



Tōpūtanga Tapuhi Kaitiaki o Aotearoa
NEW ZEALAND NURSES ORGANISATION



The Dissector

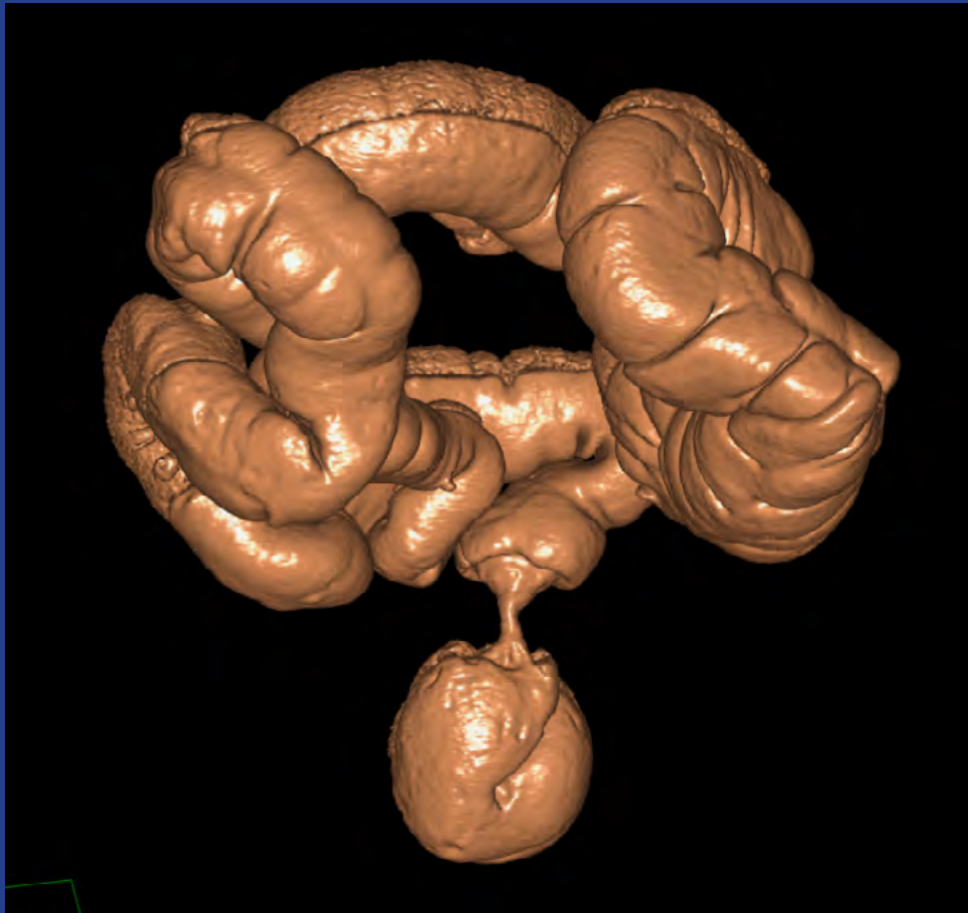
Journal of the Perioperative Nurses College
of the New Zealand Nurses Organisation

Vol. 53, No. 2 December 2025 – February 2026

MEDICAL IMAGING

Developing patient-focused care in outpatient radiology

Managing MRI related claustrophobia • Auckland-Northland Study Day



CASE STUDY: An Orthopaedic Clinical Case Review

PNC ANNUAL REPORTS • PNC REGIONAL REPORTS



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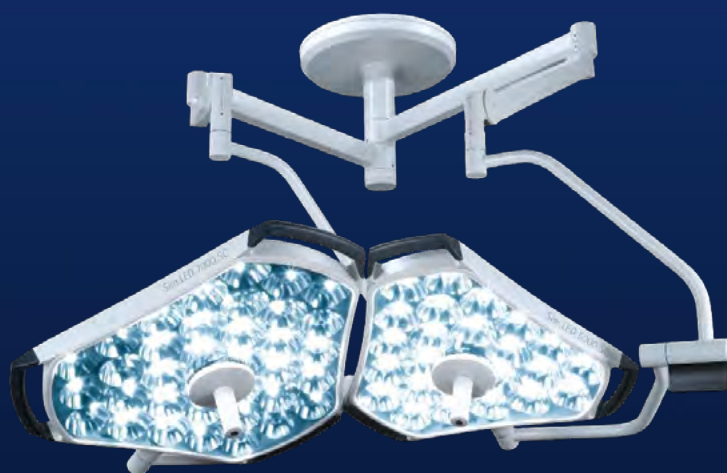
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THE DISSECTOR

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December 2025 – February 2026

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The Editorial Committee of *The Dissector* welcomes articles, reports, book reviews, letters to the editor, exemplars, case study experiences, research papers/projects, theatre regional news etc. Please send your ideas to: dissector.editor@gmail.com

Another challenging year

Tēnā koutou katoa. Welcome to the final issue of *The Dissector* for 2025, which is simultaneously the first issue of 2026.

It has been another challenging year in the health sector with financial constraints, staffing challenges and constant change. This was our 'skip' year, with no PNC conference and, whilst the decision to move to bi-annual conferences was necessary, I must admit to missing the opportunity to attend presentations, listen to interesting speakers and meet you at the trade stands during the breaks between sessions. I personally find that talking to my colleagues from around the motu really helps me understand that we all face similar challenges and I am constantly impressed by the unique and novel ways that perioperative nurses rise to these challenges. It is very inspiring to see the dedication, passion for patient-centred care, and resilience demonstrated by you all. Thank-you!

Reports, Awards

We had the Perioperative Nurses College NZNO (PNC) Annual General Meeting via zoom in October. As is usual in the end of year issue, we bring you the annual reports. Three awards were presented at the AGM; *The Dissector* awards for Best Article and the MEDSPEC Novice Writers Award and the Life Membership award. Regional reports are also included as well as brief bios of our National Committee members.

Medical Imaging Focus

We have two articles with a medical imaging focus in this issue. Our previous Chief Editor and long-time editorial committee member, Shona Matthews, has written up her conference presentation on developing patient-focused care in outpatient radiology. Shona describes how nurse review of key information combined with telephone contact,



enabled patients to be better prepared for their appointments, ensuring an associated reduction in missed appointments and improved patient satisfaction.

Current editorial committee member, Liying Duan, provides us with an article about the importance of communication skills in managing MRI related claustrophobia.

Clinical

Marvin Gonzales provides us with a clinical case review of a paediatric patient with an orthopaedic injury, based on an assignment from his post graduate study. Marvin uses the Tanner model to reflect on and evaluate the effectiveness of the nursing care provided, reinforcing that that clinical judgement and evidence-based practice is essential to patient safety.

Join our team

We are still looking for an Editorial Committee member, ideally with an OR Scrub/Circulate background, and we are also looking for a replacement Chief Editor.

If you are interested in either of these roles, please consider submitting a letter expressing your interest with a copy of your CV to the PNC secretary on periop.sec@gmail.com. For further information on the role and responsibilities of the Chief Editor, or membership on the editorial committee please contact the Chief Editor on dissector.editor@gmail.com.

Here's hoping you all enjoyed a safe and happy festive season and that you had a chance to stop, refresh and recharge your batteries.

We look forward to hearing from you in 2026 with your ideas for articles.

Noho ora mai
Bron Taylor, Chief Editor
Ngā mihi

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A life-changing moment...

Tēnā koutou katoa

It is my honour to officially have graduated to Chairperson of Perioperative Nurses College of the New Zealand Nurses Organisation. My name is Lucy Middleton and for the past eight months I have been working as Vice-Chairperson of PNC.

Wow- it has been a roller-coaster but one that I do not want to get off any time soon. Being surrounded by passionate, enthusiastic, driven, intelligent and, most importantly, fun nurses has been exactly what I have needed in my professional life.

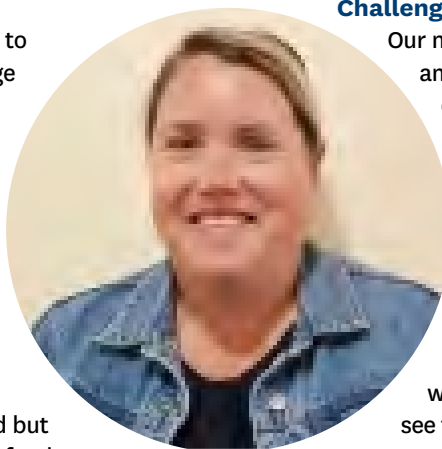
A little about me. I was born in Auckland but am a Wellingtonian at heart as some of my fondest memories are from age eight onwards when we moved to the capital.

Before my nursing training I travelled abroad for a tennis scholarship, but I was never destined for Wimbledon. Upon returning to New Zealand, sitting in a chemotherapy lounge with my mum and best friend, a discussion was had about nursing. This one moment changed the course of my life and as they say, the rest is history.

My journey with the Perioperative Nurses College (PNC) began in 2014 when I tagged along to a regional PNC meeting. From then the PNC seed was planted and for the next five years PNC was a constant in my personal and professional life.

This relationship culminated in a successful tenure as Chairperson for the Central North Island region and Conference Convenor for the 2019 Perioperative Nurses College Conference in Hamilton.

I am incredible thankful to be back in the PNC space, surrounded by incredible, like-minded individuals who have a passion for nursing.



Challenging goals

Our new national committee is gearing up for an exciting 2026. We have a broad range of expertise which makes our vision and goals for 2026 challenging yet rewarding. Our biennial national Perioperative Nurses' College conference rolls around in October 2026, with Auckland being the hosts of the 49th Annual Conference.

Planning is well under way, and we are all looking forward to the education opportunities and camaraderie that comes with conference year. This year will once again see the College host several webinars, bringing our members for the forefront of our education platform with the first session of the year being presented by myself, with regard to Tikanga in the Perioperative Space.

A big thank-you

I want to take this opportunity to thank Emma Ladley for her ongoing support and leadership she showed during her tenure. I would also like to thank Suzanne Rolls, our Professional Nurse Advisor for all her guidance, encouragement and patience with me over the past month and in the future! To all our National Committee Members, Professional Practice Committee, *The Dissector* Editorial Committee, Regional committee members and all our members- THANK YOU.

Without your continued support and input we would not be able to strive for better patient outcomes and safe/happy perioperative nurses.

Ngā mihi nui

— Lucy Middleton

Chairperson, Perioperative Nurses' College
NZNO Tōpūtanga Tapuhi Kaitiaki o Aotearoa

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FOUNDING EDITOR: Pam Marley (1974 – 1979)

EDITORIAL MATERIAL The Editorial Committee welcomes articles, reports, book reviews, letters to the editor, practice issues, exemplars, case study experiences, research papers/projects, regional news etc. Please send your ideas to: dissector.editor@gmail.com

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Dissector Awards 2025

PNC Best Article (up to \$1000)

Authors who are current PNC members and have had articles published in *The Dissector* journal in the previous year are eligible for this award. The award is judged by the Editorial Committee which uses a range of scholarly and editorial criteria (including originality and relevance to the specialty area of nursing), along with readability (engaging the audience). This year five authors were finalists.

Liyang Duan, *MRI safety: Avoiding risks related to MRI scanning*, Vol. 52, No. 2, September – November 2024

Marvin Jr Gonzales, *Physiological impact of acute intervention: Trachea and endotracheal intubation*, Vol. 52, No. 2, September – November 2024

Assunta Rodrigues, *Exploring Electrosurgical Smoke control Practices among Operating Theatre Personnel: A Qualitative Study*,

Karen Hall, *Perioperative Nurses College of NZNO Our History*, Vol. 52, No.3, December 2024 – February 2025

Sandeep Mullassary, *Intraoperative use of pneumatic compression devices to prevent DVT*, Vol. 52, No.3, December 2024 – February 2025

Winner: Liyang Duan

The Editorial Committee felt that Liyang's article was exceptionally well written, with effective use of storytelling engaging the reader. The article maintained reader interest beyond the field of medical imaging, including visual examples clearly showing potential risks to both patients and hospital equipment when MRI safety protocols are not followed. Of note, Liyang's article scored highly from an editing perspective as it required very little input or corrections.

For these reasons, the Editorial Committee was pleased to award Liyang Duan the Best Article Award for 2025. (Liyang was excluded from the judging of this award due to her conflict of interest).

Medspec Novice Writers Award (up to \$750)

First time authors are also eligible for the Novice Writer Award, sponsored by Medspec. Two authors were eligible for the Novice Writer Award. They were:

Marvin Jr Gonzales, *Physiological impact of acute intervention: Trachea and endotracheal intubation*, Vol. 52, No. 2, September – November 2024

Sandeep Mullassary, *Intraoperative use of pneumatic compression devices to prevent DVT*, Vol. 52, No.3, December 2024 – February 2025

Winner: Sandeep Mullassary

Sandeep's article was commended for its clarity, critical appraisal of the evidence, and clinical relevance to perioperative nursing practice, particularly in the area



Left: Liyang Duan (left) is presented with the Best Article Award for 2025 by Gillian Martin. Right: Sandeep Mullassary with his Novice Writer Award.

of patient safety and intraoperative care. As a first-time contributor, he demonstrated how post-graduate assignments can be effectively adapted into an engaging article, setting an excellent example for other emerging authors.

Services to Perioperative Nurses' College Award

The final award of this year is one awarded to a current or past member of PNC who has shown commitment to the College and superior contribution to its national work. It is a paid life membership in the college and journal subscription.

This year PNC was delighted to award this to Bron Taylor, our current Chief Editor of *The Dissector* journal.

Bron has been at the helm of the journal during incredibly challenging times, through COVID-19 lockdowns and the loss of the PNC Conference during those years, which was previously an opportunity for connecting with potential authors for the journal. Bron took on this role after only a year in the committee and has led with a strong work ethic and diligence to detail. Congratulations Bron and thank you for your hard work with both *The Dissector* and your role with the Professional Practice Committee.

National Trauma Symposium

This year's National Trauma Symposium will be held on Thursday, November 5, 2026 at the Intercontinental Hotel in Wellington.

This annual event attracts more than 300 trauma practitioners from across New Zealand and overseas. The programme consists of scientific presentations, facilitated debate on hot topics & wānanga spaces for all trauma practitioners to share lessons learnt.

You are invited you to take the opportunity to join us at this exciting event. Your support is very much appreciated.

Further information can be found on the Symposium website: www.traumasymposium.nz

Theatre Managers Conference

This year's Theatre Managers and Educators conference will be held from April 29 to May 1 in Christchurch. Online registration is open on the [conference website](#)

The conference will include Post Anaesthetic Care Unit (PACU) and Anaesthetic Technicians. Thus, the conference is now the Theatre Managers, Educators, PACU and Anaesthetic Technicians Conference.

The theme for 2026 is: Leadership and Innovation in the Field – Latest Technologies, Robotics, AI, and Healthcare. This theme will be explored through engaging presentations, discussions, and hands-on sessions.

"We are delighted to welcome Dr Michelle Dickinson as our opening keynote presenter," says Conference Chair Leigh Alexander.

Dr. Dickinson MNZM is a pioneering engineer and technology strategist whose career bridges science, engineering, and emerging technologies. Driven by a mission to make complex ideas accessible and engaging, she has become a global leader in translating cutting-edge innovation into concepts that inspire action.

Michelle's career has seen her advising some of the world's largest technology companies on nanotechnology and guiding them through the rapidly evolving landscapes of AI, quantum computing, and sustainable technology. She has held influential roles across academia and industry, including her ongoing position as an honorary academic in engineering at the University of Auckland.

The 2026 Conference will be held at Chateau on the Park, Christchurch, from Wednesday April 29 to Friday May 1. The programme has been extended on Friday afternoon to include optional concurrent workshops.

The conference is being organised by Conferences & Events Ltd, telephone Marg Craig: 027 359 578; Email: Marg@confer.co.nz Conference Website: <https://confer.eventsair.com/theatre-managers-conference-2026/>

Fresh new look for Tōpūtanga Tapuhi Kaitiaki o Aotearoa

Tōpūtanga Tapuhi Kaitiaki o Aotearoa, the New Zealand Nurses Organisation, has unveiled a fresh new look at the NZNO AGM.

The whakapapa is the Kaokao - a traditional Māori tukutuku (woven panel) pattern and a term for the ribs or side of the body. The chevron or V-shaped pattern evokes the bent arms and legs of a body that is grounded and poised for action.

The KaoKao signifies both a warrior and birthing stance symbolising endurance, steadiness, physical strength, and mental well-being.

For the Tōpūtanga Tapuhi Kaitiaki o Aotearoa identity, the KaoKao honours the expertise, resilience, and courage of our members who continue to extend unwavering commitment, attention, and care for whānau and communities throughout Aotearoa.

The repeated pattern form is a visual expression of the strength in numbers through kotahitanga and unity. Each line and intersection within the design arrangement represents individual voices and experiences contributing to weave together into a greater whole. This mirrors the very nature of who we are as a collective of diverse professionals, standing together to advocate for better outcomes — not just for ourselves, but for the wider health of all New Zealanders.



Battlefield wound spray stops bleeding instantly

It is a sad reality some wonderful medical breakthroughs have been developed to treat soldiers wounded in battle and to ensure they can return to active duty in the shortest time possible.

The use of ligatures to stem bleeding from soldiers' wounds was rediscovered in 1537 by French military surgeon Ambroise Paré. Although not the first to advocate the ligature, he was responsible for introducing it in place of cauterisation. It was not until World War II and the Korean War that surgeons realised that tying off or clipping injured blood vessel immediately stopped bleeding, it often resulted in limb amputation.

This helped popularise vascular repair surgery more broadly, familiarising surgeons with the techniques and with new tools such as the now-ubiquitous [Potts clamp](#). Today those tools and techniques help treat everything from heart disease to varicose veins.

The latest innovation in battlefield wound care comes from researchers at the Korea Advanced Institute of Science and

Technology (KAIST) who have developed a powder that reacts with positively-charged particles in the blood (cations) that turns it into a gel state almost instantly.

The substance is made from three natural ingredients: alginate (extracted from brown seaweed), gellan gum, a natural thickener made from bacteria through fermentation; and chitosan, a powder made from the exoskeletons of crustaceans and insects as well as from fungal cell walls.

The alginate and gellan gum turn from a powder into a gel in the presence of blood immediately upon contact. The chitosan, which has a positive charge, attracts negatively charged red blood cells and platelets, causing them to clump and stop bleeding. The powder has been named with an initialism based on its ingredients plus an "L" indicating a link between them all: AGCL.

Such a product is certain, once approved, to find a place in emergency departments and in first aid.

Source: <https://advanced.onlinelibrary.wiley.com/doi/10.1002/adfm.202523910>

Auckland & Northland | Tamaki Makaurau & Te Tai Tokerau

Interest in joining our Regional Committee is gaining pace with at least one person having spoken to committee members about this.

As our region is responsible for organising the next PNC Conference, we have been approached by Jenny Green, past committee member, who was involved with organising the last Auckland and Northland Conference. She will join the conference planning team in February. Two conference venues have been visited to assess their suitability to hold the conference

Last September 13 (2025) we held a very successful study morning, kindly sponsored and hosted by OBEX Medical. This was our annual Medical Imaging Session, but this time we expanded to include Vascular Surgery with a focus on Aortic Repair techniques. We had 26 Nurses attend and six of our Medical Imaging Technologist (MIT) colleagues. A full report appears elsewhere in this issue of *The Dissector*.

We had hoped to hold a regional committee meeting after the study session but at short notice members were unable to attend so this was cancelled.

The region's bank balance is looking healthy, so we hope to fund some regional members to attend the 2026 PNC Conference.

Gillian Martin

Nurse Specialist (RN, PG dip, VABC), Radiology Department, Te Toka Tumai | Auckland



Central North Island

It is with great regret that I announce my resignation as the CNI Regional Representative. I want to thank both the National and CNI Committee for all the support they have given me over the last two years.

It was a journey of learning legislation that governs nursing as a whole, developing leadership and courage to support my colleagues and have the understanding that

when we stand together as a team and remain steadfast, we can achieve more acknowledgement and respect from our colleagues and counterparts.

Vicki Strawn, a senior OT nurse from Tauranga Hospital, will be taking over my role. She has been a hard-working, caring, dependable NZNO delegate in the operating theatres, and no doubt she will be an asset to us as a PNC Regional Representative.

Professional Development/Networking

An educational session, "Management of the Septic Patient in the Perioperative Space" was held on August 25, 2025 at Tauranga Hospital (Nikau Meeting Room). To encourage broader participation, including from outside the region, the event was also made accessible via Zoom.

Leadership and Support

The CNI committee, together with NZNO advisers and NZNO delegate in theatre, have addressed issues concerning the proposed "Test of Change" in Tauranga Hospital Operating Theatres.

A proposed trial was considered to supposedly improve theatre efficiency by utilising an Anaesthetic Technician to carry out the third nurse role. After months of preparation, data collation and acting on behalf of the 40 or so NZNO members who voted against this trial. On July 10 we had the opportunity to meet with the Health New Zealand representative. The outcome of the discussion emphasized the importance of ongoing open dialogue, urging greater transparency and nurse involvement in the decision-making process.

May Ragot

Outgoing CNI Regional Representative

Registered Nurse, Perioperative Unit, Tauranga Hospital

Hawkes Bay | Te Matau a Maui

Hawkes Bay held its AGM on April 29, 2025, which was attended by 15 of our membership. The meeting saw election of Officers across all committee positions. Our previous secretary Rochelle Holder has taken on the Chairperson role, as Kelly Martin has stepped down, with Rebecca Wood stepping in to Vice-Chair to learn this role. Filling Rochelle's spot as secretary is Kiffany Hoffman, who will be supported by Rochelle through this transition. In the same respect Rebecca Rawnsley will support Chris Reid, our new treasurer.

This AGM we said goodbye to Jan-Marie Wilson, who I have succeeded as Regional Representative on PNC National Committee. As a committee we thank both Jan-Marie and Kelly for their service in their roles.

It is great to see movement in these positions, as they have been held by all for a long time and new faces in these roles

indicates an increase in regional involvement, which is very welcome after previous years of disruption in our region and the nation. Also discussed at AGM was the Maggie Magpie Award, which was presented to Rochelle Holder at the Education Seminar on August 16.

Hawke's Bay's footprint in the private surgical space continues to grow, with Kaweka Hospital opening the second stage of its build in July. This building boasts a ward, a cardiac cath-lab, and radiology services, including cancer care. It is a welcome addition to our services in the region.

The Royston Day Surgery commissioned it's second theatre this year, increasing its service to both private and public day-stay orthopaedic patients.

Seminar

PNC HB was proud to present its biannual education seminar on the August 16, with the theme being Self-Care and Wellness. We had 50 local attendees and the day was a great success.

PNC HB is continually committed to the education of their staff and are looking for more opportunities between our hospitals to provide our members education and professional development.

Webinar

In June the PNC monthly online webinar was presented by Hawke's Bay, with Nicola Hall presenting on her time aboard the Mercy Ships. We thank Nicola for her contribution to this and with being adaptable to the venue change the week prior!



*Ashley Walker,
Operating Theatre RN and
Theatre Education Coordinator,
Royston Hospital, Hastings*

Taranaki-Manawatu

Formerly known as Ruahine-Egmont, we are now the Taranaki-Manawatu Region of PNC. The name change reflects a better description of the region, rather than mountains. This was approved at the 2025 AGM of the National Committee.

We have a current membership of 16, with six active members.

Alison Tijssen is now our regional chair as of September 2025, with Diane McClelland staying on as secretary in the interim until a replacement is nominated. Diane is also our treasurer while our PNC National Committee representative is Mirelle Quin.

Communication

There have been informal conversations amongst active members regarding succession planning and committee member rolls.

We are having ongoing difficulties with recruitment and non-active members. Members are encouraged to apply for open national committee roles.

AGM, Regional Meeting and Education

The AGM and regional meeting was held April 12, 2025 in Whanganui. Education was on Weight Loss Surgery.

Regional Meetings

- June 28: Education Session at New Plymouth, Obesity and Orthopaedics, Malignant Hyperthermia.
- September 13: Education. Session at Palmerston North, Cell Saver, Mercy Ships
- November 15: Regional Meeting New Plymouth
- November 15: My Health Hub Webinar



*Mirelle Quinn
Scrub/Circulating and
Anaesthetic Nurse Assistant
Southern Cross Healthcare
New Plymouth*

Canterbury-West Coast/Nelson-Marlborough

Our meeting on August 2, 2025 was well attended and held at the Charity Hospital in Christchurch. Our guest speaker, Phil Bradshaw, spoke about the New Zealand Health reform and healthcare rationing which was introduced in New Zealand in the early 1990s. This led to the development of the national waiting times project altering the trajectory of demand.

The Charity Hospital in Christchurch was a concept developed to meet the needs of Canterbury and West Coast public patients which do not have access to publicly funded hospital care. It is totally funded by donations and up to the end of 2024 it had treated 25,377 patients.

In 2017 the Charity Hospital joined the Canterbury District Health Board to provide endoscopy support for patients under 50 presenting with rectal bleeding for greater than six weeks. It has over 280 volunteers and five staff.

Due to low numbers of attendance at the June meeting, the AGM was postponed to the August meeting, which was still light on numbers with 17 attendees. Treasurer Robyn

Stracham stood down and was replaced by Meg Agnew.

The crate weight portfolio has been handed over to Pam Yee as Bobby Guy is standing down. We also acknowledged the sterling work Sue Claridge undertook for our region over many years. Sue passed away in June 2025.

Committee

Our chair is Vanessa Bacaltos with Shirley Robinson filling the role of secretary and Robyn Strachan as treasurer. We have a vacancy for the Regional Representative role on National Committee, with Rebecca Porton-Whitworth continuing in the interim.

Education

The CWCNM Region held a half day study day on November 8, 2025 with a Webinar on November 18, 2025.

We have the following Study Days planned:

- Meeting – March 14, 2026 – St Georges Hospital – Christchurch.
- Meeting – June 13, 2026 – either Burwood or Christchurch Hospital – Christchurch.

*Rebecca Porton-Whitworth
Associate Theatre Manager and
Registered Nurse First Surgical
Assistant, Operating Theatre,
Southern Cross Healthcare,
Christchurch*



Otago-Southland (Southern)

Greetings from the south of the south with my first Regional Report for *The Dissector* as the National Committee Regional Representative for our combined Otago and Southland regions — now known as Southern.

April-Lily Sule stepped down from this role after her three-year appointment concluded at our AGM. I acknowledge the commitment that she has made for our region during that time, with her excellent knowledge sharing and passion for PNC. It is fantastic that April-Lily remains as a committee member.

Our regional AGM took place on the May 17, 2025 following a fantastic study day, again held at Marinoto House, which is a beautiful 1878-built grand home which became a nurses' home then a convent for the Sisters of Mercy on the grounds of Mercy Hospital in Dunedin.

These study days are social occasions to meet new and old colleagues as well as the learning opportunities. Our AGM resulted in a fresh committee, and a new secretary has

stepped up too – thanks Samantha Wells!

Our turn to host the July webinar was taken by our wonderful Blessel Paderma, Main Operating Theatre Dunedin Hospital RN Cardiothoracic, who presented on ECMO (Extracorporeal Membrane Oxygenation) and the checklist she has created for ICU nursing support when these cases occur.

The next study was planned for November 15, covering “Expanded Perioperative Practice” with a nurse endoscopist, breast care nurse, urology CNS, new guidelines for RNFA and others TBA.

Committee

Our regional chairperson is Aimee Keogh with Samantha Wells at Secretary and our tireless Sandra Millis as treasurer. Amanda Figgins is our Regional Representative on the PNC National Committee.

Past Meetings

- December 3, 2024. Held at No. 7 Balmac restaurant followed by Xmas/Summer dinner. A bit of delay because Aimee's car was unfortunately pranged on the roundabout nearby. She was OK, but the car wasn't! We had 15 attendees.
- February 20, 2025. Held at a member's home to encourage those with children to attend. We had 13 attendees, including Stella Yau visiting from the USA, a member of AORN San Diego committee and friend of our secretary.
- AGM May 17, 2025 – Held at Marinoto House after the study day. Nine attendees.
- August 21, 2025. Held at Marinoto House. Eleven attendees.

Study Days

- November 9, 2024. “Perioperative Innovations” Orthopaedic Robotics, Apifix for Scoliosis, Imaging innovations for Neurosurgery, Humiguard, Transcatheter Aortic Valve Implantation, QR codes in Perioperative setting. For this we had 50 attendees.
- May 17, 2025 “Perioperative emergencies” Compartment Syndrome, Aortic Dissection, Local Anaesthetic Toxicity, Anaphylaxis, Malignant Hyperthermia, Chest & Abdominal Trauma, and CICO (Can't Intubate, Can't Oxygenate). Four hours education with morning tea provided by the committee. This time we had 61 attendees (28 members and 33 non-member, with some joining on the day).
- November 1, 2025, with theme of “Expanded Perioperative Practice” with a meeting to follow.

Webinar:

- July 29, 2025 - Blessel Paderma Main Operating Theatre Dunedin Hospital RN Cardiothoracics presented on ECMO (Extracorporeal Membrane Oxygenation) and the checklist she has created for ICU nursing support when these cases occur.

Amanda Figgins

*Clinical Nurse Coordinator Theatres ENT/ Head & Neck and
MaxilloFacial, Dunedin Hospital Main Operating Theatres
Te Whatu Ora Southern* ■

Auckland Medical Imaging Study Day

By Gillian Martin

In 2025 the Medical Imaging Study morning that has become a regular for the Auckland-Northland Region of PNC decided to spread its wings. No, we didn't fly off to somewhere exotic, we expanded our scope by including Vascular Services. We decided that, as there is collaboration between the two services in some of the procedures which are involved, we should combine our education resources.

Once again, the morning was sponsored and hosted by OBEX Medical at their Education Centre on Carlton Gore Road in Auckland. We had 32 attendees including nurses and medical imaging technicians (MITs) from various hospitals and radiology units around Auckland, plus the speakers and the team from OBEX.

The day kicked off bright and early (for a Saturday) at gam, which unfortunately was 10pm for our first speaker, Dr Anastasia Dean, who had agreed to do a presentation — despite being in the UK at the time. Her chosen topic was 'Endovascular Aortic Intervention' which set the theme for the day.

Anastasia covered all types of interventions abdominal, thoracic, thoraco-abdominal and the aortic arch. She

explained the definition of each, the types, aetiology, and indications for treatment. She went on to talk about the different recovery times for open surgical procedures and endovascular procedures and the related complications and outcomes.

I was the second speaker of the day and decided to take a journey back in time (being a Dr Who fan).

There are mentions throughout history of peripheral vascular disease, starting with the Egyptians and the ancient Greeks, so maybe not the disease of the modern world and our lifestyle that some would lead us to believe.

Early Egyptian medical writers in 2000 BC recommended that peripheral aneurysms be treated 'with the knife and burned with fire so that it bleeds, but not too much', so not much change there. We now refer to this as surgery with the use of diathermy!

I advanced the story through the 16th, 17th and 18th centuries until we arrived in the 20th Century where many familiar names cropped up, including Dr. [Michael DeBakey](#) in the 1950s. His work included repair of aortic aneurysms and aortic dissections and the introduction of prosthetic vascular substitutes.

In 1954, DeBakey used his wife's sewing machine to make Dacron grafts, and he went on to work with an engineer to make one-piece grafts. The 1980s saw a great advancement in aortic repair around the world, with the first endovascular repair using a stent graft in a patient with a post-traumatic aneurysm.

The 1990s saw this work arriving in the southern hemisphere with two teams working in Australia. In 1998,

Author Gillian Martin (right) with some of the study day attendees.



the first fenestrated stent graft was placed in a patient in Adelaide, the same year the first endovascular aneurysm repair (EVAR) was done here in Auckland — in the 'Basement Imaging Unit' at Auckland Hospital. This brought us to the present day when ever more complex and technically manufactured aortic stent grafts are placed by Interventional Radiologists around the world, for an ever-increasing number of patients.

Interventional Radiology

Following a much-deserved morning tea, the day continued with a presentation by Interventional Radiology MIT Grace O'Neill who works at Health New Zealand Auckland (Te Whatu Ora Te Toka Tumai).

Grace gave an overview of the use and types of contrast used in Radiology, including Iodine based contrast media, gadolinium (Gd), and carbon dioxide (CO₂) and their associated risks, limits and uses with examples of imaging to illustrate this excellent presentation.

Grace completed her presentation with a case study of a patient who had experienced previous anaphylaxis reaction to contrast during diagnostic CT scan. As the patient



required endovascular aortic repair, the anaesthetics team decided on doing rapid desensitisation techniques, administering increasing amounts of contrast intravenously over a three to four-hour period in a controlled environment (the hybrid operating room), prior to the EVAR procedure.

There was a good outcome for the patient with no allergic reaction. If the patient requires further endovascular procedures or follow-up CT scans with IV contrast, the desensitisation process will need to be repeated each time.

Grace was followed by Gian Ruiz, Interventional

Radiology nurse from Te Toka Tumai who unravelled the confusing world of EVAR, BEVAR (branched endovascular aortic repair), CEVAR (complex endovascular aortic repair) and TEVAR (thoracic endovascular aortic repair) and other current iterations of endovascular repair.

Grace and Gian were both first time presenters and made excellent presentations.

The last presenter of the day was Jamie Harris, CT product Specialist for Siemens, who was the second presenter to present from afar, this time from Hawkes Bay. Jamie gave an insightful presentation about Dynamic CT Angiography. ■



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Communication in managing MRI related claustrophobia

By Liying Duan RN, BN, MN(Hons)

Introduction

Magnetic resonance imaging (MRI) is one of the most effective diagnostic techniques available today, but many patients find it highly anxiety-inducing, often linked to a fear of enclosed spaces. Factors such as the narrow bore of the scanner, proximity to the machine during imaging, loud operational noises, lengthy scan times, and the need to remain completely still contribute to feelings of claustrophobia (Blair, 2025; Hudson et al., 2022; Lawal et al., 2023).

Severe claustrophobia may lead to missed appointments, patient movement during scans, or premature termination of the procedure (Blair, 2025; Hudson et al., 2022). These issues affect not only patient wellbeing and diagnostic quality but also workflow efficiency and healthcare costs.

Given the significant impact of claustrophobia and MRI-related anxiety on both examination outcomes and patient experience, it is essential that health professionals understand the condition and adopt effective management strategies. Research has shown that communication between MRI staff and the patient plays a critical role in addressing and alleviating claustrophobia related to the MRI examination (Lawal et al., 2024).

Abstract: Claustrophobia and anxiety associated with Magnetic Resonance Imaging (MRI) can significantly affect both the quality of the examination and the patient's overall experience. Each year, there are a numbers of MRI scans cancelled or abandoned due to patient's claustrophobia, causing inconvenience and economic inefficiency for both patients and healthcare services. For health professionals, a solid understanding of claustrophobia and effective management strategies during MRI procedures is essential. This article explores the causes of claustrophobia, reviews approaches to managing MRI related claustrophobia and anxiety and emphasizes the importance of communication skills in addressing and alleviating claustrophobia in the MRI setting.

Keywords: MRI; Claustrophobia; Anxiety; Magnetic resonance imaging; Sedation; Patient-centred care; Patient outcomes; Communication

Understanding Claustrophobia

Claustrophobia is a specific phobia characterised by fear of confined spaces (from the Latin "clastro," meaning closed) (Vadakkan & Siddiqui, 2023). Many individuals experience it without receiving a formal diagnosis. According to Lawal et al. (2024), around 10 percent of patients undergoing MRI scans in many countries suffer from claustrophobia, and the number can go up to 44 percent in some specific groups of patients. The exact cause of claustrophobia is unclear, though possible contributors include genetic predisposition, traumatic experiences during early childhood, and coexisting

anxiety disorders (Vadakkan & Siddiqui, 2023).

When people with claustrophobia think about, or are placed in enclosed spaces, they may experience severe distress and a fear of being trapped, restricted or of being unable to breathe. This often includes fears of suffocation or losing control and may result in a panic attack. Symptoms can be both physical and emotional (Vadakkan & Siddiqui, 2023). Physical signs include difficulty breathing, trembling, sweating, rapid heartbeat, hot flush or chills, dry mouth, and chest pain. Emotional symptoms may involve overwhelming anxiety, fear of losing control, or an intense need to escape (Vadakkan & Siddiqui, 2023). Not all people with claustrophobia will

present all these symptoms, the presentation can be variable (Vadakkan & Siddiqui, 2023).

Globally, more than 80 million MRIs are performed annually (Enders, et al., 2011). The phenomenon of claustrophobia and anxiety because of an MRI examination has been widely reported (Blair, 2025; Dewey et al., 2007; Enders et al., 2011; Munn, et al., 2015). According to Vadakkan and Siddiqui (2023), up to 15 percent of all patients scheduled for MRI suffer from claustrophobia, with an average of 2.3 percent of them severe enough to decline scanning which delays medical evaluation or requires sedation to complete the scan, which add new costs and risks to the procedures. Overall it can be estimated that approximately two million MRI procedures worldwide cannot be performed or are prematurely terminated due to claustrophobia (Enders, et al., 2011).

Therefore, the sensation of claustrophobia is a major barrier to effective MRI scanning and therefore, effectively managing a patient's claustrophobia and reducing anxiety is critical for ensuring smooth and successful MRI procedures.

Management of claustrophobia

A variety of strategies for managing claustrophobia effectively have been recommended and reported in the literature, including creating a calming environment with soothing lighting and music, using wider and shorter bores of MRI scanners with faster scanning sequences, and when



necessary, employing mild sedation (Björkman-Burtscher, 2021; Hudson et al., 2022).

While sedation can reduce premature scan terminations, it carries risks of side effects and requires additional monitoring (Munn et al., 2015). Therefore, non-pharmacological interventions remain preferable when possible.

Despite all these valuable contributions in managing claustrophobia associated with MRI, according to research, the effectiveness of communication approaches rate the highest in reducing patients' anxiety, increasing patients' compliance with MRI examinations and

ensuring exam quality and efficiency (Hudson et al., 2022; Stogiannos, 2019). Patient-centred communication is fundamental to ensuring optimal health outcomes (Kwame & Petrucka, 2021). It is well recognised that staff having patient-centred communication skills to support and manage patient's anxiety are a key aspect to successful MRI (Hudson et al., 2022). Studies show that continuous communication throughout the scan lowers anxiety and improves compliance, while a lack of interaction increases stress (Lawal et al., 2024).

Importance of communication in management of claustrophobia

Communication leads to the right choice and most appropriate strategy for the individual patient as the staff can act on their response. Communication skills of health professionals are imperative to create a soothing and supportive atmosphere

during the MRI examination (Björkman-Burtscher, 2021). Most patients are able to complete the scan when some effort is made to support them and meet their individual needs. A key responsibility of MRI staff is to relax and reassure patients before, during, and after the scan. The best way of achieving this is by active listening, understanding patients and their unique needs, empathising, and clearly explaining the procedure to the patient (Stogiannos, 2019). The staff should provide detailed information on how the examination is carried out, what is the approximate scanning time, what they are going to experience inside the magnet and what this examination requires from them. Adequate time should be given to address questions and ensure understanding (Stogiannos, 2019).

Effective communication also



MRI scanner at Greenlane Hospital.

involves building trust, clarifying misunderstandings, and offering comfort strategies, such as using an eye mask or allowing a family member in the room when appropriate (Stogiannos, 2019). The MRI staff should avoid minimising patient concerns and instead acknowledge concerns without dismissing them, and helping them understand how they can maintain some control over the experience. Patients can be empowered to use their own imagery and self-hypnosis techniques if they can or put themselves in their 'happy place' (Björkman-Burtscher, 2021). Clarifying misunderstandings and providing reassurance — even after entering the magnet room — can help address anxiety triggered by the unfamiliar environment (Stogiannos, 2019). Studies show that patients with less communication during the scan experienced higher anxiety levels, while those who receive guidance throughout the whole scan experience lower stress hormones (Lawal et al., 2024). By maintaining a regular communication with them throughout the scan, patients' safety is ensured, any possible anxieties caused by MRI related claustrophobia are minimised and the overall quality of the examination is guaranteed.

Conclusion

MRI is a powerful diagnostic tool with many applications, but its success relies heavily on patient cooperation. The structure of the magnet bore, in conjunction with the nature of the examination, often causes high anxiety levels to patients with claustrophobia. Though claustrophobia and anxiety can hinder image quality, affect the examination process and the patients' overall experience, targeted strategies, especially supportive communication, is the most effective tool in addressing these challenges and alleviating anxiety. By maintaining effective communication, staff can ensure patient safety, reduce anxiety, and improve both the quality of MRI examinations and overall patient outcomes.



MRI scanner at Auckland City Hospital.



"You may hear some loud noises while you're in there, Mrs. Nurgler. It's just the MRI, um, recalibrating your image."

About the author:

Liying Duan completed her Bachelor of Nursing through Massey University in Wellington in 2006 and her Master of Nursing with First Class Honours from Massey University in Auckland in 2022. She has many years of experience in the cardiothoracic speciality and also worked in women's health outpatient service for five years. She currently works fulltime in the Radiology Department at Greenlane Clinical Centre, Auckland.

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Orthopaedic Clinical CASE REVIEW

By Marvin Jr. Gonzales

Background

Mstr X was an 11-year-old patient who was at a trampoline park when a “freak incident” occurred following “a regular jump” (as described by Mstr X’s parents). He landed on a ball and “fell directly on the trampoline mat”. Mstr X stayed down on the mat, visibly in pain, asking his parents for help.

Mstr X was brought to ED by ambulance for his injury, where he was treated as a high acuity patient. He had pain and swelling of his right lower leg, limb deformity, inability to weight bear and limited range of movement of the injured limb, all of which indicated the signs and symptoms of a bone fracture (Thompson et al., 2023; National Institute for Health and Care Excellence, 2022).

Not long after his arrival to the ED, Mstr X was assessed and X-ray imaging was ordered, which confirmed right tibial shaft fracture. Following the X-ray, the orthopaedic team recommended an acute surgical intervention to treat Mstr X’s injury.

The ED nursing team assessed Mstr X’s readiness for surgery. A detailed history of the patient was taken including any past history, allergies, medications, and fasting status. Mstr X had recently eaten, therefore a partial cast was ordered to help stabilise the fracture, reducing the likelihood of further damage and to achieve pain control until he could have surgery, as the risk of aspiration outweighed the benefits of emergency surgery (Nason, 2016; Hayashi et al., 2020). Surgical, and anaesthetic consents were completed by the orthopaedic and anaesthetic team

Abstract: In this article, a clinical case review of a paediatric patient with an orthopaedic injury is described and discussed. Clinical concerns identified included pain, anxiety, stress, fear, equipment availability and surgical sterility. The nursing based on these clinical concerns are reviewed and evaluated using Tanner’s (2006), four aspects of clinical judgement model.

To protect the privacy and confidentiality of the patient, ‘Mstr X’ has been used as a pseudonym for the patient. Before the gathering of any clinical data, verbal consent was obtained from the patient’s guardian.

with Mstr X and his parents.

The ED nursing team transferred his care to the perioperative surgical admission facility when he was fully fasted. Mstr X was accompanied by a registered nurse, both his parents and his cuddly toy “Bud”. The nurse introduced himself to Mstr X and his parents, advising them of his role and designation (Chichirez & Purcarea, 2018).

Nurses must perform an initial nursing assessment when admitting a patient to clinical areas (Toney-Butler & Unison-Pace, 2022). Findings from nursing assessments are imperative for nurses to make sound clinical judgements (Kurniawan & Hariyati, 2019; Toney-Butler & Unison-Pace, 2022). These assessments include subjective and objective data, vital signs, and pain assessment (Farrell, 2017). Mstr X’s vital signs were all within the normal ranges. However, when asked about pain, he verbalised that he was currently experiencing “6-7 out of 10” pain levels.

The Tanner model (2006) was used to analyse nursing interventions given to Mstr X. Tanner’s model describes four aspects of clinical judgement model. These are: noticing, interpreting, responding and reflection.

Pain

At initial assessment, Mstr X’s pain level was “6-7 out of 10”, specifically right lower leg pain. According to, Dydyk and Grandhe (2023), pain scores are useful nursing tools for both adult and paediatric patients. They provide an objective assessment of the patients’ pain and overall level

Findings from nursing assessments are imperative for nurses to make sound clinical judgements

of analgesia.

Mstr X felt acute pain in his right lower leg. This can be described as nociceptive pain (Dydyk & Grandhe, 2023), which is a typical physiological response of the human body when injured (Farrell, 2017).

Mstr X's concerns were acknowledged and he was reassured.

Although pain for an injured leg is normal, it was identified that Mstr X's analgesic control was becoming less effective and commencement of surgery needed to be promoted or further analgesia needed to be considered. Mstr X's current pain level was interpreted and aligned to anxiety, stress, and fear of being injured and being in hospital.

According to Cranston et al. (2020), paediatric patients exhibit abnormal pain behaviours that could be a subsequent reaction to their environmental and psychological state.

Giving paediatric patients oral medications before surgery increases the risks of aspirating stomach contents into the lungs, therefore only clear fluids can be given until one hour before surgery, so non-pharmacological interventions were utilised instead (Wilton, 2021). For example, reassurance that pain would be treated soon, distraction mechanisms such as watching videos on an iPad, comforting touch by parents and having a casual conversation with the patient (Cranston et al., 2020). Having a conversation about basketball appeared to help by distracting him from the pain.

Overall, the patient's pain concerns were well managed. By using non-pharmacological treatments which made a positive impact in reducing anxiety, stress, and fear, Mstr X's pain levels were reduced.

Anxiety, stress, and fear

On arrival, Mstr X, was lying supine on his surgical bed, with the head of the bed elevated to ensure ease of breathing and respiratory mechanics (Ray et al., 2022). He appeared very anxious, scared, and fearful. Tomophobia, which refers to the anxiety and fear caused by an upcoming surgical intervention, was noted (Schmid et al., 2009).

This is a normal psychological response to being in hospital. Literature suggests the pre-operative journey of paediatric patients can be challenging as they tend to show more debilitating responses to stress and anxiety. Ahmed and Rufo (2023) indicate the resulting anxiety of being in hospital for paediatric patients can vary in severity and the extent of their body and mind's psychological response is a complicated recipe for medical professionals.

Mstr X had a cuddly toy wearing a basketball uniform beside him. When asked about his cuddly toy, Mstr X's mood seemed to improve, and he began to converse with the nurse. Finding similarities in their hobbies enabled the nurse to build a therapeutic relationship. As Tanner (2006)

highlights, the nurse's relationship with the patient is critical to what nurses notice about their patients and how they interpret and respond to patient concerns.

Mstr X was highly active in sports and currently played basketball, stating to the nurse that "he loved

basketball very much". He expressed that he was scared that he wouldn't be able to play again following his injury. The nurse responded to his concerns using communication techniques such as paraphrasing, listening, paying attention, and using self-disclosure and reassurance (Stein-Parbury, 2018; Chichirez & Purcarea, 2018). The nurse reassured Mstr X that through surgery, orthopaedic rehabilitation programmes and physiotherapy, a return to basketball would be achievable (Robertson & Wood, 2015; Bhanushali et al., 2023). This reassurance improved and lightened the mood of Mstr X and his family.

Anxiety, stress, and fear affected Mstr X's psychological state pre-operatively. It is understandable for patients to feel these emotions before surgical intervention, therefore, nurses must acknowledge that these feelings are normal and to be expected.

Upon first interaction with Mstr X, his mood and demeanour were challenging and it was difficult to engage and converse with him. However when rapport was established, conversation became easier. In analysis, he and his parents received a positive perioperative experience. Gaining rapport and building a therapeutic relationship is essential in the care of an anxious paediatric patient.

Equipment availability and sterility

Mstr X was scheduled for acute orthopaedic surgery for his fractured tibia. Literature identifies tibial shaft fractures to be one of the most common paediatric fracture injuries (Patel et al., 2018). A tibial fracture requires accurate diagnosis and swift treatment to reduce complications, enhance recovery and optimise patient health outcomes (Patel et al., 2018).

Research studies suggest the usual treatment of tibial fractures is predominantly non-operative (Patel et al., 2018). However, for Mstr X, surgical intervention was essential to appropriately manage his injury. He was scheduled for a right tibial shaft fracture; closed reduction and intramedullary fixation via Titanium Elastic Nail System (TENS). Current literature highlights the rarity of this surgical intervention for paediatric tibial shaft fractures (Patel et al., 2018).

The choice of treatment for tibial injury depends on the bone age, weight of the patient, location of fracture and the type of fracture. As Mstr X's mechanism of injury was a high-velocity trauma, it required initial splinting of injury in

ED before proceeding to surgical intervention (Pogorelic et al., 2022; Patel et al., 2018).

TENS is a minimally invasive, intramedullary nail fixation system that achieves an appropriate level of reduction and stabilisation for paediatric fractures in both lower and upper limbs. This intramedullary fixation is based on the symmetrical bracing action of two elastic nails that are inserted into the metaphysis of long bones, with each nail bearing weight against the inner bone at different points within the bone. The fundamental principle of this system achieves flexural, axial, translational and rotational stability for the patient (Depuy Synthes n.d.; Dietz, 1997). TENS was selected to be the best option for Mstr X due to its advantages, such as shorter hospitalisation, early weight bearing, early bone union and ultimately, faster recovery (Uludag & Tosun, 2019).

The nurse checked with the theatre nursing team that all the positioning equipment needed was sterile and all implants were checked and accounted for (Depuy Synthes, n.d). Best practice guidelines and current literature, instructs operating theatre nurses to ensure patient safety

Although pain for an injured leg is normal, it was identified that Mstr X's analgesic control was becoming less effective...

during surgery by confirming instrumentation is sterile, available, and correct (Vogelsang et al., 2020).

Given the complexity of this case, specialty competence was essential for patient safety.

Evidence-based best practice was demonstrated by the nursing team; implants for the procedure were checked prior to commencement of the case which ensured that Mstr X would receive the correct implants and aseptic and sterile techniques were observed by all members of the

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nursing, surgical and anaesthetic teams.

Postoperative care was completed as per protocols, for example ensuring Mstr X was warm during transfer to the recovery suite and having his cuddly toy placed by his side. All pertinent documentation was completed including identification of implants. Reflecting on actions taken by the intraoperative nursing team, Mstr X received expert specialist care with appropriate nursing interventions during his perioperative journey.

The nurse accompanied the surgical team postoperatively when reviewing Mstr X on the ward, noting no complications from surgery such as development of surgical site infections. The therapeutic relationship between Mstr X and the nurse was concluded during the ward review. The nurse thanked Mstr X and his family for granting permission to utilise his details and wished Mstr X well for his recovery and return to sporting activities.

Conclusion

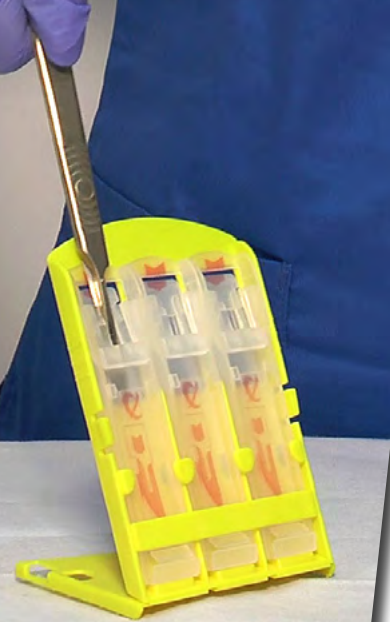
Clinical judgement in all aspects of nursing care is pertinent to patient safety. Through expert clinical judgments, the safety of the patient within this clinical case review was maintained with the highest standards of care, utilising evidence-based practice. The use of Tanner's model to reflect on the nursing interventions given during the care of the patient allowed the nurse to evaluate his own current practice and to reflect on improvements in current nursing practice. As a final point, competence in clinical judgment is a continuing journey for all nurses and the Tanner model serves as a useful tool to evaluate the effectiveness of nursing interventions.

A tibial fracture requires accurate diagnosis and swift treatment to reduce complications, enhance recovery and optimise patient health outcomes...

About the Author

Marvin Jr. Gonzales is a registered nurse working within the perioperative department of Christchurch Hospital as an acting clinical nurse specialist in Otolaryngology. Marvin was born in Davao City, Philippines, migrating to Christchurch in 2007. His journey into nursing was sparked by his mother, who worked as a registered nurse in the Philippines. From a young age he knew nursing was his calling and embarked on his training in 2016, enrolling within Ara Institute of Canterbury. His transition to nursing practice clinical placement was in the operating theatre at Christchurch Hospital, in cardiothoracic. This opened his eyes to the wonderful world of perioperative nursing practice.

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Developing patient-focused care in OUTPATIENT RADIOLOGY

By Shona Matthews RN, BN, MHSc (Hons.)

Introduction

The role of the radiology nurse has continued to evolve from its inception in the 1970s (Matthews, Freebairn & Martin, 2021). The Radiology Department at Green Lane Clinical Centre (GCC) in Auckland, New Zealand provides a dedicated outpatient service. An increasing range of palliative and better tolerated imaging, surgical and pharmacological treatment options combined with a move, where

possible, from inpatient to outpatient services, has seen the frailty of patients visiting the department increase. In addition, a high rate of nonattendance or inadequate patient preparation for some computed tomography (CT) appointments, and a critical event with a patient undergoing a procedure, necessitated a review and subsequent change to a more patient-focused approach to care for the small team of nurses and wider multidisciplinary team.

Written information has always been posted or couriered to patients prior to their procedure but was inadequate, particularly for patients undergoing CT colonography (CTC) and CT guided lung biopsy. It was therefore decided that a member of the nursing team would complete a procedure-

Abstract: Patient assessment is part of the radiology nurses' role but an increase in the frailty and complexity of patients referred for outpatient CT colonography and CT guided lung biopsy indicated the need to extend this to a pre-appointment approach. Nurse review of referral information, medication and medical history combined with telephone contact identified specific issues and enabled these to be managed before the appointment. As a result, patients were better prepared and less anxious with a reduction in non-attendance or failure to present for appointments and greater staff job satisfaction.

Keywords: radiology/medical imaging nursing, patient pre-appointment assessment, CT colonography, CT guided lung biopsy, patient-focused care.

specific patient assessment form with available history and referral information at least a week out from the examination, and then telephone and or email patients booked for either of these procedures. In this way the patient's intent to proceed with the examination could be confirmed, their specific preparation discussed, and any aftercare requirements confirmed. While time-consuming for staff, this service has been enthusiastically received by

patients and resulted in enhanced patient safety, better preparation and improved attendance as well as enhancing nurses job satisfaction.

The article reviews the specific approach developed for patients undergoing CTC or CT guided lung biopsy. The challenges of maintaining this service within the imposed staffing restraints are also discussed.

Background

There are a number of characteristics of the outpatient radiology or medical imaging environment that impact upon patient-centred care. There is a strong procedural focus with departments typically designed and organised

around imaging modalities and equipment, rather than patient needs. Patient care spaces are also typically limited. Demand for imaging services means sessions need to run efficiently so patient contact time is often brief, compounded by limited or inaccurate referral information and minimal time to check clinical records or contact patients prior to procedures.

Radiology is highly multidisciplinary, with nurses the smallest group within the team. Collaborative multidisciplinary practice encompassing booking clerks, medical radiation technologists, nurses and radiologists is essential in guiding patients safely through their procedure and attaining quality imaging (Matthews, 2006).

To address the challenges posed by the imaging environment, the GCC nursing team developed and regularly reviewed the written information sent to patients and sought patient feedback. Catering for the varying health literacy of patients, often with English as a second language, proved challenging. This concurs with an Australian study by Hyde, Mackenzie, Boyes, Symonds, Brown and Sanson-Fisher (2018) which found that few medical imaging outpatients recalled receiving recommended preparatory information, apart from the actual appointment.

Development of procedure specific assessment and examination records for key procedures was a useful initiative. These could be semi-filled in prior to the examination and completed on the day with the patient, during and after the procedure, then scanned into the electronic records. Two particular procedures carried out in the department required further attention to meet patient's specific needs, improve patient safety, reduce the rate of non-attendance and ensure appropriate preparation. The process undertaken with CTC patients and those booked for CT guided lung biopsy is reviewed in more detail.

CT Colonography

CT colonography (CTC) involves dilation of the large bowel with carbon dioxide and cross-sectional imaging of the abdominal organs. The images are then digitally combined and manipulated to provide two-and three-dimensional images of the interior of the large colon (Matthews, 2014). CTC offers a viable purely diagnostic but safer alternative to the gold standard colonoscopy especially for those with a lower risk of colorectal cancer, those with diverticulosis and the frail older person with other co-morbidities. Bowel

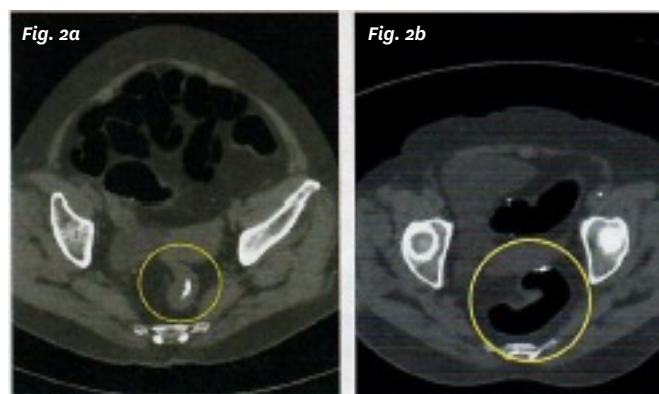


Fig. 2a: Supine Axial scan showing sigmoid colon collapse.

Fig. 2b: Sigmoid open on prone axial scan.

cleansing or at least faecal tagging is required, but the dose of Gastrografin, both a tagging agent and laxative, can be reduced. CT pneumocolon requiring no fasting or laxatives, but faecal tagging and bowel dilation only, is an option for the particularly frail. No sedation or aftercare is typically required post CTC.

With time there has been an increasing acceptance of CTC as a less invasive, safer option for imaging the bowel in frail elderly or co-morbid patients. An increased range of minimally invasive surgical and palliation procedures has provided more treatment options. Triaging of colonoscopy referrals by Gastroenterology and switching approximately 30 percent of these to CTC, based on the risk profile and co-morbidities of the patient, increased the number of referrals and complexity of bookings. The team also identified the need to manage medications for both Type 1 and Type 2 diabetics prior to fasting, with often no mention of diabetic status on the referral. While one of the GCC nursing team had always contacted some patients, especially those who had not confirmed their appointment, this was extended to all CTC bookings, some 16-20 per week.

Post-triaging by a specialist radiologist, comprehensive written information is sent out by the booking clerk with the bowel preparation. A least a week out from the appointment a nurse completes and documents a brief medical history on the specific CTC assessment form and checks medications, especially for diabetes. Telephone and or email contact is made with the patient to check that the bowel preparation has been received and seems appropriate given the information already gleaned and in conversation. At this stage the nurse may reduce the preparation, for example, if the patient has chronic diarrhoea or significant mobility issues. If a pneumocolon seems more appropriate, given the existing co-morbidities, this is discussed with the Radiologist. With many frail, elderly people living alone, often with minimal family support, their safety is paramount and falls an ever-present risk. On occasions the procedure would be declined completely or postponed until the patient was feeling better and the booking changed accordingly.

Patient specific advice is provided regarding withholding oral diabetic medication, reducing insulin dosage on the fasting day pre-procedure and checking for and avoiding hypoglycaemia. The nursing staff have a diabetic medication table developed by the Diabetes Service for this purpose. A pamphlet on diabetes management pre-CTC, developed from

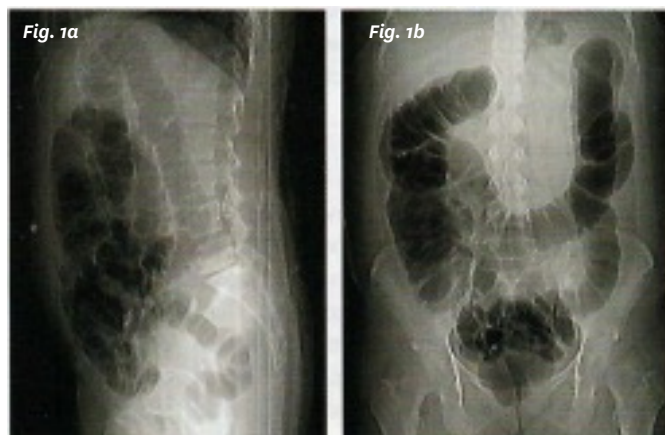


Fig 1a: Lateral Scout Image showing good dilation of the sigmoid colon.

Fig 1b: AP Scout showing clean well dilated large bowel.

one of the nurse's post-graduate study clinical practicum is also emailed out. The GCC Radiology nurse's cell phone number is also provided and well used by many patients.

Verbal feedback from patients was very positive with many commenting on how reassuring it was to have questions answered and someone to contact. Prior contact with patients also significantly reduced the rate of non-attendance on the day and compliance with bowel preparation instructions.

CT Guided Lung Biopsy

CT guided lung biopsy involves the percutaneous removal of core samples of lung tissue through the chest wall under CT guidance. The assisting nurse welcomes the patient, provides an initial brief explanation and does baseline oxygen saturations and vital signs prior to full discussion and informed consent with the Radiologist doing the procedure. An IV luer is also inserted in case it is required.

These biopsies are typically performed under local anaesthesia only, as a high degree of patient co-operation is required to remain still, take consistent breathes and follow breathing instructions. Patients are typically positioned

either supine or prone depending on the site of the suspicious lung lesion.

The biopsy usually takes about half an hour in total, with every effort made to minimise the length of time the patient is on the scanning table. As soon as it is completed, the patient is transferred to a bed with the biopsy side down. They are typically then transferred to the small day-stay area for an hour of close monitoring and care, prior to a final chest X-ray to confirm that there has been no pneumothorax develop. Assuming everything has gone well, they are discharged home, with a previously arranged caregiver organised to collect and remain with the patient overnight. Final written and oral discharge instructions highlight possible but rare complications of haemoptysis or pneumothorax and symptoms that signal the need for an ambulance.

In recent years, the GCC staff noted a significant change in the patients referred for lung biopsy from a relatively young cohort with a suspected primary lung tumour and assessment for surgery, to more co-morbid patients, often with another primary cancer elsewhere or suspected metastatic disease. This changed patient cohort is reflective of the increased range of treatment options from surgery, radiation treatment, chemotherapy, targeted treatments and immunotherapy, palliative and supportive care or combinations of any of these (Cancer Society, 2022). These therapies will potentially extend life for an older and potentially more co-morbid and fragile group of patients.

Patients with a high suspicion of cancer referred for CT-guided lung biopsy have typically already undergone a range of diagnostic testing which is yet to confirm a specific cell type, or an inadequate amount of tissue has been obtained. It is therefore important that the biopsy is completed as quickly as possible so diagnosis can be confirmed, treatment options discussed with the patient and treatment commenced within a specified time frame (Ministry of Health, 2025).

Once the booking is made, one of the nursing team completes and documents a brief medical history, checks medications and then telephones the patient to explain the procedure, confirm the history and advise anticoagulation management if appropriate. The latter was being overlooked by referrers on occasions, necessitating cancellation of procedures. It is also important that the patient is able to lie supine or prone on the scanning table as this is essential for safe completion of the biopsy. Patients are also asked to complete a coagulation screen and have the opportunity to ask questions. The nurse ensures that the patient can arrange transport to and from the department and has someone available to stay with them overnight and is staying in close proximity to a public hospital emergency department in the event this is needed.

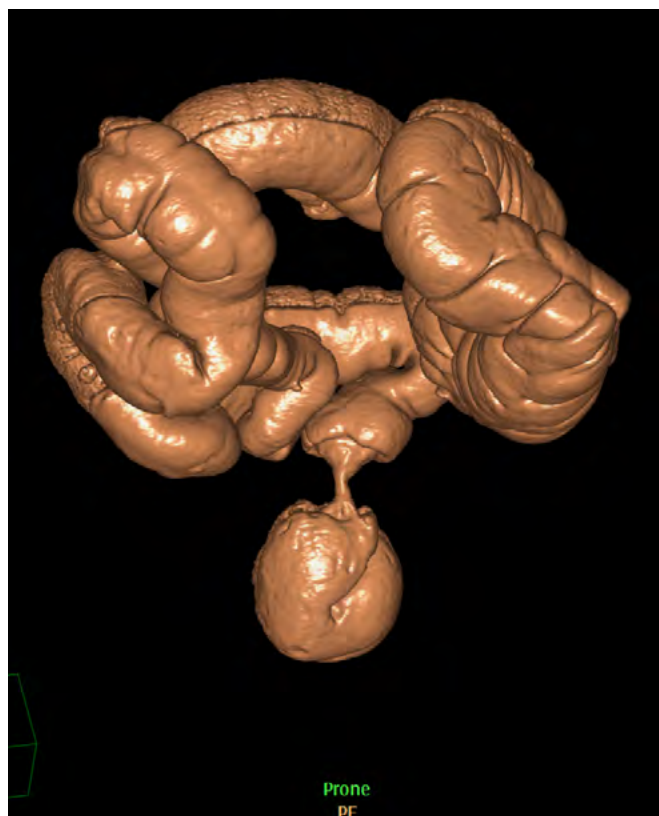
Occasionally overnight hospital stays are arranged if no other options exist. The cell phone number for the GCC Radiology nurses is provided. Any potential issues are then discussed with the performing Radiologist before the procedure, with involvement of the referring service or other specialist services as required.

The assessment conversations are clearly appreciated by the patient and result in most procedures going ahead without further issue. Information gleaned from the conversation is recorded on the assessment/procedure record.



Above: Axial image of the lung showing guide needle positioned in the tumour.
Below: Axial image of the lung showing core biopsy gun in situ.





Three dimensional CTC image of the colon showing an 'apple core' lesion and narrowing in the lower bowel.

Discussion

There is minimal literature available to support radiology nurse involvement in the pre-appointment assessment of outpatients. Assessment of patients when they arrive in the department is an accepted part of their role. Surely telephone call assessment prior to attending the appointment is more logical in ensuring patients understand the procedure, medication is appropriately managed, safety issues identified and preparation is understood and appropriate for the patient.

Interestingly, a paper from the University of Cincinnati Medical Centre talks about the need for a transformation into a patient-centred model of care in which Radiologists are reintegrated into direct patient care and imaging processes are reorganised around patients' needs and preferences (Ittri, 2015).

The initiatives developed by the nursing team in this outpatient radiology facility was done with the agreement and support of the Radiologists and resourced within the nursing team's fulltime equivalent staffing at the time. In hindsight, an initial audit of patient non-attendance or failure to proceed with CT-guided lung biopsy or CTC prior to the nurse's pre-assessment initiative would have been valuable. A follow-up audit and both a patient and staff survey post-establishment of early patient contact would have improved visibility and helped support verbal and anecdotal evidence regarding the effectiveness of the initiative.

The PowerPoint presentation this article was based on was presented at the Perioperative Nurses Conference in Christchurch in October 2024. It is an approach to care which is time consuming but rewarding for the staff and requires an experienced, stable workforce. Unfortunately,

more recent cost-cutting across the New Zealand health sector, loss of senior clinical nursing staff and a freeze on hiring, saw diagnostic radiology nurses classified as the least important members of the team. This has impacted on services and the remaining team's ability to consistently provide this level of care and support to patients.

Conclusion

Nurse review of medical records and a telephone call to patients prior to CTC and CT-guided lung biopsy proved valuable in confirming their attendance and identifying a range of issues, as referral information frequently omitted medications, patient frailty and/or mobility problems. In this way the patient's intent to proceed with the examination could be confirmed, their specific preparation discussed, and any aftercare requirements confirmed.

While time-consuming for staff, this service was enthusiastically received by patients and resulted in enhanced patient safety, better preparation and improved attendance. Positive patient feedback and successful, efficient, trouble-free completion of procedures also enhanced the nurses job satisfaction and cohesion within the wider multidisciplinary team. Pre-appointment telephone-based nurse assessment prior to specific procedures should be seen as an integral part of the radiology nurse role in the outpatient setting.

About the author:

Shona Matthews is the longest serving member of The Dissector team, joining the Editorial Committee in 2010 and serving in that capacity for five years before taking on the role of Chief Editor. By the time Shona stepped down from the editorship in 2020, she had spent ten years with The Dissector, then agreed to remain on the Editorial Committee for another three years to assist. Her nursing career began in Wellington in 1974 and in later life she worked for almost 30 years in Radiology at Greenlane Clinical centre in Auckland. She "hung up her lead apron" for the last time, retiring on Thursday December 12, 2024.



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rachel.phillips@bamford.co.nz or telephone **021 0284 7823** — or click [this link](#) for a video.



Terumo founder on 1000 Yen note

Dr. Shibasaburo Kitasato, one of the founders of Terumo Corporation, has been chosen as the portrait of the new Japanese 1000 yen note. Dr. Kitasato is a renowned medical scientist known as the "Father of Modern Medicine in Japan" for his achievements. He successfully cultivated the tetanus bacterium for the first time in the world in 1889 and discovered the tetanus antitoxin the following year.

Terumo was founded in 1921 by a group of physicians and scientists, including Dr. Kitasato, to meet the desperate need



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for production of quality thermometers in Japan.

These words appeared in the founding prospectus: "As the health of the people of Japan depends on the spread of hygiene awareness, and as the health of the people is the key to national stability, this can be called an industry of national concern."

The founder's mindset lives on in the Terumo Group Mission: Contributing to Society through Healthcare.

Terumo will continue to challenge the advancement of healthcare and the enhancement of patients' quality of life.

Photograph courtesy of The Kitasato Institute Kitasato Shibasaburo Memorial Museum



Bunzl extends its local reach

Tauranga-based healthcare products company Cubro Holdings Limited is the latest to be added to the **Bunzl Asia Pacific** operation. Cubro is the fifth New Zealand medical supplies company acquired by Bunzl.

Cubro began when the Hastings-based Currie brothers invented the Gib Lifter to fit plasterboard to ceilings in a doctor's office in Hastings. The doctor thought the safe lifting device was ingenious and asked the brothers about their other inventions, that could support patients. So began, Cubro's long history of supplying healthcare equipment to help medical professionals deliver the best care.

In 2020 it expanded into the medical devices field with the acquisition of Nelson's Opritech, which has the New Zealand agency for Skytron surgical lights and operating tables. Cubro also supplies theatre equipment and furniture, sterile storage solutions, respiratory systems, wheeled mobility solutions, ergonomic bedroom equipment, medical gas and precision lighting solutions.

Cubro also supplies modular operating theatres in New Zealand, Australia and the South Pacific (including Tonga and Fiji). For the full range of Cubro's operating theatre equipment, click [here](#)

Bunzl Asia Pacific is ultimately owned by Bunzl plc, a London-based specialist international distribution and services group. Bunzl Asia Pacific is the holding company for the Bunzl Group's MedTech and specialist healthcare businesses in New Zealand.

Bunzl plc is a successful specialist international distribution and services Group with operations across the Americas, Europe, Asia Pacific and the UK & Ireland. It was incorporated in 1940 and listed on the London Stock Exchange in 1957, but its origins date back to 1854 when Moritz Bunzl opened a small haberdashery business in Bratislava, now the capital of Slovakia. The business has changed and grown considerably over the years.

Other Bunzl acquisitions in New Zealand include **DBM Medical** (June 2024), **Toomac Holdings** (December 2022), **USL Medical** (June 2022) and **OBEX Medical** (May 2021). ■



The following reports were presented at the 52nd Annual General Meeting of the Perioperative Nurses College of the New Zealand Nurses Organisation (PNC^{NZNO}), held on October 18, 2025 in Auckland – with virtual attendance

Perioperative Nurses College ^{NZNO}

CHAIRPERSON'S REPORT 2025

It is with both immense gratitude and pride that I present my first and final report as Interim Chairperson of the Perioperative Nurses College. Over this past year, we've navigated significant challenges, leveraged meaningful successes, and laid powerful groundwork for our future. It has been a genuine privilege to serve in this capacity and to witness the dedication, resilience, and passion of our membership.

Key Highlights & Accomplishments

1. Advocacy & Submissions to the Nursing Council of New Zealand

- We submitted a comprehensive response to the Nursing Council regarding education standards, advocating for increased perioperative exposure within undergraduate nursing programmes.
- Additionally, a formal letter was presented, thoroughly articulating the crucial need for such exposure to foster awareness and skill development in perioperative nursing.
- These efforts align with our broader mission to cultivate well-prepared perioperative professionals for the future.

2. AORN Global Surgical Conference & Expo, Boston (April 5-8, 2025)

- My attendance at the 2025 AORN conference in Boston was truly inspiring. The event offered cutting-edge clinical sessions, leadership summits, ambulatory surgery tracks, and innovation showcases in technology and patient safety.
- Of particular note were the transformative strides in AI integration within perioperative care — highlighting tools like robotic-assisted surgery, workflow optimization, and predictive analytics that promise to enhance patient outcomes and support nursing excellence.
- This global engagement reaffirmed our commitment to leadership in perioperative nursing and reinvigorated our strategic vision.

3. Educational Platform Development

- We are actively looking into an education platform to offer our membership and further develop the skills and knowledge of the nurses in our profession.

4. "My Health Hub" Webinar Series

- Through our partnership with My Health Hub, we delivered multiple webinars presented by our members — including

clinical experts, educators, and researchers.

- These sessions were exceptionally well received, fostering engagement, knowledge sharing, and connection throughout our community. We look forward to continuing and expanding this successful initiative.

Challenges & Ongoing Considerations

While we celebrate meaningful strides, several persistent challenges remain:

1. Staffing & Committee Vacancies

- o We currently have several key committee positions vacant. It is imperative these be filled urgently to maintain momentum and ensure equitable workload distribution.

2. Ongoing Professional Challenges

- o The perennially evolving landscape — ranging from workforce shortages to evolving standards and technological demands — continues to place pressure on perioperative practice and education.

Looking Ahead: 2026 Conference in Auckland

- We are embarking on planning for our 2026 conference to be held in Auckland. This is a pivotal opportunity to showcase our local leadership and deepen national engagement.
- Immediate need: Members based in Auckland to join the organizing committee. If you are able to assist with planning, coordination, or programming, please step forward — your contributions will be vital to the event's success.

This year has been a testament to the strength and ambition of our College. Through thoughtful advocacy, embrace of international innovation, and dedication to accessible education, we've positioned ourselves for a bright and impactful future.

Thank you to every committee member, webinar presenter, member supporter, and advocate. Your energy and commitment drive PNC forward. I stand ready to support our continued progression and celebrate — with you — the enduring spirit of perioperative nursing in Aotearoa.

Emma Ladley

Interim Chairperson, Perioperative Nurses College
October 18, 2025



Perioperative Nurses College ^{NZNO}

Professional Nursing Adviser Report

I am grateful to the national, regional, and Dissector Editorial and Professional Practice Committees for your continued dedication to the college. I thank Emma Lineham for leading the college and ensuring the voice of perioperative nurses is present in the NZ health system. For your ongoing commitment, leadership and professional engagement, I thank the various committee members who ensured that PNC continued to advance its objectives and engage internationally on behalf of PNC members. I thank the leaving committee members across the PNC network for their participation in promoting and advancing perioperative nursing practice in NZ. None of the objectives of the college would have been achieved without your dedication.

In 2020, I spoke of the NZ graduate nursing process and the need for the perioperative nursing community to embrace graduates. However, in 2025, a mismatch is observed between the number of nurses employed and the demand for them. Additionally, first-year-of-practice graduates have had their employment reduced to 24 hours a week (0.6 FTE). Our graduates have informed us that they will not have sufficient income to cover basic expenses and repay their student debt.

We continue to advocate for and attract nursing graduates to perioperative nursing by ensuring that nursing students have a diverse range of clinical placements within the perioperative continuum and by enabling the existing nursing workforce to showcase their practice through roles as mentors and preceptors.

The Ministry of Health released a document called “Putting Patients First – modernising the health workforce.” This document undermines the nurse’s role, prioritising political mandates over public safety and replacing the profession’s core values with government priorities. NZNO objected to this attack on the regulation of the health workforce. The Ministry of Health’s analysis of this document revealed political overreach in the regulation of health practitioners. The Minister has indicated that the changes to the Health Practitioners Competence Assurance Act will occur in 2026.

I appreciate the national committee’s responsiveness in engaging with national issues, including the consultation requests from the Nursing Council of NZ’s scopes of practice and standards of education, prescribing standards for registered nurses and participating in NZNO activities that have influenced the nursing profession.

There are profound implications associated with Clause 11 of the Pae Ora Amendment Bill, which will prohibit health professionals from speaking out about patient and community safety. Employees of Health NZ will be required to be politically neutral and uphold the principles of public service.

NZNO’s Maranga Mai strategies and initiatives are progressing well. The comprehensive Maranga Mai campaign aims to secure political support and resources to resolve the nursing crisis across the entire health sector permanently. Maranga Mai is a rallying cry for every nurse and the wider community to “rise up” and support our cause. <https://maranga-mai.nzno.org.nz/>

Here are some of the activities of the Professional Nursing Adviser (PNA) team of NZNO over the last year, interspersed with some related activities of the wider professional and industrial services staff:

1. Care Capacity Demand Management (CCDM):

All PNAs are involved with Te Whatu Ora CCDM programmes, working with organisers and member delegates. Many clinical areas are reviewing their staffing methodologies in conjunction with updated standard operating procedures (SOPs). The challenge remains to ensure Health NZ employs sufficient staff to meet patient acuity. Negotiations are ongoing with HNZ on these matters, with no final resolution yet achieved. No new FTE staffing has been implemented since 2023-24, despite HNZ’s commitment to the programme. CCDM remains vital to maintaining adequate staffing across all areas, although delays in implementing CCDM have significantly impacted emergency department staffing.

2. **Providing advice to lawyers and NZNO staff**—such as organisers—on risks to nursing practice and patient outcomes. All NZNO members are required to seek advice on statements, investigations, and inquiries related to patient care. It is also strongly recommended that nurses carry indemnity insurance.

3. Nursing advisers continue to **assist members with workplace change proposals and provide support on professional matters**, including performance improvement plans, ethical concerns, and breaches of standards.

4. **The implementation of the College and Section forums and induction** sessions has been successful, enabling members to connect and share expertise. Attendance at these meetings is funded by NZNO, with the 2026 meetings planned to be linked to Employment Relations Education Leave (EREL).

The NZNO 2024-25 Annual Report is available on the NZNO website, accessible within the member login area. The recent Annual General Meeting of members addressed key issues facing the profession, culminating in the development of policy documents targeting challenges like health system privatisation, deregulation of nursing, the evolving roles

of nurses, and the removal of Te Tiriti o Waitangi from the health system under the current government.

The annual NZNO college and section forums and induction meetings are now central to our activities, and participation is vital.

Challenges are emerging in perioperative departments as new roles are introduced to replace traditional nursing positions.

We must ensure that the nursing workforce is fully utilised.

At the NZNO conference, the new NZNO logo and name were launched.

Welcome to the new committee members. I wish the college success in the coming year and look forward to working with the committees to help achieve your goals. We have more work to do! Ng with the committees to help you reach your goals.

We have more to do!

- Suzanne Rolls,

The Dissector Annual Report

It is with pleasure that I present the annual report of the *Dissector* Editorial Committee. I wish to thank Rebecca Porton-Whitworth, Finau Faka'i, Amber Cox and Sue Clynes for their support and input throughout the year.

We have a new Editorial Committee member, Liying Duan, who has recently joined us.

Rebecca Porton-Whitworth will be stepping down at the AGM and I would like to acknowledge her dedication and service to *The Dissector* Editorial Committee. Rebecca has been an incredibly prolific author and active Editorial Committee member with seven years of service. Rebecca's tenure was due to finish in September 2023, and we are grateful that she has remained on the Committee in a consult/caretaking role.

There is a need for more Committee members, especially those with an OR scrub/circulating nurse background.

The Committee has had two meetings via Zoom this year and had a face-to-face meeting on September 20. As usual we have communicated throughout the year via email and through the use of Dropbox.

Content

There have been significant delays with distribution of issues again this year, with the planned December issue not published until February (renamed December-February) and the March issue not distributed until June (renamed March-May). The delays were again mainly due to the publishers ongoing difficulties with sourcing advertising revenue.

Sourcing content also continues to be very difficult and the Editorial Committee has been under a great deal of pressure to provide material. We continue to rely on re-publishing archival articles to ensure we have sufficient content. Unfortunately, this has meant that we only be able to produce three issues this year.

At the time of this writing, the June-September 2025 issue had not been published due to a combination of lack of content & reduced advertising resource. We are hoping to get the publication dates back on track for the December 2025 issue.

In the December-February issue, along with the 2024 conference and awards reports, we re-published Karen

Hall's talk on the history of the College and Kris Kvick's archival article on the Registered Nurse as First Surgical Assistant.

The March-May issue featured Dallas Jessiman Award winner Rebecca Wood's reflection on attending the conference for the first time, Cassie Scott's QR code article based on her well-received presentation at THE 2024 conference and Sandeep Mullassary's article on Pneumatic Compression Devices. We also republished Rebecca Porton-Whitworth's award-winning article from March 2020 on the Christchurch mosque massacre.

The June-September contained Amber Cox's article on Negative Pressure Pulmonary Oedema (from her talk at conference), Sue Claridge's archival article on Florence Nightingale, *The History of the Dissector* (also from PNC Conference), Assunta Rodrigue's poster from conference and Emma Ladley's AORN Conference report.

This December's issue should include conference reports and awards recognition as well as articles. This issue was still in planning at the time of writing this report.

Regional News

A new format for Regional Reports was agreed at the face-to-face National Committee meeting in February. We are looking forward to these reports becoming a more regular feature again (twice yearly). Regional reports in the new format were published in the March-May issue and are due for inclusion in the December issue.

Incentive to Publish

The Dissector publishes articles with a strong focus on education, research within perioperative nursing, evidence-based practice and news items of special interest. The scheme was instigated in 2009 by then *Dissector* Editor Kathryn Fraser with the support of Advantage Publishing. It is essential to ensure ongoing generation of original articles as this assists PNC in meeting our professional obligation of maintaining our College status.

The incentive to publish payment continues to see College members benefit from writing. PNC provides \$100 and Advantage Publishing provides matching funds. Three authors have received this incentive this year.

Awards 2025

Two *Dissector* awards for contributing authors will be announced at the 2025 College AGM; *The Dissector* First-Time Writer Award, up to \$750 sponsored by MEDSPEC and the Best Article Award for the article judged the best of those published during the year. This award is worth \$1000.

Dissector online

The Dissector continues to be available to a wide international audience through which the College benefits as being the voice of perioperative nursing within New Zealand. Access to the articles published since 2011 is available through:

- Gale: Academic OneFile – 2011 onwards
- Gale: Nursing Resource Center – 2011 onwards
- Gale: Nursing and Allied Health Collection – 2011 onwards
- Gale: Health Reference Center Academic – 2011 onwards
- Ebsco: CINAHL Complete – 2012 onwards
- Proquest: Nursing and Allied Health – 2013 onwards

NZNO members can also access *The Dissector* electronically in the Academic OneFile database via the NZNO website. PDF copies of previously published issues (back to 2021) are available to members on the PNC website.

Circulation

The digital version of *The Dissector* is now distributed by NZNO. Distribution reports are available from NZNO on request.

Future Plans

As always, the Committee welcomes more articles featuring clinical practice, quality and/or innovation initiatives, case studies or other articles of interest to members. We would also appreciate any ideas for themes and articles. The committee is always willing to assist so please contact one of us with your ideas. Regular feedback from regions on their activities will continue to be actively pursued.

Thank you once again to Michael Esdaile and his team at Advantage Publishing for their support and valuable sponsorship of the journal and membership.

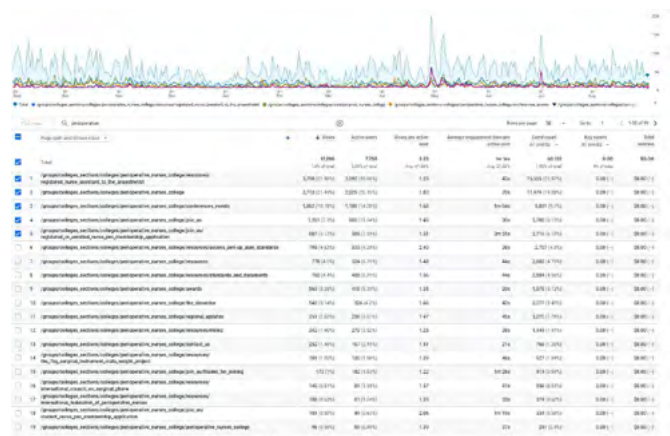
— *Bron Taylor*. Chief Editor, The Dissector

NZNO PNC web pages analytics overview 2016-2025

Late in 2023, Google changed the way Analytics works when it released Google Analytics 4 (GA4). Without going into details, when you read this report please keep the following in mind:

- Instead of Unique pageviews, GA4 now counts Users, i.e. people who go to a page.
- Instead of Avg. time on page, GA4 now measures Average engagement time, as in, people actually doing something on the page.
- GA4 does not report Bounce and Exit rates anymore since they don't reflect usefully on actual user engagement.

We can't compare GA4 with the old Google Analytics, so I started a new data series which will build up over time. For now, here's what we have.



Membership Portfolio Report

At the conclusion of a year on the National Committee of the Perioperative Nurses College, it is with pleasure that I present the annual PNC membership report for the period of 2024-2025.

The latest data reveals the following:

QUALIFICATIONS		PRIMARY WORK AREAS		ETHNICITY (continued)	
Undergraduates	4	Operating Theatres	226	Russian	1
Hospital Certificates	28	PACU	47	USA/Canadian/Hispanic	3
Diploma	34	Medical Imaging	9	Other European	2
Bachelor's degree	98	Surgical	24	REGION	
PostGrad cert.	74	Other	15	Auckland-Northland	61
PostGrad Diploma	24	ETHNICITY		Central North Island	45
Masters	20	Māori	14	Ruahine/Egmont	9
Enrolled nurses	11	Pacifica	2	Hawkes Bay	47
Registered nurses	302	Chinese	4	Wellington	40
AGE RANGES		Filipina	18	Canterbury-West Coast/	55
30 & under	12	Indian	7	Otago-Southland (Southern)	50
31 to 40	61	NZ European	219	MEMBERSHIP TYPE	
41 to 50	59	British/Irish/Scottish	3	Full membership	?????
51 to 60	105	Australian	4	Life members:	16
61 to 70	59	South African	2	Students	4
70+	9	South Korean	2	Māori/Pacifica	6

Suggested Subjects for Dissector

(Note: Two members questioned why we still request member's address now that *The Dissector* is digital).

- PACU related x12 including: Post-op delirium/ Post anaesthesia sentinel events/ Pain management /Paediatrics in PACU/ PONV
- Radiology nursing
- Other nurses work stories
- Anaesthetic assessments
- Transfusions
- Latest wound care
- Preadmission nursing & admission processes
- Emerging technologies and AI
- Staff wellbeing
- Managing incivility
- Outpatient surgery
- Robotics
- Economics and Government spending explanations
- Procurement processes from Government level
- Laryngospasm
- Recycling
- IPC
- Regional anaesthesia
- Recruitment & retention
- Trauma
- Pay Equity
- Crate weights
- Heating & ventilation / Airflows
- Reusable protective clothing
- Obese patients and surgical implications
- New Nursing competencies focusing on Maori patients
- Team culture in the OR
- Urogynaecology
- Curriculum for student nurses and what to follow.

Amanda Figgins



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