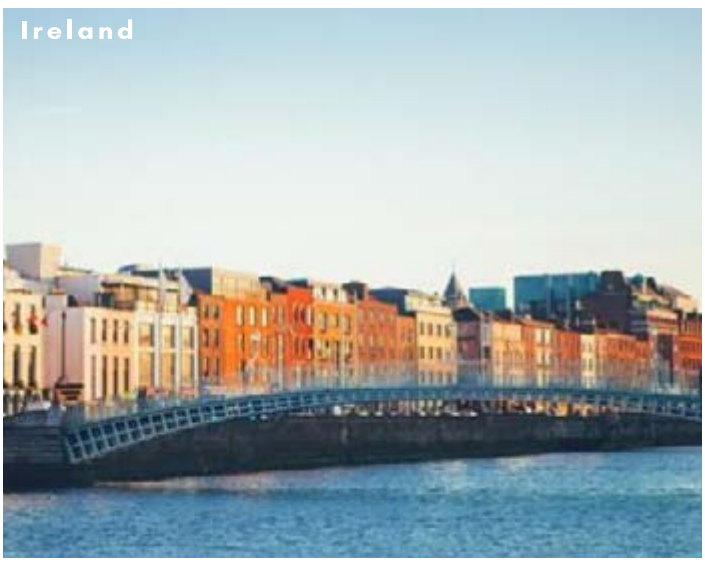

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