Kai Tiaki NURSING NEW ZEALAND

September 2020 vol 26 no 8

PHC nurses

striking for pay parity

- Profiles of mental health nurses
- Self-managing type 2 diabetes
- Crisis at Canterbury DHB

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AS USUAL, the September issue focuses on mental health nursing. There are profiles of mental health nurses working in a range of roles; and articles on those with mental illness missing out on specialist palliative care; on trauma-informed mental health care; and a dedicated education unit expanding to include mental health and addiction services. Professional education looks at self-management of type 2 diabetes.

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

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

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

This issue . . .

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

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Back to the future . . .

By acting associate professional services manager Kate Weston

Recent events at Canterbury District Health Board (DHB) are a chilling case of déjà vu. They are reminiscent of the so-called "health reforms" of the 1990s. Against the spectre of lingering COVID-19, the board has launched a health-care budget that slashes nursing numbers and medical staff and retrenches patient services.

Seven of the executive leadership team, including executive director of nursing Mary Gordon, chief medical officer Sue Nightingale and chief executive David Meates, have resigned. The loss of such key people and the board's decision to prioritise deficit management will have ongoing health effects. (See p8.)

Nurses under even greater stress

Nearly one third of proposed cuts – a loss of $16.6 million – are aimed squarely at the nursing budget and roughly equate to 200 nursing jobs.[1] This magnitude of cuts will place nurses under even greater stress. Particularly disappointing is the application of an accounting formula to determine nursing requirement. This disregards the validated tools and methodology of care capacity demand management (CCDM). It is also well outside the spirit of the safer staffing accord.

Prior to the State Services Act 1988, nursing leadership in Aotearoa was recognised. The triumvirate of matron, hospital superintendent and chair of the hospital board was a basic model of clinical governance. Then came the "health reforms" of the 1990s. I was working in a crown health enterprise and can recall the chaotic environment – roles changing from one day to the next and senior nursing positions disestablished. People with no understanding of health were brought in to run the "business" with a view to profit. The resulting nationwide loss of nursing leaders, with decades of clinical and institutional knowledge, was a critical blow to nursing and patient care. Some say the profession has never fully recovered. The emphasis on financial performance and the devaluing of nursing apparent then is again beginning to be a feature of our health landscape.

Without strong, visible nursing leadership, patient care ultimately suffers. Without a nursing voice at executive level, financially-based decisions at the expense of high-quality patient care can go unchallenged. The end result of such an approach was starkly illustrated in the 2013 Francis Report into the National Health Service's Mid Staffordshire Trust.[2]

Closer to home, in the winter of 1996, seven people died needlessly in Christchurch Hospital. A report by the then Health and Disability Commissioner Robyn Stent labelled the service as "dysfunctional and grief-stricken".[3] Stent's investigation came after multiple warnings from clinical staff and professional organisations. She recognised the damage done by cost cutting and the loss of clinical expertise, resulting in serious adverse outcomes and preventable deaths. Experienced Canterbury DHB nurses and doctors are drawing parallels between the circumstances that led to those tragic outcomes and the current budget cuts.

It is disturbing that not only in the beleaguered Canterbury DHB but across the country, there are proposals to decrease/ devalue senior nursing roles. Most DHB directors of nursing have a professional leadership but not an operational role. Most have little or no budgetary authority and some are not even at the executive leadership table – yet they lead the largest health workforce.

Mary Gordon is a recognised nursing leader – a passionate advocate for advancing nursing practice at all scopes and levels. Her collaborative approach has fostered great work in the Southern region. NZNO thanks Mary for her valiant work supporting nursing and improving patient care.

The emphasis on financial performance and the devaluing of nursing apparent then is again beginning to be a feature of our health landscape.

In this Year of the Nurse and Midwife, the loss of such strong nursing leadership and the slashing of nursing budgets are bitter blows. We need to again sound the warning that without nursing leadership and valuing the role of nurses, patient care is severely compromised. And that decline in care is apparent and measurable. Research indicates that when care is rationed, nurses endeavour to preserve life, but pressure injuries, preventable falls and infection rise sharply.[4] A focus on budgetary compliance without due consideration of the impact on the patient shows a blatant disregard for those who have no voice at the table – the ill and disabled.

It is election year. We are little more than a month away from election day. Health has to be front and centre for voters this year. Kate Sheppard won the vote for women – please use it. •

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Tell us what you think

Appreciation for article on spiritual care

THANK YOU Linda Christian for your thought-provoking article "Making space in education and practice for spiritual care", (*Kai Tiaki Nursing New Zealand*, August 2020, p30-33).

This is an especially important aspect of end-of-life care, in order to deliver holistic, ethical and culturally sensitive care. Also, incorporating spiritual education into nurse education may help with the resilence required when managing death and dying.

It takes compassion and focus on patients as unique individuals to provide holistic care.

Jan Maguire, RN (palliative care),
Wellington

And thanks for the van

MANY THANKS to Britz rentals, through the primary health care (PHC) group email, for offering camper van rental at favourable rates in appreciation of the work of PHC nurses during lockdown.

With shift work allowing me to work around conditions of hire, we travelled from Dunedin to pick up our van in Christchurch and had a wonderful four days freedom camping and rediscovering the top of the West Coast.

Our campsites included a Department of Conservation one in the Lewis Pass, sharing a starry night with busy moreporks and being lulled to sleep by the nearby stream.

In another, we watched a wonderful sunset over the Tasman Sea from 800m up on the Denniston Plateau, drink in hand, heater keeping us toasty warm, as we appreciated the hardships early occupants of the area endured.

With plans for retirement and extended travel to visit family overseas now on hold due to COVID-19, we are investigating purchasing a camper van for more local adventures!

Thanks to Tourist Holdings Ltd for their appreciation of our work . . . and here's hoping NZNO's PHC negotiating team can get us a multi-employer collective agreement that is as appealing as the agreement Britz has delivered!

Teresa Wasilewska, RN,
Dunedin

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.

Māori and Pacific nurses wanted

I WOULD like to thank all those who responded to my request for participants and those who have assisted so far with my PhD research into the characteristics, experiences and career trajectories of New Zealand nurse leaders.

The themes emerging from the data so far show potential to inform future leadership development of nurse leaders in Aotearoa New Zealand. This is such an important topic, and a larger and more diverse sample would strengthen the value of the findings.

I am therefore continuing to seek survey participants, particularly Māori and Pacific registered nurses (RNs), to ensure the research represents the body of nursing in New Zealand, and to shed light on meaningful differences in experience.

Those I am seeking are RNs with a minimum of three years' experience in a leadership role that requires others to report to them, where they are responsible for the work of others or are in a senior academic/policy position.

If you can assist, please email me at: dmlokerr@gmail.com for further information and the survey link.

Dianne Kerr RN, MHC,
Whanganui

Help available for hardship, including COVID-19 hardship

IN THESE challenging times of COVID-19 restrictions, many people are experiencing financial hardship. We are writing to highlight the help available from the New Zealand Nurses' Memorial Fund (NZNMF). The NZNMF is closely allied with NZNO and its philosophy is that it is there to help when social services and someone's own resources are not enough to meet their needs.

The NZNMF was established as a benevolent fund in 1917 in memory of the 10 nurses lost in the sinking of the *Marquette*. It has supported many nurses in times of financial hardship and emergencies for more than 100 years. We welcome applications from nurses with at least two years' post-registration experience in New Zealand.

The fund's income comes from interest on its investments and also from bequests, donations and membership subscription. You can become a member ($10 a year) or life member ($100) and support the fund to help others. You can also encourage donations and bequests.

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

Helen Williams,
On behalf of the NZNMF committee, Dunedin

Board candidate apologises: In last month's issue (p43), board candidate Diane McCulloch, in her supplied profile, stated she was a trustee of NERF (The Nursing Education and Research Fund). She is, in fact, a member of the Auckland Nurses' Education and Research Trust (ANERT) and Pollard Fund. She apologises for this error.

The kaiwhakahaere comments

By Kerri Nuku

THERE HAS been a lot of talk about equity and institutional racism within the health sector since the recommendations from the Waitangi Tribunal Kaupapa Māori Health Services Inquiry (Wai 2575). This view and justification for a "system change" is also clearly referenced in the Health and Disabilities System Review (*The Simpson Report)* released in July.

We seem to take comfort in *talking* about a system change to eliminate racism and the health system's failure for Māori. Yet, when it comes to putting system change into practice, we have a far harder time doing, let alone even speaking about, what is required to dismantle the deeply entrenched structures that perpetuate racism and inequities.

That is not to say these reports are unimportant. *The Simpson Report*, for instance, illuminates some crucial issues within the health-care system, such as the strain staff are feeling, faced with increasing demands and shortages in supply. It also acknowledges the increasing demands of changing populations and highlights the urgency of making improvements for Māori, Pacific, low-income and rural households. But most significantly for us, it talks about the need to establish a Māori Health Authority.

Yet the needs of these communities are often invisible to urban decision-makers who are so disconnected from our lived realities. It is, therefore, no surprise we are seeing such underwhelming and negative reactions to the prospect of establishing a Māori Health Authority. On the one hand, there are those who dismiss it outright as unfair privilege and, on the other hand, others accept that need for an authority but attempt to water down what it could do.

Over my time, I have seen change happen slowly because those in power don't want to lose control and instead will generate fear and hate to avoid what's just. Therefore the cycle continues – the ones disadvantaged by the system stay at the bottom, while the ones fearful of loss, and who have great ability to make change, prosper while giving up as little as possible. Meaningful change takes time, but it cannot be done through compromise. We don't want three quarters of the personal protective equipment – we need all of it. We can't have the same policies but with Māori names.

When COVID-19 struck, most of us scrambled to prepare for what would be an "unknown level 4". Many members of my community were fearful. Some were already homeless or impoverished, contemplating a hopeless future; the elderly, including my mother, stubbornly holding on to her independence to stay at home and weather the storm. But now she is readjusting to needing support to go out in public again and is troubled by debilitating panic attacks. Many I have spoken to since are not coping with the mental and emotional aftershocks.

During the first wave of COVID-19, nurses on the frontline, in aged, palliative, community, primary, and secondary care, rose up, despite already being under-resourced, short-staffed and tired. Forever a dependable workforce despite that lack of support – we push through because we are committed to caring for our communities. But there comes a time when caring is not enough to continue the uphill battle. As health-care workers and kaimahi hauora, we are experts on our communities and understand what we need to do the best job we can.

Kerri Nuku

The same goes for our wāhine Māori across the sectors, and especially those in iwi and primary health care who are continually undermined in our efforts to do what we know is best for our people.

COVID-19 has forever changed our lives and we must take charge of our post-COVID-19 Aotearoa. We need systems that are designed and led by Māori, for Māori. So how do we make people see the necessity of that change when effectively there may not be anything "in it for them"? How do we stop talking about equity, and begin putting it into practice?

My suggestion is that equity, and system change, must be understood within the context of Te Tiriti o Waitangi and He Whakapūtanga o te Rangatiratanga o Nu Tireni (Aotearoa New Zealand's Declaration of Independence signed in 1835). These documents unequivocally affirm Māori sovereignty and autonomy. So when we say we honour Te Tiriti, as a union, as health-care workers and as people living in Aotearoa, that means we are committed to mana Māori. We must be committed to listening to Māori experiences and wisdom and, most of all, we must be prepared to back Māori, especially our wāhine, to lead the change on issues that affect them most.

For some that might mean giving up power, but what that means for our communities is true mana-enhancement and a path to a just, sustainable and equitable health system. •

Correction and apology: IN LAST month's issue of *Kai Tiaki Nursing New Zealand*, the first name of board candidate Matewai Ririnui was misspelt (p43). The co-editors apologise for this error, which has been corrected in the online versions of the August issue.

Hospice apologises over cover

HE WHAKAPĀHA. Mary Potter Hospice He whakapāha. Mary Potter Hospice deeply regrets an error made in relation to the August edition of *Kai Tiaki Nursing New Zealand*. The cover featured an image of a kaumātua supplied by Mary Potter Hospice. The kaumātua depicted on the cover did not consent to the use of this image for this purpose. Mary Potter Hospice wholeheartedly apologises for this. *Kai Tiaki Nursing New Zealand* also deeply regrets this has happened.

The image has been removed from image libraries at both organisations, the online edition of this publication, and any other known existing material in circulation has been withdrawn. Mō mātou hē. E te rangatira, arohaina mai.

Andrea McCance, chair and
Brent Alderton, chief executive,
Mary Potter Hospice, Wellington

Notice to members: Subscription rates for members will increase by 1.9 per cent from October 1. The increase was due to take effect from April 1, but the board of directors deferred it for six months due to the COVID-19 pandemic. For the new subscription rates, please see p48.

Board meets in Christchurch

NZNO's BOARD of directors met in Christchurch last month – the first time it has met outside Wellington.

Board member Andrew Cunningham said the board had discussed ways of better engaging with members and moving its meeting out of Wellington was a way of doing things differently. And the COVID-19 lockdown and ongoing restrictions had been a catalyst for reaching out to people in another way, notably via Zoom meetings.

"Meeting in Christchurch was the same cost as meeting in Wellington so we decided to see how effective it would be. It worked out really well. The chief executive and other staff who report to the board did so via Zoom. And that encouraged a greater focus and we got through the board meeting effectively and efficiently."

After the board meeting, members then had a Zoom meeting with regional council and college and section chairs. That was followed by a "meet and greet" with around 20 Canterbury members.

"Discussion at both the chairs' meeting and the meet and greet focused on the board's decision to hold the conference and annual general meeting via Zoom. Members just wanted to know the rationale for that decision."

The "meet and greet" with Canterbury members had been very positive. "There has been some smudging of the NZNO brand recently, but members just wanted to engage, to know what was going on and to know how the board and NZNO were going to move forward," Cunningham said.

"I found it invigorating. Members made us feel at home and the Christchurch NZNO staff were awesome. I think all board members found it a really positive experience and we'd like to thank everyone involved."

It had demonstrated the board could hold meetings outside Wellington and would do so in the future. When that might happen was "COVID-19 dependent".

Cunningham said it was important to "look locally" to engage with members and build relationships. •

** Decisions from the August board meeting will be covered in the October issue.*

Update on NZNO conferences and annual general meetings

UNCERTAINTY CONTINUES for NZNO colleges and sections' (C&S) conferences and annual general meetings (AGMs) planned for this year. Acting associate professional services manager Kate Weston said C&S were working hard to support members' education needs. Members were keen to take opportunities which were limited elsewhere by COVID-19 but C&S were having to change plans at short notice and adapt to fewer numbers and involving virtual technologies. Below is a list of what's happening with AGMs and conferences scheduled for the rest of the year:

▶ The college of child and youth nurses' AGM is going ahead on October 12 via Zoom, but accompanying presentations had been "reluctantly" cancelled due to uncertainty, acting chair Sarah Williams said.

▶ The college of gerontology nursing has cancelled its *Sex, drugs and light sabers/technology* conference, due to be held in Wellington on October 19-20. Chair Bridget Richards said the latest community outbreak and need for aged residential care staff to be working in level-4 lockdown across the country was behind the decision.

Instead, a webinar would be held on October 20 at 6pm, featuring Edinburgh professor of nursing Brendan McCormack on developing person-centred services in gerontology in the world of COVID-19. Its biennial general meeting would also be held on that day.

▶ The college of gastroenterology was now planning a shorter one-day "hybrid" meeting on November 11, combining virtual and face to face, instead of a full conference, chair Karen Clarke said.

▶ The New Zealand respiratory conference committee was to decide on August 31 whether to go ahead with its planned conference in November 2020 in Wellington.

▶ The Pacific nursing section plans to go ahead with its AGM and symposium on November 6.

▶ The perioperative nurses college and college of emergency nurses have both cancelled their conferences for 2020 and will hold their AGMs by Zoom.

▶ The National Student Unit has planned a Zoom AGM for September 15. •

Sick leave petition handed to minister

THE COUNCIL of Trade Unions (CTU) presented a petition for safer sick leave to Minister of Workplace Relations Andrew Little on September 1, saying workers in essential services deserve safer sick leave.

Increasing the legal annual minimum from five to 10 days a year was "a basic issue of safety", CTU president Richard Wagstaff said. COVID-19 had thrown focus on the importance of staying home when sick. "But the current reality of a legal minimum of five days' sick leave is unrealistic in achieving the goal of people staying away from work if they are unwell," he said.

More sick leave and better access to it, is an important claim in this year's NZNO/district health board multi-employer collective agreement negotiations, NZNO lead advocate David Wait has said. Pay and leave, notably sick leave, were the two most "widely and deeply felt" issues at member meetings.

Wellington nurse Erin Kennedy said the people she cared for every day were "vulnerable to really serious consequences" if they got sick. "It is for them that I support safer sick leave . . . But the reality is that when people don't have enough sick leave, they go to work sick, rather than stay home and miss out on a day's pay."

The petition was signed by more than 10,000 and requests:

- Extending the COVID-19 leave support scheme for another year, to make leave easy to access for those with COVID-19 symptoms, including those waiting for a test or results.
- Increasing legal minimum paid sick leave from five to 10 days per year, with government support for small businesses to make the change.
- Making sick leave available if people need to care for dependents.
- Removing the six-month stand-down to access sick leave when starting a new job.
- Getting rid of the previous government's requirement for a doctor's certificate after just one day of sick leave. •

CTU president Richard Wagstaff and Wellington nurse Erin Kennedy deliver the petition at Parliament.

Gerontology nurses work on ARC pandemic policy

NZNO's COLLEGE of gerontology nursing has begun working with the Ministry of Health (MoH) to better protect aged residential care (ARC) staff and residents from COVID-19, in the wake of a review of the sector's response to the outbreak.

Sixteen of the country's 22 COVID-related deaths occurred in ARC settings, with five of the country's 16 clusters linked to ARC facilities.

In April, director-general of health Ashley Bloomfield commissioned an independent review of the ARC sector to find out how to strengthen its response. Its findings have led to a seven-point action plan, starting with developing a national outbreak management policy and pandemic management workbook.

College chair Bridget Richards said it was "early days", but the college had met and begun working with the MoH on developing the policy and workbook.

Gerontology nurses wanted to make sure the policy was accessible to ARC management, but also took staff needs into account, along with patients' rights, "which sometimes get lost in a pandemic", she said.

NZNO involvement 'critical'

NZNO aged-care industrial adviser Lesley Harry has said NZNO involvement in any changes was "critical" to ensuring any further outbreaks had "less catastrophic" results for residents and staff.

Bloomfield said in August that experiences from here and overseas showed that if COVID-19 gained a foothold in ARC, consequences could be "deadly".

He thanked ARC staff, saying he had heard many stories of them going "above and beyond" the call of duty in their care for the elderly. Acknowledging the ARC sector's work during the pandemic was one of the recommended actions.

Due to be finalised by November, a national outbreak management policy would cover psycho-social support for staff, residents and whānau; communication and reporting; relationship-building; decision-making and escalation pathways; and rapid formation of response teams.

Also included is the supply and stock of personal protective equipment PPE, guidance and communication on its use in ARC; and an infection prevention and control IPC strategy specifically for ARC (see www.health.govt.nz/independent-review-action-plan). •

Staff at the Mangere COVID-19 testing station. Pauline Fuimaono Sanders is at far right, in front.

New cluster puts pressure on Pacific staff

THE LATEST COVID-19 cluster has put a lot of pressure on Pacific nurses and health staff, says operations lead of Otara and Mangere's community testing centres, Pauline Fuimaono Sanders.

Of the cluster emerging after an Auckland family tested positive on August 11, Sanders said: "We all knew it would happen, it was just a matter of when."

In the cluster (totalling 149 in early September), 62 per cent were Pacific peoples, according to the Ministry of Health.

Pacific nurses and staff were in high demand to work in community testing and public health, and to support those in quarantine or isolation facilities – despite being just three per cent of the nursing workforce, Sanders said.

Their first day of testing in Otara in August saw about 600 people turn up, with similar levels in Mangere, and numbers have remained high until recently.

Having Pacific nurses working with the Pacific community helped with communication and finding culturally appropriate solutions. "If we think about that, we have to be very purposeful where we place our nurses."

But with not enough Pacific nurses, the sector has had to call on other Pacific staff, including community support workers and administrative staff to support families in the testing centres. Thinking laterally to provide a culturally appropriate workforce is also an important consideration for Pacific families in isolation and staying in quarantine facilities.

Auckland's regional public health service (ARPHS) was putting together a dedicated Pacific COVID-19 response team when the second wave arrived on August 11.

Public health nurse Justine Paterson said nurses, physicians and other health workers with Pacific backgrounds were already being seconded into the ARPHS when a South Auckland family tested positive for COVID-19.

ARPHS had anticipated further outbreaks could hit South Auckland's Pacific communities hardest, she said. Because of larger families living together, often intergenerational, some with complex health needs, it could spread quite quickly – as seen in Victoria's public housing mega-clusters.

But, despite not being 100 per cent ready, a Pacific-centred approach had been "very effective", successfully encouraging people to quarantine in hotel facilities away from family; connecting them with community welfare providers and enabling faster initiation of contact tracing and testing. Pacific staff had also liaised with community and church leaders to get public health messages out, Paterson said.

Interpreters recruited

Aware good communication would be key to controlling the cluster, Paterson said the ARPHS had also recruited interpreters for several Pacific languages. "We have some quite difficult conversations – telling people they're [COVID-19] positive is often quite a shock, then explaining the complexities of quarantine – we thought it would be better done in people's own language," Paterson said. "So even if you weren't a Pacific nurse, you had access to an interpreter."

The current surge was more complex than the first wave, which had mainly involved returning travellers. These were predominately New Zealand Europeans, under 50, with good general health, who were able to be managed relatively easily in a small travel bubble and quarantine more easily at home, she said.

However, now the virus was spreading in the wider community, affecting individuals and whānau who may already have complex health needs.

"People had been living their lives fully, going to schools, churches and other community centres, so we were having to go back and trace multiple settings, with lots of close contacts. It got pretty big, pretty quickly," Paterson said.

"We had to scale up fast, but within days we could see we would need to go out to the region to source additional staff."

Paterson said she never doubted COVID-19 would be back. "We were preparing for it – I just wish we'd had more time."

But with people seconded or on standby ready to jump in if needed, and an established contact-tracing system, "we're in a much better position than the last outbreak".

Sanders said all staff were feeling "fatigued" and it was important to protect, support and sustain the workforce in the COVID-19 "marathon".

"One of the beautiful things about the Pacific community is we are a very communal culture. Unfortunately, COVID loves communal groups, as that's how it spreads quickly, so it's a lot more of a challenge for Pacific communities to adapt to that, particularly as extended families commonly live together." •

‘Divisive’ board leads to resignation

A “DYSFUNCTIONAL and divisive governance team” is behind Canterbury District Health Board’s (DHB) executive director of nursing (DoN) Mary Gordon’s “difficult” decision to resign.

The decison was about a team that had “little understanding of the business they are governing, focused only on financials, and whose behaviours are not aligned to the values of the organisation,” she told *Kai Tiaki Nursing New Zealand*.

Over the last two months, seven of the DHB’s executive leadership team (ELT), including chief executive David Meates, have resigned. Gordon’s resignation was not related to the board’s savings plan, which includes a $16 million cut to the nursing budget. And it was not made out of loyalty to her executive colleagues, she said. She had came close to resigning in March, but could not bring herself do so in face of the COVID-19 lockdown.

The DHB had faced many challenges and had met them head on. It was no secret there had been tensions between the DHB and the ministry, she said, with one being funding. “I don’t want to go into the detail but I do want to strongly say . . . there is not one member of the executive team that finds a deficit acceptable. We were requested by the board to come up with an annual plan that would reduce the deficit and we did that.”

‘True to my own values’

Gordon said she had enjoyed 18 years with the DHB and was sad to be leaving. “However, I needed to be true to my own values and couldn’t continue in the role where saving money had rapidly overshadowed other priorities which are important to me.”

Her decision has been met with shock and grief by CDHB nurses and national nursing leaders. They are also concerned the proposed cuts to the nursing budget will threaten patient safety.

NZNO chief executive Memo Musa said the resignations of seven ELT members in a few weeks was alarming and indicated a “spiralling leadership crisis”.

Gordon’s leadership had been significant “during very challenging times, including the earthquakes, mosque massacre, and now the COVID-19 pandemic”.

Outgoing executive director of nursing Mary Gordon

The proposed nursing budget cuts, particularly the two-thirds reduction in employment of new graduates, would have serious impacts on the sustainabilty of nursing into the future, he said. And that would compromise patient care.

Chair of NZNO’s college of emergency nursing Sandra Richardson said there was “no fat left to cut”. The willingness to target nursing whenever money needed saving was long-standing. “It’s a failure to comprehend what nurses actually do and how vital their role is.”

CDHB quality and patient safety nurse Roxanne McKerras said the steps to reduce the deficit would mean nurses couldn’t provide the care they currently did. NZNO professional nursing adviser Julia Anderson said any reduction in nursing would be untenable.

McKerras and Richardson believe the the current situation has echoes of what happened at Canterbury Health in the mid-1990s, when nursing jobs were slashed and there were avoidable patient deaths.The then Health and Disability Commissioner, Robyn Stent, investigated and released her findings in 1998.

“She recognised the damage done by cost cutting and the loss of clinical expertise . . . but this seems to have slipped from the board’s collective memory,” Richardson said.

Along with concerns about patient safety, McKerras said there was “an enormous amount of grief” in the organisation over Gordon’s resignation. Hundreds of staff expressed their concerns at two gatherings outside the board office in Christchurch last month.

“Personally I feel shocked, very sad, just gutted. She has been a rock, an amazing advocate for nursing, she has resisted cuts to nursing, has been a great employer of new grads, and has always had the patient at the centre of care,” McKerras said.

Anderson said Gordon’s resignation was “devastating. She has always had nursing at the forefront of everything she does. Her resignation will be felt nationally.”

Chief nursing officer Margareth Broodkoorn said Gordon’s resignation was a ”huge loss” to Canterbury and nursing leadership throughout the country. “With over 30 years of health sector experience, Mary’s contribution to nursing has been far reaching. Her name is synonymous with nursing leadership in New Zealand and I know she will leave a huge gap.”

‘Unsettling effect’

McKerras’s quality and patient safety colleague John Hewitt said Gordon knew what staff had been through and “has always been the hand that steadies the ship”. Coming on top of the resignation of Christchurch Hospital’s DoN Heather Grey earlier this year, Gordon’s resignation had had “an unsettling effect”. But nursing at the DHB was not “rudderless”.

“Thanks to the work of Mary and the amazing executive leadership team, we still have a layer of really good nursing leadership. The legacy of those who have resigned is that we have a really good vision for the people of Canterbury and a strong framework and culture to work in,” Hewitt said. Because of this, it is not all “doom and gloom, but we have to be very wary about what happens in the future”.

McKerras is frustrated the board’s narrative about CDHB’s performance and deficit “is not the whole story. We are a high performing DHB in terms of outcomes.”

In Meates’ final *CEO Update* – he left on September 4 – he laid out reasons for the deficit. Delays to the new acute services building, Hagley, and other “facility-related inefficiencies” had cost the DHB more than $60 million each

year. If Hagley had been delivered on time in 2018, "we would be in a break even positon now", he wrote.

Other funding issues, including a smaller per capita funding increase (18.6 per cent) than other DHBs over the last seven years, and insufficient population-based funding, had also contributed.

At a COVID-19 media briefing early this month, Health Minister Chris Hipkins disputed some of these assertions. He acknowledged the "strained relationships" at the DHB, but said the deficit was "unsustainable. There are serious financial issues that have to be addressed. I know the reasons for them have been hotly contested . . . But the DHB can't keep running up deficits to the possible detriment of other DHBs," he said.

Hipkins said he would visit the DHB and and talk with "people on the ground".

At the same media briefing, director general of health Ashley Bloomfield said the ministry would play a constructive role, "primarily focused on supporting the board and the new management team coming in". He met board members, Crown monitor Lester Levy, outgoing ELT members and clinicians in Christchurch late last month. •

PHC nurses take historic strike action

AROUND 3200 primary health care (PHC) nurses and receptionist/administration staff across more than 500 general practices and accident/medical centres nationwide went on a one-day strike on September 3.

Although it was billed as a silent protest, the around 140 nurses gathered at midday before Parliament, dressed in their uniforms or in red, responded loudly to the call, "What do we want?" "Pay parity!" "When do we want it?" "Now!"

The main South Island event was in Christchurch, with members lining up along Bealey Ave. Other gatherings and rallies also took place at midday, either in town centres or outside workplaces throughout the country.

Catherine Metcalfe, nurse manager at the Mana Medical Centre in Porirua, said she and her colleagues were wearing red "because we are seeing red. Primary health care nurses provide quality health care. Why does the Government think we are worth less than our district health board [DHB] colleagues? Services continue to devolve from DHBs to primary care to take the pressure off secondary care. We are saving the Government money, yet continue to be paid 10 per cent less than our DHB colleagues."

Mana Medical Centre registered nurse Debbie Kerkvliet said PHC nurses were on the frontline of the COVID-19 pandemic response – in fact of all pandemics, including measles and meningitis – yet their work was poorly understood and mostly unappreciated. Pay parity was also needed to encourage new graduate nurses into PHC, she said. "Primary health care is a good option for new nurses. If new graduates are not encouraged into this sector, there'll be a shortage of nurses within the next few years. Nurses are not going to stay if their pay rates are much lower than those paid to nurses in DHBs."

Chris Wilson addresses striking PHC nurses in Christchurch.

Mediation two days before the strike failed to get an agreement. The cost of pay parity for PHC nurses is estimated at $15 million. NZNO PHC industrial adviser Chris Wilson said negotiations had been going on for nearly a year. "Employers say they want to pay more but simply do not receive enough funding through the DHBs. They also face significant problems recruiting and retaining staff. Seventy per cent of our PHC members surveyed say they are considering leaving the sector because of low wages."

Wilson, who addressed the 220 nurses at the rally in Christchurch, said the rallies were a great success and exceeded NZNO's and members' expectations. As well as being pleased with the turnout in larger centres, she was impressed how members in smaller centres had got themselves organised and made themselves visible. "I'm thinking of places like Gore and Tokoroa. The fact so many responded to the strike is a measure of their escalating disappointment and frustration that this struggle has gone on for so long.

"We really hope the visibility nurses and their colleagues achieved today, the increased pubilc awareness and ongoing pressure on the Government, will see a shift to a resolution very soon."

Members and their whānau are encouraged to sign and share NZNO's digital letter to Health Minister Chris Hipkins urging a resolution to the pay inequity.

Long-time Nelson practice nurse activist Diane Auld said she would like to see more pressure put on employers about pay parity. "They say they support us, but we'd like some of their financial support."

Stoke Medical Centre practice nurse Raewyn Frenguelli said she was striking for the next generation of PHC nurses. Colleague Karyn McKay said it felt great to be taking historic strike action "for what we deserve".

Tasman Medical Centre practice nurse Mel Neve said she had moved to PHC after a 20-year career in hospitals. "We should be paid equally. Our work is no less stressful than in hospitals."

A number of nurses said they felt emotional taking the historic strike action. •

Mental health nurses face ethical dilemmas

NZNO's MENTAL health nurses section raised concerns about a shortage of acute mental health beds with the Government's mental health services inquiry committee two years ago. But these concerns were ignored, chair Helen Garrick said, which "was hugely disappointing and frustrating for us".

The shortage meant nurses constantly faced ethical dilemmas around patient admissions – and were unfairly blamed when things went wrong, she said.

Chief ombudsman Peter Boshier last month released reports on five secure acute mental health units he inspected prior to COVID-19. He named two he believes breached the United Nations (UN) convention against torture "and other cruel, inhuman or degrading treatment". They were Wellington Hospital's Te Whare o Matairangi mental health inpatient unit, and Waitakere Hospital.

Boshier said that in Wellington seclusion rooms were still being used as bedrooms, although he recommended in 2017 that the practice stop. The rooms were intended as a short-term response for patients with imminent safety risk and contained "little more than a mattress". Their use was "degrading" and a breach of the UN convention's article 16.

At Waitakere, the intensive care unit had been used to house a patient long-term, due to a risk of violence. Boshier said there was no evidence that risk still existed and it was clear the patient was experiencing an escalating sense of "hopelessness, frustration and anger".

Garrick said the section raised concerns in 2018 about a lack of acute care beds and services for people with "high and complex needs" with the inquiry panel. However, the acute bed shortage had not been mentioned in its 2019 report, *He Ara Oranga,* now being implemented.

Nurses 'blamed'

Boshier told her at a 2017 meeting that he knew it was not nurses' fault – but it was nurses who were often blamed, Garrick said. "It's terrible for mental health nurses, as it sends the awful message that nurses are abusive." That discouraged people from going into mental health nursing or seeking help.

Nurses faced ethical dilemmas as a result. "If someone needs to be in hospital and the ward is full, there are two options and they're both bad. You either turn someone away or discharge someone who isn't ready. What do you do next time someone turns up and we turn them away and they go and harm themselves or someone else? As one committee member said, 'we're damned if we do and damned if we don't'."

The numbers of acute inpatient mental health beds had dropped over the past 20 years, as successive governments tried to devolve more care into the community.

Both the inquiry and this year's report by mental health commissioner Kevin Allan appeared to focus more on the "lighter" end of mental health services, Garrick said. "But what do you do with someone who had been locked away a long time and has really high and complex needs? There is a huge gap in services for these people."

A spokesman for Health Minister Chris Hipkins said the Government had earmarked $330 million for new or upgraded mental health facilities, many of which included more capacity. In Wellington, individual units were planned for the most high-needs mental health and intellectual disability patients. New acute mental health facilities were also being built at Tauranga, Whakatāne and the Hutt Valley. It was not yet clear how many more acute mental health beds would result, as detailed planning was still underway, the spokesman said.

Garrick said it was great to see the upgrades after years of neglect, but some were "years" away and it was unclear how many more beds there would be. •

Nationwide shortfall of mental health staff

A SHORTFALL of 121 mental health and addiction staff at Counties Manukau Health (CMH) is the result of inadequate mental health nurse education there, NZNO mental health nurses section (MHNS) chair Helen Garrick says. "It doesn't surprise me at all," she said. "I know from colleagues in other services how difficult it is to find staff."

In response to an Official Information Act request from Radio New Zealand (RNZ), CMH chief executive Fepulea'i Margie Apa confirmed the district health board (DHB) was short of 121 out of a total of 723 positions in its mental health and addiction service.

Apa said CMH had been working hard to recruit staff, including taking on 27 new graduates as part of the nurse-entry-to-specialty-practice (NESP) – mental health and addiction programme this year. It had also been seeking to recruit locums from overseas and temporarily moved staff from other areas to provide support, she told RNZ.

Garrick said there was a nationwide shortage of mental health and addiction staff, including nurses, as New Zealand did not provide specialist mental health nurse training.

She said it was important new graduates on NESP did not replace experienced staff and that they had senior staff to mentor them. "They are in a postgraduate programme to prepare them to work in mental health – but they can't just walk in and replace experienced people."

With no specialist mental health nurse training, New Zealand had relied heavily on internationally-qualified nurses and other staff, particularly from the United Kingdom, to fill its gaps over the years. But in a global pandemic, that was "drying up".

The section committee wanted to see a specialist mental health nursing degree in New Zealand but, failing that, more mental health training within the bachelor of nursing. •

Chief nurse resigns

CHIEF NURSING officer Margareth Broodkoorn (right) is resigning from the Ministry of Health to take up a role as chief executive at Hauora Hokianga, a Māori health provider in Northland. Broodkoorn, who took up the chief nursing role in 2018, will leave in early January 2021, director-general of health Ashley Bloomfield said in a statement.

Bloomfield said he had "mixed emotions" at her departure.

"I'm very sorry to see Margareth leave the ministry, but I'm happy she's been able to secure a great role closer to her growing family."

He said it was an opportunity for her much closer to home, which recognised her skills, experience and strong connection with the local community.

NZNO chief executive Memo Musa said Broodkoorn – thought to be the first chief nursing officer of Māori descent – brought "true cultural understanding to work around supporting and strengthening the nursing workforce and advancing nursing practice", as well as an urgency to the safe staffing agenda.

Broodkoorn recognised there were many challenges and viewpoints across the nursing profession, Musa said.

"And while we did not always agree on everything, she showed leadership commitment to work together to face challenges."

Musa said he particularly appreciated her role as leader of the Nursing Accord Co-ordination Group, and her infection prevention and control work to improve the availability of personal protective equipment across the health and disability system during the COVID-19 pandemic.

Broodkoorn was key in helping gain 100 per cent employment of new nursing graduates, and a champion of the enrolled nurse supported into practice programme. Funding for both initiatives was approved in Budget 2019.

Musa, who worked closely with Broodkoorn to prepare for 2020's International Year of the Nurse and Midwife and the World Health Organization's *State of the world's nursing* report, said NZNO would miss her strong advocacy for nursing. He wished her well in her new role. •

Mental health nurses join scheme

ALL 418 eligible registrants for the 2020 Ministry of Health (MoH) voluntary bonding scheme (VBS) have been accepted. Registered nurses (RNs) made up more than half the registrants at 273. Midwives made up the second largest group with 86 registrants.

A record number of mental health nurses applied this year, with 164 accepted. For the first time, the scheme was broadened to include enrolled nurses (ENs) working in mental health and addiction and aged care. Fourteen ENs were accepted onto the scheme, nine of them working in mental health and five in aged care. The majority are employed by the Waikato and Canterbury District Health Boards (DHBs) – five each.

Chair of the EN section Robyn Hewlett said she was delighted to see a good number of ENs accepted. "ENs have a lot to offer in the mental health and addiction area – positions are now frequently advertised for them in both community and DHB services," she said.

Just over 19 per cent of registrants were Māori, 10.5 per cent were Pacific, 16.7 per cent Asian/Indian and 53.6 per cent New Zealand European/other. There were more Māori and Pacific registrants than ever before.

The scheme aims to encourage newly-qualified health professionals to work in the communities and specialties that need them most. It also aims to increase representation of Māori and Pacific people in the health workforce. Those accepted can become eligible for payments in the first three to five years of their career, to help repay their student loan or as top-up income.

MoH data shows RNs on the scheme have higher retention in hard-to-staff specialties compared to nurses not on the scheme. The retention rate after five years is up to 27 per cent higher for those on the VBS, than those graduates who did not register for it.

Registration for next year's VBS is expected to open early in 2021. •

Melbourne stories 'moving'

Denise Heinjus

ROYAL MELBOURNE Hospital's executive director of nursing Denise Heinjus brought nurse leaders to tears as she shared her experiences working in Melbourne during the second wave of COVID-19.

Speaking at the virtual New Zealand Nursing Leaders' summit on September 2-3, Heinjus described managing Victoria's aged-care facilities and the vulnerable people in crowded public housing towers during COVID-19's second wave. Her openness and "moving" experiences moved many to tears, acting associate professional services manager Kate Weston said.

New Zealand health and disability system review panel member Margaret Southwick urged nurse leaders to see opportunities as well as challenges in the health and disability sector.

Southwick suggested management was about preserving the status quo – while leadership was about facilitating change.

More opportunities were needed for nurses to come together and ask what the future vision for nursing was going to be, Southwick said.•

Working for mental wellbeing

Mental health nurses work in a variety of settings and with different kinds of clients. But they all share a drive to help vulnerable clients change their lives. Over the following seven pages, mental health nurses share their nursing journeys.

Instilling recovery, resiliency and hope

Helping young people make changes is appealing for Jill Whitworth, a mental health nurse with a varied 40-year career, who is now working in child, adolescent and family mental health.

By co-editor Teresa O'Connor

Jill Whitworth has worked across the whole spectrum of mental health nursing in her close to 40-year career. She began psychiatric nursing training at Cherry Farm Hospital, north of Dunedin, in 1982, just a month after her 17th birthday.

Thirty-eight years on, she says "A career as a psychiatric nurse has given me such enriching day-to-day experiences. What other career could top this?"

After completing her three-year "apprenticeship", moving through all the villas at Cherry Farm, she moved into a one-off role at the care of the elderly units at Wakari Hospital and was the only registered psychiatric nurse working there. "I was the one who was sitting on the bed talking to patients, rather than getting their showers done on time." But during her two years there, she expanded her physical health-care skills and her knowledge of the crucial links between physical and mental health. That knowledge has stood her in good stead as she has worked in a variety of mental health-care settings – from alcohol and other drugs and detox services to emergency psychiatric care; from specialty youth services to forensic care to intellectual disability, including a management role. "I thought at the time rather than criticise, I should see what it's like being a manager". A few years in the role convinced her management was not her calling. "I'm more a practical, hands-on, learning-on-the-job kind of nurse and that's where my strengths lie," she explains.

She is now in her second stint at child adolescent and family mental health services at Southern District Health Board, this time working as a nurse therapist. She had previously worked there as a parent resource nurse. "Supporting young people to make change is appealing. I can show them tools that may be useful. And as a nurse therapist, I am also used as a therapeutic tool, so it's all about engagement in those relationships."

Whitworth has completed a family therapy course run by both Otago University and Otago Polytechnic one night a week over three years. Its blend of reflection, theory and practice suited Whitworth. She has also completed psychotherapy papers through the private mental health provider Ashburn Clinic, again one night a week over three years. This pattern of study fitted with her work and raising young children. She has also undertaken short courses to fill in some gaps in her knowledge, notably around child and adolescent development and behavioural issues.

The service, which caters for 0 to 14-year-olds, is staffed by a social worker, an occupational therapist, psychologists and psychiatrists – Whit-

worth is the only nurse. Referrals come from GPs, schools and other counselling services. The most common presentations are depression, attention deficit hyperactivity disorder (ADHD) and behavioural difficulties. There are strict criteria about who can access the service.

The multidisciplinary team (MDT) considers all assessments and decides on the most appropriate treatment pathway. Her caseload varies, depending on the acuity of clients. "At any one time, I might have four coming in, four I am working with and four who are close to being discharged. I might be doing a mix of eating disorder therapy, family therapy or work with parents."

Whitworth brings "nurses' holistic approach" to the "very supportive" MDT and notes that over the years she has been working in mental health, nurses have become much more empowered to speak up.

There was a decrease in referrals during the COVID-19 lockdown and an increase after the lockdown. The most common presentations during this time were ADHD, anxiety, obsessive compulsive disorder and eating issues. On the flip side, during lockdown many parents had the time to be with their children and implement treatment recommendations and for some children, not attending school meant considerably less stress.

"Since lockdown, I've noticed children becoming increasingly stressed as they are back at school and all the environmental stressors and demands are back"

Time is a "precious commodity" and Whitworth says that when a young person comes to the service "they are the centre of attention from us and from their parents and they don't get that in an ordinary day".

Social media has had a "huge impact on young people, families and parenting". Other societal pressures have led to an increase in self harm, particularly among children.

Collaboration, listening, excellent communication skills, empathy, the ability to read body language and patience are essential in her practice.

"The young person and their parent/s are often stressed when they come to us. We have to assess what's going on for their whānau and what's happening for them in the wider community. That requires a lot of patience – it is not a quick fix. We need to empower the family to have the confidence they can deal with the issue – to instill in them recovery, resiliency and hope."

Whitworth says there's a lot more stress on nurses now "in what we are managing, in higher acuity and greater expectations. We have to look after ourselves and we have to role model that."

'Since lockdown, I've noticed children becoming increasingly stressed as they are back at school and all the environmental stressors and demands are back.'

Despite the greater pressures, Whitworth has never regretted the choice she made as a naïve 17-year-old. The many skills she has refined during her career and transferred across services, and what she has learnt from clients and colleagues on her journey have been professionally rewarding and built "a great richness of practice". •

Jill Whitworth (left) and social worker Kelly Linwood review a file in the observation room/play room.

'Physical, mental and emotional health all

By co-editor Mary Longmore

Being a good listener is one of the qualities Melissa Peterson brings to her mental health practice with primary health-care patients in the Far North.

Northland mental health nurse Melissa Peterson loves seeing the changes in patients after a consultation.

"The best thing for me is seeing them smile. They come in crying, sad or stressed, but then they leave with a little smile – that's the best thing."

Australian-born and trained as an enrolled nurse, Peterson arrived in Ahipara in 2009 with her Māori husband, who had been raised there and wanted to be close to whānau.

She was working in a Kaitaia rest home in 2012, when she spotted an advertisement for a cardiovascular disease and diabetes prevention nurse at Te Hiku Haoura, the largest provider of health services in the Far North. "I thought 'that sounds interesting'," applying a day before the cutoff.

The clinic was initially doubtful Peterson, as a non-Māori - and Australian to boot - would be a good fit for services designed specifically for Māori. But she eventually got the job, successfully leading the innovative prevention pilot for the next three years – and forming many close relationships within the community along the way.

Aimed at pre-diabetic patients, the programme involved six weeks of group meetings, followed by six weeks of home visits by whānau ora nurses. It saw an average improvement of lost weight and decreased sugars in over 90 per cent of all patients (both Māori and non-Māori), with pre-diabetes who participated, Peterson said.

Melissa Peterson

Empowering patients was a key element to its success, she believes. "I really wanted to focus on giving our patients the knowledge they needed to manage themselves as much as possible." That included advice on exercise and nutrition, and also the involvement of whānau, to provide support at home "and know the journey the patients are on".

Despite its success and plans to expand the three-year pilot programme across the Far North, in 2014 the Ministry of Health announced that funding would not be renewed, leaving Peterson "devastated".

But she continued seeing most of the clinic's diabetes patients as a primary health care (PHC) nurse when, in 2016, Northland primary health organisation (PHO), Mahitahi Hauora, introduced a mental health initiative specifically for patients with diabetes. It involved a questionnaire to screen diabetes patients for symptoms of depression. Those showing signs were offered the choice of a mobile nurse service visiting them at home, or talking to a PHC nurse at the clinic. "What we found is that most people chose to come back and see the nurse in the clinic – about 80 per cent," Peterson said. More specifically, they wanted to see her. "I've been told I'm a good listener. I actually really do enjoy listening to people and hearing their stories . . . I'm drawn to this, maybe it's my calling."

Peterson believes that physical, mental and emotional health are inextricably connected, "and you have to look after all of them".

In 2017, Te Hiku's medical director Norma Nehren suggested Peterson complete a mental health and addictions credentialing programme being offered at Manaia Health in Whangārei, and more formally take on the mantle of Te Hiku's mental health nurse. Peterson happily completed the "amazing" programme in six months. "We have such a lack of mental health support in the Far North – especially for our young people and children.

The course gave her a whole new range of tools to help de-escalate issues such as anxiety, before they spiralled out of control. Those included mindfulness techniques, weighted blankets and sensory modulation – using senses such as taste or smell.

'People cry and let out all their stresses and anxieties, so a smear appointment might turn into a counselling one.'

She now focuses on all patients – not just diabetic - with mental health is-

connected'

sues, including obsessive-compulsive disorder, hoarding or anxiety and stress. The expanded skills allowed her to work more confidently and holistically, taking the whole-person approach in all her consultations.

"I had a women in for a smear, and asked her about contraception. That turned out to be a trigger. People cry and let out all their stresses and anxieties, so a smear appointment might turn into a counselling one," Peterson said. "In the end, she gave me a big smile and a hug and said 'thank you'.

"If people suffer with physical health issues, they can't get better if they're not in a good mental health space. Hauora [whole-person health] is so important."

Something unique to offer

Peterson feels nurses have something unique to offer those feeling vulnerable. "I think people feel more comfortable with nurses, as we are part of their whole life. We see them go through the years and know their family. People tend to feel they have a relationship with us."

Te Hiku management and colleagues have always been extremely supportive, allowing her and the team flexibility with appointment times, as needed, and mentoring.

Mental health visits were already double appointments but nurses would pick up each other's workloads if anyone was running late, as well as provide a listening ear. "After a difficult session I'm able to vent, so there's lots of support, which has been awesome."

Te Hiku's primary mental health coordinator Roberta Kaio had also been an "amazing support". "If I'm stuck, she helps me through it".

Beginning as a small mobile nursing team in the 1990s, Te Hiku Hauora has become the largest provider of PHC services in the Far North, serving 13,500 patients with two clinics in Kaitaia and a smaller clinic in Coopers Beach. •

A counselling qualification is another string in the bow for a mental health nurse, expanding her ability to use therapeutic skills.

Counselling diploma enhances nurse's empathy

By Mary Longmore

Auckland mental health nurse Kristal O'Neill says becoming a counsellor has encouraged her to be more outspoken and empathetic as a nurse. "I'm far more likely to advocate for people and what I feel is in that person's best interest, rather than getting caught up in institutional processes and expectations," says O'Neill, who qualified as a counsellor in 2018.

"I just really enjoy face-to-face therapeutic work, so ended up adding another string to my bow."

She sees the nursing-counsellor roles as complementary and, prior to COVID-19, was juggling a busy counselling practice with contract work delivering mental health and addictions training for prison nurses. "My private practice complemented my nursing and vice-versa so well, the cross-over in skills."

Over 15 years of nursing, O'Neill has worked in prisons, forensic services, district health boards, non-governmental organisations and acute inpatient wards. She has also worked as a clinical educator at Auckland University of Technology, in a quest to keep herself professionally "fresh". She also gained a masters of nursing in 2012.

But completing her postgraduate diploma in counselling took her mental health nursing skills to a whole new level, she believes. "The counselling diploma really expanded my ability to use therapeutic skills in greater depth – areas where I might have been only scratching the surface before," O'Neill said. Those skills included some trauma-specific interventions, cognitive behavioural therapy concepts, motivational techniques and taking a strengths-based approach.

Her counselling work has also highlighted the importance of self-motivation when it comes to change – something she suggests can be under-appreciated in nursing. "I have a far greater respect for people's autonomy and importance of driving their own life; how applying any kind of pressure can be counter-productive, and changing people's lives really has to come from within themselves," she said. "Sometimes we don't give people enough credit that they are really fully aware of what's going on for them, and they are the experts in what they need – we don't consider that enough in nursing."

Kristal O'Neill

The time to go deeper with people, allowing her to "tie all the parts" of their lives together, was gratifying. "I was so grateful for my mental health background, as the crossover felt so easy, natural and rewarding."

Conversely, her mental health nursing background has enhanced her counselling skills, bringing a wider knowledge of

the range of services available, than a counsellor might normally have. "I think I have become far more aware of people's wider supports and looking at what are the resources and supports people might tap into – not just the district health board," O'Neill said. "As a nurse, my risk assessment and understanding of the wider mental health system and concepts of wellness comes into play every time I see my counselling clients."

As a counsellor, O'Neill is particularly passionate about working with vulnerable communities such as LGBTIAQ+ (lesbian, gay, bisexual, transgender, takatapui intersex, asexual, queer or questioning) – heavily over-represented in suicide statistics – maternal mental health and youth.

Before COVID-19 hit, she was unable to meet demand for counselling but now her face-to-face work is largely on hold,

'. . . applying any kind of pressure can be counter-productive, and changing people's lives really has to come from within themselves.'

although she continues to offer virtual support.

O'Neill believes demand for mental health care will surge over the next couple of years, as people struggle to cope with the impact of the global pandemic and resultant job losses. "I feel like the interplay between financial, family/whānau, psycho-social stresses and mental health is really going to come to the surface."

O'Neill also prioritises caring for herself, in a profession renowned for burnout. "I really value the idea that we need to look after ourselves, so we can look after others."

This can be challenging, as she gets calls and messages "at all hours" from people in crisis, but she manages this by setting boundaries, trying to maintain a balanced perspective and home life and ensuring she has access to external supervision. "I do my best to balance my needs outside of work, so I feel refreshed – I have really good self-awareness and jump in when I feel stress stepping up." •

'I have a solid korowai around me'

Bridging the gap between Te Ao Māori and the western medical model is important for this southern nurse.

Tēnā koutou
He uri ahau nō Hoturoa rāua Ko Pāoa
Ki te taha o taku Koro, Ko Ngāti Maniapoto te iwi, Ko Pirongia te maunga, Ko Waipa te awa, Ko Ngāti Apakura te hapū, Ko Hiiona te marae.
Ki te taha o taku nanny, Ko Waikato rāua Ko Ngāti Porou ngā iwi, ko Taupiri rāua Ko Hikurangi ngā maunga, Ko Waikato rāua Ko Waiapu ngā awa, Ko Ngāti Aamaru rātau Ko Te Whānau-a-Te Ao, Ko Ngāti Rangi, Ko Te Whānau-a-Karuai, Ko Ngāti Rākairoa ngā hapū, Ko Te Awamarahi rāua Ko Porourangi ngā marae.

By co-editor Teresa O'Connor

Newly-registered nurse (RN) Adrienne Kiri believes she has found her "forever job"as part of Te Oranga Tonu Tanga, the Southern District Health Board's (SDHB) Māori Mental Health Service. Her specific areas of work are the acute intensive ward and the acute ward at Dunedin's Wakari Hospital.

She graduated from Otago Polytechnic in 2018 and last year completed a nurse-entry-to specialist practice (NESP) placement at the SDHB. A number of factors attracted her to mental health nursing, including her Te Oranga Tonu Tanga whānau. "After I transitioned in a medical-surgical ward, which I loved, I had a realisation, during NETP [nurse-entry-to-practice] interviews, of where I saw myself as a Māori RN. In my perspective, Māori models of practice, such as Te Pōwhiri Poutama and Te Pā Harakeke, align well with the recovery-focused nursing practice for mental health."

She's loving her job. "I love being part of the mental health, addictions and intellectual disability service whānau. I like helping tāngata whaiora and their whānau understand and navigate the secondary and tertiary mental health system. And I love the ability to work from a Te Ao Māori perspective and to share this with my colleagues.

"I am trying to bridge the gap between Te Ao Māori and the Western biomedical model of practice." She is grateful for the support and responsiveness of colleagues and the DHB's nursing leadership.

One of the drivers for becoming a nurse was to be part of bringing about positive change in Māori health outcomes and she wants to encourage more Māori into health care, mental health nursing in particular. The support she receives in her working environment has made the quest to encourage others into nursing easier. "I appreciate my employers, who value nurse perspectives and support me to develop my clinical knowledge by offering opportunities within the DHB to develop both personally and professionally."

Her knowledge and the guidance she can offer is also valued. "The rangatira in the DHB, the director of nursing and the two clinical nurse specialists I work with are all very open to change and to Te Ao Māori values."

While her role has "massive rewards", it also has a number of challenges, which "keep me on my game". One is upholding the integrity of the treaty partnership and ensuring Te Ao Māori values, eg the importance of whānaungatanga and of involving whānau in care, are integral to nursing practice. She acknowledges this can sometimes be difficult in a "big machine" such as the SDHB and when time constraints are pervasive.

Acknowledging she has been an RN for just "five minutes", there are aspects

Adrienne Kiri: 'When I graduated, my aunties came down from Auckland and said 'now the hard work begins'. '

of health care she would love to see change. One is access to appropriate services for iwi Māori. "What I have found in my two small years as an RN is that Māori tend not to engage with health-care services regularly, so they are coming through to secondary and tertiary services when they are acutely unwell."

She would love to see care better connected across services – from acute wards to the transition and community teams to GP services. "We need to keep our networks strong and know what each other's roles are within them. After someone has been in an acute inpatient ward, they must have a very strong korowai tautoko in the community so they can continue their recovery journey."

'After someone has been in an acute inpatient ward, they must have a very strong korowai tautoko in the community so they can continue their recovery journey.'

She works within her own whānau, her community networks and with other health professionals to eliminate the stigma associated with mental illness and addiction. She does this by "maintaining hope and optimism, by sharing my knowledge and experience from practice and informing others about oranga hinengaro [mental well-being] and how they can help contribute to positive outcomes for tāngata whaiora".

She sees herself continuing to work at Te Oranga Tonu Tanga because of the work that is still to be done in mental health. "When I graduated, my aunties came down from Auckland and said 'now the hard work begins'."

She would also like to see the "did not attend" rate reduced. The current rate indicates more engagement is needed. The rangitahi Māori suicide rate "continues to raise its ugly head", as does the scourge of methamphetamine.

She acknowledges her role, with its many aspects, is a big one "but I'm happy to do it. Manaakitanga is part of my Māoritanga.

As a mother of a two children aged nine and 11 – "I'm their mother, father, coach, everything" – she has little chance to wind down outside work. She sees and hears distressing events and heart-breaking stories at work and debriefs with the whānau at Te Oranga Tonu Tanga.

They also give her regular cultural supervision. "They are the cultural experts within our DHB, I couldn't operate without them, and clinical supervision from one of our knowledgeable SDHB clinical nurse specialists. I have a solid korowai around me."

She would love to see more Māori at the decision-making tables. "This would ensure the values of Te Ao Māori are upheld and integrated throughout the health-care system. What is good for Māori is good for everyone." •

'Forensic mental health units are places of care'

Hope and recovery are possible for forensic patients, says a passionate mental health nurse.

By co-editor Teresa O'Connor

In her nursing journey, Anna Cheriyakku has travelled across countries, across continents and across cultural divides. In 2005, she travelled from her home state of Kerala, India, to New Delhi and completed a four-year bachelor honours nursing degree. A year in a medical and surgical ward in New Delhi followed and then a two-year masters in nursing, specialising in mental health. This masters choice was not easy, because of the stigma surrounding mental illness for both patients and those who care for them.

However, her passion for mental health nursing had been kindled as a second-year undergraduate nursing student. "I was fascinated by the diverse presentations of people with the same diagnostic features and by the fact a drug such as Clozapine could be life changing for some, yet have no therapeutic value for others."

She graduated from the masters degree with a gold medal for academic success. Full-time work in an adult mental health unit in New Delhi followed but Cheriyakku wanted a change. Her older brother Alex was nursing in Dunedin at the time and told her of the greater autonomy and respect New Zealand nurses enjoyed compared to colleagues in India, and about the lifestyle Aoteaora offered.

In 2013, she arrived in Dunedin, completed a six-week competence assessment programme (CAP) at Otago Polytechnic and then applied for a job in

the forensic unit. She has never wanted to leave. She currently works as a clinical nurse specialist (CNS) in the Regional Forensic Mental Health Service in Dunedin, which covers both the inpatient unit and community forensic services. In the 15-bed, mixed-gender unit at Wakari Hospital she has found her "second home".

The holistic model of care and the pivotal role of therapeutic relationships were among the reasons Cheriyukka was attracted to mental health nursing. The opportunities to look beyond the signs and symptoms of the illness and to get to know the person you are working with continue to be sources of professional satisfaction.

"In forensic mental health nursing, we are working with a vulnerable population who are often stigmatised due to mental illness and/or a criminal history. A forensic mental health nurse understands the complexities of the offending behaviour and mental health issues. The inpatient unit becomes a place of hope and recovery for many.

'Those seeking help are seen as 'patients' and not 'criminals' and staff have an understanding of what the person has been through. People leave the inpatient unit when recovered, and are supported in the community by the community forensic team. The journey to recovery can be long and very slow, however to be a part of this journey is deeply rewarding."

Cheriyakku's CNS role includes providing clinical leadership to the nursing team, assessing complex patients and ensuring "an empowering nursing practice environment where nurses have a strong voice in multidisciplinary team assessments and management plans".

Anna Cheriyakku: Māori and Indian cultures share an emphasis on family.

An important aspect of her role is coaching new staff to understand the unit is not a prison and that staff are dealing with people with an illness, not criminals.

She coaches new staff to understand the unit is not a prison and that staff are dealing with people with an illness, not criminals.

She gets frustrated with the media's portrayal of mental health units as places "where you get assaulted" and where staff work with "criminals". This view often colours the decisions of potential staff to work in mental health, she said.

Another frustration is the resources poured into building more prisons. "I'd love to see more forensic units with step-down facilities rather than prisons, and that people are not rushed back to prison when there is pressure on beds in forensic units."

Referring to the goal of zero seclusion, she said resources and facilities must match that goal and the model of care must align with it. While a new hospital is underway for Dunedin, she points out those who are detained in hospital for long periods are living in very old facilities which are not fit for purpose.

Cheriyakku says her Treaty of Waitangi training through the CAP helped her bridge any cultural divide she encountered in practice. "Our ward culture – we are a very multicultural ward – is to make everyone feel welcome and the team has a strong sense of togetherness."

Māori and Indian cultures shared certain values, notably the centrality of family and the importance of family involvement in care. "And in mental health nursing, one of the key skills is to find a point of connection."

The staff of Te Oranga Tonu Tanga – the Southern District Health Board's Māori Mental Health Service – also help bridge any divide. "The service is very helpful for migrant nurses to understand Māori culture and practices and to be able to practise in a culturally safe manner," she said.

Ultimately, she would love forensic units to be understood as "places of care, not places of custody. I'm regularly asked 'are you not scared to work there?' My response is that I am privileged to be a part of the recovery journey of people whose mental illness has contributed to their offending.

"That journey is incredibly hard and it is extremely rewarding to see a patient progress through the forensic pathway to living in the community." •

Emerging from the shadows

Change within mental health must come from staff and those who provide their physical and cultural working environment.

By Mark Baldwin

I often ask, "How did I get into this situation?" In this case, following an email from a colleague, I agreed to do a short profile for the September issue of *Kai Tiaki Nursing New Zealand*. Somehow, this morphed into a request to write a viewpoint article. Cue an acute attack of "imposter syndrome" as I read some suggestions as to what might be canvassed. What did I know about the state of mental health and addiction services, given the major investment in them over the last couple of years; or the pressure points; or where more funding could make the biggest difference; or whether there are enough adequately prepared mental health nurses?

I confess I have not read *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction*.[1] I put my views at one of the consultation meetings in a room filled with doctors, non-governmental organisation (NGO) representatives and managers. I've not read the report for the same reason my psychiatric district nurse colleagues and ward nurse friends were not in that room – we are too busy doing the job. I hope the investment provides both relief from the relentless demand for secondary services, and a built environment that aids in achieving the goal of zero seclusion while keeping staff and patients from harm. Nidotherapy (manipulating the environment, not the patient, as a form of treatment) is sorely overlooked in service design and provision.

But there are no new drugs on the scene or the horizon to provide the seismic shift Chlorpromazine did in 1953.

Much has been written on whether nurses are adequately prepared to work in mental health. The statement, *"Without mental health there can be no true physical health"*, was coined by the first director general of the World Health Organization, Brock Chisholm, in 1951.[2] Yet mental health is still not well covered in undergraduate or postgraduate nursing study. I have spoken out about this, only to find myself presenting lectures and marking assignments. Many a student nurse has been thrust my dog-eared copy of *"Long-term conditions and mental health: the cost of co-morbidities"*[3] as I aim to prove that, even if they don't want to work in mental health, they need to recognise it and understand its impact on the recovery from, or management of long-term health conditions.

Why the zeal? Well, I work alongside the NGO-supported accommodation sector as a nurse practitioner (NP). The role is multi-faceted: case manager, prescribing/diagnosing and responsible clinician under the Mental Health Act (MHA). Many clients have long-term, treatment-resistant, serious mental disorders. They have suffered the effects of long-term medication, poor diet and poor lifestyle choices. There are many co-morbidities, but when they go into hospital they run the risk of diagnostic overshadowing – the mis-attribution of physical symptoms to mental illness. This is made worse by the fact that schizophrenia raises pain tolerance so the usual observable guarding or grimacing is absent. Due to the amotivation of their illnesses, they may not engage with diagnostic procedures, such as answering questions, or attending follow-up appointments.

Then there are the secondary negative symptoms usually caused by the poverty of being on a benefit, which stop them being able to afford access to health care.

Research in 1932 showed that people with mental illness died, on average, 14 to 18 years earlier than similar people in the general population.[4] This was 21 years before our first anti-psychotic (Chlorpromazine), so the mortality gap isn't all metabolic side effects.

More mental health NPs needed

More mental health NPs are needed, especially in primary and aged care. I'm glad the recently-announced funding for the NP training programme has a focus on training Māori and Pacific NP students, and to increase services for mental health and addictions in the community.

Mental health is rightly in the spotlight at the moment after too long in the shadows. Funding is coming, new services are planned, the stigma is reducing. But there are no new drugs on the scene or the horizon to provide the seismic shift Chlorpromazine did in 1953. Therefore, change needs to come from staff and those tasked with providing staff with the physical and cultural environment to work in. I look forward to watching this develop in the second half of my career. Mental health nurses are like red wine – they get better with age – and I am a long way from being a vintage. •

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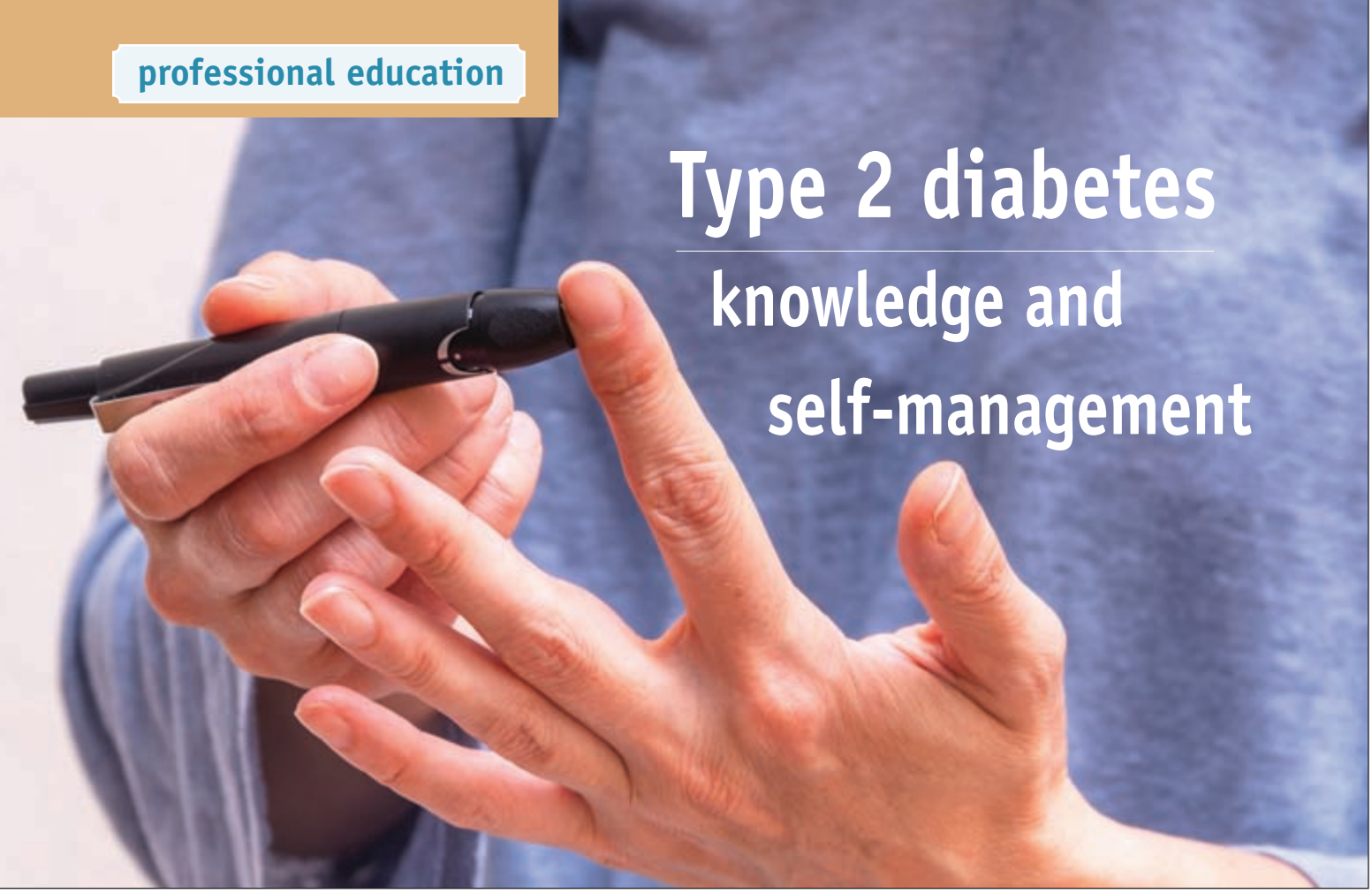

PHOTOS: ADOBE STOCK

Type 2 diabetes knowledge and self-management

In the fourth of a series of professional education articles based on the results of the *Talking about Health* study, the authors look at how people with type 2 diabetes are self-managing their condition at home.

By Claire Budge and Melanie Taylor

In this article, we use the 2016 (year 1) data from *Talking about Health*, a longitudinal study of people with long-term conditions (LTC) in the Mid-Central region.[1] We aim to:

- Explore the prevalence of type 2 (T2) diabetes and co-morbidities in our sample.
- See how well people with T2 diabetes engage in diabetes-related self-management behaviours and how knowledgeable they are about their own diabetes.
- See how having T2 diabetes relates to ratings of health and quality of life.
- See how well people report self-managing their T2 diabetes and identify what characterises the poorer self-managers.
- Share some diabetes-related advice people offered.

Measurement

Study participants were asked to self-identify whether they had diabetes as an LTC on the initial consent form. General health (GH: single item with poor/fair/good/very good/excellent response options), physical health (PH: four-item scale) and mental health (MH: four-item scale) were measured using the PROMIS Global SF.[2] 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 set of questions requiring yes/no responses was used to assess diabetes self-knowledge and management behaviours. In addition, a rating of how well people considered themselves to be managing their diabetes at home overall, using a scale from 0 (not at all well) to 10 (extremely well), was included. We also asked people to rate their "satisfaction with life as a whole" on a 0 to 10 scale ("completely dissatisfied" to "completely satisfied") and their "control over how life turns out" on a 0 to 10 scale ("no control at all" to "complete control"). A healthy behaviours scale was calculated based on the averaged responses to questions about how many days a week people ate a balanced diet, ate too many fatty and sugary foods (both reverse-coded), did gentle exercise, took medication as advised and planned nice things to look forward to.

Results

Prevalence and co-morbidity

Two hundred and seventy six people (48.5 per cent) indicated they had diabetes. As the experiences of those with type-1 are quite different from those with T2, this article focuses on the 252 individuals (91.3 per cent) with T2. The presence of other conditions (co-morbidities) was high: only 24 people (9.5 per cent) had diabetes only; the rest had at least one other LTC. For example, 61.9

per cent had hypertension, 59.9 per cent had chronic pain, 29.4 per cent had a respiratory condition and 19.8 per cent had anxiety or depression related to having an LTC. The number of people having between two and four additional co-morbidities was 64.7 per cent.

Diabetes self-management behaviours and knowledge

Responses to diabetes knowledge and self-management questions are provided in Table 1 (right). Note that the number of responses to each question (N) varies, depending on whether or not the question was applicable and was answered. For example, everyone could potentially test their own glucose levels, so the N is the whole sample (N=252) minus the seven who missed the question out, leaving an N of 245. In another example, only 106 people both used insulin and answered the question about using it as advised, and 95 of them (89.6 per cent, 95/106) said they did. Thus the percentages have been calculated taking into account the number of possible and actual responses.

From Table 1, we can see that about three-quarters of the people with T2 diabetes indicated that they test their blood glucose levels (BGLs) at home. Of these, the majority (around 80 per cent) keep a record and take their records to show a doctor or nurse. A similar number reported understanding what their BGLs mean and slightly more (86.6 per cent) knew what their BG targets were. The frequency with which people test (see Figure 1, p22) is quite varied, with the largest subset (37.1 per cent) stating they test two to four times daily. This group included 45.7 per cent of those using insulin, but also included 13.2 per cent of those not using insulin. More than half (57.3 per cent) tested their BGLs at least once a day.

Fewer than half (42.5 per cent) of the people with T2 diabetes indicated they knew what their target HbA1c (glycated haemoglobin) was. However, despite indicating they knew, some of the reported target levels were clearly not right. This suggests a need for further education and, given the technicality of the term and what it represents, may highlight a health literacy issue.

Under half (43.3 per cent) the participants with T2 diabetes used insulin and most of them (89.6 per cent) said they used it as advised. In comparison with those indicating they did use their insulin as advised, the group who said they did not were more likely to be older, male, less educated and have only just enough income for everyday needs. Just over a third (38.4 per cent) of those using insulin titrated their own doses; BGLs were most commonly used to guide adjustments, followed by activity levels and finally carbohydrate intake. Overall, 15 (39.5 per cent) of the people who titrate insulin reported taking all three factors into consideration when adjusting their doses.

A concerning finding was that six participants were taking insulin but not testing their own BGLs and three of these reported adjusting their own

Table 1. Diabetes knowledge and self-management behaviours expressed as frequency of positive responses for people with T2 diabetes

Behaviour	N	'Yes' frequency (%)
Test own blood glucose levels	245	180 (73.5)
Keep a record of BGLs	178	146 (82.0)
Take record of BGLs to health appointments	146	117 (80.1)
Check feet regularly	243	161 (66.3)
Take tablets as advised	190	183 (96.3)
Use insulin as advised	106	95 (89.6)
Adjust own insulin doses	99	38 (38.4)
Think about BGLs when adjusting insulin	38	34 (89.5)
Think about activity when adjusting insulin	38	20 (52.6)
Think about carbohydrate intake when adjusting insulin	38	19 (50.0)
Knowledge	**N**	**'Yes' frequency (%)**
Know target BGLs	186	161 (86.6)
Know target HbA1c	226	96 (42.5)
Understand what BGLs mean	237	192 (81.0)
Know when to seek help based on BGLs	186	161 (86.6)
Understand how tablets work	183	141 (77.0)

insulin doses. Of the 190 people taking oral hypoglycaemic medication for their diabetes, 96.3 per cent indicated they took their tablets as advised and 77 per cent said they understood how they worked. Although it is recommended that people with diabetes check their feet on a daily basis,[3] only two thirds of the participants with diabetes said they checked their feet regularly.

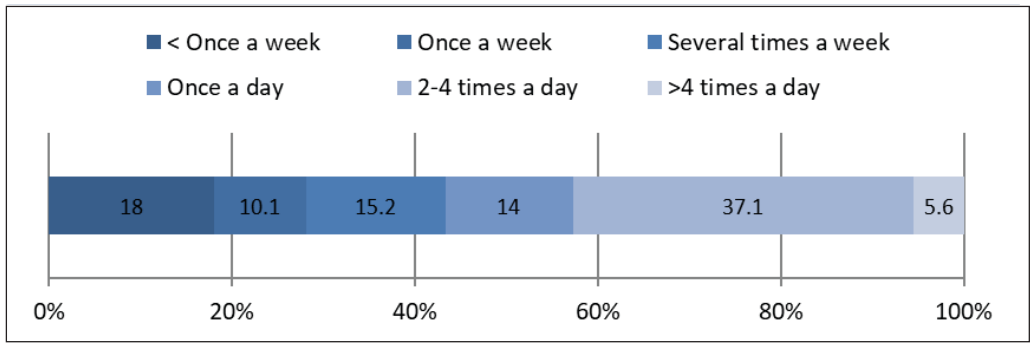

Figure 1. Frequency of blood glucose testing for people with T2 diabetes

Diabetes, health and quality of life

To look at the way having diabetes relates to self-reported health and quality of life, we compared those with T2 diabetes to those without diabetes (see Figure 2, below).

Most of these differences in mean scores were small, but the message is a consistent one: that, on average, people with T2 diabetes reported slightly less good quality of life and health than people without diabetes.

Diabetes self-management (DSM)

Self-reported ratings of how well people were managing their diabetes at home ranged from 0 (not at all well) to 10 (extremely well) (Mean=7.5, mode=8). Pearson's correlations found that self-management scores were positively associated with general health (r=.21), physical health (r=.20), mental health (r=.23), life satisfaction (r=.29), control over life (r=.21) and healthy behaviours (r=.40). The moderate-strength correlation between self-reported self-management and healthy behaviours suggests that people who rate themselves highly on managing their diabetes are also better at eating healthily, exercising and planning positive things to do on a regular basis.

There were 22 people who scored less than 5 on DSM at home. By exploring various characteristics, we found this group consisted of more women than men, who were predominantly New Zealand European (90.9 per cent) and two-thirds were aged less than 65 years. Just over half had no school qualifications (52.4 per cent) and most lived with others. Their mean healthy behaviours score was 4.1, which was notably lower than that of those scoring 5 or more on DSM (M=4.9). The majority had consulted a GP during the last year (90.5 per cent) and most had consulted a practice nurse (66.7 per cent). Fewer than half had seen a specialist nurse/nurse practitioner (42.9 per cent) or an LTC nurse in general practice (28.6 per cent). Only a few of this group (19.0 per cent) indicated they had a written care plan, compared to 25.7 per cent of those with a DSM score of 5 or more. Also, fewer of those with lower DSM scores reported having practitioner support for their health goals (36.8 per cent vs 61.7 per cent).

Advice to others

A number of participants provided diabetes-related advice for other people and a selection of quotes is provided on p23 (opposite).

Discussion

We found the level of engagement in diabetes self-management to be quite variable, but most people reported taking oral medication and using insulin as advised. Three-quarters were testing their BGLs at home, with the majority of those on insulin, and 13.2 per cent of

continues p24

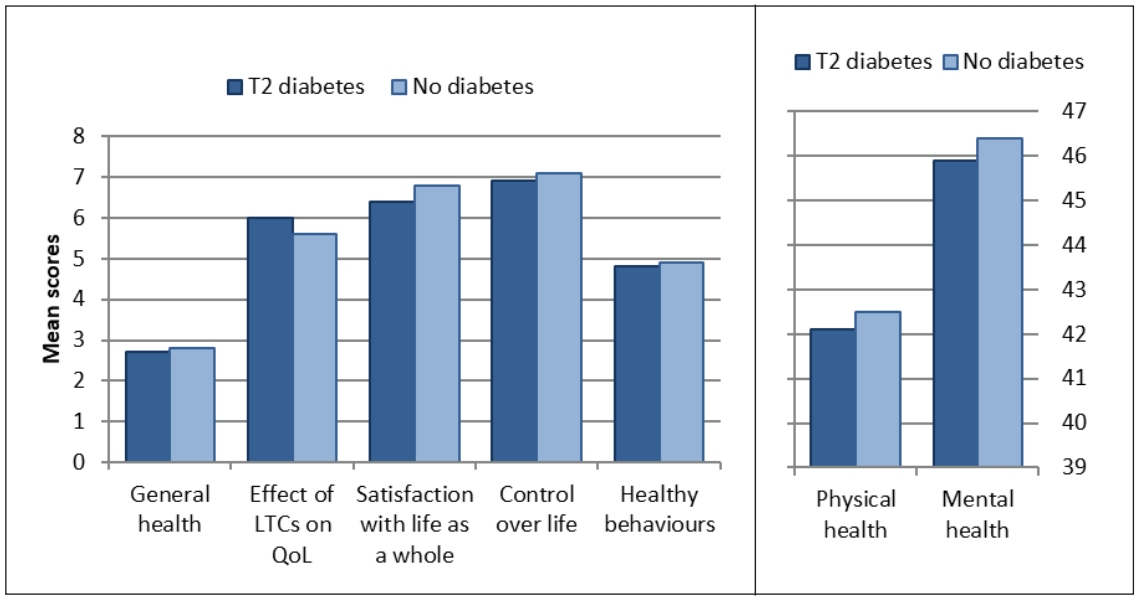

Figure 2. Mean score comparisons for people with and without type 2 diabetes on self-reported health and quality of life variables.

Key points

- ALMOST half the *Talking about Health* participants had diabetes and 90 per cent had at least one other LTC; 19.8 per cent had anxiety or depression related to having an LTC.
- THOSE with T2 diabetes reported slightly poorer quality of life and health.
- AROUND three-quarters of those with T2 diabetes tested their blood glucose levels at home, 37 per cent testing two to four times a day. This number included more of those on insulin than those not. However, almost 15 per cent did not know what their target levels were.
- FORTY-THREE per cent of the people with T2 diabetes were using insulin, but 10 per cent of these said they were not taking it as advised.
- THIRTY-EIGHT per cent of the people using insulin titrated their own doses; 40 per cent of them taking into account their BGLs, activity and carbohydrate intake to do so.
- FEWER than half the people with T2 diabetes indicated they knew their target HbA1c.
- MOST people felt they were managing their diabetes fairly well at home (7.5 out of 10 on average).
- WOMEN, people with limited education and people with less income to meet their everyday needs were over-represented in the group, indicating they were not self-managing well at home (DSM score of <5 out of 10).

- HIGHER self-management scores were weakly associated with health and quality of life, but more strongly associated with healthy behaviours such as eating well (including plenty of fruit and vegetables), not eating too much fatty and sugary food, exercising regularly and planning positive things to do.

'If you are told to exercise, exercise!'

'Go and see your doctor every three months, whether he/she wants to see you or not'

'I write my blood testing results down in a book, then I know where it is'

'I have to self-manage because who else is going to do it?'

ADVICE FROM STUDY PARTICIPANTS

'If your condition requires daily changes or attention, have a place in your house where you can keep all of the items required for treatment together. Then you can set out a workplace and not have to hunt for things'

'When dealing with busy medical folk, ensure that they fully understand all of your symptoms and problems'

'It is also necessary to work hard on motivating oneself, especially on days when blood-sugar levels are erratic'

'Get into the habit of testing your blood sugars from the start!'

'Look after what you eat and take medication in time'

Practice points

- HEALTH literacy should always be considered when supporting people to self-manage any LTC. Diabetes in particular presents a multitude of self-management challenges requiring good understanding and confidence. As a starting point, the Health Quality & Safety Commission has produced a guide for health professionals, *Three steps to better health literacy.*[7]
- ASKING people to rate how well they think they are managing their diabetes at home could lead into useful discussions on what they were thinking about when making the rating. A lack of understanding of the condition and necessary treatment combined with the costs associated with self-management (eg eating healthily, attending a gym/swimming pool, diabetes consumables) could be prohibitive, leading to poorer self-management.
- PEOPLE with a lower level of education are likely to need simpler and more prescriptive advice than those with a higher level of education.
- IT would be worth talking to people who are testing their BGLs at home to be sure they know why they are testing, and to understand their readings and the targets they are aiming for. Use of a monitoring diary, which could have targets for specific times of day added by a doctor/nurse, might help with tracking and interpreting BG results.
- ENCOURAGING people to bring their test meters to appointments can help you (a) know they are copying their readings across accurately, (b) check their recent readings if they are not using a log book, and (c) check meters are working (and being used) properly.
- NOT everyone on insulin was using it as advised and a few people were not testing their BGLs at home, some of whom said they were adjusting their own insulin doses. It is important to check that people understand the importance of BG testing when taking insulin – particularly if they are adjusting their own dose rates.
- SELF-MANAGEMENT courses for people with diabetes are provided through primary health organisations, district health boards and community organisations such as Diabetes NZ, Diabetes Trust and Diabetes Auckland.
- THE Health Navigator site (healthnavigator.org.nz) provides diabetes information on topics including driving, diabetes in pregnancy, diabetes complications and sick day planning, as well as useful diabetes apps.

those not on insulin, testing more than once a day.

There was evidence that some people are testing their BGLs at home without knowing their targets, which raises questions about their understanding of why they are testing and what they do with the results. It also suggests a need for self-management support in this area. Fisher and colleagues note the importance of individualising the frequency and timing of testing to best inform both patient and practitioner and to encourage self-efficacy.[4]

However, the health literacy levels of people with diabetes also need to be understood and accommodated. A study of people with non-insulin-treated T2 diabetes found that people with limited health literacy had poorer glycaemic control than those with adequate health literacy, despite BGL testing more regularly. This suggests that they may be following advice to test daily without understanding their results or knowing how to translate the findings into appropriate action. Reasons provided for not engaging in daily BGL testing were: not having been advised to; the cost; the pain associated with testing; and not understanding the importance of testing.[5]

A qualitative study of people with T2 diabetes found that although participants all felt responsible for self-management, those with a lower educational level wanted to follow instructions, whereas those with higher education were more inclined to make their own rules for daily management.[6] •

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By co-editor Teresa O'Connor

Mental health issues 'stubbornly similar'

The Mental Health Commissioner's biennial report on mental health and addiction services highlights some progress but says there's still plenty of work to do.

While there has been significant progress in mental health and addiction services in the last two years, some issues remain "stubbornly similar", according to Mental Health Commissioner Kevin Allan.

In his recently-released independent report on the state of these services, he includes as signs of progress, an increase in early support through primary and community care; the foundations of a new Mental Health and Wellbeing Commission, as recommended in *He Ara Oranga (*the report of the government inquiry into mental health and addiction, released in late 2018), greater Ministry of Health investment to boost capability and more money for kaupapa Māori approaches.

While there had been a welcome shift in focus towards better support for people with mild to moderate needs, there was still a "pressing need" to improve services for people with complex and ongoing needs.

The commissioner's report made 20 recommendations to the Minister of Health, including the development of an action plan to deliver on the approach set out in *He Ara Oranga*.

Repeal of Mental Health Act

He also recommended progress in the repeal and replacement of the Mental Health Act (MHA) and transparency in how this work would be done and the timeframe. He recommended tangible progress to address New Zealand's high rates of compulsion under the MHA and, specifically, identifying and addressing the factors that lead to a disproportionately high use of compulsory treatment for Māori. And he wants the minister to direct the ministry to record, and by next year, report on prescriptions in mental health inpatient units. More than 800,000 New Zealanders were prescribed a psychotic medicine in 2018, according to the report.

The commissioner's report reflects the weaknesses of *He Ara Oranga*, according to the chair of NZNO's mental health nurses' section, Helen Garrick. "The views of mental health and addiction nurses were not evident in *He Ara Oranga* and are not present in this report."

A majority of section members had not witnessed any improvement in mental health care as a result of the government inquiry. In a recent survey of section members, 80 per cent of respondents had seen no improvement in staffing; 88 per cent had seen no improvement in resourcing; 87 per cent said there had been no improvement in communication between primary and secondary services; and 79 per cent said there had been no improvement in service user satisfaction.

But Garrick said there had been progress in the focus on wellbeing and primary mental health, and there was better support for people with mild mental health needs. Access to early intervention through primary health and digital services had also increased.

The commissioner said all services needed to work for Māori and to be culturally safe. "Strengthening Māori participation and leadership in the design and delivery of services is essential, both for improving outcomes and meeting obligations under Te Tiriti o Waitangi."

The collective response to supporting people's wellbeing during the COVID-19 pandemic highlighted what was possible. "The rapid action to house people without a home and provide intensive mental health, addiction and other support shows what can be achieved when there is a will," the report said.

But there were many areas needing urgent attention. These were:

- Ensuring all mental health and addiction services worked for Māori and were culturally safe.
- Reducing high rates of compulsion under the MHA and the increasing use of seclusion, especially for Māori.
- Increasing support for people who experienced harm from substance use.
- Improving mental health and addiction services for pregnant women and new mothers, including more integrated care for women and their babies. Suicide is the leading cause of maternal mortality, with Māori whānau most affected.
- Expanding the capacity of forensic mental health services – there had been a 25 per cent increase in the prison population since 2013 . . . but hardly any increase in forensic mental health capacity.
- Supporting specialty mental health and addiction services, which were under pressure.

Referring to the commissioner's call for lowering seclusion rates, Garrick said the section remained concerned about the continued movement towards zero seclusion without recognition of assaults on mental health nurses in inpatient units. A recent survey of section members revealed 74 per cent of respondents had experienced violence from service users.

Data on the use of medication to sedate or chemically restrain tāngata whaiora needed to improve, Garrick said, as it was possible more chemical and other forms of restraint were unintended consequences of a reduction in seclusion rates.

Mental health nurses looked forward to contributing to changes to the MHA and to strategies to ensure safety for service users, families and communities, she said.

The commissioner said change was required across the whole health and disability system and must include greater integration with specialist mental health and addiction services and across other areas of health.

"More of the same will not deliver the wellbeing and recovery-orientated system that is required," the report stated. •

The pathway to a healthy career choice

The first students of Te Herenga Waka—Victoria University of Wellington's Bachelor of Health are getting set to finish their degree and start shaping the future of New Zealand's health and wellbeing.

A diverse range of skill sets will be required to build future health workforce capability, with new challenges around the corner.

For Emmerson Toomaga, who started her Bachelor of Health when it first launched in 2018, the chance to shape the future of public health was what drew her to the degree.

"I've always wanted to know why Māori and Pasifika feature highly in negative health statistics, so I brought those questions with me to my degree," she says.

"I started my degree focusing on health promotion, but moved more into policy because I want to be in the room where policies are made and be a voice."

The Bachelor of Health provides a foundational understanding of health psychology, health promotion, health services, policy and strategy, the social aspects of health, and how health issues affect populations in New Zealand and beyond.

Students learn how to critically evaluate health issues and needs and examine action plans that will lead to lasting improvements to health and wellbeing. These could include a focus on health and wellbeing in Māori and Pasifika communities, as well as considering the international context.

The Bachelor of Health offers students a choice of four majors: Health Informatics; Health Promotion; Health Psychology; and Population Health, Policy and Service Delivery. These subjects prepare students for a rewarding career contributing to good health and wellbeing in our communities.

"Health impacts everyone," says Emmerson. "There is huge scope to go into different sectors and we can work towards any number of careers in healthcare."

Good candidates for the degree are those who are motivated to make a difference—by wanting to improve understanding of the factors that influence health and wellbeing, by influencing health outcomes in their communities, or by developing the use of technology in the health sector.

Applications to begin study for the Bachelor of Health in 2021 open on 1 October 2020 and early application is encouraged.

People with a mental illness miss out on palliative care

A nursing academic wants to highlight the disparities in who accesses palliative care. It's certainly not patients with mental health issues.

By co-editor Anne Manchester

While the general population ages, people with mental health issues continue to die at much too young an age, according to University of Auckland (UoA) teaching fellow Helen Butler.

This is mostly due to unaddressed physical health issues, she says, and those with mental health issues being unable to access the services they need.

Butler is part of the mental health and addiction team at the UoA's school of nursing where she completed her masters in 2019. This looked at the disparities mental health service-users at one district health board (DHB) experienced over a six-year period and their lack of access to palliative care. She has now embarked on her PhD which will examine the same topic in much greater depth on a national and international basis.

As a nursing student, Butler experienced a turning point in her life during a third-year clinical placement in a community-based mental health acute unit in West Auckland (Te Atarau, now called Waiatarau). She so enjoyed the work, she was offered a job as a psychiatric assistant while she completed her studies. On graduating in 1993, she worked at the unit for the next 18 months.

A move to Australia followed. There she continued working in mental health and in an AIDS ward where she had her first experience of nursing people who were dying and who also faced stigma and discrimination.

"My sense of compassion deepened during this experience and was further developed when I returned to New Zealand to care for my grandmother who was dying of melanoma. This was a tough experience but also a good one, as it taught me so much," Butler said.

Helen Butler is on a crusade for change, both nationally and internationally.

Butler continued to work in mental health, had children, then began doing private nursing work, caring for people who were dying at home. One of her patients spent a week at Auckland's Mercy Hospice where Butler continued to nurse her and stayed overnight. This was the trigger that led to Butler working at Mercy Hospice. She eventually became a clinical educator, then a team leader and, at that point, began doing her masters.

It was her masters supervisor, Tony O'Brien, who encouraged her to come and work at the university, which she initially did part-time, while continuing at the hospice. She is now a full-time professional teaching fellow at the UoA – a professional direction she never expected to take.

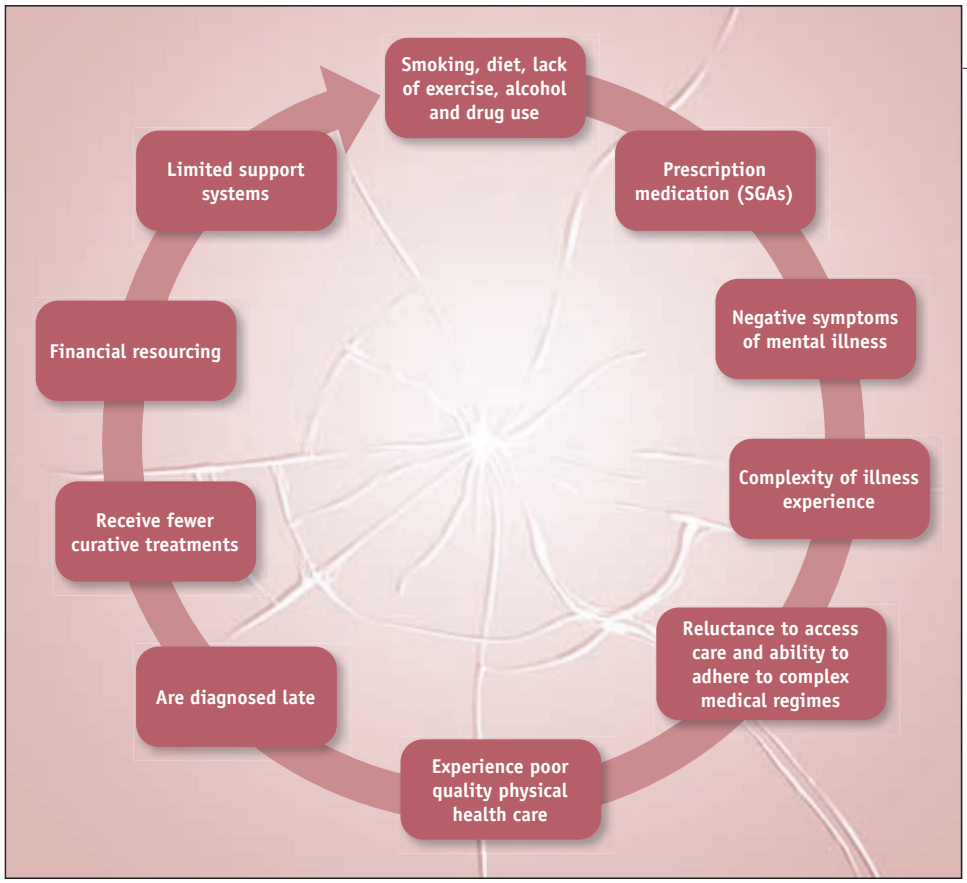
"A lot of nurses are advised to either work in mental health or physical health, but I have managed to do both. I have learnt skills in both fields and use those skills in both. I feel this makes me a more integrated nurse," Butler said.

"I am drawn to people and whānau who are experiencing mental distress. I like working collaboratively with them to find a way forward. When I was working in mental health, mostly in the community, I was aware of people with co-morbidities dying in their 40s and 50s. I could see they were suffering and I could also see that not many were being referred for specialist palliative care. When working for hospice, I noticed staff were also concerned whether they had the skills to care for patients with a mental illness diagnosis."

None of this seemed a new problem, Butler said. A study more than 80 years ago showed that people with a mental illness had very high mortality rates.[1] Recent studies have shown patients with mental health issues are dying 25 years younger than the general population, with some of the most common co-existing medical morbidities being cardiovascular disease, type-2 diabetes, respiratory disease and some forms of cancer.[2]

Issue of social injustice

"This issue really began to bug me, as it seems so clearly one of social injustice. The disparities are due to systemic problems, not to problems of people being misdiagnosed. For example, those with cancer and a mental health problem are three times more likely to die than those with cancer but no mental health problem.[3] It is about the care, or lack of care, these patients are being offered and the barriers they face accessing services, particularly specialist palliative care services.



Factors affecting people with serious and persistent mental illness getting the care they need.

"In my master's study, data collected at Capital and Coast DHB from 2008-2014 showed patients with mental health problems were 3.5 times less likely to access specialist palliative care than the rest of the population," Butler said.

With people with mental health problems more likely to also have life-limiting physical illnesses, she had expected to see more such patients receiving palliative care, but this was not the case. She also noted from her DHB data that Māori people were more than twice as likely to have mental health problems as the general population.

"My master's study led to more questions than answers. People with mental health problems face high levels of deprivation – they are less likely to be employed, and they live in poorer housing or struggle to find housing. People with difficulties in one social category will inevitably experience difficulties in other social categories – this is the synergistic effect of disparity and inequality.

"Research shows that when people with a diagnosis of mental illness access emergency department [ED] and GP services, they often experience diagnostic overshadowing. This is when any assessment of their physical symptoms is attributed to their mental health problem. Even when a physical health diagnosis is made, they are less likely to be offered curative treatment. Not having their physical issues addressed properly leads inevitably to an early death for these patients."

The single-disease focus of the health system, particularly secondary care, also makes it much harder for people with co-morbidities to have their needs addressed, Butler says.

"Mental and physical health services are separated, with those working in physical health areas lacking knowledge and confidence in how to handle patients with mental health issues. This means people with both mental and physical health issues fall through the cracks. Until we have a health system that is more coordinated and integrated, people will continue to miss out on care, will be diagnosed too late and will die sooner than they should. "

Butler sees herself as an ally, as someone wanting to highlight the disparities, as a voice for change. She also wants to be part of an international voice, as these problems occur throughout the world. She has already published her research, jointly with Tony O'Brien, in the *International Journal of Mental Health Nursing*[4] and presented her findings at the Public Health Palliative Care International conference in Australia last year.

"There is a lot of work to do to bring about change. This is not just about changing the views of individuals, but changing society's views and changing the way our health system operates. I believe mental health nurses have an important role to play in advocating for service-users who develop incurable, life-limiting physical illnesses to have access to palliative care. They can have conversations with their patients about their end-of-life care wishes and help them make good choices. End-of-life expectations are similar, whether a person has been diagnosed with a serious and persistent mental illness or not."

Mental health paper

Butler teaches a postgraduate paper on mental health and addiction for health professionals not working in these areas. She is delighted so many nurses working in primary and secondary care, particularly ED, find it helpful. "People enrol in this paper because they don't feel they know enough about mental health issues. They want to increase their knowledge and their confidence in dealing with people experiencing mental health distress and understand how unconscious bias within the health system works. The paper increases students' awareness that it is how health professionals value and treat a person with a mental illness that affects their ability to access the services they need," Butler said. •

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Trauma-informed care – What is it? Why is it important?

Levelling power differences between staff and patients/service-users – ie collaboration and mutuality – is one of the principles of trauma-informed care.

Trauma-informed care is a principled approach to reducing re-traumatisation for people who have had distressing experiences in the past.

By Brent Doncliff

The environment in which one grows up, if it is negative, can, depending on one's resilience and internal resources, have a deleterious psychological impact – more so than can be explained by genetics alone.[1] Previous studies have indicated this is a general finding around the world.[2,3] The effects of childhood trauma (due to associated stress) are pervasive and have an effect on cognition and mental health into adolescence and adulthood, with greater levels of trauma leading to poorer outcomes throughout life.[4,5,6] This can lead to reduced social functioning, poor ability to cope with stress[7] and longer periods of untreated mental illness.[8]

A person who has experienced trauma in the past can have difficulty with mental health in the future. While one cannot change what has happened in the past, what happens now can, in some way, mitigate against re-traumatising someone who needs mental health care.

One approach used to address the issues that have arisen from previous trauma is called trauma-informed care (TIC).[9] There are several aspects to TIC, which include minimising distress and promoting autonomy.[10] Six key principles have been listed by the United States Department of Health and Human Services' Substance Abuse and Mental Health Services Administration:

1) safety
2) trustworthiness and transparency
3) peer support
4) collaboration and mutuality
5) empowerment, voice and choice
6) cultural, historical, and gender issues.[9]

Safety: This relates to the organisation or health facility maintaining a physical and psychologically safe environment. Availability of same-gender staff and, if needed, separation of male and female service-users/patients to allow for separate bedrooms, private spaces and bathrooms.[11]

Trustworthiness and transparency: The organisation has open decision-making processes, in order to build and maintain trust.[12]

Peer support: Service-users and others with lived experience of trauma are available to provide mentoring and mutual self-help. Also, there are support mechanisms for staff such as clinical/professional supervision.[12]

Collaboration and mutuality: Focus is placed on levelling power differences between staff and patients/service-users. Co-design is one mechanism for collaboration, where representatives of both staff and consumers/patients have an equal input into the development of the mental health service.[13,14]

Empowerment, voice and choice: The strengths and experiences of the client/patient are recognised and fostered. A belief in resilience is at the heart of empowerment.[12]

Cultural, historical and gender issues: The mental health service addresses stereotypes and biases. This includes gender-safe service provision, the recognition and incorporation of cultural practices important to the client/patient and the conscious use of language.[12]

Practical steps

There are no set measures related to TIC, except the consideration of the above-mentioned principles. There are some practical steps that can be used to reduce the stress associated with mental

health care:

One of the first things that can be done in relation to mitigating the effects of trauma is to make hospitalisation for psychiatric distress a last option.[11] It is important for people to feel as much in control of their situation as possible, so community-based options, such as crisis respite and intensive home-based support, should be used where these services are available.

Where possible, before a crisis develops, the service-user should be supported to list any advance directives to inform staff of the choices they would like made for them in situations when they are unable to directly communicate this themselves. An advance directive is a way for the client to be involved in their own care planning. One method which seems to have good client/clinician acceptability is the mental health advance preference, known as MAP.[15] It is also important that the client/patient has input and control over their treatment plan.[16]

Where the client is at risk of serious harm to themselves or others, then inpatient mental health services may be necessary. It is important for inpatient services to be designed in such a way that reduces as much as possible re-traumatising practices, such as restraint and seclusion, which may trigger flashbacks.[11] Programmes such as Safewards[17] and the "six core strategies"[18] have been developed to reduce restraint and seclusion.

Six core strategies

The six core strategies were developed in the United States by the National Association of State Mental Health Program Directors Medical Directors' Council. They were developed following a number of major report findings and in response to the growing consumer lobby stating that seclusion and restraint were traumatising experiences, both to clients and the staff having to restrain and lock them up.[19]

The strategies are:

1) Leadership towards organisational change: articulating models of care and underlying philosophies and values which promote client-centred care and a focus on recovery.
2) Using data to inform practice: using information to identify factors involved in decisions to restrain or seclude, and to identify strategies for early intervention.
3) Workforce development: establishing environments less likely to be coercive in nature, by upskilling staff and seeking the "least restrictive alternative" ways of operating in the clinical environment.
4) The use of seclusion and restraint reduction tools: using tools such as trauma history and assessment, and identifying any pre-existing safety plans or advance directives.
5) Service user/client roles integrated into inpatient treatment settings: eg using service users as client advisers or peer support workers.
6) Debriefing techniques: examining the factors involved in the decision to restrain or seclude or using the principle of "appreciative inquiry" to examine situations where restraint and seclusion was avoided entirely.[20]

Trauma-informed care is not a theory per se, but a principled approach to reducing re-traumatisation for people who have experienced trauma in the past. By considering the effects of past trauma and limiting the use, where possible, of coercive practices, the deleterious effects of re-traumatisation can be reduced (or eliminated). The principles of TIC are not just applicable to people who have experienced past trauma, but can also be applied generally across the mental health service. •

Disclaimer: The opinions expressed in this article belong solely to the author, based on literature research and collective experience. They should not be interpreted as being part or not part of West Coast District Health Board philosophy or procedures.

This article has been reviewed by Southern District Health Board nurse practitioner Mark Baldwin and the co-editors.

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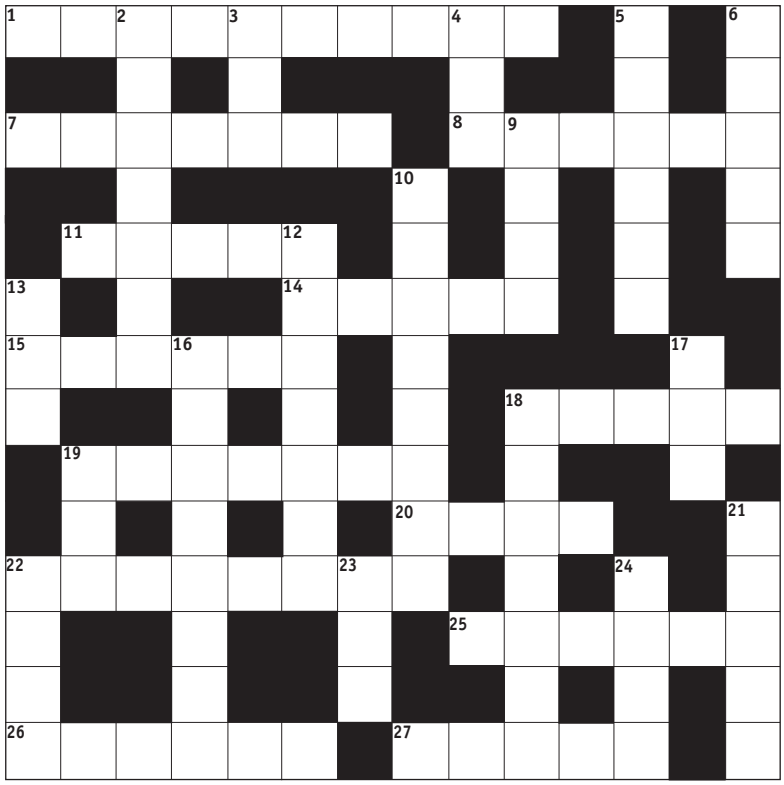
crossWORD

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



ACROSS

1) Isolation to prevent infection.
7) Ballroom dancing style.
8) Fossil fuel used in heavy vehicles.
11) End of life.
14) Manchester rock band featuring two brothers.
15) Those who purchased.
18) Cosmic payback.
19) Coalface for nurses.
20) Animal's father, in breeding terms.
22) Bold.
25) Rough drawing.
26) Deep knowledge.
27) Harmony.

DOWN

2) Worry.
3) 78% nitrogen, 21% oxygen.
4) Use head to agree.
5) Leave job.
6) Underneath.
9) Coloured part of eye.
10) Suffering.
12) Home of palliative care.
13) Flow backwards.
16) Supported.
17) Large Australian bird.
18) Prayer (Māori).
19) Pollen-loving insect.
21) Repeated sounds.
22) Defect.
23) Drink a little.
24) Eye swelling.

August answers. ACROSS: 1. Lockdown. 5. Elder. 8. Aim. 9. Aloof. 10. Pharmac. 12. Scour. 13. Eat. 15. Expert. 16. Yarn. 17. Own. 20. Kai. 21. Zinc. 23. Yet. 27. Sadness. 28. Debt. 29. Gerontology. **DOWN:** 1. Loathe. 2. Competent. 3. Decaf. 4. Warm. 6. Deodorant. 7. Referendum. 11. Aorta. 14. Hem. 17. Obeying. 18. Garden. 19. Fiasco. 22. Caddy. 24. Tsar. 25. Zero. 26. Oboe.

wiseWORDS

> "About a third of my cases are suffering from no clinically definable neurosis, but from the senselessness and emptiness of their lives. This can be defined as the general neurosis of our times."

– Carl Jung (1875-1961), Swiss psychiatrist who founded analytical psychology

it's cool to kōrero

HAERE MAI and welcome to the September column. One of Aotearoa's outstanding songsters is the korimako (bellbird). Its beautiful liquid song can differ enormously in different parts of the country. The male sings to the female as he courts her in winter, and after mating, they often duet. Korimako is just one of many names Māori have for this bird.

Kupu hou

New word

- **Korimako** – pronounced *"ko-(as in k/paw)-ri-(as in reed)-ma-(as in mah)-ko-(as in k/paw)"*

In Māoridom, great singers and orators were praised by being compared to the korimako.

- **He rite ki te kōpara e kō nei i te ata.** Just like a korimako singing at dawn.

This issue of the magazine looks at mental health. Depression is a common problem in Aotearoa. Here are some words that describe some of the ways Māori may experience depression:

- **wainuku**
low mood (the waters of the body are drawn towards Papatūānuku)
- **whakamā**
shame about yourself or your situation
- **nekeneke**
when your thoughts keep moving about, making it hard to concentrate

Whakataukī

Proverb

- **Tau mai rā te mauri āio, te mauri aroha, te mauri o ngā mātua tīpuna.**
Let the essence of peace and calm, of love and our forebears settle on us all.

(see https://depression.org.nz/get-better/your-identity/maori/)

E mihi ana ki a Titihuia Pakeho and Keelan Ransfield, and to www.nzbirds.com

‘I’m not racist . . . am I?

The following scenario is representative of an all-too-familiar experience our Māori whānau face in the health-care system. We hope you will take the time to read it and answer the questions at the end.

By Te Rūnanga member Moana Teiho

Sam is 16, a boy whose feelings of security come from his whānau. Today Sam can feel the anger building up; the stitches in his wound threaten to pull; anger overwhelms his physical pain as adrenaline kicks in.

Sam’s little sister Maia, 10 years old, is told visiting hours are over and she must leave the ward. The source of Sam’s anger is a young non-Māori nurse. Sam asked her if Maia could to stay until their mother arrived for the night. Sam’s request was abruptly dismissed and he was told security would remove her if she was still there on the nurse’s return. Sam’s distressed reaction prompted the nurse to ring security. Concerned about her brother and security, Maia leaves the ward in tears and waits outside the hospital.

Earlier, Sam had heard the same nurse speaking kindly to a non-Māori couple in the next cubicle and allowing the husband to stay on longer. From that interaction, Sam assumed the nurse would allow Maia to stay in the safety of his room. Incensed, Sam starts screaming in anger, throwing and kicking things in his bed space.

Mere has started her third night shift as a new graduate nurse. She wonders if she’ll make it home in time to get the children ready for school in the morning. Suddenly, Mere hears a ruckus from the cubicle adjacent to her patient. Mere peeks through the closed curtain, taking in the scene before her. *“Why is this boy upset?”* thought Mere. Her first instinct was to comfort him and ease his obvious pain. Mere calmly speaks to Sam; as he looks up, his face fills with tears, the pain and frustration bellowing out. After hearing Sam’s story, she calmed the boy down, putting him to bed.

Double standards

This was not the first time Mere had seen the other nurse treat whānau unfairly. While her colleagues had remained quiet, Mere had tried to calmly point out the double standards to the nurse, but had been met with defensiveness: *“Are you accusing me of being racist? I’m NOT racist. Look, we don’t have enough staff on tonight. We can’t be expected to watch you people all the time you know?”*

All this played over in Mere’s mind, making her body fill with anxiety. *Was she in the wrong? Did she really want to deal with it? Or maybe she was being too sensitive?* Mere knew better and, though she knew it would be uncomfortable, Mere felt compelled to say something. Taking a deep breath, she stepped from Sam’s bed to confront the nurse . . .

While her colleagues had remained quiet, Mere had tried to calmly point out the double standards to the nurse, but was met with defensiveness . . .

It would be easy to surmise what Mere did next.

However, we would like you to answer for yourself how you would have acted in Mere’s shoes.

As you do, we encourage you to consider the following questions:

- What are my beliefs about patients and health-care workers from other ethnicities?
- Explore those beliefs – where did they come from?
- Are there strong stereotypes about Māori that influence how I interact with them?
- What has driven me to work in a practice built on caring?
- What does caring mean to me?
- What power dynamics exist in my work that allow racism to go unchecked, whether against staff or patients?
- Have I contributed to that?
- Is the answer I give to myself now about confronting the nurse the same as what I would do in practice?
- Have there been times at work where I knew I could have spoken up but didn’t?
- How would I like to be spoken to when confronted about racism?
- How would I like people to react if I call them up on racism?

Racism influences practice

Racism strongly influences our nursing practice – despite being trained to do the opposite – our daily lives and our willingness to change, which is driven by the prejudices we harbour within. Many Māori whānau, Māori nurses, health-care workers and nursing students are frequently exposed to similar or worse situations than this scenario. Many know the paralysing fear and injustice felt from exposure to racism, whether directly or indirectly. It is an ingrained behaviour that should not be accepted or normalised.

How will you allow change to take place? How will you be part of that change?

“I am no longer accepting the things I cannot change; I am changing the things I cannot accept.” – African American political activist, scholar and author Angela Davis. •

Moana Teiho, RN, BHScN, PGCert (advanced nursing practice), PGCert (primary health care) works as a community cardiac rehabilitation nurse for an iwi provider in Tai Tokerau. She is also a B4School and Tamariki Ora nurse.

Including new services in dedicated

Incorporating Canterbury's non-governmental alcohol and other drug services into the existing mental health and addictions dedicated education unit has proved successful for all concerned.

By Maryann Wilson and Shelley Higgins

Until 2016, the Canterbury dedicated education unit (DEU) model provided comprehensive learning opportunities within Canterbury District Health Board's (DHB) specialist mental health and addiction services. However, the non-government organisation (NGO) alcohol and other drugs (AOD) sector had not been explored as a provider of learning experiences and clinical placements for nursing students.

The DEU teaching team had become aware of the "untapped hidden gems" of learning and clinical practice experiences available in the NGO AOD sector. To complement undergraduate students' mental health and addictions experience, and to expose students to the autonomous role of the nurse within the community, the DHB's mental health and addiction services DEU model was expanded to include this sector in 2016. The organisations involved include Christchurch City Mission (CCM); Thorpe House (part of CCM) regional residential withdrawal management service, withdrawal management nurses and the Salvation Army Bridge programme.

Clinical liaison nurse (CLN) Shelley Higgins and associate CLN Helen Linton, who work with the DEU, meet nursing students before clinical placements start. At this time, the AOD services DEU model is discussed, and students receive their placement roster. The students then attend an addiction services orientation day on the first day of their clinical placements. This includes a shared morning tea with staff, followed by a structured orientation programme. Students receive the services orientation booklet, a tour of the Hillmorton site, presentations from key nursing staff from services within the DEU – Hepatitis C community clinic, consumer and advocacy support, Māori mental health workers Pūkenga Atawhai and the academic nursing lecturer (ALN). The next day students attend their designated clinical placements – a three-week inpatient placement and a three-week community placement.

Results 'beyond expectations'

We used this new approach with a degree of caution, as its success was reliant, at least initially, on the DEU's team's relationships and knowledge of the AOD field. But the result of this different way of supporting learning was beyond our expectations.

Students were positive about the experience, as evidenced by their feedback and debate among students about the variety of experiences now available.

PHOTO: ADOBE STOCK

This exposure enabled students to critically consider the challenges of engaging with clients who have complex lives and who are involved with multiple agencies.

CCM community withdrawal management nurses, Raewyn Birkett and Sarah Ferguson, and manager Jan Spence were also positive about having students on clinical placement.

"It has been great to be part of the DEU and see the range of experiences the students are exposed to. And having students coming through encourages staff to keep up to date with best practice and maintain teaching and clinical supervision skills. Patients enjoy seeing students and feel empowered when asked to be part of the students' learning," Spence said.

Higgins said the DEU students were exposed to more learning than just understanding the disease process of substance use. "Students learn throughout their placement how to develop empathy without compromising personal and professional boundaries. This is role-modelled by nursing staff within the DEU, who consistently demonstrate professionalism and empathy in their everyday interactions with clients and other health professionals," she said.

This exposure enabled students to critically consider the challenges of engaging with clients who have complex lives and who are involved with multiple agencies.

The experience of clients who are on their recovery journey, who may have limited resources, who may be struggling with accommodation, financial and transport issues and who have to wait some time for help can be difficult to witness. Students can often identify the needs of these clients, but grapple with the reality that there may be no immediate answers or solutions to their situation.

At times, the CLN role can be a chal-

education unit proves a success

	Canterbury Dedicated Education Unit	Alcohol and Other Drug Services
Specialist Mental Health Services Hillmorton Hospital Canterbury District Health Board (CDHB)	**Kennedy Inpatient (Regional) Adult Medical Detox Unit** Canterbury District Health Board (CDHB)	**Community Alcohol and Drug Outpatient Service** Canterbury District Health Board (CDHB) **Christchurch Opioid Recovery Service** Canterbury District Health Board (CDHB)
Non-government organisations	**The Christchurch City Mission: Thorpe House**	**The Salvation Army Bridge Residential Alcohol & other Drug Treatment Programme**

lenge, especially when accommodating nursing students' perceived learning needs with the reality of the clinical environment. When in clinical placement, students must complete portfolio activities which support their clinical learning. These activities rely on a client attending arranged appointments. When a client does not attend, students can miss an opportunity to demonstrate newly-acquired clinical skills, how to establish, maintain and conclude a therapeutic relationship and the clinical knowledge they have gained.

The CLN can bridge this gap by liaising with nursing staff across the teams to ensure the student has the opportunity to work with a client and complete the required portfolio activities required.

The collegial partnership between the CLN and ALN is an integral part of the success of the DEU.

Maryann Wilson (ALN) acknowledged that, while the DEU model was underpinned by the principles of adult learning, it aimed to enhance learning experiences and explore the autonomous roles of registered nurses in different practice environments. To ensure the DEU's development and educational sustainability, all involved must retain a collaborative, student-focused learning approach. For example, nursing staff are rostered to students to ensure DEU sustainability and the diversity of student learning experiences. Furthermore, rostering within the inpatient units has evolved to include afternoon shifts and blended placements. These placements involve a student "floating" between two services, eg the community AOD service and the Christchurch opioid recovery service, which are in the same building on the Hillmorton site. This developed to ensure students had more learning opportunities.

Constructive feedback

The collaborative approach is achieved, in part, through constructive feedback from both students and DEU staff to the clinical areas. Not only does this provide the opportunity for strengthening relationships between clinical areas within the DEU, but the presence of the ALN and CLN also ensures there is continuing student-focused learning and clinical experiences, and course requirements are met. This has enabled an associate CLN role to be established, ensuring continuity of the DEU processes when the lead CLN is not available.

In addition, it is important for the CLN and the ALN to understand the environment within which AOD services operate in Canterbury. Flexibility is needed when considering student placements to ensure the operational needs of individual clinical areas can be met. For example, when Ministry of Health auditing occurs within a service, the DEU model enables the service to be "rested" and the allocated student is then absorbed into another service within the DEU.

Nurse educators should consider student placements in the NGO sector to increase student learning and clinical practice opportunities. For these placement to be successful, nurse educators need to know the NGO sector within their region, develop meaningful relationships with those working in the sector, and recognise the knowledge within this sector. Discussing student-focused learning and the positive contributions NGO nurses can make to supporting and strengthening nursing education in their communities may just reveal those "untapped hidden gems". •

** This article was developed from a presentation given by Maryann Wilson and Shelley Higgins to the Australasian Nurse Educators conference in Dunedin last year.*

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Celebrating mental health

COVID-19 has encouraged new ways of working at one mental health service in the Waikato. The importance of teamwork across health professions and self-care have also been recognised.

By Krizia Ledesma

The global COVID-19 pandemic has changed health care throughout the world. Those of us working in mental health have also been affected. COVID-19 has seen all mental health professionals at all levels working collaboratively and preparing for what lies ahead.

At Puna Awhi-rua – the Midland regional forensic psychiatric service based at Waikato Hospital – we are one big whānau. Perhaps the saddest part of going into lockdown in March was that our tāngata whaiora (service users) were without their family or loved ones. Others do not even have family. They said their goodbyes in our family meeting room, not knowing when they would meet again.

We treat our tāngata whaiora as if they are our sisters, brothers, mothers, fathers, or significant others. We journey with them during their ups and downs and crises, and celebrate their achievements and good times with them.

I work as a clinical nurse specialist (CNS) in Puna Awhi-rua, part of the Henry Bennett Centre at the Waikato District Health Board (DHB). Working in Puna Awhi-rua alongside our forensic mental health service users brings with it many challenges and has pros and cons – having to deal with being spat at, being called various unattractive names, being shouted at, frequent threats of verbal or physical abuse, compassion fatigue, to name just a few. We accept this as part of our job and, to counterbalance the negative factors, we foster a supportive and safe workplace. We love our mahi!

For me, the positives outweigh the negatives. This is because our values, beliefs and vision flow into our actions. We act as patient advocates, working towards providing best practice according to each person's needs. We endeavour to provide high-quality holistic care, with the emphasis on the uniqueness of the individual, taking into account the physical, psychological, spiritual, social and cultural needs of each person. We de-escalate tense situations. We hear the views of others. We are courteous and considerate. We accept differences and diversity. We have empathy. We are open and there is safe sharing. We keep staff, service users and whānau well-informed. Our direction and expectations are clear. We create opportunities for inclusive decision-making. We share the mahi. There is equal recognition for all. We have clear and transparent processes. We acknowledge and appreciate team members. We create opportunities to learn and grow. We give support, praise and feedback. We are kind and helpful to each other. In short, we give both mental health staff and mental health service users the best support we can in this setting.

Increase in mental health risks

However, when COVID-19 arrived, and in particular the lockdown under level 4 and continuing restrictions under level 3, service users' mental health risks increased. COVID-19 has had a massive impact on both staff and service users. We have been stuck in our own little bubble. This meant service users have had no whānau visits (which are important to their recovery), and no walks in the hospital grounds or leave passes to the city. As a service, we put on our thinking caps, worked together and thought outside the box. We thought of ways of calming our service users, how to be creative in our therapeutic programmes and ward activities to meet everyday needs.

We encouraged our service users to talk to their families over the phone. We tried to be flexible with using tablet devices, and set up Zoom sessions to improve communication between service users and their families. Although the communication was not face-to-face, families were pleased to be able to see their loved ones and vice versa.

Once COVID-19 had eased a bit, the Puna Awhi-rua team began meeting monthly for a variety of stress-buster activities.

We engaged in more therapeutic and sustaining relationships with our service users, encouraging them to be more physically active by playing volleyball, badminton, pool, table tennis, and walking laps alongside them in the courtyard. As a family and community, we sang inspirational songs together. We became more creative with our therapeutic programmes and ward activities. Staff who had ballet, yoga and singing talents

successes during COVID-19

or were born jokers were encouraged to share their skills. Since our service users find pleasure in healthy eating, we facilitated "Healthy cooking and eating" every Friday morning. We made wraps, pizzas, stir-fried noodles, biscuits and fruit muffins. And while cooking, staff and patients ensured good handwashing and health and safety precautions were followed.

We started every day with whakamoemiti, giving us a fresh beginning, a breath of thanksgiving, a meaningful reflection and a word of gratitude for the new day. At the same time, we emphasised the importance of handwashing and physical distancing.

Whole team plans care

We value everybody's contribution. We recognise that the care our tāngata whaiora receive cannot be provided by any one person or profession, so we value the contribution of the whole multi-disciplinary team in planning care. I work with an extraordinary team of health-care professionals – doctors, nurses, psychiatric assistants, nurse managers, occupational therapists and assistants, cleaners, administrators, security personnel, pharmacist, social worker, alcohol and drug clinician, psychologist, cultural support advocate, district inspector, medication stockists, medical supply distributor, attendants and kitchen staff. All of us are committed to delivering the best possible care under very demanding circumstances. Everyone is equally important and we all have a role to play.

In these challenging times, mental health professionals answer the call of duty with bravery, placing themselves at risk to support and care for our service users. The five Waikato DHB values – Give and earn respect (Whakamana), Listen to me, talk to me (Whakarongo), Fair play (Mauri Pai), Growing the good (Whakapakari), Stronger together (Kotahitanga) – plus the experience of COVID-19 have taught me the importance of team work, which has been integral to the care of our tāngata whaiora.

All health-care professionals have their own story to tell about their experiences during the lockdown and beyond. Some are on their own and have families living overseas. They have a more complicated COVID scenario than those born in New Zealand. People have experienced different levels of anxiety. Some have had important occasions cancelled (eg a daughter's wedding), a couple gave birth during this trying time, children were not able to go to school, so parents had to home school them. Despite these hurdles, they still chose to work and be of service to our tāngata whaiora.

As some people were deemed to be "off the floor" because of their own physical health, staffing rotations were rapidly redesigned to provide increased cover. They continue to be refined in response to changes in demand. Staff health, wellbeing and sustainability of staffing models were carefully considered at every point along the way. Planning operational issues required vital coordination, with colleagues taking on various work streams. Making sure there is appropriate supply of equipment, staff and medication in the face of a global pandemic is challenging. Managers have to find the balance between keeping the team updated vs communication overload. Due to physical distancing, new ways of working had to be explored, eg having our handover in the dining room where physical distancing is easier to maintain.

Monthly education sessions

Recently, our team started monthly education sessions. If someone wants to share a mental health update, or something they have learned during their postgraduate studies or at a seminar, they share it with others in their own creative way – a lecture, discussion, games and other activities. We need to use evidence-based best practice but appreciate that evidence changes, and we need to flow with that. Positive changes can then be made.

I wonder what the mental health profession will look like when this pandemic has passed. I hope that, as a profession, we will recognise the importance of self-care so we can continue caring for others. When COVID-19 restrictions eased, our team devised "The Social Club 032". This involves the team meeting monthly (no pressure) for relaxation, fun, a stress-buster and simply to foster team-building. Call it self-care. So far, the Puna Awhi-rua family has gone bowling, been out for pizzas and spare ribs, and played golf. We even gave Teppanyaki Japanese cuisine a try.

Proud of colleagues' work

During the pandemic, much of the attention has focused on COVID-19 statistics or the development of a vaccine. Meanwhile, I have never been more proud of, and humbled by, the tireless efforts of colleagues on my ward, in the Henry Bennett Centre, and in the Waikato DHB, for that matter in hospitals all over the world. There are still challenging times ahead with unforeseeable developments to come, but we will deal with it together. We are far stronger if we all work together! No mental health ward is an island.

This pandemic has shown the strength of mental health as we continue to answer our calling. It takes strength, courage, and dedication to selflessly show up for others, especially in these hard times. Every mental health professional has their own reason for choosing this career, but I believe mental health chooses us because of who we are. We work in mental health because caring about people is the heart and essence of who we are and what we do. We would not have it any other way.

This is my mental health nursing haerenga (journey). Kia kaha, everyone! •

Krizia Ledesma, RN, PGDipHSc, MN, is a clinical nurse specialist at Puna Awhi-rua sub-acute inpatient ward, Waikato District Health Board.

Keeping moving towards a DHB MECA

COVID-19 meant report-back meetings to members had to be held via Zoom. Negotiations were to resume earlier this month.

By industrial adviser David Wait

During August, NZNO district health board (DHB) members were updated on progress in negotiations for their NZNO/DHB multi-employer collective agreement (MECA). A handful of meetings were held face to face before the country went into COVID-19 alert levels 2 and 3. Subsequently, the meetings were held via Zoom, with an increased emphasis on online information.

This was a major disruption to our campaign but disruption caused by efforts to eliminate COVID-19 has been felt right across New Zealand. The disruption has also highlighted what might have been a missed opportunity in our negotiations.

Short-term agreement

In the second round of negotiations in late July, the NZNO and DHB bargaining teams focused on what a short-term agreement might look like. There have been recent precedents for such agreements. Earlier in the year, just as the country went into lockdown, the senior doctors' union, the Association of Salaried Medical Specialists (ASMS), ratified a short term (one-year) agreement with DHBs.

Across the Tasman, negotiations for public-sector nurses and midwives in the Australian Capital Territories had to be put on hold because of the COVID-19 pandemic. The state government increased pay and superannuation for nurses and midwives as an interim measure to ensure they weren't disadvantaged by the postponement of negotiations.

A short-term agreement would make sense for a number of reasons. It would likely provide the time for us to understand the impact and consequences of COVID-19 on our health system and NZNO members, while also avoiding the potential disruption of any industrial action. It's also likely that the outcome of our pay equity claim would be known and addressed during the term of such an agreement. Both these factors would provide a good deal of stability for our health system.

NZNO's bargaining team had another compelling reason for looking at a short-term agreement – in the online claims survey earlier this year, 71 per cent of members who responded to a question on a short-term agreement supported the team looking at such an option.

What also became clear through claims collection was that, despite recent increases to funding in the health sector, the harm caused by a decade of underfunding has still to be repaired. The strain placed on health workers and the health system resulted in members raising a significant set of claims. A short-term agreement would provide the opportunity to work through the issues, while ensuring members were not disadvantaged by any delay.

In the end, we were unable to reach a proposed settlement that was sufficiently like the one members had asked us to explore. The main stumbling block was the DHB team's desire to stay within the bargaining parameters set out in a letter to DHB chairs by the State Services Commissioner.

Further negotiations were scheduled for September 11 and 12. We know there are three key issues on members' minds:

- pay that values the work of all nurses and midwives;
- staffing that allows members to safely care for patients; and
- sick-leave provisions that protect and support our families, our communities and ourselves.

We also have claims which support professional development, and recognise the contribution members make to improving the health system and outcomes for patients.

While the inability to reach a proposed short-term agreement looks like a missed opportunity, it also underscores the gap between members' claims and the bargaining parameters DHBs are working under.

A short-term agreement would provide the opportunity to work through the issues, while ensuring members were not disadvantaged by any delay.

Both the NZNO and DHB bargaining teams continue to negotiate in good faith and with good will. However, achieving a settlement members support will require members being involved and active in the bargaining campaign. We all have a voice and when we use it together, we are strong. •

Keeping up to date with the campaign

EMAIL IS still our main channel of communication with members about the NZNO/DHB MECA negotiations. But for members covered by the MECA who are on Facebook, there is also a closed Facebook page. This has been set up as a place for members to talk with each other about the negotiations.

▶ The Facebook page is: https://www.facebook.com/groups/NZNODHBMECA2020/

▶ There's also a website for NZNO's MECA campaign. The website address is: www.dhbmeca@nzno.org.nz

Duty of care vs risk of violence

How can health practitioners protect themselves from the legal and professional ramifications of aggressive and violent workplace incidents?

By NZNO medico-legal lawyer Sophie Meares

Members are reporting managers using the nurse's duty of care as a "cattle prod" to force nurses to provide care to patients, even though there is a known high risk of potential harm to the nurse. Managers might also claim that failing to provide care in that situation is a breach of the patient's rights.

The good news is that managers in the above scenario are wrong. Neither the nurse's duty of care nor the patient's rights require a nurse to provide care in an unsafe situation. Rather, the safety of the situation and the risk to the nurse *are factors that are taken into account* when deciding if a nurse must provide care.

A nurse's duty of care is to provide "safe and competent care".[1] A potential risk of violence/aggression when providing the care would be a factor in determining "safe and competent" care under those circumstances. Importantly, a nurse's duty of care only requires the nurse to do what is "reasonable" in the circumstances.

Neither the nurse's duty of care nor the patient's rights require a nurse to provide care in an unsafe situation.

A legal judgement commentary on the duty of care discusses this point: *"In assessing whether what later events establish to have been an error of judgment was negligent, it is not enough that subsequent events show the judgment or decision to have been wrong; it must have been unreasonable in the circumstances then prevailing."*[2]

Patients have a right to health care of an appropriate standard.3 This applies to nurses and other health-care staff. The Code of Consumers' Rights clarifies what "appropriate standard" means through a series of "sub-rights" under Right 4. Of particular note is Right 4(1), which is the right to health-care services provided with "reasonable care and skill". The "reasonableness" concept is emphasised in regulation 3 of the Code, which provides:

3) Provider compliance:

(1) A provider is not in breach of this code if the provider has taken reasonable actions in the circumstances to give effect to the rights, and comply with the duties, in this code.

(2) The onus is on the provider to prove that it took reasonable actions.

(3) For the purposes of this clause, the circumstances means all the relevant circumstances, including the consumer's clinical circumstances and the provider's resource constraints.

Practitioners, nurses and other health professionals are referred to as "providers" under the Code.

The "reasonableness" condition for Right 4, regulation 3, makes clear that whether the Code was breached depends on the circumstances in which the care was provided. A potential risk of violence/aggression when providing care would be a factor in determining whether the Code was breached.

An example of the duty of care and patient rights vs violence/agression in action is where a patient requires medication but is acting violently and this poses a risk to the nurse giving the medication. The nurse's duty of care and "reasonable care" under Right 4(1) would not include the nurse putting themselves in harm's way to administer the medication.

The "reasonable" requirement for the duty of care and regulation 3 in the Code still require the nurse to take "reasonable actions" to mitigate the risk. Mitigation steps might include attempts to defuse the violence or requesting help. However, if mitigation options are not reasonable, eg there are insufficient staff, then the duty of care/patient rights would not be breached if the medication was not administered.

Onus on practitioner

If a nurse decides not to provide care, due to an unreasonable risk to their safety, they *must* document why they considered the risk was too great, and what mitigation they took to try to provide the care in an alternative way. Documentation includes an entry in the clinical notes, an incident report, personal notes and notifying your health and safety representative of the risk.

Importantly, the Code puts the onus on the practitioner to prove they took reasonable actions. Therefore, if a practitioner has not documented the risk or attempted mitigation, it is likely the Nursing Council or the Health and Disability Commissioner (HDC), when considering a complaint of breach of the duty of care/patient rights, would conclude the practitioner had not taken "reasonable actions" to provide the care.

A hurt/beaten up/bruised nurse or health-care practitioner is not someone who can provide quality care. This calls to mind the mantra – *"you must take care of yourself, in order to care for others"*.

If a member is the subject of a complaint to the Nursing Council or the HDC that they have breached their duty of care/patient rights, they should contact NZNO's medico-legal team who will help them respond to the complaint. •

* *The author spoke on this subject at NZNO's workshop,* Addressing violence and aggression against nurses, *held last month.*

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Critical care nurses pushed for 'surge' support

ANOTHER $2 million from the Ministry of Health (MoH) in August to prepare the health workforce for a possible COVID-19 surge came after hard lobbying by the college of critical care nurses (CCCN), its chair says.

In July, the MoH told district health boards (DHBs) it would give $2 million to provide staff with extra intensive care unit (ICU) training in case of a COVID-19 surge.

While there had been a surge in ICU training, "the consistent feedback was that more training needs to be done to ensure the system is best placed to respond to any future outbreaks", deputy director-general health workforce Anna Clark wrote in a letter to DHBs.

Steve Kirby

CCCN chair Steve Kirby told the NZNO college & section (C&S) day, which was held via Zoom last month, that the college had raised with chief nurse Margareth Broodkoorn its concerns about support to prepare for any COVID-19 surge.

"We are going to take at least part of the credit for that [funding]," said Kirby, also acknowledging the college of emergency nurses New Zealand (CENNZ) for its support.

He said Broodkoorn had been "very responsive" to CCCN's suggestion that all DHBs should be doing more to prepare and support staff for a possible surge.

The money would primarily be used to give staff from outside ICUs "hands-on" ICU training and orientation in case they were called on, Kirby said.

Media training?

Kirby said during the lockdown there had been huge media interest in talking to him. While NZNO's communication team provided good support, Kirby suggested media support and training for NZNO's nursing representatives be routinely available "for us to look a lot more professional in the public eye".

He said the college enjoyed a flat leadership structure, with an "openness" which allowed robust but respectful discussions, before reaching consensus. Succession training allowed plenty of time for an outgoing leader to support an incoming one.

Kirby advised C&S representatives to "have a plan, get agreement and prepare to be flexible. It's a marathon, not a sprint, and if we just keep plodding forward, we will get there." •

ENs take scope of practice to Nursing Council

NZNO acting associate professional services manager Kate Weston (left) and enrolled nurse section committee members (from left) Debbie Handisides, Michelle Prattley, Tina Giles and Robyn Hewlett (chair), with Nursing Council chief executive Catherine Byrne (second from right) and director strategic services Pam Doole (far right).

THE NURSING Council was "very receptive" to the enrolled nurse section (ENS) proposal for a more collaborative scope of practice for ENs, chair Robyn Hewlett says.

The ENS national committee met Nursing Council chief executive Catherine Byrne and director strategic programmes Pam Doole in August to discuss the current requirements that ENs must work "under the direction and delegation" of colleagues such as registered nurses (RNs).

A 2019 NZNO survey found many felt this was the most restrictive aspect of their practice. The ENS wanted the wording changed to reflect a more collaborative "partnership" relationship between ENs and their nursing colleagues, Hewlett said.

The Nursing Council staff seemed "very open" to the idea and the survey results, but advised they would need to discuss any changes to the EN scope of practice with its board of directors, after board elections on September 4, Hewlett said.

A full review of the EN scope of practice could also result, if the Nursing Council opted for it, Hewlett said.

The ENS committee expected to play a key role in any review of ENs' scope or education, Hewlett said. Another meeting was planned for November, after the Nursing Council's new board was in place.

The ENS committee has also written to directors of nursing at the country's 20 district health boards to ensure ENs had access to preceptor programmes so they could support new graduate ENs. The survey found this access was inconsistent across the DHBs, Hewlett said.

The EN scope of practice survey drew 746 responses – a 57 per cent response rate. As well as concern over restrictions on the EN scope of practice, it suggested many did not believe their RN colleagues understood their scope well. Results would be published within the next couple of months, Hewlett said.

NZNO acting associate professional services manager Kate Weston, at the college & section day, praised ENs as "masters of the long game". "They have been so tenacious and have worked so hard for years to undo the damage done in the '90s." •

Nurses fear tough calls in pandemic

ETHICAL DILEMMAS faced by nurses working in a global pandemic were raised with the national ethics advisory committee (NEAC) at NZNO's college & section (C&S) day in August.

College of critical care nurses chair Steve Kirby said at the height of a pandemic, critical care nurses could be asked to decide who gets – or loses – a ventilator. Support and guidance were needed to prepare for any such scenario, he said. "These are decisions we never thought we would have to make."

Nearly 50 people attended the day-long Zoom session on August 18, including representatives from most C&S, NZNO professional nursing advisers (PNAs) and NEAC committee members Gordon Jackman and Hope Tupara.

Gordon Jackman

Hope Tupara

'The decision on whose life to save . . . is incredibly difficult. We felt we could not write instructions for that.'

Jackman said NEAC was interested in nurses' views as it worked to finalise by late September an ethical framework for allocating resources during times of scarcity, driven by the COVID-19 outbreak.

A wider review of its 2007 guidelines, *Getting Through Together: Ethical values for a pandemic,* would follow.

Cancer impact 'massive'

Perioperative nurses college chair Juliet Asbery said during lockdown, different district health boards (DHBs) were offering different cancer care, meaning "some would receive [treatment] and some would not".

Cancer nurses college chair Sarah Ellery said the impact of COVID-19 on cancer care had been "massive". Guidance on reverse triaging had been "ad-hoc", creating "huge stress" for staff. "At what point do we not treat people?"

DHBs and other providers had been left to make their own decisions. Ellery believed an "over-arching" group was needed to provide consistent guidance and communication.

She gave an example of a patient with cancer symptoms who didn't go to their GP believing the advice was to stay away. "It's really important to get that right and we should trust the people who are telling us."

College of emergency nurses New Zealand (CENNZ) chair Sandra Richardson said emergency nurses were worried that "by default or intention" they would have to make triage calls during an outbreak that didn't reflect equity and access-for-all, "as you would normally expect . . . [They feared] the idea of being overwhelmed, that they would end up making triage calls that were well outside their scope."

Richardson said a public debate on equity in a pandemic was needed. Jackman agreed, saying equity was at the core of a global and national conversation that "we all have to deal with".

College of child and youth nurses (CCYN) acting chair Sarah Williams said ethical issues were also raised when nurses were deployed into contact tracing, leaving a "void" in communities and families who relied on a trusted nurse to care for children with conditions such as rheumatic fever.

"We were an incredibly flexible workforce, but people didn't stop and think, when pulling resources, about the void they were leaving."

Kirby said health workers needed a "robust support system" as they faced a new environment.

Acknowledging nurses were "at the sharp end" of the ethics debate, Jackman said there were only so many scenarios guidelines could specifically cover. "The reality is, there is going to be decision-making on the hoof," he said. "The decision on whose life to save . . . is incredibly difficult. We felt we could not write instructions for that."

Instead, a decision-making process for allocated resources was needed, "and we have to rely on the judgement of people making those decisions.

"In times of scarcity, . . . health workers and policy-makers should consider how resources can be allocated to mitigate adverse effects on those already structurally marginalised in the health system," he said, such as Māori or those with disabilities.

Ethical issues

NEAC is a committee of 12 appointed by the Minister of Health to advise on ethical issues in health services and research, and determine national ethical standards for the health sector.

Its draft ethical framework is based on four principles:

- All people are equally deserving of care.
- Getting the most from resources.
- Prioritising people most in need.
- Achieving equity.

Jackman said equity meant recognising people had different levels of advantage and required different approaches.

"If we truly want to be ready for a pandemic, we would want to have those structural inequities fixed in a so-called normal time," Jackman said. •

Nurses must 'be more political' – CENNZ

COLLEGE OF emergency nurses New Zealand (CENNZ) chair Sandra Richardson has urged nurses to "be more political" and work "smarter" to influence change.

"As nurses, we are very good at finding problems . . . but not always so good at following through on finding solutions," Richardson told nearly 50 college & section day attendees. Yet, with such high numbers, there was much potential to achieve change, if nurses worked together.

"There is this idea that politics is dirty . . . but everything we do is political and has been since the inception of nursing," she said. "We are already political, but we can be smarter."

CENNZ had worked hard to improve public awareness of violence against nurses. "We need to be speaking out on what's happening in our workplaces. We need to have a viewpoint," Richardson said. This was something medical staff had been better at doing, but nurses "need to be involved in the discussion".

Violence was "rampant" across nursing, yet it was hard to get traction. Her colleagues were wondering: "Is somebody going to have to be killed before this becomes an issue?"

NZNO professional nursing adviser Suzanne Rolls (left) with CENNZ chair Sandy Richardson after their oral submission to include nurses in the First Responders' bill.

Nurses could make submissions, collect data, present at forums – all of which Richardson acknowledged was time-consuming, "but we need to elevate to a political level".

Parliament's website had guidelines on how to make a submission (www.parliament.nz/en/pb/sc/how-to-make-a-submission) – it could be individual, joint or from a college or section. Oral submissions could be "really significant".

NZNO offered support with press releases and interviews, too.

CENNZ and NZNO had successfully lobbied to include nurses in the Protection for First Responders and Corrections Officers' bill. However, the bill was rejected as poorly drafted by Labour and National in July, and sent back to the justice select committee for further scrutiny, meaning it was unlikely to pass before the election.

While the outcome had not yet been successful, nurses had made an impact, Richardson said. "It's so easy to be angry about these things, but if we can work together, it makes a huge difference."

Nursing leaders throughout time had acted in a political way, to achieve change – they included cultural safety pioneer Irihapeti Ramsden, nurse registration campaigner Grace Neill, New Zealand's first registered nurse Ellen Dougherty, New Zealand Trained Nurses' Association founder Hester Maclean and Māori nursing pioneer Ākenehi Hei.

"*He ora te whakapiri, he mate te whakatariri* – there is strength in unity, defeat in anger." Richardson said. •

Respiratory nurses' K&S framework updated

THE NEW Zealand college of respiratory nurses has just released its 2020 updated adult respiratory nursing knowledge and skills framework (KSF).

Changes include a more user-friendly assessment rating scale, updated online resources and changed requirements to be "expert" and "proficient" in pharmacological management, including comments on registered nurse and nurse practitioner prescribing.

A KSF provides a formal framework to demonstrate a fundamental level of knowledge, competence and confidence in a given area/s. It informs learning programmes, and contributes to the development of specific competencies.

Benefits include:

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- Providing a mechanism for portfolio development for professional development recognition programmes and Nursing Council requirements for ongoing registration.
- Informing curriculum development for undergraduate and post-graduate registered nursing programmes.

Our updated KSF can be found on the NZNO website, in the college of respiratory nurses' resources section. Hard copies will be available at the New Zealand respiratory conference, planned for November 5-6 in Wellington (COVID-19 permitting). •

Report by nurse practitioner Sharon Hancock, a member of the college of respiratory nurses KSF review subcommittee.

Aged care: Inconsistent use of PPE

INCONSISTENT USE of personal protective equipment (PPE) by people entering some secure dementia and psychogeriatric facilities during lockdown earlier this year, potentially risked the health and safety of residents and staff, according to chief ombudsman Peter Boshier.

In a report released last month, he said the six facilities he visited were "strongly committed to residents' welfare" during COVID-19 alert levels 3 and 4 earlier this year, but some practices needed improvement.

'Bubbles' created confusion

Aged-care facilities used the "bubble" strategy to prevent the potential spread of infection. However, the makeup of bubbles created confusion in some facilities about who should be included or excluded. This had led to inconsistent use of PPE, with its potential risks. PPE practices varied across facilities, with staff of one facility wearing masks and gloves at all times when around residents, while staff in other facilities wore PPE only when they were helping residents with personal tasks, the report said.

He inspected the facilities under a United Nations human rights convention to inspect designated places where people are unable to leave at will. These included privately run aged-care facilities.

The primary purpose of his inspections was to ensure measures taken to mitigate COVID-19 were not detrimental to residents. "Residents in secure care are some of the most vulnerable in society. There is a need for an independent assessment of their treatment and conditions during lockdown, when the extraordinary use of state power results in significantly reduced oversight and access," his report said.

None of the facilities had any confirmed or suspected cases of COVID-19 at the time of inspection. But all had plans and processes for isolating residents with suspected or confirmed cases.

The ombudsman was pleased all the facilities focused on keeping residents in touch with their families. "Some facilities did exercise discretion in allowing some family members to visit dying relatives in palliative care. I was concerned to find one facility's default position was a blanket refusal."

Twenty-one recommendations

His report contained 21 recomendations, the first of which was that facilities clearly defined the size and integrity of "bubbles" and ensured clear and consistent management of them during a pandemic.

Other recommendations included reviewing physical distancing rules, providing wall-mounted hand sanitiser units in communal areas, better proactive communication with residents about the limitations on visitors and alternative ways to communicate, and more integration of Te Ao Māori.

Aged-care facilities again went into level-4 lockdown when alert levels 3 (Auckland) and 2 (rest of the country) were re-imposed last month after a community outbreak of COVID-19 in Auckland. •

Job losses at South Auckland hospice

A RECENT "radical redesign" at Totara Hospice in South Auckland has seen nursing jobs cut and other job losses. The number of full-time equivalent (FTE) registered nurses (RNs) working in the inpatient unit (IPU) has been cut from 15 FTEs to 11.4 FTEs. Eleven IPU nurses have been affected and the overall service has been reduced by 25 per cent.

The 0.6 nursing clinical quality coordinator position has been disestablished, but the director of nursing (DoN) role has been increased to 0.8 FTE. The number of FTE health-care assistants (HCAs) in the IPU has increased from 4.4 to 4.9.

NZNO organiser Sue Sharpe said some long-serving nurses had taken voluntary redundancy because they did not feel they could work safely under the new model of care in the nine-bed IPU.

An NZNO submission called for 14.91 FTE RNs in the IPU. These should be supported by one full-time DoN, one charge nurse and one nurse practitioner (NP), who would also work in the community, and a nurse co-ordinator on each day shift. There would be no increase in HCAs.

Staffing on the IPU should be: two RNs and one HCA, supported by a 0.9 FTE charge nurse, a full-time coordinator and a 0.6 FTE NP (am shift); three RNs and one HCA (pm shift); and two RNs and one HCA (night shift). But Sharpe said there were gaps in the roster, which meant fewer staff on the floor.

Community nurse numbers cut

The number of nurses working in the community – home visiting and in the day hospice – has been reduced by 2.5 FTEs. But no nurses had been made redundant because existing vacancies in community services were equivalent to the proposed redundancies.

The IPU was having staffing issues because current staffing levels were "not sustainable" and there were RN vacancies in community services, Sharpe said.

The medical team has been cut from 4.4 FTEs to 3.6 and one FTE has been cut from the senior leadership team.

The restructure was first broached in late May and the decision document released in July said lockdown had "crippled" the hospice's revenue base. The financial loss of more than $1 million was "too big" and "resizing and reshaping" were required.

The submission also pointed out that in 2017/18, IPU bed numbers were increased from nine to 12, without reliable funding or rationale for the increase.

"Despite raising concerns, staff were recruited for the bed increase. Now it is proposed working hours be reduced or jobs lost as a direct result of this. We expect it to be acknowledged that this has contributed to the hospice being in this position." •

DHBs: MidCentral revises plans to replace ENs

MIDCENTRAL HEALTH (MCH) has revised its plans to cut all enrolled nurse (EN) positions in its older adult services.
A consultation document, released in July, proposed significant changes to its service configuration, including cutting psychogeriatric beds from 14 to seven and including those seven beds in its rehabilitation ward. The proposal also included the loss of 6.4 full-time equivalent (FTE) EN positions and that of clinical manager. The new integrated service would have been staffed by registered nurses (RNs) and health-care assistants (HCAs).

Benefits of retaining ENs

The district health board (DHB) received 32 submissions on the proposal. Many, including those from NZNO's national EN section and NZNO, opposed the loss of EN jobs. MCH has now revised its proposal. In announcing its "interim final decision" this month, MCH said it had considered the feedback and acknowledged "the identified benefits of retaining ENs within the staffing mix".

NZNO organiser Donna Ryan said the change of heart over EN positions was "a win for jobs and skill mix. Members have fought very hard to retain our ENs".

But the revised proposal will still mean job losses – an FTE clinical manager position, 1.3 FTE EN positions and an 0.7 HCA position. A surplus of 1.44 FTE RN jobs will be managed by attrition and the community clinical nurse specialist position will be increased by 0.2 FTE.

In its interim decision, MCH said the original proposal did not include any change to HCA positions but, because of the decision to retain most EN positions, the revised proposal did. It wanted feedback from HCAs on its revised proposal by early this month.

In its submission on the original proposal, the national EN section said disestablishing the jobs of nine (6.4 FTEs) very experienced ENs was "very short sighted". Employment of ENs by DHBs and other providers had been increasing, funding had been provided for entry-to-practice programmes for new-graduate ENs and they were now included in the DHBs' advanced choice of employment scheme. "The HCA cannot replace the skills, experience and knowledge of an EN," the submission stated.

NZNO's submission on the original proposal, prepared by professional nursing adviser Wendy Blair and Ryan, said reducing the number of beds for a very vulnerable population was "extremely concerning". It was also shortsighted, given the ageing population.

Other concerns included that the model of care was predominantly a medical model and a lack of consultation with wider networks, including Treaty of Waitangi partners. •

New industrial staff appointed

NZNO's INDUSTRIAL services team has had some recent additions, due to resignations and reassignment of roles.

Two new organisers have started in Christchurch. Stephanie Duncan is backfilling for Tracy McLellan, who is campaigning as a Labour candidate for the Port Hills electorate. Solicitor Terri Essex has been appointed on a fixed term to backfill John Miller's organiser role. Miller is working as lead organiser.

Two new organisers have started in Tauranga, Veronica Luca and Brenda Brickland. Both have backgrounds in facilitation, mediation and restorative justice work.

Phil Marshall has been appointed as an organiser in Auckland. He has been a lead organiser for the Independent Schools Association and a project coordinator at both the Ministries of Business, Innovation and Employment and Education. Because of COVID-19 restrictions, he has been unable to start work in Auckland and has been working from the Wellington office.

30 years of service

And last month, two industrial staff – acting IST manager Glenda Alexander and lead organiser Lyn Olsthoorn – clocked up 30 years' service with NZNO.

Chief executive Memo Musa congratulated them on their length of service and said both had made significant contributions to the industrial and professional work of the organisation in that time. •

Strong support for better sick leave

SIXTY-EIGHT per cent of New Zealanders support increasing paid minimum sick leave, according to UMR polling released by the Council of Trade Unions last month. Other survey results show that:

- 61 per cent of respondents agreed with letting people access paid sick leave from the first day of work, ie getting rid of the six-month "stand down" for sick leave;
- 53 per cent believed the legal minimum should be increased to 10 days or more; and
- 63 per cent believed the Government's COVID-19 leave scheme should be expanded to cover people with symptoms waiting for test results, so they can stay home on pay.

A CTU spokesperson said this was a popular policy with working people, who understood that sick leave was not just a work-rights issue, but also a public health policy that affected everyone. •

Classified advertising

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The first ever reunion for the September 1982 Class of General and Obstetric Nurses at the Christchurch School of Nursing is being planned for September 2021.Location will be Christchurch.

If interested in further details please contact Jane Coster at jicoster@hotmail.com

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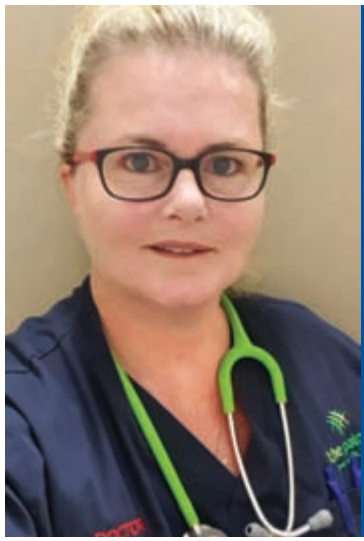

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Changes to NZNO membership fees

Earlier this year we let you know that the New Zealand Nurses Organisation (NZNO) planned to raise membership fees by 1.9 percent from 1 April 2020.

Due to COVID-19 this increase was deferred for six months and will now take effect on 1 October 2020.

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If you pay your NZNO subscription by automatic or online payment, please update these effective from 1 October 2020.

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Category	Annual	Monthly	Bi-Monthly	Fortnightly
Registered nurses and midwives	$563.76	$46.98	$23.49	$21.68
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Reduced fees for those who earn less than $26,000 gross per annum. Does not include RNs, RMs or ENs	$264.24	$22.02	$11.01	$10.16
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For more detailed information regarding the changes to member subscriptions, please visit the membership fees page on our website.

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

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