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NEW ZEALAND NURSES ORGANISATION
Kaitiaki
NURSING NEW ZEALAND

NEWS

‘We are prepared to go hard, if that’s what members want’ – frustrated bargaining team back at the table

By Mary Longmore

January 30, 2026

‘Day 42, enough said!’ These are the words of NZNO’s hard-working bargaining team, wrangling jobs and Te Whatu Ora since late 2024.

NZNO's Te Whatu Ora bargaining team were back at the table recently for day 42 of 'stuck' negotiations. Left to right: Dawn Barrett, Noreen McCallan, Allister Dietschin, Nano Tunnicliff (on screen), Rachel Thorn, Maria Tutahi (on screen), Glenda Huston, Lyn Logan and Debbie Handisides.

It’s been a long hard 16 months since 2025/26 collective bargaining kicked off in September 2024 — and NZNO’s team say they feel “disappointed and frustrated” as Te Whatu Ora continues to drag out negotiations.

“We can give you all the emotions — angry, disrespected, undervalued,” bargaining team chair and Hawke’s Bay nurse Noreen McCallan told *Kaitiaki* on their first day back at the table on January 21.

> **‘We are prepared to go hard, if that’s what members want – we want to confirm members are behind us and what the commitment is to strikes.’**

But they are steely, too, in their mission to secure safe staffing across the country.

"It's important to understand we are dealing with a Government that does not appear to be willing to fund health services safely," McCallan said.

Meanwhile, Te Whatu Ora's delay tactics were forcing nurses and kaiāwhina to continue working in unsafe conditions — for them, and for patients, Auckland RN Dawn Barrett said.

"This protracted process has meant that nothing can be done about the current staffing situation — it's delaying our ability to really get some relief from the short staffing."

Whangārei supporters during NZNO Te Whatu Ora member nationwide strikes in September.

Taranaki EN Glenda Huston added: "And the longer it takes, the more money they're saving".

Te Whatu Ora's last offer was in June 2025, with a three per cent pay rise staggered across 12 months. Soundly rejected by NZNO members, the offer was not enough to meet the higher cost of living. Nor did it meet NZNO's core claims of enforceable safe staffing, an enforceable evidence-based approach to culturally-appropriate nurse-patient ratios, full graduate employment, tikanga allowances and more pay for designated senior nurses, the team said. It has since been withdrawn.

> 'We can give you all the emotions – angry, disrespected, undervalued.'

Since then, there have been several strikes — nationwide and partial as well as uniform strikes in some regions, where members donned t-shirts or whacky scrubs at work, often sparking conversations.

What do we want?

Now the bargaining team are keen to seek direction from members.

"We are seeking direction from members to guide our next steps," Christchurch health-care assistant Allister Dietschin said. "What action are we prepared to take?"

Meetings will kick off on February 9, where members can share their thoughts on how to move forward. A survey will also be available from February 11-17.

But whatever happens next, unity — kotahitanga — is key, NZNO's team says.

"We are all in the same waka — we are united," Huston said.

"We are prepared to go hard, if that's what members want — we want to confirm members are behind us and what the commitment is to strikes, whether they be visibility strikes, or redeployment, or picketing."

North Shore district nurses on uniform strike last August.

Any progress?

And there have been wins. Te Whatu Ora has agreed to work with NZNO on researching nurse-to-patient ratios; to an extra pay step for enrolled nurses to reflect their expanded scope; and to ensure a new $24 shift coordinator allowance is consistently applied across the country. So far, 13 of NZNO's 40 claims have been tentatively agreed.

But core sticking points remain, such as:

- An enforceable commitment by Te Whatu Ora to recruit to need, as defined by safe staffing programme CCDM (care capacity demand management).
- Implementing culturally appropriate nurse-to-patient ratios within an agreed time-frame.
- Embedding Te Tiriti o Waitangi with kaupapa Māori dispute processes and tikanga allowances for members who provide cultural support.
- Full employment for new nursing graduates.
- A pay rise that reflects the high cost of living.
- A further pay rise for designated senior nurses to restore pay relativity compared to RNs.

The current collective agreement expired in October 2024. NZNO's 2024-2026 claims can be found here (https://maranga-mai.nzno.org.nz/2024_claims).

Hawke's Bay supporters during two-day NZNO strikes in September.

'We are committed', says Te Whatu Ora

Te Whatu Ora-Health New Zealand says it is committed to reaching a settlement with NZNO despite "complex" bargaining.

"The bargaining is covering a wide range of significant nursing workforce issues and is complex," a spokesperson told *Kaitiaki* via email.

NZNO members had declined two offers last year, including one which followed Employment Relations Authority recommendations after facilitation. However, bargaining was progressing "constructively" with the support of mediators from the Ministry of Business, Innnovation and Employment.

"We are continuing to work with NZNO in good faith and will resume bargaining in mid-February."

Te Whatu Ora remained "dedicated to ensuring we have the right staff and skill mix to deliver quality and safe patient care", the spokesperson said.

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NEWS

Not-so merry Christmas: Bites, bruises, threats for ED nurses over holidays

By Joel Maxwell

January 14, 2026

Emergency departments saw bites, bruises and dislocations over the holidays — and that wasn't even in the patients.

The results of an NZNO survey of emergency department health workers show that the majority of respondents faced unacceptable behaviour at work over the holidays. Photo: AdobeStock

Nearly one in five people who responded in an NZNO survey of emergency department (ED) nurses working over the holidays was physically assaulted.

Of those, about 18 per cent were left with bruises, about nine per cent were bitten, and about 13 per cent were left with sprains, strains, dislocations or concussions.

Overall, about 84 per cent of respondents faced unacceptable behaviour in the ED — ranging from shouting and swearing to physical aggression and threats.

The survey comes alongside a chronic shortage of Te Whatu Ora health workers — and a warning from NZNO's College of Emergency Nurses that long waiting times are triggering frustration from patients and their families.

The hard numbers

- About 84 per cent of 93 respondents said they'd face unacceptable behaviour between December 24-January 4.
- Most of this behaviour, about 95 per cent, included shouting and swearing — about 40 per cent included physical aggression.
- About 82 per cent of 78 respondents said they'd been verbally assaulted by a patient or their family, while about 18 per cent of those were physically assaulted.
- Of 79 respondents, about 55 per cent reported the incident — although only about a third of those were a formal Datix.
- Most, about 43 per cent, didn't report the incident because they didn't have time and had lost confidence in the reporting process.

NZNO College of Emergency Nurses spokesperson Natasha Hemopo. (File photo)

NZNO College of Emergency Nurses spokesperson Natasha Hemopo said at least 55 per cent of respondents said their ED was understaffed at the time of the incident.

"Nurses constantly raise concerns about the link between patients' frustrations which lead to abusive behaviour and short staffing in EDs. This survey further highlights the correlation between under-staffing and unsafe staffing."

Nurses did an amazing job, she said, but there were never enough of them.

'Hold his body, because I've got his arm!'

Experienced emergency triage nurse in Hutt hospital, Kelly McDonald was no stranger to the impact of violence in the workplace.

Once a male emergency nursing colleague had been punched and knocked out cold in a waiting room.

Hutt hospital emergency nurse Kelly McDonald.

Another emergency nursing colleague had a cup of scalding water thrown over her in the workplace.

More nursing graduate hires were needed in emergency nursing, she said — however the normal attrition of experienced staff was impacting the ability to train newcomers.

"It's a bummer because we need them — we need to bleed the new nurses through so we have more capability at the other end."

It was a conundrum, she said, with hospitals not employing more staff and older nurses carrying an increased workload.

McDonald had personally experienced workplace aggression — she had to insert a line in the arm of a violently thrashing man held down by security guards: "I'm saying 'hold his body, hold it, because I've got his arm!', and I put it in. Luckily he had big fat veins."

Nurses 'the face' of patient frustrations

Wellington hospital emergency nurse Ryan O'Donnell said when patients get frustrated and agitated they resort to unacceptable behaviour.

"They will view the nurse as the face of the issue, even the doctor that walks into the room as well is the face that encompasses the long waiting times; maybe they're feeling like they're not being heard, feeling like they're in the dark."

O'Donnell said the numbers in the survey seemed to be pretty reflective of what he had seen in the workplace.

Waiting times, he said, definitely added to the frustration of patients and their families — "it's absolutely fair".

Wellington emergency nurse Ryan O'Donnell on the picket line in December 2024. (PHOTO CREDIT: ROBERT KITCHIN, STUFF)

Emergency nurses were a source of calm, reassurance and knowledge in what is for everyone else a time of "confusion, unknowing and fear".

"When we're in the ED we're scared for ourselves and we're scared for our loved ones and we just want things to happen quickly: we just want to be reassured, and let known we're being seen and looked after — and that someone has us."

When emergency nurses get to do that, O'Donnell said, it was one of his favourite parts of nursing.

"When we have the correct staffing and we're not completely inundated, I think we have that time to give the patient, and I love that part of the job."

- **Click here (https://www.nzno.org.nz/Portals/0/Files/2026/Data_All_260111-(1)-(003).pdf?ver=tfsFDJ2K6COSzxcvTQd9oA%3d%3d) to see the survey.**

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NPs launch kaupapa Māori practice in Rotorua as part of primary care 'evolution'

By Joel Maxwell

January 14, 2026

The guy in the waiting room sat and waited to see Jacinda Childs, wondering the whole time what she could possibly do for him.

Rotorua nurse practitioners, from left, Jayme Kitiona and Jacinda Childs.

By the time he walked out her office door, nurse practitioners made a lot more sense to him.

Childs and fellow NZNO member and nurse practitioner (NP) Jayme Kitiona spoke to *Kaitiaki* ahead of launching their new low-fees Rotorua practice — part of an evolution away from doctor-led healthcare.

Tau Oranga Health Care opens on January 19, capping off a busy four months of preparation for the pair.

Read this story in te reo Māori here.

The NP-led, kaupapa Māori clinic planned to bring in a general practice doctor as well, as part of an eventual multidisciplinary team, said Kitiona. This was "what was great" about an evolving primary healthcare sector: no longer just the traditional model of a GP-led clinic and a nurse.

The pair met about five years ago in their NP internship, Kitiona said. "There was a group of us Māori NPs that were put together in that year so we've stayed close over that time and done our monthly peer review together."

Primary care is evolving in Aotearoa with expanding prescribing and diagnosing rights for NPs. Photo: AdobeStock

Childs said the feedback had been "amazingly positive" to NPs as people discovered their potential. "I've had so many patients say 'wow, I didn't even know you could do all this', or 'now that I've come to you I only want to come back to you'."

One told her he'd sat in the waiting room with no idea what she could do for him — when he left he was a convert, and now a regular patient.

Changes underway for NPs

A law change last year opened the way for NPs to finally prescribe the same medications as doctors. This allowed NPs to prescribe medicines funded by Pharmac but yet to be approved by MedSafe — often

brand substitutes when there were global shortages.

Meanwhile from February 1 NPs can diagnose and prescribe for ADHD — with the goal of timely and equitable access to care.

Kitiona said there were about 60 to 80 Māori nurse practitioners in Aotearoa. "We were fortunate enough to have our first hui-ā-tau as all the Māori nurse practitioners in 2023, and that was led by Rhoena Davis (https://www.nzno.org.nz/about_us/media_releases/artmid/4731/articleid/6808/nurses-mourn-rhoena-davis)."

> **"For us, I guess it's about bringing in te ao Māori into the clinical skills and all the clinical experience we have."**

Childs had worked in primary care in Rotorua for more than a decade, she said. "This is where I really love to be. I have worked at Rotorua hospital, I've worked as a clinical respiratory nurse specialist prescriber but I've always found my way back to primary care."

Kitiona loved the sector too — before returning home to Rotorua, she worked in rural primary care for about 14 years on Waiheke Island.

They trained to become NPs, Kitiona said, because they wanted to do more for patients. Registered nurses working at the top of their scope still faced the challenge of having to refer patients to GPs or NPs.

The kaupapa-Māori approach was especially important in a city with an about 43 per cent Māori population — more than double the national proportion.

The two NPs are launching a kaupapa Māori clinic in a city with an about 43 per cent Māori population. Photo: AdobeStock.

"For us, I guess it's about bringing in te ao Māori into the clinical skills and all the clinical experience we have, and working with whānau in a way that brings in ao-Māori views so that we are culturally safe and culturally appropriate."

Meanwhile the clinic has found a home in the Janet Fraser building, owned by Te Rōpū o te Ora Women's Health League, with historical links to regional iwi Te Arawa, and nursing.

In the 1930s, nurse Ruby Cameron rallied the rōpū to fundraise for a guest house for Māori often refused rooms at hotels while visiting whānau in hospital. The building eventually opened in 1948.

Kitiona said people often had a long wait to enroll in clinics in the city — then with high demand there was a long wait to get into appointments, she said.

"Before we have to add more team members on, our capacity's probably somewhere between 1300 to 3000. And then we'll grow our team, we've got lots of plans to grow and expand."

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Ka whakarewatia e ngā NP te whare haumanu kaupapa Māori hei ‘kukuwhatanga’ i te hauora mātāmua

By Joel Maxwell

January 14, 2026

I te whakaarohia e te tāne e whanga mai ana i te taiwhanga tūroro ka pēhea a Jacinda Childs kia atawhai mai ki a ia.

Rotorua nurse practitioners, from left, Jayme Kitiona and Jacinda Childs.

The guy in the waiting room sat and waited to see Jacinda Childs, wondering the whole time what she could possibly do for him.

I a ia e wehe ana i tō Childs' tari, ka taka te kapa mō te hira o te mātanga tapuhi.

By the time he walked out her office door, nurse practitioners made a lot more sense to him.

Ka kōrerotia e ngā mema NZNO, mātanga tapuhi (NP) noki, a Childs rāua ko Jayme Kitiona ki *Kaitiaki* nō mua atu i te whakarewa i tā rāua whare haumanu utu iti i Rotorua — he wāhanga anō o tētahi kukuwhatanga o te umanga hauora o mua nā ngā tākuta kē i ārahi.

Childs and fellow NZNO member and nurse practitioner (NP) Jayme Kitiona spoke to Kaitiaki ahead of launching their new low-fees Rotorua practice — part of an evolution away from doctor-led healthcare.

Ka huakina Tau Oranga Health Care i te Hānuere 19, hei whakatutuki i ngā whakaritenga nui i ngā marama e whā i pahure.

Tau Oranga Health Care opens on January 19, capping off a busy four months of preparation for the pair.

E hiahiatia ana e te whare haumanu kaupapa Māori mā ngā mātanga tapuhi e ārahi kia whai i tētahi rata hei wāhanga o tētahi tīma mātanga take maha, ka kī a Kitiona. Ko tēnei "tētahi wāhanga whakaharahara" o tētahi rāngai hauora mātāmua e kukuwhatanga ana: Kua kore ko te āhuatanga o mua anake o te whare haumanu nā te rata i ārahi me he tapuhi i raro iho.

The NP-led, kaupapa Māori clinic planned to bring in a general practice doctor as well, as part of an eventual multidisciplinary team, said Kitiona. This was "what was great" about an evolving primary healthcare sector: no longer just the traditional model of a GP-led clinic and a nurse.

NPs had been getting positive feedback from patients discovering their potential. Photo: AdobeStock

Kua rima pea ngā tau i hipa mai i te wā i tūtaki te takirua nei i a rāua e whakangungu ana hei NP, hei tā Kitiona. "Ko tērā tētahi rōpū o ngā mātanga tapuhi Māori ka tūhonoa i taua tau me te aha kua piri tonu mātou nō muri mai i taua wā, ā, ka mahitahi mātou i tā mātou arotake hoamahi ā-marama."

The pair met about five years ago in their NP internship, Kitiona said. "There was a group of us Māori NPs that were put together in that year so we've stayed close over that time and done our monthly peer review together."

Hei tā Childs he "tino whakamīharo" tā ngā tūroro whakahoki kōrero ki ngā NP i a rātou e kite ana i te pitomata o te umanga. "Anō te rahi o ngā tūroro ka kī mai 'āe mārika kāhore ahau i te mōhio ki te nui o te mahi e tāea ana e te mātanga tapuhi, 'e kore rawa ahau e hiahia kia kite i tētahi atu', rānei."

Childs said the feedback had been "amazingly positive" to NPs as people discovered their potential. "I've had so many patients say 'wow, I didn't even know you could do all this', or 'now that I've come to you I only want to come back to you'."

Hei tā tētahi atu, kua noho ia ki te rūma tūroro me te kore mōhio ka pēhea te mātanga tapuhi i atawhai mai ki a ia — engari i a ia e wehe ana ka whakaponotia, ā, ināianei ka mutu tonu tōna hokinga mai.

One told her he'd sat in the waiting room with no idea what she could do for him — when he left he was a convert, and now a regular patient.

Primary health has become the centre of a new evolution in Aotearoa. Photo: AdobeStock.

He panonitanga e haere ana/Changes underway for NPs

Ka para te huarahi tētahi huringa ture i tērā tau mō tā ngā NP tūtohu katoa i ngā rongoā pēnei ki ngā rata. Kua whakawātea ai tēnei i tā ngā NP tūtohu i ngā rongoā nā Pharmac i utu engari kāhore anō Medsafe ka whakaae — i te nuinga o te wā hei whakakapinga mō ngā rongoā e ngōuruuru ana i te ao katoa.

A law change last year opened the way for NPs to finally prescribe the same medications as doctors. This allowed NPs to prescribe medicines funded by Pharmac but yet to be approved by MedSafe — often

brand substitutes when there were global shortages.

Ā, ka mutu ka tāea e ngā NP te tautohu me te tūtohu mō te mate aro pīkari (ADHD) mai i te Pēpuere 1– i runga anō i te whāinga o te āheitanga tere, tautika noki, ki te atawhai.

Meanwhile from February 1 NPs can diagnose and prescribe for ADHD — with the goal of timely and equitable access to care.

> **"For us, I guess it's about bringing in te ao Māori into the clinical skills and all the clinical experience we have."**

Hei tā Kitiona he 60 ki te 80 te rahi o te hunga mātanga tapuhi Māori i Aotearoa. "Māringanui ka whakatūria te hui ā-tau tuatahi mō ngā mātanga tapuhi Māori i te 2023, nā Rhoena Davis (https://www.nzno.org.nz/about_us/media_releases/artmid/4731/articleid/6808/nurses-mourn-rhoena-davis)i ārahi."

Kitiona said there were about 60 to 80 Māori nurse practitioners in Aotearoa. "We were fortunate enough to have our first hui-ā-tau as all the Māori nurse practitioners in 2023, and that was led by Rhoena Davis (https://www.nzno.org.nz/about_us/media_releases/artmid/4731/articleid/6808/nurses-mourn-rhoena-davis)."

I mahi Childs neke atu i 10 tau i te rāngai hauora mātāmua i Rotorua, hei tāna. "Ka nui tōku aroha ki tēnei tūranga. I mahia ki te hohipera i Rotorua, i mahia hei tapuhi clinical respiratory specialist prescriber engari i te wā katoa ka hokia ki te hauora mātāmua anō."

Childs had worked in primary care in Rotorua for more than a decade, she said. "This is where I really love to be. I have worked at Rotorua hospital, I've worked as a clinical respiratory nurse specialist prescriber but I've always found my way back to primary care."

Kei te aroha a Kitiona ki te rāngai hoki — nō mua atu i tāna hoki mai ki Rotorua ka mahia e ia i te hauora mātāmua tuawhenua mō tata ki te 14 tau i te motu o Waiheke.

Kitiona loved the sector too — before returning home to Rotorua, she worked in rural primary care for about 14 years on Waiheke Island.

The two NPs are launching a kaupapa Māori clinic in a city with an about 43 per cent Māori population. Photo: AdobeStock.

I whakangungu rāua hei NP, ka kī a Kitiona, nā te mea i hiahia rāua kia tautoko ake i ngā tūroro. Ahakoa ka mahia e te tapuhi rēhita i te tihi o te whānui o te āheinga umanga me tuku tonu ia i ngā tūroro ki te GP, NP rānei.

They trained to become NPs, Kitiona said, because they wanted to do more for patients. Registered nurses working at the top of their scope still faced the challenge of having to refer patients to GPs or NPs.

He tino hira te whai i te kaupapa Māori i tētahi tāone nui me te tata ki te 43 ōrau taupori Māori — neke atu i te huarua i te wāhanga ā-motu.

The kaupapa-Māori approach was especially important in a city with an about 43 per cent Māori population — more than double the national proportion.

"Mō māua pea, ki taku whakapae, ko te mea nui ko tā māua e kawe mai ai te ao Māori i roto i ō māua pukenga haumanu me ngā wheako haumanu katoa, ā, me tā māua mahitahi me te whānau i runga i tētahi ara e tae rā anō ana ki ngā aronga Māori hei whare haumaru ki te tangata i te ahurea e tika ana."

"For us, I guess it's about bringing in te ao Māori into the clinical skills and all the clinical experience we have, and working with whānau in a way that brings in ao-Māori views so that we are culturally safe and culturally appropriate."

"Mō māua pea, ki taku whakapae, ko te mea nui ko tā māua e kawe mai ai te ao Māori i roto i ō māua pukenga haumanu me ngā wheako haumanu katoa."

Heoi anō ka noho te whare haumanu i tō te Rōpū o te Ora whare Janet Fraser me tētahi hītori whakamīharo e tuhono ana ki te mana whenua Te Arawa, me te ao tapuhi hoki.

Meanwhile the clinic has found a home in the Janet Fraser building, owned by Te Rōpū o te Ora Women's Health League, with remarkable historical links to regional iwi Te Arawa, and nursing.

I ngā tau 1930, ka whakahaua e te tapuhi Ruby Cameron te rōpū kia rapu putea hei hanga i tētahi whare manuhiri mō ngā tāngata Māori i aukatingia kia noho i ngā hōtēra i a rātou e peka ana i tō rātou whanāunga i te hōhipera. Ka huakina taua whare i te 1948.

In the 1930s, nurse Ruby Cameron rallied the rōpū to fundraise for a guest house for Māori often refused accommodation at hotels while visiting whānau in hospital. The building eventually opened in 1948.

Hei tā Kitiona, he roa te wā e tātari ana te tangata kia whakauru ki ngā rārangi tūroro a ngā whare haumanu i te tāone nui — kātahi, ka tātari roa anō rātou hei whai i tētahi wā ki te kite i te rata, ka kīia e ia.

Kitiona said people often had a long wait to enroll in clinics in the city — then with high demand there was a long wait to get into appointments, she said.

"I mua i tā mātou tāpiri i ngā mema tīma anō, ko tō mātou āheinga i tēnei wā ko te rārangi tūroro i waenganui i te 1300 ki te 3000. Ā, kātahi ka whakatupu i te tīma, kei a mātou ngā mahere maha kia whakatupu anō, kia whakanui noki.

"Before we have to add more team members on, our capacity's probably somewhere between 1300 to 3000. And then we'll grow our team, we've got lots of plans to grow and expand."

- **Nā Joel Maxwell tēnei pūrongo i whakamāori/translated by Joel Maxwell.**

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NEWS

ED nurses urged to share violence and aggression incidents

By Renee Kiriona

January 8, 2026

Tōpūtanga Taphui Kaitiaki o Aotearoa – NZNO wants to hear from nurses working in emergency departments (ED) throughout the country about any violent, aggressive and threatening behaviour they have experienced while on duty over the holiday period.

NZNO president and ED nurse Anne Daniels.

The survey closes this Sunday at midnight, takes about five minutes and has been emailed to all ED nurses who are NZNO members.

"I've been threatened and abused many times including by a gang member who said he would take out a contract on me," NZNO president Anne Daniels, who is an ED nurse, said.

"I know we should have a zero tolerance on violence and abuse, but I never take it personally because most patients have had it by the time they get to ED. They shouldn't have to tolerate this broken health

system either."

> **'Sadly, a lot of ED nurses are too run off their feet to report incidents but I urge them to please take the time to do this survey.'**

Many nurses never reported incidents which meant Te Whatu Ora – Health NZ did not believe violence in the workplace was a big issue, she said.

"Sadly, a lot of ED nurses are too run off their feet to report incidents but I urge them to please take the time to do this survey, so our union can advocate for system changes – safer staffing and solutions to address the crisis we're seeing in the health system."

Call for 24/7 security

NZNO's college of emergency nurses (CENNZ) has been advocating for 24/7 security for all EDs around the country to combat rising violence and aggression

CENNZ chair Lauren Miller told *Kaitiaki* in January last year that social and economic pressures had seen a rise in violence and aggression to "unacceptable levels".

While Miller was aware of Government efforts to improve security, inconsistencies between EDs were "vast" and there had been no commitment to round-the-clock security.

Some incidents reported by the media in 2025

- January: An ED nurse at Middle Hospital was hospitalised after being allegedly punched and choked to unconsciousness by a patient. It took five staff to pull the man off as security guards were not present at the time.
- March (https://www.rnz.co.nz/news/national/411316/hutt-hospital-attack-report-details-poor-communication-confusing-alarms-and-lax-security): Release of a report about four ED nurses at Hutt Valley Hospital who were assaulted on Boxing Day. One nurse had a table hurled at her, striking her in the back and the other three nurses were punched by the same patient.
- May (https://www.nzherald.co.nz/nz/christchurch-hospital-nurse-assaulted-walking-to-work/HQQ55672WRCNPBCND55PFSDFTY/): An ED nurse at Christchurch was attacked in close proximity to her workplace while walking to work, only to end up in ED herself.
- April (https://www.rnz.co.nz/news/national/558121/gun-wielding-man-jumps-into-palmerston-north-nurse-s-car-threatens-her-outside-hospital): A Palmerston North Hospital ED nurse was held up at gunpoint when she left work.
- December 2024 (https://www.rnz.co.nz/news/political/539174/union-mulls-stab-proof-vests-personal-alarms-after-nurse-attacked): A Rotorua Hospital nurse was hospitalised after being stabbed by a patient.

Not just an issue in ED

NZNO is planning another similar survey for all nurses, including, mental health nurses. A 2023 NZNO survey of mental health nurses found that violence and aggression was a major concern for them while on duty.

RELATED STORIES

Round-the-clock security needed in EDs, say emergency nurses

Eleven days after a nurse was choked to unconsciousness, NZNO's emergency nurses say 24/7 security is needed in all emergency departments (EDs).

Kaitiaki Nursing New Zealand

It's time to say enough is enough: Addressing workplace violence against nurses

Many nurses and other health-care workers see violence as part of the job or fear retaliation if they speak up. This has to stop.

Kaitiaki Nursing New Zealand

Rotorua nurses raise violence, safety concerns with local MP

Nurses in Rotorua this month raised concerns about violence and aggression and unsafe staffing with their long-time local MP Todd McClay.

Kaitiaki Nursing New Zealand

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NEWS

Kenepuru Hospital on patient advocate watchlist

By Renee Kiriona

January 7, 2026

A 24-hour accident and medical service at Porirua's Kenepuru Hospital, which the Government wanted to chop, is being watched even more closely now.

Porirua speaking up last year to keep Kenepuru Hospital's afterhours service alive.

It follows the service going without a doctor (https://www.rnz.co.nz/news/national/583211/no-doctors-overnight-in-wellington-urgent-care-clinic) between 10.30pm on Sunday and 7am on Monday because the rostered staffer was sick, and Health NZ could not find anyone to cover the shift.

Patient Voice Aotearoa co-founder Malcolm Mulholland said while there were no reports that any patients were harmed, it showed that Health NZ and the Government did not have any back up plans to service Porirua's large and vulnerable population of more than 100,000 people.

Malcolm Mulholland (PHOTO: PETER MCINTOSH, OTAGO DAILY TIMES).

"Let's not forget that Health NZ and the Government wanted to cut this service last year but did a U-turn because the community stood up to them," Mulholland said.

"The same 24-hour service in Napier was another they wanted to chop but like Porirua, its community stood up too and said 'no'".

He did not want to see what happened in Buller happen in Porirua or Napier, "more so because they aren't rural areas – they have huge and vulnerable populations".

"The best thing we can do right now is 'watch', monitor and get ready as communities, patient advocates, iwi and unions to fight for these services."

Association of Salaried Medical Specialists (ASMS) executive director Sarah Dalton also weighed in on the Kenepuru concern.

Sarah Dalton.

“It shows that there’s no wriggle room in the current budget and rosters at Kenepuru. It also shows that Health NZ has gone with the status quo – no investment.”

She believed Health NZ was relying too much on the telehealth model rather than in person support.

“Porirua has told them that they want local access to doctors and nurses. They don’t want to be getting care services over the phone.

“They are treating Porirua like a rural town when it’s actually an urban centre.”

Hayden Wallace, with his wife and kids and a supporter, at a recent safe staffing strike at Kenepuru Hospital.

NZNO delegate at Kenepuru Hospital Hayden Wallace said Porirua communities would fight again if the service was put back on the chopping block.

"Our community and iwi of Porirua are keeping this service alive. The Government will have a huge fight on their hands if they decide again to mess with this service."

RELATED ARTICLES

Kenepuru Hospital: 'All hell will break loose if he doesn't keep his word'

Porirua Mayor Anita Baker says she will hold Health Minister Shane Reti to his word that the after-hours accident and medical service at Kenepuru Hospital will not be chopped and replaced with a telehealth service.

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NEWS

Visibility strikes: ‘Annoy the powers that be but keeps our message alive’

By Renee Kiriona

January 7, 2026

Outspoken NZNO delegate Al Dietschin is calling on all unionised hospital nurses and health workers to take part in visibility strikes, to keep the spotlight on safe staffing.

Whangārei Hospital ED delegate Rachel Thorn (right) with some of the nurses who've opted to change-up their standard nurse uniforms for more colourful scrubs to push their safe staffing message.

The effectiveness of visibility strike action or uniform strikes is being experienced by more and more health workers at hospitals around the country. Many are changing from the standard blue uniform to different colours and designs to highlight serious understaffing issues.

North Shore, Waikato and Nelson – set off visibility strike fever

Visibility strikes, also known as uniform strikes, have become an effective way to get out the safe staffing message since three groups of nurses and health workers, all

"This type of action is effective. It pisses off the powers that be, but it allows us to keep alive our message about the need for better staffing, safer staffing," Dietschin, who works as a health-care assistant at Christchurch Hospital, said.

"When patients, their family members and friends see us dress differently, from the standard staff uniforms, they usually ask 'what's happening here?' and that gives us an 'in' to tell them about Te Whatu Ora and the Government refusing to fix the unsafe staffing crisis we're experiencing."

NZNO delegate and health-care assistant Al Dietschin at Christchurch Hospital chose to wear this T-shirt rather than his standard uniform.

There are currently 86 public hospital sites and health facilities throughout New Zealand and more than 37,500 NZNO members working as nurses, midwives and health-care assistants in them.

Asked if visibility strikes at all those sites was realistic, Dietschin responded: "Yes, but they need to work with union organisers and be a bit creative – make their own safe staffing T-shirts if they can't afford to buy (https://nzno.digitees.co.nz/shop/category/View-all?c=0) them.

"The point is to dress in a new way that prompts patients and their family to ask a question."

The visibility strike at Christchurch Hospital, which started October last year, had been so effective that NZNO members want to extend that strike action, Dietschin said.

Whangārei Hospital ED nurses join in

NZNO delegate and bargaining team member Rachel Thorn joined other nurses at Whangārei members of NZNO, stopped wearing their standard work scrubs last year.

North Shore district health nurses on uniform strike last year.

It began in August last year when North Shore district health nurses got fed up with constantly being short staffed.

"[We're] short of six staff at least. We're often working late, unpaid. It's just really stressful as we have to triage on a daily basis about who we can and can't see. It's really shocking over winter," NZNO delegate and district nurse Lesley Pook told *Kaitiaki* last year.

Waikato Hospital oncology nurses on uniform strike last year.

Oncology nurses at Waikato Hospital caught the visibility strike action fever in October to highlight how cancer, heart and trauma patients were being treated in the most understaffed wards in the country, with half of all shifts not meeting safe staffing levels.

Hospital ED who began their two-month visibility strike last Thursday.

That same month, Nelson Hospital ED nurses got the fever too.

"We've been in bargaining with Health NZ for 18 months, much longer than we should be, and while they say they have a recruitment uplift underway to increase desperately needed nurses, in reality we aren't seeing that on the floor.

Rachel Thorn.

"That's why we are taking this latest strike action."

When patients ask: "I tell them that this Government is purposely understaffing our hospital so it can save money – at the expense of their health and ours as nurses," Thorn said.

Striking nurses are also wearing "striking for safe staffing" stickers and hanging safe staffing posters throughout the department, including, the public waiting area.

"Health NZ has told us that they will phase in 80 per cent of the nurses we need, but we're thinking they won't start that in any serious way until the next financial year (June). Our nurses are bleeding right now – they are exhausted and our patients are feeling it too in terms of waiting times."

Thorn said that the ED was one to two nurses short per shift.

Thorn will continue to wear her frog and fish patterned scrubs rather than the standard navy-blue uniform through to the last day of the strike on February 28.

(NZNO-made safe staffing t-shirts can be purchased online)
(https://nzno.digitees.co.nz/shop/category/View-all?c=0)

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NEWS

Charlie and Penny: Two dogs looking out for their whānau

By Melissa Jacobsen

January 20, 2026

In a Kaitiaki summer feature we're sharing our readers' amazing pets – answering the age old question of what makes the perfect animal companion to the busy health professional.

Penny looking out for her whānau.

These are two top dogs.

This is my old man Charlie snuggling his favorite toy and our pretty Penny, above, looking after everyone around her.

For other nursing pet stories, find out about Daisy, Bunny and pals here, Lilah here, Reecee here, and Tibbs, Ziggy, Panda and Jaina here.

Old man Charlie.

- *Melissa Jacobsen, RN Anaesthetic Preassessment, Tauranga Hospital, HNZTWO*

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OPINION

Tackling a taboo: Nurse writes ‘book about vaginas’

By Lynda Lovatt

January 22, 2026

Personal trainer returns to nursing to save ‘one vagina at a time’.

Wellington nurse Lynda Lovatt combines her pelvic fitness and gynaecological nursing expertise to help people maintain their pelvic and vaginal health, including during menopause. Photo: Tabitha Arthur.

People ask me what triggered my interest in vaginas?

To start with it was my mum's story about my delivery. The Neville Barnes forceps that were used to pull me into the world. She relayed that story to me so many times. At first, when I graduated from nursing school amongst the sulphur fumes in Rotorua, gynaecology was not something that I had any interest in.

'I knew it was a thing that happened to me'

My pelvic floor muscles had been totally ignored, yet I'd delivered two babies, and I had some clear risk factors and reasons for referral to pelvic health physiotherapy. I didn't know about my risk factors from

Eewww! No, I did not want to do that — it was taboo, too private and personal. I was young and vaginas were awkward. We don't talk about them, do we?

I went on to work as a nurse across medical, haematology, plastic and reconstructive surgical, and paediatrics in New Zealand and the United Kingdom over the next decade.

> **I'd get up with a driving force to save one vagina at a time.**

But after my own experiences of childbirth — with its trauma, tearing, pushing, leaking and stitches — my interest in vaginal and pelvic health returned.

I also wanted to focus on wellness, after seeing so much raw sickness and suffering. So, after 13 years, I quit nursing and retrained as a personal trainer, focusing on women who had given birth and damaged pelvic floor muscles.

My nursing knowledge came in handy as I developed an award-winning postnatal recovery programme to help women recovering from childbirth trauma, getting them back to health, work and the gym.

It became a passion that got me out of bed every day — I'd get up with a driving force to save one vagina at a time.

pushing for a long time during Skye's birth, or the ventouse extraction and perineal tear to name a few. The gym had no idea to ask questions about people's vaginas before they exercised them.

Sometimes I started to leak, well almost lose the whole lot of urine when I laughed.
Other times I would leak when I ran to hit a volley in tennis (I had taken up tennis again too.) I didn't see leaking urine as a problem, because to me it was expected, it was what happens when you have given birth, and you are around forty. It was normalised. I knew it was a thing that happened to me, and most probably to other mothers at the gym.

— extract from Lady Talk (https://lyndalovattladytalk.co.nz/lady-talk-book).

But after 12 years in the fitness industry, it began to feel repetitive. As I approached 50, I realised I needed to think about my next steps.

In 2022, I decided to return to nursing. As part of my return to nursing competency assessment programme (CAP), I did a clinical placement in gynaecology, caring for women recovering from vulval and ovarian cancers. That was confronting and drove me to set up my own nurse-led practice in Wellington, focusing on pelvic health.

Lynda Lovatt in 2017

There, I look at vaginas most days to assess and treat vulval skin conditions, sexual pain and pelvic floor issues. I also work with women on menopause/perimenopause symptom management and preventing chronic disease through lifestyle changes.

Bringing it all together

In 2021, when I hit 50, I thought three things.

Firstly, as a nurse I had seen things that others don't — the grim reality of frontline health care. I thought by writing about my experiences, I might be able to improve people's health and, in some cases, prevent disease happening in the first place.

Secondly I wanted to talk about the taboo topics in women's health. The book opens with this passage:

I was never really into vaginas to start with. I mean people don't openly talk about them, do they? It's as if they are taboo or that it's so private that no one feels comfortable discussing it.

But this shyness can have health impacts, if we don't get things looked at or even look at it ourselves.

It's so important for people to know their own vulva and vagina — get your mirrors out ladies, there are things to see! We need to look and feel what our vaginas are like, inside and out, and start talking.

Take action on birth trauma — physical, mental and emotional — and do your pelvic floor exercises every day for life!

Thirdly, I wanted to share my experiences of opening a nurse-led clinic (https://lyndalovattladytalk.co.nz/), Ladytalk, in Wellington four years ago focusing on menopause and pelvic health. Was I allowed to?

Yes! As a nurse, the world is your oyster.

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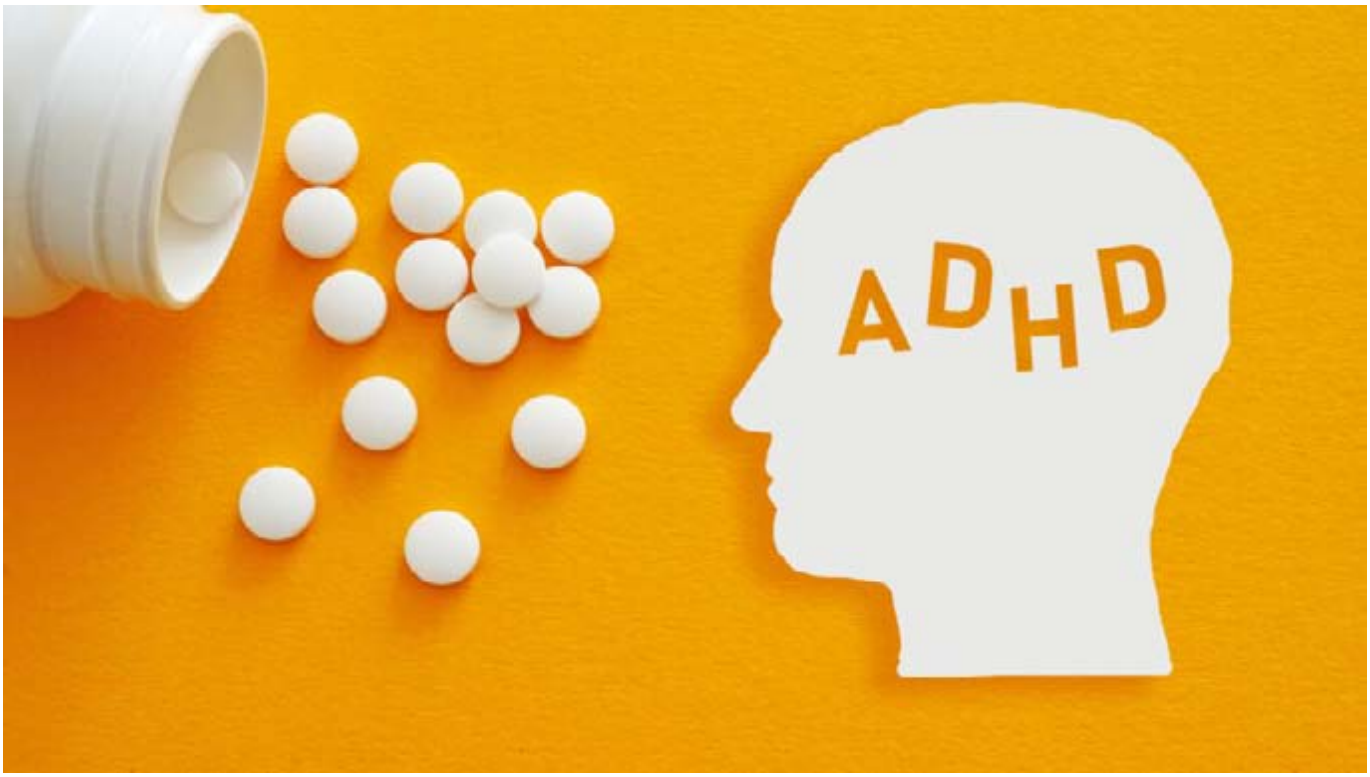
OPINION

‘Long overdue’ milestone coming for ADHD care – and for nurse practitioners

By Sam Hargreaves

January 5, 2026

From February 1, nurse practitioners in Aotearoa will be able to initiate and prescribe stimulant medicines for ADHD, including making funded special authority applications within their area of practice.



Long-overdue recognition of nurse practitioners' expertise is about to arrive with upcoming changes to ADHD regulations. Photo: AdobeStock

For those of us working at the coalface of ADHD assessment, this change is more than a technical tweak to regulations – it is a long-overdue recognition of nurse practitioners’ expertise and an important step towards more timely, equitable ADHD care.

What is changing – and why it matters?

Medsafe's new Gazette notice and Pharmac's decision update remove the requirement that ADHD stimulant treatment must be initiated or endorsed only by psychiatrists or paediatricians, and instead allow nurse practitioners to diagnose ADHD and start methylphenidate, dexamfetamine and lisdexamfetamine within their scope. Pharmac has aligned funding rules so nurse practitioners can submit and manage special authority applications directly, rather than relying on a medical specialist's signature. The explicit intent is to expand the prescriber workforce, improve timeliness of diagnosis and treatment, and relieve pressure on specialist services that have struggled to meet demand.

Nurse practitioner Sam Hargreaves.

ADHD is common, impairing and treatable, yet many people in Aotearoa wait years for an assessment and even longer for funded medication. In everyday nursing practice, especially in community mental health and primary care, we see the impact of untreated ADHD: school exclusions, relationship breakdowns, job losses, injuries, and preventable co-occurring depression, anxiety and substance use. When stimulants are carefully prescribed as part of a broader plan, the benefits can be profound – improved focus and organisation, reduced risk-taking, better work and study performance, and a renewed sense of self-efficacy for people who have spent years feeling like they are 'failing'.

Allowing nurse practitioners to diagnose and prescribe will not, on its own, solve workforce shortages, but it removes a structural bottleneck that has forced many service users to wait for a single specialist signature. People can now access treatment through clinicians who already know them, their whānau and their context, and who are used to working across physical and mental health needs.

Recognising nurse practitioner mahi

The Ministry of Health's (MOH) clinical principles framework emphasises that ADHD assessment and diagnosis should be undertaken by appropriately trained clinicians with expertise in ADHD, including nurse practitioners working within their area of practice. Medsafe's consultation similarly acknowledged that nurse practitioners already hold advanced skills in assessment, diagnosis and prescribing for complex conditions, including controlled drugs. Across the motu, mental health nurse practitioners have been completing comprehensive ADHD assessments, coordinating multidisciplinary input and managing long-term follow-up, while having to rely on a psychiatrist's approval to prescribe stimulants or renew special authorities.

Sam Hargreaves: 'Safe stewardship of stimulants means comprehensive assessment that rules out alternative explanations for inattention.' Photo: AdobeStock

This has been inefficient for services and frustrating for service users, who often perceive that the nurse practitioner 'doing the mahi' is not allowed to finish the job. Bringing prescribing and diagnostic authority into alignment with actual practice closes that gap. It formally recognises that nurse practitioners are autonomous clinicians who bring nursing philosophy, advanced clinical reasoning and a strong focus on whānau-centred care, risk assessment and supported decision-making to ADHD treatment. It also affirms NZNO's long-standing advocacy for nursing leadership and advanced practice roles that use the full extent of nurses' education and experience.

Equity, access and a nursing lens

Nurse practitioners are often embedded in communities where ADHD is under-recognised and under-treated – Māori and Pasifika whānau, people in low-income suburbs, and those navigating MSD, ACC, justice and Oranga Tamariki systems. In these settings, ADHD rarely arrives as a neat, standalone diagnosis; it sits alongside trauma, housing instability, substance use and chronic health conditions. Clinical principles for ADHD in Aotearoa emphasise cultural safety, te Tiriti obligations and attention to social context as core elements of quality care, not optional extras.

> **"When stimulants are carefully prescribed as part of a broader plan, the benefits can be profound."**

A nursing lens means seeing ADHD not just as a cluster of symptoms but as a pattern of life-long barriers that can be shifted when systems adapt around the person. Nurse practitioners are well placed to integrate ADHD assessments into existing nursing relationships, reducing the need for multiple referrals

and fragmented care pathways. They can provide psychoeducation that is accessible, culturally grounded and whānau-inclusive, and advocate for reasonable adjustments in education and workplaces, linking people with peer support, ADHD networks and community resources beyond the clinic.

When stimulant prescribing sits within this broader, relational model of nursing care, the risk of 'diagnose and dispense' is reduced and the potential for genuine life change is increased.

Safety, training and stewardship

Any expansion of prescribing must be matched with robust training, clear standards and good systems. Medsafe and Pharmac have explicitly timed the implementation date to align with new clinical frameworks and to allow development of education programmes and guidance for practitioners initiating ADHD medicines. Nursing and nurse practitioner organisations now have an opportunity and responsibility to support consistent, evidence-based practice – including nurse practitioner-led education, peer supervision and clinical networks.

Nurse practitioners are well placed to integrate ADHD assessments into existing nursing relationships. Photo: AdobeShop

From a nurse practitioner perspective, safe stewardship of stimulants means comprehensive assessment that rules out alternative explanations for inattention, including sleep problems, mood and anxiety disorders, trauma, substance use, learning disability and medical or neurological conditions. It requires baseline cardiovascular and metabolic screening with ongoing monitoring, especially where there are comorbidities and polypharmacy, following recommended review intervals for weight, blood pressure and pulse. It also requires clear escalation pathways and shared-care arrangements with psychiatrists, paediatricians and other specialists for complex presentations or safety concerns. Current methylphenidate shortages and supply changes add another layer, so nurse practitioners will need to stay familiar with new funded formulations, switching strategies and communication with whānau about supply.

Nurse practitioners are already accustomed to operating within prescribing frameworks for controlled drugs, including regular audit, peer review and adherence to local policies. Extending this to ADHD stimulants is a natural progression rather than a radical departure.

Challenges, risks and opportunities

There are real risks. Increased eligibility and more prescribers will drive demand into systems that are already under strain, particularly in regions with limited mental health services or high staff turnover. Without adequate investment in training, supervision and time for thorough assessments, there is a danger of narrow, medication-only responses that fail to address trauma, learning needs and social determinants. There is also a risk that inequities simply shift rather than shrink: people with the resources to self-advocate may access diagnosis and treatment more quickly than those facing language barriers, stigma or previous negative experiences with health services.

Nurse practitiioners with their grounding in te Tiriti and equity can help priorotise under-served communities. Photo: AdobeShop.

Nurse practitioners, with their grounding in advocacy, te Tiriti obligations and equity, have a key role in resisting this drift by actively prioritising under-served communities and using their expanded authority to challenge, not reinforce, existing gaps. This includes speaking up about service design, staffing and funding, and ensuring that ADHD pathways work for those who most need them, not just for those who shout loudest.

This change arrives at a time when public understanding of ADHD is rapidly evolving, particularly among adults and women whose symptoms were missed in childhood. It invites nurse practitioners to step fully into ADHD care – not just as implementers of others' decisions, but as clinicians who lead assessment pathways, design service models and contribute to research, policy and guideline development. For individual NPs, it will mean new responsibilities, but also new opportunities for advanced practice, mentorship and leadership within multidisciplinary teams and within NZNO.

On February 1, 2026, the legal wording changes; the real work is what happens next in our clinics, communities and services. As nurse practitioners, we are ready to do that mahi alongside our nursing colleagues, people with lived experience of ADHD, and their whānau.

- *Sam Hargreaves is a mental health nurse practitioner working for Te Whatu Ora in South Auckland and in private practice, with a focus on ADHD assessment and treatment across the lifespan. He was a member of the Ministry of Health clinical reference group and a working group with Pharmac that helped develop the New Zealand Clinical Principles Framework for ADHD (https://www.health.govt.nz/publications/new-zealand-clinical-principles-framework-for-attention-deficit-hyperactivity-disorder?fbclid=IwY2xjawOsWh5leHRuA2FlbQIxMABicmlkETEyVXp4N0lrZVh3d0JyelJSc3J0YwZhcHBfaWQQMjIyMDM5MTc4ODIwMDg5MgABHgD9HcVyCJ064nxWtk64EqUUko-KUgfUo6Ruv53S_pqpcSZToGn6RIS4qf14_aem_pITZLdBA9wDcJSlOcIQBlQ) and the upcoming changes to ADHD prescribing and training requirements.*

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PROFESSIONAL

Expanding primary health student placements: Lessons from a hub-and-spoke model

By Karla Breen Rickerby

January 21, 2026

A pilot "hub and spoke" programme allowed nursing students to experience a wide range of primary health clinical placements in their final year.

Students who took part in the programme, which ran for a year in the Nelson-Marlborough region, reported improved understanding of primary care, cultural safety and family/whānau-centred practice, along with greater confidence and adaptability. Educators and providers noted students' stronger communication skills and improved workforce readiness, as well as a reduction in placement pressures.

Karla Breen Rickerby

Importance of primary health care

Experiencing health care beyond hospital walls in their clinical placements is essential for nursing students to understand the full patient journey.

Primary health care is a cornerstone of the Aotearoa New Zealand health system, which was highlighted during responses to the recent COVID-19 pandemic and measles outbreaks.

While undergraduate nursing programmes do include clinical placements in primary health, the allocation and emphasis of these vary between institutions and regions, and many students still spend a large proportion of clinical hours in hospitals. This limits students' opportunities to understand how health care is delivered in primary care settings.[1,2]

The Nelson Bays Primary Health Organisation (PHO) and rural community health care services partnered with education provider, the Nelson Marlborough Institute of Technology (NMIT), to pilot a hub-and-spoke student placement model to increase the diversity of their primary health care clinical experiences.

Benefits of the pilot included increased placement capacity, reduced burden on individual placement providers and richer and more diverse learning experiences for students that strengthened their workforce readiness and their understanding of culturally safe, whānau-centred practice.[3], [4] The trial was was part of the students' third-year family, whānau and community nursing module.

Why a hub-and-spoke model?

Traditionally, nursing students are allocated to one clinical area or specialty for the duration of their placement. While this can provide continuity, it also limits the range of learning opportunities and puts significant pressure on single providers.

Such siloed placement experiences can restrict the students' understanding of the whole patient journey and discourage smaller providers from participating due to concerns about the limits of of their resources.[3]

Hub-and-spoke models have been shown internationally to improve student satisfaction, foster positive perceptions of primary care and increase the health services' capacity for placements.[3]

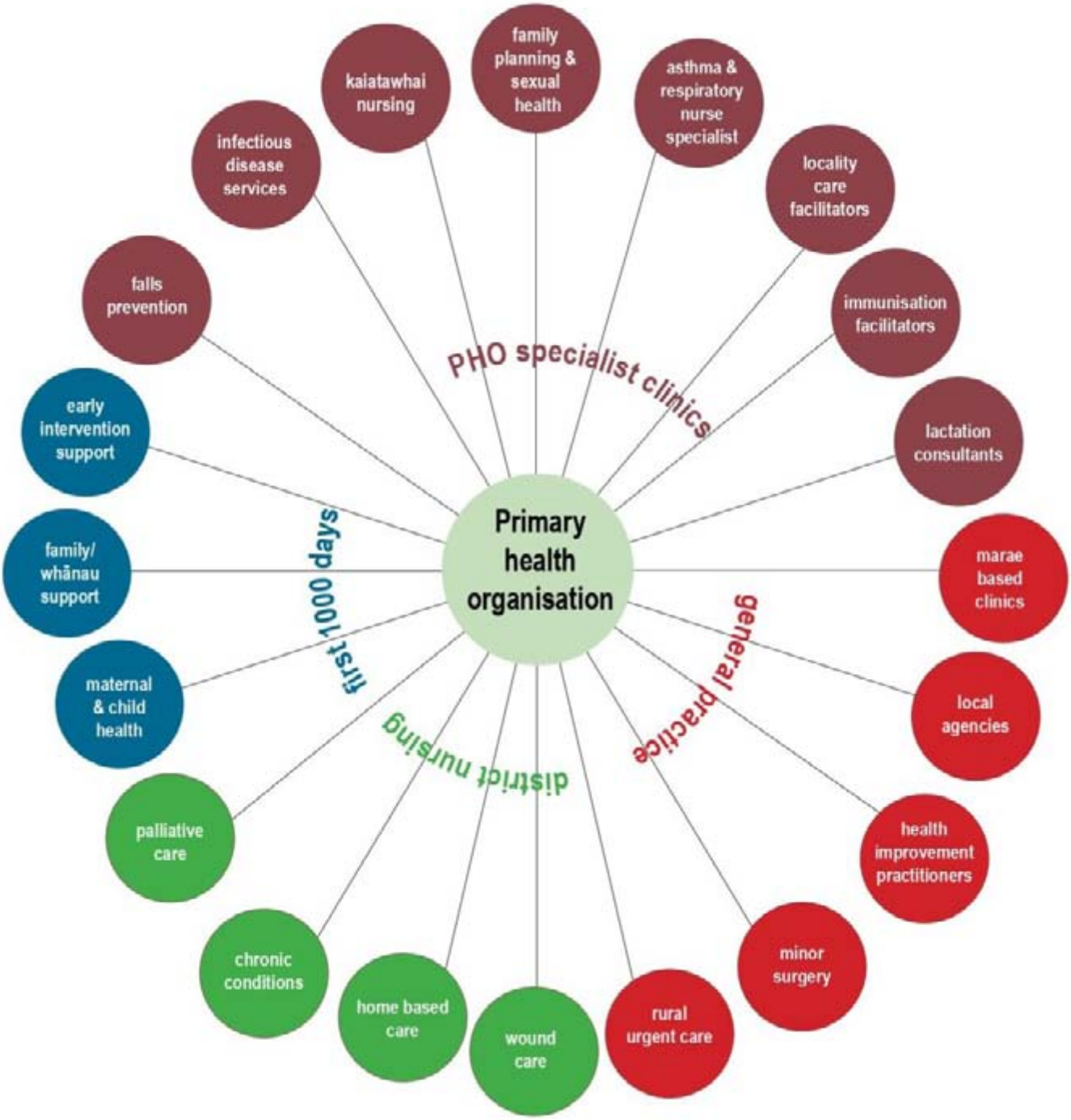
Hub-and-spoke structure

In this pilot, the "hub" for student placements was the Nelson Bays PHO, which provided access to a range of primary health care services and coordinated learning opportunities across its network. From this hub, students rotated through a series of "spoke" placements, each offering distinct perspectives on the delivery of primary health care.

The spoke placements were grouped across four different sectors of the PHO's services — PHO specialist clinics, general practice, district nursing, and the First 1000 Days (a multidisciplinary service for babies, mothers and whānau) — and the students rotated through these four sectors. In this way, they were able to experience diverse "spoke" placements, including Māori health providers, marae-based clinics and specialist services.

Spokes across the four sectors included:

- **Specialist services:** Placements with services such as lactation consultants, family planning, a Health Care Homes facilitator and locality care facilitators (who link primary care with specialist and community services for patients with complex needs).
- **General practice:** Spokes included marae-based clinics in partnership with Māori health providers, local health agencies and rural urgent-care services.
- **District nursing:** Spokes provided exposure to home-based care, chronic condition management, wound care management, palliative care and community nursing initiatives.
- **First 1000 Days:** Spokes included placements in the multidisciplinary First 1000 Days collaborative, which brings together Well Child/Tamariki Ora providers, midwives, public health nurses and Māori and community health services. Students gained experience in postnatal care, early childhood health, and whānau-centred support within an integrated, culturally responsive model of care.



The hub-and-spoke configuration enabled students to gain an integrated understanding of the primary health care continuum, while maintaining a consistent link to the PHO as the central coordinating hub.

At the start of their placement, students were oriented to the hub-and-spoke model at the PHO, starting with a karakia, followed by whānaungatanga with preceptors and hub-and-spoke staff. Students rotated for two to three weeks through each of the hub sectors, accessing a range of spokes in the rural community to gain a broad and varied primary care experience.

The hub-and-spoke model was designed to broaden student learning, strengthen provider collaboration, and deepen cultural engagement in primary health care placements.

Shared supervision across sites reduced the pressure on individual providers while fostering teamwork and continuity of learning.

It enabled students to experience diverse community settings, offering a holistic view of care across general practice, public health, maternal and child health, and outreach services. Shared supervision across sites reduced the pressure on individual providers while fostering teamwork and continuity of learning.

The model also embedded cultural safety principles, aligning with Te Pae Waenga[5] and Te Tiriti o Waitangi/the Treaty of Waitangi by promoting equity, partnership and whānau-centred practice.

Some challenges were experienced in the operation of the hub-and-spoke model. These included variations in how ready some spoke sites were to receive students, the demands of coordinating the scheme, and ensuring consistent supervision and assessment. Overall, however, the model showed that meaningful primary care placements can be achieved through shared commitment, flexibility, and strong relationships between education providers and health services.

Evaluation of key findings

Student perspectives

Students reported that the hub-and-spoke model gave them a more authentic understanding of primary health care. Many had assumed public health and general practice were "routine" or a "retirement job," but rotations revealed the breadth of care, including chronic condition management, health promotion, child health and outreach services.

Placements within the spokes, particularly with kaiatawhai nurses, deepened the students' understanding of cultural safety and whānau-centred care, reinforcing classroom learning with lived practice.[4]

One student reflected:

> *"Seeing how the kaiatawhai worked with whānau made me realise that health care is more than treating illness — it's about relationships, trust, and culture."*

Another student highlighted their learning goals and the hub-and-spoke model's emphasis on holistic practice:

> *"I am hoping to meet all competencies! However, I expect there will be a strong focus on cultural safety and therapeutic relationships. I am hoping to develop good assessment skills that focus on the patient and family/whānau as a whole rather than focusing entirely on symptoms and symptom management as I have experienced in secondary health care."*

Another student commented:

> *"[I] gained understanding of local health services."*

Students reported increased confidence, adaptability and understanding of the whole patient journey. This mirrored findings in a Scotland study, where hub-and-spoke placements enhanced students' sense of belonging and connection with communities.[6]

Educator perspectives

For educators, the hub-and-spoke model provided confidence that students were receiving consistent support while experiencing diverse clinical environments. They saw students develop stronger communication and adaptability skills as they transitioned between settings and engaged with multiple providers.

Some spokes had not previously been used for placements, so these provided new learning opportunities, exposing students to different aspects of nursing in primary care.

One educator noted:

> *"... from what I saw, the students' experiences really gave them a clearer sense of the issues affecting patients' communities."*

These findings align with research showing that students benefit from participating in a variety of workplaces with differing work patterns and methods of care delivery, which enhances their workforce readiness and appreciation of primary care roles.[1, 3]

PHO and practice perspectives

The PHO viewed the hub-and-spoke model as a way of strengthening relationships across its network. Practices reported that, although hosting students required time and supervision, the rotational structure ensured that no single site carried the full placement load.

By distributing students around the spokes, workload was shared more equitably, enabling staff to engage with learners without compromising service delivery. At smaller rural and kaupapa Māori providers, this arrangement allowed staff to confidently support students while maintaining high quality care.

Providers also said this approach supported workforce development by encouraging nursing students to consider careers in primary health.[7] Staff valued the opportunity to share and promote the work occurring in their services, which in turn fostered student interest and sector engagement.

Providers also said this approach supported workforce development by encouraging nursing students to consider careers in primary health.

Challenges and considerations

The model was not without challenges. Coordinating timetables across multiple spokes required careful planning, and students sometimes found frequent transitions between settings demanding. Robust communication between the hub, spokes and NMIT was essential to avoid supervision gaps.

Despite these challenges, most participants felt the benefits outweighed the difficulties. This is consistent with other research noting that while hub-and-spoke models require coordination, they are sustainable when underpinned by strong institutional partnerships.[3]

Impact on cultural safety and whānau engagement

A notable outcome of the hub-and-spoke model was its contribution to cultural safety. Rotations through kaupapa Māori health providers and marae-based services exposed students to care shaped by a te ao Māori worldview and tikanga (protocol), encouraging reflection and reinforcing whānau-centred practice.

Cultural safety in nursing is best understood as a dynamic practice, built on relationships and situated within communities, which requires nurses to recognise power and privilege.[4] This was evident in students' reflections, which highlighted the relational and trust-based aspects of care.

Primary health care addresses the social determinants of health and supports intergenerational wellbeing.[8], [9], [10] This pilot aligns with these principles, embedding students in integrative, community-based services.

Robust communication between the hub, spokes and NMIT was essential to avoid supervision gaps.

Importantly, primary health care encompasses care across the individual's lifespan. The hub-and-spoke model offered the nursing students opportunities to understand intergenerational health advantage and disadvantage, which consolidated their understanding of the social determinants of health. This aligns with the Nursing Council's standards,[11] which require integration of person and family/whānau-centred care across primary, secondary and tertiary settings.[12]

Lessons learned and future directions

The hub-and-spoke approach illustrates how nursing education can foster experiential, community-based learning that aligns with Te Tiriti o Waitangi/the Treaty of Waitangi principles, supports inter-professional collaboration and equips students to meet the complex and diverse needs of Aotearoa/New Zealand communities.

The model shows that student placements in primary health care can be expanded through creativity, collaboration and shared responsibility. The model reduced pressure on individual clinical areas, strengthened cultural safety and provided students with experience in the predominant setting in which an individual's health care is delivered.

Through rotations across the spokes, students developed clinical skills, adaptability, and confidence, while gaining insight into the diversity of primary care services and the importance of culturally safe, family/whānau-centred practice. Educators and providers reported enhanced communication, workforce readiness and engagement with the primary health care sector, supporting students' future career pathways.

The framework also highlighted areas where the curriculum could be improved and clinical learning experiences for nursing students further developed by strengthening exposure to coordinated, interprofessional models of care.

This model could be scaled up to national level in nursing education.

However, challenges were also identified. These included the need for consistent coordination between education providers and placement sites, equitable resource allocation, and the ongoing mentoring required to sustain quality learning experiences across multiple settings. Ensuring cultural safety and workload balance for preceptors, particularly in smaller or rural practices, remains essential for long-term viability.

Although this pilot only ran for one year, it has had a positive ongoing effect on clinical placements in the Nelson region, opening up new opportunities in primary health, particularly in the PHO. The hub-and-spoke programme opened doors and allowed managers in health providers to see the benefits of taking on students for clinical placement.

This model could be scaled up to national level in nursing education, to improve access to community-based clinical placements, address placement shortages, enrich student learning, and prepare a nursing workforce capable of delivering culturally safe, and community-focused care.

This aligns with Health New Zealand — Te Whatu Ora's Health Plan ,[5] which emphasises the need for a new system of coordinated student placements to meet future workforce demand. Successful expansion requires institutional commitment, robust coordination, and sustainable partnerships between education providers and primary care services.

Recruiting and retaining nurses and allied health professionals in primary health remains vital to addressing inequities and delivering on Te Tiriti o Waitangi/the Treaty of Waitangi commitments.

Karla Breen Rickerby, RN, PhD, is an experienced primary health care nurse, who alternates between primary health work in the Nelson region, and in Aboriginal-run clinics in remote areas of Queensland, Australia.

** This article was reviewed by Anna Askerud, RN, MHSci, DipTchg, PhD, a senior lecturer in the Department of Nursing, University of Otago, Dunedin. She has worked in both primary health and acute care and her special research interest is integrating care of people with long-term health conditions.*

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PROFESSIONAL

After 25 years of NPs in New Zealand, where are we now?

By Deborah L Harris and Eileen McKinlay

January 26, 2026

Twenty-five years on, New Zealand's first nurse practitioners (NPs) have proven their worth — but obstacles remain, our first-ever NP finds.

New Zealand's first registered nurse practitioner Deborah Harris and colleagues are looking at how NPs have advanced over the past 25 years.

Why this research matters for everyday nursing practice

In December 2026, Aotearoa New Zealand will mark 25 years of nurse practitioner (mātanga tapuhi) practice. Since 2001, nurse practitioners (NPs) have become an established part of the health workforce. Yet questions remain. What do NPs, as an advanced nursing practice role, do? Where do they add value? And how does their work contribute to patient and whānau care and health outcomes?

The findings are consistent across health-care settings. NPs provide expert clinical care in hospitals, primary care, rural services and communities.

A recently published integrative review on the first 20 years of NP practice[1] draws together peer-reviewed New Zealand research published since NP registration began here. Where NP-specific data could be identified, the aim was to understand how NPs contributed to clinical practice and health policy during the formative years of the role.

Co-author, University of Otago primary health professor Eileen McKinlay.

The findings are consistent across health-care settings. NPs provide expert clinical care in hospitals, primary care, rural services and community contexts. They work collaboratively with other health professionals. They support access to care for populations with high need. They bring a nursing perspective to complex clinical decision-making. Over the 20 years, the volume and sophistication of NP research has increased and more recent studies are investigating patient outcomes of different models of care.

Alongside these contributions, the review identifies persistent structural constraints. These include limited opportunities and involvement in policy development, service design and system-level decision-making.

Twenty years of New Zealand research show that NPs add clear value to patient and whānau care, and that they are a well-accepted workforce. But it also shows the full contribution of advanced nursing practice is still shaped, and often constrained, by the systems in which it sits.

Across the 20-year period, there was no coordinated national evaluation of the NP role, which limits what can be concluded about changes in how NPs practise, location of practice, preparation of NPs, workforce changes, roles satisfaction, employment, long-term outcomes, equity and system impact

What is an integrative review?

An integrative review brings together evidence from different types of research to build a comprehensive understanding of a topic. It may include qualitative studies, surveys, audits and mixed-methods research.

For this review, peer-reviewed New Zealand research published between 2001 and 2021 in which NP data could be clearly identified was systematically searched, critically appraised and analysed. This approach allows patterns, strengths and gaps in the evidence to be identified [2] .

Why share this research beyond academic journals?

Many nurses cannot easily access academic journals. There are many barriers, including subscription costs, limited institutional access, and at times technical and inaccessible language.

The full contribution of advanced nursing practice is still shaped, and often constrained, by the systems in which it sits.

Sharing research through accessible nursing publications supports informed professional discussion. It strengthens understanding of nursing roles across the workforce. It also helps ensure research reaches those delivering care, leading services, and shaping how health care is organised.

What this review means for nurses

This review provides a consolidated account of how NPs have contributed to health-care delivery in New Zealand during the first 20 years of the role. It shows that advanced nursing practice supports access to care and responsive service models.

The review also highlights the importance of organisational, funding and policy alignment. When these are misaligned, opportunities to use advanced nursing skills fully are reduced. These constraints affect how nursing expertise is recognised and integrated across the health system.

As the profession approaches 25 years of NP practice, evidence from the first two decades supports informed and realistic conversations about strengthening nursing roles.

At a glance

- Nurse practitioners (NPs) improve access to care. NPs frequently work with populations experiencing health inequities, including Māori and Pacific communities — although their ability to address inequity was often constrained by funding and policy settings.
- NPs are grounded in nursing philosophy. Findings reflect nursing values they encompass, including holistic care, relational practice, and whānau-centred approaches.
- The role is shaped by system settings. Funding models, organisational structures, and role clarity influence whether NPs can work to their full scope of practice.
- Policy engagement remains limited. NPs contribute substantially to service delivery, but involvement in health policy development and governance is inconsistent in the published literature.

Deborah L Harris, **NP, MSc, PhD,** was New Zealand's first registered nurse practitioner. She is now professor of nursing and midwifery research at the University of Newcastle and Hunter New England health, Australia. Her expertise includes neonatal care and NP workforce development and she hopes to build strong trans-Tasman partnerships to advance the NP role in both countries.

Eileen McKinlay, RN, MA, is director of the University of Otago's division of health sciences Centre for Interprofessional Education and a professor in primary health care.

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See also: *NPs gifted new Māori title*

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PROFESSIONAL

From concept to screen: a step-wise approach to creating health education videos

By Tracy Klap, Jacqui Grannetia, Stephen James and Maureen Coombs

January 15, 2026

Health education videos are increasingly being used to provide information to patients and whānau as they navigate their way through health services.

Each of the videos featured a host speaking to camera, with additional B roll. (Photo 1)

Given these videos can be accessed at a time and place convenient to health consumers, they provide a useful information resource alongside discussions held with clinical staff and local written information

resources.

As a team of nurses from Wellington Hospital intensive care unit (ICU), we have been developing nationally available, evidence-based health education videos (https://info.health.nz/hospitals-services/services-support/public-hospitals/critical-care) for a clinical specialty often seen as a stressful and foreign environment to patients and visitors, with unfamiliar sounds, sights and experiences.

Providing quality information in the ICU is key to enabling effective decision-making and engendering psychological safety for the critically ill patient and their support network. However, with so much information covered in key meetings with clinical staff at time-critical points in the ICU stay, education videos offer a reliable source of information that can be returned to at any time.

Drawing on our experience, this paper provides a practical guide for nurses looking to develop information videos in their work area.

The ICU videos came with reo Māori subtitles. (Photo 2)

Why health education videos?

Health education videos are used to improve patient knowledge, increase satisfaction with care, facilitate greater decision-making capability and reduce levels of anxiety in patients and whānau.[1] With particular uptake in surgical and oncology settings, videos often focus on information-heavy areas that can result in high stress levels.[2] Within critical care settings, there are crucial transition points where information loading and distress levels can be high such as admission to,[3] and discharge from critical care.[4] Information videos can be a useful additional resource at this time.

When thinking about developing health education videos, it is important to consider how people learn. We process visual and auditory information simultaneously in our cerebral cortex. Known as the dual-channel principle,[5] this means that information obtained through listening to and watching videos can be processed, understood and retained. However, when incoming information exceeds the capacity of the audio and visual channels, cognitive overload occurs and learning ceases.[6] [7] Use of concise

narration with short captioned video sections and good quality sound maximises effective use of working memory pathways. [8]

Taking on board these principles, we have developed short patient and whānau-focussed videos to assist with: patient admission to critical care; discharge from critical care; and preparing patients for the first 24 hours in intensive care after cardiac surgery (hosted by an ex-patient). We are also developing a video about intensive care survivorship to be filmed in ex-patient's homes.

> **"Providing quality information in the ICU is key to enabling effective decision-making and engendering psychological safety for the critically ill patient."**

In all of our videos, which were supported by charitable grants, we followed a step-wise approach consisting of scoping, pre-production, production and post-production. In this paper, we describe this approach and some of the lessons learnt.

How to begin: Scoping

Before you start any project, it is important to know what is already out there and where the gaps are. It is essential to know that you are not replicating something already available and that your project will have impact and value for money.

Each of our video projects began by scoping existing resources to identify relevant videos using search engines (for example, *Google*) and on-line video-sharing platforms (for example, *YouTube*). Current clinical guidelines or seminal academic papers in topic were identified through on-line searches and by reaching out to local clinical networks (such as ICU nurse educators). Each resource was reviewed and key details noted, such as country of origin, date, video content and innovative filming approaches. This was key to inform our thinking about content and design options.

'We developed short, patient and whānau-focused videos. Photo: AdobeStock

Preparing to film: Pre-production

Building in time for pre-production is important to deliver a quality video. Detailed planning is important in this phase, as is identifying the right people with the right skills to develop the video. Pre-production also includes development of the video script and scene outline.

Each of our videos were carefully planned over a four to six month period using a GANNT chart. This ensured timely delivery alongside our other workloads. The project team members were the experts who brought clinical expertise and wider skills (such as writing the script, facilitating meetings, simulation expertise). The project team comprised of nurse educators and, depending on the focus of the video, also included intensivists, clinical psychologists and ex-patients. Projects funded by external grants required larger governance groups to provide project oversight.

It was also important to have input from subject matter experts (SMEs) in the field. Using our clinical networks, we were able to identify SMEs from disciplines across the motu. For each project, two SME meetings were set up: the first to review the script and the second to review the initial cut of the video. We were able to identify a videographer, proficient in filming, directing and editing. In reviewing their previous work, we were confident they could work within the sensitive hospital setting and deliver high-quality, professional videos.

Each of the videos took up to six months of planning. Photo: AdobeStock

Having identified the team needed to produce the videos, the next step was to develop the video script. This takes time and requires many iterations. Achieving the right balance between using accessible language for patients and whānau whilst delivering the appropriate level of detail for long-term use was key. We had to present all of this in a way that wasn't overwhelming or alarming. Once the script was developed, it was reviewed by the SME group and any changes made.

Once the script was finalised, a storyboard was created. The storyboard provides a scene-by-scene outline of how the video will unfold. It tells the story of the video detailing what will happen, how it will happen, who will be involved, what will be said, and where it will be filmed. In our videos, we used one key person (the host) to deliver the main script straight to camera. We then used general ICU and hospital shots or simulated patient and whānau situations as supporting film to visually detail what was being spoken about (B roll footage). The final video was planned to cutaway from the host to the B roll.

From the storyboard, a shoot schedule was developed (table 1), specifying the time allocated to film each scene along with the location, required action, actors (or talent), and necessary equipment or props. Selecting the location for filming was challenging in order to keep disruption to clinical care, staff and visitors, at a minimum. Mapping out the timeframe for the shoot helped anticipate and prevent any issues. Filming was planned for when the area was most likely to be quiet or available and we have used commissioned but unopened beds and empty cubicles for all of our filming. Selection of the hosts and actors was the final consideration and these were sourced from clinical contacts and families of staff.

Table 1: Example of production shoot schedule

Location/filming time/action/talent/equipment/props/voiceover script

ICU Bed space	Dynamic shot, wide to narrow focus	Patient Nurse A	Patient in bed intubated with, chest drains,	After your surgery, you'll be moved from

20 minutes	indicating admission into bed space to support text. Patient lying quietly in the bed with nurse A and B calm but busily connecting equipment.	and B	external pacemaker, central and arterial line and full patient monitoring. Bed space setup with all equipment required for a cardiac admission. 2 x infusion pumps with propofol and noradrenaline running.	the operating theatre to the ICU whilst still asleep, where you'll be looked after by the ICU and cardiac surgery team.
ICU Bed space 20 minutes	Dynamic narrow to wide shot focussing on the monitors blood pressure alert. Shot then pans out to include patient. Patient sitting up, appears slightly concerned. Nurse A enters frame, silences the alert and reassures the patient.	Patient Nurse A	Patient in bed, sitting up and extubated with nasal prongs insitu. Bedside monitor in SIM mode. Heart rate, arterial and central line, Oxygen saturations all visible. Arterial blood pressure alarming marginally low.	You'll be connected to a monitor that tracks your vital signs. If there are any changes, a machine alert will let the team know. This can be unsettling but it's pretty normal and doesn't necessarily mean there's an emergency.

Subject matter expert meetings identified a person with proficiency in videography and directing. Photo: AdobeStock

Beginning with the end in mind, we identified the relevant platform to host the final videos early on. Initial contact was made with the web content and channels team for the info.health.nz Health New Zealand website to explain the project, timeframes and for us to understand upload and hosting processes for the platform.

Filming day: Production

Although methodical planning and set up is required for a smooth filming day, you still need to be prepared to pivot to accommodate the needs of the clinical environment around you. Filming days are long and intense. The team need clearly defined roles and responsibilities, for example director to support videographer, ICU and actor liaison, and simulation lead. Communication is key. We blocked filming into full days beginning with set-up at 7am, with close of day around 4.30pm after cleaning and reset of the clinical areas was complete.

Using the pre-production shoot schedule to guide the production day, we first filmed the host delivering the entire script direct to camera (photo 1) before filming B roll footage. This meant that, regardless of what happened during filming, we always had the host film to fall back on. As clinical staff and their whānau were actors for the day, creating a relaxed and supportive atmosphere was essential for them to deliver natural performances and allowed the right balance of gravitas and warmth to come through.

> **“Filming days are long and intense. The team need clearly defined roles and responsibilities.”**

Finally, there are significant ethical issues to consider when producing videos. All actors and those captured in background shots were consented. No patients or visitors were filmed so there was no breach of confidentiality.

After the filming: Post-production

The final phase begins after filming. Here, the raw footage is assembled into a finished film and then distributed. In our videos, the film taken on the day was edited to include audio sound effects (like monitor alarms) and background instrumental music was added. This process was managed using software which allowed the project team to collaborate on the edits. Once the first, rough cut of the video was completed, the second SME meeting was held to review video duration and highlight any errors. Final modifications were then made with captions and acknowledgements (such as funding sources, sites involved) added.

English – Admission to critical care

05:57

We offered our videos with English, reo Māori and Samoan language captioning (photo 2). This was informed by national demographics of the ICU patient population. Once the videos were finalised, the video links were sent to professional translation services. Re-connection was made with the Health New Zealand Te Whatu Ora web content and channels team for video upload and generation of URL and QR codes.

The final stage in post-production is dissemination. We developed digital posters, distributed via our SMEs and clinical networks, for display in patient and visitor-facing areas. The URL links were available for incorporation into local patient and visitor information resources. For wider reach, we also emailed information to key stakeholders including senior ICU staff across the motu and also wrote pieces for NZNO's Critical Comment and Tū Mata Kōkiri Health New Zealand.

Final thoughts: It's a wrap

As nurses, we work in environments and situations where we learn to be adaptable and resourceful. Whilst developing health education videos may seem out of scope, it is an exciting area that nurses have many existing transferable skills. The same project management skills used to plan a study day can be used to map out the project and organise the filming day. Existing clinical networks can be used to identify the project team and SME group. Video development is a team effort and we've found that people are genuinely supportive and keen to be involved, whether that be centre stage or in the wings.

It can also be exciting to learn new skills. It is a different way of thinking to develop a script that has generalisability across all critical care areas whilst having some depth of clinical detail. Thinking about the aesthetic of a video and how the film shots support the narrative of the video are new areas of learning too. Although this learning process can be challenging, it becomes incredibly rewarding when you see the finished video and hear feedback on how it's been used.

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FEATURES

Ka whai wā te tapuhi ki te whāngai i ngā tini e haere mai nei ki Rātana

By Renee Kiriona

January 26, 2026

E hia manomano tāngata Māori, kaiārahi tōrangapū, Māngai Pāremata hoki puta noa i te whenua e whakarite ana mō ngā whakanuitanga ā-tau i Rātana kia whakanui i tō te rangatira hāhi whānautanga. Ā, kei waenganui i a rātou tētahi tapuhi hōhipera kiriwhakapōtae e whāngaia ana te tini.

Awhina from the Rātana Church marching at the 2021 commemoration of their movement's founder Tahupōtiki Wiremu Rātana. Photo: ROBERT KITCHIN / Stuff. Inset photo: Nurse Parekura Mako-Kairimu.

Thousands of Māori people throughout the country, political leaders and MPs are gearing up for the annual Rātana commemorations to celebrate the birth of the church's founder. And a graduate hospital nurse will be among those who feed them.

Kua whā ngā marama a Parekura Mako-Kairimu, 29, e mahi ana i te mātūtū whakaora i te hōhipera o Whanganui, engari i whai wāhi ia ki te Hāhi Rātana mō te katoa o tōna oranga, i whakatipua i tō te hāhi kāinga (Rātana Pā) i waenga i a Bulls me Whanganui.

Parekura Mako-Kairimu, 29, is in her fourth month of working the medical ward at Whanganui Hospital, but she has been part of the Rātana Church and movement since she was born, raised at its home (Rātana Pā) which is located between Bulls and Whanganui.

Tahupōtiki Wiremu Rātana – the Methodist farmer who formed the Rātana Church after losing 18 of his 22 cousins to influenza.

Ka mutu, mēnā i whāia e ia ngā hiahia o tōna māmā ka tū hei 'awhina' ia i tēnei wā.

In fact, if her mother had it her way she would be an awhina right now.

"Kua whakatenatena tōku māma i a māua ko tōku tuahine mahanga kia whāi wāhi ki ngā awhina — ko tō mātou hāhi hāngaitanga ki te tapuhi, engari me pono, kāhore i te pai aua kākahu ōrite ki ahau," ka katakata mai a Mako-Kairimu.

"Mum tried to get my twin sister and I to be awhina – our church's equivalent of a nurse, but to be honest that uniform just wasn't me," Mako-Kairimu giggled.

“You the nurses, I now say that the name ‘nurse’ should be deleted from among you, and instead place the name ‘awhina’ as your title.”

I whakatūria e te rangatira a te hāhi a Tahupōtiki Wiremu Rātana i te tūranga awhina — he tapuhi ā-wairua — i te 1926 kia whakatō te manawa ora, te whakapono me te whakamātūtūtanga i roto i ngā hapori Māori puta noa i te whenua i parekuratia e te mate urutā rewharewha. I mate te nuinga o ō Rātana kaihana nā te rewharewha.

Church founder Tahupōtiki Wiremu Rātana created the role of awhina or spiritual nurses in 1926 to help instill hope, faith and healing back into Māori communities throughout the country who had been ravaged, and lost thousands of family members, to the influenza pandemic. Rātana himself lost the majority of cousins to the disease.

Māori nurses gathered at Wairoa in 1926 during a speech by TW Rātana that he would create a special ‘awhina’ position/role for them in the church. PHOTO: Rātana Church.

I a Rātana e takaāmiomio ana i Te Tai Rāwhiti, ka tauākīa e ia ki ngā tapuhi e mātakitaki mai ana ka taea e rātou te whaiwāhi i tētahi tūranga i roto i āna mahi: “Ki a koutou ngā tapuhi, ka kīia e au ka murua tō koutou ingoa, ā, ka whakakapia hei awhina.”

While touring Wairoa in the East Coast, Rātana declared to Māori nurses present, that he would make a place for them in his work: “You the nurses, I now say that the name ‘nurse’ should be deleted from among you, and instead place the name awhina as your title.”

Ka tū tonu taua tūranga tae noa ki tēnei wā, hei tā Mako-Kairimu.

Mako-Kairimu said awhina still exist in the church today.

Politicians for decades have magnate to Rātana for the popular commemoration of its founder and kaupapa. PHOTO: Reece Baker.

"He awhina tōku kōkā. He tino hira tō rātou tūranga i ēnei rā tonu, kia peka atu ki ngā tūroro mōrehu i ō rātou whare hei whakapiki i te wairua, hei whakamoemiti anō hoki."

"My aunty is an awhina. They play an important role, even today, visiting our sick and ill mōrehu [church followers] at home to uplift them using whakapiki [increasing their wellbeing] and whakamoemiti [prayer].

"E kore ngā awhina e whakahōu i ngā tākaikai, e tui i te tangata rānei. Kāhore rātou i mahi pēnei ki tāku i mahi ai i te hōhipera. Ka whakamātūtū rātou i te mamae ā-wairua kua huna engari i noho nei i te tangata."

"Awhina don't change bandages or stitch people. They don't do what I do in the hospital. They work on the mamae or hurt that can't be physically seen but is definitely there."

E whakapae ana he 40,000 ki te 45,000 o ngā mōrehu puta noa i te ao.

There are estimated to be 40,000 to 45,000 mōrehu worldwide.

Ka tū ngā whakanuitanga mai i te Tāite tae atu ki te Rātapu i Rātana Pā. Ka tae mai ngā kaiarahi tōrangapū, ngā Māngai Pāremata me Te Arikinuni Nga wai hono i te po, i te Paraire

The Rātana celebrations kick off on Thursday and run through until Sunday at Rātana Pā. On Friday, political leaders, MPs as well as the Māori Queen Te Arikinui Kuini Nga wai hono i te po.

NZNO's Māori nurses council Te Poari always sends a delegation to the Rātana celebrations.

Kia eke mai he ope o ngā tautapa NZNO o Te Poari i te pā i te Paraire hoki.

Delegates from NZNO's Māori council Te Poari will also gather at the pā on Friday.

"Ko tāku mahi kia whakahaere i ngā bain-maries i te kīhini, nō reira ka whai wā ahau ki taua tūranga a muri atu i tāku wā mahi i te hōhipera."

"My role is to manage the bain-maries in the kitchen, so I will be finding time to do that once my morning shift at the hospital is done."

Ka kī a Mako-Kairimu ka whakaohoohotia ia kia whai i te mahi tapuhi nā runga i te hiahia kia whakatakoto i ngā whanonga pono Māori, Rātana hoki nō roto i tōna whakatiputanga. Ā, nā runga hoki i te kitenga e tino hiahiatia ana ngā tapuhi mātanga ahurea.

Mako-Kairimu said she was inspired to become a nurse because she could apply the Rātana and Māori values she was raised in. And because she could see the need for more culturally competent nurses.

"Ko tōku wheako tuatahi i roto i te punaha hauora ko tō tōku pāpā urunga ki te hōhipera. He tino uaua mō mātou kia mārama ki ngā kaimahi i reira i mua i tā mātou kite i tētahi tapuhi Māori i taea te kōrero ki tōku pāpā i tōna reo tuatahi, arā, ko te reo Māori.

"I got my first experience with the health system when my pāpā had to go to hospital. It was hard for him and us to understand most of the staff there, until we came across a Māori nurse who was able to talk with him in his first language – te reo Māori.

Michelle Fairburn

"Ka tere whakatau ahau i taua wā kia tū hei tapuhi. He pai hoki ki ahau te mahi tapuhi nā te mea ka taea e au te whai i ōku uara o te whakapono, whaimaramatanga me te manaakitanga."

"That's when I decided, I am going to be a nurse. Nursing also attracted me because it allows me to practice my values of whakapono, whaimāramatanga and manaakitanga."

E ai ki te tautapa NZNO i te hōhipera o Whanganui a Michelle Fairburn, e hikaka ana ia ki tāna whaiwāhi tuarua ki Rātana, i tēnei tau.

NZNO delegate at Whanganui Hospital, Michelle Fairburn, said she was looking forward to attending her second Rātana commemoration this year.

"Mēnā e hiahiatia ana tā mātou tutuki i Te Whare Tapa Whā me te kōkirikiri a te NZNO i ō mātou wawata Tiriti o Waitangi, he tino hira ā mātou whakarongo, titiro noki ki ngā hapori Māori, ā me te tuhonohono hoki me ngā nēhi nō ngā pito e whā o te whenua, ā, mā tēnei taiopenga e tukua taua āheinga.

"If we are to achieve Te Whare Tapa Whā and advance NZNO's Te Tiriti o Waitangi aspirations, then it's important that we observe and listen to the health aspirations of Māori communities, and network with other nurses from around the country, and events like this give us that opportunity.

"He hītori nui tō Rātana, hei tauira ki te katoa. Koia rā tētahi kaipāmu, nā tētahi matenga kāhore i te mōhio, ōna tino tāngata i whakamate, ā, ka atawhai ia i a rātou hei ara ake anō.

"Rātana has such a rich history we can learn from. He was a farmer who lost the people he loved to a disease his people knew nothing about, and helped them rise above it."

He tino hira kia tae atu ā-tinana ki ngā taiopenga nui i te ao Māori, ka kīia e te kaiwhakahaere o te NZNO a Kerri Nuku.

Showing up at key events in te ao Māori was important, NZNO kaiwhakahaere Kerri Nuku said.

"I tae atu ngā ope o Te Poari ki ngā taiopenga katoa o te ao Māori i tērā tau, e tae rā anō ana ki Rātana me Waitangi. He tino hira te tuhonohonotanga, kāhore mō ngā tūroro anake, engari mō ō rātou whānau me ō rātou iwi."

"Delegations of Te Poari attended every event in the Māori calendar last year including Rātana and Waitangi. It's important we stay connected, and that we are visible to not just our patients but the whānau and iwi they come from.

"Mā te tae atu ki ngā hui e rangona ō rātou wheako, ō rātou māharahara e pā ana ki te pūnaha hauora, hei aha? Hei whai mātou i te ara tika," ka kī a Nuku.

"Being present at these events allows us to hear their realities, their concerns with the health system and that helps to inform what direction we need to be taking," Nuku said.

Kerri Nuku

- ***Nā Joel Maxwell tēnei pūrongo i whakamāori/Translated by Joel Maxwell.***

Tōpūtanga Tapuhi Kaitiaki o Aotearoa
NEW ZEALAND NURSES ORGANISATION
Kaitiaki NURSING NEW ZEALAND

FEATURES

Nurse finds time to feed masses heading to Rātana

By Renee Kiriona

January 22, 2026

Thousands of Māori people throughout the country, political leaders and MPs are gearing up for the annual Rātana commemorations to celebrate the birth of the church's founder. And a graduate hospital nurse will be among those who feed them.

Awhina from the Rātana Church marching at the 2021 commemoration of their movement's founder Tahupōtiki Wiremu Rātana. Photo: ROBERT KITCHIN / Stuff. Inset photo: Nurse Parekura Mako-Kairimu.

Parekura Mako-Kairimu, 29, is in her fourth month of working the medical ward at Whanganui Hospital, but she has been part of the Rātana Church and movement since she was born, raised at its home (Rātana Pā) which is located between Bulls and Whanganui.

Tahupōtiki Wiremu Rātana – the Methodist farmer who formed the Rātana Church after losing 18 of his 22 cousins to influenza.

In fact, if her mother had it her way she would be an awhina right now.

Read this story in te reo Māori here.

"Mum tried to get my twin sister and I to be awhina – our church's equivalent of a nurse, but to be honest that uniform just wasn't me," Mako-Kairimu giggled.

> **"You the nurses, I now say that the name 'nurse' should be deleted from among you, and instead place the name 'awhina' as your title."**

Church founder Tahupōtiki Wiremu Rātana created the role of awhina or spiritual nurses in 1926 to help instill hope, faith and healing back into Māori communities throughout the country who had been ravaged, and lost thousands of family members, to the influenza pandemic. Rātana himself lost the majority of cousins to the disease.

Māori nurses gathered at Wairoa in 1926 during a speech by TW Rātana that he would create a special 'awhina' position/role for them in the church. PHOTO: Rātana Church.

While touring Wairoa in the East Coast, Rātana declared to Māori nurses present, that he would make a place for them in his work: "You the nurses, I now say that the name 'nurse' should be deleted from among you, and instead place the name awhina as your title."

Mako-Kairimu said awhina still exist in the church today.

Politicians for decades have magnate to Rātana for the popular commemoration of its founder and kaupapa. PHOTO: Reece Baker.

“My aunty is an awhina. They play an important role, even today, visiting our sick and ill mōrehu [church followers] at home to uplift them using whakapiki [increasing their wellbeing] and whakamoemiti [prayer].

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"My role is to manage the bain-maries in the kitchen, so I will be finding time to do that once my morning shift at the hospital is done."

Mako-Kairimu said she was inspired to become a nurse because she could apply the Rātana and Māori values she was raised in. And because she could see the need for more culturally competent nurses.

"I got my first experience with the health system when my pāpā had to go to hospital. It was hard for him and us to understand most of the staff there, until we came across a Māori nurse who was able to talk with him in his first language – te reo Māori.

Michelle Fairburn

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NZNO delegate at Whanganui Hospital, Michelle Fairburn, said she was looking forward to attending her second Rātana commemoration this year.

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Kerri Nuku

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NEW ZEALAND NURSES ORGANISATION
Kaitiaki NURSING NEW ZEALAND

FEATURES

A life of dedication: Remembering Sue Claridge 1955-2025

By Marilyn Casey

January 15, 2026

It is with profound sadness that we bid farewell to Sue Claridge, a cherished colleague, mentor and friend, whose legacy will resonate throughout the perioperative nursing community of Christchurch and New Zealand.

Sue Claridge

Sue passed away suddenly at her Hoon Hay home in Christchurch on the weekend of June 28-29, 2025.

Her nursing journey began at Princess Margaret Hospital, where she trained from 1974 to 1977, before graduating as a registered nurse (RN).

Her early career saw her working across various health-care settings, but it was in 1987 that she found her true calling at St George's Hospital theatres in Christchurch. There, she flourished in both the main theatre and day surgery unit, remaining a steadfast presence until her retirement in 2022 — save for a two-year stint in the United Kingdom (2005-2007), where she successfully established a day surgery unit as a theatre manager.

Affectionately known by colleagues as "SueMac," "Smack," or "Sister Supine" in the orthopaedic theatres, Sue was a nurturing figure to many. She lovingly referred to student nurses and new staff as her "chickadees" while they fondly called her their "theatre mother".

Christchurch Philatelic Society remembers

Sue Claridge was one of our life members.

When it comes to organised philately (the collection and study of postage stamps), the list of what Sue has been involved with is monumental and the shorter list would actually be what she hasn't done.

That short list probably includes not spending enough time on her own collections.

A brief selection of her contributions starts with the Christchurch Philatelic Society, where she had a long involvement with the committee, also holding roles as president and secretary among others.

She was also a philatelic judge and commissioner, serving at many New Zealand and overseas exhibitions, helped run the

Her warmth, humour and unwavering support made her a pillar of the operating room and a beloved mentor.

Passionate advocate

Beyond her clinical role, Sue was a passionate advocate for perioperative nursing. Her involvement with NZNO's perioperative nurses college (PNC) spanned decades, and she contributed at both local and national levels.

Sue Claridge, left, with fellow long-serving PNC committee member, former secretary/treasurer Berice Beach.

"I cannot recollect a time when I was not a PNC member," she once said, a testament to her enduring commitment.

Sue's editorial contributions to PNC publication *The Dissector (https://www.nzno.org.nz/groups/colleges_sections/colleges/perioperative_nurses_college/the_dissector)* were significant. She served on the editorial committee from 1998-2000 and as chief editor from 2000-2003.

Her talent for encouraging others to share their experiences and insights enriched the journal and inspired many to contribute.

Her leadership roles included:

- National PNC committee member
- National PNC secretary
- Secretary and chair, Canterbury-West Coast PNC

Sue's influence extended to conference planning and international representation. She played a key role in organising the AORN (US-based Association of Registered Perioperative Nurses) 12th world conference in Christchurch in 2001. She was also instrumental in planning the 2022 PNC conference, also in Christchurch, where she was honoured with life membership.

Christchurch youth club and hosted stamp camps in Canterbury. She also held the post of secretary with Canpex (Canadian national philatelic exhibition), the Christchurch-based wing of the global exhibition-organising group.

Her death came as a shock to all who knew Sue, and — let's be honest — most philatelists in New Zealand knew Sue.

She had a long and distinguished time in various roles in the Philatelic Youth Council and there are many younger philatelists who benefitted from her wisdom.

She had a very wide collecting interest, including military, medical, ophthalmology, hospitals, Florence Nightingale, Edith Cavell and World War I.

Sue served on the New Zealand Philatelic Federation for a long time and gave talks to many member societies. Outside philately, she was a very keen gardener.

She will be greatly missed.

— by Christchurch Philatelic Society president Paul van Herpt

Her sudden passing last year has left a void in the hearts of many.

Former perioperative nurse and PNC member Sue Frost recalls returning to Christchurch from the United States in the early 1990s to work with Sue Claridge on drafting New Zealand's first set of perioperative nursing standards (https://www.nzno.org.nz/groups/colleges_sections/colleges/perioperative_nurses_college/resources/standards_and_documents#PNC%20Standards). The pair spent a weekend in the boardroom of the old St George Hospital building, working on the draft standards, which were then distributed around the country for input and clarification and eventual adoption.

Frost recalls a fun-filled weekend for the two passionate perioperative nurses, debating New Zealand standards of care against the Australian and American ones.

A woman of many talents

Outside nursing, Sue was a woman of many talents. A passionate philatelist, she was an international judge of stamp collections and a gold medal winner for her Florence Nightingale exhibition — which featured in *The Dissector* (December 2010).

She also had a keen interest in history, particularly in collecting historical hospital postcards from across New Zealand. In 2025, she was actively involved in re-establishing the Pat Cotter Medical Museum in Christchurch, helping to re-catalogue and restore its displays following the 2011 earthquakes.

Sue Claridge was a tireless advocate for perioperative nursing, always encouraging membership, professional development and community engagement. Her sudden passing last year has left a void in the hearts of many.

She will be remembered not only for her professional excellence but for her kindness, humour and unwavering dedication to the nursing profession.

Sue was a true friend, a guiding light and a legacy who will continue to inspire generations of nurses to come.

Sue holidaying in Los Angeles.

— Marilyn Casey was a colleague and friend of Sue Claridge. This tribute was reproduced with permission from The Dissector (https://www.nzno.org.nz/Portals/0/Files/Documents/Groups/Perioperative%20Nurses/Dissector/2025-09%20The%20Dissector%20Vol_%2053%20No_%201.pdf?ver=s5Bq7WXdRFmsaszcZ1mybw%3d%3d) (June-September 2025), with additional edits by Kaitiaki coeditor Mary Longmore.

Michael Esdaile, of Advantage Publishing in Tauranga, has published The Dissector since 1998. The journal last year celebrated 50 years of publication. Bound copies dating back to 1975 are available at the NZNO library: library@nzno.org.nz.

Tōpūtanga Tapuhi Kaitiaki o Aotearoa
NEW ZEALAND NURSES ORGANISATION
Kaitiaki NURSING NEW ZEALAND

FEATURES

Daisy, Bunny and pals: I work in residential care, my pets are my therapy when I get home

By Emily Bolton

January 12, 2026

In a Kaitiaki summer feature we're sharing our readers' amazing pets – answering the age old question of what makes the perfect animal companion to the busy health professional.

Foster kittens looked after by this caring NZNO member.

My mahi is in residential care with head injury kiritaki (clients). It's full on. I love it but it sure can take it all out of me.

My wind-down therapy is coming home to my two pups, four cats and currently three wee foster kittens.

I've been a volunteer at the SPCA for 20-plus years now and have fostered hundreds of cats and kittens. It's so rewarding seeing them off (or not, times-four!) to good homes.

What makes my pets special to me? They can't talk and are not constantly in my ear like the kids are (insert laughing emoji here!).

Daisy, front, and Bunny the pups.

They're so loyal and ask for nothing. Even their love for me is entirely unconditional.

Daisy the dog is 18 months old, Bunny pup is 11 weeks.

The four cats are self sufficient and the wee foster kittens are about five weeks old. My kids (eight and nine) adore all of the above and I love seeing them learn how to care for them.

They take Daisy for walks around the block, help me feed everyone and carry them around like babies.

Beats screen time!

- *Emily Bolton.*

For other nursing pet stories, find out about Lilah here, Reecee here, and Tibbs, Ziggy, Panda and Jaina here.

One of Emily Bolton's children and a very huggable foster kitten.

Proud of your pet? Send a photo with a few words on why they're the perfect health professional companion to coeditors@nzno.org.nz.

Tōpūtanga Tapuhi Kaitiaki o Aotearoa
NEW ZEALAND NURSES ORGANISATION
Kaitiaki NURSING NEW ZEALAND

FEATURES

Tibbs, Ziggy, Panda and Jaina: They help me through the hard times

By Aura Sanderson

January 5, 2026

In a Kaitiaki summer feature we're sharing our readers' amazing pets – answering the age old question of what makes the perfect animal companion to the busy health professional.

From left, Tibbs, Ziggy and Panda.

My animals keep me grounded and in touch with everyday life.

Tibbs the cat always ready with a gentle purr and ready to listen.

Ziggy the dog always offers snuggles and kisses that remind me life is not all that bad.

Tibbs.

Meanwhile, Panda the dog is the big bad boy, with a bigger heart.

My old girl Jaina, is 15 and still going, she has seen me through many a hard time and has seen and absorbed many tears.

For more nursing pets stories, meet Lilah here, and Reecee here.

- *Aura Sanderson, registered nurse.*

Proud of your pet? Send a photo with a few words on why they're the perfect health professional companion to coeditors@nzno.org.nz.

Jaina, who is 15 years young.

Tōpūtanga Tapuhi Kaitiaki o Aotearoa
NEW ZEALAND NURSES ORGANISATION
Kaitiaki NURSING NEW ZEALAND

LETTERS

‘We should be free to worry about grades, not jobs’ – student nurse on hiring fears

By Hannah Watson

January 26, 2026

Nurses’ work is irreplaceable, says University of Auckland nursing student Hannah Watson — but why then are her cohort worrying about their future in the profession?

Nursing students should be free to worry about grades, not future employment, says Hannah Watson. Photo: AdobeStock

What do you want to be when you grow up? A question I never thought ‘nurse’ would be the answer to.

Now I am about to begin my final year of study, and I am loving the choice I made those years ago.

Not only have I learnt a great deal of theoretical knowledge, but I have also gained valuable advice from everyone I have interacted with.

However, now the question has shifted to: why would you still want to be a nurse?

People see the strikes, hear about staffing shortages, and the lack of hiring, and they are concerned.

As a student nurse, I understand those uncertainties; they are valid and experienced by hundreds.

Nursing student Hannah Watson.

I look around my class, hearing everyone's worries, and think about how many of us will actually be hired after graduation.

I have seen my peers work so hard, going through a variety of experiences in clinical placements and to see these worries consume all of it adds another layer of fear.

We bond together as a cohort over these worries, but should the worry be that final-year nursing students are more concerned about whether people will want to hire them, when the most strenuous worry should be their grades?

Despite all of these uncertainties, there is one certainty that I have witnessed and experienced.

Nurses are a community. Everyone has seen us stand together, protest for what is right and safe, and for what is irreplaceable.

Not everyone has the opportunity to be a part of something so special. Therefore, despite all my worries, all our worries, there is one certainty — that nurses are family, and for that I will forever be grateful.

- *To find out about the growing group of nursing graduates looking for work read here. The latest job figures come after two years of struggle from graduates to find mahi.*

Tōpūtanga Tapuhi Kaitiaki o Aotearoa
NEW ZEALAND NURSES ORGANISATION
Kaitiaki NURSING NEW ZEALAND

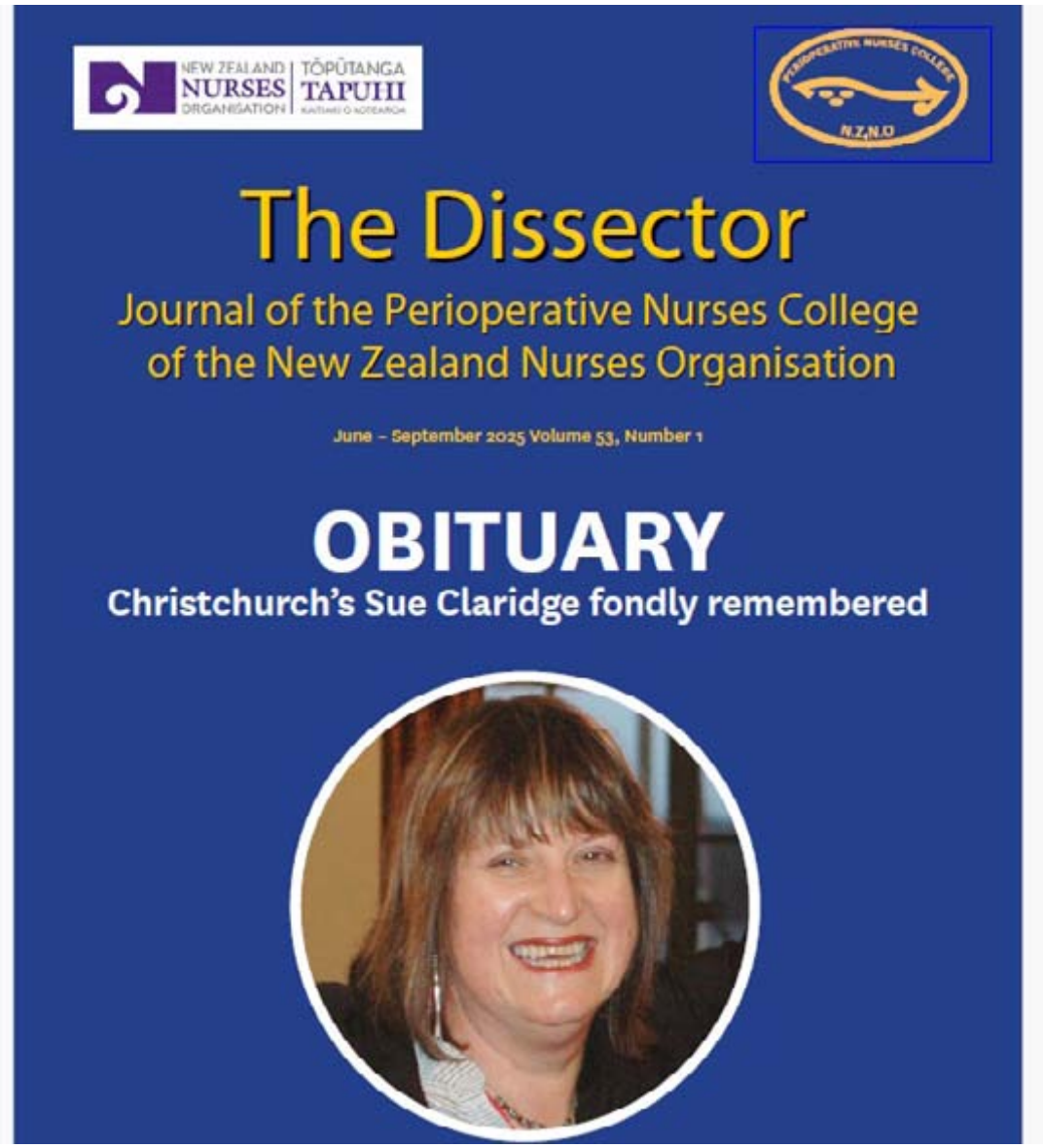
LETTERS

50 years of publishing and loss of beloved nurse leader in latest edition of perioperative journal 'The Dissector'

By Michael Esdaile and Bron Taylor

January 15, 2026

Welcome to the latest edition of *The Dissector (https://www.nzno.org.nz/groups/colleges_sections/colleges/perioperative_nurses_college/the_dissector)* — the quarterly journal of NZNO's perioperative nurses college.



New Zealand's operating theatre nurses journal was first published in September 1974.

We managed to maintain it as a printed journal until January 2024.

Since then it has been an interactive digital journal published as a PDF with 'clickable' links.

In this latest issue (volume 53, number 1), we have an article on the 50-plus year history of *The Dissector.*

We also farewell one of the New Zealand perioperative nurses college unsung heroines, Sue Claridge, a real dynamo in the Christchurch region and for the college nationally.

We hope you enjoy this issue and marvel at the 50-year history of the journal.

Without the support of the medical suppliers who advertise, there would be no journal — so we encourage you to explore their advertisements.

The company logos are 'clickable' which means more information on these products is just the click of your mouse away. Give it a try.

Michael Esdaile of Advantage Publishing in Tauranga has been publishing The Dissector since 1998.

Bron Taylor is the outgoing editor of The Dissector after five years, as per PNC committee rules. Expressions of interest (https://www.nzno.org.nz/groups/colleges_sections/colleges/perioperative_nurses_college/the_dissector#EOI) are being sought for the role.

Tōpūtanga Tapuhi Kaitiaki o Aotearoa
NEW ZEALAND NURSES ORGANISATION
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SUMMER WRITING

When tomorrow comes

By Mary Death

January 23, 2026

We asked how you got through your toughest health-care moments. Today, retired palliative care nurse Mary Death shares some writing which helps her celebrate many of the encounters she experienced.

Photo: AdobeStock.

He had a label

not unlike the label on the old jar at the back of the pantry

only his read RECLUSE not LENTILS

I wonder if the words of the Beatles played over in his head

had his troubles seemed so far away yesterday?

because today it looked as if they were here to stay.

Death is not always filled with peace and light and fragrant candles

it can be gross and smelly and disgusting

pain can overwhelm every sense

The pain

of regret

of loss

of words unsaid

of words said

The pain

of brittle bones

deep wounds

wounds of the flesh

of the heart

of the very soul

He asked me to bring to him

a team that

cleansed his wounds

held his hand

prayed with him

when he asked

gave him peace without him asking

by just being at his side

It was tough on him

and tough on them

but he couldn't do it alone

any more

They came in time

they understood

what he needed

and didn't need

and how he wanted it to be

they judged him not

He rediscovered

the love of his family

there all along

behind the walls

they had built

Gently I gained his trust

from a life of perceived rejection

he was cautious

As I left one night

he sat on the verandah, alone

I waved to him

I commented on the coolness of the evening

he simply said

feel my arm

I am not cold

I reached for the thin pale arm

this seemed to be my test

my non hesitation

to make skin to skin contact

gave me a pass

I sat

we talked for over an hour

about many many things

He told me he was a different man

to the scared and shy man that

had come through the hospice doors

ten days ago

He felt accepted

for the man he was

his illness

just a part of him

Now he has a different label

It shows the dates of his life on earth

Wherever he is

I pray he is now

surrounded

by peace, love and fragrant candles

and the knowledge

that he was loved

Mary Death

— Mary Death worked as a palliative care nurse for 25 years. Now retired, she is a funeral celebrant based in Wellington.

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SUMMER WRITING

South Sudan: A Drop in the Ocean

By Colette Blockley

January 16, 2026

We asked for your toughest health-care experiences. After returning to 'forgotten' war-ravaged South Sudan, Dunedin nurse supervisor Colette Blockley shares her despair — and amazement at the dedication of local nursing and midwifery students.

Colette Blockley (centre) with some nursing and midwifery students in South Sudan.

Over the years since my children became independent, I have been privileged to have had opportunities to volunteer as a registered nurse (RN). This has taken me from Mother Teresa's Home for the Dying Destitute in Kolkata, India, to a mobile clinic for the poor in a Santiago slum in Chile; an AIDS hospice in Edinburgh and an orphanage for children with AIDS in rural Thailand.

In 2015/2016, I first volunteered with Solidarity for South Sudan, teaching nurses and midwives in the classroom and at the local hospital in the country's second largest city, Wau.

I returned to South Sudan in 2024. It was my most challenging mission. The country has been embroiled in a nasty civil war since 2013. The two political leaders are from opposing tribes and cannot agree on anything of importance. Political leadership is sadly lacking.

Child with malaria in the hospital.

Some recent statistics

- Seven million of the 12 million people in South Sudan go hungry every day.
- Only 46 per cent of children go to school. This is the second lowest country in the world out of 123 countries to provide primary school education and the last in the world for secondary education.
- 65 per cent of the population are women due to the war — yet 92 per cent of women are illiterate.
- 38 per cent of adults are illiterate, one of lowest rates in the world.
- 42 per cent of girls are married between the age of 15-18.
- Seven per cent of girls are married when they are under 15.
- South Sudan has the highest maternal and child death rate in the world.
- 78 per cent of the police are illiterate. Because many haven't been paid for months, they are open to bribes in order to support their families.
- There are 64 tribes. 6-7 million people are Dinka and within the Dinka are 25 clans many of which are fighting with each other.
- The life expectancy is 56.

Solidarity with South Sudan is a Catholic organisation whose mission is to empower the people to be independent by training teachers, nurses and midwives. It also offers trauma-healing workshops for those severely affected by the war and provide education on basic agricultural practices.

> **Often, as I wandered the wards of the Comboni Hospital, I despaired at the seemingly hopeless plight of so many.**

Many of the people are third-generation refugees, so previously-handed down farming practices have been lost.

As a nurse and teacher, I lived and worked with five sisters and one priest from various religious congregations in the Catholic Health Training Institute, in Wau. I was the only lay person. We lived in a convent on a 60-acre compound, guarded 24/7 by armed guards. The students lived in dormitories on the compound which also contained the school and the administration block.

The nursing and midwifery students come from all over the South Sudan for the three years of their education. Three quarters are men, as many girls are not educated to the standard required to be accepted for training.

'Amazing' student dedication

During both missions, the dedication of the students never ceased to amaze me. Many left their families for the whole three years of training because they could not afford to go home during the semester breaks. English was the third language for all of them. Their tribal language is their first language, Arabic is the most widely spoken language and English is only spoken by those lucky enough to go to school.

Often, as I wandered the wards of Wau's Comboni Hospital, I despaired at the seemingly hopeless plight of so many. Hundreds of people lined up patiently waiting to be seen at the outpatient clinic or emergency department. If they couldn't be seen on the day, they would sleep in the hospital compound overnight, risking being bitten by the ever-present mosquitos carrying malaria, or snakes.

Waiting for treatment outside Comboni Hospital's emergency department.

As the children lay dying, all I could do was keep the flies off the child and hold the hand of the mother sitting close, so quiet, with the saddest of eyes.

They had often walked a long way from distant villages for treatment. Vultures would loom close by, waiting patiently for morsels of food.

Malaria is rife and is the highest cause of death. I acquired malaria on both missions. I have never been so ill. Malnutrition is rife and two wards were full of desperately-sick children as a result of malnutrition. As the children lay dying, all I could do was keep the flies off the child and hold the hand of the mother sitting close, so quiet, with the saddest of eyes. Many women have been through this before.

Kidnapping risks

Because I am white, I was a kidnap risk in the war-ravaged country. When I travelled from the compound to the hospital, an armed guard as well as a driver was present at all times. The people are so desperate, that crime is a way of surviving. Whilst at the hospital, an interpreter was also present because I am not fluent in Arabic.

I also spent a day at the Agok Leper Colony, near Wau. The suffering there was confronting. The people there with leprosy had been abandoned to live in paddocks of scrub far from anyone else.

Sister Bibiana came faithfully every week, distributing medicine, food, buckets, drinking water etc. Their joy and gratitude was apparent. She was the only assistance the 30-40 lepers had.

During both missions, the dedication of the students never ceased to amaze me.

Living with the sisters, attending daily Mass and participating in the prayers of the church, sustained me when the going got tough. And it was tough. The heat and humidity was oppressive. Climate change has ravaged the country. I noticed a huge difference from 2016 to 2024. The people are disillusioned because the war has continued for so long and no help is available from the politicians. Refugees filtering from the Sudan are creating more famine and subsequent crime.

A woman with leprosy in the Agok Leper Colony near Wau. She has no hands, but the washing still has to be done.

Is there hope?

Is their hope for South Sudan? Without the missionaries, at this point in time, I don't believe so. Solidarity for South Sudan intends to slowly withdraw within 10 years and hand over to suitably-trained South Sudanese people. However many of the nurses and midwives travel to Kenya or Uganda where they can earn a lot more money to help their families.

Did I make a difference? I hope so. Mother Teresa used to say that what we do is a drop in the ocean. If that drop wasn't there, the ocean would be less. Will I go back? No, my children have suggested that my next mission be in one of the Pacific Islands. That way they can come and visit me!

— Colette Blockley is a professional nursing supervisor based in Dunedin.

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SUMMER WRITING

Did I ever work through it?

By Elaine Franks

January 9, 2026

We asked for your toughest health-care experience. Christchurch nurse Elaine Franks recalls a devastating experience when she was a young trainee nurse just out of London.

Photo: AdobeStock.

Did I ever work through it? I'm not sure. Has it framed some of my practice? I'm not sure of that either.

Take my older self back to my younger days and commencing my psychiatric training at an old asylum in the United Kingdom (UK) on the outskirts of London.

Shenley was the largest psychiatric hospital in the UK when opened in 1934. Probably of little relevance to my story but it was a very different setting to where you (my younger readers) will hopefully be today. It opened up a very institutionalised system of care where I met old ladies who had been there for 50 years for various reasons, including getting pregnant when unmarried, being afraid of air raid sirens and other perceived misdemeanors. I should add I was the oldest in my group having done my general nurse training some years before – so around 28 years old.

I lived in a massive nurses' home with very limited facilities. Bathrooms and kitchens were shared with another 100 residents on my floor — I wish I had some photos I could share with you, but sadly not.

Elaine Franks

Signs of psychosis were very limited and not at all obvious especially to a young student nurse.

However — and it is a big however — it was fun, friendly and safe. My group of peers was small and we lived, socialised and worked together. Often of a night, we would all pile into my Talbot Samba and drive to Trafalgar Square to climb the lions and get a ticking off from the local bobby. We also didn't have student loans and were paid whilst on placement.

On placement (three-month placements were typical) at a very acute psychiatric admission ward I encountered severely and acutely unwell patients. This particular memory is about a young 18-year-old male who was mostly presenting as depressed but was being assessed for elements of psychosis. I built up a therapeutic rapport with the young man and possibly was a bit boundaryless — not in terms of my behaviours — but I found him pleasant and good company.

Shenley Hospital just north of London.

I remember going into his large dormitory one morning with the sun blazing in over his bed and him lying face down listening to John Lennon singing *Imagine.* I felt a rush of sadness for this young man. It was a very poignant setting which left me feeling unsettled with feelings of helplessness.

Signs of psychosis were very limited and not at all obvious especially to a young student nurse. I attended ward rounds but as a very junior member of the team was not encouraged to participate in any way. His parents had limited contact and visited rarely. Anti-psychotics were prescribed with little effect – possibly the only effects of chlorpromazine were to induce drowsiness.

I grieved silently, too ashamed to talk about my feelings to anyone.

On the night of the 5 th of November, 1985, the hospital celebrated Guy Fawkes with a bonfire, which very traditional in the UK ! I did not go along as was at work on the said ward. I received the news around 9pm that the patient had thrown himself on the bonfire and had been taken to the local burns unit in a pretty dire condition. The next day he sadly passed away from his burns.

I don't find it at all difficult to recall my feelings which shows I probably didn't process it at all well — also by virtue of the fact that I am here, writing about it today. My feelings were anger and sadness, probably in that order. Angry with the organisation and the lack of understanding of this young person, and sadness that a life had been taken away. I blamed the hospital managers, the ward managers and the nursing team, rightly or wrongly.

'Devastating'

I can look back with hindsight and see my feelings were possibly not all professional and lacked boundaries but they were human feelings and I hope I still have human feelings today. We are all human and we will all form some sort of feelings for our patients and to deny that is invalidating our humanity. It is important to recognise those feelings and to be proud of them. We are clinicians because we care.

As is sometimes the case, his death was described at the funeral by his parents, as a happy release. This was devastating to hear, however I heard it again from a partner's family (later in my life) whose other son had suicided. I understand this was their way of making it okay and bearable but it was unbearable for me to hear at the time. Raising a glass to their dead son in their living room to this proclamation was the final straw.

I can look back with hindsight and see my feelings were possibly not all professional and lacked boundaries but they were human feelings.

I deeply considered not continuing with my training at that point, ended my relationship with my then-partner who was a senior clinician (not even on the same ward) and grieved silently, too ashamed to talk about my feelings to anyone. I did carry on and I have witnessed many other difficult events since that time, but none I carry more deeply.

There was no supervision, no one offered to see how I was going and I was left hanging with my sadness and anger. I carry those feelings in my gut to this day and would encourage each and everyone of you to have supervision. If you don't gel with your supervisor, get another one — it's no one's fault or problem. We are only human and need to connect.

— Elaine Franks is a clinical nurse specialist at the South Island eating disorders service.

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SUMMER WRITING

My toughest challenge: At 50, I became a registered nurse

By Sione 'Ulufonua

January 2, 2026

We asked for your toughest health-care experience. Former flight attendant Sione ‘Ulufonua shares the challenge of retraining as a nurse at 50.

Sione 'Ulufonua then... and now

February 2024 marked the month I began my new career as a new graduate registered nurse (RN).

Leaving Air New Zealand after 15 years as an international cabin crew member was quite a tough pill to swallow, but for many of us, we had to take a dose of redundancy. The airline industry was the hardest hit during the pandemic.

In the spur of the moment, I decided to study nursing; on reflection, I was naïve to think that nursing would be a breeze. It was hard mahi from 2021-2023. In May 2024, as a 50-year-old, I graduated with a bachelor of nursing Pacific from Manukau Institute of Technology.

> **Suddenly, I was faced with real lives, unpredictable emergencies, and the need to make decisions under intense pressure.**

Adjusting to the health-care environment was a significant transition, and the shift from working at 35,000 feet to supporting patients on the ground tested me emotionally, physically and mentally in ways I hadn't anticipated.

I thought studying was the hard part, but I got a reality check when I started working as an emergency department nurse. The pace was relentless, and every shift brought new challenges that pushed me far beyond the textbooks and simulations of my student days. Suddenly, I was faced with real lives, unpredictable emergencies, and the need to make decisions under intense pressure. The learning curve was steep, and I quickly realised that the transition from student to practising nurse was a whole new ball game.

After enduring three consecutive days of gruelling 12-hour shifts, I realised I needed to adjust my schedule for my own well-being. I switched to working three days of 8-hour shifts and one day of 12 hours, hoping it would make a difference. However, even with this change, I found myself constantly exhausted and noticed that my life outside of work was beginning to unravel. The persistent fatigue made it difficult to maintain relationships and enjoy the activities I once loved.

Sione ʻUlufonua recharging in Split, Croatia.

I was starting to question myself whether I made the right decision, as I had the opportunity to go back to Air New Zealand post-COVID. Doubt crept in during those difficult months, and I often wondered if returning to my familiar career in aviation would have been the easier path. I was starting to dislike the profession, yet, despite the uncertainty, something inside urged me to persevere and keep moving forward in this new chapter.

If we don't stand together and fight for what is fair for both patients and us nurses, we risk putting our well-being in jeopardy.

Sione ʻUlufonua in Bratislava, Slovakia

It was interesting during and after COVID; for the longest time, the last thing I wanted was to get on a plane. But this year, after accruing annual leave, the travel bug bit again, and I found myself embarking on a five-week trip to Europe. The journey began with two days in Hong Kong, followed by three days exploring Amsterdam, before setting off on a memorable 15-day Rhine and Danube River cruise from Amsterdam to Budapest. Along the way, we stopped in several charming German cities in the Bavarian region, such as Cologne, Koblenz, Bamberg, and Nuremberg, among others. We then spent two days in Budapest, before flying to Vienna for another two days.

From Vienna we crossed the border to Bratislava for a day trip, we then travelled to Croatia, spending two days in Split and Dubrovnik, soaking in the Adriatic coast. The adventure continued with two days in Rome, followed by a scenic train journey south to Bari for another two days. After returning to Rome, we transited to Catania in Sicily and stayed in the picturesque town of Taormina for two more days, talk about saving the best for last! Taormina was amazing! We headed back to Rome for another two days, then made our way home via Hong Kong. Travel proved to be therapeutic, providing the perfect escape and rejuvenation I needed after such an intense period of change and adaptation in my career.

Nursing profession at a ‘crossroads’

The nursing profession is at a crossroads, and if we don’t stand together and fight for what is fair for both patients and us nurses, we risk putting our well-being in jeopardy. Safe staffing is paramount to improve the quality of patient care and protect us from burnout. The challenges I’ve faced have shown me how critical it is for nurses to advocate for safe working conditions and support systems. Only by working collectively can we ensure that the profession remains sustainable and that both nurses and patients receive the care and respect they deserve.

Looking back, I pat myself on the back for persevering through the toughest periods of self-doubt and exhaustion.

To all the 50-year-olds out there: if you have dreams yet to achieve, remember you are still young enough to chase them. Age is no barrier—your determination and courage can open new doors, no matter where you are in life.