Kai Tiaki NURSING NEW ZEALAND

May 2020 vol 26 no 4

Holding the line on COVID-19

• Resignations spark petition for new board •

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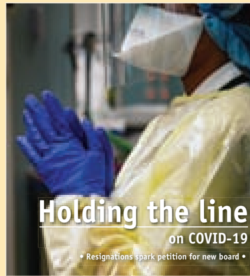

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THIS ISSUE has also been produced during the COVID-19 pandemic. Nurses remain at the frontline of the battle to eliminate the spread of the virus. This issue includes interviews with nurses from a range of specialties about the impact of COVID-19 on their practice. There's also a profile of industrial services manager Cee Payne, who left NZNO last month, and a defence of Florence Nightingale's reputation. The professional education feature focuses on chronic pain.

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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.

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Teresa O'Connor, Anne Manchester and Mary Longmore.

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

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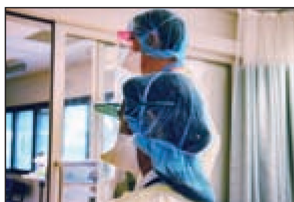

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Need information, advice, support?
Call NZNO's Membership Support Centre: **0800-28-38-48**

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Where to from here for NZNO?

By co-editors Teresa O'Connor, Anne Manchester and Mary Longmore

In the October 2019 issue of *Kai Tiaki Nursing New Zealand*, we wrote an editorial calling for unity, after the bruising events of the previous few months culminated in a board attempt to remove president Grant Brookes. In the editorial we said: *"Never before have we witnessed the division now so sadly evident."*

Well, we have now witnessed even greater division. This is a very sad time for NZNO – for its members, its remaining board members and those who have resigned, and the staff. All are coping, to greater or lesser degrees, with two crises – the externally-generated COVID-19 pandemic and the internally-generated one. The latter detracts from nurses' critical and courageous work in the former.

In the midst of this worldwide pandemic, nurses have been an integral part of the global response; the work of frontline nurses has been exposed and appreciated as never before. And, as nurses relate in this issue, they are proud to be part of that global response. That timing makes the implosion of NZNO's board even more regrettable.

That implosion began with the resignation of vice-president Cheryl Hanham in early March for "personal reasons". Twice-elected president Grant Brookes resigned last month for reasons that have been well documented in his public blog and in this issue (p8). His resignation was followed closely by three board members elected last year. They stated the board was not a safe place to be.

This sequence of events has triggered a range of responses – anger, bewilderment, disbelief, frustration, deep concern, embarrassment and apathy. Facebook – at times like this a rancorous echo chamber – has been where many have vented their spleen. Personal insults, wild accusations and misinformation have swirled around in a deeply unedifying (not to mention unprofessional) way.

One of the key reasons advanced by Brookes for his resignation was the deteriorating bicultural partnership within NZNO. There is an inherent tension between a "democratic organisation" – a western world view – and an organisation which genuinely reflects te Tiriti o Waitangi – a te ao Māori worldview and one supported by many Pākehā. "Pure" democracy – one member one vote – will always mean the views of tāngata whenua are outvoted, and that is iniquitous. Finding a structure that genuinely reflects both world views is the first challenge. Finding a way that ensures both partners are able to resolve the difficulties that inevitably arise is a greater challenge. What seems to be apparent is an inability to address the current challenges partly because of the strictures imposed by the constitution. That constitution, adopted in 2012, fundamentally changed the structures and processes of NZNO and was supported by 6.2 per cent of members.

Every protagonist – and every bystander – in this situation will have their own truth. Whether you believe this to be a battle between two opposing ideologies, a contest between starkly differing philosophies, a power play between two forceful personalities, a fight for the soul of a professional association and trade union – all these are immaterial in the face of what is at stake here: the future of NZNO.

Brookes said he could no longer see a way to forge a path forward. Kaiwhakahaere Kerri Nuku sees his resignation as a personal attack. All organisations operating in the wider political arena are prey to these age-old ingredients – anger, personal agendas, long-held resentments, power plays, broken trust, confidentiality agreements, cultural (in the widest possible sense) clashes. Whichever of these might be fuelling the wider ongoing dysfunction in NZNO must be put aside, if the organisation is to move forward. Collaborative leadership based on an agreed common goal would be a powerful first step. A re-look at the constitution could also be helpful.

One of the silver linings of the COVID-19 pandemic is that it has provided a chance to reflect on what is truly important in our personal lives and in wider professional and political contexts. How can the respect the profession has earned during this crisis be maintained and properly valued?

Despite the current rancour, NZNO is bigger than this. It can and must survive and continue to be the voice of all nurses in Aotearoa.

Would that this time of reflection be used to ensure NZNO can take the painful lessons of the last two years and again be an organisation that is respected professionally, truly representative, open to change and renewal, and that is robust enough to deal with deep divisions with respect. That outcome is in the members' hands, should they choose to become more fully involved in the workings of NZNO.

At this time of reflection, our overwhelming sense is one of deep sadness. Sadness that the governance structure of an organisation with a legacy of 111 years, a membership of more than 51,000, a staff of close to 150 and a unique and empowering blend of professional and industrial aspirations, should be in this situation. NZNO is bigger and more enduring than one president, one kaiwhakahaere, one chief executive, one seriously depleted board of directors and one crisis. Despite the current rancour, NZNO is bigger than this. It can and must survive and continue to be the voice of all nurses in Aotearoa. •

Tell us what you think

Appalled at the state of 'chaos' within NZNO

I AM writing to request a vote of no confidence in the current board and associated upper management. This request is not done lightly and is a result of my view on how those in these positions are not making decisions for the benefit of union members. The chaos will result in a continuing lack of support for members and poor decision-making for all within the union.

As a member of NZNO for more than 30 years, I am appalled that the union has come to this state of chaos. I would like some clarification around how the elected president, vice president and three board members have felt their only option was to resign. This is a clear indication that within NZNO management there are discrepancies about how and who NZNO is working for. I have known Anne Daniels [a board member who has resigned] for many years. She has always been transparent and desired unity, action and only the best for nursing. For her to resign indicates she felt how the board was functioning, and how it expected her to function, was a severe compromise of her ethics and all she stands for.

There are also questions that require more open answers:

What is meant by the president's statement regarding further legal advice being taken? Is this a continuation of the previous conflict? Is it a new allegation? Have members been advised of this?

Given that board meetings discuss current concerns relating to the management of the union, ways forward in the upcoming negotiations for the district health board multi-employer collective agreement, furthering the professionalism of nursing, challenges within nursing etc – all of which impact on members – one has to ask why a confidentiality agreement is necessary? This indicates there were issues being discussed that the board felt required no membership input. This should not be the case. As members, we deserve to know what is happening in our union.

> **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.

How is this internal chaos benefiting the professionalism and standing of nursing?

I would like to suggest that when the country is pulling together and working hard to preserve the health and wellbeing of its citizens, NZNO should also look to do the same for its members. Prime Minister Jacinda Adern is putting aside her possible political and personal agendas and working hard to provide a united front and firm leadership to get through the current COVID-19 crisis. I am sure NZNO can do the same to protect and advocate for its members.

I will be posting these questions on the New Zealand Please Hear our Voices Facebook page, and will be updating that page with your response. [Abridged]

Deidre Lovell, RN, BHlthSci, PGDip
Auckland

Resignation causes 'sadness'

IT WAS with great sadness I read the post from Grant Brookes stating he had resigned. He has had an expensive and enduring campaign of bullying against him for far too long. He deserved better. We, the members, have had to swallow the fact that our own money was been used to get rid of a president we wanted and respected. He was one of the few who initially would only accept a salary that was similar to what we got on the coal face. It was galling to see how much energy and money was used to remove him, instead of focusing on looking after NZNO members and treating them as well as staff treated themselves. Why has NZNO continued to hide its staff's collective employment agreement, when ours is open to the public? Where is the so-called transparency?

Why do most members feel they are fighting on two fronts at DHB MECA negotiations? NZNO needs to return to us, the workers, and be honest and transparent as it claims to be. Words of unity and strength are merely words, if they are not followed by action. How are we supposed to feel safe, if our own union is eating its young?

It's time we removed the dead wood; those who are only following their own agenda. It is unnecessary and expensive to keep them on the payroll *members* pay for. We need a leader elected by the members, who is for *all* of us. At the moment, I just feel like an ATM.

Alana Whiting, RN
New Plymouth

Call for a no-confidence vote

I am a member of NZNO. Following the recent resignations from the NZNO board of the president, vice president and three board members, I started to question the leadership/rangatiratanga, unity/kotahitanga, growth/whakatupu and equity/mana taurite in the governance of the current board.

I reviewed statements made by the resigning board members and then the statement of the remaining board members. I do not have confidence the current board is aligned with the values as stated above.

The purpose of a union is to have power in numbers. If this current dysfunction at board level continues, there is real potential for a mass exodus of members. To have power, we must have solidarity – not just for one, but all joined as one. My impression is that unity and professional cohesion are heavily compromised within this board. NZNO is the members.

I send a message calling for a vote of no confidence in all the current board and leadership group.

(We have received 10 letters the same or very similar to the one above.)
Co-editors' note: Many of the questions raised in the letters on this page will be answered in news and events coverage.

'Be calm and be kind'

IN THE current circumstances, with five of NZNO's board of directors (BoD) having resigned, it's possible employers will use this situation to their advantage. They may believe we, as NZNO, are not united. This may be true for membership, but our staff are united. They are in an unenviable position, as they are not members of the BoD, yet must continue doing their work.

It's possible for the BoD to continue with the remaining six members. This situation is not ideal and has already dimmed the leadership of NZNO – the members who remain on the BoD.

There is already speculation and abuse on social media. Let's stop the abuse and collectively pause. Let's elect new BoD members to help us all operate this great nursing union. Let's behave as union members – one for all and all together – for the good of health care.

I'm sure the six remaining BoD members will advise us in due course about current issues. In the meantime, we need to back our remaining BoD and just be calm and be kind!

Heather Symes, RN, NZNO delegate
Christchurch

Pandemic tests nurses' resolve

NURSES ARE people too. Merely a month ago, we were stressed and anxious, preparing for the impending onslaught of COVID-19. A nurse on my team broke down in tears with fear at the prospect of working on the frontline, of contracting the disease and of how her 60-year-old body would cope.

It is impossible for a nurse who interacts with those most vulnerable to maintain a safe distance of two metres. The only barrier between a nurse and COVID-19 is personal protective equipment, when and if available.

There is no hazard pay for being a nurse during a pandemic. Nurses do not have the option of staying home – our work is vital. Rather, we come face to face with those infected by the disease, and continue our normal duties too – caring for the sick and dying and now, daily, also exposing ourselves to a life-threatening disease. It is an extremely trying time to be a nurse. This pandemic is testing our resolve, and our reasons for becoming a health-care worker. It feels like going into battle every day – risking your own life to save others. The psychological toll of the stress and anxiety alone are sure to have an impact on those who braved the frontlines of COVID-19 every day.

There has been acknowledgement, but none financially – no compensation. We do not qualify for hazard pay. We have not been on the receiving end of any quantitative easing.

Nurses all over the world have had to dig deep, confront their fears, and carry on working on the frontline with dedication and compassion. I hope when the battle is over, nurses internationally are finally recognised and compensated for their skills, bravery and unwavering dedication to people in their communities.

Nursing has historically been a female-dominated profession and this has always been reflected in their pay. Nurses are due pay equity. New Zealand has the opportunity to lead the charge and set a precedent. This needs to be addressed internationally when the world starts to recover. Nurses need acknowledgement for the work they do every day.

Nicole Minskip, RN,
Wellington

Notice to members:

THE MINISTRY of Health has contracted the National Telehealth Service to provide a dedicated COVID-19 telephone advice line for clinicians working for primary and community care organisations. The number is **0800 177 622,** and is now operational, offering clinical support and advice Monday to Saturday 8am-7pm (except on public holidays).

Community health providers including primary care, pharmacies, midwives and aged residential care providers can access general advice about management of COVID-19, peer review of presenting problems and advice on specialist referral or connection to other services. The helpline will be staffed by primary care nurses, with at least one GP on every shift.

(Information from Clare Perry, acting deputy director-general health, system improvement and innovation)

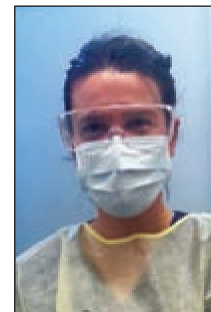
Dear Prime Mi

An NZNO organiser writes to Prime Minister Jacinda Ardern.

Kia ora Prime Minister,
I'm one of 900 registered nurses who re-entered the profession to assist in the national effort against COVID-19. I felt compelled to write to you to paint a picture from a frontline perspective and to demonstrate the incredible efforts of health workers in our country.

My day job is as an organiser with NZNO. When COVID-19 became a reality here, I, like many others, answered the call from the Ministry of Health (MoH) and registered my availability to assist in any way towards the national effort.

In mid-April, I received a call from Canterbury District Health Board (CDHB) advising I was needed at Rosewood Rest Home, which at the time was the epicentre of the country's most significant aged residential care COVID-19 outbreak. As Rosewood's permanent employees were placed in isolation post-exposure, CDHB was charged with the coordination and staffing of the facility.


Danielle Davies

Before commencing work, I experienced typical first-day jitters. Would I be able to find my way around the place? Would I remember the residents' names? What I hadn't considered or ever experienced, was working at a site that had none of its regular workforce.

I can only characterise this recent experience as nothing short of remarkable. All the workers were essentially strangers, thrust together for the sake of keeping Rosewood afloat. Despite the diversity of our backgrounds, we all shared the same aims:

inister . . .

to care for the remaining residents; and to provide them with routine, compassion and service.

This experience taught me two main lessons about health workers and our health system. Our current industrial structure links employees' terms and conditions with their particular employers. Not only is this structure arbitrary, but it results in vast inequities between health workers across employer groups. From wages to professional development, to health and safety, there should be no difference in the value of a health worker from one employer to the next. Those I worked with at Rosewood came from many health sectors – operating theatres, mental health support workers, newly-retired nurses, students. The work ethic and comradery was second to none – what bonded us was our mission to care for the Rosewood residents and the ease at which working together fell into place was extraordinary.

The second lesson came from comments you made during the daily briefing with Director-General of Health Ashley Bloomfield on April 28, in which you surmised that COVID-19 had demonstrated that our health system needed to be more connected.

The positive and pragmatic way CDHB coordinated Rosewood cannot be understated. The high level of communication, provision of PPE, occupational health considerations and general professionalism is to be commended. This showed me that health services perform best when there is close coordination, similar expectations and oversight of care from the MoH.

Finally, thank you for your presence throughout COVID-19. My health-care comrades have the greatest respect for your leadership over this time and feel proud of the way our country has fought its campaign against COVID-19. [Abridged]

Danielle Davies, RN, BN, MN
Christchurch

The kaiwhakahaere comments:

By Kerri Nuku

OUR "NORMAL" every day life has been changed forever, by "bullets" naked to the human eye but with the power to incite fear across the world. These invisible bullets have brought down economies, caused death and dying across borders worldwide. This destruction has happened while we watch from our isolated pūangiangi (bubbles).

The uncertainty and fear of the unknown has seen a range of different human reactions: from greed, anger and fear, to anxiety and depression. There are those in survivalist mode; those standing in long lines at the supermarket loading up food trolleys; those fighting to protect their own interests and needs; those preparing for the unknown and wondering what lockdown means or how long food supplies might last. It is difficult to prepare for uncertainty and to protect against something we cannot see. On the flipside, some of us were not in a position to plan ahead, we didn't have that disposable income to buy additional food, let alone have a secure place to call home. We could only watch with fear and uncertainty.

The World Health Organization set COVID-19 guidelines as measures to arm us globally against the invisible. These included social distancing, staying home and staying within our defined pūangiangi. Staying away from our loved ones has been incredibly hard; reaching out to them over video calls has replaced the warm hug and affectionate embrace, where once words were not needed.

These restrictions have meant adjusting to working under a state of emergency, where consideration of human or cultural rights are not front of mind. As one of the last bastions of Māori culture, tangihanga has survived wars, colonisation, assimilation and diseases, until this invisible bullet. Coping with COVID-19 death and dying has restricted cultural practices. These included caring for the tūpāpaku (loved one who has died), and poroporoaki (farewell speech to the dead), meaning tangihanga have been distressing for whānau. These restrictions have seen limitations on celebrating cultural burial practices, including the number of attendees (10), funeral homes being the only venues for ceremonies and the inability to have traditional hākari (celebratory feast) after burial. As health professionals and whānau members, this is something we probably never contemplated would have such distressing implications, as we were forced to remain in our pūangiangi.

Kerri Nuku

Nelson Mandela said: *"What counts in life is not the mere fact that we have lived, it is the difference we have made to the lives of others."* In these times of crisis, we have seen people rising up and unselfishly going to work as essential workers, isolating and voluntarily distancing themselves from whānau to enable them to continue working while ensuring they kept their whānau safe. Over these weeks of unpredictability and fear, I have taken heed of and solace in the work of Te Puea Herangi during the 1918 influenza outbreak, as she nursed flu cases and cared for orphans, while her husband helped bury the dead.

Kia kaha to all those brave nurses caring for our whānau, hapū, iwi and communities. •

Petition to be presented this month

A PETITION calling for a special general meeting (SGM) to enable fresh elections for NZNO's 11-strong board was to be presented to chief executive Memo Musa in mid-May. It had attracted close to 1600 signatures at press time, well over the one percent of members threshold needed to trigger an SGM. An SGM would be held within 30 days of the petition being lodged, Musa said.

The resignation of NZNO president Grant Brookes last month (see p8) and the subsequent resignations of three newly-elected board members, Katrina Hopkinson, Anne Daniels and Sela Ikavuka, was the catalyst for the petition, launched early this month.

It has been supported by three former NZNO presidents concerned at the "deep divisions" within NZNO. Diane Stutchbury (formerly Penney), Marion Guy and Nano Tunnicliff have joined forces to call for fresh elections to end the internal divisions (see also p9).

Tunnicliff, president from 2009-2012, said 1600 signatures was encouraging in the context of nurses' traditional lack of participation in presidential and board elections. "Of course we'd love 25,000 signatures but we have to be realistic. Nurses traditionally don't put their heads above the parapet."

The petition was launched by NZNO Democracy Now. Tunnicliff said this was a group of members from around the country and from all health sectors, who wanted to rectify the problems, rather than make divisions deeper.

But kaiwhakahaere Kerri Nuku is "disgusted" the petition is happening during the pandemic. "I can't stop any members from calling an SGM, but why they are doing so in the public domain is beyond me. I'm really disgusted this is happening at this time, in this way."

Meanwhile, the six remaining board members – Nuku, Titihuia Pakeho, Anamaria Watene, Margaret Hand, Andrew Cunningham and Simon Auty – have announced plans to hold by-elections to replace the president, vice-president and the three board members. "NZNO has democratic processes in place for this to happen where everyone will have a voice," Nuku said.

The petitioners want an all-member ballot on their motion for fresh elections. "The feeling we are getting from members is that they want one member one vote on the issue; they don't want it voted on by member representative groups," Tunnicliff said.

By-election plan

At press time, Musa said he was proceeding with by-election plans as approved by the board. He would be seeking guidance on the petitioners' request for one vote per member, as SGM voting appeared to be restricted to member groups (regional councils, colleges and sections) according to the constitution.

However, member groups were obliged to consult their members before voting, he said. Musa said his role as CE was to ensure the board was informed to make its decisions and it was his job to implement those decisions.

"The board has decided to proceed with a by-election and we will follow due process." Until he was presented with a petition, he would continue to plan for an election, with nominations from June to July. He hoped "members will join the board and work on its governance role, relationships and strategy, and directors will tread a path of collective ownership of their decisions.

"All I know, is I have a mandate to proceed with by-elections."

Musa planned to continue as CE, despite the resignations. "I am employed by the board, to enable it to make strategic and financial decisions which inform operational work. Governance relationships are a matter for the president and kaiwhakahaere. I do not have any governance role other than making sure the board has all the information it needs to make decisions."

The current resignations were "destabilising" for NZNO, and the timing was "not great". However, this would not impact on its operational work.

While other organisations were likely to be concerned, "most were focused on the work we do collectively, not the problems. I'm still going to the CTU, nurse leadership and other forums, and contributing on behalf of NZNO and working to advocate for, lobby on behalf of, and represent members. We don't talk about the board problems, we just carry on with the work that needs to be done". •

Increase in resignations and calls of concern

There was a noticeable increase in the number of members leaving NZNO in the week following the resignation of president Grant Brookes, according to manager of corporate services, David Woltman. From April 27 to May 6, 330 people had resigned. The percentage citing dissatisfaction with the organisation – 23 per cent – had also increased.

Eleven per cent said they were leaving NZNO to join another union. More than half the resignations – 54 per cent – were from the district health board [DHB] sector, with 23 per cent from primary health care and eight per cent from aged care.

While the daily total of resignations was higher than at the same time last year, Woltman said a better picture of the rate of resignations would be gained by the end of May.

Member Support Centre (MSC) lead adviser Jo Stokker said call advisers had noted an increase in email traffic and calls from members expressing a range of concerns about the recent resignations of the president and three other board members. From May 1-6, MSC staff had received 34 such communications. •

Resignation a 'personal attack'

GRANT BROOKES' resignation as NZNO president has left kaiwhakahaere Kerri Nuku "disgusted that a personal agenda would take precedence at this time".

His resignation was the result of a "personal agenda to take the organisation down and bring members into this ugly situation".

NZNO's bicultural relationship had also suffered collateral damage, she said.

Nuku disputes whether the resignations of Brookes, vice-president Cheryl Hanham in March for "personal reasons" and three other board members last month, signals disunity.

"I'm not sure if I consider that disunity at all. The board left behind is absolutely unified. Most are being subject to bullying on Facebook – which tells only one side of the story – but they are standing there as elected board members and the board is very much united."

Nuku said Brookes' resignation – publicly announced in a blog on April 22 – had left her "surprised, bewildered and shocked", despite last year's attempt by the board to remove him, prompted by an early-morning text to then industrial services manager Cee Payne. An investigation by employer lawyer Steph Dyhrberg found serious misconduct. The board's attempt to remove him narrowly failed at a special general meeting (SGM) in September.

A second SGM in December, mounted by members earlier in the year and calling for a vote of confidence in Brookes, failed. Two thirds of member representatives voted not to support him.

'Due diligence' by board

That result prompted Nuku to put the issue on the agenda for the April board meeting. She said the timing in the midst of the COVID-19 pandemic was "unfortunate – it should have happened in February – but it was a piece of work that had to be concluded. We had to tidy up loose ends from the second SGM. It was due diligence on the board's part".

The decision of the board to seek legal advice on the implications of the December SGM was one of the catalysts for Brookes' resignation. "I have to make this really clear – the board has never gone out to take legal action against Grant. We had no intention of doing that and I signalled that to Grant," Nuku said.

In the days leading up to his resignation, Brookes had not indicated any concerns, she said. It was "really unfortunate" he had chosen to leave at such a critical time for members.

Kerri Nuku

The subsequent resignations of three other board members (Katrina Hopkinson, Anne Daniels and Sela Ikavaku) were also a surprise. "I'm surprised they have let down the members who elected them, who had voted them in on support for the [district health board] MECA."

In their resignation statement, the three said the board was not a "safe place to be". Nuku said she did not know what that claim was about. "I do know that governance is a big step up from being a delegate. When you are elected to the board, you are representing all members. They have shown a lack of governance understanding and responsibility to members," she said. "And unionists don't give up at the first fight."

Brookes' resignation was a personal attack. "Let's not hide that in the shadows. The union is still strong, is still carrying on and advocating more strongly than ever to address the issues that have arisen during the pandemic."

Nuku said looking back on the last year, she would not have done anything differently. "I provided leadership to the organisation in a positive way and would have changed nothing."

She rejected Brookes' assertions that NZNO's bicultural partnership had deteriorated, saying that was a "distorted view. NZNO has no problem with biculturalism – that' s my view, that of Te Rūnanga and of kaumātua Keelan Ransfield. Not to have engaged with Māori about his concerns says a lot about the integrity of people saying those things," Nuku said.

She "absolutely refuted" Brookes' claims, detailed in his resignation letter, that he had tried to raise his concerns at board level on a number of occasions. "It has never happened, not to myself, not to the board. He might have mentioned it once in a report, but he never discussed it with me."

Bicultural partnership 'evolving'

NZNO's bicultural partnership was always evolving, Nuku said. Māori membership and participation in NZNO had increased and "our world view is included in submissions and policy statements".

Claims the way in which Māori leaders were elected was undemocratic were "offensive". NZNO members, at the 2017 annual general meeting, had voted in favour of the changes to the terms of office for the kaiwhakahaere and tumu whakarae (from two consecutive terms of three years to no time restrictions). That demonstrated members "understood the different way leadership in the Māori world is developed and appointed".

Every year, these two officeholders had to gain the confidence of Māori members at the annual hui ā-tau. "If you haven't performed in that year or are not somebody members can look up to, then you are gone. It is a more open, more transparent and empowering process than that for the president. To suggest our process is flawed is ignorant," she said.

Looking ahead, Nuku said the "very united board" would continue to connect with members and its focus would be on COVID-19 issues, winter rosters and other issues affecting nurses. "We will continue to be open and transparent in our processes."

She is not concerned the infighting will trigger an exodus of members. "I am confident that with the balanced and accurate information we put out, they can make up their own minds and come to an informed decision." •

No way forward – Brookes

DEPARTED NZNO president Grant Brookes said he decided to quit when the board agreed to seek further legal advice about his presidency, after spending an estimated $250,000 on legal action related to Brookes in the past two years.

"I'd had enough," said Brookes, who was first elected in 2015, and was re-elected unopposed in 2018. "I could see there was no way forward and did not want to see any more members' money wasted, he said. "It was clear Kerri [Nuku, kaiwhakahaere] could get a majority all of the time."

Brookes had hoped a new board, with new members voted in after promising transparency, democracy and action last September, would make it easier for him to transform NZNO into a "genuinely" bicultural and member-driven organisation, he said. But the vote to seek further legal advice at an April 8 board meeting – an agenda item requested by Nuku – made it clear to him that would not be possible.

Brookes, having declared a conflict, abstained, as did Anne Daniels and Sela Ikavuka. Katrina Hopkinson voted against, while Simon Auty, Tithuia Pakeho, Margaret Hand, Anamaria Watene and Nuku voted in favour of seeking further legal advice. Andrew Cunningham was not present. Board minutes confirm these numbers.

Dissenting comments 'expunged'

However, dissenting comments – raising the possible impact on reconciliation and cost to members of further legal action – had been expunged from the final minutes approved by the six remaining board members, Brookes noted. This was "concerning", as without the "dissenting minority" views, the minutes were not true and accurate, said Brookes, who had not seen NZNO board minutes edited in that way previously.

Nuku said the final minutes and any amendments were approved by the board.

The vote on seeking more legal advice followed a special general meeting (SGM) in December, where 66 per cent of member group representatives voted against a motion of confidence in Brookes, rejecting a members' petition calling for support. That was an about-face from an earlier SGM in September 2019, where 50.5 per cent of member group representatives voted in support of Brookes.

Both SGMs followed a drawn-out dispute born during contentious nurse pay bargaining and strike action in 2018, and involving a late-night social media message from Brookes to the then industrial leader Cee Payne, who laid a complaint. A legal review commissioned by the board found serious misconduct by Brookes, who was simultaneously taking an Employment Relations Authority claim of unfair treatment. He dropped the case and pledged a fresh start after winning the members' support in September.

Grant Brookes

Brookes has blamed "shadowy forces" for long seeking his ousting, and said his resignation followed two years of "extreme ill-treatment and bullying", which had been "devastating" for him. Those behaviours included excessive scrutiny of his work and exclusion from "secret" board meetings held in 2018 and 2019.

In recent times, he had repeatedly witnessed "unethical" behaviour at governance level, but "excused them" as he wanted to preserve NZNO's bicultural relationship. However, he could no longer stand aside, he said.

A February board decision to send a Te Rūnanga member in Brookes' place to accompany Nuku to the International Council of Nurses conference in Geneva, instead of the vice-president Cheryl Hanham, was a last straw, as it was a clear "breach" of the board's own policies and NZNO's bicultural model, he said. Hanham resigned shortly afterwards. Nuku said Brookes had not proposed the vice-president go in his place at any point, and absented himself from the discussion.

Nuku was a "key figure" behind the board's attempts to remove him from office, and – after four and a half years of trying – it was no longer possible for him to work with her, Brookes said. "Strengthening a partnership is impossible unless there is active commitment from both partners," Brookes stated in his resignation letter.

The board's decision – at Nuku's behest – to "re-open the bitter divisions of 2018-19, while our members on the frontline and our communities in lockdown needed us most of all to be united against COVID-19, was a truly appalling thing to do". Nuku had previously told *Kai Tiaki Nursing New Zealand* that any further action would only come at the request of member groups.

Systemic change wanted

Brookes said he did not want to focus on the personal division between Nuku and himself, but systemic change. "It's about an individual, but it's not about an individual. It's about getting NZNO's system and its democratic processes working."

Brookes said his hopes for NZNO were that it could become a membership-driven and genuinely democratic organisation, rather than "top down". A "renegotiation" of how to create a genuinely bicultural relationship was needed. His "biggest mistake" was supporting the removal, in 2017, of time limits for the kaiwhakahaere and tumu whakarae terms of office. He now believed this was hampering development of new Māori leaders.

Brookes, a mental health nurse, has joined the Public Service Association, but said NZNO had some "amazing" staff and services. He would continue his NZNO professional membership and urged others to do the same. "Storming off never crossed my mind. What I want to see is a genuinely bicultural organisation."

He is returning to the frontline, with a new fulltime role this month but, in his blog, has pledged to "continue fighting . . . to take back our union for members".

Resigning the presidency, he said, was a "huge burden off my shoulders". •

Bicultural partnership part of NZNO's 'essence'

A PETITION seeking fresh board elections (see p6) has been labelled a "personal attack" by kaiwhakahaere Kerri Nuku. The petition has the backing of three former NZNO presidents, Diane Stutchbury (formerly Penney), Marion Guy and Nano Tunnicliff.

The petition called into question "the very fabric of democracy as it was calling out people who had been elected by the members. It's a personal attack on all existing board members", she said.

Those behind the petition were calling to account the bicultural partnership, she said, "when they themselves are not Māori. It's a concern for me that they are bashing that Māori card around.

"In any partnership, if you have a concern, you talk about it together. They [the former presidents] are making statements, based on Grant's perception that the partnership is not working," she said.

President from 2009-2012, Tunnicliff denied it was an attack on NZNO's bicultural partnership or on remaining board members. "The bicultural partnership has huge value and is part of the essence of NZNO. It is growing and developing and is important for equity within the health sector," she said.

'A lot at stake'

Those behind the petition were working for the good of the whole organisation – "there is a lot at stake here", she said.

Those who remained on the board "had worked hard and put themselves up for the voting process. And they can stand again in fresh elections", she said

Tunnicliff and Nuku were NZNO's co-leaders when the constitution, which fundamentally changed NZNO's structure and processes, was developed. It was endorsed in an all-member ballot in 2012. Just under 12 per cent of all members voted in the ballot and of those, 6.52 per cent voted for the constitution.

The current situation had shaken confidence in NZNO's democratic processes "as practice has strayed far from the constitution's original intention", Tunnicliff said. "That was to increase member participation, but it hasn't done that and the constitution hasn't been in the best interests of the organisation."

The current situation arose from two special general meetings (SGMs) last year about Grant Brookes' presidency (see p7).

Tunnicliff queried whether members had been consulted by their representatives before the second SGM. "Members were canvassed before the first SGM, but I didn't see any of that prior to the second SGM. As a member of a regional council, and a college and section member, I was not asked about how our representatives should vote," she said.

And the fact voting at both SGMs was secret had contributed to the current disunity and distrust, she said.

She questioned why reconciliation hadn't occurred after the first SGM and noted that it had also been recommended in Ross Wilson's report on the bargaining process for the last district health board/multi-employer collective agreement. A full review of the constitution would have to be a part of any reconciliation process, Tunnicliff said.

Stuchbury was president when the memorandum of understanding between NZNO and Te Rūnanga o Aotearoa NZNO was instituted 20 years ago, heralding the bicultural partnership. "I am distraught to see the deep divisions opening up along a number of fronts," she said.

The election of six new board members last year had not healed the divisions "as they remain mired in unresolved conflicts . . . We need a clean slate. That's why I'm supporting the call for fresh elections for all 11 positions", she said.

Guy, who served as president from 2005-2009 and again from 2012-2015, is concerned at the lack of governance experience at the board table.

Nuku, in a statement, said the petition was "extremely divisive" in attempting to undermine NZNO at a time when NZNO needed to be united and supporting members in the fight against COVID-19. •

Auty 'surprised' at resignations of board members

THE SOLE board member elected from activist collective, the members' action group (MAG), left on the NZNO board of directors, Simon Auty, says he was surprised by the resignations of his fellow MAG candidates.

"They [Katrina Hopkinson, Anne Daniels and Sela Ikavuka] didn't tell me anything about it, I had no idea," he said.

The four campaigned for the board last year as MAG members, promising more transparency, accountability and empowerment for members. The MAG was formed in 2018 in a response to members' frustration at how NZNO handled the district health board (DHB) pay negotiations.

Auty said it was "a shame" Grant Brookes and the three MAG members had left just as NZNO was starting to pull together in response to COVID-19.

"As for unity within the board and wider organisation, although some may say it didn't push hard enough, the organisation performed really well over the lockdown. In many ways, it was the starter version of what the organisation could be," he said.

"Members and organisers fed information and their concerns into the member helpline and other channels. The industrial and professional services teams worked together, along with leadership and board members, to formulate a response, or help with solutions."

Auty planned to continue in the role and said members could have their say in the review of the constitution, planned for later this year. "You can't effect change in the board if you're not there."

Auty voted for legal advice on the result of the second special general meeting (SGM) where member groups voted down a motion of confidence in Brookes, as "it was pretty clear . . . no-one understood what the result actually meant".

He believed it would have more likely removed any threat to Brookes, who could only be removed through a third SGM "constituted with that specific purpose". •

NZNO contributes to PPE review

NZNO HAS raised concerns about nurses' wellbeing and the lack of protection many have experienced over the past few weeks with the Office of the Auditor-General (OAG). The office is currently reviewing the management of personal protective equipment (PPE).

And NZNO's college of gerontology nursing (CGN) also wants better PPE access, regulation and resourcing for the aged-care sector. NZNO acting associate manager of professional services Kate Weston, kaiwhakahaere Kerri Nuku, industrial adviser David Wait and professional nursing adviser Marg Bigsby told the OAG health sector manager Greg Goulding in early May about the problems nurses and health workers had experienced accessing adequate PPE – particularly at iwi providers – and the importance of nurses "feeling safe", as well as being safe, Weston said.

The OAG is reviewing the Ministry of Health (MoH)'s management of PPE, including the supply and distribution, and is due to report its findings later this month.

"Six weeks into this and we're still talking about PPE," Weston said. But after "thousands" of complaints early on, they were now only "sporadic", she said. At some district health boards (DHBs), nurses and colleagues were unable to access it "as it's being kept in a locked cupboard somewhere".

With winter arriving, all respiratory complaints would have to be initially treated as potentially COVID-19, with appropriate protections worn, she said.

Patient influx expected

NZNO's critical care and emergency nurses were also preparing for an influx of patients who had become acutely ill at home during lockdown, as well as a possible spark of community transmission under looser lockdown.

Meanwhile, the college of critical care nurses (CCCN) and college of emergency nurses (CENNZ) are discussing with the Nursing Council and chief nurse Margareth Broodkoorn their call for nationally consistent guidelines on responding to COVID-19, including the use of PPE.

Current guidelines were "highly variable" around the country, CCCN chair Steve Kirby said. "We feel the need for a national baseline of guidelines."

NZNO's CGN is also calling for better regulation and resourcing of the aged-care sector, after COVID-19 exposed how "fragmented" it was. Chair Bridget Richards also called for improved access to PPE, infection prevention and control support and extra staff.

"Unlike DHBs, where there are standard policies and procedures and stocks and supplies of staff (nursing, catering, cleaning, laundry), equipment and funding, the aged-care sector is fragmented and without a central core. It becomes a free-for-all and those with sufficient funds and structures can access appropriate PPE and staff, and ensure they have training in infection control and donning/doffing PPE correctly," she said.

NZNO has also started researching nurses' access to PPE during COVID-19, and how secure and confident they felt, principal researcher Jinny Willis said. •

• See also news focus p12-13.

Auckland nurse hospitalised, others infected

NZNO wants an investigation into the use of personal protective equipment (PPE) at Waitakere Hospital in Auckland, after five nurses became infected with COVID-19. One nurse in her 20s is in a serious condition and has been hospitalised. She is believed to be the country's first health worker to be hospitalised from the virus, according to NZNO acting associate professional services manager Kate Weston.

The nurses fell ill after six COVID-19 patients were transferred from St Margaret's Hospital and Rest Home in Te Atatu, Auckland, to Waitakere Hospital last month. Three of those patients have since died and 57 staff were stood down. Several staff were still in isolation awaiting clearance, Weston said.

At Waitakere, staff had continued to work across wards, including those with COVID-19 patients, only starting a ward "bubble" in early May, after NZNO intervention.

Weston said the cases suggested a failure to protect frontline nurses, and NZNO would be "aggressively" asking questions of the Waitemata District Health Board (WDHB) and for its investigation findings.

Kate Weston

"PPE availability and appropriateness must be a factor thoroughly investigated, now there are five nurses infected with COVID-19 (that we are aware of) after working with a COVID-positive patients on the ward at Waitakere Hospital."

WDHB has stated that the recent cases had been identified and isolated early as close contacts, "and were previously undetected, either because they had very mild symptoms or their symptoms developed during the period of isolation".

There was no evidence of recent infections, although further spread could not be ruled out and "strong precautionary measures" were being taken, it said.

Earlier this month, the Ministry of Health said 169 health-care workers had been infected to date in New Zealand, including 52 nurses. •

Fallen nurses and health workers honoured

NZNO MARKED International Nurses Day (IND) by urging nurses to gather together in homes, at letterboxes or in their workplaces at 7pm on May 12 and light candles to acknowledge and celebrate all nurses, health-care assistants and midwives of Aotearoa. The silent vigil was a way to honour their colleagues' and their own selfless work and brave sacrifices, said associate industrial services manager Glenda Alexander.

NZNO also supported the Australian Nursing and Midwifery Federation's online candlelight vigil to remember the many hundreds of nurses and health workers around the world who have lost their lives treating COVID-19 patients. Around 100 photos of New Zealand nurses were included in the online tribute.

Earlier on May 12, the Office of the Chief Nurse hosted a Zoom meeting, attended by nurses and nursing groups from around the country. Speakers included chief nursing officer Margareth Broodkoorn, Minister of Health David Clark, last year's Florence Nightingale medal winner Felicity Gapes and general manager, nursing and clinical strategy, Oceania Healthcare, Frances Hughes.

The International Council of Nurses (ICN) marked the day by calling on governments around the world to do much more to ensure nurses' health and safety at work, and to improve their pay and conditions. "We must never be as globally under-prepared for a pandemic again," ICN president Annette Kennedy said.

Staff at Palmerston North's Metlifecare Care Home and Hospital submitted this photo to the Australian Nursing and Midwifery Federation's online candlelight vigil to honour nurses and health workers who have died after nursing patients with COVID-19.

By early May, there were 3.5 million confirmed cases of COVID-19 around the world, with at least six per cent of these cases being among health-care workers, ICN said. "This suggests there could be more than 200,000 health worker infections globally, and a death rate in the hundreds," chief executive Howard Catton said. Around 200 nurses have already died in the United Kingdom.

ICN has slammed governments for not systematically collecting data on health-care worker infections and deaths. The failure to collect this data, it said, was putting more nurses and their patients in danger, and was not honouring the sacrifices they were making. Having such data would also inform prevention strategies, such as addressing fundamental issues, including testing and the lack of personal protective equipment (PPE).

"If governments do not count the number of nurses who have lost their lives, if they continue to turn a blind eye, it sends a message that those nurses' lives didn't count," Catton said.

Kennedy said the best way to honour the loss of nurses was to ensure the legacy of 2020 was a stronger nursing workforce, through greater investment. •

New tauira award

Kuia Marie Noa (left) presents NorthTec student Kiriwai Flavell with Te Rūnanga's first outstanding Māori nursing student award earlier this year.

Te Rūnanga Te Tai Tokerau representative Moana Teiho said Flavell was a unanimous choice because of her leadership skills, her unconditional awhi (support) of other Māori students and active Te Rūnanga involvement. The taonga – karanga mai, a call for excellence and leadership – was carved by Te Rūnanga member Margaret Hand's husband, and gifted to Te Rūnanga Tauira.

Five themes for manifesto

NZNO IS calling on any future government to make primary health care "free for all" within a generation.

Its 2020 draft election manifesto, *Nursing Matters – even more in 2020*, highlights health issues for nurses and health professionals to consider in election year. Key questions for NZNO are what will support the health sector's recovery from the COVID-19 pandemic and how to reduce the harmful consequences of inequitable access to health care.

The manifesto addresses five themes: health workforce, health funding models, achieving health equity, health determinants and the health-related referendums.

NZNO wants enough resourcing for equitable access for Māori to all services, from primary to tertiary; an internationally bench-marked reduction in youth suicide target; safe staffing and skill mix in the aged residential care sector "which was under-prepared for the impact of the pandemic", and investment in upgrading equipment stocks, such as personal protective equipment and buildings.

It also calls for all health workforce-related pay equity claims to be settled, including for nurses working in iwi-based health services. Finally, low-cost housing must also be funded to ensure all families living in poverty can be homed by 2030.

Feedback on the manifesto from all member groups is invited by June 8. •

COVID-19 exposes weaknesses in aged care

NZNO and aged-care staff are hoping the current focus on shortcomings within the sector, highlighted by the pandemic, may lead to much-needed change.

By co-editor Mary Longmore

Aged residential care (ARC) in New Zealand has borne the sharpest edge of COVID-19, enduring more than half the country's 21 deaths so far. More than half – 12 to date - were from the Rosewood Rest Home dementia unit in Christchurch, another three from St Margaret's Rest Home in Te Atahu, Auckland. Three more rest homes are linked to significant clusters, meaning five of the country's 16 clusters are linked to ARC facilities.

While most of the elderly residents in 660 rest homes across Aotearoa have escaped the worst ravages of COVID-19 seen overseas, the outbreak has nonetheless exposed deep flaws in the sector, NZNO professional nursing adviser Marg Bigsby says. "It's exacerbated a lot of the things that were already wrong."

Those include inadequate staffing levels, relatively low pay compared to district health board (DHB) rates, high turnover and lack of registered nurses (RNs) on site, she said. Staffing standards were voluntary and out-of-date. Since their inception in 2005, residents' acuity and complexity had grown, as people were encouraged to stay home longer, requiring "more intense" care when admitted.

Smaller providers lacked resources to invest in RN staff, training and leadership, she said. "ARC has run on the smell of an oily rag in terms of staffing, for a long time. The smaller facilities don't have ways to offset the costs, whereas the larger chains have other property – retirement villages – to offset the losses."

Lockdown had placed further pressure on staff, without residents' families to provide relief. "It's really hard for nurses to compensate for that," she said.

Rosewood Rest Home staff show their support for International Workers' Memorial Day, April 28, and health workers around the world who have died during the pandemic.

The Canterbury community was hit hard by the Rosewood cluster. "The flow-on effects on the rest of the team caring for these patients were considerable. They had to be tested, then isolated, sometimes from their own families. The human cost was high," Bigsby said.

NZNO hoped that, with such a high number of COVID-19 cases and fatalities from within ARC, this would eventually lead to "a bit of focus on shortcomings and maybe the opportunity to advance some issues", she said. "But right now we're just surviving."

A broken system?

NZNO, which represents about 6600 aged-care workers, has partnered with E tū, which represents about 4000 workers, on the *In Safe Hands* campaign. This was launched last year to raise minimum staffing levels required by the Ministry of Health (MoH) standards, and make them compulsory. Its 2018 research, involving 1200 ARC workers, suggested a "broken system".

At present, staffing is guided by the voluntary 2005 *New Zealand Standard Indicators for Safe Aged Care and Dementia care for Consumers*. These include a suggested average of six minutes of care hourly for dementia patients – and even less for rest-home residents, according to a 2012 Human Rights Commission (HRC) report *Caring counts Tautiaki tika*.

Yet, over the past 15 years, people have been entering ARC much later in life, with more complex needs, *In Safe Hands* reported. The low staff ratios meant care was rationed, leading to lack of supervision, missed diagnoses and delayed medication. Staff couldn't do "little things" like make tea, help with lipsticks or even have a conversation.

With voluntary standards, employers tend to allocate staff according to revenue, which can be as low as one staff to 10 residents, according to *In Safe Hands* research.

New Zealand has acted swiftly, and "done an incredible job" checking the virus, says NZNO industrial adviser Lesley Harry, who has recently picked up the aged-care sector. "But that doesn't mean

there are no problems." The long-standing pressures had left the ARC sector "unprepared" to respond adequately to the virus with "nimble" infection control measures – and that had been disastrous for residents, their families and staff of affected rest homes, she said.

Significant changes were needed to the funding, regulatory and staffing model. "What COVID-19 has highlighted are the systemic flaws in the sector, which have led to a response that could certainly be improved upon."

The fact that Rosewood's recent MoH audit found no issues with infection prevention and control illustrated "the failure of the standards to ensure facilities are fit for purpose and to respond adequately to infection spread and control," an internal NZNO discussion document suggests.

ARC had been chronically understaffed for years, with little professional development available to expand workers' skills and capabilities, or sound infection protocols, to adapt to extreme situations like this. "I think many of the concerns are around preparation, education and resources available should they be needed – such as PPE [personal protection equipment]," Harry said.

St Margaret's staff told NZNO that there was a "complete lack" of PPE available to them – and DHB staff standing in – immediately after the cluster was confirmed.

ARC staffing guidelines, particularly for dementia units, were not "fit for purpose", requiring only "minimal oversight" by an RN, who didn't even have to be on the premises, Harry said. *Caring counts* recommended pay parity with DHBs, improving staff qualifications, compulsory staffing standards and a "five star" quality rating system – to be fully implemented by 2016. But little had changed, with "chronic" under-staffing and inadequate regulation and standards, Harry said.

The HRC concluded that demands on ARC staff were more complex, yet mandated staff ratios had dropped. It found safety concerns around infection control, access to sick and special leave, and inadequate equipment. The HRC said it believed a mandated "basic floor" of staff mix was needed to protect residents, their families and the workforce, but this would still allow the flexibility desired by many providers.

"The comment [from the report] that resonates with me is that the value of older people is reflected in the value of the people who care for them," Harry said. "If we compare ourselves with what has happened internationally, we've done an incredible job. But the ARC sector has its own unique issues that have been largely swept under the carpet. But now the spotlight has been on the sector for a few weeks, there will be a chance to make positive change from this."

NZNO wanted to see more investment, including funding according to acuity, rather than per bed; higher and mandated staffing levels and more RNs in the staff mix. "It's about number, skill mix, training and supporting the nursing team – and being adequately equipped, which at the moment means PPE," she said.

The Office of the Auditor-General (OAG) is currently reviewing the management of PPE, including its procurement, distribution and how stock levels are controlled, after complaints about lack of access for health staff.

Chief Ombudsman Peter Boshier is also inspecting ARC dementia units to independently assess how they are responding to COVID-19, to seek reassurance "that the facilities are doing all they can to stop the virus from spreading to those most at risk, and that steps are being taken to make sure the basic human rights of residents are protected".

'Aged residential care has run on the smell of an oily rag in terms of staffing, for a long time. The smaller facilities don't have ways to offset the costs . . .'

Director-General of Health Ashley Bloomfield has also ordered a review of the facilities with clusters.

E tū says a $26 million funding boost to help the aged-care sector deal with COVID-19 would merely be a "band aid" without ongoing safe staffing levels and adequate PPE. E tū wants a full inquiry to ensure mandatory safe staffing – possibly by expanding the Ombudsman's current investigation beyond dementia units, and involving unions and staff.

NZNO members in ARC right now were most worried about infection control measures, access to PPE and special paid leave, Harry said. ARC workers often worked across several locations, meaning when they were stood down it could have a wider impact on the sector, as evidenced in Canterbury. The NZNO discussion document suggests aged care is "continuously on a knife edge. The slightest bump in the road can cripple entire facilities and consequently be detrimental to an entire region's ability to contain the spread and manage risk".

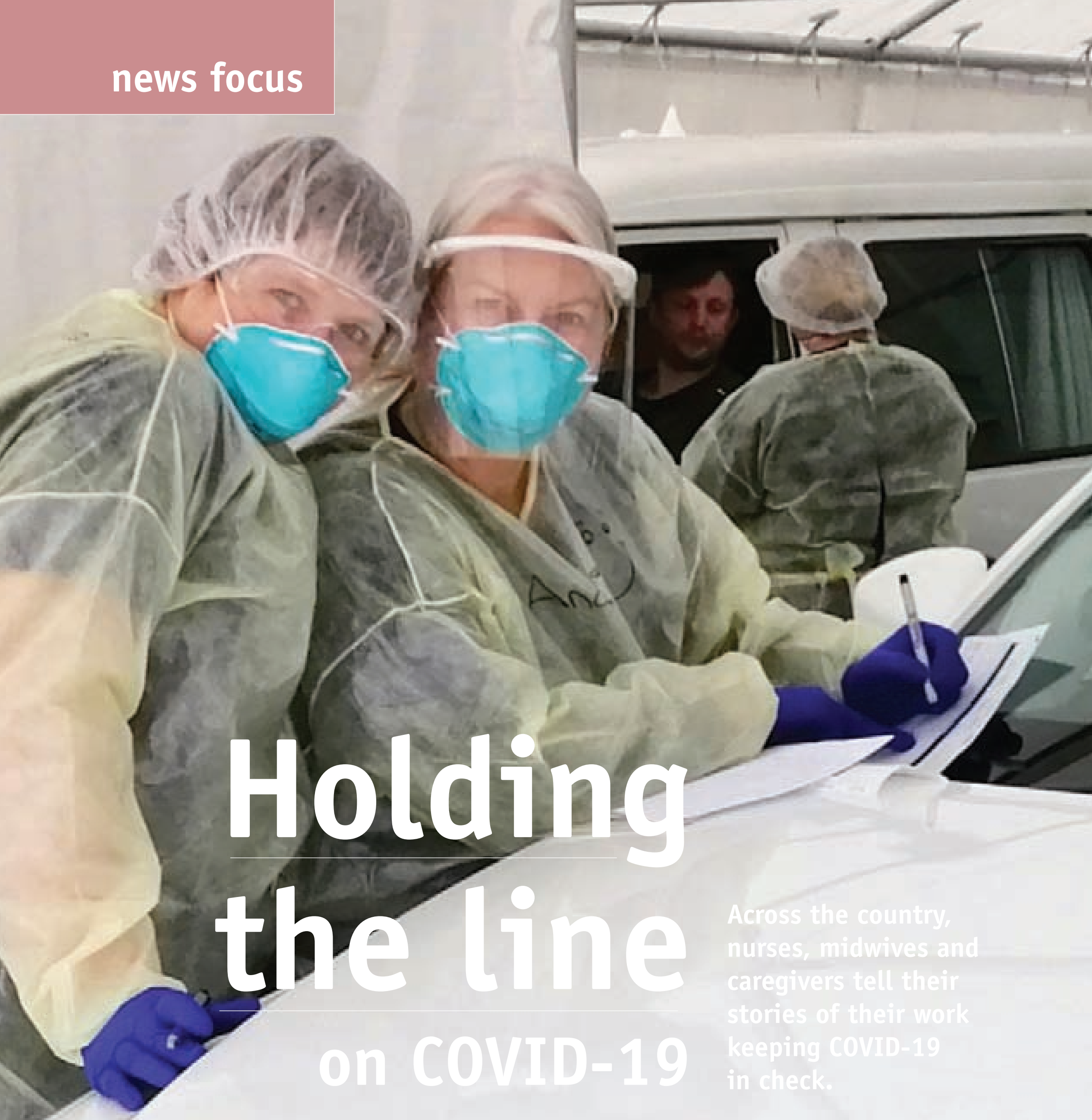
NZNO's college of gerontology nurses' chair, Bridget Richards, is only just back at work after isolating herself after exposure to an infected patient at the Waikato's Atawhai Assisi rest home, linked to 15 cases.

Recruiting staff and high turnover have long been a problem in the sector, she said, which lacked a multi-employer collective agreement (MECA) like the DHBs. Instead, ARC providers negotiated individually, leading to a lack of consistency for pay and conditions across rest homes,

Turnover was rising, according to the Aged Care Association's industry profile 2017-18, and had reached 27 per cent across all staff and 38 per cent for RNs in 2017. "Part of the problem is we cannot recruit nurses, it's really difficult," Richards said. "At one point, five out of nine of us at Atawhai Assisi were in isolation." Part-time staff did more hours and community volunteers, nursing educators and other health workers responded to calls on social media for fill-in staff. "We just have to do the best we can."

Richards was surprised there had not been more outbreaks in rest homes, as quite a few had shared bathrooms. "I think we have done amazingly well. Most of the fatalities have been from one dementia unit, which is a very different environment from a rest home, in terms of isolating people.

"Nurses have done a fantastic job. They've really had to step up and fill the gaps, and a lot of them have done really well." •



Community nurse Andrea Knowler (right) and colleague Rachel Hall at the Queenstown pop-up clinic in April.

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

First pop-up clinic 'huge success'

Southland community nurse Andrea Knowler has been in on the ground setting up community-based assessment clinics.

Andrea Knowler didn't hesitate when asked by her employer, primary health organisation WellSouth, about her availability to work in a community-based assessment clinic (CBAC) in her home town of Invercargill.

It was a far cry from her usual role at WellSouth, as a long-term conditions (LTC) registered nurse, taking referrals from general practice and supporting practice nurses.

"In March we became aware of the virus and that 'business as usual' would change and that change happened pretty quickly."

The first CBAC was established in Dunedin, followed by Invercargill. WellSouth developed processes for how these new clinics would operate and Knowler felt confident with what she and other staff would be doing. "We spent a huge amount of time donning and doffing PPE, with someone observing us and there were no problems with access of supply."

Knowler works at the Invercargill CBAC, four days on/four days off, maintaining the same "work bubble" of colleagues. The clinic became busier as the change from alert level four to level three approached. Nurses do 90 per cent of the tests, with other health professionals, including a physio, clinical pharmacist and occupational therapist, in support roles.

Knowler was involved in the country's first "pop-up" clinic, held at a Queenstown supermarket. "It was a hugely successful day and was organised in a very short space of time. The call to establish the clinic came at 2pm the day before, so the organisation to establish the clinic, get all the people and

equipment organised, was phenomenal."

Working in a drive-through clinic was different from a more formal CBAC, Knowler said. "It is very dynamic doing it as a drive through. You are very focused on keeping yourself protected, as you don't know what you might be coming across. But I don't think we could have given a better service that day."

The pop-up clinic wasn't advertised. WellSouth took over part of the supermarket carpark and teams at the entrance to the supermarket told shoppers about the voluntary testing.

"At first, there was just a trickle but that turned into a stream as people heard about it. At one stage there were 18 cars lined up," she said.

All up, 345 people were swabbed. It takes about 10 minutes to conduct a swab. The nurse, in full PPE, introduces themselves, explains the testing process, gets informed verbal consent and all the demographic information required. Some people didn't have NHI numbers and these had to be allocated before the test could take place.

"Wearing full PPE makes communication difficult – the people can only see your eyes through goggles and a visor. It certainly challenged my communication and other nursing skills," Knowler said.

The swab, resembling a "tiny bottlebrush", is inserted in both nostrils and down the throat and rotated at each site for 15 seconds to ensure the viral DNA is secured.

"It is a very invasive, intrusive procedure which often activates the gag reflex and always brings tears to people's eyes. We always have tissues on hand. We often count down the last five seconds to help people through the process."

The swab is then placed into a medium, double-bagged and placed in a chilly bin by a "runner". Each tester has a runner, admin and IT support. And the person tested is provided with follow-up information and how to manage if COVID-19 positive. Everybody was personally informed of their test results within two days.

'It is a very invasive, intrusive procedure which often activates the gag reflex and always brings tears to people's eyes.'

The procedure is the same at the CBAC, except baseline observations are taken before the test and there is more time to talk people through the process and ensure they understand COVID-19 symptoms.

Knowler has been a nurse for more than 30 years and both the pop-up clinic and the CBAC have provided challenges. "One of the biggest has been to communicate in a different way. With PPE, there can be no therapeutic touch, which is really hard if a person is particularly anxious. We are behind a shield and a face mask – there are only our eyes to have a calming effect for a patient."

Despite the heightened anxiety generally because of COVID-19 and the invasive nature of the procedure, Knowler said "99.9 per cent of patients" thank the nurses for their work and are very grateful.

At the start of her day, Knowler changes into clean scrubs and dons her PPE. If she has been coughed or vomited on during the day, she showers immediately and puts on new scrubs and PPE. Before leaving work, she has a shower, washes her hair, changes into clean clothes and goes home. She does not have to launder her own scrubs. She has never felt anxious about returning to her bubble, which is busy and complex – herself, her husband, two daughters and her mother-in-law who has an LTC. Knowler has also had to cope with a 19-year-old son unable to get home from South Africa because of the lockdown.

Despite the professional and personal pressures, Knowler is utterly committed to her work.

"I'm just doing my job, but it's quite a different job from what I normally do. We are part of a global response. It is a critical time in a worldwide pandemic and the more swabs we do, the more understanding we are going to have of what is happening.

"I am just one part of a massive team effort from our director of nursing, Wendy Findlay, to administrators. We are working in extreme circumstances and we all have each other's backs. As a nurse, I will never forget this pinnacle time." •

Knuckling down to find solutions

Primary health nursing director Pauline Fuimaono Sanders has had her work cut out setting up community testing in the Auckland suburbs of Panmure and Otara.

Setting up and supporting two community testing centres – one in Panmure, the other in Otara – and establishing a mobile COVID-19 clinic has kept Alliance Health Plus (AH+) nursing director Pauline Fuimaono Sanders extremely busy over the past two months.

Sanders is of Samoan decent and has been managing the Panmure site alongside AH+ nurse adviser Joe Glassie-Rasmussen, who is of Cook Islands decent. Sanders has also worked closely with staff at Counties Manukau District Health Board (DHB) and other primary care organisations to get the services up and running as quickly as possible. She has found her former charge nurse skills gained over five years at Counties Manukau DHB have been put to good use as she has helped set up the teams.

"It's been a real team effort," she said. "Nurses and the wider teams have come together across service areas, using their networks, and sharing their skills and experience to source the staff, supplies and equipment needed. Nurses have been at the forefront of the community response to this pandemic – they can feel justifiably proud. No egos have been involved – we've just knuckled down to

find the solutions to achieve the results needed."

The testing centres have mostly offered a drive-through service, with people either self-referring or attending after speaking to their GP or a Healthline nurse. Triaging and swabbing is done by a nurse in full personal protective equipment (PPE), with either a doctor or nurse practitioner (NP) on site to conduct any medical reviews. These reviews have sometimes resulted in a patient being transferred to hospital for further tests or treatment. So far, all tests at the Otara testing centre for COVID-19 have been negative, with seven positives at the Panmure site.

Having Pacific nurses at the testing centres has been a great advantage, Sanders says, as being able to speak to people in their own language who know the culture, helps relieve anxiety. The majority of the staff at the Otara CBAC are Pacific but less so at Panmure.

"There is a shortage of Pacific nurses working in primary care, as most elect to work in hospitals. However, some have come out of hospitals to work at the testing centres, which has been great," Sanders said. "There are also school-based nurses and Plunket nurses who have not been working during level 4 but who have been deployed to work for us."

Some nurses have not been so comfortable being on the frontline. They might be caring for vulnerable people at home, have compromised health themselves or feel anxious about being on the frontline. This has been respected, with these staff offered contact tracing or Healthline work instead. There are different ways nurses can provide support.

Having Pacific nurses at the testing centres has been a great advantage, as being able to speak to people in their own language who know the culture, helps relieve anxiety.

The latest initiative – a mobile service – is proving extremely effective for reaching vulnerable groups of people in their own environments, Sanders says. There are now three mobile teams – one based in Panmure, one on the North Shore and one in Henderson. The service is for people with flu-like symptoms who can't get to a testing centre or to a GP.

Overseeing work at the Panmure testing centre are (left) c and operations lead Pauline Fuimaono Sanders.

"One of our concerns is that because so many primary health care services are now operating as virtual services, many people with long-term conditions are not accessing them, for different reasons. If the referral has come from a GP, then we will know what other health conditions the person might have. We can give flu

NP called in to help set up national contact

Nurses brought particular strengths to the team setting up the contact-tracing database.

New Zealand's first nurse practitioner, nursing lecturer Deborah Harris, was in right at the start of a national COVID-19 contact-tracing centre.

She was at the launch of a midwifery programme on March 18 at Victoria University of Wellington (VUW), when Capital & Coast District Health Board (C&CDHB) chief nursing officer Emma Hickson got a message from chief nurse Margareth Broodkoorn. Broodkoorn was seeking five nurses to help the Ministry of Health (MoH) set up the centre.

"I didn't hesitate," Harris said. VUW's head of nursing, Kathy Holloway, granted her leave. So, along with four other Wellington nurse leaders –Lynette Singh, Cheryl Hunt and Helen Costello of C&CDHB, and the DHB's former director of nursing Andrea McCance – Harris joined a MoH-led team. This included public health specialists, specialists in contact-tracing for cattle infection mycoplasma bovis, police, customs and Ministry of Social Development staff. Its aim was to urgently develop a new national close contact tracing service.

Working long hours, they began calling members of the public identified as close contacts, while others began setting up a national tracking framework, where the team's own findings could be added to data from public health units and Healthline. The resulting "really cool" database has pulled together "end-to-end" COVID-19 data, a "considerable achievement", Harris said.

Nurses brought particular strengths in communication, collaboration and understanding health needs to those they contacted, Harris said. "Some of the key things that nurses do well are manage relationships and listen, and that communication was fundamental to helping people listen and feel safe. A lot of

clinical lead Joe Glassie-Rasmussen and nursing director

vaccinations to those who are eligible and see other members of the household who might have a health issue. We aim to provide a comprehensive service."

Currently, each mobile team consists of a GP and two nurses. Although the support of the GPs has been much appreciated, in the long-term Sanders believes the ideal mobile team would comprise two nurses and an NP. However, there are too few NPs working in primary care at present, which necessitates the inclusion of a GP in each team.

Mobile teams have been making up to 10 visits a day, sometimes seeing around 25 people. The mobile teams are also supporting surveillance testing at high-risk essential workplaces. Sanders expects the service to continue while the country remains in the various alert levels, with referrals increasing in the coming weeks.

Strict infection control measures are maintained to avoid cross contamination between staff and those visited. One member of the team remains in the van while two go into the house. The van is kept as a clean area, with the two visiting team members removing their PPE outside the van and placing it in a yellow bin before getting back in the van. A fresh set of PPE is worn when making the next visit.

There are guidelines about what testing centre and mobile staff need to do when returning home. Clothes must be removed and washed separately and staff must shower before having contact with their family.

The mobile teams have found no positive swabs as yet. But what they have experienced is enormous gratitude from the people visited. "Many people have been feeling very anxious and fearful about how the virus might affect them if they got it. They are also anxious about the loss of jobs and difficult living conditions," Sanders said. "When family tension increases, so does the incidence of family violence. There is the ability to arrange food parcels for families and emergency accommodation for those unable to comply with self-isolation in their current living situation. We can answer questions about what the various levels mean and suggest ways they can stay connected to one another. We also provide medication as needed."

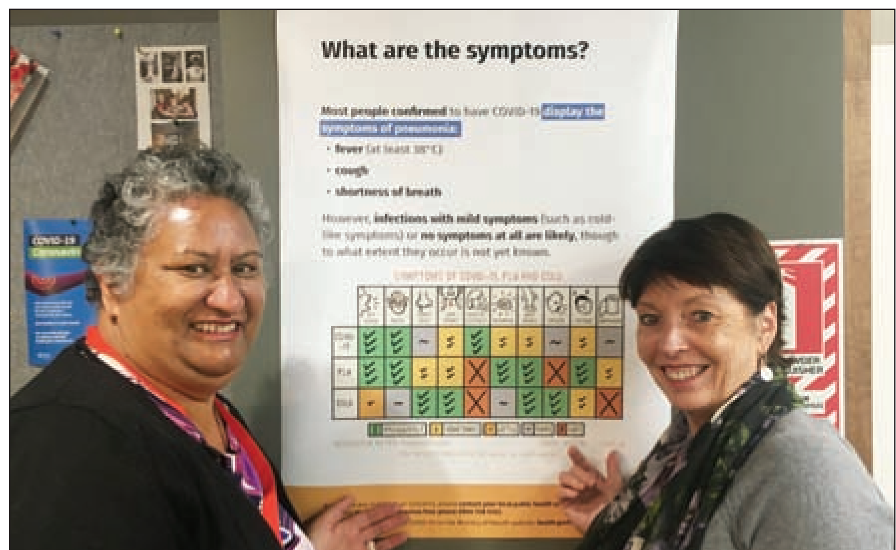
Isolation is proving a major problem for many Pacific families who can no longer take part in their usual social activities, particularly those centred on church. Cultural practices have totally changed, including not being able to attend funerals in the same way. "Pacific people are communal people. When our usual practices are significantly affected, anxiety and stress levels increase. However, we have noticed a lot of older people using social media more to maintain their family and community connections," Sanders said. •

-tracing centre

people were sick, frightened and alone. Nurses are really good at dealing with these kind of things – being empathetic and empowering people to feel more comfortable in challenging situations."

The team of nurse leaders wrote scripts for the calls, which needed to give a "clear and consistent" message to everyone. "We are used to talking to people about difficult health concerns – we are well placed to help the public in this way."

The centre "scaled up" very quickly, with health-care professionals like midwives and registered nurses (RNs) doubling daily. All the nurse leaders were coordinating caller shifts; Hunt, Singh



Ministry of Health COVID-19 cultural and clinical lead (kaitautoko) Cherene Neilson-Hornblow (left) and Victoria University nursing lecturer Deborah Harris.

and Costello were more involved in training new staff, while Harris was asked to manage complex clinical cases – such as those identified as more vulnerable, with mental health issues, another area where nurses' communication and empathy skills were key.

She "welcomed" infectious disease physician Ayesha Verrall's audit for the MoH. This found the MoH needed to urgently scale up its capacity to trace up to 1000 contacts daily, and proved a "very useful" guide to shaping the service.

The goal was to contact 80 per cent of people exposed to the virus within 24 hours, so they could quarantine, and this had been met, she said. "The key to managing the virus is in contacting the people who have been in contact with confirmed cases in as short a time as possible – and that's definitely happening. You can see the evidence of that, by the number of cases in New Zealand."

Flexible and nimble

While the slowing numbers had reduced the workload, the centre was designed to be flexible and nimble. "So if we get an outbreak, we have the ability to step up our contact tracing immediately.

"Contact-tracing is key, but the important thing is New Zealanders are listening and they are self-isolating. These two things, together, are 90 per cent effective [in stopping COVID-19] – that's better than vaccination."

Recently, Harris moved onto the MoH's COVID-19 planning and capacity team, where she is drawing on her clinical, writing and research skills to write policy for the first time. "I'm writing policy which underpins how this service will run. I have limited experience, but this is an outstanding opportunity and I'm well supported by MoH staff. I'm seeing the machinery of Government at work, and contributing to documents which go on to Cabinet."

Harris believes the service will continue to be useful for public health, Māori health and epidemiology (disease control) well beyond COVID-19. "Now we are going to have a database for the whole country, end to end, that manages an infectious disease, which could be the start of a new streamlined public health strategy." •

'Much of my work I do outside a mother's house from my car' - midwife Amy Taylor

A new style of midwifery

A new midwife had to adjust straight away to lockdown practice.

Newly-graduated midwife Amy Taylor had only experienced a couple of months of normal practice when the country went into lockdown. It was a shock to her, but even for midwives who had been around much longer than she had, there was a lot of adapting and changing to do in a very short time.

As a new graduate, Taylor does not take a full client load as she has mentoring and study requirements to fulfil. She takes on two to three women per month and has an average caseload of about 28.

"Everything I am doing I am experiencing for the first time, including managing pregnant and birthing women during a lockdown. There have been many challenges but I have been enjoying all the experiences very much," Taylor said.

Three of Taylor's clients gave birth during the lockdown – two at Te Awakairangi Birthing Centre in Lower Hutt and one at Hutt Hospital. "There might be a global pandemic, but babies will still be born and that is something really positive to focus on," she said.

During the lockdown, Taylor noticed more women were keen to birth at the birthing centre and avoid having to be transferred to the hospital for an epidural or other medical procedure. This was partly because they were reluctant

to be in a hospital environment where there might be some risk of being exposed to the virus and partly because, in the hospital, partners were not allowed to stay postnatally.

"In the hospital, fathers could be in the delivery suite but were not allowed to go to the postnatal unit once the mother and baby were transferred there. Partners were then not able to see the mother and their child again until after discharge. Under level 3, partners can now visit but not stay in the postnatal room. In the birthing centre during level 4, partners could stay but could not come and go as they used to."

Recognising the benefit that women experience having their partners with them during and after birth, hospital midwives had increased the amount of contact they were having with new mothers, offering them more support.

Taylor, like all lead community carers, has been following College of Midwives lockdown guidelines. These stipulate that visits to mothers should be kept under 15 minutes, with most contact via phone, Skype or Zoom. Midwives were not required to wear personal protective equipment (PPE) unless a woman was symptomatic. PPE is worn, however, during the second and third stages of labour.

"Keeping visits to under 15 minutes is very challenging, especially when you know a new mother is feeling lonely and depressed. This is the very time when a woman needs her community around her, so lockdown makes things particularly tough. Much of my work I do outside a mother's house from my car, only going into the house to weigh the baby. And when I do go in, I leave my bag, phone and pen behind.

"When a mother has breastfeeding issues, the usual practice is to observe a feed. We sometimes try to do this via Zoom but it is hard. Sometimes I do go into a home to watch, but I have to try and keep the visit short. Everything I do now has been taking twice as long as before the lockdown, and anything I take into the house has to be sterilised. I now do all my documentation at home, and send online copies to women, rather than recording directly into their books."

One of the safety measures Taylor has adopted is to space out her home visits rather than crowding them together. When she gets home, she removes her shoes before going into the house and disinfects her equipment, including the inside of her car and her glasses. She goes nowhere near her own children until she has showered and changed, and put her clothes on to wash. She has never done so much laundry in her life!

'Keeping visits to under 15 minutes is very challenging, especially when you know a new mother is feeling lonely and depressed.'

Wearing PPE during the second and third stages of labour has created particular challenges.

"Women like to see a midwife's encouraging face and smile, but they can't see your expressions when you're wearing a mask. They also like to be touched and stroked – doing this while wearing gloves is not the same.

"Midwifery is a relational profession – the restrictions we have all been under means relationship-building has been much more difficult, and I don't expect things to be very much different under level 3. All the time a midwife must check she is doing the right thing – it is a challenge.

"However, I am happy to adopt these safety measures. Getting a handle on the regulations might be stressful, but I can see the sense in them. When I speak to midwifery friends in the United Kingdom, I realise how lucky we are – the situation could be so much worse. I am proud of the way our country has responded and glad to feel safe. Changing our practice to keep safe is fine by me. We must continue to be careful to make sure we keep the gains we have made already in controlling this virus." •

Keeping open the lines of communication

Healthline nurses provide knowledge and reassurance at the end of a phone.

Marley Mueller's day begins at 5.30am. On these crisp, autumnal mornings in Central Otago, she gets up, breakfasts, takes the 30 steps to her home office and, at 6am, begins her shift with the National Telehealth Service (NTS), run by Homecare Medical (HCM), either on the dedicated COVID-19 Healthline or on the "normal" Healthline. Ten minutes before her shift officially begins, she logs on and reads updated COVID-19 information, messages from the Ministry of Health (MoH) and finds out her role for the day.

Mueller is an experienced paediatric nurse who worked at Starship for close to 20 years, including in its intensive care unit, and surgical and oncology wards. She joined Healthline in December 2016, motivated by a desire to work in primary health care and for change and challenges. She's got them aplenty. While COVID-19 meant an overwhelming increase in the number of calls – the daily tally peaked at 14,000 and was averaging about 6000 a day last month – it has not changed the basic philosophy of care: "to guide all callers into clinically safe outcomes," she said.

The NTS team was aware from late January that COVID-19 would have a major impact on its work. It had a dedicated COVID-19 number set up by early February. Around 600 extra staff, including more than 100 nurses, were recruited to the dedicated line, some from within its own ranks, others from different health-care sectors, according to NTS COVID-19 service delivery manager Sarah Tan. The Chinese community was particularly affected and HCM employed Mandarin and Cantonese-speaking non-clinicians initially and subsequently employed Mandarin and Farsi-speaking nurses. A

Marley Mueller fielding calls on Healthline. At the peak of COVID-19 calls, callers were having to wait up to 90 minutes.

number of its existing nursing workforce can speak at least one other language apart from English. The number of nurses responding to COVID-19 calls can flex up and down as required.

Tan explained that they have a close working relationship with the Ministry of Health and public health units around the country. HCM's clinical lead physician developed its own document on COVID-19 – "the single source of truth," as Tan describes it. This document, which is closely linked to the ministry's information, has mirrored the changes and evolution of knowledge about the virus, with close to 100 iterations sent through all HCM's communication channels over the course of the lockdown.

Non-clinicians answer calls in the first instance, gaining callers' personal information and the reason for their call and symptoms, if they're calling for clinical advice and information. The details for those requiring a clinical response are passed onto registered nurses who then call back and undertake a comprehensive clinical assessment. At the peak of COVID-19 calls, callers were having to wait up to 90 minutes for a call back. That had dropped to six and a half minutes by last month. Abandonment rates, ie when callers give up holding on, have also plummeted.

Mueller said at the peak, "the crescendo of calls was so loud". She has had total confidence in the information contained in the "single source of truth" document, which is regularly updated, hourly at times.

She said that callers' anxiety during lockdown sometimes affected her. "None of us is immune to taking particular calls with us when we hang up. But we are encouraged to manage our breaks, have a stretch, have a cup of tea. And we can have a clinical debrief if needed. Managers are available 24/7. I have felt really supported. We have been encouraged to look after ourselves in this situation, which is new to all of us."

Tan acknowledges the "health anxiety" present in the community at large and lists the supports available to nurses – clinical supervision through clinical leads, including senior nurses, a psychiatrist, a GP and an emergency department physician. The NTS mental health counsellors are also available.

Some of that anxiety has been fuelled by "the hysteria of social media" according to Mueller. "It is really important to direct callers to look at approved websites for information on COVID-19."

Mueller finishes her first work stint at 10am and resumes again at 4pm, working through to 9-9.30pm. She works full-time from her Ohau home and loves it. "I feel very

'We haven't eliminated it yet'

For an Auckland public health nurse, there is cautious optimism and worry.

Emerging from level 4, Auckland public health nurse Justine Paterson is trying to be "cautiously optimistic" after an intense three months corralling COVID-19 – first at the borders, and now in the community – but is anxious.

"I'd be really happy to be proven wrong, but I'm worried that the excitement of exiting level 4 will lead to some undesirable behaviour," says Paterson, part of Auckland's Regional Public Health Service (ARPHS). "We're watching with interest what will happen over the next week or two, especially after seeing people congregating in the McDonald's carpark."

Paterson was pulled off her regular communicable diseases role, onto the border team at Auckland airport in late January as COVID-19 cases began to soar globally. When New Zealand sealed its borders on March 20, she moved onto contact-tracing, where the long hours continued. About 30 extra staff – nurses from schools, other regions or district health boards, and medical officers – were pulled onto the ARPHS contact-tracing team. Contact-tracing is an "intricate" job, which can involve "hundreds" of phone calls per infected individual.

While slowing of case numbers had seen workloads drop towards the end of April, the team was poised to react to any COVID-19 surge. "We're a little bit worried," Paterson said. "We are prepared for months, because even if we get to zero cases, the border will open to some degree. Quarantine will help us, but it can't happen forever."

She said they expected to see more cases in coming months, and were constantly planning and sharing ideas on how to prepare. "It will be interesting to see in the next week or two, as the average incubation seems to be five to seven days – although it can be as long as 14."

"I'm cautiously hopeful, but it's an

proud to be doing this work – to be part of the response to COVID-19 and to be making a difference in people's lives."

That pride is echoed by Tan and NTS chief executive Andrew Slater.

"Nurses have been doing an amazing job in how they are dealing with the situation," Tan said.

'I feel very proud to be doing this work – to be part of the response to COVID-19 and to be making a difference in people's lives.'

Slater said the organisations work was underpinned very strongly by the profession. "Never in our history have we taken on the task we have taken on in the last eight weeks. The New Zealand health system has shone and the spotlight has been on nurses who, day in, day out, deliver advice to New Zealanders. The quality of care nurses have been providing is phenomenal."

He points out that in more than 200,000 Healthline contacts during the pandemic [up to mid-April], the organisation has received just 78 complaints. "That is a phenomenal credit to the profession and our nursing team." •

Virtual boost to equity

Plunket staff use lessons learnt during the earthquakes to provide lockdown services.

For Christchurch Plunket nurse Sarah McKenzie, the pandemic has meant a huge change in both her practice and her perception of that practice.

"Like many nurses, I have had to manage the changing situation and adapt quickly to meet the needs of those I'm caring for."

She works in inner-city Riccarton, the city's most diverse suburb, with many migrant families.

She says Plunket learnt a great deal from the Christchurch earthquakes, notably the need to provide digital services. One such service, launched in late 2018, is the video conference lactation consultation service for women needing help with breastfeeding, which has been "hugely successful".

Along with experience working in the virtual space, Plunket has also been able to provide ideas and resources to families whose children are not attending early childhood education. "We are aware that the loss of early childhood education can have a dramatic effect on children. Plunket has been really good at filling that space, providing lots of ideas about interactive play through Facebook and through virtual groups, including a music group in Timaru and parenting groups. The feedback from mothers is that they have loved it."

"There has been more interest in virtual groups, with mothers quite keen to connect with people not just in their own city. Virtual groups work for people who are not confident to connect in person."

McKenzie said Plunket was very aware of the stress social isolation placed on families and the increased risk of domestic violence. *(Continued on p22)*

unusual disease. We are learning all the time, but signs are good. But, like [director-general of health] Ashley Bloomfield said, we haven't eliminated it, yet."

A huge focus has been on tracing contacts linked to two clusters in Auckland. At one facility, more than 50 staff had to be stood down for quarantine. Another 110 people linked to a different facility had to be called daily to check their symptoms.

Particularly in such high-risk settings, "meticulous" conversations were needed to find out exactly when people were infected, when symptoms started, where they worked and who with – before tracing could even begin. "It's quite a huge burden of work. We have to make sure vulnerable people are protected."

Many essential workers across the Auckland region have been affected by COVID-19, either as cases themselves or close contacts.

"It can be hundreds and hundreds of people followed up over the week." Although facilities and the national contact tracing centre helped, ARPHS tried to keep oversight of its clusters. "It's a big job, we have teams of up to 20 people working on it. We want to manage the cluster with continuity, with the same team, if we can, so things don't get missed and to keep the vision of what is happening at the facility. It's quite intricate."

'Meticulous' conversations were needed to find out exactly when people were infected, when symptoms started, where they worked and who with.

However, ARPHS staff were being well looked after, with breaks and time off. Paterson said it was also "really interesting" work. "It's tiring but the complex cases, the risk assessments, make you really think, and it's still good to be part of something that has been successful."

Nurses had "stood up to the challenge" really well and developed their skills – and were a critical part of the decision-making. "I think that the nurses in our team are showing really good leadership and are seen as experts. They are experienced public health nurses, and thriving, working alongside doctors in case management and contact-tracing." •

COVID-19 has meant an increase in the number of children living in poverty and McKenzie and many other Plunket nurses are giving families information on support services and connecting them with support agencies. Plunket nurses were very good at working across sectors and that ability was particularly important when many families were struggling to get enough clothing or equipment for their newborn, she said.

Sarah McKenzie

One of the positives to emerge from the pandemic has been more communication with more community organisations who, McKenzie says, are "really committed to working together".

"We have to recognise that this stress affects the marginalised more. Plunket has been very good at recognising that. All its prioritised virtual services are totally focused on our families/caregivers with babies under three months, Māori and Pacific families and families with complex social circumstances," McKenzie said. But she points out that in these times, hard-to-reach families may become even harder to reach. "We are just one of many, many agencies calling them. They are being inundated with calls and they may just have one mobile phone for the whole family." But, she says, Plunket nurses are really good at "not giving up".

It has been a "huge adjustment" for nurses to move from a universal to a more targeted service and from face-to-face care to virtual care and the associated loss of therapeutic touch for both mother and baby. And they are having to cope with heightened anxiety among those they are working with.

Is my baby growing? Do I still need immunisations? Is it safe to go to the doctor? are common questions Plunket nurses are fielding.

"There is fear in the community and how do we, as nurses, alleviate that? We can't do that in person, but we can still be face-to-face via Zoom," she said.

While physical examinations of babies are out of the question during lockdown, McKenzie said "nurses can still do a conversational growth assessment. We can ask how breastfeeding is going, has the mother noticed anything different. If a family has a set of scales, we ask them to use them and write the baby's weight in their Plunket book. We can look at the baby and see if there are any skin rashes, for example. And we can give reassurance."

Zoom also enables breastfeeding support and help with sleep soothing techniques.

With fake information abounding during the pandemic, families saw Plunket as a reliable source of COVID-19 information, she said.

Partner at home

McKenzie said many families had enjoyed having their partner home and that extra support had really helped with breastfeeding, she said. But many mothers were worried about how they would cope once partners returned to work.

On a macro level, McKenzie said virtual services had boosted equity, as Plunket's programmes and services could reach a far wider audience. "And our story won't end when lockdown ends. We will add the innovations we have come up with to what we were already doing."

The lockdown has challenged McKenzie personally and professionally. It has also affirmed for her that "while we are all in the same storm, we are not in the same boat". •

Four-phase app

Emergency nurses in Dunedin are wary of the virus rebounding, and the approach of the winter flu season.

With winter tailing COVID-19, emergency nurses at Dunedin Hospital cannot relax just yet, says emergency department (ED) charge nurse Janet Andrews. "We are still preparing for the worst, in case we need to."

With level 3 comes new opportunities for the virus to rebound, and staff were prepared for an influx should that happen. "We are hoping people don't think it's all fixed. Particularly, we in the ED know winter is very busy with influenza-like illness and, at this stage, we will have to treat them as COVID-19."

While presentations over the lockdown had dropped from around 160 to 40-50 daily, they were starting to grow again. "Our biggest concern is people are at home with co-morbidities but are too frightened to come in."

Isolation pod

The ED has developed a four-phase approach. In the first, patients are screened with some basic questions then sent into "red" or "green" areas for a full triage. "Red" patients – those with possible COVID-19 exposure or infection – go into the red isolation "pod", which was formerly the observers' unit, in which staff wear the higher level of protection.

Thirdly, the ED is currently being expanded into the former orthopaedic ward, to allow physical distancing. And the final stage, if

Dunedin Hospital emergency department staff.

roach in ED

there was a large surge, would be to split the ED into two – a red and green zone – expanding into the acute patient zone. "This would be a huge, logistical exercise, effectively doubling the ED," Andrews said. "We believe that we may not have to do this, but we have it in the drawer, just in case."

ED had been given lots of guidance from its infection prevention and control team on PPE use, including "donning and doffing" of the gear.

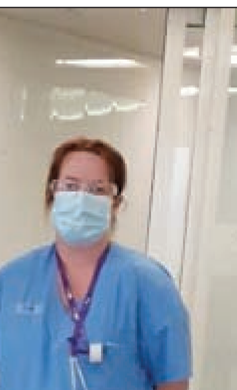
'Our biggest concern is people are at home with co-morbidities but are too frightened to come in.'

The past five weeks had been "a whirlwind", as the region dealt with fallout from significant COVID-19 clusters, including the World Hereford conference in Queenstown and the Wanaka A&P show.

"We have changed processes in hours, which would normally have taken months. It's been challenging and really difficult, but staff have really stepped up."

The hardest thing was not having the normal ways to de-stress, such as going for walks or coffees with friends, she said. But camaraderie in the ED was "awesome", with lots of laughs and social media connection, she said. Quite a few nurses who were older or vulnerable in some way were helping in other ways from home, doing work like contact-tracing.

"Most nurses don't want to be sitting at home, they want to be working and helping," she said. "The nurses have been so adaptable, they have been amazing."



Again, she said, the challenge had brought leadership opportunities. "It's definitely showed our true leaders in this type of environment," Andrews said. "We have to adapt to change and unpredictability that comes through the door with a worldwide pandemic." •

We catch up with some of the nurses and a health-care assistant whom we profiled in the April issue.

CAROLYN CLISSOLD infection prevention and control

'A very intense month'

INFECTION PREVENTION and control (IPC) nurses' college chair Carolyn Clissold "nearly cried" on May 4 when there were zero new COVID-19 cases reported. "It's been a very intense month," she said. "I'd like to say I'm cautiously optimistic, but we will continue to see cases [coming in] from overseas, and in hospitals, so we can't drop our guard just yet.

"We still have to make sure we have good systems in place. Even though we can be a little bit relaxed, we still need to have staff training and good personal protective equipment [PPE] processes."

The current focus was on aged residential care (ARC), linked to five of the country's 16 significant clusters. IPC nurse leaders across district health boards had been asked by the Ministry of Health (MoH) to review every ARC facility to check their plans in case of a COVID-19 outbreak.

Most were in good shape, Clissold said. "They're doing really well. They are absolutely committed to not having outbreaks, they have really had to set up new systems, using video-chat and bubbles within bubbles in the homes at dinner times. Aged-care workers are absolutely committed."

It had been "tricky" to manage the evidence-based guidelines with the expectations of health professionals, patients and the public, she said. "It's fear rather than science, so we don't want that to be the guide."

Clissold – who is part of the MoH's COVID-19 technical advisory group – is looking to the United Kingdom's "sessional" model – where PPE was used for sessions of up to four hours, rather than changed for every patient interaction.

"I think we'll have to continue to be flexible on it, and make our decisions based on our community rates or community-transmission rates. People will also gain confidence as weeks go by."

It had been "amazing" to see how suddenly the whole hospital process had changed in response to COVID-19, with isolation wards set up, emergency departments changing their environments and "the whole flow is different". •

MARITA ANSIN-JOHNSON aged care

'A time of anxiety and fear'

FOR HEALTH–CARE assistant Marita Ansin-Johnson the four weeks of level-4 lockdown were ones of uncertainty, anxiety, fear of the unknown, ongoing stress and continued short staffing.

"I started this journey with mixed feelings. I didn't know if this invisible enemy was going to take my world. My approach was to always wash my hands – that was nothing new – and to do all that was asked of us. We had to wear 'civvies' to work, change into our uniform at work and when we'd finished our shift, change back into our clothes. That was different and we had to trust in our employers' instructions and trust all staff were doing that too."

Maintaining social distancing was difficult. "How do you do this when you are showering a resident or helping them with daily living tasks?"she asked.

Staff were told they didn't need masks or gloves. "The thought you could be the person responsible for bringing COVID-19 to vulnerable people in the rest home and which had the potential to kill them, was very stressful. You also were dealing with your family, people you care about, on the outside. You felt torn between the two families you care for."

Ansin-Johnson has had to make that very difficult choice and is now on "essential leave" because of health concerns about a family member in her bubble. "It became apparent I needed to choose what was best for me, my family and the residents I look after."

She is grateful to the efforts her manager and the organisation she works for are making to support staff and their wellbeing.

"I observed lots of stress every day

and my co-workers trying to give their best under immense pressure. The media headlines of another rest-home resident dying were very stressful," she said.

She wonders why it has taken until this pandemic for the Ministry of Health to ask district health boards to "look after rest homes. Why does it take a pandemic and rest-home deaths for DHBs to take more interest?"

Ansin-Johnon, a long-term delegate, has been involved in many aged-care campaigns over the years. "This CO-VID-19 pandemic has highlighted issues that have always been there. People are frightened, scared, frustrated and leaving aged care, so we are back to the same problem – short staffing. Without the loyalty of dedicated staff, most rest-homes would not survive." •

MARGARET HAND
primary health

'Work is harder and slower'

NORTHLAND NURSE practitioner Margaret Hand says nurses at her clinic continue to work harder but slower as the response to the pandemic continues.

Nurses at Te Hau Āwhiowhio ō Otangarei health care clinic work in two different bubbles – those based at home and those able to work at the clinic. "We have come down a level, but we still have to manage our patients safely, minimising any contact they might have with each other and the face-to-face time we spend with them. Patients are triaged at the clinic's front door, with one patient allowed in at a time. We have minimised the furniture in the consultation room, keeping only the essentials, which we clean between each consultation," Hand said.

As well as keeping consultations to 15 minutes or less, nurses are increasingly using virtual consultations and seeking to improve the technology as this continues. "We've been ringing every one of our patients to check on their health status. The medication pick-up and drop-off service is continuing, with no charges made for these medications.

"We've also begun screening for COVID-19 and have ordered the cabin which will be erected behind the clinic and operate as a red zone. This is where symptomatic patients or those needing more privacy will be seen. Keeping this well ventilated, with nurses wearing personal protection equipment is critical to maintaining good infection control."

Hand predicts that working in these ways will continue until a vaccine is developed and available. "We must plan for the future, with the understanding that we have at least 12 months ahead of us of needing to work in these new ways. Providing a safe service for the elderly, many of whom are frightened to leave their homes, is another concern. We are considering setting up a separate building near our present clinic where we could keep elderly patients separate from other whānau."

Home visits are continuing, with an emphasis on completing vaccinations for children and flu vaccinations for those in high-risk categories. COVID-19 testing can also be done at a patient's home. However, dealing with patients who are against being vaccinated at all is an on-going issue. Hand hopes these attitudes will not persist when a COVID-19 vaccine finally arrives. •

STEVE KIRBY
critical care

'Fewer patients, higher acuity'

AUCKLAND CRITICAL care nurse Steve Kirby, chair of NZNO's college of critical care (CCCN) nurses, said he and colleagues were "extremely glad we haven't seen the number of cases we might have seen, if we hadn't gone into level 4 lockdown".

At the beginning of lockdown, Kirby said nurses around the country had no idea how bad it would get in New Zealand, after seeing the virus spread and deaths soar globally, and were preparing to be over-run. "We were apprehensive at the beginning about what was coming, but it's not been as strong."

However, while there were fewer inpatients, they were of "much higher acuity".

Intensive care unit (ICU) educators had done a "phenomenal job" around the country training staff to work in ICUs in preparation for COVID19, he said.

While relieved, Kirby urged continued vigilance, as the lockdown relaxed. •

NATALIE SEYMOUR
aged care

'Adjusting to a new normal'

AGED RESIDENTIAl care (ARC) service manager at Christchurch's Nurse Maude Hospital, Natalie Seymour, is cautiously optimistic and has unpacked her bag, stashed away at the beginning of rahui level 4, in case she needed to move into the facility.

But, after seven straight weeks, "I'm still looking for that elusive day off", she said. "There is going to be a time when I can take a day off – but not now."

Seymour and staff had adjusted to a "new normal" where they are the only face-to-face contacts residents have, but keep residents and their families connected with video chats and a live stream of their ANZAC day service. "It's certainly getting easier. We are more accustomed to our new normal," she said. 'It's not such an unknown."

Staff had been "phenomenal", providing "excellent" care to the 75 or so residents of the rest home and hospital facility. "They left their bubbles to provide support to other peoples' families and they have done it with no complaints, even though they're tired, they have done loads of hours."

With mostly permanent staff, just one employee worked across different rest homes but chose to work solely at the Nurse Maude home, as required under levels 3 and 4.

At one point, the home was preparing isolation protocols to accommodate residents from the COVID-19-stricken Rosewood Rest Home, as so many of its staff were stood down. But when the time came, it had no beds available, Seymour said.

However, about eight new residents had moved in during the lockdown and were kept in isolation for two weeks, she said. "Every day has been slightly different, and I don't really know what the day is looking like until we get here." •

Clinical nurse specialist Debbie Thurlow (left), service manager Natalie Seymour and registered nurse Rommel Agudo, at Nurse Maude Hospital, in Christchurch.

JILL CLENDON

DHB nurse leader

Swoop teams in action

NELSON MARLBOROUGH District Health Board (DHB) had planned for the worst-case COVID-19 scenario, which fortunately didn't eventuate. But the DHB's associate director of nursing and manager of ambulatory services, Jill Clendon, said a positive case late last month in Nelson, after 31 days without one, had come as a shock.

While the DHB was one of the first in the country to treat a COVID-19 patient in intensive care – the patient subsequently recovered – it had few unwell COVID-19 patients to deal with in hospital, Clendon said.

But an innovation introduced at the time of the pandemic – the swoop team – has been used with 32 patients since early April. The idea behind the team is to keep people out of hospital and treat them at home. The criteria for its use was deteriorating COVID-19 patients – it has not had to be used in that situation – and patients with an acute exacerbation of a chronic illness, who preferred to stay at home than be admitted to hospital. Clendon said a number of the patients cared for by a swoop team had been tested for COVID-19 – "it has also worked as a mobile swabbing unit for these patients".

The swoop teams – a nurse practitioner (NP)-led model, with registered nurse, NP and GP care, depending on the situation – will continue post-pandemic. "The teams are filling a gap in health care and will continue while we decide whether that gap ought to be filled by other people or the swoop teams."

Clendon believes the DHB had put in place very good processes and procedures and had really good nursing leadership for the pandemic and that meant nurses' anxiety had been managed "because they knew what they were doing was safe".

And she is grateful for the "incredible flexibility" of the DHB's public health nurses – around 14 full-time equivalents – who are attached to the DHB public health unit. "This meant we had a fantastic group of highly-skilled nurses who could respond to a whole lot of different situations – from daily phone assessments of COVID-19 patients at home to giving flu vaccinations to vulnerable populations to virtual Be4 school checks." •

SUE HAYWARD

DHB nursing/midwifery chief

Out of isolation

COMING OUT of self-isolation and getting back to work was a real relief for Waikato District Health Board (DHB) chief nursing and midwifery officer Sue Hayward.

She'd done her best to manage staff via e-connections, but had been looking forward to more face-to-face contact when *Kai Tiaki Nursing New Zealand* spoke to her last month.

She has nothing but praise for how nurses at the DHB have adapted their practice to meet new constraints. "Our nurses continue to impress me with their flexibility and humility, as they have adapted their practice. They have stepped up to staff the community-based assessment centres [CBACs] and worked in wards where they do not normally work. They have taken annual leave when needed and come back to work when asked to."

Nurses' formal education has continued, she said, conducted via Zoom or Webex. Hayward herself has been providing some postgraduate education, answering nurses' pre-set questions.

"When we went into lockdown, our hospitals had a 50 per cent occupancy rate. Now, as we have entered level 3, these rates have increased to 83 per cent. With increasing numbers of people on site, we have had to take extra precautions. The rules around family visits have relaxed a little, but only one key family member per patient is allowed. We have a responsibility to protect all our patients and to be able to contact trace easily, should someone become symptomatic. Families understand and accept these restrictions."

With winter on its way, Hayward predicts the usual peaks of seasonal illnesses will occur and patient numbers will inevitably climb.

Restrictions and new ways of working will need to continue until a vaccine is found, Hayward says. Despite there being no evidence of community transmission in the Waikato, gathering data from the CBACs will continue and is vitally important. "Only with the right data, can the right decisions be made at a regional and national level."

Hayward believes nurses have every right to feel proud of their efforts. "With International Nurses Day this month and 2020 being the Year of the Nurse and Midwife, there's never been a better time to say thank you to nurses. Without the nursing workforce, the world and New Zealand would be in a much worse state." •

Planning for a COVID-19 crisis

A new era of critical care nursing began at Wellington Hospital's intensive care unit in March as staff began preparing for a possible catastrophe.

PHOTOS: LYNSEY SUTTON-SMITH

By Lynsey Sutton-Smith

Facing up to the reality of COVID-19 for staff at Wellington Hospital's intensive care unit (ICU) started on March 4. Senior nursing and medical colleagues had gathered at the Australian and New Zealand Intensive Care Society conference in Napier to share and learn. As they listened to our critical care colleagues from Italy share their experiences of a novel virus, little did they know that a new era of critical care was evolving. We were told to prepare to ventilate and prone patients in droves, to plan for surge capacity, to upskill teams on a rapid scale. In short, we were told to plan for a catastrophe. From that moment, pandemic planning began at both a national and local level.

A registrar and nurse practise intubation simulation skills on a maniken.

Planning at Wellington ICU began on a large scale. While our co-clinical lead was busy leading the national planning work, the senior nursing team began preparing closer to home. We had started to think about the impact of this new virus on the nursing team and resources. Colleagues from China and Italy reported unprecedented admissions, bulging hospitals with sick, vulnerable patients ventilated in car parks, corridors, or in purpose-built hospitals, of nursing teams proning patients en masse and running out of ventilators and personal protection equipment (PPE).

The pressure to find answers to how we could accommodate patient admissions on a scale we had never seen before was enormous. How would we be able to ventilate them? How would we care for them if half our teams were sick? Most of all, though, we lost sleep over what the impact on our health-care friends and colleagues would be. How would we cope with the tragedy we were seeing overseas? These questions seemed unfathomable and insuperable at the time.

Our primary focus in those early days was on establishing ICU capacity, nursing and medical resources, and how we could increase our isolation facilities. Within three weeks, we had increased our isolation beds by turning our brand new south wing into a negative pressure area. We planned to migrate over to the post-anaesthesia care unit (PACU), which was also refurbished with further negative pressure beds, and to eventually venture into theatre space. We planned for nearly 60 ICU beds.

New negative pressure areas

On March 25, the architect and builders finished repurposing the south wing and PACU into negative pressure areas. Building work which could have taken weeks under normal circumstances took little over 16 hours to complete. Workforce planning was a massive undertaking. The senior team worked tirelessly completing nursing models and sourcing resources based on several contingency plans to ensure we could meet demand. We were grateful to our regional hospitals for supporting us with surgery and offers of help. We developed and tested a new model of care for the surge in admissions and planned that an extra 75 full-time equivalent staff would be needed to support the ICU in full pandemic mode.

At the same time, the educators – a team of seven – had a different kind of planing to do. Not only were they tasked to think about how we would orientate all our new nurses, they also needed to think about how we could enlist help from other sources, then orientate and educate them to become safe ICU practitioners. While we advertised for nursing volunteers locally and regionally, the educators developed orientation modules, training courses, timetables, manuals, workbooks, videos, resource guides and tools to rapidly orientate nurses back to critical care.

We soon had a growing list of ex-Wellington ICU nurses. The offers of support and help were overwhelming. Within two weeks we were orientating our new former ICU nurses on site. It was like old times again! They were happy to help, to do anything they could, and they were astounded at the level and speed of work we were doing to prepare. Teaching and training left our educators not only hoarse and tired but exhilarated, inspired and enthused. To date, we have

orientated an extra 140 staff over the space of four weeks to be part of our ICU team, should the need arise.

COVID-19 committee

By March 5, we had established a COVID-19 committee. This has more than 58 members – nurses, senior medical officers (SMOs), registrars, health-care assistants and administration staff. The 11 project steering groups are managed by 15 senior nurses and SMOs. By the end of March we had multiple policies and guidelines signed off on family visitation, end-of-life care, a poster on how to care for a COVID-19 patient, a COVID-19 manual, resuscitation and intubation guidelines, proning guides, wellbeing resources, and cleaning and infection control. The patient at risk (PAR) team developed guidelines on safe transfer of patients. Simulation training on transfer to CT scanning, from the wards and emergency department, was up and running by early April.

We collaborated closely with other teams around the hospital. For example, we knew we would need palliative care (a lot). Wellington ICU already has strong ties with palliative care. Their staff attend our multi-disciplinary team meetings (MDTs) and are heavily involved in the care of our patients. We and they recognised they would be an integral part of the ICU team in COVID-19 times.

Virtual meetings became the norm for everyone. We went from knowing a little about Zoom to using it daily, becoming experts within the space of a week. Large groups disbanded and we were zoomed into meetings, ward rounds and MDTs. Suddenly Zoom was everywhere – on our phones, home desktops and clinical computers. By early April, information technology delivered six Zoom-enabled cell phones and we created guidelines and policies on virtual family meetings.

Equipment and technology

We are using Zoom daily to connect with our patients' whānau, as well as phoning each day to impart progress reports and nursing and medical plans. The daily video messages and phone calls have become vital tools for patients, families and staff. Instead of connecting face to face, we had to connect in a different way that would still impart compassionate care and sensitive communication.

Our specialist nurse technicians had been busy behind the scenes when they wrote our unit's very first COVID-19 guideline on setting up ventilators with higher viral filtration. They took on coordinating our PPE process. This involved procuring the correct gear to keep our team safe and developing multimedia training resources. By early April, "team tech" had trained hundreds of staff in enhanced airborne precautions. Radiographers, cleaners, physiotherapists, anaesthetic technicians, biomedical engineers and SMOs all enthusiastically came together for PPE training.

It became clear that, in the event of a surge, we would need more equipment, including ventilators and oxygen. We also needed more dialysis machines, humidifiers, Airvo machines, ultrasounds, monitors and more. We had to ensure we had appropriate emergency procedures, such as evacuation of our COVID-19 patients in case of fire. Safe manual handling during proning of COVID-19 patients was another important consideration. Our team of nurse technicians was inundated by a never-ending list of questions and found creative solutions to them.

A specialist nurse technician demonstrates how to don and doff PPE safely to nurses being orientated to the ICU.

Towards the end of March, our first patient with COVID-19 was admitted. Everything we had theorised, taught, learned, developed, designed and discussed was suddenly practised at the bedside. We quickly re-adapted guidelines that did not work. We made sure our nurses were supported at the bedside, but we also saw how hard it was to work in PPE. Regular breaks and a buddy nurse are so very important. We managed the patient with mechanical ventilation and provided diligent, high-quality supportive care, as we would any other patient.

We were also aware of the anxiety frontline bedside nurses were experiencing around caring for patients with COVID-19. The wellbeing group, established in our unit in 2016, developed resources around support, mindfulness and caring for each other. Dedicated peer support groups were developed and we encouraged staff to use the "Chnnl" wellbeing app the unit now has access to. We also had voluntary clinical psychologists present in the unit when staff needed more focused help.

There is still uncertainty and anxiety around the care of our COVID-19 patients – and this is the same for all of us working in critical care. We are still desperately trying to find the answers as we go, trying to support each other and wondering how it will all play out. There is a seemingly endless list of jobs, an ongoing list of questions, of things to consider – the hows, whys and whats. However, a successful lockdown has meant we have had time to prepare. Many of our overseas colleagues have not been so lucky. The navigation around what will be a new normal for us in critical care seems terrifying. What will our units look like next week, next month, next year? But nurses, including critical care nurses, are by nature resourceful, intelligent, thoughtful, pragmatic, creative and determined. What drives us is the responsibility to do the best we can for our patients, our teams and colleagues in truly awful times. This is what we do. •

Lynsey Sutton-Smith, RN, BN, MNCl, is a clinical nurse specialist at Wellington Hospital's intensive care unit and a teaching fellow in the School of Nursing, Midwifery and Health Practice, Victoria University of Wellington.

By lead organiser Andy Hipkiss

Supporting members through COVID-19

Organisers' role during this pandemic has been to give members the best advice possible, despite restrictions on their work.

On March 23, 2020, Prime Minister Jacinda Ardern announced New Zealand was moving into COVID-19 alert level 3 for just over 48 hours. From 11.59pm on March 25, the country would be locked down at level 4 for at least four weeks. This was how seriously the Government took the pandemic.

For NZNO, we had members who were essential workers who had to remain at work and risk looking after COVID-19-infected patients. Organisers' priority was to ensure members got the best support and advice the level-4 restrictions allowed. Our first steps were to abandon our offices and take computers, phones and whatever else was required home, and set ourselves up to work remotely. This in itself caused problems, as not everyone had an internet connection or mobile phone coverage and some didn't have much by the way of a home office. In one case, an organiser didn't even have a permanent "home" to go to, as she was having a house built and her rental had ended before her house had been completed. But the most important thing was to get ourselves set up and ready to support members remotely.

PPE an immediate concern

Before the announcement of the alert increasing to level 4, we started getting COVID-19 inquiries from members. Immediate concerns were about the provision and appropriateness of personal protective equipment (PPE). There was all sorts of social media "advice" about what PPE was required when looking after COVID-19 patients and this made an already confusing situation worse. Members were also asking for advice on vulnerable workers and those with vulnerable people at home.

As everyone now knows, different levels of information were made available at different times and from different sources. District health boards (DHBs) quickly produced some good guidelines and frequently-asked questions, that were updated and reviewed regularly. However, these weren't useful when talking to members working for aged-care or primary-health providers. It also didn't help that, at the beginning, some DHBs chose not to speak with unions about many of the decisions being made. Information was an important resource to support members, but at times it was contradictory, changed without notice or had simply not been consulted on.

NZNO lobbied heavily for PPE to be made available to all members at all sites and for the Government to obtain more. We did see some progress in this area and our professional nursing adviser (PNA) colleagues were a great help. Eventually, PPE-related issues had to be divided into professional (use of PPE) and and health and safety (availability of PPE). PNAs gave advice on use and appropriateness of PPE and organisers advised on any health and safety issues.

The situation for vulnerable workers and those with vulnerable family members at home was the source of many calls. In fact, the phones were so busy, the member support centre opened through weekends and public holidays to be as responsive as possible to members. Again, DHBs took a lead in defining what a vulnerable worker was, and what precautions had to be taken to keep them safe. The Ministry of Health (MoH) also provided some guidance, although this was less detailed than that of the DHBs. NZNO organisers had many robust discussions with employers across the country, using the MoH guidelines as the basis for advice to support members who were vulnerable or had vulnerable people at home. Just before writing this industrial focus, I was on a Zoom meeting with representatives from the three Auckland region DHBs and they reported that every submission for vulnerable worker assessment by Occupational Health had been completed. So, I guess our work in this area has paid off for members.

Eventually PPE-related issues had to be divided into professional (use of PPE) and and health and safety (availability of PPE).

Meeting the pandemic head-on

Thankfully, New Zealand hasn't been hit as hard as other countries by the pandemic. If, as a country, we continue to tread carefully and take measured steps, we will eventually see alert levels lowered and New Zealand will remain a safe place. What will always be remembered is that our health workers stayed at work, looked after us in communities and hospitals across the country, and did their best to meet the pandemic head-on. I hope NZNO made that just a little bit easier for you, and that we were able to provide some comfort and support, given the restrictions we were under while you worked on. •

Ensuring nurses have PPE

The COVID-19 pandemic has meant unprecedented demand for personal protective equipment. NZNO has had to lobby long and hard to ensure all who needed it, had access to it.

By acting associate professional services manager Kate Weston

We have been living in interesting times and, as I write, we are in level 3 lockdown until at least May 11. The Government took some very hard decisions early on in the emerging crisis. These have meant our health system has not been overwhelmed, as has been the case in so many other countries.

NZNO has received a lot of media exposure during the pandemic. Much has been about personal protective equipment (PPE) – what people believe they need and what they have or haven't got. Some pretty big gaps have been exposed. It became clear the rhetoric about how much PPE district health boards (DHBs) had and where it was being allocated, did not match the reality of members' experiences across the country and in all sectors of health care.

As the acting associate professional services manager, I have been involved in the national COVID-19 discussions between DHBs and health unions. The need to respond urgently to PPE issues led to the establishment of a subgroup headed by chief nursing officer Margareth Broodkoorn. The unions were represented by Deborah Powell from APEX/Resident Doctors' Association, Caroline Conroy from midwifery union MERAS and myself from NZNO. We met daily with the chief nurse and other Ministry of Health staff to address PPE concerns.

100 PPE calls a day

At the height of the PPE issue, NZNO's member support centre received a staggering 100 calls about it in one day. One of the most distressing cases was where 11 members from one unit in a large facility independently contacted NZNO – each with the same story about rationed PPE. Seven of these calls were on one day, with three similar complaints being laid with the other unions.

Initially, concerns were raised about availability of PPE, especially in remote and rural areas, aged care and Māori and iwi providers. We were assured there was no shortage, "just a maldistribution". So "fix it", chorused the unions and, as if by magic, the masks – stored in some warehouse – appeared and were distributed.

Still, members were reporting that, even when they had assessed patients as high risk, PPE was removed and their clinical judgment ignored. Even requests for the most basic of PPE – the humble surgical/medical grade mask – were seemingly ignored.

This wasn't just about understanding the science of infection prevention and control (IPC); it was equally about health-care workers feeling safe and patients/clients feeling safe to seek health care when they needed it, rather than when their health had deteriorated. This understanding led to constructive engagement with union representatives and the ministry revising its guidelines on the use of PPE. The guidelines were changed to facilitate use of surgical masks when working within one metre of any patient with an unknown COVID-19 status. NZNO has also been working on its own PPE resources for members.

NZNO has also received reports of staff being advised to use hand-made cloth masks; of gloves that were not of an adequate grade; and of paper gowns ripping easily. PPE has been rationed, including being locked in cupboards, and difficult to access. We even heard reports from large DHBs that N95 masks were going to be "reprocessed" but not re-used; ie, they were going to be "saved". For what? International evidence indicates masks can be re-used, after reprocessing. But if there is not a supply issue, why would this step be needed? We know what happens to N95 masks that are "saved" – they turn to dust or the elastic perishes. NZNO welcomes the Auditor General's review of the distribution of PPE.

Sadly, as has been the case internationally, the hardest hit sector for deaths and exposure has been the elderly. However, it became apparent that PPE availability was not up to scratch at a number of aged-care facilities. Aged-care members were asking for additional PPE, such as hair and foot coverings, despite these not being included in the ministry's PPE guidelines. Staff dealing with elderly, confused dementia patients have to contend with saliva and other body fluids. Clusters of COVID-19 positive patients in a number of aged-care facilities made it even more important that staff felt safe – another example of the science of IPC meeting the reality of practice.

We will come through these times with long-lasting positive practice changes.

NZNO is keen to continue working with the aged-care sector to address skill mix, nursing care and the adequacy of funding models. These issues will continue to have an impact long after the COVID-19 crisis has been resolved.

During these unprecedented times, as well as addressing the issues, it is also important to look at how NZNO has supported health-care workers. Our advocacy has been at local, national and ministry levels and has effected positive change. We will come through these times with long-lasting positive practice changes.

From adversity comes innovation and in Aotearoa we are very good at that. This International Year of the Nurse and Midwife has the tag line *Nursing the world to health*. Dealing with a global pandemic is not what we asked for, but we are doing it and doing it well – #thereforyouNZ. •

Experiences and self-management of chronic pain

PHOTOS: ADOBE STOCK

By Claire Budge and Melanie Taylor

In the second of a series of professional education articles based on the results of the *Talking about Health* study, the authors look at chronic pain, how it can be better managed, and how it relates to health and quality of life.

Introduction

In this article on chronic pain, we use the 2018 (year three) data from *Talking about Health*, a longitudinal study of people with long-term conditions (LTCs) in the MidCentral region.[1] The aims of this article are to:

- explore the prevalence of pain and co-morbidities in our sample
- see who is consulted for pain management
- describe the location of pain and circumstances in which it is experienced
- see how having pain relates to ratings of health and quality of life and self-care challenges of sleeping and anxiety/depression
- see how self-management of pain relates to ratings of health and quality of life and self-care challenges of sleeping and anxiety/depression
- share some of the advice participants offered

Measurement

Chronic pain is persistent or long-term pain that lasts for more than three months.[2] Pain as an LTC was self-identified by study participants on the initial consent form. In the study, general health (GH: single item with response poor/fair/good/very good/excellent), physical health (PH: four-item scale) and mental health (MH: 4 item scale) were measured using the PROMIS Global SF.[3] The effect of LTC/s on quality of life was measured with a single question, rated on a scale from 0 (no effect) to 10 (very large effect). A list of self-care challenges was provided and respondents were asked to tick each one that applied to them and to add extra ones as required. Pain self-management was measured with a single question asking how well people considered themselves to be managing their pain at home overall on a scale from 0 (not at all well) to 10 (extremely well).

Results

Prevalence and comorbidity

Of the 370 participants remaining in the study by year three, 234 (63.2 per cent) had chronic pain, and of these, 147 (62.8 per cent) had arthritis, 90 (38.5 per cent) had another type of pain and 35 (15.0 per cent) had both. The presence of other LTCs for those experiencing chronic pain was high; eg 58.5 per cent also had hypertension, 44 per cent had diabetes, 35 per cent had a respiratory condition, 23.9 per cent had depression or anxiety related to having an LTC, 17.9 per cent had memory issues and 16.7 per

cent had angina. Over half the people with pain (58.1 per cent) had two to four other LTCs.

Pain management consultations
Twenty participants (9.2 per cent) indicated they had not consulted any health professionals about pain in the previous year. The number of people consulted ranged from zero to nine, the average being 1.8 (mode/most common=1). The individuals consulted are displayed in Table 1 (right). Therefore, with the exception of the 20 per cent of people consulting physiotherapists, the small numbers of people seeing a practitioner outside their general practice team suggests that pain is generally being managed within general practice. Only a small group received input from pain specialists. Participants were asked if they had a plan, agreed by a doctor or nurse, to manage their ongoing pain. About a third (35 per cent) said they had, almost half (47.7 per cent) did not and 17.3 per cent were unsure.

Pain locations and experiences
The location of the pain experienced is presented in Table 2 (N=215) on p22. The percentages add to more than 100, as most people indicated they had pain in more than one location. The number of pain locations ranged from one to 11 (M=3.9, mode=3). The most common pain sites were lower back, knee, shoulders and hip.

Pain is experienced most often at night, when walking and when going up and down stairs.

To explore the times at which people experienced pain, we included the pain items from the Nottingham Health Profile,[4] which requires respondents to answer "yes" or "no" to whether or not they are currently experiencing pain during the times/activities listed. The results are presented in Figure 1 (see p33).

Pain is experienced most often at night, when walking and when going up and down stairs – all of which affected approximately two-thirds of the pain participants. A third said they experienced constant pain, a fifth indicated that their pain was unbearable and 30 (14.9 per cent) said it was both constant and unbearable. Looking at these people more closely, there were more women than men and ages ranged from 40s to 85-plus years. All but one had consulted a practitioner about their pain in the previous year. The number of people consulted ranged from one to nine (M=2.5), and included pain specialist doctors (n=4), pain specialist nurses (n=5) and a neurologist (n=1). Only 11 of the 30 indicated they had a pain

Table 1. Number (per cent) of people indicating they had consulted specific health professionals regarding their pain

Practitioner	N (%)
General practitioner	186 (85.7)
Practice nurse	57 (26.3)
Physiotherapist	46 (21.2)
PHO-based LTC nurse	33 (15.2)
Massage therapist	13 (6.0)
Chiropractor	12 (5.5)
Osteopath	10 (4.6)
Specialist pain doctor	10 (4.6)
Specialist pain nurse	9 (4.1)
Acupuncturist	4 (1.8)
Orthopaedic surgeon	3 (1.4)
Rheumatologist	2 (0.9)
Nurse practitioner	2 (0.9)
Neurologist, Ora Kinetics clinic, podiatrist, urologist, Wellington Hospital, occupational therapist, hospital, kidney specialist, oncology, lymphoedema practitioner, orthotics, vocational therapist	1 (0.5)

Table 2. Location of chronic pain

Location	N (%)
Hip	95 (44.2)
Knee	113 (52.6)
Lower back	152 (70.7)
Upper back	39 (18.1)
Shoulders	98 (45.6)
Elbows	27 (12.6)
Wrists/hands	97 (45.1)
Ankles/feet	83 (38.6)
Internal	28 (13.0)
Head	24 (11.2)
Neck	88 (40.9)

plan, 10 did not and nine were unsure.

To convert responses into a score, predetermined weights were assigned to the "yes" responses. These were then added together to generate a scale where 0 represents good and 100 represents poor health. The mean score was 44.0 and the standard deviation was 28.4. Moderate-strength Pearson's correlations (which measure the strength of the association between two variables) were found between the Nottingham pain scores and GH (r=-.39), effect of LTCs on quality of life (QoL) (r=.42), PH (r=-.58) and MH (r=-.30). This suggested that the more circumstances under which pain is experienced, the poorer the health status reported and the greater the negative impact LTCs have on quality of life.

Pain in relation to health and quality of life

To examine the way having ongoing pain relates to self-reported health and quality of life, we compared those with pain to those without (see Figure 2, p33).

Here we see that, on average, people with pain reported poorer general, physical and mental health, and indicated that their LTCs have more of an impact on their QoL than people without pain. With respect to self-care challenges faced, we found that more of those with pain than without pain reported sleeping to be a challenge (51.7 per cent compared with 29.4 per cent) and more with pain than without pain reported anxiety/depression to be a challenge (30.3 per cent compared with 14.7 per cent).

ADVICE FROM STUDY PARTICIPANTS

'Use distraction therapy like reading a book, or watching a TV programme you enjoy.'

'Get all the help you can from everywhere, including using equipment.'

'Try to retain a normal lifestyle, ie outings, meetings, sport and exercise.'

'Use hot water bottle on back when sitting – relieves pain well.'

'Each morning when you wake, take a deep breath and remind yourself this is a marathon, not a sprint.'

'Take somebody to appointments with you – husband, partner, friend or relative – especially when you are in a lot of pain. They can do your talking for you.'

'Try to exercise each day, but know your limits.'

'Talking to others with similar issues helps.'

'Make sure you get your medications ahead of time so you are not stressed about running out.'

'Learn to listen to your body and don't force overdoing as it will take much more time to recover.'

Key points

- CHRONIC pain was experienced by more than half the participants.
- PEOPLE with pain had poorer health and indicated that their LTCs had a greater impact on their quality of life than people without pain.
- PAIN was most commonly experienced in the lower back, knee, shoulders and hip.
- A third said they were in constant pain and a fifth said their pain was unbearable.
- THE more circumstances in which people experienced pain, the poorer their self-rated health.
- SLEEP and anxiety/depression were bigger problems for people with pain than for those without pain.
- PEOPLE with pain who experienced sleep disturbance and/or anxiety and depression related to their LTCs managed their pain less well than others.
- PEOPLE who felt they were managing their pain well reported better health and rated their LTCs as having less impact on their quality of life.
- MOST people with pain did not have a pain plan or were unsure if they had one.

Pain self-management in relation to health and quality of life

Ratings of pain self-management ranged from 0 to 10 (M=6.9, mode=8). Again, moderate strength correlations with GH (r=-.39), effect of LTCs on QoL (r=.42), PH (r=-.58) and MH (r=-.30) were found. This suggested that people who perceived themselves to be managing their pain well had better health and considered their LTCs to be having less effect on their QoL than those managing less well. People who indicated that sleep was a challenge rated themselves as managing their pain less well than those who did not (M=6.4 compared with M=7.3). The same applied to those indicating anxiety/depression was a challenge (M=6.3) compared to those who did not (M=7.1).

Advice to others

Finally, we asked our participants what piece of advice they could provide to others and some examples are provided on page 32.

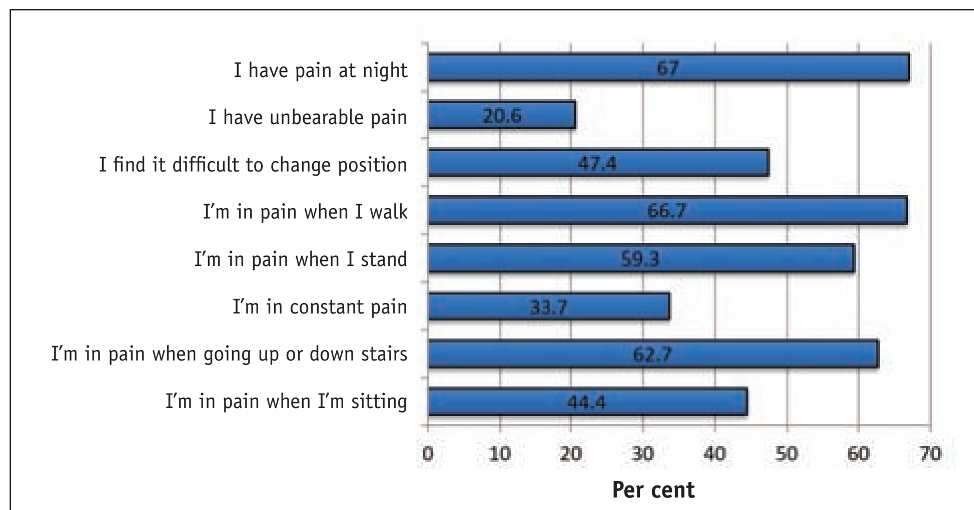


Figure 1. Per cent of 'yes' responses to the Nottingham Health Profile pain questions

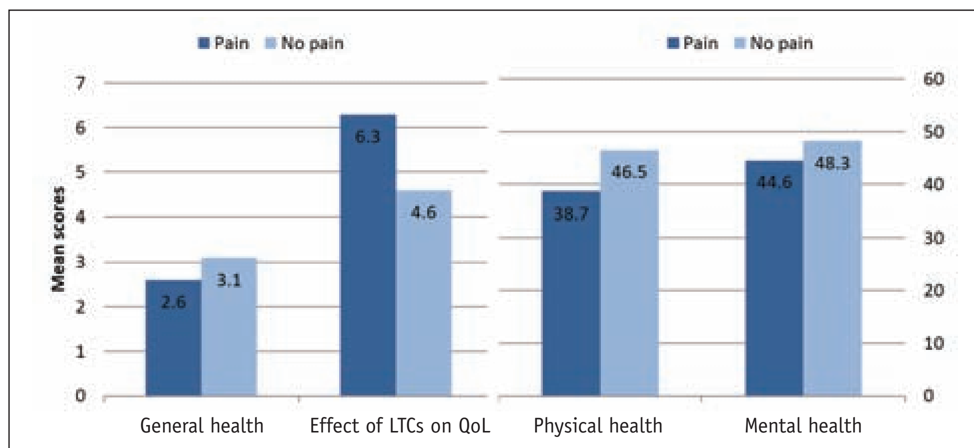


Figure 2. Mean score comparisons for people with and without chronic pain on measures of self-reported health and impact of conditions on quality of life

Practice points

- Think about what your primary care practice could do in the waiting area to encourage people to share their pain concerns. Is managing pain included in the brochures or posters on display? Is it on health TV or part of a questionnaire?
- Develop a pain plan in partnership with the client to enable them to identify goals and know what to do on bad days. Make sure they have a hard copy so they can refer to it at home to guide their self-management.
- Use a "what matters most" approach in the consultation to enable people to share their concerns about ongoing pain.
- Many people have benefited from attending the Stanford Chronic Disease Self-Management Programme. This six-week programme is available across most of New Zealand, and covers how to improve self-management knowledge, skills and confidence in general. Pain and managing the symptom cycle are key components. Some regions offer a chronic pain version of this programme.
- The Health Navigator site has very good information, resources and videos for managing chronic pain. Get to know it, so you can advise clients on how to use the site.
- Learn more about providing good self-management support from the self-management support tool kit (www.smstoolkit.nz).
- As many of the participants had arthritis, contact with Arthritis New Zealand may benefit them. They can ring 0800-663-463 for education and advice.
- A mobility action programme (MAP) is available in many areas; in Manawatu it is called the hip and knee mobility action plan. This is a community-based intervention for people with hip or knee osteoarthritis and/or lower back pain, focusing on learning long-term self-management.
- Some regions have dedicated services for chronic pain. Find out if there is a care pathway and what the referral criteria is in your region.

Discussion

From these results, we can see that chronic, or ongoing pain, was a major problem for many of our study participants, and its presence was associated with poorer ratings of health and LTCs having a larger impact on quality of life.

Chronic pain affects a much larger proportion of people than many practitioners realise. The latest New Zealand Health Survey found that one in five adults experience chronic pain.[5] Pain is a common co-morbidity for people with more generally acknowledged LTCs such as diabetes, and cardiac and respiratory conditions,[6] but is not always discussed during primary-care consultations. This can be because not all practitioners feel competent in managing pain. Or it may be because people themselves don't bring it up, as they assume that it is something they "just have to put up with" as a normal part of ageing, or they don't like the idea of taking pain medication.

Pain, especially in combination with sleep problems and depression as is often the case, can be extremely debilitating.

However, pain, especially in combination with sleep problems and depression as is often the case, can be extremely debilitating. As such, it warrants exploration during consultations, even if it is not broached spontaneously by the patient. The emphasis today is on patient self-management and for this, good self-management support – including recommendations of good websites and resources to use – is important. A good approach to providing self-management support for people living with pain is the strategy wheel devised by United States psychologists Richard Wanlass and Debra Fishman.[7]

Likewise, the need for regular review and follow-up is vital, and referral to other skilled practitioners, including the community pharmacist, may improve the management of people's chronic pain. •

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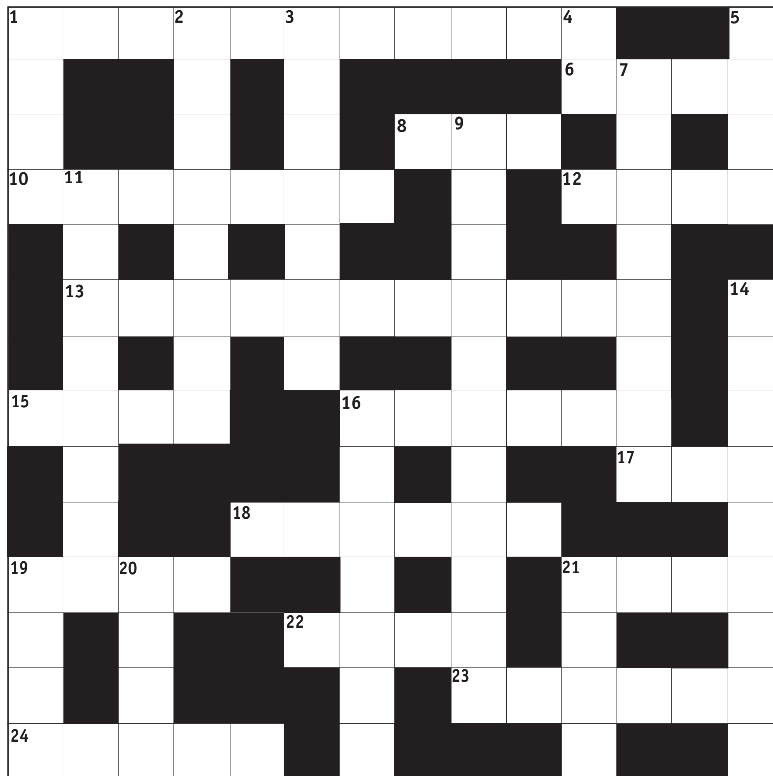
crossWORD

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



ACROSS
1) Family of viruses including common cold and COVID-19.
6) Greasy.
8) The earth below, the ___ above.
10) First artificial satellite in space, sent up by Soviet Union in 1957.
12) Sturdy footwear.
13) Waikato town, home to Tūrangawaewae marae.
15) Extremely.
16) Neck swelling, due to iodine deficiency.
17) Lair.
18) Extended family (Māori).
19) Imperial land measure.
21) Red planet.
22) Black coastal bird, seen perched on rocks.
23) Turn up.
24) Sweet-tasting food ingredient.

DOWN
1) Found on dairy farm.
2) Article about someone written after their death.
3) Worried.
4) Therefore.
5) Fluid-filled lump under skin.
7) Cut off from others.
9) Solidarity (Māori).
11) International disease outbreak.
14) Christchurch psychiatric hospital, closed in 1999.
16) Computer artwork.
19) Upper limbs.
20) Ladder step.
21) Night flying insect.

April answers. ACROSS: 1. Contraception. 7. Fold. 8. Overpaid. 10. Rangatiratanga. 13. Neon. 14. Axe. 16. Irate. 17. Ammonia. 19. Asleep. 20. Sigh. 22. Radiation. 23. Beach.
DOWN: 2. Nylon. 3. Abortion. 4. Eyebrow. 5. Tip. 6. Onion. 7. Forensic. 9. Handwashing. 11. Genitals. 12. Anxious. 15. Imperil. 18. Peer. 19. Acne. 21. Iris.

wiseWORDS

“A sister from the ward next to mine came to ask if we had any sputum mugs. When I said no, she asked, 'Well, what are your patients doing?' 'Spitting on the floor,' I replied. 'Well,' she said, 'mine will have to spit on the floor too!”

– Trainee nurse Winifred Muff, working at Christchurch Hospital in the 1918 flu epidemic

it's cool to kōrero

HAERE MAI – welcome to the May kōrero column. During level 4, the silence in formerly bustling city streets led some of Aotearoa's wild creatures to investigate. In April, a kārearea, (the New Zealand falcon, also called the bush hawk or sparrowhawk) was seen in central Wellington, hunting starlings and perching on office buildings. You can see kārearea on the New Zealand $20 note.

This bird of prey can fly faster than 100km/h and catch prey larger than itself. Electrocution on high-voltage electricity transformers is a major threat.

Kupu hou

New word

- **kārearea** – pronounced *"Car-rrre-(as in red)-ah-rrre-ah"*

New Zealand falcon

Whakataukī

Proverb

In Māori bird lore, the kārearea's cry was believed to foretell the weather:

Ka tangi te kārewarewa ki waenga o te rangi pai, ka ua āpōpō.
Ka tangi ki waenga o te rangi ua, ka paki āpōpō.

When a kārearea screams in fine weather, next day there'll be rain.
When it screams in the rain, next day will be fine.

(NB: "kārewarewa" is an alternative spelling.)

Rerenga kōrero

Phrases

Repeating two simple messages:

- **Horoi ō ringa. Mahia te hopi me te wai.**

Wash your hands. Use soap and water.

- **He waka eke noa.**

We are all in this together.

E mihi ana ki a Titihuia Pakeho and Keelan Ransfield.
Learn more about kārearea at www.doc.govt.nz/nature/native-animals/birds/birds-a-z/nz-falcon-karearea/

Defending Florence Night

A leading international Florence Nightingale scholar rebuts Grant Brookes' and Kerri Nuku's viewpoint on the founder of modern nursing, published in the April issue of *Kai Tiaki Nursing New Zealand*.

By Lynn McDonald

'Why we aren't celebrating Florence's birthday"[1] is a thoroughly nasty and outrageously inaccurate attack on Nightingale.

Of course New Zealand nurses should celebrate New Zealand nurses, certainly indigenous nurses. No contest. But vilifying Nightingale, who in fact was a leading anti-racist at a time when racism was rampant, is wrong.

Have a look at what she wrote that the authors misconstrue or omit. Note also their sexism, calling her – an adult woman – by a first name as if she were a child, while men get their surname and title (eg Governor Grey). Yet the authors claim to be speaking for "feminist nurses".

Lack of historical context

Some of the criticism levelled by Brookes and Nuku shows a gross lack of knowledge of historical context. Yes, Nightingale said that to be a "good nurse," one had to be a "good woman," a statement that would need to be re-worded to "person" to apply nowadays. One must realise that many British "nurses" in Nightingale's time were disreputable women, notorious for drinking on the job, taking opiates and demanding bribes for services. They were badly paid and their working and living conditions were appalling.

It is hard to imagine how any hospital would accept trained nurses from Nightingale's (or any other) school, if they could not count on them being sober on the job and honest. Nightingale wanted nurses to have decent pay, living and working conditions, and had to be able to supply reputable nurses to achieve that.

Nightingale's MP grandfather for decades worked with William Wilberforce on the abolition of the slave trade and slavery. She grew up with values of racial equality. Her *Sanitary Statistics of Native Colonial Schools and Hospitals*[2] gives a clear statement of that belief. She was appalled by the high death rates of indigenous school children, *"double that of English children"*.[2,3] They should not be higher and that they were, indicated bad living conditions. She argued: *"By far the greater part of the mortality is the direct result of mitigable or preventable disease."*[2] Those diseases should be prevented! This required practical efforts and research to see what worked.

Professor Lynn McDonald with the 16-volume *Collected Works of Florence Nightingale, 2001-2012*.

Much of the critique of Nightingale on race is an accusation that she used the terms of the time, not of the 21st century. But they were the terms of the scientific literature, not pejorative, which she never used. "Civilisation" and "civilized" referred to societies with permanent settlements, implying nothing about race. Clearly many non-white societies had cities, even very large ones.

The term "native" simply refers to being born in, as opposed to having come from another country. And terms change. When I worked with Canadian indigenous women on rights issues in the 1970s and 1980s, they had organisations with names like "Indian Rights for Indian Women" and "Native Women's Association of Canada". The latter is still a force.

Nightingale did refer to the "blessings of Christian civilization", but she also qualified it as "Christian in name, but far from Christian in reality", which is not mentioned in the viewpoint.

She agreed also that imperial rule was "violent," "overbearing," "self-seeking" and "oppressive".[4]

In a letter to Sir George Grey, she was

ingale's reputation

rude about the New Zealand missionaries: *"what idiots those missionaries, not the converts, must be".*[5]

Brookes and Nuku incorrectly accuse Nightingale, in her *Sanitary Statistics of Native Colonial Schools and Hospitals*, of explaining the high indigenous mortality rates in terms of the "discredited miasma theory". Discredited? Hardly. Miasmata were the physical habitats of unseen germs or bacilli. When Nightingale wrote *Sanitary Statistics*, bacilli had not been identified. That study (as did her earlier books) predates even Joseph Lister's 1867 breakthrough with antiseptic surgery (but even he did not use "germs" in the article). Acceptance of germ theory is commonly dated to 1879, with bacteriologist Robert Koch's publication of the "four postulates" theory.

In any event, belief in miasmata did not hinder disease prevention, for in getting rid of the disease-laden miasmata, one also got rid of the bacilli. The head of the Sanitary Commission that did the most to bring down the death rates in the Crimean War hospitals, Dr John Sutherland, only accepted germ theory after the discovery of the cholera bacillus, in 1883, when, also, Nightingale made the switch.

Training at her school, from 1860 on, included lectures, academic content that raised the educational level of nurses and probably helped to open up higher education for women.

Other misinformation

Nightingale did not oppose higher education for women, but actively supported it. But note that no higher education for women was available in the United Kingdom when she started her nurse training school. The first women university graduates (and then only a few) date to the 1880s. Training at her school, from 1860 on, included lectures, academic content that raised the educational level of nurses and probably helped to open up higher education for women.

The complaint about her not supporting nurse "registration" can be applied fairly only to the particular proposal for state registration advanced by the Royal British Nursing Association (RBNA), which had serious defects. It failed to protect the public, as no nurse could be removed, even on a criminal conviction or malpractice.

The RBNA was run by male doctors, with Queen Victoria's daughter Princess Christian as president but no nurses. Nightingale believed that nurses should run their profession, not doctors.

Recall that, in Nightingale nursing, nurses would take medical orders from doctors, for only doctors were qualified to diagnose. But nurse administrators should make all the decisions on hiring, dismissal, discipline and dismissal.

Did Nightingale foster *"the eventual dominance of the medical model of health,"* as Brookes and Nuku state? No again. She saw medical science as important, but so were public health measures: health promotion and disease prevention, principles she advocated throughout her life. Better to prevent disease than have to treat it after it sets in.

In *Notes on Nursing* (Conclusion) she could not have been clearer, that neither medicine nor surgery could "cure," but only remove the obstacles to healing: "*nature alone cures*."[6]

Nightingale complained that "nursing" used to signify little more than *"the administration of medicines and the application of poultices. It ought to signify the proper use of fresh air, light, warmth, cleanliness, quiet and the proper selection and administration of diet – all at the least expense of vital power to the patient."* (Introductory)[6] The nurse's task was to aid Nature, mentioned frequently in Nightingale's writing.[7] Brookes and Nuku have it backwards! •

Lynn McDonald is the director of the 16-volume *Collected Works of Florence Nightingale, 2001-2012* and a co-founder of the Nightingale Society. She did her PhD at the London School of Economics, is a Member of the Order of Canada, a Fellow of the Royal Historical Society and is now a professor emerita in sociology at the University of Guelph, Ontario. She has also been a successful health-care reformer. As a New Democrat MP, she authored Canada's Non-smokers' Health Act, 1988, the first legislation in the world to establish smoke-free work and public places.

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A 30-year chapter has ended

Cee Payne has worked for NZNO – and its predecessor NZNA – for close to 30 years. She reflects on the changes she has lived through over that time.

By co-editor Teresa O'Connor

Thirty years is a long chapter in the story of a person's life. That's the length of time NZNO industrial services manager (ISM) Cee Payne was with NZNA/NZNO and it was an action-packed chapter. Payne left NZNO last month.

While most of the characters may have changed, both the core values and the work have remained constant. And, given the time span, there's been plenty of action. As the lead character, Payne has played important roles in rebuilding nursing collective agreements shattered by the Employment Contracts Act (ECA) of 1991; developing industrial strategies and campaigns, notably in the private sector; and overseeing both large and smaller-scale negotiations.

Navigating political waters

She has had to navigate changing and, at times, treacherous political waters and has led the industrial services team (IST) for the last 15 years. That role has meant she's faced a number of challenges. And, now as this chapter in her life draws to an end, she has been helping develop NZNO's response to COVID-19.

Throughout her time with NZNO, Payne has been an upbeat, optimistic presence. Her values of caring for people, collectivism and solidarity, were shaped in her large family – she has eight siblings – and the left-wing Catholic community her family lived in during her teenage years with five other families in Christchurch. "We were exposed to left-wing thinking and were politically aware from a young age."

That early exposure has always shaped Payne's career – from her decision aged 16 to go nursing; to studying politics and sociology at university while nursing part-time in aged-care; to working for the Clerical Workers' Union with district health board (DHB) members. During that time, she chaired the Canterbury regional Combined Health Employees' Committee and was co-leader of a local action group to oppose the 1988 Gibbs Report (the blueprint for the subsequent National Government health reforms of the '90s).

When she began work as an industrial officer with NZNA in 1989, it felt like "coming home. That decision brought everything together in my life – my understanding of politics, of unions and health care were developed and I felt it was the perfect place for me. I thought 'this is my mahi'. It was significantly better than being a nun," she laughs.

The sense that her work with NZNO meshed her personal, professional and political backgrounds has stayed with her over the years, but she admits that as part of a management team she "can't shape everything that happens in NZNO".

When she began as a regional industrial officer, the organisation was small, with just eight regional officer staff and there was no separation between the industrial and professional arms. "I would give both industrial and professional advice. In those days we also represented members in the Coroners Court."

She is unsure whether the significant change to distinct industrial and professional staff has been the right course, but she believes, that in the workplace, organisers and professional nursing advisers work well together, bringing their respective knowledge to their representation of members.

Payne believes the ideal structure for NZNO is something that still needs to be grappled with. "There is no perfect solution and NZNO has been adaptable over my 30 years." After being an organiser, she became one of the organisation's first industrial advisers, a position she job-shared with Glenda Alexander. She had responsibility for the private sector and Alexander the public sector. "We still had a lot of contact with members in that role."

So why, 15 years ago, did she decide to take up the role of ISM? "Being a manager in a union is a challenge and I like a challenge. I wanted to lead the industrial services staff – I still continue to have a great affection for the staff in our team – and I wanted to build the industrial strength of other sectors of NZNO's membership. Members in the private sector, being much fewer, and across hundreds of workplaces, had always been the poor cousins when we amalgamated with NZNU. I wanted to see industrial strategies and collective bargaining developed for the aged care, private hospitals and primary health care sectors to deliver more equitable pay and working conditions, as well as increasing private sector membership."

Cee Payne

'NZNO members do not split themselves into professional and industrial halves . . . So many members' issues have both an industrial and professional component.'

Another significant change has been the shift in the nature of staff and management contact with members. Payne feels it is no longer as casual or as con-

nected as it was in the past. She recalls conferences when members and staff enjoyed dining and dancing together at annual conferences, and she laments the loss of a more open relationship with the board of directors and te poari.

"I feel much more distanced from the membership than I have ever felt. We are a member-driven organisation and are here to do the mahi that is most important for members. That has always been a huge motivator for me and something I really valued in the organiser role."

Managing a team of 60 industrial staff has been a roller–coaster ride at times – "mostly highs when looking back at the big picture. Working with a committed team of unionists doing amazing work and giving everything to work they believe in is very special."

She's proud the proportion of private-sector members has increased as a percentage of the overall membership and that NZNO is the fastest growing union in the country. "Every year for the last decade, membership has increased by an average of 1000 members. "This has been achieved by all NZNO staff working in all parts of the organisation and by members engaged in their sectors."

'Making things better for workers'

Payne has enjoyed being a strategic leader in the wider union movement. "I have enjoyed working at the leadership level. We all have the same, common goal – making things better for workers."

One of the undoubted highlights of her time was her involvement in the care and support workers equal pay settlement negotiations. "Having the opportunity to be part of those negotiations was hugely positive. Representing some of Aotearoa's lowest-paid, female-dominated workforces was something I felt passionate about. I will never forget working alongside Kristine Bartlett and other members of the negotiation team – it was a privilege."

One of the achievements she is proudest of was the establishment of the member support centre. "It has enabled more timely and consistent support to members. Our call advisers provide a very high standard of service and are ably led by Jo Stokker."

In 30 years, there have been plenty of challenges, not least of which was helping rebuild the national DHB multi-employer collective agreement (MECA) after the national award for public hospital board members was shredded by the ECA in 1991. And it was the negotiations for the last 2018 DHB MECA that provided one of the most challenging times of Payne's career.

"It was a very complex, challenging time that left me exhausted. As the union lead, I had a responsibility to hold up the negotiation team. Staff and delegates got hammered and some people tried to deliberately undermine the union. There were some difficulties regarding communications and campaigning resources; the negotiations took a lot of extra time; there was relentless media pressure; and there were several issues concerning others' behaviours, some of which haven't yet been resolved. I had never experienced anything like that. We just had to put our heads down and keep going."

And she points out that, like most women workers including nurses, she had family and other responsibilities to attend to at the same time.

Payne denies NZNO was behind the eight ball in terms of members' expectations for the last negotiations. "We were doing what had been largely successful for years. One day we knew the time would come when members would say, 'we want to go on strike'. We couldn't predict that time – we had to await the signal from members. When that signal came, we did everything we could to respond. I am proud of the negotiation team – it was extremely difficult for them all."

She welcomed Ross Wilson's independent report into the negotiations, and its 15 recommendations. "It was really helpful after such an extraordinary event. The most significant thing for us as NZNO leaders was to implement the lessons. This time we know what members want us to do differently and we are doing them." She believes time is a great healer and, as NZNO implements the changes identified in the report, trust will be rebuilt, both within the organisation and among members.

Payne said the last DHB negotiations had fired up members and they had been far more engaged than in previous years. "There had been a certain amount of apathy and just a small number of activists. Social media has given members more tools to organise and when they are used in an ethical way, they enable us to organise in new ways that increase members' voice and achieve members' aspirations."

Despite the turbulence of the negotiations, Payne said the outcome was a good one. Along with the pay increases, members won the commitment to a backdated pay equity settlement, the safe staffing accord and stronger levers to force implementation of care capacity demand management.

'There had been a certain amount of apathy and just a small number of activists. Social media has given members more tools to organise . . .'

On the eve of her departure, Payne has reflected on the health of NZNO. "There are positive signs, with both the high density of NZNO membership among nurses in all sectors and the significant growth of Māori members engaged in NZNO's hui ā-tau and other organisational structures – measures of increasing biculturalism and member engagement."

But she has some concerns about the lack of in-depth governance experience on the board of directors. "The constitution asks for people with governorship/directorship experience but there is now less experience in governance than when the board started [under the new constitution]. I think there should be some ability to co-opt independent members onto the board. A board with relatively limited governance experience is a risk for NZNO."

As this 30-year chapter drew to a close, Payne, was feeling "very positive and strong" about her choice to have a year to reflect on life, support her own whānau and do things that have long been on the back burner. The thought of 24 hours of freedom every day was energising. "NZNO whānau and union comrades across the union movement will be friends for life and I will simply never forget this amazing chapter in my life." •

Honouring the lessons of history

Māori nurses are working hard to protect their communities from COVID-19. One nurse draws parallels between her work at the Ministry of Health with that of her aunt a generation ago.

By Cherene Neilson-Hornblow

For most of my career I have worked in forensic, mental health and intellectual disability. In March, as COVID-19 threatened our country, a karanga (call) came from Te Rau Ora for Māori nurses and other health workers to kotahitanga (unite) against COVID-19. Newly established roles of kaitautoko (cultural and clinical leads) and a Māori rōpū were formed as we aligned ourselves with the Ministry of Health's Māori health directorate. Wih registered nurse Carmen Timu-Parata and myself at its head, we supported a diverse Māori rōpū of workers from different hapū and iwi on how to manage COVID-19 for our communities and all of Aotearoa.

As I took up this role, I began thinking about my aunt, pioneering Māori nurse and midwife Charlotte Bradshaw. In her day, she, too, had to work with the challenges of disease and infection.

Auntie Charlotte's work with World War II soldiers, leprosy and tuberculosis patients in the 1940s has, in some ways, given me a tohu, a sense of warning, to be vigilant about the current coronavirus pandemic. Charlotte had many gifts

Charlotte Bradshaw at Whakatāne Hospital, mid-1970s

– ngā taonga tuku iho o ngā tūpuna. I have come to admire greatly the care and responsibility she showed for those populations most at risk. She is a shining example of our tūpuna showing resilience and leadership embedded in our being, tikanga and te ao Māori.

Our whenua has been under a rāhui (lockdown) as a means of controlling the virus. Tikanga has been vital for this work. Through karakia, waiata, whakapapa, whakawātea and whakawhanaungatanga, we established links and made connections. Team relationships were strengthened so we could focus on resolving problems, providing rapid responses in a time-pressured environment, and ensuring safe realistic solutions.

Auntie Charlotte stood up to the challenges of her time. Now it's our turn and a reminder not to take things for granted, and to care about the things that matter, including our whānau, our community and Papatūānuku.

Given sufficient funding and resources, whānau, hapū, iwi and communities have the answers to improve their own health and wellbeing. If a stronger focus on equity is placed at the heart of health care, then everyone benefits. My moemoea (vision) is that one day a nationwide service will be established to collect and analyse high-quality ethnicity data for whakapapa protection, enabling early detection, rapid response and early intervention. The ultimate goal would be the creation of a First Nations' global indigenous pandemic response plan to protect future generations.

As my parents taught me: *Titiro whakamuri, Kia matarā ki nāianei, E ora ai ngā uri whakaheke* – Look to our past, be vigilant in our present, so that future generations may thrive. •

Charlotte Bradshaw – a pioneer in her time

Charlotte Bradshaw was a humble Māori registered nurse and midwife who, throughout her 40-year-long national and international career, was meticulous in everything she did. She dedicated her life to helping the most vulnerable in our communities – from those living with leprosy in isolated villages in Fiji to caring for wounded soldiers during World War 11. She became a mentor and role model for many.

Charlotte was born in 1921 in Waihou Valley in Northland. She was the third of nine children whose parents, Harata Rameka and William E Alexander, worked hard to put food on the table. She began working as a nurse aide in 1937 at the newly built Rawene Hospital, enticed there by one of the matrons, her aunt. The hospital was touted as "the best and most up to date in the country".[1] More women had begun having their babies at the hospital, leading to an increase in live births and a decrease in infant mortality.

Like many rangatahi, she soon felt the urge to leave her whānau and papākainga to work in an urban centre. She moved to Auckland to work at a private hospital, then to Rotorua Hospital where she cared for soldiers returned from World War II. A hospital matron encouraged her to complete her nurse training, which she did in 1947, followed by her maternity training two years later.

Charlotte began her overseas experience in Fiji where she nursed leprosy patients on Makogai Island. By 1948, there were 700 patients with leprosy living on the island.[2]

From 1949-1951 she was seconded to the Department of Island Territories in Rarotonga to work at the sanitorium for tuberculosis (Tb). In her history of Tb in the Cook Islands, Debi Futter-Puati found

the following:

"The frontal attack on Tuberculosis of the 1950s reached 63 percent of the total population, with 93.3 percent of the negative reactors to tuberculin receiving a BCG vaccine. The population coverage achieved by the campaign probably made an impact on the future low TB rates of the Cook Islands."[3]

Charlotte was sister in charge at the sanatorium, responsible for administration and training local people. In 1951, the local chief medical officer Thomas Davis wrote that Charlotte carried out her work diligently with intelligence and initiative. He would not hesitate to recommend her for employment as a nurse, he said.[3] Charlotte registered as general nurse in the Cook Islands in 1951 and as a midwife the following year.

Experience in Australia

When she was 31, she moved to Australia to maintain training at King George V Memorial Hospital for Mothers and Babies in New South Wales. In 1952, she completed a six-month postgraduate course in nursing of thoracic diseases at Sydney's Royal North Shore Hospital. She gained wide experience in both medical and surgical thoracic nursing. During this time she contracted Tb.

Charlotte's ethnicity often confused people. Some spoke to her in Greek or Italian thinking she was from those cultures. When she was in Rarotonga, some thought she must be Tahitian. Despite this, Charlotte was proud of her of Māori whakapapa.

Back in Aotearoa New Zealand in 1954, Charlotte worked for the Hawkes Bay Hospital Board as a general nurse. Superintendent I.H. Henderson described her in a character reference in 1955 as *". . . reliable, efficient and maintains a high standard for herself professionally including her appearance as immaculate. She has shown particular interest in teaching student nurses and has given them much guidance and encouragement."*

In 1957, Charlotte joined Auckland Hospital and worked with infectious diseases, specialising in medical, psychiatric and paediatric nursing. During this time she met her future husband, Warwick Bradshaw, a school teacher, at te reo classes at the University of Auckland.

In 1958, Charlotte returned to Rarotonga where she worked in general nursing. Warwick joined her there and, a few months later, they married. As job prospects were limited for professional couples in 1959, they moved to Whakatāne where Warwick completed a stint of rural teaching. Charlotte nursed at Whakatāne Hospital and tutored as a sister in obstetrics.

Charlotte and Warwick had no children of their own, but Charlotte became very close to many of the children she nursed. One of them was Amohaere

Amohaere Tangitu with Charlotte Bradshaw

Tangitu, who also began her career as a nurse aide. Before retiring in 2018, Amohaere was director of Regional Māori Health Services at the Bay of Plenty District Health Board.

In February this year she told me: "I met Sister Bradshaw in 1961 when I was 13 and spending seven months in Whakatāne Hospital children's ward. Sister Bradshaw was sister in charge and the only Māori nurse and midwife at the hospital."

Amohaere said she knew there was something special about Sister Bradshaw as she had a "beauty within. She would come onto the ward and hold my hand which reassured me. I never knew she was Māori but I knew she was different. She left a deep impression on me as a child – the way she connected with people.

"Many years later I returned to Whakatāne and we renewed our special bond. She would ask me to call her Charlotte but, out of respect, I continued to call her Sister Bradshaw and she called me Judith. I shared with her the Māori health strategy and initiatives I was involved in."

Amohaere's work bringing cultural perspectives and practices into health care, and making treatments culturally safe for Māori and all patients is described in *Bringing Culture into Care: A Biography of Amohaere Tangitu*.[4]

In the book, Sister Bradshaw is described as getting excited when hearing about the future directives for caring for Māori patients in mainstream hospitals.

Sister Bradshaw was vegetarian and practised Buddhism. She retired from nursing in 1985 and died in 2014, aged 93, at Whakatāne Hospital, survived by her husband Warwick.

In her last days she was comforted by the hospital's kahui kaumātua group, of which she was a member, who provided her with karakia and waiata. To the end of her life, Sister Bradshaw remained a role model to many. •

Acknowledgements: I thank the following people for their contributions to this article: Warwick Bradshaw, Amohaere Tangitu, Carmen Timu-Parata (national Māori adviser, Ministry of Health), John Wigglesworth, (chief executive Hokianga Health Enterprise Trust), and Te Kaunihera o Ngā Neehi Māori.

Cherene Neilson-Hornblow, RN, Ngāpuhi and Ngāti Porou, has worked in mental health, forensics and intellectural disability nursing for 25 years. She is currently a kaitautoko for COVID-19 at the Ministry of Health.

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Primary health care: Ratification underway

RATIFICATION FOR the primary health care multi-employer collective agreement (PHC MECA) is underway this month. The online ratification, which began on May 5, will close on May 19.

NZNO PHC industrial adviser Chris Wilson said those eligible to vote in the ballot were members working for employers who voted "yes" in the New Zealand Medical Association (NZMA) ratification for the MECA. This amounted to around 490 workplaces, she said, but that figure was changing daily.

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

Of six employers who had voted against the MECA, NZNO had talked to four informally about their concerns and they had changed their vote. NZNO entered formal "serious negotiations" with one employer, who had also changed their mind and, at press time, NZNO was still to talk to the remaining employer.

Wilson said some of these six employers voted against the MECA on principle, as they wanted a settlement that more closely reflected pay parity with district health board nurses. Others had financial concerns.

Four employers had not voted in the NZMA ratification and NZNO was following up with these employers.

Another 20 employers had not participated in the negotiations at all "despite many endeavours" to encourage them, Wilson said. Around 90 members were working for these 20 employers.

NZNO would continue to pursue these employers, who had a legal obligation to take part in negotiations as their employees had voted to be part of the PHC MECA.

All Green Cross worksites had ratified the MECA.

COVID-19 issues

Wilson said some issues were now emerging as a result of the COVID-19 pandemic, which had seen a significant drop in presentations to general practice. And accident and medical clinics which did not have enrolled populations would have lost all their Accident Compensation Commission work during the lockdown.

Some practice nurses were facing a temporary reduction in hours and some restructuring proposals were emerging, Wilson said. •

Nurse Maude members ratify agreement

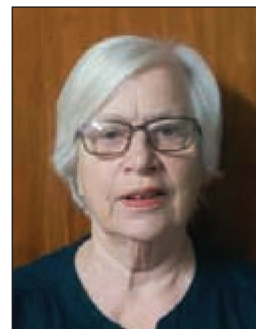
NZNO MEMBERS working for Nurse Maude have voted online for a collective agreement (CA) which delivers a 2.3 per cent increase across all current paid and printed rates (excluding those roles covered by the care and support workers' settlement), backdated to September 1, 2019.

After a partial strike involving district nurses in Canterbury had begun, and notice of a full 24-hour strike in early April had been issued, the employer asked to meet NZNO in late March. Nurse Maude presented a changed position but with no improvements on earlier offers, which members had rejected. During the negotiations, the Government announced the escalation to level-4 lockdown.

Organiser Helen Kissell said members had made a "pragmatic decision" to ratify the CA, given the limitations imposed by the COVID-19 restrictions and because the agreement would expire on August 31, 2020. "I'll be initiating bargaining for the next CA next month," she said. •

Long-serving delegate marks 70th birthday

LONG-SERVING NZNO delegate and enrolled nurse in operating theatres (OTs) at Capital and Coast District Health Board (DHB), Jenny Kendall (below), has turned 70. Ironically, turning 70 during the COVID-19 pandemic meant she was unable to continue practising in OT but was happy working to support nursing and nursing policy.



As well as celebrating her 70th birthday late last month, Kendall, who still works full-time rostered and rotating shifts, marked 45 years working in the DHB's OTs on May 5. "That makes me feel ancient," she laughed.

She has never felt inclined to move out of the specialty. "I love the variety."

Kendall has been involved with NZNO and its predecessor NZNA since the early '70s and has had a range of roles. She is currently one of the lead delegates at the DHB. She served on NZNA's executive committee for a decade until 1996 – the first nurse below the rank of nursing supervisor to be elected to that committee.

She was involved in the establishment of the national EN committee and well remembers the 1976/77 battle opposing the Nursing Council's plan to cut the registered community nurse training to a year. A survey of all such nurses in the country was answered by 91 per cent of them – all opposed to the change.

"That was the first concerted action which got us started as a national group," she said. She received a service to NZNO award last year.

Kendall has also been involved for years in sourcing and supplying medical equipment to the Pacific Islands, notably Tonga. She is also a voluntary director of the Medic Alert Foundation.

Organiser Jo Coffey said Kendall had been a stalwart of NZNO/NZNA throughout her career. A small birthday celebration is planned once COVID-19 restrictions are lifted, Coffey said. •

DHBs: Negotiations to start next month?

BARGAINING FOR the next NZNO/district health board multi-employer collective agreement (DHB MECA) may start next month, under a recently-developed NZNO timeline.

Under the timeline, bargaining will be initiated on June 1, with the first set of negotiations due to begin on June 23, with another set on July 7. The current DHB MECA expires on July 31.

NZNO DHB industrial adviser David Wait said members had made it clear they wanted bargaining to begin before the current MECA expired. Wait said the timeline was realistic from NZNO's point of view. "We are prepared to begin negotiations then. It remains to be seen whether DHBs will be but, as this is an important issue for our members, we expect DHBs to be just as keen to negotiate." He pointed out that DHBs had a legal obligation to negotiate.

Negotiations could take place under lockdown. "There is nothing to prevent bargaining in lockdown. Obviously it is better to be in the same room to pick up all the nuances involved in negotiations but they could be done virtually and NZNO would be willing to do that."

An online claims survey began late last month and was to close on May 17. Endorsement of the claims, the 12-strong negotiating team and the ratification process, would take place online between May 24 and June 6, with the final claims and issues paper ready on June 7.

The timeline indicates meetings will be held in late August to update members on the progress of the negotiations.

Twenty-five people were nominated for the bargaining team and the national delegates' committee (NDC) selected 12, who have to be endorsed by members. Wait was pleased at the number nominated and said all 25 were of a high calibre. The negotiating team was a strong one, he said.

Those selected by the NDC are: Waikato DHB health care assistant Rhonda Hare; Southern DHB mental health nurse Matewai Ririnui; MidCentral DHB registered nurse (RN) Grant Cloughley; Tarankai DHB community mental health nurse Jenni Rae; Hutt Valley DHB clinical nurse consultant Hutt Valley DHB Julie Pritchard; Capital and Coast DHB enrolled nurse Angela Crespin; Bay of Plenty DHB clinical nurse specialist (CNS) Cheryl Hammond; Southern DHB RN Nigel Barr; Canterbury DHB CNS Karen Marshall; midwife at Pukekohe Primary Birthing Unit Judith Couch; Hauora Tairawhiti RN Camille Collier; and Waitemata DHB charge nurse manager Geraldine Kirkwood. Full profiles are at: https://campaigns.nzno.org.nz/bargaining_team. •

Supporting members through COVID-19 issues

HEALTH UNIONS and district health boards (DHBs) have agreed on a document covering COVID-19-related changes in the workplace.

NZNO DHB industrial adviser David Wait said it was a set of principles to be followed when there were changes in the workplace arising from COVID-19. The key points to note were: the primacy of the NZNO/DHB multi-employer collective agreement; that consultation may happen quickly, but must still happen in accordance with the MECA; and that changes to place of work, eg working in another facility, were only included in the document in relation to staff safety.

NZNO has developed advice for members asked to work in other facilities, including non-DHB workplaces. Among the key points are:

- This is voluntary. Members can be asked, but not directed to do so.
- Terms and conditions of work under the NZNO/DHB MECA, eg hours of work and penal rates, still apply.
- NZNO advises members to volunteer only if they feel safe to practise in the non-DHB environment, based on their nursing experience.

The document is available on NZNO's website: www.nzno.org.nz. •

Charging for carparking 'mean-spirited'

NZNO SAYS all district health boards (DHBs) should continue offering free parking to all essential workers now Aotearoa New Zealand had moved from rahui (lockdown) level 4 to level 3.

NZNO kaiwhakahaere Kerri Nuku said it was disappointing Auckland, Waitemata and Northland DHBs had again started charging health workers for parking after the country moved down alert levels. Other DHBs had not re-introduced such changes.

"In a time when we're being asked to act with kindness, this decision feels opportunistic and a little bit mean-spirited.

"Just because DHBs are returning to business as usual as we move into rahui level 3, that doesn't mean COVID-19 is any less of a challenge for our frontline people," she said.

In fact, NZNO said health-care workers, particularly in surgical and critical care areas, were concerned the move to level 3 would increase workloads, as people with non-COVID-19 related health issues sought treatment.

"This will worsen the pressure felt by our already stressed and fatigued frontline staff, Nuku said.

In addition to alleviating their stress, extending free parking would be a small but concrete way of showing appreciaiton to nursing staff. She urged DHBs, in the International Year of the Nurse and Midwife, to show a "little bit of kindness" by extending free parking until at least the end of May. She commended the DHBs that had chosen "not to treat nurses as a source of income at this time". •

Kai Tiaki NURSING NEW ZEALAND

writing guidelines

Guidelines for writing articles for *Kai Tiaki Nursing New Zealand*

We welcome articles on subjects relevant to nurses and nursing, midwives and midwifery. These guidelines are designed to help you write an article which is accurate, clear, easily read and interesting.

The main reason you want an article published in *Kai Tiaki Nursing New Zealand* is so other nurses/midwives will read it and hopefully learn something valuable. Therefore the subject must interest nurses/midwives and be written in a way that will appeal to them.

The essence of good writing is simple, effective communication – a good story well told. Even the most complicated nursing/midwifery care scenario, theory of nursing/midwifery practice or research study can presented in a straightforward, logical fashion.

This list should help you construct an article that will be read, understood and appreciated.

• **Always remember who your reader is.** Your readers are nurses/midwives, so what you write must be relevant to and understood by nurses/midwives. The focus of your article must be what the nurse/midwife does, how the nurse/midwife behaves, what affects the nurse/midwife. If you are writing about a new technique in your practice area, explain how it changes nursing/midwifery practice and its advantages and disadvantages to the nurse/midwife and patient/client. If you are discussing a theory of nursing/midwifery practice, link this to concrete examples of working nurses/midwives.

• **Avoid using big words, complicated sentences and technical jargon.** They don't make you smarter or your article better. Writing clearly and plainly is your goal. Widely used nursing/midwifery terms are acceptable, but avoid overly technical jargon. American writer, editor and teacher William Zinsser stresses the need for simplicity in writing: *"We are a society strangling in unnecessary words, circular constructions, pompous frills and meaningless jargon."*[1]

• **These questions will help you pull together all the relevant information needed for your article: Who? What? Why? When? Where? How?** Don't assume all other nurses/midwives know the ins and outs of your particular area of practice. If you are unsure about how to express a particular idea or technique, think how you would explain it to a student nurse/midwife.

• **Maximum length is 2500 words,** which, with illustrations, fills three pages of *Kai Tiaki Nursing New Zealand.* Longer articles need to be discussed with the co-editors.

• **References should be presented in the APA style.** Some examples:

Articles:

Sampson, M. (2013). Seeking consistency when managing patients' pain. *Kai Tiaki Nursing New Zealand; 19*(5), 26-28.

Bryant R. (2012). Nurses addressing access disparities in primary health care. *International Nursing Review; 59*(152). doi:10.1111/j.14667657.2012.01003.x

Books:

O'Connor, M. E. (2010). *Freed to Care, Proud to Nurse: 100 years of the New Zealand Nurses Organisation.* Wellington: Steele Roberts.

Websites:

Ministry of Health. (2010). *Cancer Control in New Zealand.* Retrieved from http://www.moh.govt.nz/cancercontrol

• **Submit your article via email** (to coeditors@nzno.org.nz). Type with double-spacing and wide margins and include your name, address, phone number/s, current position and nursing qualifications.

• **Photographs and illustrations are welcome.** They need to be high-resolution, at 300dpi, and at least 200kb or more. We prefer jpeg format; send them as attachments to an email rather than in the email itself. Cartoons and diagrams are also welcome, and we can also use black and white or colour prints.

• **Most clinical articles are reviewed** by ***Kai Tiaki Nursing New Zealand*** co-editors and two clinicians with expertise in the subject the article explores. Authors will be informed of the outcome of the review and the reasons why their article was accepted, rejected, or requires more work.

• **Contributors assign copyright to NZNO.** If an article is accepted for publication, copyright is automatically assigned to NZNO. Permission to republish material elsewhere is usually given to authors on request, but manuscripts must not be submitted simultaneously to other journals. •

Reference

1) Zinsser, W. (2001). *On Writing Well. The Classic Guide to Writing Nonfiction* (25th anniversary edition). New York: Harper Collins.

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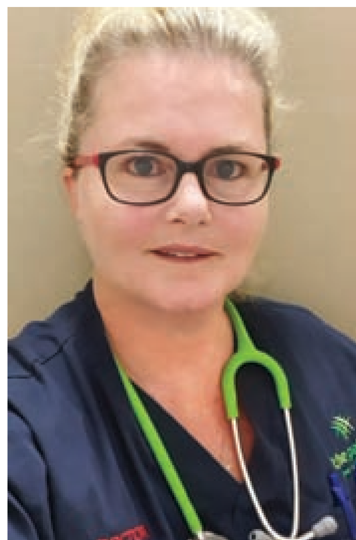

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- To provide an incentive for them to remain nursing in Aotearoa New Zealand.

Nomination criteria:

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

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

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

There is a two phase nomination assessment process:

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

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

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

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

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

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

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

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

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Akenehi Hei Memorial Award

Nominations are now open for the Akenehi Hei Memorial Award. Te Akenehi Hei Award is the highest award of honour for Te Rūnanga o Aotearoa, New Zealand Nurses Organisation (Te Rūnanga) which is awarded every two years at the Indigenous Nurses Aotearoa Conference.

The Award was commissioned by Te Rūnanga in 2001 and is an NZNO award, under the kaitiaki of Te Rūnanga.

Eligibility of candidates

This award is available to all Māori Nurses (does not have to be an NZNO member).

Key Criteria

Based on the information provided when considering the successful candidate, the kōmiti is required to determine the candidate's suitability and "significant contribution to Māori Health", using the following criteria:

- **Rangatiratanga :** Leadership role/positions influencing positive health and wellbeing outcomes for Māori – Whānau, hapū, iwi, urban Māori towards Whānau Ora.
- **Whanaungatanga :** Ability to connect with others and establish effective working caring relationships – whānau, hapū, Iwi, urban Māori – towards Whānau Ora
- **Kaitiakitanga :** provision of guidance, support, ability to empower and care for others ie education, mentorship, engagement, whānau, hapū, Iwi, urban Māori – towards Whānau Ora
- **Kotahitanga:** demonstrates ability to promote Unity and establish collaborative working relationships to improve the health and well-being outcomes of Māori and others - whānau, hapū, Iwi, urban Māori – towards Whānau Ora.

Information on Akenehi Hei Memorial Award are available on the Te Rūnanga o Aotearoa, NZNO website
https://www.nzno.org.nz/groups/te_runanga/awards#TeAkenehi

The online nomination form can be found below:
https://www.nzno.org.nz/support/scholarships_and_grants/akenehi_hei_memorial_award

NOMINATIONS CLOSE FRIDAY 29 MAY 2020 at 5:00pm

MARGARET MAY BLACKWELL

TRAVEL STUDY FELLOWSHIP AWARD FOR NURSES OF YOUNG CHILDREN

Nominations from employers are invited for this prestigious award:

- Up to $10,000 is available to fund a nurse working in early childhood health to undertake a project related to the topic of primary health care in child health nursing (0-5 year olds).
- The successful applicant is expected to disseminate information gathered for the benefit of early childhood health in New Zealand

All applications must be emailed to: **grants@nzno.org.nz**
Website: **http://www.nzno.org.nz/support/scholarships_and_grants**

Applications close at 4.00pm on 17 July 2020

THE NEW ZEALAND NURSING EDUCATION AND RESEARCH FOUNDATION

Need information, advice, support?

Call the NZNO Member Support Centre

Monday to Friday 8am to 5pm
Phone: **0800 28 38 48**

A trained adviser will ensure you get the support and advice you need.

If you have an issue related to your employment or nursing practice including: a Police, Coroner's, Nursing Council, Disciplinary or Health and Disability Commissioner investigation, seek support from NZNO.

www.nzno.org.nz

For more Events & Reunions go to www.kaitiakiads.co.nz

DISCLAIMER: Recruitment Agencies: Kai Tiaki Nursing New Zealand accepts advertising from nurse recruitment agencies but cannot guarantee the quality of their service, however, we expect agencies to provide a good service and that their advertisements should not be misleading. Complaints about poor service from advertised agencies should be directed to: Co-editors, Kai Tiaki Nursing New Zealand, PO Box 2128, Wellington 6140. Ph 04 4946386. These complaints will be treated confidentially but the nature of them will be passed on to the agency concerned.

Directory

Have you changed your address, workplace, name or phone number? Please let NZNO know of any such changes so our records are accurate and you receive *Kai Tiaki Nursing New Zealand* and other important NZNO information. It doesn't cost anything to let NZNO know — just ring 0800-28-38-48 or fax 04 494 6370 or 0800 466 877, anytime, day or night. Post the information to NZNO membership, PO Box 2128, Wellington or email: membership@nzno.org.nz

NATIONAL OFFICE

L/3, 57 Willis St, PO Box 2128,
Wellington 6140.
Freephone 0800 28 38 48 fax (04) 382 9993,
website: www.nzno.org.nz
email: nurses@nzno.org.nz.

Memo Musa (chief executive), David Woltman (manager, corporate services), Mairi Lucas (manager, nursing & professional services), Suzanne Rolls, Anne Brinkman (professional nursing advisers), Leanne Manson (policy adviser - Māori), Heather Woods (librarian/records manager), Margaret Barnett-Davidson, Sarah Eglinton (lawyers), Rob Zorn (communications/media adviser).

REGIONAL OFFICES

WHANGAREI
Julie Governor, Odette Shaw, The Strand, Suite 2, Cameron St, PO Box 1387, Whangarei 0140. fax (09) 430 3110, Freephone 0800 28 38 48.

AUCKLAND
Carol Brown, Christine Gallagher, Fuaao Seve, Sarah Barker, Craig Muir, Sue Sharpe, Christina Couling, Andy Hipkiss, Donna MacRae, Sharleen Rapoto (organisers), Rob George (educator), David Wait (industrial adviser), Margaret Cain (competency adviser), Angela Clark, Kate Weston, Catherine Lambe (professional nursing advisers), Sue Gasquoine (researcher/nursing policy adviser), Param Jegatheeson (lawyers), Katy Watabe (campaigns adviser).
11 Blake St., Ponsonby, Auckland, PO Box 8921, Symonds Street, Auckland 1150.
fax (09) 360 3898, Freephone 0800 28 38 48.

HAMILTON
Georgi Marchioni, Anita Leslie, Lisa Fox (organisers), Rob George (educator), Lesley Harry (industrial adviser), Annie Bradley-Ingle (professional nursing adviser).
Level 1, Perry House, 360 Tristram St, PO Box 1220, Hamilton 3240.
fax (07) 834 2398, Freephone 0800 28 38 48.

TAURANGA
Paul Mathews (lead organiser), Sharon Andrews, Kath Erskine-Shaw, Veronica Luca (organisers), Selina Robinson (organiser/educator).
141 Cameron Road, Tauranga, 3112 Freephone 0800 28 38 48

PALMERSTON NORTH/ WHANGANUI/TARANAKI/HAWKES BAY
Lyn Olsthoorn, Donna Ryan, Stephanie Thomas, Sue Wolland, Hannah Pratt, Gail Ridgway (organisers), Wendy Blair (professional nursing adviser), Angelique Walker (educator), Manny Down (Māori cultural adviser).
PSA House, Suite 1, Floor 1, 49 King St, PO Box 1642, Palmerston North 4440.
fax (06) 355 5486, Freephone 0800 28 38 48.

WELLINGTON/WAIRARAPA
Jo Coffey, Laura Thomas, Drew Mayhem, Penny Clark (organisers).
Findex House, 57 Willis St.,
Wellington 6011, PO Box 2128, Wellington 6140. fax (04) 472 4951,
Freephone 0800 28 38 48.

NELSON
Denise McGurk, Daniel Marshall (organisers), Jo Stokker (lead adviser, member support centre), Shannyn Hunter (call adviser, member support centre).
Ground Floor (south), Munro State Building, 190 Bridge St.
PO Box 1195, Nelson 7010. fax (03) 546 7214, Freephone 0800 28 38 48.

CHRISTCHURCH
Lynley Mulrine (lead organiser), Helen Kissell, John Miller, Lynda Boyd, Tracey McLellan, Danielle Davies, Tracie Palmer (organisers), Chris Wilson (industrial adviser), Julia Anderson, Marg Bigsby (professional nursing advisers), Jinny Willis (principal researcher), Kiri Rademacher, Sophie Meares (lawyers), Maree Jones (CCDM co-ordinator).
17 Washington Way, PO Box 4102, Christchurch 8140.
fax (03) 377 0338, Freephone 0800 28 38 48.

DUNEDIN
Glenda Alexander (acting manager, industrial services), Simone Montgomery, Celeste Crawford, Karyn Chalk, Colette Wright (organisers), Mike Yeats (industrial adviser), Michelle McGrath (professional nursing adviser), John Howell (educator), Jock Lawrie (lawyer).
Level 10, John Wickliffe House, 265 Princes Street,
PO Box 1084, Dunedin 9054.
fax (03) 477 5983. Freephone 0800 28 38 48.

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TE TAI POUTINI – VACANT

SOUTHERN/TE TAI TONGA – MATEWAI RIRINUI email: m.ririnui@hotmail.com

TAI TOKERAU – MOANA TEIHO email: mojo.teiho48@gmail.com

BAY OF PLENTY, TAIRAWHITI – ANAMARIA WATENE
email: anamaria.watene@bopdhb.govt.nz

TOP OF THE SOUTH – VACANT

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ANDREA REILLY (VICE-CHAIR) email: andrea.reilly@westcoastdhb.health.nz

SECTIONS & COLLEGES Go to www.nzno.org.nz. for a list and contact details of NZNO's 20 sections and colleges - colleges and sections are listed under Groups. You can then visit the home page of each section or college and download an expression of interest form.

"We can make a difference."

– Sarah, Health Centre Manager

Sarah joined Corrections five years ago. Prior to nursing in prison, she was a nurse in an emergency department. After 15 years she felt like she needed a change.

"No day is ever the same at Corrections. More often than not, offenders haven't seen a doctor for a long time. There is no limit to what we might deal with in a day, it might be administering medication, helping with mental health and addiction concerns, a toothache or a cardiac arrest.

"In this role, there's a little bit of everything. There are educational opportunities to progress. Nursing inside Corrections is getting big, and there's a lot of support there for ongoing learning.

"The essence of nursing in prison isn't just treating people for their health problems, we're also caring for their safety, their overall wellbeing, their future and their children's future. We can make a difference and we do make a difference".

Corrections is looking for nurses ready to make a difference.

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ARA POUTAMA AOTEAROA
DEPARTMENT OF CORRECTIONS

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