Nelson Marlborough Health
TE WAIORA

CONNECTIONS

Tūhononga

A magazine for Nelson Marlborough Health staff

Spring 2021

IN THIS ISSUE:

CE UPDATE

The last few months have been exceptionally challenging as we rolled from winter RSV to COVID-19 in the blink of an eye.

Leading through adversity

The reappearance of COVID-19 demonstrated the rapid preparedness of our health system. Following the Alert Level 4 lockdown announcement in August, you transformed seamlessly to new ways of working.

I am immensely proud of the behaviours and actions I have seen across the board within Nelson Marlborough Health.

Overnight I saw you draw upon our NMH values of integrity, teamwork, respect and innovation, to prepare our hospitals, workplaces and home offices for the unknown Delta element.

Resilience, a core characteristic of leadership, continues to be displayed as our Te Tauihau vaccination programme aims for the highest vaccination coverage, ensuing the ongoing safety of our community.

In this edition of Connections you will see further displays of leadership as we introduce Ō Tātoa Hautūtanga – Our Leadership Framework. I am excited by the introduction of this framework as it enables us to foster and develop the language of leadership, creating clear expectations and learning and development pathways.

Live well, get well, stay well, die well?

The End of Life Choice Act: 2019 comes in on 7 November 2021. This means that a person with a terminal illness who meets the eligibility criteria will legally be able to request medication to relieve their suffering and end their life.

The implementation of the Act may create a time of heightened vulnerability for you, please reach out to your colleagues, professional leaders and managers if needed. Take the time to empower yourself by reading the resources provided by the Ministry of Health. As you build your knowledge and skills you can increase your confidence in responding to a person who raises assisted dying.

Assisted dying does not replace palliative care. In this edition you will read of the wonderful Te Ara Whakapiri – Care in the Last Days of Life resources making a difference at Nelson Hospital. There is also advice from our Consumer Council on how to have good conversations and a quick look at some of the resources from the Health Quality and Safety Commission including advanced care planning, shared goals of care and serious illness conversations.

Lexie O'Shea, Chief Executive

Living with COVID-19

As we move through the Alert Levels our attention has turned to resurgence planning and a future which includes living with COVID-19.

We need to ensure that our facilities and our healthcare delivery processes are as safe as they can be for you, our patients and whānau. We continue to align both nationally and regionally as we prepare for the challenges COVID-19 will send our way, functioning more and more as a collective system.

BOARD TALK

When I think of Spring it brings on images of flower blossoms, warmer, longer-days and a sense of hope for new beginnings.

This winter was hard. We managed to break the back of RSV hospitalisations with an even greater threat, COVID-19. National lockdowns have kept the virus at bay for now and I am proud of how you worked to ensure any interruptions to our health care services were kept to a minimum.

Our vaccination rollout continues at an awe-inspiring pace; a public health campaign unlike anything we have seen in our lifetime. It demonstrates our values of teamwork and respect as Iwi, primary and community care and secondary support all work together for the benefit of our Te Tauihu people.

And all the while, as a system we experience workforce pressures and whole-scale change as we shift towards one health system for New Zealand.

The approach of Spring may not give us greater control over these external pressures, but it does provide us with the opportunity to take care of the most important person, ourselves.

Ō Tātoa Hautūtanga – Our Leadership Framework, introduces the concept of resilience as a characteristic of leadership. It is easy to think of resilience as something that you either have or don't. But in fact it is something that you need to consciously grow and nurture.

Te Whare Tapa Whā encourages us to take a holistic approach to our wellbeing, with a need to ensure balance amongst our Taha

Wairua (spiritual), Taha Hinengaro (mental and emotional), Taha Tinana (physical), Taha Whānau (family and social) and our Whenua (land, roots).

So as we move through Spring, towards an uncertain Summer, please take the time to nurture and grow your resilience. It is ok to not be alright. Looking after yourself means better care for your whānau, your colleagues and your patients in the long run.

Jenny Black
Board Chair

FRONT COVER: Julie Young (Receptionist), Jeannie Dobson (Dental Therapist), Janet Sullivan (Dental Therapist), Tracey Arnold (Dental Therapist), Ansie Biggs (Dental Assistant), and Emma Coles (Dental Assistant) celebrating the 10 year anniversary of the community oral health service in Richmond

GOOD ON YOU

FEEDBACK: MAKING A DIFFERENCE AT END-OF-LIFE

A note of thanks for the care given to mum while in Wairau HDU, Medical and ATR recently. She was a frail, very ill woman with severe hearing loss and the family appreciated the effort of staff to provide appropriate treatment, and make her stay comfortable despite her circumstances.

I was impressed with the open and honest conversations that HDU started about her end-of-life care. This theme continued throughout her stay and fitted well with the discussions we had previously had with mum and the immediate family.

Keep up the great work teams- a credit to those working in an often-stretched system.

My mother in law passed away peacefully this morning after a massive brain bleed on Sunday. Both her son (my husband) and daughter are in Queensland and unable to travel due to COVID-19 so other family members and friends have been helping us get through this difficult time.

We were able to set up a 'zoom' meeting yesterday so we could all say our goodbyes. The nurse looking after her was so lovely and he explained everything they were doing to make her comfortable.

I just want to say thank you on behalf of the family and we are so grateful for the wonderful care given to her during her final days.

It is one year today since [my husband] was admitted to Nelson Hospital following a seizure while we were on holiday. He was scanned immediately and it was found that he had brain, lung and back cancer. I wanted to just write and thank you and all of your staff who helped us through this very sad time.

[My husband] was treated with kindness and respect through all of this and so was I. The Doctors and Nurses were absolutely amazing. The Nurses on the ward of very confused patients were so kind and caring. [My husband] was eventually transferred to [another] Hospital and there was many a time I wanted to move to Nelson so his wonderful care could be continued.

So thank you all, and just know that you all made a terrible time the very best it could be. He passed away on December 3, 2020 and lived his best life right up to when he passed.

Find out more about the End of Life Choice Act: 2019 on page 28

Do you have feedback, a story idea or photos to share?
Get in touch.
Connections is your quarterly staff magazine produced by the communications team.
You can contribute articles or contact us with any feedback or story ideas on:
comms@nmdhb.govt.nz

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MATARIKI: NGĀ MATA O TE ARIKI O TĀWHIRIMĀTEA

THE EYES OF TĀWHIRIMĀTEA

Shaun Wharehoka, Pouherenga Cultural Advisor in Wairau has always had a keen interest in the stars, but it's really only in the last couple of years he has started looking at Matariki.

"Most of the information I have is from Dr Rangi Matamua, a Māori cultural astronomer," Shaun said.

"Rangi was gifted a manuscript from his tipuna tāne, great grandfather, and has spent the last 20 years in kōrero with kuia and koro throughout Aotearoa, piecing together the story of Matariki."

Shaun was quick to highlight that in te ao Māori, knowledge is known to have many expressions.

"When we talk about Matariki, it isn't about saying that this is the story of Matariki or that there is only one true story. This isn't a Māori way of approaching knowledge.

"Instead, what you will read here is how I know Matariki to be, which will be different to how other tribes or regions may know it to be. These differences are something we celebrate."

CREATION

Sky father Ranginui and earth mother Papatūānuku were embraced together for all of eternity. Their sons, who would later become gods, were squashed up in between them. The sons weren't happy about this and so each tried to separate their parents.

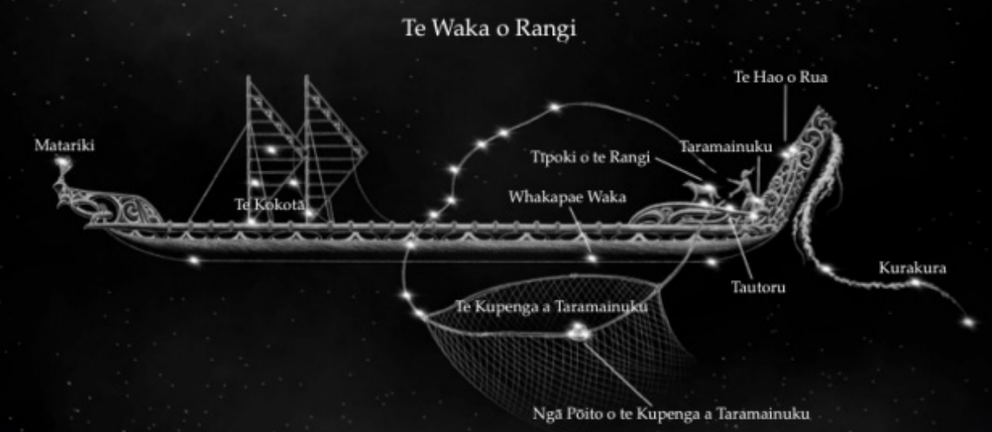
Finally Tāne, god of forests and birds, pushed with his strong legs and ripped them apart. One of the brothers, Tāwhirimātea god of the wind and storms, was particularly angry at this because he was closer to his father.

Freedom was not what the brothers expected. In his rage Tāwhirimātea defeated all his brothers. Only Tūmatauenga, god of war and human activities remained. They clashed until, facing defeat, Tāwhirimātea clawed out his eyes in anguish and grief, crushed them in his hands and threw them to the sky. They stuck to his father's chest, forming the stars.

Matariki actually means Ngā mata o te ariki o Tāwhirimātea – the eyes of Tāwhirimātea.

This act is also represented in tikanga, traditional practice. When someone passed away, Māori would quite often cut their hair or mark themselves to express the emotion or pain of losing someone.

MATARIKI FEATURE



"If nothing else, Matariki can allow us to take the time to stop. To take a breath. To sit down. Then once you have taken that pause, stand up. Now, how am I going to move forward? What is going to be different this year?"

— Shaun Wharehoka, Pouherenga Cultural Advisor

MARAMATAKA - LUNAR CALENDAR

Back in the day Māori didn't have a smartwatch or digital watch or any sort of watch, so the environment was their indicator for different times of the year. They followed their maramataka, the lunar calendar, and the triangulation of sun, stars and moon along with other seasonal factors.

The Māori year is actually only 354 days long, and every three years there would be an extra month inserted into the calendar based on the sighting of Matakriki.

Each star represented either food, water, weather and depending on how bright they shone or how hazy they were, spoke to how that year would unfold in terms of fishing, growing crops, and the health of the Iwi.

The tohunga who could read the stars were taught from a really young age. So night after night they would watch the stars. To the naked eye you can probably only pick out five or six, but they could pick out nine quite easily.

The Matariki celebration would include an ahi, a fire specifically for the stars. An offering of kai from fresh water, sea water, the sky, and the ground would be put into a hangi. During the ceremony the steam would be released and the kai offered up to Matariki and the rest of the stars.

TIME OF REMEBERANCE

Matariki is part of a combined constellation Te Waka o Rangi, where it sits as the head of the canoe. The waka rises with Matariki each night, as captain Taramainuku casts his net and scoops up those who have passed that day.

After 11 months, the waka dives under the horizon and disappears for a month taking the souls to the underworld. When the waka rises again, and as part of the Matriki celebrations, we call out the names of those who passed in the last year, and Taramainuku releases them into the sky so they become stars. And the cycle begins again.

You might notice that when someone passes Māori wait 12 months before they unveil the headstones. If the person was particularly close to you, you might not speak on a marae for 12 months or you might wear black for 12 months and the only time we would stop that was when Matariki rose again.

LOOKING TO THE FUTURE

Shaun has been encouraged by the visibility of Matariki as a celebration this year and is looking forward to Matariki being celebrated as a national public holiday from 2022.

"These things that were traditionally practiced are now making a comeback," he says. "It is wonderful to see how they materialise in a modern contemporary world."

"Even though Matariki is a celebration of Māori culture, it is really a celebration of all culture. With next year as a public holiday, this celebration is only going to grow.

"This year a team of us from Wairau Hospital's Emergency Department were able to celebrate Matariki with a fire and ceremony down at the lagoons. It was a small affair but felt really nice and something I'm keen to see if we can make an annual event."

MATARIKI MARKS THE CHANCE FOR NEW BEGINNINGS

Often called the 'Māori New Year', Matariki provides an opportunity to stop and reflect in a holistic way. In this article Sarah McKenzie and Cynthia de Joux from the Smokefree Team reflect on their role as a quit coach, sharing a meaningful moment from the past year.

CYNTHIA DE JOUX

Describe a significant moment for you as a quit coach last year?

The abruptness of lockdown was difficult for me as preference for face-to-face contact has been disrupted. I had to learn to communicate using other platforms that I wasn't particularly comfortable with. It was like I went into overdrive, over-compensating through a less than effective method of working with clients.

How did it impact you in the moment?

I like to read people when I'm working with them because it's my way of monitoring how the process is working. To have that style taken away from me was challenging for my way of delivering this service.

I have a short attention span over the phone and Zoom is not conducive to my practice because the 'vibe' is missing that you get from face-to-face. I had to learn to be okay with different ways of communicating to people and maybe getting the information to them more effectively.

How are you a different person/practitioner today?

I find that it's easier to accept when I haven't got the patient on board. I used to chase clients via phone, text or cold calls hoping to save them all. After lockdown and realising that people had to be more self-reliant, I understood that I couldn't be there as often as I had prior to lockdown. If they aren't ready, it doesn't feel like I have failed them anymore, they just aren't ready and that's okay.

What message could you share for others to learn from this experience?

Just to remind ourselves that any wellbeing journey is client lead and that I am not here to resolve everyone's problems. I need to go easy on myself when it comes to managing my work load. I now accept all responses and know that when they stay engaged it means something to both of us.

SARAH MCKENZIE

Describe a significant moment for you as a quit coach last year?

This year after quit coach input the Pēpi First programme (for supporting smokefree pregnancy) was extended to include a support person incentive. It felt great to be able to offer this incentive to encourage whānau or friends who smoke to engage alongside their hapū mama. Seeing and smelling tobacco smoke are powerful triggers to smoke. Creating safe spaces away from these triggers is a great support to hapū mama and having someone quit alongside you is motivating too.

How did it impact you in the moment?

This was the first time I was able to formally recognise and reward the effort of a father who stopped smoking after the birth of his daughter. I saw how much his partner appreciated that and what a big change it represented for them and their young family. I know his actions mean that she is less likely to relapse back to old smoking habits. Together they created a smokefree whānau.

How are you a different person/practitioner today?

Now we are able to routinely offer the support person incentive. Women can have mixed emotions about discussing this with partners or friends and seeking their support. The incentive can be a valuable icebreaker or conversation starter for them.

What message could you share for others to learn from this experience?

Some people might question the role of incentives in healthcare but there is strong evidence that these are helping pregnant women and their whānau to engage in a conversation and make change. I would like to thank everyone who shares with others about the program and encourage people to be more active in this space if there are opportunities for them to do so.

KEEP SMOKEFREE CONVERSATIONS SIMPLE TO SUCCEED

Above: The Smokefree team at their planning and development hui. Front Row: Cynthia DeJoux, (Quit Coach), Miraka Norgate (Health Promoter) Back Row: Sonia Hepi-Treanor (Te Ha Pukenga Manaaki), Sarah McKenzie (Quit Coach), Gayle Rawstorne (Health Promoter), Karen Petrie (Quit Coach), Cheyenne Galiki (Quit Coach), Kelly Atkinson (Team Leader Smokefree), Karen McIntosh (Health Promoter), John Hart (Te Ha Pukenga Manaaki). Missing: Brenda Chilvers (Te Ha Pukenga Manaaki), Michelle Trow (Te Ha Administrator)

Right: From left, health promoter Karen McIntosh, medical records administrator (and video star) Karla Matthews and health promoter and video producer Gayle Rawstorn on the Wairau Hospital film set.

To help support efforts to keep NMH grounds smoke- and vape-free, Smokefree Health Promoter Gayle Rawstorn has produced a video guide outlining how talk to people smoking onsite.

The 4-minute video was launched on World Smokefree Day in May and can be watched on the intranet on the 'Smokefree' site.

"It's our job as healthcare workers to inform people about our smokefree policy. We want to protect patients, visitors and ourselves from second-hand smoke," Gayle says.

"It's not our job to enforce the smokefree policy, only inform people about it and a simple, kind and quick conversation can be all that's needed to remind people that NMH grounds are smoke- and vape-free. And this can be done in a non-confrontational way."

The video is introduced by Jane Kinsey, GM Mental Health, Addictions and Disability Support Services. It features medical records administrator Karla Matthews and youth health promoter Reuben Molnar.

For a quick overview, here are Gayle's six steps:

1. Keep it simple, kind and quick
2. Introduce yourself as a staff member
3. Remove blame and save face
4. Explain why NMH ground are smoke- and vape-free
5. Inform the person where they can smoke and vape
6. Give the person space and move on

SPOTLIGHT ON THE SMOKEFREE SERVICE

Referrals can come from an individual, GP, midwife or other health practitioner. Quit coaches provide behavioural support for patients on medication, track their progress and refer them back to their GP if they are experiencing adverse symptoms from the medication.

Smokefree Nelson Marlborough is a collaborative model including Nelson Marlborough Health, Marlborough Primary Health, Nelson Bays Primary Health and Te Piki Oranga Limited. Programmes include Pēpi First, Te Hā (The Breath), group and workplace programmes.

The service predominantly operates in the primary and community environment with patients, however it also has a role in secondary care as an educational and promotional support to the inpatient care team. Examples include ensuring health providers have completed the ABC Smoking Cessation Training, staff are confident addressing smoking onsite (e.g. new video), and maintaining HealthPathways.

Community HealthPathways

TRANSFORMATIONAL PEER SUPPORT

Peer support and a collaborative approach to supporting wellbeing is having a quietly powerful transformational effect at the Nīkau Hauora Hub.

The Hub, on the corner of Selwyn Place and Sussex St, is a welcoming environment where people can go via referral or self-referral to access a range of services to support their mental wellbeing.

It's a holistic approach which combines intentional, trained peer support with access to Te Waka Hauora and clinical staff and complementary support such as a wellness nurse and other onsite social agencies as needed.

The Hub itself is the latest chapter in a nearly 30-year story of community-based support for mental wellness.

One very significant aspect of the collaboration at the Hub is the work that peer support and advocacy service COMPASS is helping Nīkau Hauora Hub whānau apply for paid roles working in the kitchen to provide a lunch service three days a week at the Hub.

COMPASS Team Leader Marina Keenan says that the experience of applying for jobs as kitchen assistants and dishwashers has been an excellent one for whānau.

"Whānau came upstairs in person to our office to get an application form, with peer support available to do so if needed. They also prepared a CV and attended an interview for the role, again with support available. For some people that was their first job interview ever so it was an important process to go through.

"If they were successful in obtaining a role they then learnt about skills such as communicating tasks, time management, and nutrition-based menu planning. Tikanga is also central to everything we do, so we always say a karakia before serving food. Sharing kai in itself is a very important activity for our Hub community.

"Whānau have said that going through the application process and successfully obtaining a paid employment opportunity that provides them with experience to list on a CV, makes them feel valued and provides them with the means to save towards a tangible goal such as taking a trip away. It's also expanded people's thinking in terms of trying different foods and cooking for themselves when they aren't at the Hub."

"It's good fitness having a job," says Daniel Timms, one of the Nīkau Hauora Hub kitchen assistance and dishwashing team, "(and a) good reason to keep me motivated to come to Nikau. Having extra money has helped a lot."

"This is a real stepping stone process and we hope that some people who have worked in the kitchen can go on to find paid work in the community," Marina says. "More importantly, it's about enhancing self-worth and empowering people to realise that they have more potential than they have perhaps realised in the past."

Those enjoying the kai at the Hub are also learning new skills as they have come to grips with using a new app where whānau and invited guests can book and pre-pay for their lunches.

"The Hub is a place where peers will walk alongside you and where you can be yourself," Marina says. "The first step for all of us is self-acceptance. Having been on that journey myself I know what is possible and it's a privilege to be a part of that process now for others. We learn from each other."

Marina Keenan (Compass Team Leader) serves Lisa Duffy whānau (Kitchen Assistant) fresh lemon chicken pasta with spinach and rocket salad

Health Action Trust
Te Mana Taki Hauora

compass

WHANGAIA NGĀ PĀ HARAKEKE: FINDING CARE AND AROHA

Mel Round (front row middle) is welcomed into the Te Rūnanga o Ngāti Rārua whānau.

The Whangaia Ngā Pā Harakeke model is a national principles framework that focuses on reducing the incidence and prevalence of family harm in communities as well as reducing the impact that family violence has on whānau who are enduring or at risk of harm.

Nelson Marlborough Health teams collaborate with NZ Police and the Health Action Trust staff across the region to carry out this work.

A mihi whakatau was held on Friday 18 June to officially welcome Mel Round to Te Rūnanga o Ngāti Rārua, in a joint role with New Zealand Police which also contributes to reducing harm.

Te Rūnanga o Ngāti Rārua Pou Hononga Koren Grason said Mel's appointment as facilitator will enhance work already underway in the family harm prevention space under the umbrella of Whangaia Ngā Pā Harakeke. Mel will be involved with initiatives designed to assist whānau by ensuring the appropriate care and aroha for their needs.

"Our hope is that we can collaboratively build the inter-agency approach which will broaden thinking and get better results for whānau who have high family harm risk," Koren said.

NZ Police Inspector Mat Arnold-Kelly has been part of a wider implementation team which has culminated in mahitahi with Ngāti Rārua to nestle roles within the rūnunga.

VOLUNTEERS KEEP THE WHEELS TURNING THIS NATIONAL VOLUNTEER WEEK

Kathy Cuthbert knows a thing or two about volunteering having organised the volunteer buggy service at Nelson Hospital since it was established in June 2006.

Kathy worked at Nelson Marlborough Health for 38 years in finance, as secretary to Sandy Russell and in the enquiries and patient travel team. These bookkeeping, transport and organisation skills make her the perfect fit for coordinating the 30-strong volunteer buggy service at Nelson Hospital.

"The shuttle buggy idea was born in the early 2000s when I was working in enquiries by the entrance of the hospital. I noticed how out of breath people were, those not well and elderly, after walking up the hill from the car park," Kathy said.

Not deterred by funding barriers, Kathy persisted and was rewarded with the green light to establish a committee and raise the funds for the buggy service independently.

Fifteen years on and the service continues to be funded through public donations allowing for the upkeep and maintenance of the buggy and consumables such as uniforms and wet weather gear.

"We certainly couldn't do it without donations from the public. We have a donation box on the buggy and people are very generous. We occasionally have 20 dollars, but even 20 cents, it all adds up."

Kathy likes to help volunteers from across Nelson Marlborough Health to connect with each other beyond shift handovers.

"We do a few get-togethers throughout the year and have a good chat. It's a good way for the volunteers to meet the other volunteers, otherwise they only see who they take over from."

On Sunday 27 June, 24 volunteers shared afternoon tea at Stoke Retirement Village. The volunteers were from the shop, meals on wheel, the buggy service and Nelson Hospital's Emergency Department.

The personal benefits of volunteering are evident in Kathy's smile.

"I never thought it would go on for this long and never dreamt I would be involved in a second buggy – which we achieved in 2019. It has been wonderful to know that we have really made a difference, and continue to make a difference with well over 1000 people a year supported."

THE FIRST 1000 DAYS: SUPPORTING WĀHINE AND THEIR WHĀNAU

A child's home environment, particularly during the first 1000 days of their life will influence their future outcomes. By supporting the mother and strengthening her mental health and wellbeing, improvement can be seen in the home environment and the outcomes for her tamariki and whānau.

This is the aim of Hei Pa Harakeke – The First 1000 Days Project, first piloted in Motueka in 2018. The multi-agency approach works with whānau to improve the health of the mother and their tamariki through developing strong infant-parent relationships.

"A strong nurturing bond with a caregiver creates the stable foundation a child needs to develop," explains Anne-Marie Ballagh, Early Intervention Practitioner for the project.

"We support mothers and caregivers to develop this bond which often starts with them learning to care for their own mental health and wellbeing".

The project team saw an opportunity in Facilitated Attuned Interactions (FAN) training, to better equip frontline health and social services staff to support vulnerable wāhine.

FAN teaches valuable skills to calm and support vulnerable people and strengthen and build trusted relationships with them. Building trust helps break down barriers and creates opportunities to support a mother who, in turn, becomes receptive to the support.

Earlier this year, thanks to the Care Foundation and Nelson Rotary Club, staff from NMH, Plunket and Te Piki Oranga were able to undertake the training.

The staff found these new skills particularly valuable during COVID-19 lockdowns, helping them de-escalate anxiety and better support wāhine in their roles as mothers.

"It is not about telling our wāhine what to do, but knowing how to support them to use their own kete of skills and create a safe and nurturing home for their tamariki," Anne-Marie says.

"The training tapped into our innate knowledge and gave us the framework we needed to support our work, the results have been so rewarding. To look at the little one's face when they interact with their mother, to see the mums grow and bond with their tamariki is precious."

"It was exciting to hear the hopefulness," adds Leanne O'Hara, another training participant and a Plunket Karitane nurse in Marlborough. "It is improving how we support carers and work through them to improve healthier outcomes for infants."

She is thrilled by the impact it is having in her whānau groups, it has even created some 'lightbulb' moments for some, which she says has been very rewarding.

Nelson Marlborough Health Ki Te Pae Ora towards a healthy future

General Manager of the Care Foundation, Clare Haycock, is encouraged by the feedback.

"It is a really important health focus," she says. "The Care Foundation is pleased to have contributed over $65,000 in the last year towards infant and maternal mental health training."

"We have had incredible support, the Nelson Rotary club for example and in particular, Gaile Noonan and Jan Heslop have been instrumental in sending the Nelson-based staff on the training.

"So it is great to hear such positive outcomes from those who have undertaken the course. That is what it is all about, supporting initiatives that improve the outcomes of our future generations."

The training was initially offered to those involved in the pilots in the Motueka and Marlborough areas. However, the as The First 1000 Days Project expands across the region, the benefits will extend to all vulnerable mothers and whānau in Nelson Marlborough.

If you are interested in the area of infant and maternal mental health and want to know how to be involved, contact modelsofcare@nmdhb.govt.nz

NEW TRAINING IS IMPROVING OUTCOMES FOR SMALL BABIES

District Health Boards nationwide are seeing the effects of a programme for staff involved in pregnancy and the care of newborns.

The Growth Assessment Protocol (GAP) programme teaches healthcare workers how to identify babies that are small for their gestational age. Nelson Marlborough Health is one of 15 DHBs, with support from ACC and the Perinatal Institute, now implementing the programme, and the remaining five are in the planning stages.

EARLY SIGNS OF SUCCESS

NMH signed up to the programme in 2019 and Lucia Alonso-Gonzalez was appointed as the GAP Lead Midwife for Nelson Hospital in early 2020.

"I'd been exposed to the GAP programme a couple of years before and had seen the impact it had on reducing stillbirths. As a midwife, I had cared for a woman whose baby passed away in utero, and although GAP wouldn't have saved that baby, I saw the opportunity to help prevent similar tragedies in the future."

When Lucia took on the role, Wairau Hospital had already started implementing the programme – which induced some healthy competition between the two hospitals. Implementation in Nelson began in the early days of the COVID-19 pandemic, when COVID was the only thing on people's minds.

"It was daunting in those first few weeks. Clinicians had been trained and used customised growth charts, but only 15 per cent of babies had their birth centiles recorded, and not everyone was measuring babies in the standard way," Lucia says.

"My approach to get people on board was to use humour and try to make it fun. I came up with the idea of using the 'G-word' (GAP), to help people temporarily forget about the 'C-word' (COVID-19) – which seemed to resonate!"

Lucia says it became clear through the training that clinicians didn't fully understand the long-term impact of babies being small for their gestational age and that it could potentially lead to long-term health and developmental issues.

"Once people started putting their training into practice and identifying small babies they might have otherwise missed, it really started to hit home for them, and that's when I started getting requests from their colleagues to access the training," Lucia says.

"Now the results are clear. We used to have about seven or eight missed small babies per month and now we're only seeing one or two. Across Nelson Marlborough Health, 98 per cent of babies now have their birth centiles recorded."

Ō TĀTOA HAUTŪTANGA

OUR LEADERSHIP FRAMEWORK

Nelson Marlborough Health is proud to introduce Ō Tātoa Hautūtanga – Our Leadership Framework. Created in consultation with staff, the framework leverages the knowledge of the public sector model for leadership development and matches it with the needs of the NMH workforce.

Ō Tātoa Hautūtanga is an important framework because it:

- fosters the development of the language of leadership
- articulates what good leadership looks like
- allows people to place where they are, and therefore…
- allows people to plan their leadership journey or pathway.

We caught up with seven NMH leaders to find out what capabilities they value and what capabilities they are looking to develop as they continue on their leadership journeys.

DIANE SCOTT

Title: *Community Physiotherapist and Clinical Coordinator - Community Physiotherapy (Workforce Support)*
Leadership position: *Leading where I stand*

What leadership capability do you value and why?

I value enhancing people performance. I have been fortunate to be on the receiving end of this with coaching from my team leader (Deidre Crichton) within the scope of my clinical coordinator role. I have also benefited from the positive culture within Allied Health to explore leadership within a range of opportunities.

What leadership capability are you keen to develop and why?

I am keen to develop leading with influence. I am fortunate to work in a supportive team and have grown with coaching from my team leader. Going forward, I would like to develop my influential leadership skills so that I continue to support our organisation's journey towards achieving equitable health outcomes.

LISA LIVINGSTONE

Title: *Clinical Lead – IT Projects*
Leadership position: *Leaders of people*

What leadership capability do you value and why?

For me developing talent has always been my guiding leadership capability, without active leadership in this area any organisation or team will fail. We have to always as leaders be looking to how we can extend and grow our team or mentor others to develop.

What leadership capability are you keen to develop and why?

For me I would like to work on leading with influence in my current role it is about how I can light the fire of change within others for the future projects that I support.

SUE LAWRENCE

Title: *Change Manager Clinical Administration*
Leadership position: *Leaders with no direct reports*

What leadership capability do you value and why?

Lead strategically is a capability I particularly value. Being able to create a shared vision for the direction of the team, service and the organisation as a whole is critical, so change, people development and performance is aligned and directed towards this shared direction. I think leading change is most effective when this alignment exists along with strong visibility of the direction, in language people understand. Having the courage to do so when the environment is uncertain or ambiguous is also key. Being able to lead strategically picks up all these dimensions.

What leadership capability are you keen to develop and why?

Leading with influence. Working with others to make change happen requires being able to lead and communicate well, to be convincing. This is often hard so I am very open to improving my ability to do this, to learn new tools.

SIMON LANGFORD

Title: *CNM ED/HDU/AAU Marlborough*
Leadership position: *Leaders of people*

What leadership capability do you value and why?

Although all the capabilities are fundamental to success in leadership the one I value the most is talent management. Throughout my career I have had the opportunity to learn and develop knowledge and skills which have not only made my work more satisfying, but have increased my ability to improve patient outcomes. I have been fortunate to have mentors and managers who have supported me along the way and as a charge nurse manager I see one of my key roles as encouraging and facilitating staff to grow and develop new skills and knowledge. Our most important resource is our people and we should always strive to invest in them to provide the best possible service to our community.

What leadership capability are you keen to develop and why?

Recent events have stressed the importance of planning ahead and forecasting what our world will be like in 6 months, a year or even 10 years. Developing strategic leadership will allow me to explore what our service might look like in the future and engage with others to ensure that emergency and critical care delivery meets the needs of our community and remains responsive to whatever comes our way.

JASON NICHOLLS

Title: *Workforce and Professional Development Facilitator*
Leadership position: *Leaders with no direct reports*

What leadership capability do you value and why?

Engaging others. I enjoy working as part of team and believe that better outcomes are achieved when the collective wisdom of a group is harnessed.

What leadership capability are you keen to develop and why?

Enhancing people performance. Putting the systems, processes and programmes in place to support staff to achieve their learning and development goals is what my role is all about. I know there is lots more to do in this area so want to develop this capability further.

REBECCA MCKEGG

Title: *CNM Paediatrics Nelson*
Leadership position: *Leaders of people*

What Leadership capability do you value and why?

I value all leadership capabilities, however enhancing team performance resonates with me. I am lucky to have worked in and around some high performing teams in my career. To me, effective teams are the cornerstone of any organisational structure. It is not about the individual but about how we work together to enhance our performance, promote best outcomes for our patients and maintain our professional and organisational values.

What leadership capability are you keen to develop and why?

On a personal and team level I would like to develop my ability to influence. Transformational change comes about when stakeholders are aligned around ideas, actions and outcomes.

KERRI SHAW

Title: *Nurse Manager – Informatics CCDM*
Leadership position: *Leading where I stand*

What leadership capability do you value and why?

Leading with influence is the leadership capability that I most value as being able to influence others maximises the potential of the whole team to perform at the top of their game to achieve collective targets and goals.

In order to lead with influence it is essential to be authentic and be seen to 'walk the talk' demonstrating a strong collaborative work ethic, honesty, transparency, being flexible and open to change so that others are able to have trust and confidence to be positively influenced. This is particularly important when courageous conversations are required to respectfully address issues or challenge the status quo in order to improve performance.

What leadership capability are you keen to develop and why?

I would like to see resiliency developed throughout the organisation. Resilient individuals and organisations are future focussed building coping mechanisms in order to be prepared to deal with whatever is around the corner. Resiliency means being flexible in order to be able to adapt to whatever challenge is being faced be it a disaster such as the impact of COVID-19 or general business such as future proofing the workforce by developing robust succession plans.

LEADING THROUGH OUR VALUES

Assessment, Treatment and Rehabilitation (ATR) staff are demonstrating their commitment to NMH's value of 'teamwork' with the instigation of an Employee of the Month award.

ATR Acting Charge Nurse Manager Christian Pesino said the awards are a great way to focus attention on positive behaviours and attributes as staff are able to nominate each other for the award.

"The employee of the month award is an excellent way to promote leadership skills and attributes among staff at every level of care. This is evident in the fact that employee of the month awardees in ATR have been a mix of different health team members – from household staff, healthcare assistants, to nurses and the team leader.

"Recognising staff members through this award has certainly helped boost morale and added a positive vibe to the ATR team's culture."

Ō TĀTOA HAUTŪTANGA

Our Leadership Framework is the premier piece of a broader programme of personal and professional development opportunities under development.

Over the coming months expect to hear more about the following leadership programmes:

- To Mātau Whanaketanga Whakahaere | Our Management Development
- Mana Taurite o Ngā Ahurea | Leadership in Cultural Equity
- Hauora. Rauhī | Healthy. Together. Leadership in Wellbeing

JANUARY

Congratulations to Ren Campos – who received his award for his kindness, patience and general helpfulness to patients and staff. Ren always goes the extra mile and nothing is ever too much trouble.

FEBRUARY

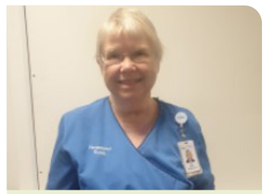
Congratulations to Rachel Rutherford – who received her award for her work ethic, attention to detail and the high standard that she completes her work each day.

MARCH

Congratulations to Mathews Jose – who received his award to for positive patient feedback and to acknowledge his leadership and team ethic, specifically as he was the instigator of the Employee of the Month award process.

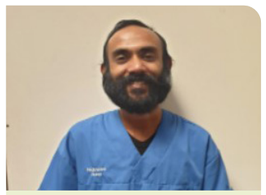
APRIL

Congratulations to Libby Wehner – who received her award for demonstrating professional maturity and leadership above her years of clinical practice. Libby is also commended for her superb manner with confused and distressed patients and the empathy she demonstrates in her interactions and nursing care.



MAY

Congratulations to Joan Knight – who received her award for her tireless work and commitment in advocating for her colleagues as ATR's NZNO delegate.



JUNE

Congratulations to Arjun Sasi – who received his award for his gentle nature and approach when caring for his patients. He always ensures to provide time to listen and attend to his patients' needs.

JULY

Congratulations to Christian Pesino – who received his award for his great leadership skills, support and ability to calmly manage the ward, staff, families and patients with expert knowledge and in a lovely manner.

AUGUST

Congratulations to Rocheneil Dela Cruz - who received his award for his hard work, reliability, willingness to help and being a great role model for the HCA role. He is amazing and just gets on with it!

LEADING THROUGH SYSTEM STEWARDSHIP

Our Wairau Physiotherapy Team were able to demonstrate system stewardship recently as they supported their colleagues in Invercargill.

Three team members were lined up to attend Southern DHB in person to help manage the waitlist backlog before newly recruited staff could arrive.

Although the plans were disrupted due to the latest COVID-19 lockdown, Nicola Westend, Wairau Team Leader Occupational Therapy and Physiotherapy, was proud of the way the team demonstrated active listening and problem-solving skills as they worked together to determine whether they could offer support.

Why did the team want to help?

If a call like that comes out from your colleagues then you acknowledge that they must have a significant need. When previous requests have come through we haven't been in a position to assist due to our own staffing situations.

The Wairau Physiotherapy Department has previously been short of staff so we know how it feels.

When the call came out we were in a good staffing situation so I felt comfortable putting the request to the team and a number responded that they could be available.

What problems did it raise for the team that they needed to work through to assess if it was possible?

The team first needed to determine who would be keen to go and what dates they would be available. I was keen to review leave/on-call roster/planned meetings etc over the time period that would need to be covered.

How did the team work through these?

Having looked at these things, I put to the team the option of rotating, going on different weeks for a minimum of three days. With travel down to Invercargill it made more sense to do a full week travelling down on a Monday and back on a Friday to keep it within a working week. Also for cover purposes it was easier to have one person away at a time.

We emailed our proposal to Southern DHB – and waited for their response. When they came back with dates and level of experience required I went back to the team and discussed if we could meet their request and agreed we could.

What contributed to the team being able to operate at this level?

The team were supportive of each other, there were no issues raised in regards to cover with everyone being open to being flexible and encouraging of each other. I listened to their concerns about where they would be covering and assured them that we would work with Southern DHB to match their experience to the work, noting that three of the four who offered are within their first years of graduating and all reasonably new to the team. Three hadn't actually been here when we had been exceptionally short staffed. Other staff who for a variety of different reasons didn't volunteer were supportive of their colleague's offers.

Above: Physiotherapists Akane Matsumoto, Holly Fletcher and Reuben Rhodes, pictured in the front, prepare to head to Invercargill with support from their colleagues Alastair McPherson, Lucy McIlraith, Lynnette Stewart, Marg Gilbert Andrea Barnaby and Renee Ashby

Council members Esme Palliser, Nikita Takai, Angelea Stanton, Marie Lindaya, Soni Tanikula, Brenda Chilvers and Geoff Ormandy caught up in March.

GROWING THE CONSUMER VOICE

The 2022 establishment of Health NZ and the Māori Health Authority will see the consumer voice present in decision-making at all levels of the health system.

Consumer Council Chairperson Angelea Stanton has been part of the council since it was established in 2017 as an advisory group reporting to the Nelson Marlborough District Health Board.

"The consumer voice needs to be present at every level and stage of the system," Ang explains. "Originally we started out simply looking at poster designs or checking the way a letter was worded."

"But over time we have really come into our own. Recently we have been able to create strong connections with the Clinical Governance Committee. This has allowed us to get ahead of the work plan rather than waiting for things to come to us."

"We try and make sure we challenge what is happening so that consumers are involved in changes in the health system. We always encourage teams to check whether it is appropriate to be making decisions without talking to the people they are providing the services for."

The Consumer Council members are cognisant that their personal biases shouldn't be reflected in their feedback and guidance.

"We are only a small group of people," Ang says.

"We are not everyone in our community. So we assist teams in a number of ways, either by helping to source or support particular consumers of interest, or by canvassing general views or opinions with our 'talk-to-ten' approach."

The talk-to-ten approach has been a very successful way of gauging consumers' thoughts and themes on a particular topic.

The Consumer Council was asked to advise on communication as this was a strong theme in the general feedback provided to NMH.

Each member canvassed the views of ten consumers and then together they reviewed what good communication looks like. This is summarised in the table to the right.

"The talk-to-ten is a great way for us as Consumer Council members to gain a broader view and allows us to build connections in the community. It means we are able to provide NMH with consumer insight that is relevant to specific projects."

The council has been involved in a number of high-profile successes including the development plans for Nelson Hospital, Ki Te Pae Ora Programme work, advance care planning, telehealth and the restorative approach in the context of adverse events management.

"The restorative approach work provided a real moment for me as we look at how we partner with consumers and clinicians after adverse events," Ang says.

"I have sat with and heard stories of consumers who have been involved in serious adverse events. I have often not looked beyond the impact on that person as the consumer.

"I found it helpful to understand that the clinicians are affected also. I think this tends to be forgotten and shows that an approach offering an opportunity to connect and communicate builds better outcomes for all.

"It can be easy to look at the impact on the direct person involved and not so easy to look at those indirectly involved."

Looking to the future, Ang is really positive about the impact of the Consumer Council and the partnership opportunities for projects large and small within NMH.

"There is a clear message that consumer engagement is top priority in the future of our health system with consumer councils likely to be one of the ways the consumer voice is fed back to Health NZ.

"We really want people to take up the opportunity to engage with the council early on. No project is too small or too large. You don't need to do it alone, if you are, it isn't consumer engagement and not a collaborative approach to design."

What good communication in healthcare looks like – Advice from the Consumer Council

What it is	What it looks like
Be a good listener	Give undivided attention to patients while they are sharing their request/concerns/ailment (eg. not multitasking on the computer or paperwork).
Demonstrate cultural awareness and sensitivity	Being aware of cultural differences (eg. some cultures do not make eye contact with people they regard to be above their status). Respectfully using words in the person's own language.
Be empathetic	Show respect and acknowledge consumers concerns, questions and comments.
Convey respect	Respect people's personal preferences (eg. transgender may prefer the use of their "adopted" name rather than their "dead" name).
Be personable	Be a good listener by summarising your understanding of consumer's problems and concerns. Need to be culturally aware and sensitive.
Be clear and concise	Check to ensure that you are not missing anything important. Give clear, concise instructions. Make every effort to ensure the patient understands what is happening next.
Be appropriately honest	Give a brief rationalisation for the proposed course of action. Demonstrate that you understand and know what you are doing.
Have an open mind	Be open to giving and receiving feedback and paraphrasing.
Involve and empower patients to be part of the process	Outline possible considerations, approaches, options and/or further investigations.
Clarify and confirm what's next	Get consensus (buy-in) on the action plan.
Display relaxed and friendly non-verbal communication skills (body language)	Signal you are taking time to think by confirming you understand the situation.
Respect the patient's confidentiality	Make every effort to convey to patients that your discussions are held in confidence.

WEAVING WELLBEING INTO ECHO WAITLISTS

Clinical Nurse Specialist Rebecca Eddington was awarded the Nurse Investigator of the Year award by the Cardiac Society of Australia and New Zealand.

He whiringa takitahi ka hunahuna
He whiringa ngatahi, ka raranga, ka mau.

If you plait the strands, one strand at a time, the ends will fray and fragment. If you weave them together, they will hold.

For newly appointed clinical nurse specialist Rebecca Eddington this whakataukī represents the future of older adult healthcare in cardiology, with clinicians weaving all parts of patients' wellbeing together.

At the Cardiac Society of Australia and New Zealand (CSANZ) annual scientific meeting in June, Rebecca was awarded the Nurse Investigator of the Year Award. This recognised her success in reducing echo waitlists by determining patient's goals of care and assessing overall wellness/frailty (biological resilience to undertaking stressor) in a nurse led clinical trial.

"The biggest opportunity also provides us with our greatest challenge," Rebecca explains. "We now have advancing technologies and an expanding interventional window for our older population, a rapidly growing group."

"Our echo waitlist will continue to grow alongside our technological advances and so to manage this we need to find new ways of doing things that both improves patient centered care and is fiscally responsible."

In the two week trial, Rebecca held one hour sessions with 29 patients utilising geriatric assessment tools, discussing shared goals of care and providing important patient education.

"Empowering patient decision making significantly reduced the echocardiography valve surveillance waitlists," Rebecca said.

"The trial showed that responding to patients' individual needs, not only helped them to navigate their health goals but also allowed informed decision making ensuring patients were choosing wisely."

The data speaks for itself. Of the 29 patients enrolled in the trial, only 10 continued with echo surveillance following the clinic. Four patients were discharged from the service due to prohibitive health issues and 15 elected to withdraw from surveillance, realising it didn't match their goals of care at this point in time.

"Elderly patients present with complexities that challenge our algorithmic approach to cardiovascular care," Rebecca explains. "The varying levels of frailty, social support, cognitive and functional impairment can challenge routine care."

"The reason we do valve surveillance is to consider whether surgery or valve intervention may be of benefit in the future.

"We previously discharged patients aged 80 however we now know that there is an expanding diagnostic and therapeutic window for these patients. So people over the age of 80 may benefit.

"However if they demonstrate things like significant frailty, intervention could be at the detriment of their quality of life, even leading to a loss of their independence."

Rebecca was cognisant of the time spent with patients discussing individual health profiles and goals of care.

"The majority of the time was spent talking with patients about what matters most to them and giving them a lot of individualised support and education around where they are in terms of their health profile.

"If their goals of care meant they didn't currently want to consider having surgery, then I was able to educate them about symptoms so they could have early review by their GP in case they changed their mind and wanted to come back into surveillance at a later point."

This time and education was something the patient evaluation showed they valued deeply.

Rebecca recalled one women who was ecstatic to find out she didn't need to attend surveillance as surgery wasn't something that she would consider in her goals.

"I remember this one women who essentially thought that this was her warrant of fitness. She didn't realise that this was a possible lead in to valve intervention which she said she would never consider.

"She had lived her life and her husband had passed away. She said she would live happily now but she would also be happy when it was her time.

"For her, as she doesn't drive, coming to the appointments was quite an ordeal. Just those small things. Not only does it improve their patient journey, it opens up spaces for patients who truly need the echo surveillance."

Rebecca was guided by training in advanced care planning and serious illness conversations.

"There needs to be a whole emphasis on discussing death as a meaningful part of your life," she reflected.

"Becoming more skilled in that area is something we as clinicians are going to need to get better at as we treat more of the population as they age; and as they become more confident and comfortable to have those discussion with us going forward.

"With our older population we can no longer simply look at a patient's pathology such as aortic valve disease in isolation. We need to look at their whole being as one and unless we look at everything then we are not doing the best service or allowing them to make truly informed decisions.

"In a way it comes down to a health system that funds treatment rather than funding discussion. But the more time we can give to having these discussions earlier, the better the service we provide to our patients who can then make informed decisions about their goals of care."

PATIENT FEEDBACK

"Long enough (time) to be thorough and give me a clear idea of future pathway as to my health and what treatment I could have if needed. Able to gain confidence that I understand my health situation. Comfortable too, warm and not concerning or making for anxiety, friendly."

"That I have a decision documented that I do not want intervention and I don't have to come for more tests as I cannot drive."

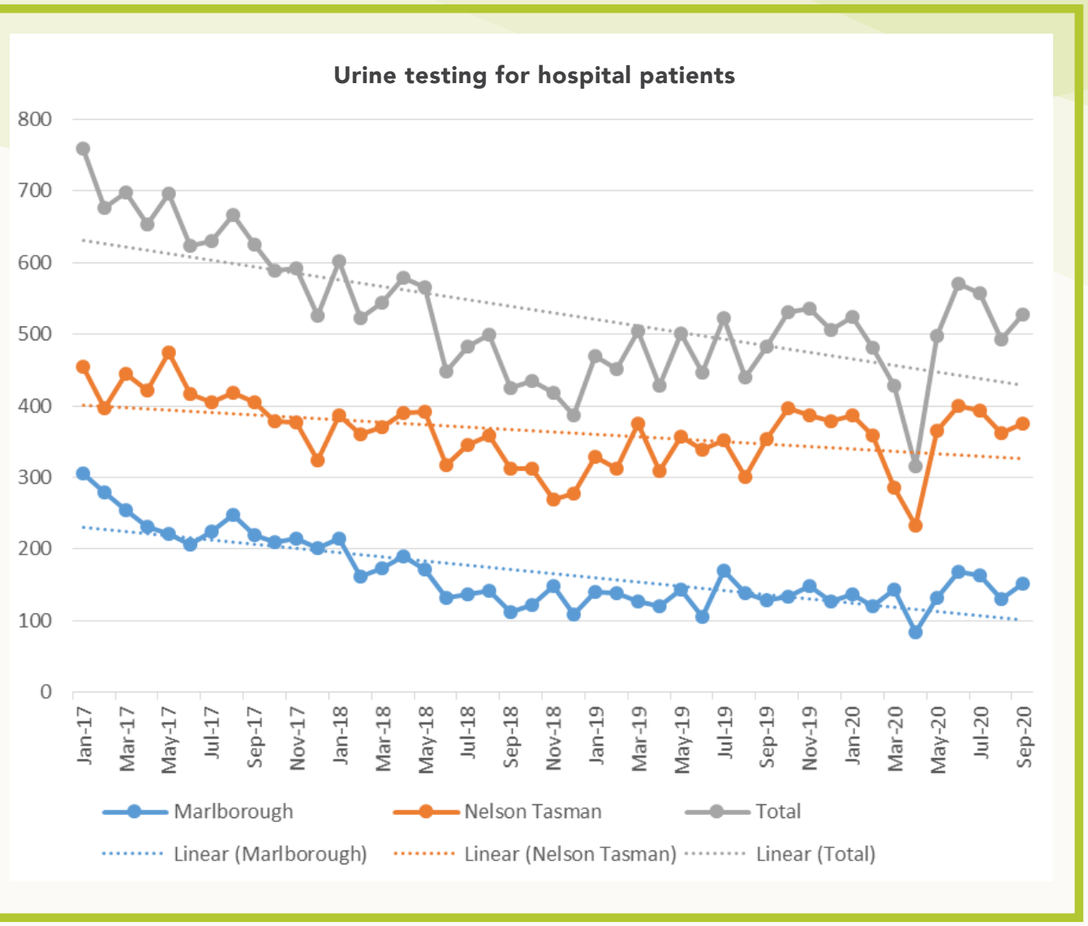
"Giving us an opportunity to think about these issues. This is the 'human' side of medicine. Makes us feel we matter."

"Most probably most informative discussion on heart valve I have ever had."

"Very helpful, I am grateful that the hospital has been able to give me this time for tests and explanations to assess my present health and what range of future possibilities there are."

"Bringing attention to my memory and planning for future intervention or not."

"Reminding me about what signs to look for regarding possible future deterioration."



DITCHING THE DIPSTICK

A Choosing Wisely project has seen the end to an often-unnecessary test – and 1200 fewer plastic urine collection tubes used each year.

Urine sampling is frequently undertaken in patients presenting to hospital. A common misconception is that urine should be 'sterile' and that the presence of bacteriuria must always be treated.

Asymptomatic bacteriuria (ABU1-3) or ABU is the presence of bacteria in the urine without any symptoms of a urinary tract infection (UTI).

Many medical colleges now advise against treating ABU as part of the Choosing Wisely initiative, which seeks to reduce patient harm from avoidable and low-value tests and treatment.

Dr Juliet Elvy, Consultant Clinical Microbiologist for Medlab South, says ABU is very common and does not require treatment unless the patient is pregnant or going to have urological surgery. It is especially common in elderly patients and those in long-term care facilities.

Often in the past a dipstick was used to test urines almost routinely and this would uncover ABU which did not actually need treating. The urine sample would commonly be sent to the lab for culture and the patient treated with unnecessary antibiotics; overuse and inappropriate use of antibiotics causes harm to patients and contributes to the rise in antimicrobial resistance.

"A urine culture cannot differentiate ABU from UTI – only the presence or absence of symptoms can do that. Similarly, a positive urine dipstick result may indicate the presence of bacteriuria but cannot differentiate ABU from UTI. Treating patients with antibiotics when they don't need them can lead to considerable harm."

In 2017-18 Dr Juliet Elvy, with the help of medical student Tea Elliott, undertook an audit titled, Is it time to 'ditch the dipstick?' An audit of urine testing for hospitalised patients at NMDHB.

Their study found 4,420 urine samples were taken and processed from inpatients at Nelson and Wairau hospitals over a 12 month period. This represented 14 per cent of all patients having a urine sample sent to the lab.

An audit of 100 of the tests discovered that 'no clinical indication for urine culture was able to be determined' in 34 per cent. If extrapolated across the total number of requests, this amounts to 1,500 urine samples per year being unnecessary and potentially harmful.

The study also explored staff knowledge and understanding about indications for urine sampling and interpretation of results.

In addition to this study, in 2019 Billy Kwok, a resident medical officer, ran a project to improve the quality of urine cultures sent from Wairau Hospital Emergency Department. His audit found 27 per cent of the samples sent to the lab did not follow NMH testing guidelines and 24 per cent were contaminated by skin flora (micro-organisms that live on our skin).

This meant about one in four urine samples sent to the lab did not offer any benefit to the patient. Associated with this is treatment delay, inappropriate antibiotic therapy, and unnecessary use of healthcare resources.

As a result of these findings urine dipsticks have been removed from wards (excluding obstetrics, patients receiving chemotherapy and emergency departments). A mandatory requirement for relevant clinical details for all urine samples has also been added to the eLab ordering system.

Clinicians are now asked to carefully consider whether sending a urine sample for testing is clinically indicated or will be of benefit. If they decide to test, the technique should be optimised to avoid contamination.

Over the course of this work the numbers of unnecessary urine samples sent to the laboratory has dropped so much that there is now a saving of approximately 1200 urine sample pots per year across the district.

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WHAT IS CHOOSING WISELY?

More isn't always better when it comes to healthcare. That's the thinking behind Choosing Wisely, a global initiative to stop unnecessary tests and treatments. Nelson Marlborough Health supports the initiative by promoting a culture where low-value, no-value and inappropriate clinical interventions are avoided.

Choosing Wisely involves important discussions around tests, treatments and procedures between healthcare professionals and patients. Certain low or no-value treatment and test activities have been nominated by the Australasian and New Zealand medical colleges. These are intended to start conversations about what is appropriate and necessary in a patient's healthcare plan.

Patients play an important role in Choosing Wisely. Some tests and procedures provide little benefit so it's important patients ask questions to ensure they end up with the right amount of care – not too little and not too much.

Choosing Wisely is facilitated by the Council of Medical Colleges in New Zealand and involves a number of professions including doctors, nurses, midwives, pharmacists and other professional groups. For more information see www.choosingwisely.org.nz

IT'S TIME TO HELP PEOPLE THINK ABOUT, TALK ABOUT AND PLAN FOR END-OF-LIFE

Dr Elizabeth Wood, Clinical Director Community and Chair of the Clinical Governance Group, reflects on end-of-life conversations.

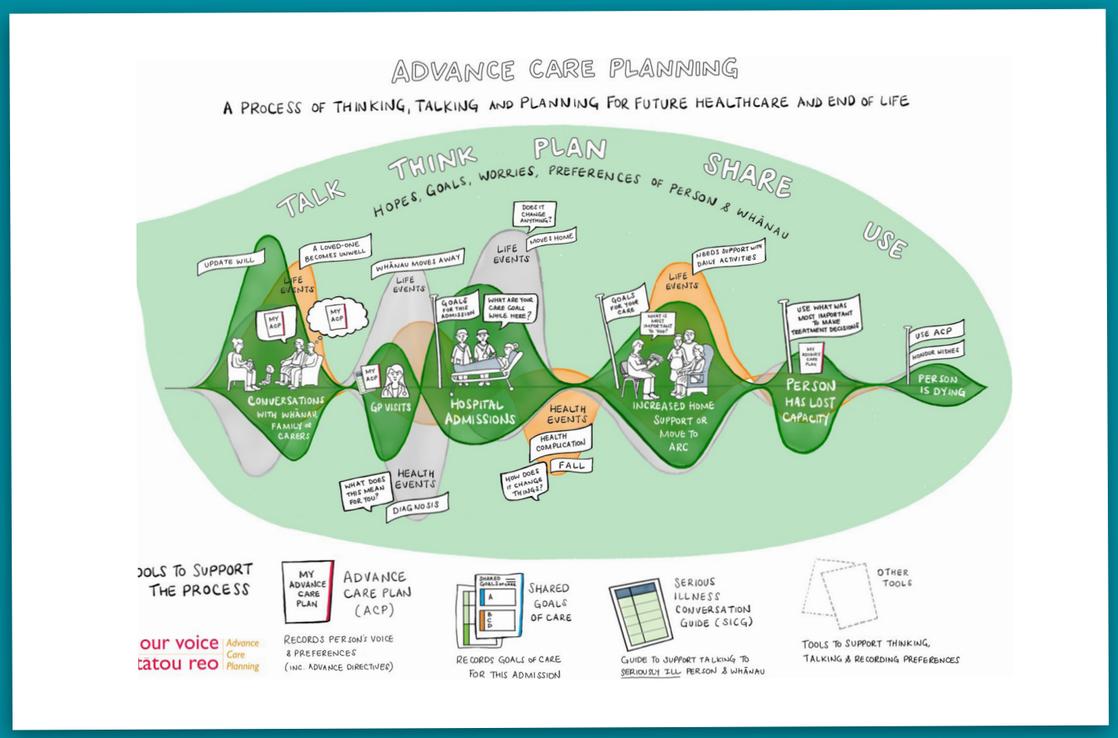
Healthcare decisions are often thought to be entirely scientific. Much of the time of course decisions are based in science and logic, but the application of all this knowledge needs to be adapted to an individual and their whānau's particular situation, preferences and needs.

The Health Quality and Safety Commission (HQSC) have worked alongside clinicians, patients and whānau to understand and provide tools to enable people to have these health planning conversations.

Whether it is encouraging someone to complete an advanced care plan, talking through shared goals of care, or engaging in a serious illness conversation, as healthcare professionals, we all have a role in helping end-of-life planning conversations to occur.

Good decisions are made when the patient and their whānau already have a clear idea of the things that are most important to them. Knowing and describing these things is not something that can easily happen in a situation of acute distress, worry or pain.

We know that it can be a source of significant solace for families to know that the decisions made with them by clinicians when their loved ones are no longer able to speak for themselves, are in line with the previously stated wishes of their loved ones.



END-OF-LIFE FEATURE

A CASE FOR CHANGE

At times clinicians avoid discussing prognosis – what really matters to the patient – and end-of-life issues with patients because they feel uncomfortable having these discussions.

Their discomfort comes from:

- a perceived lack of training
- stress
- not enough time to attend to what might come up for the patient
- a fear of upsetting the patient
- a feeling of inadequacy or hopelessness regarding availability of further curative treatment.

Avoiding these conversations or only initiating them late can lead to:

- anxiety and poorer patient quality of life
- patient and whānau distress
- prolonging the dying process
- unwanted and unwarranted treatments and their complications
- patient mistrust of the health system
- clinician distress
- low value care in which seriously ill patients do not receive the kind of care they desire.

It is in the patient's best interests to offer prognosis information rather than withhold it to protect the patient from losing hope or being upset.

Patients and whānau want open and honest information and a balance between realistic information and appropriate hope.

Evidence suggests that patients can engage in such discussions with minimal stress and maintain a sense of hope even when the prognosis is poor.

TOOLS FOR CHANGE

Advance care planning is not just about end-of-life care and treatments.

It is the process of empowering consumers to participate in their healthcare planning and deciding what treatment and care best meets their values, goals and preferences now and in the future.

An advance care plan captures what is important to the person and outlines the care and treatment they would want if unable to communicate for themselves.

Shared goals of care discussions are a part of the advance care planning process. These discussions are with a person and/or their whānau about the goals of care for a specific admission to hospital, aged residential care or long-term care facility.

The Serious Illness Conversation Guide Aotearoa supports clinicians to have conversations with seriously ill people and their whānau, including shared goals of care discussions.

HEALTH QUALITY & SAFETY COMMISSION NEW ZEALAND
Kupu Taurangi Hauora o Aotearoa

Kimah Rua RN, Annie Tonks RN, and Christie Narain RN from the Medical Ward talk with Palliative Care Nurse Educator and Clinical Nurse Specialist, Annie Wallace at Nelson Hospital about Te Ara Whakapiri.

TE ARA WHAKAPIRI: CARE IN THE LAST DAYS OF LIFE

Palliative Care Nurse Educator Annie Wallace is pleased to see an increase in the use of the last days of life care plans at Nelson Hospital following the launch of the revised documentation in July.

"The point of using something like Te Ara Whakapiri: Care in the last days of life, is that dying is a normal process, but it takes a bit of planning," Annie explains.

"We can really make a difference to how families feel and help in the bereavement period when we've managed to facilitate as good a death as possible.

"I feel confident that we provide very good end-of-life care here at Nelson Hospital. However it can be helpful with busy workloads to have prompts to make sure we attend to what is important.

"Te Ara Whakapiri makes sure we, the family and the patient if they are conscious, know what is happening."

About 30 per cent of people in New Zealand die in hospital. International evidence shows that having an end-of-life care plan improves the quality of dying.

"The reality is there will always be deaths in hospitals," Annie says.

"Ideally people are managed in the community, that is most people's preferred place of care, but when people call 111, they are brought into hospital and so might die here. So we want to manage that the best way we can."

Te Ara Whakapiri is endorsed by the Ministry of Health, and provides guidance and tools to help plan for end-of-life in the hospital setting.

"The guidance takes the principles and philosophy of hospice specialist palliative care and enables the treating teams to have tools so that a death can be as good as it can be, regardless of the place, whether that is a hospital or an aged care facility or the community."

Changes to the documentation include updated medications guidelines and flowcharts enabling doctors to pre-prescribe medicines for the end-of-life so they can be given in a timely way.

Streamlining documentation has also been a big focus. The baseline assessment document has reduced from six pages to a single double-sided sheet and the previous booklet has been condensed into an easy-to-use observation or ACE chart, with changes documented in the clinical notes.

"What we do know through auditing is that often the areas that are neglected when we are supporting people and families in the last days of life is the spiritual and cultural needs assessment.

"This is key to finding out what is important to that person, whether they have any specific spiritual beliefs that would be helpful for us to know about or support them with, for example, whether they would like the support of the hospital chaplaincy team.

"It's amazing when you ask the question how often people will say 'yes I would like that', but if we haven't asked the question they won't often say that they would like the hospital chaplaincy team to visit, or even know they are available."

Understanding cultural needs is about more than knowing ethnicity, Annie explains.

"Cultural needs are anything that is important to the person, so for some people it might be finding a way to say goodbye to animals and pets.

"Someone asked me the other day if they were allowed to bring flowers in, their mum was a really keen gardener. They didn't know and they wanted to ask the question.

"Te Ara Whakapiri supports treatment teams to find out what is important and provide support. Which could be as seemingly simple as people bringing in pictures to put up on the walls to make the hospital environment as nice as possible for that time."

Creating an environment of calm can be difficult in a busy hospital ward and so the team have introduced a visual aid in the form of a kowhai sign.

"With the consent of the family we put a kowhai sign on the door and that just alerts staff, cleaning staff, household staff that someone is actively dying and to be mindful of the environment outside the room. For example reducing loud vacuum noise outside the room or avoiding taking big food trays into the room."

Evidence suggest that health professionals find looking after palliative care patients and people who are dying as a satisfying area of health.

"It's just like birth, it is really important to get it right and you only get one chance at it. Hard, but satisfying.

"How people die lives on in the memories of those left behind. If we have a good death it reduces the risk of complicated grief. If we have a distressed death it really does impact on people and the grieving process. Lots of good reasons to do this and plan, inform and support."

FIND OUT MORE ON HEALTH PATHWAYS

Te Ara Whakapiri: Care in the last days of life can be found on HealthPathways.

Community HealthPathways

HE KARAKIA TĪMATANGA:

Ma te hau mahana o te kāhui o te Rangi
May the warm winds of the spiritual realm
Me te wairua o ngā tūpuna
and the spirits of our ancestors
Tātou e tiaki tātou e manaaki
guide and take care of us
I ngā wā katoa
always
Āmine
Amen

THE IMPORTANCE OF END-OF-LIFE CONVERSATIONS

Alene and Shona have open-heartedly shared their family story for the benefit of others to be informed and prepared as well as possible, 'to die a good death'.

Both sisters have relatively high levels of health literacy, with backgrounds in pharmacy and speech-language therapy.

And yet, faced with the end stage of their mother Colleen's life in 2020, and not sure they were quite there yet, they felt themselves to be flying blind.

"As a family, we worked well together to support mum through her dementia and decline. We had her best interests at heart and were attuned to her needs and preferences," Alene said.

"We have nothing but praise for the healthcare workers involved in our mothers care.

"However, despite our collective capabilities and resilience, the healthcare system was still challenging to navigate."

On reflection of the experience, Alene and Shona are keen to highlight the value of preparing people for the process of end-of-life.

Since their mother's death, they have encountered useful tools such as advance care planning, shared goals of care and serious illness conversation guides.

"It would be really valuable if these end-of-life planning conversations were standard healthcare practice.

"We all hope for a natural, comfortable-as-possible death, without our loved ones grappling with heavy-lifting and hard calls. On balance, this makes having some confronting conversations seem somewhat easier," Alene said.

COLLEEN WAS PROUDLY OF PĀKEHĀ AND KĀI TAHU DESCENT. SHE WAS A REAL LADY, A QUEEN OF STYLE WITH AN ENDEARING PERSONALITY THAT ATTRACTED MANY FRIENDS.

As Colleen's enduring power of attorney for health, Shona had to make decisions on behalf of her mother and feels she would have benefited from multi-disciplinary end-of-life discussions.

"It was a drawn-out process that perhaps didn't need to be," Shona reflects.

"If we had all been able to get together, the doctor, caregivers and family and talk through the rapid deterioration we were seeing, we may have concluded that mum didn't want to be here anymore.

"Mum had herculean determination," Alene explains. "She had come back from many other ailments and trips to hospital.

"So, when her best friend suddenly passed away, we had a sense this would have an enormous impact on our mother." The sisters' instinct was correct; Colleen subsequently went into rapid decline.

Within a few days, Alene observed that her mother had withdrawn inward. "Her breathing was more laboured than usual, alertness and communication was minimal, and her eating and drinking was extremely effortful and insufficient."

Alene called her sisters to come, and together with Shona it was decided to call an ambulance.

Severely dehydrated and diagnosed with pneumonia, Colleen was given antibiotics and IV fluids in hospital.

"We had the CPR conversation when mum first entered the rest home in 2017," Shona said. "She was very clear on her wishes not to be resuscitated by CPR."

"But we hadn't talked about other forms of life-prolonging interventions. When mum received IV fluids, I did notice she was very agitated after receiving them."

Alene explains the turbulence of decision making under pressure as akin to being at sea.

"Without a serious illness conversation, we had advocated for our mother to go to hospital. There, they gave her an IV while all these investigations were happening.

"We didn't realise IV could be a life-supporting intervention with the consequence of extending the dying process.

"We didn't know if mum was going to do a Houdini and bounce back like she had many times before or if this was actually the end."

Six days into the hospital stay, the family had their first experience of a serious illness conversation where Colleen was confirmed to have incurable aspiration pneumonia.

This diagnosis unequivocally pointed to palliative care; the sisters were able to take their mother to the rest home and stay with her until she passed away.

"It was a huge relief," Alene said. "We were holding all of this. Then, when we realised where we were at, finally I could make peace with it."

For Shona, the impact of the decision for IV fluids would mean she could not be at her mother's passing.

"It was quite sobering to find out that the IV fluids had prolonged my mother's life. It took eleven days for her to pass away – in addition to the three weeks before palliative care – by which time I was needed with my daughter who was due to have her first baby."

The sisters want to use their experience to help raise clinicians' awareness of the value of end-of-life conversations, including advance care planning, shared goals of care and serious illness conversations.

"I feel no blame towards anyone. Everyone involved in our mother's care was doing their best," Alene said. "The reality is that we had to make these tough decisions under stress on the spot."

"It would be great if all staff were able to share information," Shona said. "A doctor who might visit once a week won't have the same knowledge as the caregivers providing food and drink and care for the patients.

"If we had all talked, we may have noticed that mum was ready to go."

Alene said, "Our solace is we, as family and friends, were able to be with mum day and night for the duration of her passing, surrounding her with family aroha alongside the excellent care of her palliative care team."

"Fortunately, she died ten days before COVID-19 was first reported on our shores. Only one month later, our attendance would not have been possible. Given this pandemic era, this uncertainty adds further importance to these signposting conversations."

Mihi ki a koe e whaea, e kui, kua ngaro ki te pō, kua whetūrangitia. Haere haere haere atu rā.
He karakia whakamūtunga:
Kia tau tō rangimārie ki runga i ngā iwi o te ao. Āmine.

Let your peace settle upon the people of the world. Amen.

WHENUA KI TE WHENUA – ADVANCE CARE PLANNING GUIDE FOR WHĀNAU LAUNCHED

In August the Health Quality and Safety Commission launched Whenua ki te whenua: A taonga for your whānau, a new advance care planning guide designed using kaupapa Māori processes.

TALKING ABOUT THE JOURNEY OF LIFE

'E hono ana tātau ki te whenua mai i te matihe o te ora tuatahi tae noa ki te whakamutunga. E kawea ana te wairua i roto i te puku o te hau ki te okiokinga o ngā tīpuna.'

'We are connected to the land from the first breath of life to the last. Our spirit is carried within the belly of the wind to the resting place of the ancestors.'

– Len Hetet

The whakatauākī created by Len Hetet resonates throughout the design and content of the document.

'This proverb is about knowing who you are and where you are from – whakapapa. It draws on the caring, nurturing and the upbringing of a loved one from birth to death, and the important role that family, friends and carers play,' said Len.

The tohu design is based on the pito (umbilical chord) and the traditional Māori practice of burying it as a way of connecting a newborn baby to the ancestral lands.

'Through this tikanga the link is made with Papatūānuku (Earth mother) and the role that both whenua, the land, and the pito play in a spiritual sense,' he said.

The tohu represents the pito of life that connects us to the land and the spiritual ascent to the resting place of our ancestors. This is also reflected in the use of the kuaka which is said to accompany the spirits of the departed back to Hawaiki.

'For me it is talking about the journey of life,' Len said.

Physical copies of Whenua ki te whenua and can be ordered free of charge from the Health Quality and Safety Commission online in English and te reo Māori.

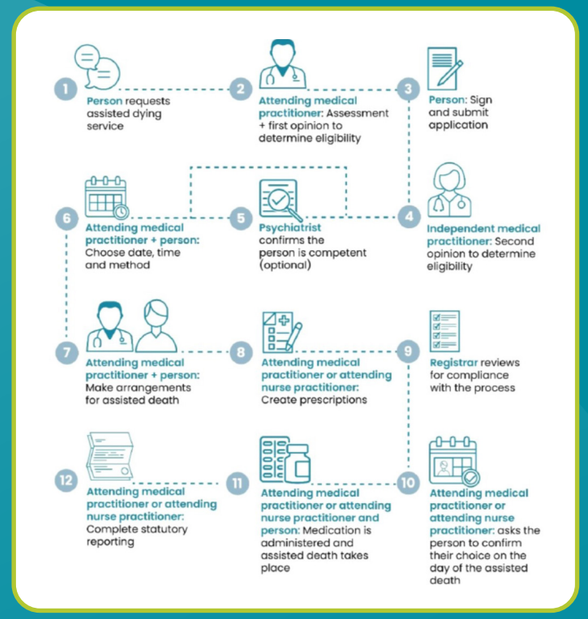
END-OF-LIFE FEATURE

PEOPLE WILL BE ABLE TO REQUEST ASSISTED DYING FROM 7 NOVEMBER 2021

The End of Life Choice Act: 2019 outlines the legal framework that allows a person who has a terminal illness and meets the eligibility criteria to request medication to relieve their suffering and end their life.

A person can choose to self-administer the medication (in the presence of a medical or nurse practitioner), or request that a medical or nurse practitioner administers the medication.

Assisted dying is another option for people who have a terminal illness and exists within the context of other health services. It is not a replacement for palliative care or healthcare services more generally.



FREQUENTLY ASKED QUESTIONS

When can people request assisted dying?

People will have the option to request assisted dying from 7 November 2021. This is a year after the results of the 2020 public referendum to determine New Zealanders' support for the Act were announced.

Assisted dying remains illegal in New Zealand until this date, and no part of the process can start before then.

What do I say to someone who asks about assisted dying?

The Act is clear that the person requesting assisted dying must be the one to raise it first. Health professionals are not able to suggest assisted dying as an option or initiate discussion about assisted dying unless the person has done so first.

Who is eligible for assisted dying?

A person cannot receive assisted dying solely because they are suffering from a mental disorder or mental illness, have a disability, or are of advanced age.

To be eligible, a person must meet all of the following criteria:

- be aged 18 years or over
- be a citizen or permanent resident of New Zealand
- suffer from a terminal illness that is likely to end their life within six months
- be in an advanced state of irreversible decline in physical capability
- experience unbearable suffering that cannot be relieved in a manner that the person considers tolerable
- be competent to make an informed decision about assisted dying.

How do you know if someone is competent to make an informed decision?

The person requesting assisted dying must be assessed and found competent to make an informed choice about assisted dying. A person's competence is not assumed.

Both the medical practitioner treating the person and a second, independent medical practitioner must agree that the person is eligible for assisted dying.

What if someone changes their mind?

If a person changes their mind about choosing assisted dying, they can stop the process at any time up until the point that the medication is administered. The medical practitioner must explain that they can change their mind as part of the assessment process.

What if I want to conscientiously object?

You do not have to be involved in providing assisted dying services if you have a conscientious objection.

If you are a medical practitioner you do need to inform the person of your objection and tell the person that they have the right to ask the Support and Consultation for End of Life in New Zealand (SCENZ) Group for the name and contact details of a medical practitioner who is willing to participate in assisted dying.

Other health practitioners can follow these steps as well as suggest that a person talks to their medical practitioner about assisted dying.

Regardless of your personal beliefs you should still meet professional standards by not inhibiting someone's access to lawful medical treatment and ensuring that continuity of care is maintained for a person requesting assisted dying.

https://www.health.govt.nz/system/files/documents/pages/end-life-choice-act-2019-information-health-professionals-may21.pdf

FIND OUT MORE ABOUT HEALTH PROFESSIONAL'S RIGHTS AND RESPONSIBILITIES UNDER THE ACT THROUGH THE MINISTRY OF HEALTH'S LEARNONLINE PLATFORM.

Have you completed the 'End of Life Choice Act 2019: overview' e-learning module?

This module takes 20 minutes and covers an overview of the Act and assisted dying, some of the key safeguards in the assisted dying process and how assisted dying fits into existing health professional roles.

www.learnonline.health.nz

STEPHEN GULLY

CHAPLAINCY – SPIRITUAL CARE

QUICK FIRE

If I could be anywhere in the world right now it would be?

In Tekapo enjoying the Church of the Good Shepherd, the night skies and views.

Who are your three dream dinner party guests and why?

Sir Edmund Hillary because as a child I was captivated by his journey to the South Pole.

Jesus Christ, because he is the Son of God.

Nelson Mandela, because of the example he set opposing oppression and deprivation.

What is your favourite food?

Battered blue cod, chunky chips and tartare sauce.

INTRODUCING REV STEPHEN GULLY

Pick three words to describe yourself.

Listener, encourager, compassionate.

What's your role here at Nelson Marlborough Health?

I am the lead chaplain for NMH. I oversee Wairau Hospital chaplaincy in addition to being the Nelson Hospital Chaplain. I am there for all people, whether lonely, troubled, or in spiritual distress.

I visit wards and meet with patients, whānau and staff, of every or no faith, to listen, comfort, support, encourage, or just to be present with them in whatever way they require.

For some people, prayer, blessing, anointing or Holy Communion is important. I train and lead a team of volunteers who also visit patients on the wards. We conduct services both in the chapel and regularly on Sunday morning in the AT&R ward lounge.

What's been your journey to your role now?

I have been formed for this role through a lifetime of working with people largely in human resources management and latterly as a career development specialist and professional supervisor.

Seven years ago I felt a strong call to hospital chaplaincy ministry and in 2016 started training as a volunteer here at Nelson Hospital. Since then I have gained experience as a voluntary chaplaincy assistant and locum chaplain.

My training has included completing a unit in clinical pastoral education, preparation for being ordained as a deacon in the Anglican Church and priesting which will take place in November this year. I am continuing to study towards a Graduate Diploma in Theology that builds on my Bachelor of Social Science degree. I have also undertaken training in palliative care and introductory mental health.

What is something you're working on currently or something people might not know you do at NMH?

I undertake room blessings and am training selected staff to do the same.

What do you like most about your work?

Being with, listening to and supporting people when they are in need. Bringing hope. Developing and working with our team to do the same.

What are the challenging bits?

When I hear of conflict within families that is preventing them from being together with their loved one at important times.

LEARNING FROM THE PAST TO CREATE A DIFFERENT CHOICE

As New Zealand races to achieve maximum levels of COVID-19 vaccination by Christmas, Te Waka Hauora General Manager Ditre Tamatea says history can be an important ally in getting the message about vaccination across.

"I'm certainly taken back to a conversation with my kuia (grandmother). She talked to me about the Spanish flu and the impact of that many, many years ago for the Māori community."

At its peak the Spanish flu affected millions of people across the globe. Of those affected by the disease in Aotearoa New Zealand in 1918 and 1919, the people who suffered the most were Māori.

"My grandmother talked about there being carriages of people, carriages with dead people killed by the Spanish flu," Ditre says.

And perhaps more shocking than the casualties was the denial of access to healthcare when it was needed.

"She talked about many of our whānau needing to have hospital services, and as they tried to get to hospital they were stopped by the police from reaching the Gisborne hospital.

"So they returned back to the marae – it became their substitute for a hospital, and of course many of our whānau did not live, they died.

"In this day and age we have a different choice, whereby if we want to, the options are available to us to get vaccinated.

"There's lots of different options: you can go to your marae you can go to your local iwi, you can go to Māori providers.

"You can get informed by your doctor, your GP about how to get vaccinated."

Ditre says there's a simple answer for people who are unsure about getting the vaccination – use the services that are available.

"My word to you would be get vaccinated. Let's not have what happened in the past happen.

"Things are different now, because in this day and age we're reaching out as a health sector to our people…we don't want to actually have the same results that we had many, many years ago.

"Take care of yourself, take care of your whānau, and take care of those that you love."

TE TAUIHU COLLABORATION AIMS TO KEEP WHĀNAU SAFE

The eight Iwi of Te Tauihu (Top of the South) pulled their resources and whānau networks together to ensure an equitable vaccination rollout for Māori in our region.

The local vaccination campaign saw an increase in vaccination update by Māori people at the start of the Alert Level 4 lockdown in August. In one week in August, 932 Māori were vaccinated with 84% of those being first dose vaccinations.

"We saw this increase in uptake as very important and positive because it shows that many whānau are making the decision to protect themselves and their wider hapu and community," says Dr Lorr Eade, Pouwhakahaere of Te Kotahi o Te Tauihu Charitable Trust.

The collaboration involves Māori Hauora providers Te Piki Oranga and Te Hauora o Ngāti Rarua, Omaka, Whakatu and Te Awhina Marae, Nelson Marlborough Health, primary health organisations and Iwi who have come together in an act of kotahitanga (oneness) to drive a successful campaign.

The joined up campaign has leveraged the 'Karawhiua' campaign led by Te Puni Kōkiri (Ministry for Māori Development), co-delivered by Te Hiringa Hauora (Health Promotion Agency), and supported by the Ministry of Health New Zealand and the Unite against COVID-19 teams. Karawhiua means "Give it heaps! Go for it!"

Iwi tailored the campaign with local messaging and the recruitment of whānau champions to reflect their communities in an authentic way through live panel discussions, video, photos on billboards and banners to running education workshops across the region.

"The way in which we are working together reflects treaty-based principles of engagement from conception, development to delivery and brings to the surface how our incredible Māori health workforce, addresses inequity," says Dr Eade.

"Working collaboratively, we are able to collectively target resources with appropriate solutions. As an example, if we need to take the vaccinations to whānau in certain communities to address barriers to the vaccine, we can pull our resources to ensure that happens."

"We encourage whānau to book in for their vaccinations if they haven't already (bookmyvaccine.nz). They can check out our Facebook pages for updates on the various ways they can get vaccinated and seek support through the lockdown in Te Tauihu. Go to @TeKotahioTeTauihu."

ABOUT TE KOTAHI TE TAUIHU CHARITABLE TRUST

Te Kotahi o Te Tauihu Trust was set up by the eight iwi of Te Tauihu o Te Waka-a-Māui (the top of the South Island) to realise our shared aspirations for the Māori communities of Te Tauihu. Working together ensures we have roadmap for the future across our shared aspirations of Whāngai, Feeding our people; Tāwharautia, Shelter & Support; Whiwhi Mahi, Work & Training; and Whai Oranga, Holistic Wellness.

NGĀ IWI O TE TAUIHU OF TE WAKA-A-MĀUI

Ngā iwi o Te Tauihu of Te Waka-a-Māui (The eight iwi) are: Ngāti Apa ki te Rā Tō, Ngāti Koata, Ngāti Kuia, Ngāti Rārua, Ngāti Tama ki Te Waipounamu, Ngāti Toa Rangatira, Rangitāne o Wairau and Te Ātiawa o te Waka-a-Māui.

OUR HEALTH PARTNERSHIP WITH THE MAKO GROWS STRONGER

The Tasman Rugby Union's (TRU) partnership with Nelson Marlborough Health has seen Mako players promote health initiatives such as encouraging kids to drink water and avoid sugary drinks.

Now some of the players are using their influence to encourage others to consider COVID-19 vaccination. 21 players and TRU staff were vaccinated at the Trafalgar Park headquarters, consenting to media coverage, photography and video work then used to promote vaccination.

TRU commercial and marketing manager Les Edwards says that the benefits of the partnership have taken on new meaning in the last 18 months.

"As a rugby team it's really important that once we get into Alert Level 2 and start training and playing as a group again that we get as many of the team vaccinated as we possibly can."

Many players come from different parts of the country and move on to other teams and contracts when the season is done. During lockdown the players have been isolating - and training – in their bubbles. Vaccination was important on several levels.

"As we go around the country [it shows] we've set a good example - not only for ourselves, but for our rugby fans."

Being able to provide players and staff a health service through Nelson Bays Primary Health was especially welcome, he said.

"Wonderful – a minimum of fuss. It's nice that they can come to their own team room environment and get it done."

People were able to make their own decisions about the vaccine, but it was important to consider the "greater good of the community," Les said.

"The TRU encourages any one of our fans who is sort of vacillating between getting vaccinated or not, to make that decision for the greater good of the community and get vaccinated.

"It'll all mean that we can come out of this and into normality quickly."

Normality also means everyone can enjoy a game of footy in the spring time sun.

"We want to be playing rugby in front of a full house at Trafalgar Park and Lansdowne Park in Blenheim."

The Nelson Bays Primary Health vaccination team held a clinic in the player's room at the Mako headquarters. 21 players and staff were vaccinated with a mix of first and second doses.

***Right to left:** Max Hicks, Rebecca Colley, Ngaire-Dawn Munro, Les Edwards, Steph Anderson, Caroline Bureka, Brittani Beavis, and Megan Spick.*

Taina Fox-Matamua was one of 21 Mako players and staff vaccinated at a recent clinic run by Nelson Bays Primary Health at the Tasman Rugby Union rooms.

TASMAN MAKO NUMBER 8 TAINA FOX-MATUMUA HAS A PRETTY SIMPLE REASON FOR GETTING HIS VACCINATION: WHĀNAU.

"The reason I came to get vaccinated was to take care of my whānau.

"My baby is two years old. I want to take care of my family, and my kaumatua at home. And looking after the rest of New Zealand."

As a professional sportsperson, Taina's decision was influenced by a heightened sense of exposure as his role requires a lot of travel.

"We travel up and down the country, so our chances [of catching COVID-19] are more than the average person at home. We're more susceptible, so it's time to protect myself and my people."

Tania also said it was important for people to be able to make informed decisions regarding vaccination.

"If you're sitting on the fence don't be afraid to ask questions – I certainly have been.

"Figure it out, learn what you've gotta learn, and then once you're comfortable, come along and get it done."

Selina Hunter and Sang Ni were two of the welcoming faces at sign-in; DHB staff and Chin community translators worked together to offer health services in the community.

SMART CONNECTION BUILDS COMMUNITY

Pharmacist Dee Magee not only knows her community – she's been able to use her knowledge and connections to help improve the health services on offer.

Some years ago, as former refugees became more regular users of her pharmacy in Victory, Dee partnered with NMH to employ an interpreter – who she also trained to work in the pharmacy.

The unique partnership has produced long-term results, and because it is needs-based, it works for any situation – including COVID-19 immunisation clinics.

"I had a pharmacy student at the start of the year from the Chin community, and she got started on contacting people for this clinic."

After a couple of education sessions, the doors of the Victory Community Centre were open all day on Saturday 31 July, with community and cross-agency support.

Interpreters were stationed at every stage of the process, from sign-in to recovery, and proved to be a critical part of the process.

"Often it is the clinical aspects of health care that are quite difficult for [people with English as a second language] to understand.

"Because I have interpreters onsite at the pharmacy they'll come with their hospital letters. If I can't manage, I get Cheryl or Steph at Victory Community Centre to help…it's about ensuring they get the best clinical care."

Long-standing relationships and collaboration are important aspects of the overall success, Dee says.

"It can be quite difficult when you're trying to have a coordinated service. This approach is bringing an efficiency that you wouldn't get otherwise. It's quite a well-practiced procedure…clinicians working together to provide the best service for the community."

Like others involved in delivering the clinics, Dee enjoys the community-centred approach.

"I was sitting looking after babies, it's a lovely atmosphere. They're coming in family groups, so it's not like the other clinics where each individual gets a time, you come on your own and you go through the process. Here people more comfortable, it's reassuring for them."

And the level of reassurance will go up a notch next year as one of the Chin community will become a qualified pharmacist.

"I'm going to have an intern pharmacist with me for the next year and she's Chin, so she belongs to the community we vaccinated today. So they're going to have one of their own community as a pharmacist.

"That's how it should be done - developing the workforce within communities, so the patients are more comfortable approaching somebody for help because they're speaking the same language."

The results speak for themselves. At the two clinics held in July more than 600 people received their first vaccine dose, and had the opportunity to make follow-up bookings.

Dee says she hopes the successful healthcare approach pioneered in Victory can be applied in other communities too.

James Lian, his wife and daughter were some of the more than 300 people vaccinated at the Victory Community Centre COVID-19 vaccination clinic on Saturday 31 July.

CONVENIENCE, COMMUNITY AND CARE

James Lian heard about the COVID-19 clinic through his community. He and his wife and daughter all attended.

"Having the clinic at the weekend is the best time," he said.

James admitted being slightly nervous ahead of the vaccination.

"One of the ladies told me there might be a little pain with the injection."

He turned his head away so he didn't have to look.

"I couldn't feel it. Finished – just like that! Amazing."

James was appreciative of the care he received.

"The people were all very good. [It went] smoothly, and I didn't have to wait long."

WORKING TOGETHER FOR VICTORY COMMUNITY

Refugee and public health nurse Sheryl Hockey is pleased with the results she saw at the community COVID-19 vaccination clinics in July.

"Three hundred and twenty people said yes to coming," she said. "Through Dee the pharmacist, and the interpreters getting in touch with people, that represents nearly half of the Chin community in Nelson."

But good numbers through the front door didn't necessarily mean getting people through the vaccination process was a cake walk.

"This is a community where western-style names are generally not used. The first challenge is getting the name and the NHI number. It can be difficult, because names do change, from driver's licence, to hospital records. Family groups can also be different.

"We had a list from the pharmacy, and we were also on Health Connect South, so we could match it all up."

Once an NHI number had been located, people could go through to reception where the appointment was put onto the COVID-19 Immunisation Register.

People were then escorted to the pods where vaccination took place. The community clinic was able to see patients in family groups; sometimes up to three or four people at a time.

"An interpreter was available at each pod to answer any questions the patients may have had about the vaccine or the process. They also checked if people were well, or were taking other medication and so on.

"All the interpreters have such good knowledge of the community – it makes our job much easier.

"Once everyone was vaccinated, they would go through to recovery. There was a handover from the vaccination nurse to the recovery nurse. Again, there were two interpreters in recovery to check on patients and help with any communication needs."

Re-bookings for second doses were also available while people waited in recovery.

Sheryl is convinced the needs-based and community-centred approach is the way to go and the number of people in attendance back up the success of the model.

The communities are grateful for the effort and care that goes into each clinic with each community taking it is turns to cook a lunch.

"We've got close relationships with the PHO and the DHB and the community," Sheryl said.

"It helps to decipher systems and processes for people, and gets the clinical care where it is most needed."

Refugee and public health nurse Sheryl Hockey (left), pharmacist Dee Magee (middle), and community nurse Steph Walker (right) combine skills, experience and rock solid working relationships to deliver needs-based community centred COVID-19 vaccination clinics for former refugee and migrant communities.

LAUGHTER, CONVIVIALITY AND VACCINATION

A vaccination story from the field by reporter Richard Liddicoat.

One of the many success stories in the Nelson Marlborough response to COVID-19 is the care offered to aged and vulnerable populations by the team of vaccinators from the public health nursing service.

One of the team, Jessica Sturrock, said the scope of the work was wide and varied.

"As well as the aged residential care (ARC), we're doing all the vulnerable house-bound people, visiting the homes of anyone who can't get out to a clinic. The idea of the service is to go to them."

When I met the team at Oakwoods Retirement Village in August, it was their second clinic. Earlier that morning they had visited a supported accommodation facility.

Charge nurse manager for the public health service Nicola Thompson says Nelson Marlborough was one of the first districts to start this outreach work.

"The ARC programme started in late March. The amount of time and effort required was considerable as the ARCs are a home not a clinical environment, so it often required a bit of planning to set up a vaccination event."

Nicola says these challenges meant the team initially spent time working on the right model of care.

"Traditional models may not work for vulnerable communities. We took an approach where we're developing alternative models of primary health care.

"We're also dealing with vulnerable people where they might have a whole range of issues we have to deal with in the short time frame of a vaccination event."

Logistical challenges added another layer of complexity. The vaccine required cold storage; vaccinators needed to be trained; and internet access to the COVID-19 Immunisation Register (CIR) had to be available everywhere the team went.

Remarkable then, that within a couple of months, all of the facilities had been visited, thousands of people were vaccinated and most clinics were complete.

"More than 2000 people over 48 clinics across Nelson Marlborough (not including catch-up clinics such as the one today)," Nicola said. "Most clinics averaged 100 people, with the biggest clinic being approximately 250 people."

This clinic was a smaller event, to cater for people who had missed earlier opportunities or who had moved into the facility recently.

"Now we're doing a bit of catch-up and that will be ongoing."

Oakwoods Retirement Village manager Andrew Morrison says the service has been continuously improved.

"It's a one-stop shop, and it's hugely appreciated."

"There's a sense of cooperation and shared purpose around what we're doing. The first visit we were kind of working it out, but we've had various iterations of improvement.

The first patient of the day, Beverley Pullar, was determined to get her first vaccine dose.

"I want to get it done," she said. This was no time for fence sitting. Her advice to anyone still contemplating their decision? "Get it done."

It was the second shot for Rex Strawbridge, and while he appreciated the care and the work of the visiting team, he didn't want to muck around, either.

"They've been very good. The first one, I never felt a thing. I can't wait to get [the second dose] done. Bloody keen! Got to get rid of that disease."

The third patient of the day, Alex "Johnny" Johnstone, is a bit of a star at Oakwoods – he's recently hit the 100-year-old mark.

"I'm used to getting inoculations and vaccinations," he said. "I've travelled quite a lot."

Serving in the air force during World War II, he visited Ireland, England, Ghana and Nigeria. He also studied Russian, then got a job for the Department of Foreign Affairs. He was working in San Francisco as vice-Consul when he was asked to help open the New Zealand Embassy in Moscow.

We could probably have spent all day talking, and perhaps that was the real evidence of success – chatter, laughter and conviviality – all delivered at the same time as a vital health service.

Top Left: *Nicola Thompson and Andrew Morrison (right) say the one-stop shop approach has made delivering the vaccination service much more efficient.*

Top Right: *Jessica Sturrock and Alex Johnstone enjoy a chat at the Oakwoods Retirement Village.*

Bottom Left: *Got to get rid of that disease: Nicky Cooper gives Rex Strawbridge his second vaccination at Oakwoods Retirement Village.*

Bottom Right: *Beverley Pullar and Nicola Thompson catch up after the vaccination.*

A MOMENT OF APPRECIATION

Caroline Allen, Community Pharmacy Facilitator, encouraged us to reflect on the contribution of community pharmacists on World Pharmacists Day, Saturday 25 September.

Pharmacists don't just count tablets, Caroline says.

"Pharmacists are medicine experts and check that medicines you have prescribed are safe for you to take and they advise you on how to take medicines for the best effect.

"They are the first place to go for the whole family for advice about whether an ailment can be self managed or if it needs medical treatment. They can provide support for people having problems managing their medicines or long term conditions.

"They can help with disease prevention in the form of vaccinations and lifestyle advice including smoking cessation. There's a whole range of services available, so whatever your health needs, ask your pharmacist!"

Andrew McGlashen, pharmacist and owner of McGlashen's Pharmacy Richmond says that he is honoured to represent Nelson Marlborough pharmacies in high-level health discussions for our region with the Top of the South Health Alliance.

"During the COVID-19 pandemic, pharmacies have been a key part of a collaborative and integrated health work force continuing to offer a high level of service to the community, and I am particularly proud of the on-going roll-out of the COVID-19 vaccinations by community pharmacies," Andrew says.

Caroline also says she's proud of pharmacists' role in the vaccination programme. The Ministry of Health report that 14% of vaccines have been administered by community pharmacists.

"I am very proud to be a pharmacist and to work with, and represent, pharmacies across Nelson and Marlborough and it is a privilege to be part of the wider healthcare team," Caroline says.

"My colleagues and I are pleased to support the community pharmacies, and to see our communities taking up the COVID-19 vaccine to protect themselves, their whānau and ultimately their freedoms. By working together, 80% of the local community has received their first vaccine and 49% are fully vaccinated, helping us to unite against COVID-19."

Above: *Pharmacists Caroline Allen and Andrew McGlashen take time to reflect on World Pharmacists Day in September.*

PROVISIONAL VACCINATORS AT THE READY

Jenny Wraight is a registered nurse who works in the casual pool. She's also a nursing tutor at Nelson Marlborough Institute of Technology.

But on a winter's day in August, she was the student – and being assessed under the knowledgeable eye of Marion Thomas of the Immunisation Advisory Centre.

"I've done all my theory work, and I've become a provisional vaccinator," Jenny said.

"I recognised as a registered nurse it was an ideal time for me to become a vaccinator and be involved with the rollout of the COVID-19 vaccine in the community."

Jenny is one of hundreds of people across New Zealand who received training and assessment to be granted provisional vaccinator status for the COVID-19 vaccination rollout.

Her assessor Marion has been busy with assessments in the Nelson Marlborough region since March, after moving down to Nelson from the North Island. Previously, she also completed an assignment in Samoa.

Vaccinators come from a wide range of backgrounds, Marion says.

"I've had paramedics, retired nurses returning to the workforce, I've had pharmacists – I had a dietitian yesterday. Medical lab people also come through, and we're getting some third-year students from NMIT."

Jenny says the experience is highly valuable for the students.

"It's very exciting for our nursing students to be involved in this type of thing. It's happening out in the community rather than in the hospital – there needs to be quite a big focus on that – and it gives them a lot of community experience."

Although the job may appear easy, Marion reiterates being a vaccinator is more than simply giving people a shot in the arm.

"You've got to ask the questions, and make sure that you have made a clinical decision to vaccinate that person."

That's where appropriate training and assessment comes in. Jenny says she gained a lot of knowledge from the course.

"Even as an experienced registered nurse I must admit I learnt a lot from doing the full vaccinator course. It's broadened my scope and it's great for me to have that knowledge as a tutor."

The course can be challenging, Marion says, but participants find it worthwhile.

"Especially for those that have retired…some of them have found it quite hard. But they say the challenge has been interesting and they enjoy coming back into the workforce and knowing they're doing something for the community."

PROVISIONAL VACCINATORS HELP WITH STAFF INFLUENZA CAMPAIGN

Increasing availability and accessibility to vaccines was the driver for registered nurse Lynn Main to become a provisional vaccinator.

"People are more aware this year about hand hygiene and staying home if they are unwell," Lynn said. "Vaccination adds that extra layer of protection. So lots of people are saying yes."

Lynn saw an expressions-of-interest piece on becoming a provisional vaccinator on the intranet. She took up the challenge and after completing the training, now has an authority letter enabling her to provide MMR, influenza and COVID-19 vaccinations over the next two years.

"The COVID-19 response was still gaining momentum at the time, so in the meantime I thought I would help with the staff influenza vaccinations."

"Sally Puklowski was the only one able to support our ward (Nelson Hospital's Intensive Coronary Care Unit). Having two ward vaccinators to cover around 50 staff in our unit seems a lot more manageable."

The duo provide great coverage for the ward, being available to support staff on night shift, afternoon shift or mornings.

"People are surprised at how easy it is, because I come to them.

"This year was a lot less intrusive for the staff, instead of coming in on their day off or having to go somewhere to go get it, I could just be in the ward and do it. It's really quick and they can get back on with their work.

"They did have people come round to the ward last year but it's hard to match with when people have time."

Lynn is happy that between herself and her vaccinator colleague they have completed vaccinations for people who wanted them.

"Getting vaccinated is important because you are protecting not only yourself but everyone else in the ward from the flu. If everyone is sick, we will be doing more overtime, picking up shifts. It feels good to have that sorted for our ward."

Lynn has also spent time reminding people what they get both the COVID-19 and the flu vaccination, with space between the two.

PROTECTING VULNERABLE MUMS AND BUBS FROM FLU

Midwives Silke Powell and Tarn McConaghy are making it easier for Wairau Hospital midwives to protect mums and bubs from the flu.

"It has been great being able to make it easier for people," said Silke. "I've found that it isn't necessarily that people don't want to have the flu vaccination. It's that it needs to be convenient."

One benefit Silke and Tarn find in vaccinating their colleagues is that they can incorporate flu vaccination into the shift workflow making the most of opportune moments.

"We can work a night shift and vaccinate people there," Silke said. "We can catch people at that available moment lowering the barrier."

Tarn agrees time is the biggest barrier.

"I think everyone has gotten the COVID-19 vaccine so that has been the real priority. And then we can keep reminding people that we are available to provide the flu vaccine."

Silke explains the unique opportunity COVID-19 and the provisional vaccination programme has enabled for a workforce that traditionally provides vaccination education and information, rather than delivery.

"There has always been a little course in the background that midwives can do but in the whole country I only know of one person who has ever actually completed it. She lives very rurally and so she provides it as a service.

"We generally talk to parents about vaccinating their babies but we don't perform the vaccination ourselves."

Responding to a call for vaccinators as part of the COVID-19 response, Silke and Tarn completed the training through the Immunisation Advisory Centre (IMAC).

"I thought I was doing a basic COVID-19 training," Silke said, "but we needed to do the full provisional vaccinator course and then a tag on for COVID-19."

"When we were completing it there were still so many unanswered questions about which vaccine we were looking to use or how it would work.

"Then we had to do another webinar and a practical signoff. And needed to have resuscitation certificate as well. So there was a lot of bits of the puzzle to put together which caused a bit of frustration but the online course itself was very well written and good."

As well as providing flu vaccinations for their colleagues in the maternity unit at Wairau Hospital, the duo also undertake shifts at the Blenheim COVID-19 vaccination clinic.

"It's a mammoth task," Silke said. "It is monumentally relentless. We do about 500 a day in Blenheim with six vaccinators. And that is just at the main clinic, six days a week. They also do outreach clinics."

"It's very extensive. It is a lot of people to get through. After one day, I'm thinking how many people are there in Blenheim! Where do they come from? But it has gotten slicker over time and is very well organised."

CELEBRATING 10 YEARS OF THE COMMUNITY ORAL HEALTH SERVICE

Dental surgeon and Clinical Director Philip Sussex is looking forward to the next 10 years.

We have a fantastic team of motivated staff who are committed to top-quality universal free dental care for our children.

How did it all begin?

In the early 20th Century Plunket's founder Dr Truby King recognised just how important childhood oral health is to our health generally. This year the New Zealand School Dental Service celebrated its 100th birthday.

In the early 2000's however, it became increasingly apparent that the old model of small clinics at individual schools, with therapists working in isolation, was no longer fit for purpose. The Community Oral Health Service was established in 2011 as part of a nationwide reorganisation of how we provide oral healthcare to children.

What have you noticed as a result?

The multi-clinic hubs and mobiles are all about staff working together and supporting each other as a team – they use modern equipment to provide top-quality oral health care with caregivers actively involved in the experience.

What should we be looking to address over the next 10 years?

Our key focus for the next 10 years is delivering oral health services to those whānau for whom engaging with the service is most challenging. The oral health of our tamariki varies hugely across Nelson Marlborough. Moving forward we need to focus on innovative strategies that improve oral health equity for everyone.

GREAT SMILES START AT THE DOOR

It is no easy feat to book oral health check-ups and follow-ups around children's extracurricular activities and parents' work commitments.

In addition, bookings for the rural mobile service and the demands of a constant stream of face-to-face activity add to the workload for our largest Community Oral Health Hub in Blenheim.

And yet for Rawinea 'Winnie' Harper, it is all in a day's work.

"I love it. The people I work with are amazing and I love seeing all the different people coming in."

Winnie, who is one of seven receptionists and two service administrators in the Community Oral Health service, understands the value of a warm welcome.

"Sometimes children can come in a bit scared, or hide behind their parents, but you just talk to them about who they are going to see, or anything really, to take their mind off it and they soon come round," Winnie says.

Oral Health Educator Heidi Owers says receptions staff play a really important role in making sure children, and parents, leave with fond memories of their oral health experience.

"The kids love the waiting room. Everyone knows everyone in Blenheim; it's very friendly. Celebrating the faces of the people who work here helps us to show that connection."

In celebration of the 10 year anniversary the waiting area was decorated and a competition run for the children.

"The kids loved it," Winnie says. "They were excited to discover that we would have a birthday too. Birthdays are a big deal for kids.

"There were three prize boxes filled with all sorts of things like lunchboxes, toothbrushes and a fidget toy.

"The kids had to answer a few questions in a quiz and then pop the answers into a prize box which was a shaped like a shark's mouth. With lots of teeth."

Heidi says it was really precious to see the answers to the quiz which included a question on what the children liked about the clinic.

"The children put in a lot of effort, we got some really creative answers."

***Above:** Ashley Turrell and Winnie Harper (front) and Alofanga Palanite, Catherine Houston, Nicola Fowler and Kate Logan (back), welcome whānau with big smiles at the Community Oral Health Hub in Blenheim.*

A DYNAMIC DUO – WENDY AND MARG

Dental therapist Wendy Barry and dental assistant Margaret Croft teamed up 10 years ago when the Blenheim Community Oral Health Hub was established.

They are a well-rounded duo whose ability to make meaningful connections is evident, not only in their Blenheim clinic but also on the road as they take the mobile clinic into rural areas.

"We knew each other quite well previously, but we know each other very well now," says Wendy jokingly.

With 36 years continuous service and more than 50 years since graduation, Wendy is looking forward to this being her last year, or one of her last years at least.

"In the old school-based clinics, we did focus on prevention and education, but it is more in-depth now. The opportunity is greater as parents or caregivers such as grandparents come along for the visit," Wendy says.

This is something Marg values too. "It means we can really talk to people. In the old service children used to come up from the classroom and you would send them home with a form for parents to sign if they needed treatment."

"It might have been more convenient, but it didn't help parents to engage with oral health for their children."

Looking to the future the team are keen to restore principles of continuity of care, broadly defined as an ongoing relationship between a healthcare provider and a patient, or a consistent approach to the provision of someone's care. It can come under pressure in a public health system which needs to treat large numbers of people.

"Continuity of care is sneaking back into conversations," Wendy says. "This really helps us to develop relationships with children, parents and families to make an even bigger impact."

WORK THAT'S WORTH SMILING ABOUT

Of all the responsibilities she's had in her 40-year career, it is providing continuity of care and establishing long-term generational relationships that brings the biggest joy to dental therapist Jeannie Dobson. For dental assistant Emma Coles, it's the endearing nature of working with children.

"You wouldn't do this this job if you didn't like children," Emma says. "I've seen some little pre-schoolers come in and followed them right the way through to year 8."

Jeannie and Emma have worked together for the past 12 years, meaning they worked through the changes to the Community Oral Health Service together 10 years ago.

"We never would have been able to get modern equipment for every small school dental clinic," Jennie says.

"It would have been too expensive especially with the upgrades and maintenance needed to ensure equipment meets today's health and safety standards."

They both agree that the biggest change in paediatric dentistry has occurred in the last five years with the introduction of stainless steel crowns for baby teeth.

"They are very successful. They never cause issues, whereas a filling in a baby tooth can break and require repeat treatment," Jeannie says.

"For stainless steel crowns all we need do is put little bands in between the teeth for a couple of days to create a gap. You then find the crown that fits, put in some dental cement and place it over the tooth. It then stays in place until the tooth comes out naturally."

The pair are very conscious of creating a positive experience for children.

"Some children can be anxious, however it is very rewarding over time when we see their confidence grow. It is special to be able to see them manage their treatment and feel happy and positive about their experience."

"But the best thing is when they have no cavities."

HEALTHY SMILES

- Brush with fluoride toothpaste for 2 minutes twice a day.
- Spit but don't rinse.
- Under six years use a smear of toothpaste.
- Over six years use a pea-sized amount of toothpaste.

HE NIHO PĒPI HE ITI KURA
PARAWETIA RUA WA, IA RA

General phrases

Have a go at these simple, everyday phrases.

Hello

Kia ora

Tēnā koe

How are you?

Kei te pēhea koe?

E pēhea ana koe?

Kei te aha koe?

Did you know?

Kia ora

means

Thank you

as well as

Hello

Good

Kei te pai

E pai ana

Ka nui te ora

Bye

Hei konā

Haere rā!
(speaker stays)

E noho rā
(speaker leaves)

Check out our great audio tips to help with your pronunciation of Māori here: **www.tetaurawhiri.govt.nz/resources**

'Kia ita!'
Te Taura Whiri i te Reo Māori
MĀORI LANGUAGE COMMISSION

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