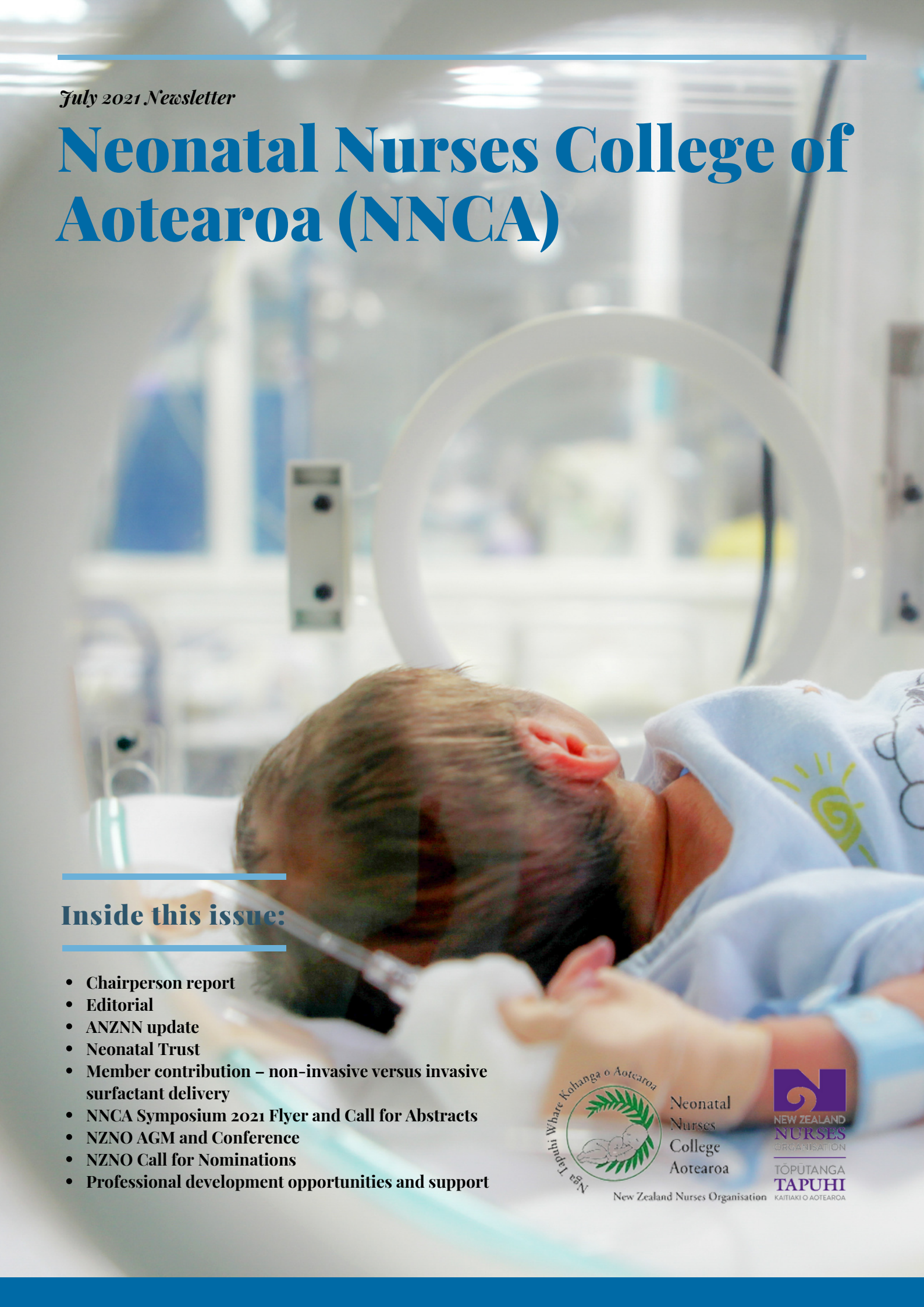
July 2021 Newsletter

Neonatal Nurses College of Aotearoa (NNCA)



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TŌPŪTANGA TAPUHI KAITIAKI O AOTEAROA

Chairperson's Report

Presented by Merophy Brown, Chair

Covid continued to impact the day to day planning of neonatal care. Despite the decrease in total births, NICUs and SCBUs throughout the country have continued to be over capacity with high acuity.

As a College, our committee continued to have our regular meetings to ensure core business remained ongoing. We came to have a new-found love for Zoom which kept us connected. Conversations continued to take place with the national newborn clinical network regarding the ongoing concern with over capacity. The following is a summary of NNCA's Annual Report for the NZNO AGM in September.

IMPROVED HEALTH OUTCOMES:

- Emphasis on developmental care, providing a co-ordinated, consistent approach nationally through planned delivery of FINE training in a multi-centred roll out
- Supporting work on implementing MoH recommendations to operationalise Transitional Care. This will reduce unnecessary admissions to SCBU/NICU, relieving pressure on cot availability at a time of increased demand, and reduce unnecessary separation of the mother and baby dyad.

SKILLED WORKFORCE

- FINE training planned
- We were able to hold our annual symposium, which was a good opportunity for neonatal nurses throughout the country to network.
- AGM was held in November 2020. Following the successful completion of her tenure we said a fond farewell to our outgoing Chairperson Gina Beecroft and new Chairperson Merophy Brown was elected
- Role-specific professional meetings were held for Nurse Managers, Nurse Educators, Nurse Practitioners, and ANZNN data collectors, and overall the event was a great conduit for networking.
- CCDM FTE calculations have been underway in many units with some now completed. These calculations have identified a significant deficit in some areas and data is now being used to support necessary recruitment to additional nursing posts.
- Continued participation in ANZNN
- Presentation of Neonatal Nurse of the year, recognising ongoing contribution to Neonatal nursing

STRONG WORKFORCE

- With anticipated increased FTE being available there is a drive to get more nurses interested in Neonatal Nursing through structured orientation programmes
- Availability of internationally qualified neonatal nurses looking to relocated has been restricted due to Covid
- Theme of healthy workforce and wellbeing activities for staff evident across DHBs
- Continued to work on improving national sharing, collegial networking, sharing of practices, guidelines and experiences

EFFECTIVE ORGANISATION

- Use of Zoom to support ongoing meetings where physical gathering potentially limited
- Increased use of different social media platforms and technology to engage members more effectively
- Reviewed scholarship application process
- Work in progress to formalise MOU with Australian College of Neonatal Nurses (ACNN) and the Neonatal Trust
- Representation on National Newborn Clinical Network
- Formalising standard operating procedures for Chair, Secretary and Treasurer roles in preparation for those holding these positions currently standing down at the end of their term. This should help ensure continuity and consistency.
- Reviewing and updating current resources
- Financially healthy, reinvesting in the members, through scholarships and COINN membership
- Quarterly newsletter

Nāku noa,

Merophy Brown
NNCA Chairperson

Juliet Manning

From the Editor

Negotiations continue for the NZNO DHB MECA with member surveys collecting views on what further action (if any) will be taken in response to any changes to the proposed offer from the DHB negotiating team. The strike action taken on June 9th created some challenges for NICUs and SCBUs across the country with staffing levels in some areas exceeding what would normally be available day-to-day. Comments and discussion on social media sites suggests that this issue was consistent across other inpatient wards and specialties, and sends a very clear message that staffing levels within workplaces often fall short of those required for "life preserving services". Its clear that areas across all services require additional resources to achieve safe staffing levels. It is heartening to see the recent increase in FTE for RNs and senior nurse roles achieved in the Wellington NICU through the CCDM process Wellington neonatal unit gets big staffing top-up – Kai Tiaki Nursing New Zealand. Other units around the country are working through the CCDM FTE calculation process and looking forward to having robust data that backs up what nurses are saying about workloads that impact on patient and staff safety. The next challenge will be recruiting staff from our already under-resourced nursing workforce.

As the MECA negotiations stretch out over several months, many are wondering how the negotiation process will look from July 2022 when proposed health reforms come into effect with the creation of the Health New Zealand (HNZ) and Maori Health Authority (MHA) entities. The government has allocated $480 million to support the transition to the new health entities, beginning with the establishment of a transition unit headed by former director-general of Health Stephen McKernan. Health and Disability Review Transition Unit | Department of the Prime Minister and Cabinet (DPMC) Indications are that over the next few months there will be new laws introduced as the foundation for the proposed reforms, with these laws being presented to parliament in September. These changes would effectively see DHB nurses transferred to the employment of HNZ and/or MHA, and would include the transfer of employment contracts that extend past July 1 2022. How the negotiation process will work from there is still unclear. What is clear though, is that nurses are determined to achieve remuneration and working conditions that recognise our level of education, professional practice and commitment to safety for patients and staff.

On a brighter note, the June issue of Kai Tiaki featured our NNCA Treasurer Helen Barwick talking about her career in neonatal nursing. Helen is a great advocate for neonatal nursing and gives a heartfelt description of the challenges of balancing science, technology and continual learning with the care and empathy that characterises neonatal intensive care. 'A lot more joy than sadness' in neonatal care – Kai Tiaki Nursing New Zealand.

Stay safe, be kind, and look after each other as we work our way through the MECA negotiations and whatever collective action that entails.

ANZNN update

Hello to all ANZNN Tertiary Data Managers and wonderful contributing neonatal nurses in the Level 2 Neonates/SCBU's.

Your DHB's continued contribution to ANZNN contributes to many ongoing research studies, care and treatment improvements and reminders to services to keep a close eye on vulnerable babies and toddlers. The year is slipping past and data deadlines are looming. The usual qualifying babies (born at less than 32 weeks gestation, or weighing less than 1500 grams, or who had respiratory support for four hours or more, or had major surgery, or who received therapeutic hypothermia) birth to discharge data for 2020 is due by July.

It is always appreciated and makes the data collecting so much easier, if the discharge summary contains the data that is required. If you are constantly reading every line of the notes to find dates/times/total hours etc, try speaking to your unit manager and adjust the baby's discharge template to include the required information. When changing a template please inform the technical support that ANZNN may change the data collect yearly.

I'm not sure if all are responsible or aware that these very small babies are followed up again at 2-3 years. It has been expected the tertiary centre collects this information but as NZ families move about as they do, this data request can lead to non-tertiary Developmental Services or Paediatric services completing the assessment and thus data to collect. Though I'm aware ANZNN data collection expands beyond the neonatal period, currently the other services are extended to the point the data collect has fallen on me, the neonatal nurse, who collects data in my "down time" and happens to know how the data collect system works.

I've requested ANZNN, through Sharon Chow, to develop a guideline document of data collection responsibility and rationale for non-tertiary DHBs to give all data managers or collectors and Service Managers the background for the resources for the time involved to submit this data.

As a reminder, the 2-3 year follow up data of babies born 2017/18 who were less than 28/40 or less than 1000g is due by July. For the 2017 births, ANZNN added follow up for any baby who was cooled for any length of time. This data collection is to determine growth and development of the toddlers and should include information on the Bayley's assessment or, in the least, an informal examination to determine sight, hearing, movement, oxygen requirement, type of feeding, growth, weight and height. This information can reflect on the care provided from birth. The next ANZNN forum will be held in November in Hawkes Bay, a day prior to the NNCA annual symposium. With thanks to NNCA there is no charge for attending the ANZNN data manager forum. Agenda topics will include consent process, parental introduction, and engagement towards the 2-3 year follow up and upcoming new data requests. Sharon Chow will join us via Zoom to answer any queries.

Any further topics are welcomed and can be emailed to me.
Looking forward to a sunny and warm information sharing forum in Hawkes Bay!
Barbara.Hammond@wdhb.org.nz
Whanganui DHB
He Hāpori Ora - Thriving Communities

Neonatal Trust

The Neonatal Trust continues to go from strength to strength in supporting neonatal families and units across Aotearoa New Zealand and aims to continue growing throughout 2021. It goes without saying that 2020 was a difficult and traumatic year for many, however, this has confirmed our resolve to 'do more for more families' and we've got a great plan to go with this mantra.

For families whose baby enters a NICU or a SCBU a care pack is now provided for each of these families and is no longer received based on the gestation of their baby at birth - we feel any time spent in a unit deserves support. Our aim is to continue with these packs being made available at all of the units plus we've reached out to create long-term partnerships for us to expand the items included in this pack so watch this space. Should your unit need a replenishment of these items, do sing out!

Our team has expanded in the last year to include Jadey in the Waikato, Anoushka in Dunedin and more recently Catherine in Auckland, with recruitment in play for Middlemore and Christchurch. Plus we are setting up volunteer veteran parents to host a weekly or a fortnightly morning tea at a variety of other units such as Lower Hutt, North Shore, Waitakere and New Plymouth and we'd love to see this extend to as many units as possible. If you think this could benefit the families in your units and there is somewhere either on the unit or within the hospital where we could host this do get in touch with me so we can make this happen!

In addition to this we've provided Graduation Certificates and selfie frames, plus '100 Day' certificates for units to gift to families, and of course Mother's Day wouldn't be complete without our bag of goodies for the amazing mamas. Father's Day is hot on its heels and we'll be in touch with each of the units about this closer to the time.

Beyond the units our post-discharge playgroups are spreading across the country and we now have six regular groups (Auckland, Hamilton, Hawkes Bay, Tauranga, Wellington and Dunedin) for families to attend free of charge. These groups are facilitated by either a Physiotherapist or an Occupational Therapist who is there to answer questions and offer advice in terms of baby's development plus it's a great space in which families can connect with other families who just 'get it'. We'd thoroughly appreciate your help in letting parents know about this service, do feel free to point them to our website or Facebook page for details on the groups in their area. Ideally by the end of 2021 we'll have more group set up - we've got Whangarei, New Plymouth, Palmerston North and Christchurch in our sights.

And in order to ensure we're providing the right type of support and also how we can increase our services we will soon be conducting an independent survey with families and the teams in the units to help us determine where we need to focus our attention and what best practice support looks like, so do keep any eye out for this and encourage families and teams to partake as the more information we get the better we can support you and your families. We're truly grateful for the support shown to us by each of the units and hope that the work we do benefits all who come into contact with us.

Nga mihi
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Neonatal Trust

Care packs for all NICU families

Graduation Day selfie frame

Developmental Playgroup

Mother's Day gifts

Morning Tea provided recently

Member Contribution

Less Invasive Surfactant Administration (LISA) / Minimally Invasive Surfactant Therapy (MIST) versus INtubation – SURfactant – Extubation (INSURE) in preterm neonates

Alison Pile
Registered Nurse
NICU, Dunedin

Respiratory distress syndrome (RDS) is a common condition that affects premature neonates (Lau, Chamberlain, & Sun, 2017). It is directly caused by a deficiency of surfactant in the lungs. Surfactant deficiency causes elevated atelectasis at the end of expiration, poor pulmonary compliance, and ineffective clearance of the fluid filling the collapsed airways. (Holme & Chetcuti, 2012) The disease process of RDS is detailed, as its effects are multifactorial but overall are identified by gas exchange impairment, acidosis, and ventilation to perfusion mismatch. (Sinha, Miall & Jardine, 2018. Holme & Chetcuti, 2012). If RDS is left untreated, it increases the likelihood of intraventricular haemorrhage, patent ductus arteriosus, chronic lung disease, pneumothorax, necrotising enterocolitis, ultimately resulting in respiratory failure.(Sinha, Miall & Jardine, 2018).

Over the last several years there have been many advances in the treatment of RDS as new knowledge of the illness is discovered. Treatments such as antenatal steroid administration and postnatal exogenous surfactant replacement therapy have been two of the most effective treatments for RDS (Nanda, Nangia, Thukral & Yadav, 2020). The use of early surfactant administration has been one of the most beneficial treatment advances (Gortner, Schüller & Herting, 2018). Effective surfactant treatment allows for the effective gas exchange and ventilation-perfusion match by increasing lung compliance and preventing the alveoli from collapsing on expiration by creating a moist lining to the alveoli (Holme & Chetcuti, 2012). This would be clinically obvious by increased oxygen saturations and decreased fraction of inspired oxygen (Fi02) requirement. The overall goal of surfactant delivery is for rapid delivery to reduce airway obstruction time, and widespread coverage to all of the lung tissue as effectively as possible (Nouraeyan et al., 2014).

The delivery of surfactant varies depending on the method each NICU and clinician uses. This essay will be comparing two common administration techniques. These are MIST (minimally invasive surfactant therapy) or LISA (less invasive surfactant administration) and InSurE (intubation - surfactant - extubation) otherwise known as invasive surfactant therapy (De Kort, Reiss & Simons, 2013).

Surfactant replacement therapy has been used clinically to treat RDS for more than 30 years (Aldana-Aguirre, Pinto, Featherstone & Kumar, 2016). Evidence shows that the use of prophylactic surfactant delivery dramatically reduces the negative outcomes linked to RDS in neonates. (Roberts et al., 2021). In the past, studies have shown that there was a lot of trauma caused by routinely using mechanical invasive ventilation for every neonate suffering from RDS (Shim, 2017). Due to the subsequent increase in associated lung injury, there was a shift towards using non-invasive respiratory assistance such as CPAP (Morley et al., 2008). Research then further showed that non-invasive respiratory assistance was further enhanced by the use of surfactant therapy (Gortner, Schüller & Herting, 2018). The current controversy among medical staff in the ongoing discussion of the best treatments for RDS is which of the mechanisms of surfactant delivery is best.

LISA/MIST

MIST or LISA is a mechanism of delivering surfactant into the neonate's lungs without fully intubating the neonate to treat RDS (Aldana-Aguirre, Pinto, Featherstone & Kumar, 2016). As invasive surfactant delivery often requires the neonate to be consequently connected to some form of mechanical ventilation, it triggered the search for another delivery method with fewer side effects and removed the need for mechanical ventilation (Herting, Härtel & Göpel, 2020). Several different techniques have been developed as a less invasive administration technique (Reynolds & Lillitos, 2017). The newer technique that is used in clinical practice today is using a catheter to pass through the neonate's trachea into the lungs and administering the surfactant while the neonate continues to breathe using a non-invasive respiratory mechanism (Shim, 2017). LISA/MIST requires a small angiocath to be inserted through the trachea into the lung space, a CO2 detector is usually then placed on the end of the angiocath to confirm correct placement. Surfactant dose is then administered in a steady continuous push (Newborn Clinical Network, 2019). LISA/MIST is performed all while the neonate maintains CPAP. MIST/LISA requires the neonate to be spontaneously breath-taking, equal or over 28 weeks gestation, have a chest x-ray to confirm the diagnosis of RDS, and must be otherwise stable with no large apnoeic events and a stable HR (Dargaville et al., 2017). Obviously, the use of some form of CPAP is a requirement and the FiO2 (fraction of inspired oxygen) must be greater than 30%. (Newborn Clinical Network, 2019).

According to a study done by Canadian neonatal intensive care, 95.7% of the babies that received LISA/MIST as the method of delivering surfactant were successful administrations and did not require further intubation or mechanical ventilation (Bhattacharya, Read, McGovern & da Silva, 2018). Compared to invasive surfactant therapy, there appears to be fewer side effects associated with the procedure itself. Coughing and occasional transient bradycardias were noted in fewer than half of the neonates, with 36% needing post-procedure positive pressure inflation breathes (Dargaville, Aiyappan, Cornelius, Williams & De Paoli, 2010). Most studies on MIST were done with CPAP insitu throughout the entire procedure as recommended (Newborn Clinical Network, 2019).

Studies have also shown that there were reduced negatives outcomes such as bronchopulmonary dysplasia (Dargaville et al., 2017), a shorter time spent needing oxygen therapy (Olivier et al., 2017), and fewer cases of pneumothorax (Dargaville, Aiyappan, Cornelius, Williams & De Paoli, 2010).

MIST/LISA delivery is shown to reduce the chances of intraventricular haemorrhage (Roberts et al., 2021) as the reduction in RDS symptoms reduces the pulmonary pressures overall allowing accurate pressures to flow through the cardiovascular system (Holme & Chetcuti, 2012).

A complication with MIST/LISA is that the research is mostly on 28 weeks gestation and greater (Bhattacharya, Read, McGovern & da Silva, 2018, Wong, Meyer, 2018). It is the same in New Zealand as this is only a recommended procedure for over 28 weeks' gestation neonates (Newborn Clinical Network, 2019). The study by Wong (2018) focused on the use of MIST for 25-28 week gestation neonates and concluded that neonates of this age group has reduced outcomes of CPAP failure post MIST (Wong, Meyer, 2018). The sample size of this study was 90 neonates therefore further research should be completed regarding treatment of those neonates who are born less than 28 weeks but have spontaneous breaths and are able to maintain breathing without mechanical ventilation. Also, most of the LISA/MIST delivery methods still require the insertion and use of a laparoscopy causing discomfort and potential trauma to the neonate (Herting, Härtel & Göpel, 2020). Further research is still needed to attempt to identify and trail even less invasive methods of surfactant therapy.

InSurE (INVASIVE)

Another method of surfactant delivery is invasive surfactant delivery also known as InSurE (Intubate - surfactant - extubate) (De Kort, Reiss & Simons, 2013). This method involves complete intubation of the neonate therefore, interfering with the neonate's ability to breathe spontaneously (De Kort, Reiss & Simons, 2013). The procedure of InSurE often begins with the neonate being given sedative drugs as per common practice in NZ (Newborn Services Clinical Practice Committee, 2020), endotracheal intubation, then surfactant is delivered down the endotracheal tube (ETT). This tube is then connected to some form of mechanical ventilation, whether that be neo puff or a full ventilator circuit to aid the surfactant to be dispersed throughout the lung tissues, and then a full extubation of the neonate onto CPAP or keep the neonate on mechanical ventilation until clinically deemed stable to extubate (Newborn Services Clinical Practice Committee, 2020).

In the late 1990s-2000s when the benefits of surfactant treatment were well regarded, extremely preterm infants would receive prophylactic surfactant treatment via the InSurE method, placing the neonate directly onto invasive ventilation, which lead to an increase in lung tissue injury, trauma, pneumothorax and prolonged oxygen therapy which collectively lead to more severe chronic lung disease (McCrossan & Sweet, 2018).

A study conducted by Gupta, Saha, Mukherjee & Saha (2020), examines the outcomes of preterm infants who received the InSurE delivery method over the newer MIST method. They noted no difference in outcomes between those who received intubation and those who didn't. It states there is no increase in the neonate needing invasive mechanical ventilation within the first 72 hrs of life alongside no difference in the likelihood of the neonates developing known RDS complications such as IVH and BPD (Gupta, Saha, Mukherjee & Saha, 2020). It is to be noted that for their research, no sedation or medication was given previously to intubation when neonates received InSurE method (Gupta, Saha, Mukherjee & Saha, 2020). It was noted that there was a prolonged hospital stay for those who received InSurE then their fellow counterparts. In some studies, there was a slight increase in the need for a further surfactant treatment for those that received MIST compared to those who had InSurE (Celik et al., 2017). According to Celik et al., (2017), this may be due to the lack of positive pressure to aid the surfactant in spreading to all areas of the lung tissues. It should be noted that in the studies mentioned above when discussing MIST/LISA, all units maintained CPAP while doing the procedure, while the later study does not mention if CPAP was maintained therefore, these findings may possibly be due to CPAP not being maintained during MIST/LISA as it is recommended to be.

A study completed on the risk factors associated with an ineffective INSURE method surfactant therapy concluded that extremely preterm neonates and extremely low birth weight neonates were more likely to have an adverse Insure reaction (Peirovifar, Gharehbaghi & Khogasteh, 2014).

Compared to the literature and research conducted on MIST/LISA surfactant administration method, there is limited available up to date studies about INSURE, as it appears the evidenced based best practice in units is to now begin neonates experiencing RDS and/or extremely premature neonates on non-invasive positive airway pressure ventilation such as CPAP.

A study by Morley et al., (2008) examined non-invasive CPAP vs intubation for preterm infants born between 25-28 weeks gestation. It concluded that neonates who had non-invasive ventilation were less likely to suffer from bronchopulmonary dysplasia or morbidity then neonates who were intubated, but were 9% more likely to develop a pneumothorax (Morley et al., 2008). This is relevant as very preterm infants are the most fragile neonates and often do not tolerate invasive procedures such as intubation without major events (Peirovifar, Gharehbaghi & Khogasteh, 2014). This study demonstrates that intubating these neonates may not be the best practice therefore nulling the need to use INSURE surfactant delivery if avoidable. As sedative premedications are given routinely in some NICUs, the potential adverse effects of InSurE are increased (De Kort, Reiss & Simons, 2013). Some studies state that premedication is linked to hypoxic bradycardia followed by tachycardia once intubated and an increased ventilation requirement post intubation as there is a loss of all respiratory effort (Nrusimha, Rawat, Lakshminrusimha & Chandrasekharan, 2018). Risks associated with intubation also need to be considered when choosing a delivery method. There is a risk of vocal cord tear or damage, scarring to trachea or oesophagus, and potential trauma to lung tissues if incorrectly measured (Celik et al., 2017., Peirovifar, Gharehbaghi & Khogasteh, 2014). The ETT tubes are also firmer than the catheters used in MIST/LISA (Dargaville, Aiyappan, Cornelius, Williams & De Paoli, 2010).

In conclusion, there is a lot of research that has been conducted in regards to the topic of surfactant treatment for RDS in neonates. It is clear that it is a well-respected, widely accepted and effective form of treatment for RDS. From the evidence collected, both methods of delivery are effective and achieve the treatment objective. There is less risk involved, albeit slightly less, to administer surfactant in the least invasive way possible. As evidence shows fewer risks associated with using non-invasive CPAP with surfactant administration, it supports that if there is no clinical need to intubate the neonate, then it is best to avoid it completely. MIST/LISA has fewer side effects in relation to the procedure itself but also the fact that there is no sedation or pre medication routinely given to the neonate is a positive. This reduces risks associated with these drugs and their effect in the neonate. MIST/LISA also is less invasive to the neonate causing less discomfort, yet is just as effective at delivering the surfactant widespread and fast if paired correctly with non-invasive CPAP ventilation to provide pressure into the lungs. The long term outcomes of lower rates of bronchopulmonary dysplasia along with a shorter time on oxygen therapy reduce the risk of potential complications in later life for the neonate. From a holistic point of view, the evidence that neonates therefore, have shorter NICU stays when not put on invasive ventilation as is possibly done when using the InSurE technique, the families can have reduced stress that accompanies shorter NICU stays.

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Hawke's Bay Special Care Baby Unit presents...

the

NEW ZEALAND NEONATAL SYMPOSIUM

"ALL THINGS BEING EQUAL"

Friday, 12 November 2021

NAPIER WAR MEMORIAL CENTRE

CALL FOR ABSTRACTS AND POSTER PRESENTATIONS

The media described 2020 (*ad nauseam)* as unprecedented due to rampage of COVID-19 across the world. This impacted on:

- how we interacted with others,
- lived our lives,
- how we worked,
- who was in our "bubble," and
- navigating the new "normal."

In different ways, COVID-19 impacted us all from a combined:

- fear of the unknown,
- lockdowns,
- changing alert levels,
- economic stresses, and
- living in "bubbles."

Is this an apt analogy to apply to families when neonatal care is required? Did these families need to go into a neonatal lockdown to experience anxiety and fear, daily uncertainty, economic stresses, isolation from home, living alone and being in a different "bubble?"

We know COVID affected many, and it has the potential to increase inequities in health.

- Is this the same for those receiving neonatal care in New Zealand?
- Do we understand the lived experiences of our diverse population enough to provide appropriate support?
- Are we doing enough to address inequities, ensuring resources are spread equitably, so that any negative outcomes do not fall unevenly amongst the diverse population in our neonatal units?

This symposium we look at those experiences, the reality of our neonatal units and if all things are indeed equal?

We want to hear about initiatives that improved the lived experience for all our families or that were targeted as the most in need.

Hawkes Baby Special Care Baby Unit conference committee invite neonatal nurses to submit abstracts for an oral presentation or poster display on topics related to the above.

Hawke's Bay Special Care Baby Unit

are proud to host the

NEW ZEALAND NEONATAL SYMPOSIUM

'ALL THINGS BEING EQUAL...'

Friday, 12 November 2021

NAPIER WAR MEMORIAL CENTRE
48 Marine Parade, Napier

Conference programme to follow

For further information contact:
Michelle Robertson, Nurse Manager
michelle.robertson@hbdhb.govt.nz

NEW ZEALAND NURSES ORGANISATION | TŌPŪTANGA TAPUHI KAITIAKI O AOTEAROA

NZNO AGM and Conference 2021 Wednesday 15 and Thursday 16 September 2021 Museum of Te Papa, Wellington

15-16 September 2021

Museum of New Zealand, Te Papa Tongarewa, Wellington

Wednesday 15 September: Conference is open to NZNO members and non-member nurses, health professionals, and anyone with an interest in nursing.

Thursday 16 September: AGM is open to NZNO members
If you have any queries please email conference@nzno.org.nz
Website: Home (eventscloud.com)

2021 NZNO Board Election

Nominations are now being called for the following positions on the NZNO Board:

- President
- Vice-President
- Kaiwhakahaere
- Tumu Whakarae.

Financial NZNO members are eligible to stand as a candidate. All candidates must be nominated and seconded by two financial NZNO members and be endorsed by regional council, Te Poari or national colleges or sections.
Download the Candidate nomination form.

Candidate information booklet

Any financial NZNO member who is considering submitting a nomination is encouraged to read the Candidate information booklet and familiarise themselves with the Code of conduct and Campaigning guidelines.
The Candidate information booklet is also a great resource for anyone wanting to know more about how the election will be run, even if they do not intend to submit a nomination.
The election is being conducted by electionz.com Ltd, an independent election management services company. Most of the election information will be sent to NZNO members by iro@electionz.com via email, including the calling for nominations and voting details.
Members are encouraged to update their contact details via the NZNO website.

Election key dates

- Nominations open Friday 18 June 2021
- Nominations close 12 noon, Friday 16 July 2021
- Voting opens Wednesday 4 August 2021
- Voting closes 12 noon, Friday 10 September 2021.

Completed nominations must be received by the Returning Officer by 12 noon on Friday 16 July 2021.
If elections are required (i.e. more than one candidate is nominated for a position), the positions for President and Vice President will be elected by a postal and online ballot of financial members between Wednesday 4 August and Friday 10 September 2021. The positions for Kaiwhakahaere and Tumu Whakarae will be elected at Hui ā-Tau.
For further details call the election helpline on free phone 0800 666 044 or contact Returning Officer Warwick Lampp at iro@electionz.com.

NNCA Professional Development Grant

NNCA has up to $10,000 available each year to support Professional Development Grants. The scholarship is $1,000.00 per person. Scholarships of more than $1,000.00 may be awarded at the discretion of the NNCA Executive Committee, and applications are considered at the quarterly national executive meetings or on an as needed basis. Recipients will be expected to write an article for publication in the NNCA Newsletter within six weeks of completion.

Application closing dates:
Jan 31
April 30
July 31
Sept 30

Eligibility: Applicants must be a current financial member of NZNO and a full member of the NNCA College for at least 12 months.
Criteria/Comments:
Courses, seminars, conferences or projects relating to neonatal nursing.
Priority will be given to nurses embarking on research or writing for a peer reviewed journal.
If funds are not awarded they will be made available the following year, up to a maximum of two years.

Get the current application form on the NZNO Scholarships and grants page.

Send applications to:

Scholarships & Grants National Administrator
NZNO National Office
P O Box 2128
Wellington 6140
Fax: 04 382 9993
OR **E-mail:** sally.chapman@nzno.org.nz

There are also a number of grants and scholarships available through the Nursing Education and Research foundation (NERF).

There are a range of grants available that may be useful for neonatal nurses who aren't eligible for the NNCA scholarship as well as undergraduate nurses which may be useful for the shining stars among students on placement in your NICU.

List of available NERF Scholarships with criteria

Minister of Health Volunteer Awards

The Minister of Health Volunteer Awards are an opportunity to recognise the thousands of unsung heroes who support New Zealand's health and disability services.
Organisations can choose to nominate an individual volunteer or team of volunteers. Nominations could be for long-term commitment and achievement, an outstanding success, or action above and beyond the call of duty.
Minister of Health Volunteer Awards | Ministry of Health NZ

The Māori Health Leadership Scholarship programme is an initiative to build equity in health and wellness in Aotearoa New Zealand. It will enable more Māori to be in decision making leadership roles within the health sector.

Workforce development scholarship investment of **$20,000** per annum is available to individuals who are on a trajectory to make a difference in health equity outcomes. A maximum of **$10,000** can be awarded to any one individual in a year and the scholarship can be used to pay for tuition fees, living costs or any bills related to your study.
Apply at: Maori Scholarship - New Zealand Health Group (nzhealthgroup.com)