

# ANMJ

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## ENGAGING FAMILIES

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FAMILY HEALTH NURSES

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# ENGAGING FAMILIES

MATERNAL, CHILD AND FAMILY HEALTH NURSES



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## Editorial

Lee Thomas, ANMF Federal Secretary



Last month the nation turned its back on exclusion when the majority of Australians voted yes to marriage equality.

The reading of the vote was a momentous victory for the LGBTQI community in which decency and fairness prevailed.

However, tainting the victory was the postal vote process which created a deep division within the community—many endured great distress as a result. Already those within the LGBTQI community suffer poorer health outcomes than others because of discrimination and this is why discrimination and divisiveness must stop altogether.

The ANMF has long campaigned for marriage equality for LGBTQI

Australians. Now that the nation has voted we are strongly urging our politicians to support the introduction of a Bill allowing same sex couples to marry by the end of the year.

After months of vigorous negotiations and industrial action, the ANMF (Victorian Branch) and its members are making headway in settling their enterprise bargaining agreement with aged care provider Bupa.

I applaud the strength of the nurses and carers who took industrial action to fight for what they believed in. Building on this momentum the ANMF is campaigning to fix the aged care crisis countrywide including mandated ratios. I urge you to support this campaign throughout 2018. No longer can we stand by and allow providers to get away with putting profits before their staff and the people they care for.

As I mentioned in last month's issue of the *ANMJ*, after 20 years in the union movement I am stepping down as ANMF Federal Secretary. Not only will this be the last *ANMJ* for the year, but this will also be my last editorial.

I would like to thank you all for the wonderful support you have shown me and to the union movement over the years. Together we have faced many battles resulting in some solid outcomes for members and the community. The unwavering support of members to do what is right for nurses, midwives and the healthcare needs of the community has been nothing short of awe-inspiring and what has kept me passionate and committed to the professions and to the union movement.

LASTLY, AS I SIGN OFF MY FINAL EDITORIAL, I WOULD LIKE TO TAKE THIS OPPORTUNITY TO WISH YOU AND YOUR FAMILY SEASON'S GREETINGS AND A HAPPY AND PROSPEROUS NEW YEAR.

The New Year brings new beginnings and I know I am leaving the union in good hands. To this end, I am certain the ANMF will continue to grow from strength to strength in protecting and developing the industrial and professional needs of all nurses and midwives for many years to come.

Lastly, as I sign off my final editorial, I would like to take this opportunity to wish you and your family season's greetings and a happy and prosperous New Year.

lee



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## BUPA AGED CARE WORKERS BACK PROPOSED DEAL

The standoff between private aged care provider Bupa and its Victorian workforce is nearing an end after 37 days of unprecedented industrial action that triggered historic rolling strikes and a spirited 400-strong rally outside Bupa's Melbourne headquarters.

Fighting for fairer wages and improved staffing levels since 2016, nurses and carers from Bupa's 26 Victorian nursing homes last month voted to stop industrial action and endorse the aged care provider's latest offer, which delivers an 11.25% wage rise over a three-year agreement, including back pay from August this year.

The proposed settlement includes a boost to the Sunday morning shift penalty rate from 150% to 175% for personal care workers and support staff; plus a transition to retirement clause to enable nurses and carers to reduce their hours without affecting their long service leave entitlements.

The deal also contains a fixed workload management clause to address periods of high acuity by encouraging dialogue around emerging workload issues.

Registered Nurse Kitsa, who looks after 65 residents during her regular afternoon shift at one of Bupa's facilities, said she was glad the difficult period for nurses and carers, residents and families was over.

"It is relieving because I think it was only going to get uglier and more confrontational with the company," Kitsa said.

Kitsa conceded Bupa's lack of movement on staffing levels would mean the current strain faced by aged care workers would likely continue.

"We're just going to have to keep doing what we're doing. Luckily, a lot of us are passionate enough to never let our residents' care go downhill."

Kitsa, who was among 400 nurses and carers that rallied outside Bupa headquarters in October and at the time described the historic moment as “spine-tingling” believes the show of strength can still have a lasting impact.

"BUVA MEMBERS BECAME  
ACTIVISTS AND DEMONSTRATED  
THEY'RE SICK OF WEAK AGED  
CARE LEGISLATION THAT FAILS  
TO PROTECT RESIDENTS OR  
THOSE RESPONSIBLE FOR THEIR  
NURSING CARE."

"I think it [the industrial action] has shown Bupa and other aged care facilities that we've had enough. We are prepared to stand up and say no this isn't good enough."

Members from Bupa's 26 Victorian nursing homes began fighting for fairer wages and improved staffing levels in July 2016, when negotiations commenced with management to iron out a new enterprise bargaining agreement.

Despite Bupa posting a \$45 million profit in aged care alone last year, its Victorian nurses and carers languished among the lowest paid in all aged care facilities across the state.

Initial talks saw Bupa management offer a 2.1% wage rise under a rolling one-year agreement.

Almost a year on, in the face of growing resistance and protected industrial action steered by the ANMF (Vic Branch's) #BeFairBupa campaign, the private aged care provider significantly upped its wage rise offer.

The deadlock is now virtually resolved, bar further discussions regarding the ANMF's recommended classification structure that took place at the Fair Work Commission last month.

A final formal ballot will also be undertaken once proposed EBA drafting is complete.

ANMF (Vic Branch) Secretary Lisa Fitzpatrick praised the efforts of the trailblazing aged care nurses and carers who stood up for quality care.

"Victorian Bupa nurses and carers should feel really proud of what they've achieved because this has been a ground breaking dispute with so many firsts in the private-for-profit aged care sector," Ms Fitzpatrick said.

"Bupa members became activists and demonstrated they're sick of weak aged care legislation that fails to protect residents or those responsible for their nursing care."

After making significant inroads, the ANMF (Vic Branch) will now seek to capitalise on the momentum of the Bupa dispute by helping to drive a national campaign for legislated ratios across the entire aged care sector.

"We'll follow the bold new path they've carved and we'll build on that as part of a national ratios campaign."

## NURSING/ MIDWIFERY LEADER APPOINTED TO NPS MEDICINEWISE BOARD

DR ROSEMARY BRYANT  
PHOTO – GREG ADAMS



Australia's former Chief Nurse and Midwifery Officer, Dr Rosemary Bryant AO, has pledged to push for all nurses holding the power to prescribe following her appointment as a director to the Board of independent medicines information organisation NPS MedicineWise.

Dr Bryant joined the Board in October, replacing nursing researcher and long-serving member, Associate Professor Kay Price. She revealed her main motivation behind nominating to sit on the Board surrounds advocating for all nurses having prescribing rights.

"I'm very excited about the possibility of all nurses prescribing and NPS MedicineWise would have a role to play in that in assisting

with education for nurses because if all nurses were to prescribe they would need to do some further education as Nurse Practitioners (NPs) do," Dr Bryant explained.

"Primary healthcare particularly, a nurse being able to prescribe would be beneficial to patient care, patient ease of access, and access to the right drugs."

Established in 1998, NPS MedicineWise is a not-for-profit, evidence based organisation that aims to lead innovation and improvement in the way health technologies, medicines and medical tests are prescribed and undertaken.

Dr Bryant brings a wealth of experience to the Board garnered from high-profile past roles including her time as the Commonwealth Chief Nursing and Midwifery Officer, a position she held for seven years while leading policy development relating to the nursing and midwifery workforce, as well

as a period as the Executive Director of the Royal College of Nursing, Australia.

Dr Bryant previously combined with NPS MedicineWise several years ago when helping to develop prescribing competencies for medical professionals.

Keeping a close eye on international trends, Dr Bryant said nurses in Spain and the UK currently possess the right to prescribe, however not all nurses choose to take up the option, with just 30% in the UK, for example, pursuing the path.

Dr Bryant said if nurses had prescribing rights they would be able to increase their scope and improve the continuum of care.

Dr Bryant said she is eager to begin her new role and promote nursing and midwifery.

"I have had not only a lot of experience in nursing and midwifery but I've had a lot of experience in health and with other professions and the policies around the practice of health professionals," Dr Bryant said.

"It is really important in all areas or scenarios of health that the nursing voice is heard and that nurses bring a different perspective to the table from other health professionals."

Dr Bryant added that one of the advantages of her new role as a director on the Board meant she would now also be able to relay the work of NPS MedicineWise of relevance to nurses so they remain up-to-date with important developments.

NPA MedicineWise Chair Peter Turner said Dr Bryant's knowledge of the health system and strategic leadership would prove a valuable asset.

"Rosemary's impeccable record and leadership credentials representing the nursing and midwifery professions on high-profile government committees make her a highly-valued addition to the Board."

## NEW AGED CARE WORKFORCE TASKFORCE SNUBS NURSES

The federal government has announced the line-up of its new aged care workforce taskforce but nurses are nowhere in sight.

Established to develop a wide-ranging workforce strategy in order to meet growing demand for aged care services, the taskforce will tackle workforce planning, recruiting and retaining qualified staff, examining the sector's leadership and fostering innovative workplace practices in a bid to improve the quality of care.

Professor John Pollaers will lead the 12 member "expert taskforce", which also

includes Dr Stephen Judd, CEO of aged care provider HammondCare, Pat Sparrow, CEO of Aged & Community Services Australia, and Ian Yates, Chief Executive of Council on the Ageing (COTA).

Federal Aged Care Minister Ken Wyatt listed safety and quality as the biggest priorities, pledging exhaustive national consultation would take place with families, consumer organisations, informal carers, aged care workers and volunteers.

Minister Wyatt claimed the taskforce featured people selected from a broad range of areas, including from the aged care sector and beyond, however, the lack of nursing representation marks an obvious slight.

ANMF Assistant Federal Secretary Annie Butler labelled the decision to exclude hard-working frontline nurses and care staff from the taskforce unacceptable.

"It's inconceivable that the federal government has set up a taskforce to investigate aged care workforce issues and develop a strategy without utilising the knowledge of nurses and carers," Ms Butler said.

"Nurses and carers working on the frontline in aged care are best placed to inform on what is required to ensure proper, safe care is provided to elderly nursing home residents.

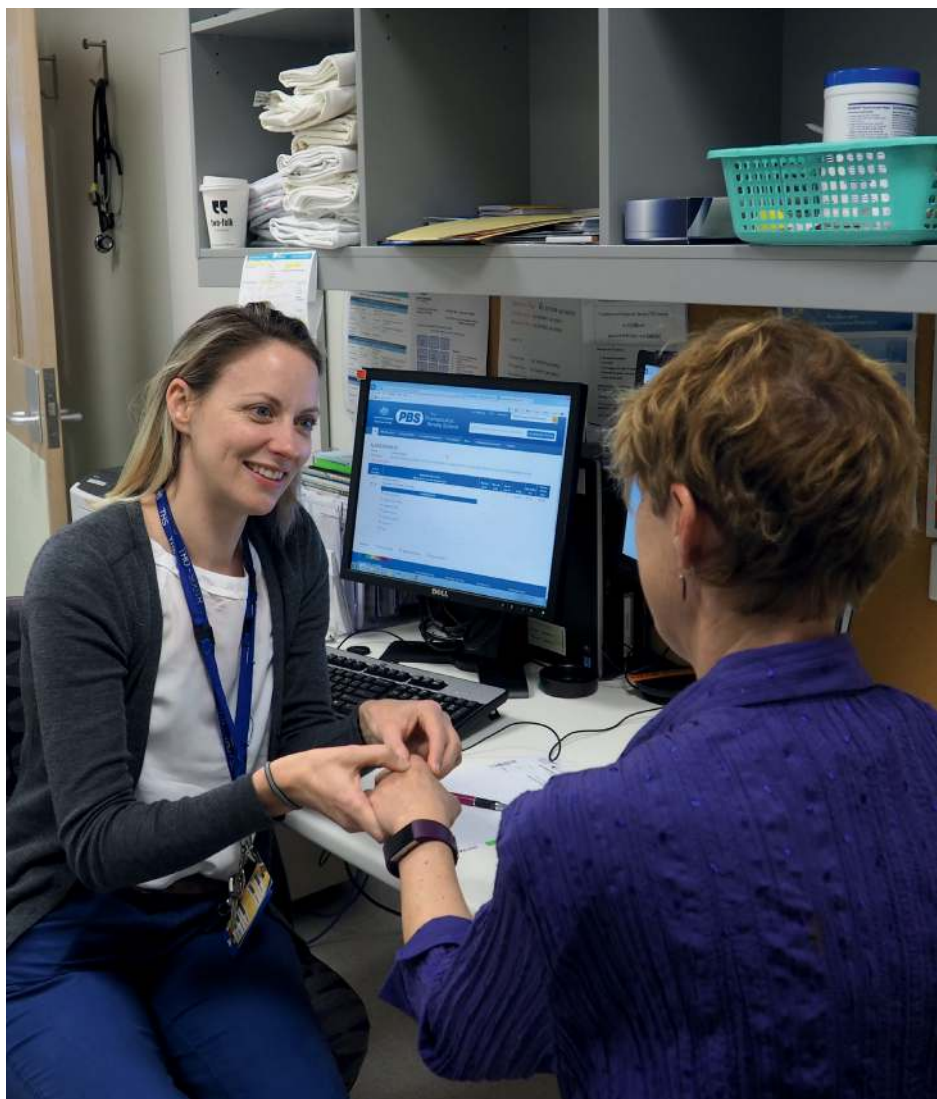
"They are the ones that fully understand the complex conditions of the frail aged and the amount of qualified staff and skills mix required to deliver proper care."

The ANMF has voiced its disappointment to Chair Professor Pollaers, as well as Aged Care Minister Ken Wyatt at being "shut out" from the taskforce.

Nonetheless, the ANMF remains committed to working constructively with all aged care stakeholders as it strives to fix the aged care crisis and safeguard the future of elderly Australians living in nursing homes and their families.

In carrying out its work, the taskforce will assess trends and emerging issues affecting the current and future aged care workforce, consider wider government policy settings relevant to the workforce, keep up to date with Inquiries on aged care workforce matters and engage and consult widely with stakeholders.





TASMANIAN RHEUMATOLOGY NURSE  
EMMA BAVAGE TREATING A PATIENT.

Ms Bavage said specialist rheumatology nurses play a critical role in delivering education, support and helping patients manage their condition.

"In all chronic disease management you get to form close bonds with patients and see how they go over the continuum of their disease," she said.

"We see patients on diagnosis. We educate them on their disease and on all their medications that they may be on. We often become the point of contact if they have a nasty flare-up and we're often that conduit between the patient and the rheumatologist or the primary healthcare provider, so the GP and the rheumatologist."

Ms Bavage said international studies had reinforced the value of specialist rheumatology nurses in improving health outcomes but that Australia had failed to build and attract an adequate workforce.

She took part in the project and assisted by revealing what she considers the largest barrier being funding.

MS BAVAGE SAID INTERNATIONAL STUDIES HAD REINFORCED THE VALUE OF SPECIALIST RHEUMATOLOGY NURSES IN IMPROVING HEALTH OUTCOMES BUT THAT AUSTRALIA HAD FAILED TO BUILD AND ATTRACT AN ADEQUATE WORKFORCE.

## REPORT UNDERScores NEED FOR MORE RHEUMATOLOGY NURSES

A new report by the country's peak arthritis organisation, Arthritis Australia, has drawn attention to the lack of sufficient rheumatology nurses to provide care to an estimated 1.7 million sufferers of chronic, inflammatory forms of arthritis.

Despite inflammatory forms of arthritis costing the Australian health system about \$2.8 billion in 2015, the report found just 39 full-time equivalent rheumatology nurses practice in Australia, or only one nurse for every 45,000 sufferers.

The Australian Healthcare and Hospitals Association prepared the report, *Rheumatology nurses: Adding value to arthritis care*, with backing from peak body Arthritis Australia.

Inflammatory forms of arthritis encompass people living with painful and disabling conditions such as rheumatoid arthritis, ankylosing spondylitis, psoriatic arthritis, gout and juvenile arthritis.

According to the report, only 23% of people with severe and inflammatory arthritis have ever seen a rheumatology nurse as part of their care, and 80% of rheumatology practice takes place in the private sector, meaning that most sufferers do not get access to treatment.

The report argues an increase in rheumatology nurses would result in quicker diagnoses, better psychological support for patients, better quality care, improved health outcomes and reduced health system costs.

"This research confirms that people who see a rheumatology nurse as part of their care are much more satisfied with all aspects of their care than those who do not," Arthritis Australia CEO Ainslie Cahill said.

Tasmanian rheumatology nurse Emma Bavage has almost a decade of experience in the field and works at the Royal Hobart Hospital as well as in private practice.

Ms Bavage welcomes the report's recommendations to drive change by more clearly defining and recognising the rheumatology nurse role, including the skills and competencies required for varying levels of practice, and supporting models of care incorporating rheumatology nurses in both public hospitals and the private sector.

"Because there's so few of us a lot of nurses have never met a rheumatology specialist nurse so they don't actually know the job's available," she said.

"I think musculoskeletal disorders in general get overlooked in training but if you're working on a geriatric unit nearly every single patient is going to have some form of arthritis."

Ms Bavage believes the report can have a significant impact in facilitating improved collaboration between rheumatology nurses and rheumatologists and ultimately improve health outcomes.

"One of the things for patients with inflammatory arthritis is if they don't have good control of their disease they don't participate as well in the workforce, and they have more presentations to Emergency Departments. So if you can have a team that includes a rheumatology specialist nurse to help that control, economically it does make sense."



## SUPERVISED INJECTION ROOM TO BE TRIALLED IN VICTORIA

A medically supervised injecting room will be trialled in the Melbourne suburb of Richmond.

The two-year trial will be supported with an increase of an additional 100 residential rehabilitation beds.

The ANMF (Vic Branch) supported the harm minimisation and health approach in a joint submission with the Victorian Trades Hall Council, to the Victorian Parliamentary Inquiry into medically supervised injecting facilities earlier this year.

"It's heartening to see the government listening to the evidence, changing its mind and making bold decisions to address significant health and safety issues affecting Victorians," said ANMF (Victorian Branch) Secretary Lisa Fitzpatrick. "Sydney's safe injecting room experience and evidence indicates a trial in Melbourne will save lives. Sydney has managed around 6,000



overdoses and has not had one fatal overdose in its 16 years."

Each year more than 1,400 Australians lose their lives as a result of a drug overdose, a figure comparable with Australia's national road toll, said Melanie Walker, Chief Executive Officer of Australian Injecting and Illicit Drug Users League.

"In this context, it's important to focus on practical things that can be done right now in Australia to save lives. If the initiatives outlined in the new National Drug Strategy are to be implemented, federal, state and territory governments all have an important role to play and the Victorian government

has demonstrated its strong leadership in this area."

Ms Fitzpatrick said the trial will provide a unique opportunity for life changing conversations between people with drug addictions and nurses and doctors to help access rehabilitation and support services where they can start taking positive steps to recover. "As a society we are spending way too much at the crisis end of the issue once a person has overdosed. This trial will save and improve lives and facilitate a far better use of local police resources and reduce criminal system costs."

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## NATIONAL PUSH TO CURB SECLUSION AND RESTRAINT

Inadequate staffing levels, lack of resources and nurses grappling with demanding workloads comprise the leading factors standing in the way of reducing or eliminating the use of seclusion and restraint in mental health services, a new research project has revealed.

Undertaken by the Australian College of Mental Health Nurses (ACMHN) and funded by the National Mental Health Commission (NMHC), the project investigated nurse perceptions regarding the barriers and enablers to curtailing the practices within psychiatric inpatient settings and emergency departments.

The report argues national system-wide implementation to reduce or eliminate seclusion and restraint remains inconsistent and that meaningful reform requires collaborative efforts from key stakeholders together with cultural change within the workforce.

Key findings included nurses facing threatening situations on their units and feeling "only somewhat safe", the ability to deliver person centred and trauma informed care being negated by the daily challenges of caring for acutely unwell consumers, and widespread concerns surrounding safety, skills mix and staffing.

The report makes 13 final recommendations it believes can help trigger positive change to reducing and eliminating seclusion and restraint in mental health settings.

They include the NMHC establishing a multidisciplinary Implementation Group to address issues emerging from the research; requiring all nurses working in mental health settings to possess formal postgraduate mental health qualifications; training nurses in de-escalation techniques; providing nurses with the resources to access alternatives to

seclusion and restraint; and actively engaging consumers in prevention strategies.

The report recommends every workplace identify a Clinical Nurse Consultant (CNC) trained in trauma informed care who champions the 'recovery approach' to treatment.

"The improvements needed must include strong clinical leadership, trained and experienced staff, adequate staffing levels, the establishment of constructive staff-consumer rapport and good therapeutic relationships with a focus on trauma-informed, empathic care and team collaboration and cohesion," ACHMN CEO, Adjunct Professor Kim Ryan said.

ANMF (Vic Branch) Mental Health Nursing Officer Donna Hansen-Vella (pictured) said the union welcomed the opportunity to help drive strategies outlined in the report and was eager to be involved in the proposed Implementation Group.

Ms Hansen-Vella said the report's findings echo problematic issues that the ANMF, who represents 20,000 mental health nurses, has been drawing attention to for many years like inadequate staffing and high workloads.

"We know that no nurse goes to work with a plan to restrain or seclude somebody that they are providing care to," she said.

"It's not what you wake up for each day to go to work for. But sadly, we also know that for too long, there's been inadequate investment in what our members report are required levels of qualified nurses in the wards and other care environments like the emergency department."

Ms Hansen-Vella suggested seclusion and restraint still occurred due to a cluster of factors including the poor design of some wards and care environments, as well as emerging violence and aggression seen from patients increasingly admitted to mental health wards incorrectly against their will.

"There's also importantly been reductions in public treatment facilities for people with acute drug and alcohol presentations, which means they are taken to the ED and often admitted to mental health wards against their will while they're still exhibiting high levels of aggression and that often results in an episode of restraint or seclusion."

Ms Hansen-Vella commended the report's goal to ignite a cultural shift towards embracing trauma informed care but stressed change could only occur through investment in qualified nursing staff and ensuring their safety at work.

"When you provide the care that's required because you've got adequate numbers of staff available, you often can intervene and de-escalate something and therefore it doesn't escalate to a situation that requires restraint or seclusion."

"I think these recommendations have the capacity to make a difference but they will require collaborative implementation inclusive of the ANMF, first and foremost, and secondly they will actually require some degrees of funding."

## NEW STROKE AMBULANCE HITS MELBOURNE STREETS



Australia's first ever 'Stroke Ambulance' took to the roads in Melbourne last month. The purpose built vehicle is designed to provide the quickest possible diagnosis and treatment for patients suffering from a life threatening stroke.

The Ambulance features a CT scanner and is staffed by a neurologist, stroke nurse, radiographer and Ambulance Victoria paramedics.

Stroke Foundation Chief Executive Officer Sharon McGowan said with a CT brain scanner on board, assessment and treatment of stroke could begin immediately "in the field", rather than waiting until the patient had arrived in hospital, saving precious time. "When a stroke strikes, every minute counts. Stroke is treatable but it is a time critical medical emergency. A CT scan is needed to diagnose a stroke before the appropriate treatment can be started. Interventions such as thrombolysis (blood clot busting medication) need to be given within 4.5 hours of stroke onset.

"If we can treat patients faster, we can give them the best possible chance of survival and recovery."

Stroke is one of Australia's biggest killers and leading cause of disability. It kills more women than breast cancer. It is estimated Victorians will suffer more than 14,000 strokes this year alone and there are almost 120,000 stroke survivors living in the community.



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## UNNECESSARY USE OF ANTIBIOTICS COULD DIMINISH EFFICACY

Turning to antibiotics to treat a host of common conditions such as leg ulcers, respiratory tract infections, middle ear infections and fevers in children may be pointless and inadvertently increase antibiotic resistance, according to national initiative Choosing Wisely Australia.

Led by Australia's colleges, societies and associations and facilitated by NPS MedicineWise, the organisation aims to improve the quality of healthcare by highlighting unnecessary health practices and encouraging dialogue on tests, treatments and procedures which evidence shows provide no benefit and in some cases can lead to harm.

During World Antibiotic Awareness Week last month, Choosing Wisely Australia emphasised the need for Australians to discuss the proper use of antibiotics with their health professionals.

To push the message, the initiative released 14 recommendations regarding antibiotic use developed by 10 of Australia's specialist medical colleges and societies.

Examples include the Royal Australian College of General Practitioners

discouraging the use of antibiotics to treat middle ear infections in non-Indigenous children aged two-12 where reassessment is reasonable, and the Australasian College of Dermatologists challenging the prescription of antibiotics for inflamed cysts on the skin.

Similarly, the Australasian Society for Infectious Diseases warned against using antibiotics to manage leg ulcers without clinical infections and to treat respiratory tract infections.

NPS MedicineWise CEO Dr Lynn Weekes claimed the unwarranted use of antibiotics could have harmful side effects and ultimately, reduce their power.

"Around 29 million prescriptions are issues annually in Australia, making us one of the highest antibiotic prescribers in the world," Dr Weekes said.

"It's important for doctors to avoid the unnecessary prescribing of antibiotics and for patients to avoid the unnecessary consumption of antibiotics, or we risk losing their effectiveness."

Dr Weekes said consumers could help prevent antibiotic resistance by only taking antibiotics when needed.

She said Choosing Wisely encouraged people to ask their doctors during appointments about antibiotics, the risks, and alternative options.

## PHARMACIES SET TO EMBRACE MY HEALTH RECORD

The federal government's Australian Digital Health Agency has teamed up with the Pharmaceutical Society of Australia (PSA) to boost the number of pharmacists using My Health Record, a digital system that seeks to improve the quality of care by allowing healthcare providers to share secure patient data.

Committed to digitally transforming the health sector, the federal government's latest strategy attempts to increase the number of pharmacists using the so far problematic My Health Record.

The PSA is the peak national body and represents 30,000 pharmacists nationally across diverse settings.

"This partnership will help PSA increase the number of pharmacists working in all practice settings registered, able to view, and automatically upload medicines information to My Health Record," Federal Health Minister Greg Hunt explained.

"PSA will also review, update and develop professional guidelines for pharmacy practice, and implementation tools for digital health."

More than five million Australians currently have a My Health Record, with 12.8 million prescription and dispense records already uploaded to the system.

Australian Digital Health Agency CEO Tim Kelsey argued that the use of My Health Record enhanced clinical decision-making and improved consumer care, particularly for people seeing multiple healthcare providers.

"My Health Record also provides pharmacists access to clinically relevant information from other healthcare providers including hospital discharge summaries, GP shared health summaries, and consumer-entered information about over-the-counter medications and other supplements," Mr Kelsey added.

PSA National President, Dr Shane Jackson, said the partnership would improve collaboration and communication between pharmacists and other health professionals, resulting in safer and more effective healthcare.

"Pharmacists will be able to understand what's happened to the patient in hospital, what changes may have been made, and what they need to do to follow up."



## GAYLE'S LAW SPREADS NATIONALLY

Gayle's Law legislation that strives to prevent remote area nurses from working alone and reduce the risk of violence is likely to extend nationally following unanimous support from Australia's health ministers.

Led by the South Australian government in the wake of the tragic murder of remote area nurse Gayle Woodford more than a year ago, the legislation will enforce a two-person minimum for after-hours callouts in a bid to protect nurses.

The South Australian government is well ahead in enshrining Gayle's Law protections and other states are now on the brink of following suit after last month's COAG Health Ministers' meeting in Canberra where the legislation was solidly backed.

"There will be better protection for our magnificent nursing staff, particularly in rural and remote areas," Federal Health Minister Greg Hunt said.

"The Gayle's Law from South Australia has broad support, unanimous support. Each state will deal with it in its own way, shape and form, but the tragedy of South Australia will now, however, lead to better protection for our nurses around the country."

Christopher Cliffe, CEO of CRANApus, the professional body representing remote health professionals, welcomed the development yet underlined meaningful change would require the implementation of good practices and strategies in consultation with the workforce and communities.

"I'm not sure any one piece of legislation is going to fix the problem," Mr Cliffe said.



"IT MAY HELP. IT MAY CREATE UNKNOWN PROBLEMS FOR PROVIDING HEALTH SERVICES. THERE'S AN AWFUL LOT OF OTHER WORK THAT NEEDS TO BE DONE BEFORE WE CAN SORT OF SIT BACK AND FEEL THAT OUR REMOTE HEALTH WORKFORCE IS SAFE IN ALL LOCATIONS AT ALL TIMES."

"It may help. It may create unknown problems for providing health services. There's an awful lot of other work that needs to be done before we can sort of sit back and feel that our remote health workforce is safe in all locations at all times."

In July this year, CRANApus released its comprehensive Remote Area Workforce and Security Project, which aims to tackle the complex issue.

Strategies include fostering national consultation, the development of national safety guidelines, promoting appropriate infrastructure and a suite of resources including a risk assessment tool, handbook and training materials.

More than a year on since Ms Woodford's death, Mr Cliffe said the remote health

workforce had been galvanised but that progress remained inconsistent.

"I think there are pockets of areas that are doing incredibly good work in regards to addressing all the different challenges that there are to safe workplaces in remote. [But] there are other places that maybe don't see the risk as high as other places do and they also have probably been a bit lax in following or keeping up with the industry, because the industry is ploughing ahead, as is the workforce, in regards to improving safety and security."

Mr Cliffe said recent extra funding received from the government would allow CRANApus to undertake additional safety and security education sessions across the country and ultimately lead to reducing embedded levels of acceptance surrounding unsafe practices.

He commended legislative change but stressed it needs to be backed by greater support and investment.

"We also have the challenge of ensuring that we provide good, safe, accessible and timely healthcare to these people and often these people are some of the sickest people in the country," he said.

"It would be very sad if this legislation went through without consideration of the additional funding that's going to be required to make sure there are two people available at all times in a timely manner."

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## SA BILL AIMS TO PROTECT WORKPLACE HEALTH AND SAFETY REPS

A Bill to increase support for workplace health and safety representatives, including the expanded ability to call on experts to resolve issues, has passed through South Australian Parliament.

Spearheaded by Greens MLC Tammy Franks, the Work Health and Safety (Representative Assistance) Amendment Bill was introduced as part of a campaign to boost support and protection for all workers' safety.

Its approval broadens the scope around who can assist a workplace health and safety representative when issues emerge, allowing for more support and access to greater expertise.

The Bill also brings South Australia in

line with the harmonised model adopted in Eastern states and removes restrictions put in place by the state's Liberal Party back in 2012.

Greens MP Tammy Franks described the development as a "small but significant change" that would save lives.

"This is a Bill that applies to each and every workplace and industry across our state, removing unnecessary restrictions on workers' access to safety assistance and expertise when they need it, preferably before accidents occur," Ms Franks said.

Ms Franks said the rationale behind the Bill was to enable the right experts to determine and resolve safety issues. "The reason for this change is so that assistants have the right experience or expertise to actually help, while dispensing with the need to wait for committee approval."

## FIRST NATIONAL RURAL HEALTH COMMISSIONER UNVEILED

The federal government has appointed Australia's inaugural National Rural Health Commissioner to advocate for rural health reform across the country and help achieve better outcomes.

Professor Paul Worley officially took up the role in late October following a formal announcement at the Rural Medicines Australia Conference in Melbourne.

His focus will surround improving access to rural health services and advancing the National Rural Generalist Pathways, which aims to tackle the longstanding shortage of doctors in regional Australia.

Federal Assistant Health Minister Dr David Gillespie labelled Professor Worley, who holds extensive experience in rural health as both an academic and GP and presently works part-time at a rural practice in South Australia, as a "passionate advocate" for strengthening rural health outcomes.

As the nation's new Rural Health Commissioner, Dr Gillespie said Professor Worley would engage a wide-range of health professionals and stakeholders while working to improving rural health policies and championing rural health issues.

"While developing pathways for rural doctors is a priority, the Commissioner will also consider the needs of the nursing,

PROFESSOR PAUL WORLEY



dental health, pharmacy, Indigenous health, mental health, midwifery, occupational therapy, physical therapy and allied health workforce in rural areas," Dr Gillespie pledged.

ANMF Senior Federal Professional Officer Julianne Bryce said the union looked forward to working collaboratively with the Rural Health Commissioner in order to highlight the importance of all health professionals, including nurses and midwives, and not just doctors working in rural and remote.

"We are cautious about the potential undue focus on the doctor in this role," Ms Bryce said. "The doctor is typically viewed as the answer for rural health when we know the further rural and remote you go the last woman [or man] standing will be a nurse or midwife."

Ms Bryce said the Rural Health Commissioner offered an opportunity to ensure rural health was granted proper

consideration during the development of a range of policies, including those broader than health.

It will be crucial to address the social determinants of health such as education and employment that shape the sustainability of rural areas, she added.

For nursing and midwifery, Ms Bryce said workforce challenges remain the biggest hurdle to delivering the level of care people need in rural and remote, suggesting that nurses need more people supporting them to work to their full scope of practice and allowing them time to carry out essential Continuing Professional Development (CPD) and stay up-to-date with evidence based practices.

"Given that nurses are the largest part of the health workforce in rural areas the ANMF would hope that the workforce focus includes nurses and midwives," Ms Bryce said.

"A lot of maternity services in rural areas have closed so we would like to see a strategy for how they're going to deal with that because there's still far too many people who are having babies on the side of the road or in hospitals where there's no maternity service."

Looking ahead, the Commissioner will also become a member of the federal government's Rural Health Stakeholder Roundtable and Rural Health Distribution Working Group reviewing systems to encourage more regional and remote doctors.

Ms Bryce noted the ANMF had already raised the absence of rural nursing and midwifery representation at the Roundtable with Dr Gillespie and would echo the concerns to Professor Worley in due course.





## NEW PERINATAL MENTAL HEALTH GUIDELINES TO SUPPORT HEALTH PROFESSIONALS

A new set of national guidelines will allow maternal and child health nurses working with pregnant and post natal women to pinpoint those at higher risk of mental health issues and provide improved care.

Released in late October, *Mental Health Care in the Perinatal Period: Australian Clinical Practice Guideline*, arms Australia's health professionals working in the field with access to the latest evidence on best practice in mental healthcare in the perinatal period (during pregnancy and the 12 months following birth).

The guidelines outline direction on screening and assessment, supporting the emotional health and wellbeing of women, assessing mother-infant interaction, psychological approaches to prevention and treatment of depressive and anxiety disorders and the risks and benefits associated with prescribing in

pregnant and breastfeeding women.

Co-author, Executive Director of the Centre of Perinatal Excellence (COPE) Dr Nicole Highet said while the focus of the guidelines was on women, the effects of maternal mental health also extended to infants, families and paternal perinatal mental health.

Dr Highet said the guidelines placed a significant emphasis on supporting increased rates of screening for depressive and anxiety disorders and reducing their impact through early identification and specialist care.

"As well as screening and psychological assessment, the guidelines provides guidance on care for women with depressive and anxiety disorders, severe mental illness (Schizophrenia, bipolar disorder and postpartum psychosis) and borderline personality disorder."

Dr Highet said local and international studies had uncovered a high prevalence of depression and anxiety during pregnancy and in the year following birth.

Ultimately, the guidelines will help health professionals detect and treat conditions that may have a potentially damaging impact on maternal and infant outcomes, she added.

The guidelines, which will apply for the next five years, were updated for the federal government by COPE and an Expert Working Group, and endorsed by the National Health and Medical Research Council.

The guidelines are available on the COPE website: <http://cope.org.au/wp-content/uploads/2017/10/Final-COPE-Perinatal-Mental-Health-Guideline.pdf>



## UNDERSTANDING COGNITIVE DECLINE

Growing awareness of dementia is leading some older Australians to believe their cognitive ability is in decline when it is not, according to a report from National Seniors Australia.

"Consequently people may self-limit their behaviour if they believe they have serious decline, even if the reality is they don't," said Research Director Professor John McCallum.

Fear of consequences such as losing their driver's licence, being ostracised or anxiety about where to go for help caused people to delay diagnosis of cognitive decline.

Conversely, the report, *Better ways of assessing cognitive health*, also found cognition amongst older Australians could deteriorate without people realising it, causing problems in decision-making and putting people at risk.

"Cognition can deteriorate without people being aware of it," Professor McCallum said. "People have to make important decisions about their finances as they age and these decisions can have a major impact on their quality of life, where they live, even their health."

Professor McCallum said the research wanted to find ways to assess alternative screening for cognitive function; if people would use the services if they were available; and where they would prefer to have services delivered and by whom.

He said it took an average of about three years from when the symptoms of cognitive decline first appeared to disease diagnosis. But during this period people could be making important decisions that impacted their personal life and their jobs. "This is especially risky in occupations where a high level of cognitive functioning is assumed, for example among doctors; when people are managing large amounts of money; or when they are deciding on health treatments, housing or when to retire," Professor McCallum said. "Early detection is critical as it allows people to be better prepared to make choices or adjustments before cognition is significantly impaired."

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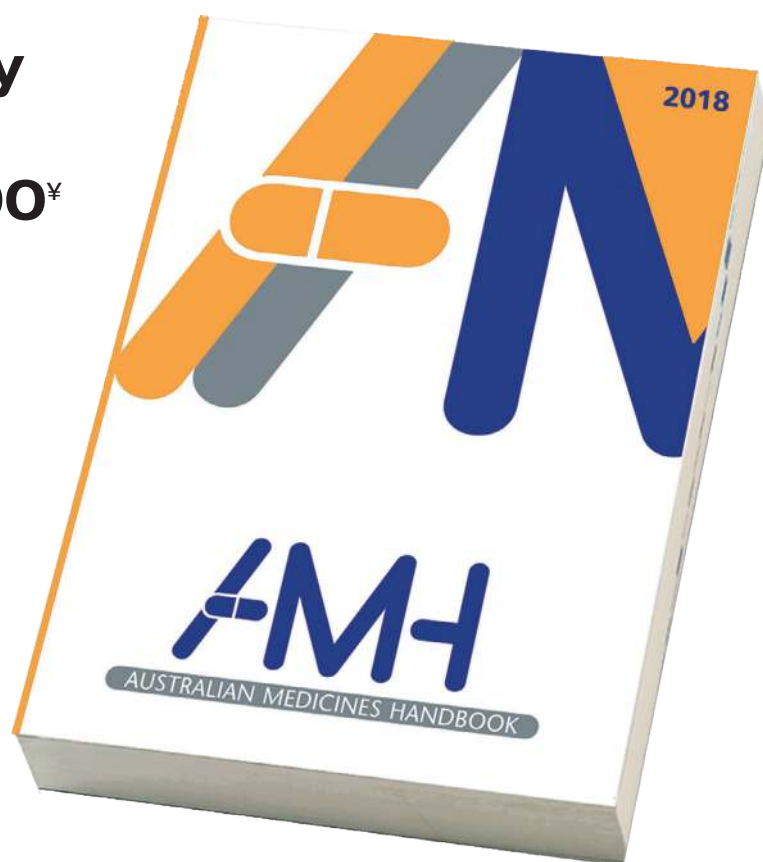
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### \*Here's what Greg had to say:

*“The conference was a success and the location was fantastic. We probably would never had experienced that without AMH.”*

**Adj Assoc Prof Greg Mapp.**

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## TASMANIA'S ACUTE HEALTH SERVICES PROBED

Rising patient demand is stretching Tasmania's public hospital system to breaking point yet funding that would address the problem and enable nurses and midwives to deliver better care remains almost non-existent, the ANMF (Tas Branch) has warned at an Inquiry into the state's acute health services launched last month.

In its detailed written submission to the Upper House Parliamentary Inquiry, the ANMF (Tas Branch) paints a bleak picture of the state's acute health system, suggesting that poor staffing and insufficient resources are compromising patient care.

"Fundamentally, the Tasmanian acute health service is chronically under-resourced in terms of funding, infrastructure, and staffing," ANMF (Tas Branch) Secretary Emily Shepherd said.

"Members and their patients are now suffering from the lack of a long-term strategic plan that is not tied to an individual party or election cycle. The end result is a system that is constantly focussed on reacting to the next crisis and providing short-term stop gap solutions."

In framing its stance, the union pointed to troubling statistics showing that during 2015/16 Tasmania had on average fewer available hospital beds than others across Australia.

Similarly, it cited Australian Institute of Health and Welfare (AIHW) data from 2014/15 that found Tasmania continues to function at least 82 beds short of the national average, with a further 200 beds, or a 16.7% increase required to reach the norm.

The ANMF's written submission highlights a range of problem areas it believes are preventing hospitals from



keeping up with demand.

They include long-standing staffing shortages compromising patient care, nurses commonly being forced to work overtime and being exposed to increased risk of burnout, clinical governance breakdowns, and the rise of bed block where patients needing care have to remain in emergency departments for hours on end because ward beds are unavailable.

The submission also includes personal accounts from members that help further illustrate the strain and impact felt by many frontline workers.

One employee at the Royal Hobart Hospital discloses a senior staff member flouting patient safety by proposing a potentially suicidal mental health patient be admitted to a general medical ward due to lack of beds.

Another ANMF member says the current situation is nearing breaking point.

"I've worked in the Tasmanian health system for all of my career but I have never seen it under this much stress and close to breaking point," the account reads.

At the Inquiry, the ANMF proposed several solutions to improve Tasmania's acute health services, including a wide-ranging long-term strategic plan that considers not just acute health services but also preventative healthcare, as well as major investment in the nursing and midwifery professions.

## SUPER CHANGES PUT WORKERS' RETIREMENT AT RISK

The Australian Council of Trade Unions (ACTU) has urged crossbench senators to oppose the federal government's superannuation Bills currently before Parliament.

The ACTU warned proposed changes to industry superannuation would give more power to banks to access workers' superannuation.

It followed a dossier released by the ACTU last month that details more than 100 banking scandals reported this year. They include situations where customers' superannuation was ripped off, overcharging, and staff harassment.

The government's changes would make it harder for unions to ensure employers were paying workers' super, ACTU President Ged Kearney said.

"The government's changes will mean that workers' super payments will be accessible to the big banks and that as a result, it will be harder to ensure employers are paying workers their super."

The changes before Parliament would remove representatives of working people from super fund boards and subject industry super to more regulation than the banking or financial sector have to comply with.

"The government's changes will see the boards of industry super stacked, and reduce the collective power of working people to get better returns," ACTU Assistant Secretary Scott Connolly said.

Independent research already shows that \$5.6 billion of super is unpaid every year.

The ACTU report shows bank scandals and rip-offs cost Australian workers more than \$480 million since 2015.

The ACTU also called for shareholders of Commonwealth Bank (CBA) to support resolutions to hold CBA to account. The CBA has been ordered to pay back more than \$100 million to its superannuation customers after systematically overcharging them. CBA also stands accused of breaching anti-terror and money-laundering laws, defrauding customers and stealing workers' wages.

The ACTU dossier, which will be sent to all MPs, was further proof of the need for a Royal Commission, unions argued.

## NURSE PRACTITIONERS WANTED

The University Of Sydney is seeking Australian Nurse Practitioners (NPs) to take part in a study to investigate their current prescribing practices.

The purpose of the study is to explore the different medicines, behaviours and information sources that shape prescribing medicines in current practices. Exploration of this study will help researchers understand the capabilities of Australian NPs in their current prescribing practice. To take part in the study participants need to complete an anonymous online survey, which should take approximately 25 minutes.

To partake in the survey go to: <https://redcap.sydney.edu.au/surveys/?s=4CY7RAMX7H>

For further information contact Jacqueline Fong on 0405525482 or [Jacqui.fong@sydney.edu.au](mailto:Jacqui.fong@sydney.edu.au)  
Survey closes 22 December 2017

NSWNMA DELEGATES AT ANMF'S BIENNIAL NATIONAL CONFERENCE



## ENACT MARRIAGE EQUALITY LAW THAT REFLECTS YES VOTE

The ANMF warmly welcomed the result of the marriage equality postal survey and immediately called on politicians to pass a same-sex marriage Bill that reflected the 'yes' vote.

The ANMF has long-campaigned for marriage equality for LGBTQI Australians. The push to change the law to allow same-sex couples to marry was widely supported at the ANMF's Biennial National Conference in October.

"It's a special day for our members in same-sex relationships who can be heartened that Australians have spoken and have come out in strong support of equality – introducing a new, fairer law which will give same sex couples the same rights as the rest of the community," ANMF Federal Secretary Lee Thomas said following the result on 15 November.

It was the end of a divisive three-month campaign, Ms Thomas said.

"Unfortunately, the plebiscite has created deep division within the community and as healthcare professionals, we acknowledge the compelling research that shows that members of the LGBTQI community suffer

poorer health outcomes, compared to others, as a result of discrimination."

Debate on potential amendments to a Bill to legalise same-sex marriage began in the Senate on 16 November, the day after the historic national postal survey result.

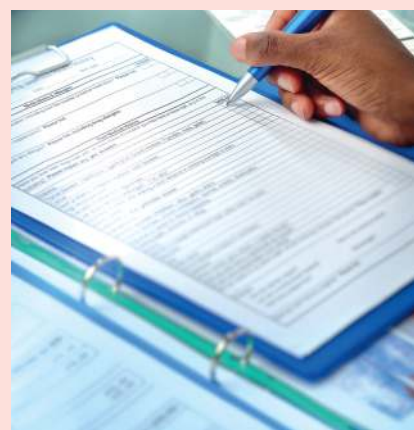
Politicians must respect the result of the national vote and support the introduction of a Bill that allowed same-sex couples to marry by the end of the year, Ms Thomas said. "Any other Bill, as being put forward by Conservative MPs, will be contrary to what the majority of Australians have voted for – a fair go for all."

**POLITICIANS MUST RESPECT THE RESULT OF THE NATIONAL VOTE AND SUPPORT THE INTRODUCTION OF A BILL THAT ALLOWED SAME-SEX COUPLES TO MARRY BY THE END OF THE YEAR**

Labor Senator for South Australia Penny Wong said Australians did not vote to licence more discrimination.

"I think Australians would look very unkindly upon people who seek to move amendments that they know are about trying to sink the Bill because that would be a breach of faith with the Australian people and the result that has been announced."

Any law could not be changed before the House of Representatives reconvened for Parliament's final sitting which began on 27 November, as the ANMF went to print.



## LOST OPPORTUNITY TO USE PATIENT SAFETY RECORDS

Australian hospitals must release more patient safety records and treatment outcomes in order to drive the improvement of care and better engage consumers, according to the Consumers Health Forum (CHF).

A report issued by the Grattan Institute last month found while hospitals routinely collect large amounts of patient data only a small amount ever reaches the public or doctors outside of hospitals.

The report, led by Professor Stephen Duckett, found hundreds and thousands of incident reports are made each year.

Yet in Victoria, for example, the state's investment in facilitating increased reporting led nowhere and did not trigger recommendations or actions to improve care.

"Given modern day expectations of transparency and accountability, hospitals and governments should be enabling the orderly release of these data to doctors and patients," CHF CEO Leanne Wells said.

"We are foregoing a treasure trove of information which could support both better care and better-informed consumers.

"Quite apart from the lost opportunity to deploy effective hospital reporting to support better training to help reduce avoidable outcomes like hospital-acquired infections and surgical problems, consumers are being deprived in many cases of the detailed information collected on hospital performance which could help them assess which hospitals to go to."





## GLOBAL

## WHO APPOINTS CHIEF NURSING OFFICER

The World Health Organization (WHO) has appointed a Registered Nurse from the Cook Islands with more than 30 years' experience in public health as its new Chief Nursing Officer.

Registered Nurse Elizabeth Iro (pictured), the Cook Islands' current Secretary of Health, will step into the role following an announcement by WHO Director-General Dr Tedros Adhanom Ghebreyesus at the recent 68<sup>th</sup> session of the WHO Regional Committee for the Western Pacific, held in Brisbane.

The appointment of a nurse to WHO's senior leadership team marks a significant development that will ensure the profession's voice is heard.

As Secretary of Health in the Cook Islands, Ms Iro has implemented health reforms to strengthen the country's health system, including the development of the country's National Health Roadmap 2017-2036 and Health Clinical Workforce Plan. For the first 25 years of her career, she was a staff nurse, midwife and charge midwife at hospitals in the Cook Islands and New Zealand.

"Nurses play a critical role

not only in delivering healthcare to millions around the world, but also in transforming health policies, promoting health in communities, and supporting patients and families. Nurses are central to achieving universal health coverage and the Sustainable Development Goals," Dr Tedros said.

## UK

## ENGLAND CHALLENGED BY DROP IN NURSE NUMBERS

National policy and planning for the National Health Service (NHS) workforce in England is falling short, with high staff turnover and a drop in student nurses among widespread problems, according to a new Health Foundation report.

Despite the NHS workforce increasing by 2% in the year to April 2017, the number of nurses fell by 0.2%. Elsewhere, 1,220 fewer students from England began undergraduate nursing degrees this year.

The report also showed the annual rate of people leaving the NHS reached 30% in some trusts, triggering both financial implications and reducing the continuity of care for patients.

Royal College of Nursing (RCN)

Chief Executive Janet Davies said the drop in nurse numbers was "deeply worrying" and potentially damaging due to nurses tackling rising patient numbers.

"The reduction in students begs the question of how the promised expansion in nurse numbers in the future can be achieved," Ms Davies warned.

"It is shocking to learn that some parts of the NHS are losing almost a third of their entire staff every year. We know that poor morale among nurses is being exacerbated by low levels of pay and inadequate staffing."

## IRELAND

## IRISH HEALTH SERVICES FACE LOOMING CHALLENGES

A 5% increase in the nursing and midwifery workforce over the next five years is among core goals flagged as crucial to addressing Ireland's impending rise in demand for its health service.

The Economic and Social Research Institute released a report that outlines massive challenges ahead for Ireland's health service due to demographic changes set to occur in the country in the next 12 years to 2030.

The report identified a need for major expansion of all areas of the health system to ensure services can meet anticipated demands, declaring the use of acute hospital services would rise up to 33% and older person services up to 54%.

The report backs the Irish Nurses and Midwives Organisation's (INMO) calls for greater investment in the country's nursing and midwifery workforce, including education and retaining sufficient nurses, along with a minimum of 2,000 more acute beds to meet growth and funding to establish a range of services such as long stay and intermediate beds to cater to older people.

The INMO called on the government and all key stakeholders to move from analysing and strategising about the challenge to committing to real action, capital investment and delivering a sustainable health service capable of meeting demand.

"This is a most sobering, evidence based and well researched report which confirms the dramatic challenges facing the health service over the coming decade and beyond." INMO General Secretary Designate Phil Ni Sheagghdha said.

"This report requires an immediate, collective and sustained response from the political system and across society, which must address the resource implications arising from the report."

## NEW ZEALAND

## NURSES SEEK FUNDING BOOST

The New Zealand Nurses Organisation (NZNO) is calling on the country's new government to restore \$2 billion in cuts to health funding executed earlier this year by the previous government in what it's dubbed the 'scrooge health budget'.

NZNO acting Chief Executive Jane MacGeorge said health emerged as the leading issue in the recent election and that the organisation had welcomed numerous Labour Party initiatives including nurses in schools, increased funding for the delivery of primary healthcare for mental health, and reduced fees for GP visits.

Yet with just five months until the current government delivers its own debut budget, Ms MacGeorge forewarned that it was now time for action to correct a health budget plagued by years of funding stagnation.

"The underfunding of our health services has led several district health boards (DHBs) to cut costs, resulting in fewer nurses being available to ensure safe staffing levels and practice and cutbacks in expenditure on basic healthcare tools."

Ms MacGeorge said surveys had revealed many nurses believe cost-cutting is affecting the time it takes for their patients to recover.

"Underfunding ripples across the system, for example, limiting the time nurses have to support new graduates, attract and retain senior staff, take up new training and has a negative impact on job satisfaction and workplace relations."







# ENGAGING FAMILIES

## MATERNAL, CHILD AND FAMILY HEALTH NURSES

Have you ever wondered what's involved in practising as a maternal and child health nurse? **Natalie Dragon** investigates the different aspects of the role and the significant difference these nurses can make to the lives of young families.



**"**I enjoy the real life complexity. As much as our role is based around growth and development assessment, it's also much more than that - it's about family functioning," says Victorian maternal and child health (MCH) nurse Fleur Turner.

Every day the maternal and child health service is accessible in Bayside, Melbourne through home visits, drop-in sessions and the 24-hour phone line.

"It can be daunting when parents go home from hospital with a newborn baby. I feel privileged to go into somebody's home; it can be quite intimate with new parents looking at a baby only five to 10 days old in the first home visit," says Fleur.

"You have to be mindful that you are in someone's home. It's a different shift to when someone comes in to see you in your office."

Support and education for families is really important, says Fleur. "Baby cues, sleep and settling, skin care, growth and nutrition in the first few months then starting food. Then it becomes sleep and behaviour, toilet training, etcetera as they get older. It's the changing milestones.

"I love doing what I do mostly because of the continuity of care. It's such a privilege watching them grow from babies to pre-schoolers."

Victorian MCH nurses follow 10 key growth and development assessments from birth to three and a half years.

"Our role also encumbers immunisation promotion and information, breastfeeding and lactation support and linkages to local services such as new parent groups, playgroups, playhouses and kindergarten services," says Fleur.

"The other enhanced area is support for vulnerable and high risk families with complex needs, such as mental health issues, drug and alcohol use, child protection, and domestic violence."

Victorian MCH nurses screen women for domestic violence at four weeks.

"I think because we directly ask a question. We are often the first person told, we refer on but we still need to handle that conversation which is why it's so good to have that continuity of care," she says.

Similarly, women are screened for postnatal depression at eight weeks post birth. "Sometimes a woman might be smiling at me and she's scored very high for stress, anxiety and depression. Often if you don't directly ask you wouldn't know. Some people are really very open and other people feel shame and guilt," says Fleur.

"It's why communication skills are so important. It's why I always ask 'How are you?' I stop looking at the baby and look at the mother. Some women will say 'I'm having a bad day'."

While not counsellors, Fleur says a key attribute of the role is the ability to listen and be sensitive, particularly when wanting to guide families towards referral.

"If there's a developmental issue, for example there is no eye contact with a child, you have to be gentle in providing that message.

"Sometimes it's about planting the seed and asking the question. Often it sits with someone and they may come back to you, such as smoking or domestic violence."

Fleur says she gets immense satisfaction in making a difference to helping people. "It's a satisfying job."

### Primary healthcare role

There are many different titles of the role both within Australia and overseas. In the Australian setting maternal, child and family health nurse (MCAFHN) is the term used to describe the specialty.

The role is embedded in the principles of primary healthcare under an umbrella of universal service delivery. MCAFHN work in community settings within the primary healthcare domain.

Many nurses have gained midwifery qualifications but it's not required in all state and territories. Most will have a specialist child and family health postgraduate university qualification.

Previous research has highlighted that inconsistencies between jurisdictions in educational requirements, nomenclature and professional recognition of practice makes it difficult to define and work towards standards for best practice for the MCAFHN.

Former ANMF Federal Vice President and Victorian MCH nurse Maree Burgess says the specialty is a diverse group that provide a range of services to children and their families.

"Indeed, on a state by state and territory basis, the more we network, the commonalities in practice become very clear and the differences better understood.

"I believe that across Australia, maternal and child health nurses have a common vision for the provision of health services for families, however we acknowledge the very real differences between the states and territories in relation to educational preparation and service provision.

"It is paramount that in our deliberations, we respect difference, continue to build connections and look to develop standards



WA MCH COORDINATOR LIESL BAXTER WITH CLIENT KATHRYN



of professional practice which acknowledge the breadth of practice in Australia."

Several states, including Victoria and Tasmania recently celebrated 100 years of service provision. In the early days, prevention of transmission of infectious disease was the biggest issue, such as diarrhoeal diseases which were killers of infants, says Maternal, Child and Family Health Nurses Australia (MCAFHN) President Creina Mitchell.

"It was education on the importance of hygiene and sanitation. Now, it's immunisation. In Victoria and NSW there have been recent outbreaks of measles and [MCAFHN] nurses are explaining the importance of immunisation."

A health promotion focus now includes early onset of chronic diseases and risks such as obesity, with education on appropriate nutrition and child size serves.

"A lot is about education, such as cleaning teeth and dental caries. There are high rates of hospitalisation for under-fives to remove decayed teeth due to drinking sweet drinks where children are not taught to clean their teeth," says Ms Mitchell.

## Childhood health and wellbeing

Research increasingly shows the early years are vital: early exposures and experiences

impact on the developmental trajectory, including health, across the lifespan.

The role of MCAFHN across Australia is to deliver services to enhance the growth and development of children in the early years, says Ms Mitchell.

"For MCAFHN in Australia the workforce is involved largely in service delivery which is nurse led and at the forefront in primary and prevention for families with pre-school children."

Health promotion and early intervention are key components of the role. After initial post-birth home visit, well baby checks are routinely conducted by MCAFHN in Australia. Not just to 'weigh babies' but to provide advice, education and support.

The role is comprehensive and diverse and differs to that of GPs who work from a different model, says Ms Mitchell.

"They [GPs] are the first port of call when families and children come in unwell or perform the child health checks. We provide another service – of education and support and assessment of child development. It's not surprising that MCAFHN have a really broad scope of practice."

It's an area well known to the service users, largely women who have had children – who have a real understanding of what the service offers, says Ms Mitchell.

"Outside of this, the role is not that well

known and nurses have not necessarily seen it as exciting as say the ED."

Child and family nurses provide family centred nursing care, she says.

"MCAFHN build relationships and trust, they see that families can be complex; there are real issues and you need to start with what's most important, not all at once. It's about what's a priority in partnership with that family 'this is the biggest issue for me.'"

"It's about working with parents. We are really trying to upskill and support families at this time with a focus on positive parenting practices."

## Therapeutic relationships

Working in partnership with families and developing trusting relationships is crucial, says ACT's Jill Pearson.

"I work with families in a partnership model; I work with them to their strengths. It's so important to listen. What you think they want is often not what they might want. I often say 'from my perspective if I referred you on to...will that help?'"

A large part of the role is often giving people support for unexpected outcomes, says Jill, a MCAFHN of nine years.

"The woman who has had a third degree tear after childbirth. We cannot answer all of people's needs; there are community resources to refer people on to.





**‘THE SCIENCE SHOWS US THAT BIOLOGY IS NOT DESTINY – AND THAT WHAT CHILDREN EXPERIENCE IN THE EARLIEST DAYS AND YEARS OF LIFE SHAPES AND DEFINES THEIR FUTURES...’**

UNICEF Executive Director  
Anthony Lake 2016

CITY OF WHITTLESEA  
ABORIGINAL MCH NURSE TEAGEN  
CORNELISSENS (CENTRE)

“We need to be able to assess in our home visits and glean enough of the history to ascertain the level of support needed. And ask: ‘How are you feeling?’ ‘I am feeling and doing ok.’ If not, we need to give the support early on so that parents do not flounder. The service is there for as often or as little as families need.”

### Child health specialists

Maternal, child and family health nursing is a specialty, says Jill. “We have a fairly defined area of practice – zero to five years and so we do become specialists - child health nurse specialists.”

Nurses looking for a career path in the specialty should immerse themselves in the knowledge of normal child health and development, she says.

“The biggest thing is to have a really good knowledge of child development, to have that base knowledge of what’s normal: soak yourself in the normal.”

“The role is to know the normal to be able to pick up the abnormal. To know what to expect at two, four, and six weeks to 12 and 18 months and then three and four years. To know what the normal is and systematically go through the process of growth and developmental check.”

It’s also important to question what you know, says Jill. “The more you know, the

more you know you don’t know.”

### Strengths based approach

The MCHFN emphasises a strength based approach working with the strengths of the family and empowering them.

The nursing role is supporting that family whether that be a listening ear to initiating referrals for an identified need, says City of Whittlesea Maternal and Child Health Coordinator Karen Mainwaring.

“It’s a big transition period for families with newborn babies. The MCH nurse role is empowering families in making that transition, providing them with education on new baby forming attachment, growth and development; linking them into any other supports or services they might need; and being supportive with decision making.”

Whittlesea Council is one of 10 organisations across Victoria to have just received additional funding to deliver improved maternal and child health services to Aboriginal families and children.

The Whittlesea catchment, north of Melbourne is a significant growth area. There were 3,400 births in the past financial year, with a significant Aboriginal population in the 0-5 age group.

While many engaged with the maternal and child health service there were a number who had disengaged for various reasons,

says Ms Mainwaring.

“We identified the need to strengthen our partnerships in providing care to women and babies in the antenatal to postnatal period and beyond. It’s the whole gamut of maternal and child health services and to look at families who are disengaging - to give families a choice of the care they want, the universal maternal and child health service or alternate pathways to bridge the gap.”

“With the Aboriginal service, it’s individual and it’s about choice. Many families are happy to engage with the universal service. Other families have specific needs.”

City of Whittlesea have a MOU with the Northern Hospital and the Koori Maternity Service. Whittlesea Aboriginal MCH Nurse Teagen Cornelissens attends antenatal appointments with a midwife at the Northern Hospital where appropriate to make the bridge from the hospital to the community.

“I make face to face contact and get to know them [clients] in addition to the midwife. This is a significant approach to work closely with Aboriginal women, to engage them and have continuity of care.”

A proud descendant of the Badimia People in Geraldton, Western Australia, Teagen says trust builds over time with Aboriginal families and children.

“We know from the broader picture that this group has significant health risks,



## 'YOU BUILD THAT RELATIONSHIP – THAT IS THE ESSENCE OF MATERNAL AND CHILD HEALTH NURSING AND THE CONTINUITY OF THAT RELATIONSHIP.'

Catina Adams

not just necessarily in Whittlesea and there is risk of disengagement because of past experiences."

Trust is crucial for these families, says Ms Mainwaring. "It's a journey alongside families to support them in their journey of parenthood. The service is voluntary. Families choose to come to us – it's their choice. If they aren't happy or comfortable they won't come back. We have to recognise what's the most important thing for a family at that time."

The service also offers a Universal Family Engagement Program which seeks to engage families who are unaware of the service or have disengaged for some reason. It is a range of ways of engaging including pop-ups at play centres and play groups where families meet.

"We set the scales up and let families know we are available. We have had to be flexible and creative to meet the needs of families in the community," says Teagen.

Each municipality looks at what they need; there is no one size fits all, says Ms

Mainwaring. "We change to meet the needs of families, we need to continually review – it's about being proactive not reactive."

### Engagement

The Child Health and Parenting Service (CHaPS) was recently awarded for its work by the ANMF Tasmanian Branch. CHaPS is a state-wide service for children 0-5 years, in two regions North-North West and South of Tasmania.

CHaPS Assistant Director of Nursing South Kim Parker said historically it had been difficult to engage and keep the community engaged in the region.

"We have been able to think outside the square and work in partnership with the community, to better meet their needs, and build on their strengths rather than focus on the negative. Now our rate of engagement in the first year of life of that child we have close to 100% and even into the second year."

CHaPS CFHN Wendy Spinks says the service needed to come up with sensible engagement and sometimes think outside the box.

"We have some extraordinarily complex families - we have a disproportionate amount of congenital defects, complex medical conditions, drug and alcohol use, complex mental health issues - and it really guides our practice.

"We had to go in and acknowledge where there was disrespect we fostered respect; where there was miscommunication we developed excellent communication; where there was equity issues we provided honesty about what we could do. Getting to the core is respect, communication and client-centred goals."

Wendy says CHaPS practice nursing based on a primary nursing model for the family.

"We make a five-year commitment and get to know our families - it might take two to five years to reach our outcomes."

Nurse Unit Manager Liz Jayatunge said routine growth and developmental checks were really important to reach the next level for clients.

"They open the door for families to come back when they have a need – when they need that extra support and realise that you are there. Where we have needed

to make some changes, we demonstrated real partnerships with vulnerable families to achieve good outcomes."

CFHN Gwyneth Delpero said honesty with clients also helped foster engagement. "Honesty from day one really helps, particularly for when you are delivering distressing news. We do deal with vicarious trauma and that is quite confronting. We keep clients in the loop and have an open conversation."

Similarly, Derbarl Yerrigan Health Services in WA has seen positive results in engagement and uptake of maternal and child health services.

Maternal Child Health Coordinator and Eligible Midwife and RN Liesl Baxter said maternity services were welcoming, culturally safe, responsive and respectful. The underpinning Maternal and Child Health Model of Care in the Aboriginal Community Controlled Health Sector was an accepted and community informed model of care in the Indigenous demographic.

A big part of the organisation's success is the Aboriginal health workers first policy with key role models engaged in service delivery, strong community advisory and evidence based practice, Liesl says.

"Essentially what we deliver is the same as mainstream services. It's the way we deliver it – the HOW we do it that is different and that's really important."

It's about development of therapeutic relationships and the development of trust, she says. "We provide longer appointments and we really focus on continuity of care to keep that engagement strong. We have had strong successes such as increased immunisation and Pap smear screening rates.

"Every Aboriginal woman wants what other women want and that's continuity of care and even more than other women they need longer appointment times in terms of the cultural context. The midwife is often working with concepts of care that a client has not grown up with and it's not necessarily something a client may understand. You may not be scared of a stethoscope because you've grown up knowing it but an Aboriginal woman may view it with suspicion and may need to know it doesn't extract or give spirits. Similarly sometimes health decisions may involve a family, not an individual. Empowering clients with knowledge and understanding and ensuring informed consent for health care is integral for all clients. Ensuring foreign concepts are understood takes development of trust and extra time to ensure understanding cross culturally."

As a practitioner, Liesl acknowledges she is in a unique position of advocacy.

"My job is to maximise opportunity to provide a holistic patient journey that is protective of the client. I need to ensure as much as possible that people come out the other end feeling better not worse for the experience. We need to facilitate a safe experience for them and as practitioners really understand the Equal Opportunities adage "In order to treat me fairly you may have to treat me differently."

"I ask myself often 'Why do we do what





THIS PAGE: CHaPS TASMANIA: L - R KIM PARKER ASSISTANT DIRECTOR OF NURSING SOUTH, WENDY SPINKS CFHN, GWYNETH DELPERO CFHN, SUE-ELLEN MCSHANE CFHN AND LIZ JAYATUNGE NURSE UNIT MANAGER. OPPOSITE PAGE: CHaPS CFHN'S WENDY SPINKS (FAR LEFT) AND SUE-ELLEN MCSHANE (SECOND RIGHT) WITH MUMS EMILY AND SHANNON

we do? The reason is that I want to make a difference. I wake up every day and know that I have the capacity and the honour to make a difference with every patient interaction I have."

### Vulnerable families

Research has identified the need for nurses to develop trusting relationships with 'at risk' families. Churchill Fellowship recipient Catina Adams is currently studying enhanced programs offered by maternal and child health services in Victoria.

"The intention is to support vulnerable families. Any family can become vulnerable; changes in their circumstances can make them vulnerable.

"This may include losing a job, the mother losing someone important to her, or having a child with an illness.

You have to be respectful of priorities, says Ms Adams who works with vulnerable families in Broadmeadows, Melbourne.

"My priority as a maternal and child health nurse might be to get a child weaned off a bottle at two years to protect their teeth and for better nutrition. As I work through this with the woman, I realise that the bottle is protective because when the baby cries, her husband becomes angry. Women are very good at working out what they need to do. You need to let her tell you, she's not worried about the bottle at all - she actually needs support with a safety plan."

Ms Adams' research is also looking at patterns of disclosure. "It's about having conversations. And it's done in the client's home, on her turf, you're her guest. Not in the clinic where she is less likely to disclose to you.

"We receive a referral 'my baby won't stop crying' or 'my toddler is out of control'. The nurse gets to the home and it's not about the baby at all. In two to three visits it might be significant mental health issues where the woman is really depressed and anxious, or undisclosed family violence. You build that relationship – that is the essence of maternal and child health nursing."

Ms Adams says it is about developing the therapeutic relationship. "When you have a therapeutic relationship it doesn't matter what we are saying whether it's about healthy food and nutrition, safe sleeping, whatever you are talking about, it's the relationship. It's having the support from a non-judgemental caregiver that is important to women."

You have to keep the big picture in mind, but it's also about the individual interaction, Ms Adams says. "I know that every single word, every single exchange with a woman has the potential to change her life. I know that we make a difference every single day, one woman at a time."



**'I KNOW THAT EVERY SINGLE WORD, EVERY SINGLE EXCHANGE WITH A WOMAN HAS THE POTENTIAL TO CHANGE HER LIFE. I KNOW THAT I MAKE A DIFFERENCE EVERY SINGLE DAY, ONE WOMAN AT A TIME.'**

Catina Adams

## DEMENTIA AWARENESS ALARMINGLY LOW

More than 80% of Australians are unaware that dementia is the second leading cause of death in the country, a new survey has revealed.



The alarming statistic emerged despite one-third of respondents reporting someone close to them had been diagnosed with the condition.

The survey, conducted by Ipsos Australia, found while there was some level of understanding about dementia within the general community, it nevertheless remains worryingly low.

More than half the survey respondents did not understand the relationship between Alzheimer's disease and dementia; almost 40% did not know that dementia is not a normal part of ageing; while 39% of people revealed they felt awkward around someone with dementia.

The results of the survey were released to coincide with the launch of Dementia Australia, the new national voice replacing Alzheimer's Australia.

Almost 413,000 Australians live with dementia and numbers are expected to increase to 1.1 million by 2056.

It is the second leading cause of death of Australians and now the leading cause of death for women.

There are more than 100 types of dementia, with Alzheimer's disease the most common form. Dementia Australia Chair Graeme Samuel said the disturbingly low awareness and understanding of dementia among Australians was "quite simply not good enough".

"So few people understand just what dementia is and how it impacts people with a diagnosis and the research shows that people even find talking to someone with dementia confronting."

The new united Dementia Australia will look to use its collective drive to lead better outcomes for people with dementia.

"Having all these organisations and people who have been so dedicated come together, unified as one, will help us have a bigger impact, be a stronger voice, provide better support services, have a greater reach and, ultimately, better serve the people we are here for, people living with dementia, their families and carers," Dementia Australia CEO Maree McCabe said.

## ENGAGING MEN WITH DEPRESSION

Mental health providers must better engage men with depression to ensure they access crucial mental health services, according to new research from the University of Sydney.

The number of men seeking clinical intervention to treat depression has risen 10% over the past decade but PhD candidate at the University's School of Psychology Zac Seidler, said men still account for three quarters of Australian suicides.

Mr Seidler claims mental health clinicians must change how they deliver treatment in order to curb the male suicide epidemic. "A lot of men now seek help but many aren't engaging with their treatment and therefore don't stay as long as they should."

"With available data suggesting many men who commit suicide seek professional help beforehand, this is a critical period in many people's lives and one we ought to be getting right."

Conducting in-depth interviews with 20 Australian men suffering mild to moderate depression, Mr Seidler's research paper '*Men in and out of treatment for depression: Strategies for improved engagement*' investigated

treatment regimens and found them inadequate.

For example, most clinicians mistakenly assumed clients understood the treatment process, while few gave clients goals to work towards or armed them with skills they could use to tackle depression. Mr Seidler's research shows most mental health strategies place an undue emphasis on unstructured talk therapy and suggests clinicians need to rethink the processes around delivering treatment such as clinical relationship and communication.

"This perceived unstructured approach juxtaposed the action-oriented, functional treatment these men were seeking," he said.

"Men tend to want an idea of how treatment is going to work from the outset, a structured plan for working towards recovery, the power to gain skills that help them deal with depression and to feel in control of their lives."



## BREAKTHROUGH ON WHY SIDS OCCURS

New research has uncovered a developmental abnormality in babies that could be the reason why some babies sleeping on their front are at bigger risk of sudden infant death syndrome (SIDS).

The abnormality affects the brain's control of head and neck movement, breathing, heartbeat and the body's response to lack of oxygen.

The study, conducted by researchers in the Adelaide Medical School, University of Adelaide, in partnership with Harvard Medical School and Boston Children's Hospital, breaks new ground in directly linking the abnormality with SIDS deaths.

The study investigated 55 SIDS cases in the United States.

"While the exact cause of death in SIDS has not been identified, multiple studies have pointed to a subset of SIDS babies that are not entirely 'normal' before death," said Dr Fiona Bright, Research Associate in the Adelaide Medical School, University of Adelaide.

"These infants all seem to have some form of underlying vulnerability, exposing them to increased risk."

The study pinpointed a significant abnormality within key regions of the brainstem in SIDS babies, specifically in parts of the brainstem that control breathing and movements of the head and neck.

It is a key reason why it is more dangerous for babies to sleep on their front, it concluded.

"An infant with this abnormality is likely to have impaired respiratory and motor responses to life-threatening challenges during sleep. While they may be otherwise healthy looking, there is an inability for that child's brain and body to respond appropriately to an event in which the child is deprived of oxygen in some way," Dr Fiona Bright said.

The study also showed that the abnormality is substantially influenced by prematurity and male sex, with the results backed up by the increased risk of SIDS in premature and male infants.





Julianne Bryce



Elizabeth Foley



Julie Reeves

**ANMF Federal  
Professional  
Officers**



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## CONDUCT MOST BECOMING

According to Roy Morgan Research, nurses continued their supremacy of Australia's most highly regarded professions with "94% of Australians in 2017 (up 2% from 2016) rating nurses 'very high' or 'high' for their 'ethics and honesty'". Since inception of the annual Image of Professions survey by Roy Morgan in 1994, nurses have remained at the top as the most trusted of all professions.

The fact that this is so should be no surprise. A *Code of Professional Conduct for Nurses in Australia* was first published in 1990, which provided guidance on minimum standards of conduct expected of members of the nursing profession. It should also be no surprise that the then Australian Nursing Federation (ANF) was a lead organisation in the Code's development, and has continued involvement over the years since in subsequent revisions. Again, in 2008, the ANF contributed to the first *Code of Professional Conduct for Midwives in Australia*.

Given the good standing of nurses and midwives in the community, it's reasonable to conclude these Codes have played their part in upholding standards of professional conduct above what could be expected of the 'ordinary person in the street' (Nursing and Midwifery Board of Australia, 2010).

Since 2010, the practice of nurses and midwives has been governed by the *Health Practitioner Regulation National Law Act 2009* (the National Law) (Office of the Queensland Parliamentary Counsel, 2008). Registration standards, codes and guidelines for nurses and midwives fall within that National Law, and this has included the Codes of Professional Conduct. Whether they provide direct care to individuals or communities, or use their nursing or midwifery knowledge in management, research, education or policy roles, all nurses and midwives on the register are bound by these codes for their professional behaviour.

Under the National Law, the Nursing and Midwifery Board of Australia (NMBA) is obliged to review all standards, codes, and guidelines for the nursing and midwifery professions on a regular basis. This ensures these documents remain evidence-based and relevant to contemporary professional and societal expectations and needs. Earlier this year the NMBA commenced a process of revising the *Code of Professional Conduct for Nurses in Australia* and the *Code of Professional Conduct for Midwives in Australia*. Extensive research included a review of relevant international and national literature and other codes of conduct; an analysis of

notifications (complaints) made about the conduct and behaviour of nurses and midwives; workshops with key groups, key stakeholder working groups (one each for the nursing and midwifery professions); focus groups; and, a period of public consultation. During this process the decision was taken to streamline documentation by incorporating the *Nurses' guide to professional boundaries* and *Midwife's guide to professional boundaries* within the Codes of Conduct documents.

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In its submission to the public consultation, the ANMF requested the NMBA consider combining the Codes of Conduct and the Codes of Ethics for the professions into one document, just as the Professional Boundaries document had been incorporated within the Codes of Conduct document. We argued there is an extensive number of regulatory documents that nurses and midwives need to read and consider in order to safely undertake their day to day practice. It thereby makes sense to streamline their professional reference material by combining the Codes into one document, as is the case in the United Kingdom (Nursing and Midwifery Council, United Kingdom). However, there wasn't sufficient support from all stakeholders for a merging of the Codes of Conduct and Codes of Ethics, for this notion to be pursued at this time.

Although there was overwhelming support from nursing for one Code of conduct for nurses and midwives, the

NMBA has elected to stay with two Codes. On 1 March 2018 a new *Code of Conduct for Nurses* and a new *Code of Conduct for Midwives* will come into effect. These documents are essentially the same except for the different terminology of 'person-centred practice' and 'woman-centred practice' respectively. The Codes are substantially different from the predecessors in language and layout. Of particular importance is a focus on Aboriginal and Torres Strait Islander peoples' health and cultural safety. Members' attention is specifically drawn to a definition of 'Cultural safety' in the Glossary, which has been provided by our colleagues at the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM). Other notable inclusions are mandatory reporting, bullying and harassment, end-of-life care, and, professional boundaries.

The new Codes' documents for nurses and midwives feature four domains, namely:

- practise legally;
- practise safely, effectively and collaboratively;
- act with professional integrity;
- promote health and wellbeing.

Under these domains are principle and value statements to guide professional behaviour and conduct expectations for all nurses and midwives, irrespective of context of practice. This includes those in direct clinical care, and those working in non-clinical roles such as management, education, research, regulation, or policy.

While the primary intent of the Codes of Conduct is to guide professional behaviour and conduct of nurses and midwives, they also serve as the standards the public can expect from nurses and midwives in Australia.

# NURSE ACADEMICS SPEAK OUT FOR NURSING STUDENTS

By Louise Ward, Kathryn Hoare,  
Carmel Mcleod, Julie Ellis and  
Tony McGillion

**As nurse academics, students are our primary focus. We watch them battle to meet a number of competing demands including work, family, systems and clinical placements.**

We drive them hard in preparation for a career that involves caring for others. We watch them grow and challenge them to challenge themselves. We celebrate when they walk across the stage at graduation and look forward to when we see them return to commence postgraduate studies. This is a short article written in tribute to their efforts, as seen by us.

There are many challenges faced by nursing students today, as well as many opportunities. Nursing students may not always understand how much we, the nurse academics, are aware of the challenges they face- but we are.

We understand that some of the greatest hurdles they face is balancing all the different aspects of their life; their role as a student as well as their need to work and their responsibilities to family and friends.

The different aspects of their role as a nursing student brings many other challenges; new information and skills to learn, classes to attend, learning how to negotiate information systems, assignment writing, undertaking quizzes, exams to attend and group work to participate in. When you consider the list of skills required by the contemporary nurse, you wonder why nursing is not in the Top 10 highest paid professions.

The list is not exhaustive, but it is 'exhausting' in terms of the depth and breadth of the inventory- time management, clinical decision-making, empathy, new technology skills, coping with change, conflict management, working in an inter-professional team, and promoting patient quality and safety.

Students state that they worry about their poor time management skills, that often means they fail to undertake pre-reading, attend class and even register assignment due dates. They also worry about failing subjects, and how prepared they are for clinical placement. Throughout the curriculum, we encourage nursing students to see the bigger picture and to embrace the 'journey'.

However, students are also aware of the opportunities they have enrolling in a Bachelor of Nursing (BN) course. They understand that they are receiving an education that will allow them to join a highly reputable and exciting profession that will lead to many other prospects. As a nursing student they are learning skills in a supportive environment and then given the opportunity to practice those

skills, undertaking up to 900 hours of placement.

During their placements, they learn about the role of the nurse in different clinical settings such as both community and hospital settings, aged care, medical, surgical, paediatric, mental health, and primary healthcare. Students' clinical experience requires the commitment of a 40 hour week, undertaking shift-work that may be eight to 10 hour shifts rostered throughout a 24 hour period over a seven day week.

An important part of the clinical experience is students' involvement with patients, their family and significant others. This experience can be complex as these interpersonal interactions represent the nature of nursing and may be demanding for students within the BN as they learn to manage life and death situations.

Beyond simply learning about nursing, students learn to become a nurse. Even though support within the BN course is linked to the wider tertiary support services, the requirement is for teaching staff within the curriculum to embed support that is responsive to students' clinical and educational needs.

In the final semester of the BN course, students experience a myriad of feelings. There is excitement that finally the end is within reach; however, also apprehension and fear that course completion may not be achieved.

Compounding this are other factors such as consolidation of clinical practice, preparation and submission of graduate nurse applications, attending interviews and the anticipation of the release of graduate year positions. Whilst most students transition through the last semester and quite enjoy the experience, others find this phase of the course stressful.

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TODAY, AS WELL AS MANY  
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ARE AWARE OF THE CHALLENGES  
THEY FACE- BUT WE ARE.

In the final semester of the course, students participate in extended clinical practice rotations, enabling consolidation and a smooth transition to the graduate nurse year. This extended rotation, plus participation in night or weekend shifts, leads to feelings of exhaustion as students juggle academic, clinical and personal life issues and commitments. The highlight of the final semester is, however, the announcement of graduate nurse positions and staff receive excited calls or emails from students advising of their success.

As nurse academics we know that patients have always yearned for the essentials of care, the fundamentals of being and feeling 'clean', listened to, encouraged and pain free. Providing patients with these essentials gives them the best opportunity to recuperate to their relative targets and abilities. Nurturing the essentials of nursing students, encouraging them to achieve whilst recognising and supporting their limitations, is caring for them in a way that they can ultimately care for their patients.



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# DO YOU HAVE ANYTHING TO DECLARE?

By The Australian Nursing and Midwifery Federation Professional Advisory Committee

On making application to the Nursing and Midwifery Board of Australia (NMBA) for registration to practice as a nurse or midwife in this country, all applicants need to meet certain requirements. There's obvious ones, such as completion of an educational program at an institution and to a level specifically approved by the NMBA, for the nursing and midwifery professions. Then there are others, which apply to all regulated health practitioners.

These include:

- English language skills;
- continuing professional development;
- recency of practice;
- professional indemnity insurance arrangements; and,
- criminal history.

When a person first applies for registration as a nurse or midwife, the Australian Health Practitioner Regulation Agency (AHPRA) requires the applicant to declare their criminal history.

The criminal history that must be declared includes the person's life within Australia as well as any time spent abroad, either having lived overseas prior to applying for registration, or having been an Australian resident holidaying in another country. Members should note that even an offence committed as a child is required to be declared, for example, shoplifting as a 15 year old.

For initial registration, AHPRA conducts an Australian criminal history check and obtains a criminal history report on behalf of the applicant, prior to their being registered. The overseas criminal history check requirement by AHPRA relates to any applicant who has resided in a country or countries other than Australia for '...six consecutive months or longer, when aged 18 years or more' (AHPRA).

Once registered, nurses and

midwives must disclose at annual renewal of registration if there has been a change to their criminal history either in Australia or in any other country, since their last declaration to NMBA. This includes any charges or findings of guilt which have occurred during the last registration period (a year), where they were:

- charged with an offence punishable by 12 months imprisonment or more, or
- convicted or found guilty of an offence punishable by imprisonment in Australia and/or overseas.

MEMBERS SHOULD NOTE THAT EVEN AN OFFENCE COMMITTED AS A CHILD IS REQUIRED TO BE DECLARED, FOR EXAMPLE, SHOPLIFTING AS A 15 YEAR OLD.

Why should the regulatory process make such a big deal about a health professional's personal criminal record? What's the relevance to their professional life, particularly when offences may have occurred outside of the work situation or even prior to becoming a registered health practitioner? In other words, what impact could personal conduct have on a person's professional standing?

Well, let's just look at the nursing and midwifery professions. Nurses and midwives deal with people who are generally experiencing varying degrees of crisis or disruption to their normal living arrangements, due to some level of health impairment (from relatively minor to catastrophic). Whatever the reason, all could be considered to be in a more vulnerable state than usual. In addition, there is a power imbalance in the relationship between the nurse/midwife and person for whom care is being provided. All of this means that trust becomes an essential element in the relationship between the person providing care – in this case the nurse or midwife, and the person receiving care. Trust will be built through feeling assured of the competence of the nurse or midwife for the care needs required. But it will also be built through knowing that the nurse or midwife is a fit and proper person to be trusted with personal and sensitive information, to be engaging in oftentimes intimate actions for hygiene or wound care purposes, to be introducing foreign objects (medical devices) or potentially

poisonous substances (medicines) into their bodies, or to be caring for their vulnerable young or frail elderly relatives.

This is where the regulatory process plays its part. By implementing a regime of standards that must be met in order for a nurse or midwife to practice (Professional Practice Framework), the NMBA provides a risk management process through which the consumers of health and aged care (and their families) can be assured of the character and competence of the nurses and midwives on the register. There's the upfront safeguard of criminal history declarations made on initial registration, and then there's the facility for on going monitoring of nurses and midwives through registration renewal declarations.

If a nurse or midwife does declare criminal offences, how does the NMBA assess the significance for the practice of that individual? Refer to the *Registration standard: Criminal history* document which details 10 factors the NMBA considers when determining the relevance of what's been declared, to the practice of a nurse or midwife. The authority for enacting this Standard comes from its inclusion in the *Health Practitioner Regulation National Law Act 2009* (the National Law). While the 10 factors seem pretty clear, confusion and even anger have arisen at times when ANMF members have experienced decisions differing from those implied in the Standard. How could this occur when the Standard falls under the National Law? Quite simply, the National Law at times falls victim to the fact that Australia functions under a federated system. This means that, although the National Law is the overarching legislation, differing state/territory legislation on criminal offences can impact on implementation of the national criminal registration standard applied by the NMBA. One example of this is that in Tasmania nurses and midwives have been considered as having a criminal history if they had a parking or speeding fine and had admitted to this offence by paying the fine. In all other states and territories traffic infringements are not considered to be part of a criminal history.

Members are encouraged to familiarise yourselves with the *Registration standard: Criminal history* at: [www.ahpra.gov.au](http://www.ahpra.gov.au)

**The Australian Nursing and Midwifery Federation (ANMF) Professional Advisory Committee is made up of professional officers from ANMF state and territory branches across the country.**



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Linda Starr

## GOOD FROM EVIL

Violence in the workplace is a hazard and risks the health and safety of all those working in that environment.

In a health setting workers are exposed to violent acts that range from physical assault and verbal abuse through to threats, belittling and intimidation, from patients, members of the public, colleagues and managers. Whilst employers have a legal obligation to ensure their employees have a safe and secure environment to work in and, in many cases have stringent measures in place addressing workplace violence, there is a constant line of examples that remind us that often this is not enough.

Whilst there are a number of options open to healthcare workers who experience workplace violence, often the damage is done, the impact has taken its toll which at times can prematurely end the practitioner's career. This was the case for a Queensland nurse who recently won \$1.4 million dollars in compensation from her employer in a successful claim of damages for psychiatric injury which led to her early medical retirement.

Robinson was a DON and experienced long term bullying by Turner the CEO of the hospital who for months unfairly blamed, undermined, humiliated and belittled Robinson often in front of other staff. The court found the defendant vicariously liable for failing to take timely and decisive action regarding the managerial mismanagement that caused the plaintiffs significant harm.

Sadly however, there are other cases of workplace violence that end in tragedy that are not so easily addressed.

On the morning of 24 August 2016 Mr Keith Woodford awoke to find his wife, Gayle, a Remote Area Nurse missing from their accommodation in Fregon SA. The ambulance was also missing although her blue bag/pouch she always wore was left behind – which was unusual.

Assuming she had been called out to a patient somewhere in the APY lands he was not immediately concerned. It was not until he contacted her colleagues a short time later that he found she had not shown up for work. Alarm bells soon rang and the police were contacted.

Tragically after a significant search by police Gayle's body was found in a shallow grave near their town several days later. Dudley Davey had somehow managed to get Gayle to leave her home in the night and accompany him before he raped, murdered and buried her body before



WHILST THERE ARE A NUMBER OF OPTIONS OPEN TO HEALTHCARE WORKERS WHO EXPERIENCE WORKPLACE VIOLENCE, OFTEN THE DAMAGE IS DONE, THE IMPACT HAS TAKEN ITS TOLL WHICH AT TIMES CAN PREMATURELY END THE PRACTITIONER'S CAREER.

morning. Davey is now serving a life sentence with a 32 year non parole period.

Fortunately such tragic events are infrequent however, this does not lessen the devastation experienced by those who have lost a loved one, the communities who have lost a trusted, loved and relied upon serving member and her colleagues in the profession to which she belonged.

Whilst this case led to some review of local policy that was in place at the time regarding the safety and welfare of health workers in remote areas it also highlighted the real and ongoing risks that remote area nurses face in the ordinary course of their work and the fact that more needs to be done.

These risks were already well known and in a recently published report by CRANAplus *Remote Area Health Workforce Safety and Security Report* have been succinctly restated along with some recommended strategies to address these.

A campaign for 'Gayle's law' began following her death to introduce legislation that would end single

nurse posts and establish a practice that two nurses attend call outs. In place policy and guidelines for best practice requiring this proved to be insufficient to protect these nurses.

Whilst there is yet to be a national approach to this important issue the South Australian government has taken the initiative and introduced a Bill 'Health Practitioner Regulation National Law (South Australia) (Remote Area Attendance) Amendment Bill 2017, proposing restrictions on single person attendances in remote areas.

Significantly the Bill proposes that a second person must accompany a nurse on after hours (between 5pm and 8am) and weekend appointments and emergencies.

This measure is supported by further provisions that provide some protection for nurses if they refuse to attend a call out in the absence of a second responder when acting in good faith and without negligence.

Whereas the intent of this Bill is a step in the right direction, there are some limitations with respect to improving the safety and welfare of all remote area nurses in Australia. For example, remote area nurses beyond SA borders are not afforded the protection of the SA proposed Bill and as such are largely left with policy frameworks that do not have the same legal force. Furthermore, whilst this Bill addresses the need for a second person to be present on call outs after hours, weekends and public holidays, it does nothing to protect remote nurses at other times of the day. Violent behaviour does not keep specific hours – the risk is there around the clock.

Despite Commonwealth funding to a number of these services it is unlikely that we will see a national law addressing this issue soon. As such it will be up to individual state and territory governments to step up and develop their own legislative response to this gap in workplace safety.

It is hoped that in the meantime governments around the nation, local health services and the health professions will continue to work in collaboration to improve the safety of work environments for all healthcare workers to minimise the risk that became a reality for these two health practitioners.



### Reference:

CRANAplus, January 2017

Health Practitioner Regulation National Law (South Australia) (Remote Area Attendance) Amendment Bill 2017

Robinson v State of Qld [2017] QSC 165

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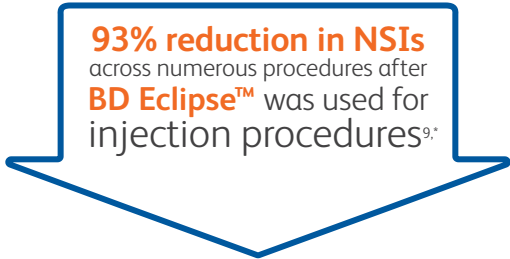


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\*Compared to when healthcare professionals were using conventional devices

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# LIVING WITH DIGNITY:

## A palliative approach to care at the end of life

By Professor Claire Johnson

Dignity is a fundamental concept that defines how we interact and care for every person in our society. Our understanding of dignity and its significance for people at the end of life (EOL) is crucial to informing our day-to-day interactions with these patients.

Dignity is described as a multifaceted social construct, comprising values and feelings experienced by an individual. The Oxford Dictionary defines dignity as 'the state or quality of being worthy of honour or respect', (Oxford Dictionaries 2017) whereas the Cambridge

Dictionary defines it as 'the importance and value that a person has, that makes other people respect them or makes them respect themselves' (Cambridge University 2017). Both definitions capture the objective nature of dignity - that dignity is intrinsic, that every person has the basic right to be treated with dignity (Clark 2010).

These definitions allude to what has been classified as 'subjective dignity', (Clark 2010) a concept that involves personal self-respect and self-esteem, or 'self-regarding dignity' - how a person feels about him/herself and how they perceive they are treated by others (Clark 2010; Gallagher 2004; Nordenfelt and Edgar 2005). How an individual perceives and treats another person has been labeled 'other regarding' dignity (Clark 2010; Gallagher 2004).

We may take dignity for granted, but its violation can be devastating for how we view and value ourselves (Jacobson 2009). Perceptions of dignity vary according to personal values and priorities. Each of us has distinct views of what contributes to our self-worth and the character of interactions which constitute a violation to our self-respect and dignity (Jacobson 2009; Killmister 2010). Due to the multi-dimensionality of dignity, there are many components of any given interaction, which may maintain or damage self-worth and, thus, dignity.

Sociologists theorise that our perception of self is developed and sustained through our interactions with others and that we see ourselves,

largely, as others see us (McAdams and Olson 2010; Muller and Carpendale 2014). Self-esteem and self-worth increase if others hold us in high esteem and treat us with dignity (Horberg and Chen 2010; Muller and Carpendale 2014). Therefore, as health professionals, it is imperative we consider how we honour these concepts in our conduct with others - ensuring that our interactions are dignity enriching.

Any examination of quality in health and social services must consider the impact of ill health on individuals' perceptions of their self-worth and dignity. The risk to dignity at the EOL as health deteriorates is a particular concern. 'Living with dignity' reflects having one's human value acknowledged, irrespective of circumstances. It recognises personhood and self-worth - the individual's sense of identity, autonomy and self-determination in the face of a body, and often a mind, that is functionally declining. It encompasses being cared for respectfully and empathically, and addresses physical, emotional, social and existential suffering at a time of profound loss (Proulx and Jacelon 2004). Chochinov and others agree

that loss of dignity, autonomy and self-determination are important underlying reasons why people request euthanasia or assisted suicide (Wilson et al. 2005; Chochinov 2006; Street and Kissane 2001).

In Chochinov et al.'s (2002) model of dignity, the effect of intense, prolonged symptoms on an individual's psychological wellbeing and the importance of functional independence and cognition on perceptions of personal dignity at EOL were identified. Psychological distress, in particular uncertainty about one's health status, and anxiety about death also impinge on feelings of self-worth. This model acknowledges that even when facing serious illness and death, many people maintain their sense of dignity through their own personal perspectives and practices and seek to build resilience in those who are at risk of its loss (Chochinov 2006; Chochinov et al. 2002; McClement et al. 2004).

Research has demonstrated that an individual's perception of their dignity can be encouraged and developed by the way care is provided (Chochinov 2006; Chochinov et al. 2002; McClement et al. 2004).



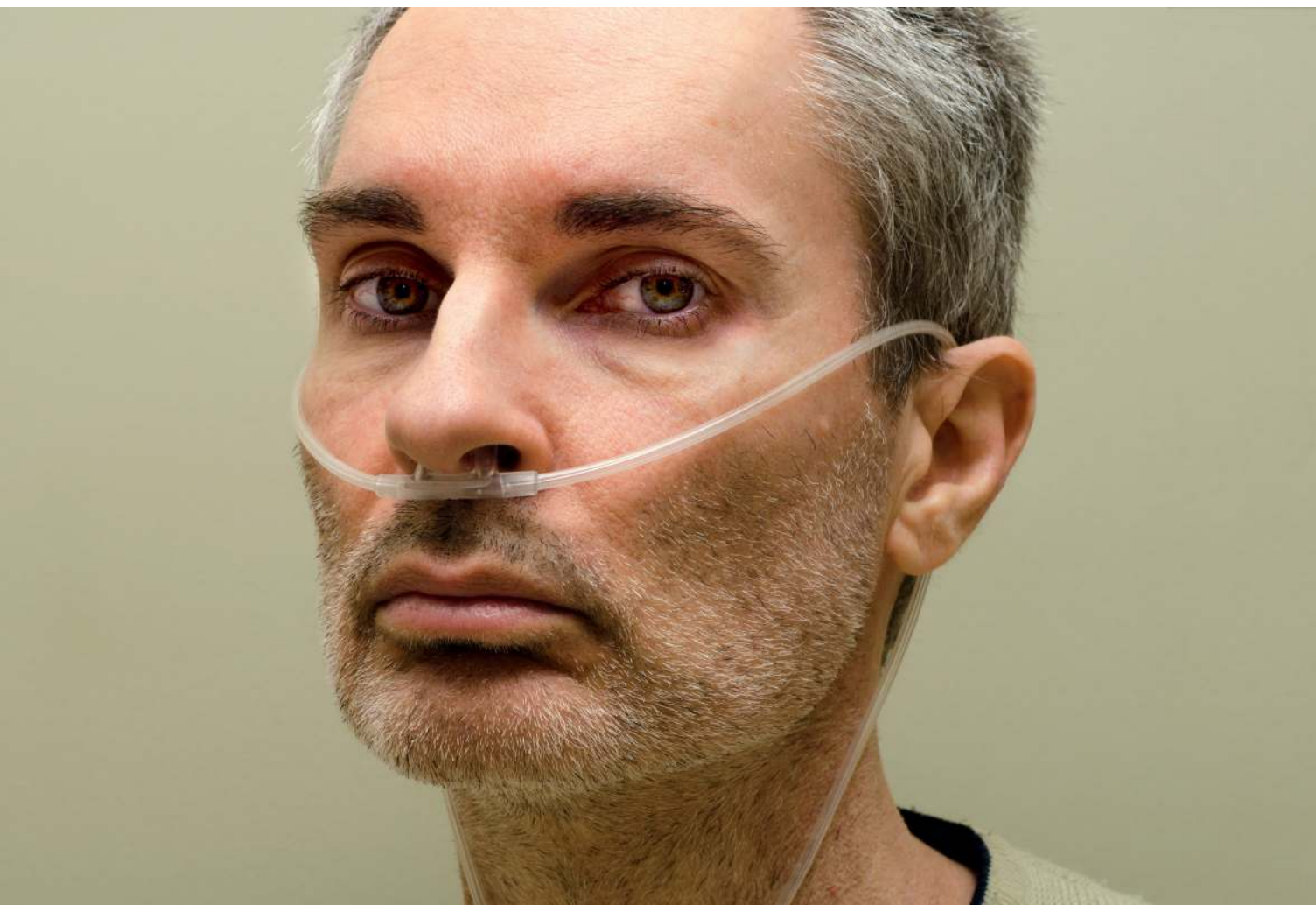
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This has profound implications for how our health services and we, as health professionals, accommodate and support people at the EOL (Clark 2010). Individual preferences must be considered in relation to how we address physical symptoms and needs, promote autonomy, communicate, interact with families, support individual cultural observances, even how we use humour. With each interaction consideration must also be given to how likely it will promote a sense of self-worth and dignity.

It must be acknowledged that in healthcare a shift towards person-centred care, individualised care plans, the use of targeted therapies, and even biomedically, all promote the concept of the uniqueness of each individual.

One of the most notable developments in promotion of dignity specific to the EOL is palliative care. Palliative care emerged from the hospice movement in the middle of the last century, however, it is remarkably misunderstood. Lack of awareness and many misconceptions among consumers, the media and health professionals present major barriers to the provision of, and

early access to, palliative care for people who could benefit (Johnson et al. 2011a).

RESEARCH HAS  
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While many nurses have a good understanding of palliative care, it is important to clarify what palliative care is, and is not, and its role in maintaining personal dignity. The World Health Organization (2006) definition of palliative care is used throughout the world as a conceptual basis for EOL care. It describes palliative care as:

"an approach that improves the quality of life of patients and their families who are facing problems associated with a life-threatening illness. It prevents and relieves suffering through the early

identification, correct assessment and treatment of pain and other problems, whether physical, psychosocial or spiritual." (World Health Organization, 2017).

Palliative care does not aim to lengthen or shorten life, but adopts a holistic, person-centred approach to relieving distress and suffering, whatever the cause. A palliative approach should be available at any point in the disease process, irrespective of the modality of treatment (World Health Organization 2017)

Palliative care supports the identity and values of the whole person and, while not explicitly articulated, the conservation of dignity is a central principle. It promotes self-determination and autonomy, and is built upon precepts of open, honest, sensitive communication and inclusiveness. Given that quality of life means different things for different people and is shaped by an individual's historical, social and cultural perspectives, palliative care adopts a holistic approach in its assessments of physical, social, emotional, cultural, and spiritual care needs and other relevant life circumstances.



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Palliative care is available throughout Australia - its availability and mode of delivery is dependent on local needs, policies, governance and resources. In using a palliative approach, an individual's everyday healthcare team applies the principles of palliative care when planning and delivering day to day management (Palliative Care Australia, 2005).

General practitioners, community nurses and hospital doctors, nurses and other health professionals can utilise a palliative approach at any point in their treatment. Indeed, I argue that the principles of a palliative approach are the minimum standard upon which all care should be based, irrespective of diagnosis.

Numerous education and support programs aim to improve the care provided for people at the EOL, irrespective of site of care. Free online education packages and regular face-to-face education programs for hospital staff, GPs and community-based health professionals are available (Caresearch 2017). Palliative care advocacy groups and health administrators are working to ensure palliative care is embedded in all health professional training.

Specialist palliative care services and health professionals are available when people present with complex, problematic or persistent problems associated with their illness. Specialist palliative care services are interdisciplinary, with different professions bringing different approaches to addressing a patient's problems (Palliative Care Australia 2015). Research has demonstrated that, with early referral, the quality of life for both the patient and carer is improved, symptom management is improved, the number and length of hospitalisations are reduced, (Gomes et al. 2014; Haun et al. 2017) and now, a growing body of evidence showing improved survival (Temel et al. 2010).

While the management of pain and other symptoms or the need for support during the dying phase often precipitate referrals to specialist palliative care, the concepts that profoundly contribute to dignity such as complex psychological problems, family dynamics, existential distress, and EOL decision-making and discussions are often not identified or overlooked as triggers (Beernaert et al. 2014).

Many misconceptions about palliative care act as barriers to referral. Failure to open discussions with the dying person about diagnosis, disease trajectory, prognosis and wishes for EOL care results in neither a palliative approach nor referral to specialist palliative care being offered (Hawley 2017). Misunderstandings about

appropriate timing for referrals exacerbate the problem. Some health professionals are reluctant to initiate EOL conversations due to concerns about destroying hope, the patient "is not up to that stage yet", a belief that patients want increased survival irrespective of quality of life, and that patients will initiate these discussions. Yet patients believe their doctor will open these discussions when it is appropriate (Johnson et al. 2011a; Johnson et al. 2011b). Consequently, people working in palliative care or palliative care advocacy continue to still hear, "Why was I not told that I could be referred to a palliative care service; that I could be referred earlier; that palliative care is not just about dying?" from both patients and family members.

**MANY MISCONCEPTIONS ABOUT PALLIATIVE CARE ACT AS BARRIERS TO REFERRAL. FAILURE TO OPEN DISCUSSIONS WITH THE DYING PERSON ABOUT DIAGNOSIS, DISEASE TRAJECTORY, PROGNOSIS AND WISHES FOR EOL CARE RESULTS IN NEITHER A PALLIATIVE APPROACH NOR REFERRAL TO SPECIALIST PALLIATIVE CARE BEING OFFERED**

Take John\*, a 55 year old engineer, diagnosed with advanced glioma as an example. John underwent surgery, radiotherapy, and then several rounds of chemotherapy in his initial treatment. He returned to work after initial treatment but soon realised he could not manage and took extended leave 'until he improved'. After several months his headaches returned, he started having seizures and episodes of confusion. John was readmitted to hospital to commence another round of chemotherapy. His family (wife Tina and three sons; the youngest was preparing to do higher school exams) were emotionally and physically exhausted. Physically, due to the demands of 'keeping John safe' with his erratic behaviour; and emotionally from being constantly positive and up-beat to combat John's anxiety and depression - because John was going to 'stay positive and beat this thing'.

On readmission, no one discussed the natural course of John's condition, its likely outcome, the possibility that further treatment may not

prolong John's life or its potential impact on his quality of life. John died five days after re-admission, having not commenced his new round of chemotherapy. He was on anti-epileptic medications, opiates for pain and sedated. The family was extremely distressed and Tina commented, "I didn't know he was that sick".

Up until several days before John's death, the family didn't know about palliative care or how it could help. A family friend/nurse intervened in the last few days of life to get the palliative care team involved, initially to provide support when John went home. Ultimately, it ensured optimal pain relief and started providing support to the highly distressed family.

This family's chaotic experience of death will be the foundation upon which other, future, death experiences will be built. But this story could have been so different. It may have been something like this...

After an initial barrage of diagnostic tests, John's neurologist discussed the case at the multidisciplinary team meeting where it was acknowledged that John's outcome was likely to be poor. Given his age, family and work situation the team had concerns about how the family would deal with the news. The neurosurgeon was tasked with discussing treatment options with John and family and suggesting that the palliative care team be involved early. The nurse coordinator was asked to follow the family closely, to educate about treatment and to identify specific concerns. John agreed to surgical ablation of the tumour, radiotherapy and chemotherapy. A palliative care social-worker helped John decide to take early retirement and access his superannuation. A palliative care psychologist worked specifically with the son approaching his exams and discussed options for deferment. John and Tina were kept up to date about John's progress. Prognosis and outcomes were discussed openly but compassionately. This was what John wanted.

The family was encouraged to discuss what was important to them if John's condition deteriorated. John's ambition to take the boys hiking resulted in a one-week trip to Yellowstone National Park just after he finished his first round of chemotherapy.

The community palliative care service met John and Tina early. John deteriorated, he started fitting, his headaches returned and he became increasingly confused. The palliative care physician and oncologist discussed more chemotherapy but



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in view of the limited benefits, John opted for supportive treatment only - steroids, pain relief, anti-epileptics, sedation if absolutely necessary. He wanted to stay at home, so the palliative care service organised support for John and respite for Tina. As John deteriorated further, he needed someone with him at all times. Family and friends rallied so that Tina could rest if John was restless. Inpatient palliative care was offered as an option and his need for high level and consistent care resulted in admission to the service two days before he died, which occurred quietly with family around. Despite their grief, his family and those close agreed he had received the best possible care, given his diagnosis.

But is supported dying like this possible in more isolated areas, outside the reach of specialists? Recent unpublished research has demonstrated how, with a commitment of time, skill and 'self' on the part of the GP, a multidisciplinary approach, high levels of interpersonal/professional communication, advance care planning and coordination of care and services, such care is not beyond the resources of rural and regional communities.

In a world where voluntary assisted dying is promoted as 'dying with dignity' we MUST get palliative care right. If we are to promote palliative care as an approach that addresses

the factors which contribute to requests for assisted death then 'dignity' needs to be a more explicit focus of palliative care. Services must be accessible, available when needed and effective in managing patients' concerns.

Promotion of early access to palliative care presents a number of challenges. Palliative care must be well understood and be adequately funded both as inpatient and community-based services. The palliative approach must be embedded in all health professional training. Comprehensive palliative care systems need to be available to support information sharing and seamless transition between care settings. Population-based modeling could help identify areas of high need. Identification of people with advanced malignant and chronic diseases, combined with open, honest compassionate discussion about the disease trajectory, goals of treatment and preferences for care all contribute to a holistic model for supporting people at the EOL.

Within palliative care services there must be a culture of excellence, where the need for specialist skills and training is recognised. All care must be underpinned by evidence, and a model of open inquiry about how we can do this better - exploring what people want both individually and collectively to continue to live with dignity right up until the EOL.

It must be acknowledged that there are people with intractable symptoms and palliative care specialists must work collaboratively with disease specific specialties to investigate new treatments and ways of addressing such concerns.

Attributes of dignity that are important to one person are not necessarily the same for another. And while we promote palliative care as holistic, patient-centred care, we must then continue to ASK each person, "What do I need to know about you as a person to give you the best care possible?" (Chochinov 2002) and where there is an understanding of what is important and there must be a WILL to provide that care, whatever the setting.

\*Cases cited are not real people but are based on real events.

**An abridged version of the 2017 Vivian Bullwinkel Oration, presented by Professor Claire Johnson at the Nurses Memorial Centre, Melbourne on 24 August 2017.**

**Professor Claire Johnson is the Vivian Bullwinkel Chair of Palliative Care Nursing, Monash Nursing and Midwifery, Monash University, and the End of Life Care Clinical Lead, Eastern Health, Melbourne, Victoria**



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# ADOLESCENCE AND BODY IMAGE DISSATISFACTION: INCREASING AWARENESS OF HEALTH PROFESSIONALS

By Luciane Simões Duarte, Mary Steen and Elizabeth Fujimori

Adolescence is a time of life when many changes occur physically, emotionally and socially.

These changes are influenced by intrinsic (personality, genetic predisposition) and extrinsic (peers, family, society) factors (WHO 1986). In this period of life, the body image concept takes an important significance.

Body image relates to the perceptions and attitudes a person holds toward one's own body especially, but not exclusively, their physical appearance. Body image is a multidimensional construct that can be influenced by interpersonal experience, personality, social and cultural norms (Cash and Pruzinsky 2002).

This multidimensional construct can be simplified by using a three dimensional approach: cognitions and affect regarding body, body importance and dieting behaviour and, perceptual body image.

The first dimension refers to the thoughts and feelings concerning the body and to physique as a whole. The second dimension represents the importance of body image and the dieting behaviours, in order to obtain or maintain their body shape. The third dimension reflects the perceptual distortions for particular body parts (Banfield and McCabe 2002). Within this approach, body image dissatisfaction integrates the first dimension of this three-model construct and reflects the affectivity and how an individual feels about their body.

## Adolescent body image and research evidence

In three large studies, the percentage of adolescent girls reporting body image dissatisfaction varied between 28 and 48%, whereas the respective percentages of boys ranged from 19 to 37% (Mäkinen et al. 2012; van den Berg et al. 2010; Knauss et al. 2007).

Dissatisfaction with one's body image tends to manifest differently according to gender, weight status and age group. In general, body image dissatisfaction is highly prevalent and more common among girls than boys, among overweight than non-overweight and among older adolescents than younger adolescents (Calzo et al. 2012; Mäkinen et al. 2012; Paxton et al. 2006).

In this context, there is some evidence about the negative health outcomes associated with body image dissatisfaction such as: eating disorders (Espinoza et al. 2010; Neumark-Sztainer et al. 2006a), smoking and low level of physical activities (Neumark-Sztainer et al. 2006b), low self-esteem (van den Berg et al. 2010; Paxton et al. 2006; Presnell et al. 2004; Stice and Whitenton 2002) and depressive symptoms (Crow et al. 2008; Daniels 2005). In addition, body image dissatisfaction can continue to effect individuals across their



lifespan and may lead to eating disorders and obesity over time (Neumark-Sztainer et al. 2007).

## Conclusions and recommendations

Research shows there is a significant percentage of body image dissatisfaction within the adolescent population and this has a clear impact on health-related behaviours. It is therefore vitally important health professionals gain knowledge and some understanding of the negative health and wellbeing impact body image dissatisfaction has upon adolescents and how this relates to public health in general. Interestingly, body image satisfaction is an identifiable, modifiable and under-utilised factor that can be used to protect against health-risk behaviours. Health professionals can play an essential role and help to promote a healthy body image satisfaction. It appears, however, there is an urgent need to educate health professionals about body image and the links to health related behaviours. Education should include contemporary research evidence and guidelines on how to support adolescents and their parents to enable them to develop positive ways to have a body image satisfaction and adopt healthy habits. Ultimately, the overall aim should be to help adolescents gain a healthier perception of body image and general health status.

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GIVEN THAT AROUND 90% OF PATIENTS DO NOT SURVIVE CARDIAC ARREST (SASSON ET AL. 2010), IT IS TIME TO RECONTEXTUALISE RESUSCITATION EVENTS TO ADOPT A MORE FAMILY-CENTRED APPROACH TO RESUSCITATION CARE.



DR TRACEY GILES

## CARING FOR PEOPLE AT DEATHS DOOR DURING RESUSCITATION EVENTS

By Tracey Giles

The number of people dying in hospital without family present could be reduced if current practices were changed, according to a Flinders University research study.

Thousands of people suffer cardiac arrest in Australian hospitals each year and around 90% of those patients die - frequently separated from family during resuscitation events.

Family presence during resuscitation (FPDR) was introduced in the 1980s so family could be with their critically ill loved ones during life-threatening events and it has been practised internationally for decades. FPDR has important proven benefits such as facilitating closure and grieving (Pasquale et al. 2011) and reducing incidences of post-traumatic stress (Jabre et al. 2014).

However, despite strong support from the public and endorsement from professional groups such as the Australian Resuscitation Council, FPDR is not practised widely in Australia.

In the first study to examine decision-making around FPDR (Giles et al. 2016), Dr Tracey Giles conducted 28 in-depth interviews with Australian nurses, doctors, paramedics, family

members and a resuscitation patient to interpret and explain their actions when deciding whether to practice FPDR. Findings showed that decision-making around FPDR occurred in time-poor environments and in the absence of local institutional guidelines. Clinicians appeared to be motivated by doing 'what's best' for patients and their families when allowing or denying FPDR. However, their individual interpretations of 'what's best' were subjective and did not always coincide with family preferences or with current evidence that promotes FPDR as beneficial. As a result, practices were inconsistent, and some families missed the chance to be with their loved ones at the end of life.

Given that around 90% of patients do not survive cardiac arrest (Sasson et al. 2010), it is time to recontextualise resuscitation events to adopt a more family-centred approach to resuscitation care. We know as a society that

a 'good' sudden death involves family wherever possible in the last hours and minutes of life. Yet family members continue to be separated from their potentially dying loved ones during resuscitation events without sound rationales.

The introduction of standardised clinical guidelines and associated education would be an important starting point to help establish:

- what safe and effective practice is;
- to legitimise family presence during resuscitation in the same way we have legitimised family presence for other end of life practices; and
- to ensure that future practice is guided by evidence and standards for health consumers' safety and welfare.

**Dr Tracey Giles is Senior Lecturer and Researcher at Flinders University College of Nursing and Health Sciences.**



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# PALLIATIVE AND END OF LIFE CARE: AN OVERLOOKED ASPECT OF DIABETES CARE

By Trisha Dunning, Peter Martin, Neil Orford and Liliana Orellana

The way people die remains in the memory of those who live on (Dame Cicely Saunders).



Palliative and end of life care are essential aspects of comprehensive diabetes management, but they are often overlooked.

Globally diabetes is linked to 3.7 million deaths per year (Centre for Disease Control and Prevention 2016) meaning one person with diabetes dies every six seconds.

Palliative care can be combined with usual diabetes care to promote comfort and improve quality of life and function at any stage (WPCA/WHO 2014).

Health professionals are ideally placed to identify when older people with diabetes could benefit from palliative care and help them ascertain their values, preferences and care goals and document these in Advance Care Directives.

However, health professionals often miss opportunities to initiate conversations about Advanced Care Directives (Claessen et al. 2014), and sadly such conversations often occur during Rapid Response Team interventions (Jaderling et al. 2017), which is not an ideal time to make informed decisions. Thus, costly, burdensome care often continues unnecessarily.

People with diabetes want to discuss palliative and end of life care but are reluctant to initiate such discussions because they don't want to upset health professionals and because health professionals don't ask about such issues (Savage et al. 2012; Dikkers et al. 2013).

Advanced care planning involves people discussing their preferred future care while they are capable of making autonomous choices.

People who document and communicate their care preferences are more likely to receive care consistent with their values and preferences (Swerissen & Duckett 2014). People value having reasonable control over their death, being comfortable, having time to complete unfinished business and time to say goodbye to important people in their lives (Swerissen & Duckett 2014).

Good information and decision aids can enhance decision-making (O'Connor 2001). But there is limited information about advanced care planning and directives for older people with diabetes.

That's why we are currently undertaking a study to:

- develop and evaluate a suite of information to help health professionals, older people with diabetes and their families recognise the 'right time' to begin discussing palliative and end of life care; and
- evaluate the suite of information with health professionals and consumers in focus groups and via written feedback on the draft information.

The suite of information was developed in close collaboration with an advisory group of older people with diabetes, including the information for health professionals.

Summative evaluation is currently underway and includes focus groups and written feedback from older people with diabetes, their families and health professionals from various disciplines including palliative, end of life care and diabetes experts.

Independent experts will then use the Well Written Information for Consumers (Curie 2000) to determine the content relevance, usability, and appropriateness of the design in the penultimate draft. The study is due to finish in December 2017.

The information could help older people with diabetes, families and health professionals initiate discussion about treatment options, their risks and benefits and result in informed decisions about end of life preferences.

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<b>Topic 1</b> Principles of Palliative Care	<b>Topic 2</b> Communicating with People with Life-limiting Conditions	<b>Topic 3</b> Principles of Symptom Assessment and Management
		
<b>Topic 4</b> Assessment and Management of Pain	<b>Topic 5</b> Optimising Function in Palliative Care	<b>Topic 6</b> Terminal Care and Bereavement Support

## PREPARING ENs TO MEET PALLIATIVE CARE NEEDS

EN TOOLKIT

By Kylie Ash and Patsy Yates

Graduates from the Vocational Education and Training (VET) sector play an important role in the care of people at the end of life.

Building on its successes with implementation in the higher education sector, the Palliative Care Curriculum for Undergraduates (PCC4U) has undertaken a specific project to promote the inclusion of palliative care teaching and learning within the VET sector. The project has resulted in the development of the PCC4U Enrolled Nurse Toolkit for inclusion in training packages preparing enrolled nurses (ENs).

The development approach involved scoping, industry consultation and resource build. Mapping identified that the palliative care graduate capabilities were appropriate for courses preparing ENs (Palliative Care Curriculum for Undergraduates (PCC4U) Project Team 2012). Core and elective units within the Diploma of Nursing HLT54115 were mapped to identify units of competency relevant to palliative care teaching and learning.

Consultation activities were undertaken in line with the PCC4U VET Sector Implementation Framework:

- Identification of individual and professional stakeholders.
- Establishment of links with Registered Training Organisations (RTOs) delivering EN training packages and peak bodies influencing the VET sector nationwide.
- Accurate reporting of project outcomes and consultation with stakeholders.

Key stakeholders were engaged through phone and email communication, teleconferences and face to face workshops. Consultation with industry identified the need for a flexible resource, allowing users to select content and learning activities to suit their student cohort. The EN Toolkit includes versatile eLearning sessions within six topic domains.

Content was adapted from the existing PCC4U learning resources and extended to meet sector requirements. Each session includes a range of active learning activities and PCC4U case study vignettes. Each topic has been peer reviewed


and feedback has strengthened the quality and usefulness of the resource.

Educator resources have been developed to support implementation, including:

- a curriculum blueprint; and
- an implementation guide.

The EN toolkit is accessed via the PCC4U website and the eLearning files may be downloaded for seamless delivery within the RTO's learning platform. Uptake of the EN toolkit will be recorded as per the established PCC4U implementation and evaluation processes.

For further information contact [pcc4u@qut.edu.au](mailto:pcc4u@qut.edu.au)

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# WORKING IN MULTIDISCIPLINARY TEAMS:

## UNDERSTANDING GP CLINICAL PRACTICE IN THE END OF LIFE CARE

By John Rosenberg

Despite most deaths taking place in hospitals, the bulk of palliative and end of life care (PEoLC) is given in primary care settings, such as the home or residential aged care.

While key players in primary care include GPs, practice managers, practice nurses, and community care services, these personnel are not always included in multidisciplinary teams, which can impact quality of PEoLC.

The *Centre of Research Excellence in End of Life Care* examines approaches to PEoLC by GPs. The *GP EoLC* project looked at the ways GPs identify approaching end of life in their patients, how their practice changes, and the challenges they confronted. While many GPs provided some PEoLC, the willingness of GPs and their patients to discuss a poor prognosis varied considerably.

It's been widely reported that limited time with an increasingly busy workload, reluctance in opiate prescribing, and constraints in reimbursement all present challenges to GPs' involvement in PEoLC (Aldridge et al. 2016; Luckett et al. 2015; Mason et al. 2015; Murray et al. 2015). A lack of regular patients requiring PEoLC also impacted GPs knowledge and confidence (Aldridge et al. 2016; Carmont et al. 2017; Murray et al. 2015; Rhee et al. 2008).



DR JOHN ROSENBERG

It is clear that *integrated* models of PEoLC are most effective, where GPs and their interdisciplinary clinical partners communicate openly, share care pathways, have appropriate training, and are supported by viable funding models (Carmont et al. 2017; Mitchell et al. 2015).

It is in these collaborations where early identification of, and planning for PEoLC needs is communicated in a timely way to team members (Aldridge et al. 2016; Carmont et al. 2017) and where case conferencing can directly impact upon reducing care burden, preventable admissions to hospital and improved quality of life (Mitchell et al. 2008, 2014; Hollingworth et al. 2016).

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## DYING TO TALK IN THE BUSH: SUPPORT FOR RURAL AND REMOTE AUSTRALIANS

Palliative Care Australia (PCA) and the Royal Flying Doctor Service (RFDS) will work together to support rural and remote Australians to discuss their end of life care wishes with their healthcare team.



PCA CEO Liz Callaghan says the project will use PCA's *Dying to Talk* resources in RFDS primary care clinics in Victoria, NSW, Queensland and South Australia to facilitate conversations between RFDS health professionals and their patients.

"We know that four out of five Australians think it's important to discuss their end of life care wishes, but only one in five has had the conversation.

"This project will explore how the use

of the app affects a person's willingness to discuss their wishes and then put in place plans for their future care. By using the *Dying to Talk* Discussion Cards, people will be able to work out what's most important to them," Ms Callaghan said.

RFDS CEO Martin Lavery says the project will assist both patients, family members and clinicians to plan for the future, especially for people who are over 65 or have chronic illnesses.

"In cities the provision of end of life care is well catered for, but it is not so easy in the bush. Problems of distance and access to specialist services are never easy and managing a patient requiring aged or palliative care within rural and remote areas can be difficult.

"It all starts with a conversation with loved ones and we are confident that this project with Palliative Care Australia will assist in that regard, better understanding the options for end of life care and thus more comfortable in decisions on behalf of their family member. The project will also assist healthcare workers have conversations with people about their end of life preferences," Mr Lavery said.

The project is supported by a grant from the Dementia and Aged Care Services Fund and will be completed by December 2019.



## APP TO SUPPORT PEOPLE WITH LIFE-LIMITING ILLNESSES

Palliative Care Australia (PCA) has launched an app that creates a caring community around people with life-limiting illnesses.

The app, AllowMe!, allows carers, families and friends to create a community of care to support the person as they approach the end of their life.

PCA CEO Liz Callaghan said the app would assist people with life-limiting illnesses to receive care at home and stay connected with their loved ones.

"This smartphone app will allow primary carers, family members and friends of people who are sick to create a community of care based on specific needs.

"It could be anything from providing a meal, washing the dishes, mowing the lawn or taking the pets out for a walk.

"This app provides an easy and practical way for carers to communicate the help they need by using a simple and coordinated channel for family and friends to respond. It also allows the carer and care recipient to track how they are feeling and provides resources to the community about what to expect as the person approaches the end of their life," Ms Callaghan said.

The app also provides information about grief and bereavement to users.

"We anticipate that people will continue to use the app as a support network for each other long after the person they have cared for has died."

AllowMe! is available at the App Store and Google Play

Find more information about AllowMe! at [www.palliativecare.org.au/allowme](http://www.palliativecare.org.au/allowme)

## FUNDING INJECTION INTO PALLIATIVE CARE

More than \$60 million for new projects that will help improve quality and access to palliative care has been pledged by the government.

The funding announced includes \$45.4 million through the National Palliative Care Projects grants initiative for 12 projects that will help people on their final journey, and their families, with end of life care.

The funding comes as palliative care demand in Australia widens, along with public discussion around making provisions for end of life care.

While the need for palliative care can affect people at any age, Australia's ageing population and a rise in chronic and incurable illnesses has seen an

increase in palliative care service provision.

One of the recipients of the funding, Palliative Care Australia (PCA), will receive a \$5.5 million grant to continue its sector leading work promoting quality end of life care for all.

"This funding will support PCA to continue its national leadership in the palliative care sector by administering the National Palliative Care Standards and Assessment Program, providing resources to services and advising government, PCA CEO Liz Callaghan said.

"PCA will also continue to lead the National Policy Advisory Committee to advise governments and services about best practice palliative care and inform them of innovation in the sector.

"The funding also supports PCA's *Dying to Talk* initiative that supports the community to talk about their end of life wishes as well as developing new resources for healthcare professionals, carers, patients and families.

The funding will also help other areas of palliative care including research.





Jilian  
ACU graduate  
Brief interventions  
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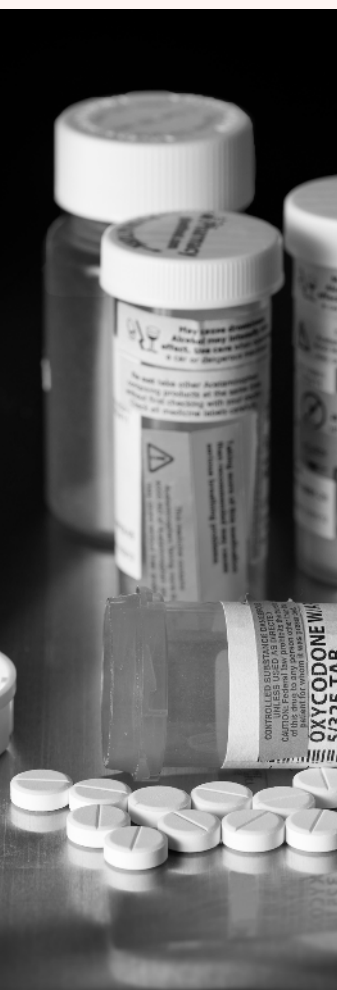
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# MEDICATION ERRORS WITH OPIOIDS: SCOPING THE EXTENT OF THE PROBLEM IN SPECIALIST PALLIATIVE CARE INPATIENT SERVICES

By Nicole Heneka, Tim Shaw, Debra Rowett, Samuel Lapkin and Jane L Phillips



Opioids are a high-risk medicine, used extensively in palliative care to manage cancer pain and other end of life symptoms (Therapeutic Guidelines Limited 2017).

When errors in opioid delivery occur, the consequences for palliative patients can be catastrophic (Clinical Excellence Commission NSW Health 2016).

As part of a larger pain initiative (Phillips et al. 2017), palliative care clinicians identified medication errors with opioids was an area of growing concern. Despite their widespread use, little is known about the burden of opioid errors in palliative care (Heneka et al. 2015).

The project was conceived following discussions with senior palliative care clinicians (nurses and doctors) who identified addressing opioid errors within their services was a quality improvement priority, given their frequency of errors and the potential to cause patient harm.

This mixed-methods project sought to identify the characteristics and impact of opioid errors for palliative care inpatients. This project, conducted at three specialist palliative care inpatient services

in New South Wales, utilised a combination of incident review, multi-incident analysis, and focus groups/semi-structured interviews with palliative care clinicians and service managers.

## Key project findings to date

Analysis of reported clinical opioid incidents over two years (n=67) indicated approximately three-quarters of opioid errors reached the patient, one-quarter of which resulted in temporary patient harm requiring clinical intervention. Patients were more likely to receive an opioid under-dose (53%), than overdose (41%), due to an opioid error, primarily due to omitted opioid doses. Opioid administration errors were the most frequently reported, accounting for half of all reported opioid incidents. Most opioid errors were due to non-compliance with medication management policy or deficits in clinical communication.

Focus groups and interviews to date (56 participants) have highlighted the:

- high volume of opioid administration routinely undertaken in inpatient palliative care services;
- key risk areas for opioid error in the opioid delivery process;

- impact of skill mix on error identification and prevention; and
- the importance of a safety culture that empowers nurses to challenge opioid orders and practices they perceive to be incorrect; and a non-punitive reporting culture that encourages learning from error (Textbox 1).

## Textbox 1: Nurses' perceptions of opioid use and safety culture in palliative care

*I've probably given 15-20 (opioids) today, that's one shift, one ward, no PRN (as required), you can have shifts where you've given 30, you have one unstable patient who you've given six (opioid administrations) and you feel like you're constantly in front of the (drug) cupboard. (ID\_38)*

*You should feel empowered to challenge because number one, it's your registration. Number two, you know what's happening is not the right thing. If you go down that path of not doing the right thing and not pushing back, then you really set yourself up for a bit of a fail. (ID\_34)*



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Web addresses - The full web address should be included followed by the date accessed eg: Department of Health (2015) Annual report 2014-15 [www.health.gov.au/internet/main/publishing.nsf/Content/annual-report2014-15](http://www.health.gov.au/internet/main/publishing.nsf/Content/annual-report2014-15) (Accessed Jan 2016).

At the completion of this project, recommendations to support medication safety with opioids across the palliative care delivery process will be developed and provided to participating services.

**Nicole Heneka, MHumNutr, PhD Candidate, School of Nursing, University of Notre Dame Australia, Darlinghurst Campus**

**Professor Tim Shaw, Director Research in Implementation Science and eHealth (RISe), Charles Perkins Centre, Faculty of Health Sciences, University of Sydney**

**Professor Debra Rowett, Discipline Leader Pharmacy External Relations, School of Pharmacy and Medical Sciences, University of South Australia**

**Dr Samuel Lapkin, Postdoctoral Research Fellow, Centre for Research in Nursing and Health, St George Hospital, NSW**

**Professor Jane Phillips, Professor Palliative Nursing, Director IMPACCT – Improving Palliative, Aged and Chronic Care through Clinical Research and Translation, Faculty of Health, University of Technology Sydney**



# THE IMPORTANCE OF THE SPECIALIST PALLIATIVE CARE NURSE

By Suzanne Collier and Stacy Blythe

There is an assumption in healthcare that any nurse in any setting can undertake palliative care.

In theory, this is true but in practice specialist palliative care nurses give the most appropriate supportive care patients can receive at the end of life. A specialist palliative care nurse has the knowledge and expertise to undertake the care that benefits patients and their families.

This care extends beyond the patients' death to follow up and support for family during bereavement. Specialist palliative care nurses work in a variety of

settings and have been identified as pivotal in both hospital and community settings to the supportive care of patients and their families (Georges et al. 2002; Cameron and Johnston 2015).

Providing end of life care to patients by a non-specialist palliative care nurse has many issues for those nurses. Nurses have to deal with all aspects associated with death and dying including end of life discussions. Non specialist nurses find aspects of care confronting and challenging (White et al. 2014). It has been identified that the work of a specialist palliative care nurse is stressful however this stress is greater for nurses in a setting other than palliative care (Whittaker et al. 2014).

Specialist palliative care nurses are more than navigators within the health system, they recognise that people are living with these illnesses. Nurses can act as a conduit to identifying the goals and wishes of the person and facilitating through information, support and honest communication to assist them to achieve what they need to achieve (O'Connor and Chapman 2008).


## Research project


Using a qualitative interview, this study will gain an understanding of

how specialist palliative care nurses across hospital and community settings undertake their role and how the streamlined continuity of care benefits patients and families who are referred to specialist palliative services. Focus groups will be conducted to gain supplemental data from the medical officers and allied health staff of the palliative care team. This will help to identify all aspects of care provision of the specialist palliative care nurse 'as the identity of nurses cannot be derived merely from the set of tasks they perform' (Georges et al. 2002).

## Practical outcomes

It is hoped this research will highlight the importance of providing experienced specialist nurses to undertake care of people at the end of their life in all settings.

 **Suzanne Collier is Clinical Nurse Consultant at the Mount Druiitt Palliative Care Unit.**

 **Dr Stacy Blythe is Senior Lecturer in the School of Nursing and Midwifery at Western Sydney University and Professor of Nursing at the Clinical Nursing Research Unit at the Nepean Blue Mountains Local Health District.**



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## END OF LIFE CARE FOR ACUTE CARE CLINICIANS

By Deb Rawlings,  
Kim Devery and  
Deidre Morgan

With 54% of Australians dying in hospital (Swerissen and Duckett, 2014) there is an imperative to provide acute hospital staff with the knowledge and skills to provide better, evidence based care to those at the end of life and to be more confident in doing so.

The 'End of Life Essentials for Acute Hospital Clinicians' project has been developed and administered by staff at Flinders University. The project, which commenced in 2014, is funded by the Commonwealth Department of Health, and is based on the Australian Commission on Safety and Quality in Health Care's National Consensus statement on Essential Elements for safe and high-quality end-of-life care. End of Life Essentials (EOLE) provides free, evidence based, peer-reviewed online learning modules that covers:

- dying (a normal part of life);
- patient centred communication and shared decision making;

- recognising end of life;
- goals of care;
- teamwork; and
- responding to concerns.

The modules are case-based and there are resources and webpages available to support learning.

The EOLE project is ongoing until 2020, and three new modules will be produced:

- for Emergency Department staff;
- to support care immediately after death (bodies, families, staff) and;
- care of patients living with chronic complex conditions.

The videos that constitute part of the modules have been viewed over 25,000 times on YouTube. To date over 5,000 learners have completed the modules, (the majority of whom are nurses).


Evaluation has also been undertaken and of the respondents, 90% agree or strongly agree that they have increased their knowledge about important elements of end of life care skills. Ninety three percent said they had increased their knowledge and skills about end of life care, while 92% said they felt more confident about recognising patients approaching the end of life and felt more confident in discussing goals of care.

Just under 90% felt more confident approaching conflict and 85% felt more confident in managing disagreements. Feedback from those undertaking the module has also been sought (with permission):


*"I think the End-of-Life-Essentials learning modules are excellent. They make you think how you would react in end of life situations and give*

*excellent guidelines to help manage such situations in the future. I believe every healthcare professional should be strongly encouraged to complete these learning modules. I now feel like I might be more confident in handling conversations in end-of-life situations"* (Registered Nurse)

In light of EOLE's positive uptake and evaluation to date, an acute end of life care topic will be developed and included in the Flinders University postgraduate palliative and end of life care studies program from mid 2018. The courses offered in postgraduate palliative care can be taken online, are multidisciplinary and are targeted at clinicians working in relevant areas and settings. Nurses are at the forefront of end of life care in hospitals and this practical, relevant information can help to improve practice and ultimately the way in which people die in acute care.

 **Deb Rawlings is a Registered Nurse and lecturer in palliative care**

 **Kim Devery is lead on End-of-Life Essentials and Head of Teaching Section Palliative & Supportive Services**

 **Dr Deidre Morgan is an occupational therapist who has worked in public health for 26 years, 13 of those in specialist palliative care. She currently works as a lecturer in Palliative and Supportive Services**

**All are based at Flinders University, South Australia.**



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## ACTING COMPASSIONATELY FOR OTHERS IS GOOD FOR YOU

By Anne Hofmeyer, Terri Gibson and Kate Kennedy

Working in palliative care can be both rewarding and demanding. Nurses build empathic relationships with their patients as they put themselves in someone else's shoes and feel with their suffering.

Yet there is a cost to this type of caring, as many nurses experience fatigue, occupational stress and burnout. While self-care activities can help, recent studies in neuroscience can also provide significant new evidence that may improve nurses' understanding, wellbeing and resilience (Vachon et al. 2015).

What is depicted as compassion fatigue may be empathic distress that is created when caregivers feel they cannot relieve suffering (Vachon et al. 2015). Neuroscience research shows when you see others anxious and suffering you activate similar areas in your brain if you can do little or nothing to relieve it, so you are at risk of empathic distress (Lown 2016). Whereas compassion is acting to relieve the suffering of others, and evidence shows that compassion activates other areas of the brain associated with positive feelings, reward and satisfaction resulting from making a difference (Lown 2016).

Palliative patients say care may be technically correct, but when compassion is lacking, their need for human connections and relationships is not met. Patients say small acts

PATIENTS SAY SMALL ACTS BY NURSES SUCH AS TOUCH CAN CONVEY COMPASSION AND MAY RELIEVE SUFFERING

by nurses such as touch can convey compassion and may relieve suffering (Bramley and Matiti 2014).

In our study of compassion (Hofmeyer et al. 2017), a student described a brief discussion she observed:

*A nurse saw her colleague was assigned a palliative patient for the shift so she offered to swap because she knew the nurse had experienced a recent family bereavement so did not want her to be in a distressing situation.*

The student said the nurse acted with compassion to support her colleague's emotional wellbeing and ability to do her job. This is a simple

example of a small act of compassion between nurses that potentially made a big difference to the nurses themselves and to their patients.

Vachon and her colleagues remind us 'true compassion cannot fatigue. Compassion may be a source of resilience and hardiness and may be essential to our wellbeing. To engage in compassion for others we must first practice self-compassion' (2015 pp969). What self-compassionate act can you do today?

**Dr Anne Hofmeyer is Senior Lecturer in the School of Nursing and Midwifery at the University of South Australia and Visiting Professor at Anglia Ruskin University, Cambridge UK**

**Dr Terri Gibson is Program Director Postgraduate & International Programs in the School of Nursing & Midwifery at the University of South Australia**

**Ms Kate Kennedy is Research Assistant in the School of Nursing and Midwifery at the University of South Australia**



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## CALL FOR ABSTRACTS

# 19th South Pacific Nurses Forum:

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The 19th South Pacific Nurses Forum in the Cook Islands will bring together evidence, experience and innovations highlighting nursing contribution to universal health coverage and demonstrating how nurses are important to ensuring access and quality of healthcare for all.

The theme of this year's meeting: *Transforming Leadership – Nurses as Change Agents for Non Communicable Diseases (NCDs) in the Pacific* encourages nurses to take the lead and lead by example to be full partners with other health professionals in redesigning and advancing healthcare to address the challenge of NCDs.

NCDs are the greatest challenge to the Pacific people in this 21st century.

Nurses need to lead the way in the prevention and management of these conditions to improve the health and reduce the mortality and morbidity of Pacific people.

### Key Dates

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Submission of abstracts opens

**23 April 2018**

Deadline for submission of abstracts

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## 46th Global Nursing and Healthcare Conference

Exploring latest innovations in nursing and healthcare  
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## International Human Rights Day

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## 47th Global Nursing & Healthcare Conference

Exploring latest innovations in nursing and healthcare  
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## 5th International Conference Global Network of Public Health Nurses

**5-7 March 2018,** Safari Park Hotel and Casino, Nairobi. [www.icn.ch/](http://www.icn.ch/)

## 23rd Commonwealth Nurses and Midwives Federation Biennial Meeting

**9 March 2018,** London UK. [www.commonwealthnurses.org/](http://www.commonwealthnurses.org/)

## 4th Commonwealth Nurses and Midwives Conference

**10-11 March 2018,** London UK. [www.commonwealthnurses.org/](http://www.commonwealthnurses.org/)

## 24th Global Registered Nurse and Nurse Practitioners Conference

Dredge into the advanced approaches of nursing  
**19-20 March 2018,** Bali, Indonesia. <http://registerednurse.nursingconference.com/>

## 20th Global Nursing Education Conference

Current challenges and innovations in nursing education  
**21-23 March 2018,** New York, USA. <http://nursingeducation.nursingconference.com/america/>

## Australian Healthcare Week Expo

**21-23 March 2018,** International Convention Centre Darling Harbour. <http://bit.ly/2u8HODS>

## Nurse Practitioners - Pharmacology and Prescribing Conference

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## Lung Health Promotion Centre at The Alfred

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# MAY

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**1-4 May 2018,** Crown Promenade Melbourne, Victoria. [www.dconferences.com.au/nne2018](http://www.dconferences.com.au/nne2018)

## Lung Health Promotion Centre at The Alfred

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**3-4 May 2018,** Melbourne. [www.ausmed.com.au/course/enrolled-nurses-conference](http://www.ausmed.com.au/course/enrolled-nurses-conference)

## 7th World Congress on Breast Cancer

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## 4th World Congress on Midwifery and Women's Health

Caring women and newborns with skill and compassion  
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## Global Experts Meeting on Neonatal Nursing and Maternal Healthcare

Novel advancement in neonatal nursing & maternal healthcare research  
**14-16 May 2018,** Singapore. <http://neonatal-maternal.nursingconference.com/>

## Palliative Care Nurses Australia Inc Biennial Conference

**20-21 May 2018,** Hilton Brisbane Qld. [www.pcna.org.au/](http://www.pcna.org.au/)

## 26th World Congress on Nursing Care

Advanced technologies and best practices in nursing & integrated care  
**21-23 May 2018,** Osaka, Japan. <http://nursingcare.nursingconference.com/asia-pacific/>

## Inaugural Australian Clinical Supervision Association Conference

Clinical 'SUPER' vision – people, passion, purpose  
**22-24 May 2018,** ANMF House, 535 Elizabeth Street, Melbourne. Check out the conference hashtag at: #ACSA18 or <https://www.acsaconference2017.org.au/>

## 3rd World Congress on Nursing Practice & Research

Hand in hand creating tomorrow: Nursing practice, education and research  
**23-24 May 2018,** Montreal, Canada. <http://nursepractitioner.nursingconference.com/>

## 3rd International Conference on Nursing & Midwifery

Leading the way: Nurses & midwives for a safe healthy and peaceful world  
**23-24 May 2018,** New York, USA. <http://nursingmidwifery.nursingconference.com/>

## Melbourne Nurses' Conference

**24-25 May 2018,** Oaks on Market, Melbourne Victoria. [www.ausmed.com.au/course/melbourne-nurses-conference](http://www.ausmed.com.au/course/melbourne-nurses-conference)

## Australian College of Perioperative Nurses (ACORN) and joint Asian Perioperative Nurses Association (ASIORNA) Conference

**23-26 May 2018,** Adelaide Convention Centre, South Australia. [www.acorn.org.au/conference2018/](http://www.acorn.org.au/conference2018/)

## Care of the Older Person into the 21st Century - Alaska

What does the future look like as the population ages into the 21st century and what are the implications for healthcare delivery?  
**27 May-3 June 2018.** Held aboard the Celebrity Infinity cruise ship, you will experience the majesty of the Hubbard Glacier in Alaska. [www.nursesfornurses.com.au/events](http://www.nursesfornurses.com.au/events)

# NETWORK

## Royal Women's Hospital student midwives, March group 1983-1984 reunion

Contact Maureen Boston (nee McFadden) E: [maureen\\_boston@hotmail.com](mailto:maureen_boston@hotmail.com) or M: 0428 552 475

## Prince Henry's Hospital, 1/73, 45-year reunion

**27 January 2018.**  
Contact Jeanne O'Neill (nee Pinder) E: [ej\\_oneill@yahoo.com](mailto:ej_oneill@yahoo.com)

## Austin Hospital, Group: 76/1, 42-year reunion

**February 2018.** Seeking fellow students for reunion. Contact Carol B E: [Austin76one@gmail.com](mailto:Austin76one@gmail.com)

## PHH, POW and Eastern Suburbs Hospitals, NSW reunion for PTS intake of Feb 1973

**17 February 2018.** Contact Roslyn Kerr E: [gert2@optusnet.com.au](mailto:gert2@optusnet.com.au) or Patricia Marshall (nee Purdy) E: [tapric135@bigpond.com](mailto:tapric135@bigpond.com)

## St John of God Hospital Ballarat Past Students reunion

**14 April 2018,** Ballarat Golf Club. Contact Geraldine Vagg E: [gerryvagg@hotmail.com](mailto:gerryvagg@hotmail.com) or M: 0418 554 096

## Alfred Hospital, Group 3/68, 50-year reunion

**June 2018.** Contact Isabelle E: [isabellehenry360@gmail.com](mailto:isabellehenry360@gmail.com)

## NDSN Bendigo School 71, 50-year reunion

**2018.** Seeking students from Bendigo, Castlemaine, Echuca, Swan Hill and Mildura. Contact E: [margie\\_coad@hotmail.com](mailto:margie_coad@hotmail.com) or M: 0427 567 511



Email [cathy@anmf.org.au](mailto:cathy@anmf.org.au) if you would like to place a reunion notice

# THE POWER OF TOUCH

Sally-Anne Jones, ANMF Federal President



Every time I travel from Brisbane for federal ANMF meetings, I become anxious in anticipation of the flight. Despite the science and logic of its safety, I simply don't like flying. It's something that has emerged as I got older.

Perhaps I am feeling more mortal since I have had a family, but the more I read up on it, it seems late onset flight anxiety is not such an unusual phenomenon. I do all the recommended strategies to overcome a fear of flying and so far it has never stopped me getting on a plane.

This November, we met for the final Federal Executive meeting for the year in Melbourne. There had been a series of cold fronts and associated vicious storms sweeping across the southern part of Australia in the weeks before we were due to go. Beth Mohle, Secretary of the Queensland Nurses and Midwives' Union (QNMU) and I usually travel to Federal Executive meetings together and we had experienced a pretty scary descent and landing into Melbourne in the face of a storm front a year or so before and I was secretly terrified of going through that again.

What makes travelling to the meetings more bearable for me is the calming and physical presence of Beth- sometimes I touch her arm, sometimes she touches mine. Sometimes I hold her hand in a vice-like grip as the plane jiggles a bit in the jetstream or bounces through some clouds on the way up or down. It got me to thinking about the connection between fear, anxiety and the comfort of touch or presence in our patient experience.

In the week before the Federal Executive meeting, my Hospital and Health Service's Nursing and Midwifery Leadership team

met to work on the priorities for nursing and midwifery for the next 12 months. We talked a lot about how the mechanisation and digitalisation of our work has changed nursing and that as a result, it feels like the 'care factor' has gone out of our daily activities. There isn't the time to chat with our patients anymore, to spend an extra few minutes asking about their work, family or holiday. I think our patients are missing it. And so are we, as a profession, even though I would not ever undo the development of our professions into the autonomous, proficient, expert clinicians that we have become. The pressure within the health system (in any sector) cannot be underestimated for what it contributes to the sense of disconnectedness in the patient experience either. Perhaps it is because we have become so acutely aware of invading personal space, potential risk of accusations of inappropriate conduct and maintaining a safe and professional distance but it seems touch is not what we do as much anymore. As the demands in our day to day work increase, *touch* or *presence* is never more important to those in our care. Are increasing patient complaints and our discontent with the dehumanisation of our work the symptom of a lack of 'care factor'? Are we suffering the loss of the therapeutic relationship as we knew it?

TOO OFTEN WE  
UNDERESTIMATE THE POWER  
OF A TOUCH, A SMILE, A KIND  
WORD, A LISTENING EAR, AN  
HONEST COMPLIMENT, OR THE  
SMALLEST ACT OF CARING, ALL  
OF WHICH HAVE THE POTENTIAL  
TO TURN A LIFE AROUND.

Leo F Buscaglia

Renowned neuroscientist David Linden, author of *Touch: The Science of Hand, Heart and Mind*, says that the most critical function of interpersonal touch is to build trust and cooperation. Deriving from maternal touch when we are babies, and mentioned in numerous developmental theories, touch is a social glue that persists throughout our lives. Humans have lived in social groups for hundreds of thousands of years, evolving our ability to read each other's facial expressions, tone of voice, body language. So when we are distanced from each other by technology or 'busyness', the difference between a passing word of condolence or actually reaching out to touch and console someone is the missing component of the human experience.

The word comfort is derived from the Latin prefix *com*, meaning 'with,' and *fortis*, meaning 'strong'. Originally, the English definition meant 'to encourage or support'. Through our touch, we offer encouragement, supporting people to feel stronger in their ability to cope with physical, mental, and emotional challenges. Touch is offered in a way that provides assurance and a calming comfort in our health environments where fear is evoked from the noises, the procedures, the unknown, or being lonely.

I am not sure how much of the nursing theorists remain in our everyday consciousness, but elements of this concept were thoroughly explored as part of understanding the art and science of nursing. Parse, Paterson, Watson, Travelbee – are some whose scholarly enquiry sought to distinguish the role of the therapeutic relationship between nurse and patient through touch, presence, being, empathy – on top of the tasks, duties and skills attributed to the profession.

And further, Reiman (1986) found that when patients described no-caring behaviour they referred to the quality of being physically present but emotionally distant.

I don't think that we have to become gushy parent-figures for our patients, healing the deficits of the world with hugs – not at all!

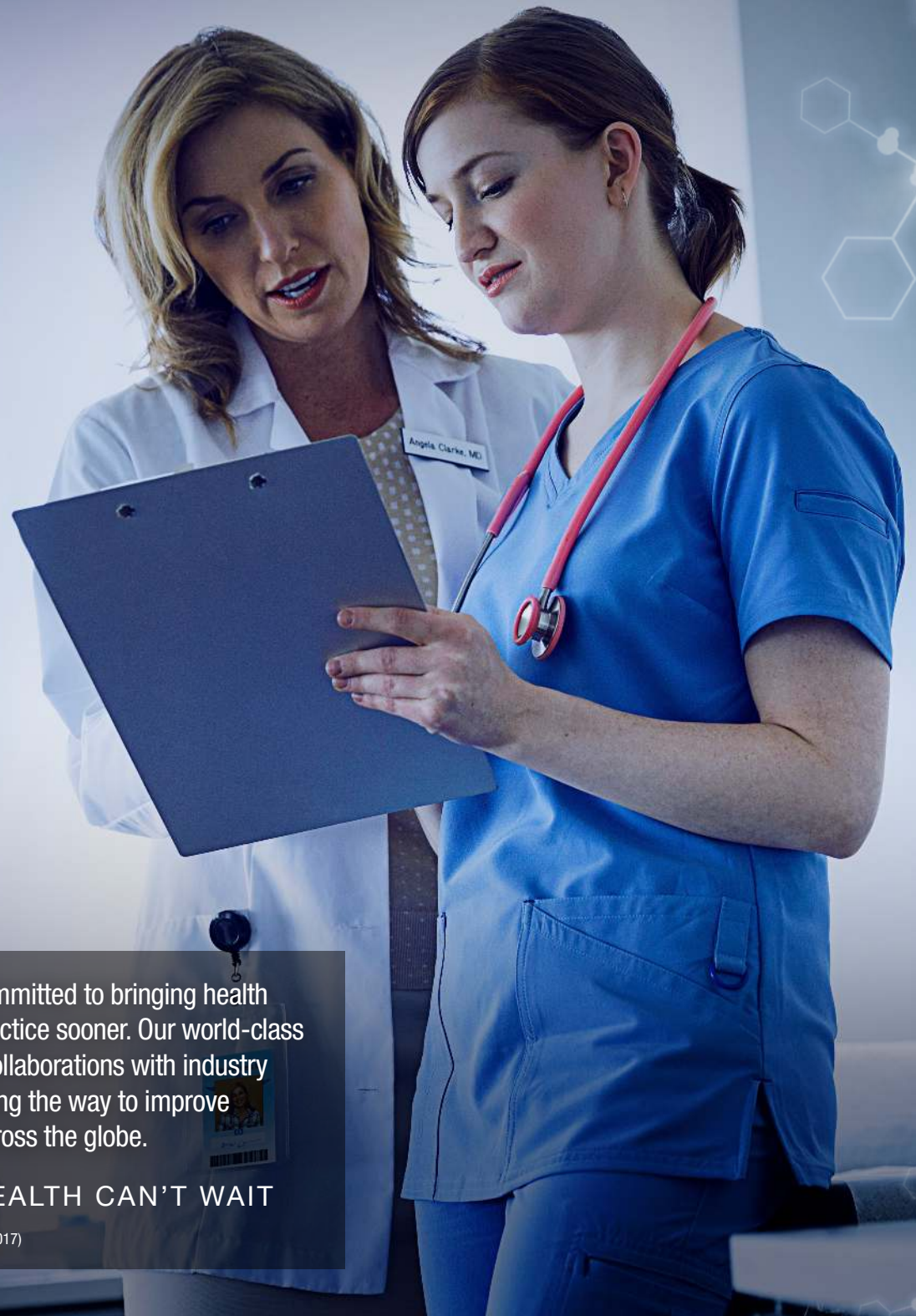


But just as I find comfort for my fear in the presence of my travel companion – be it Beth or a complete stranger (to whom I introduce myself and explain how I might need them, and to date have never minded), I do think that we need to be mindful of the power of comfort that a touch or our presence can bring to someone who is in our emergency departments, wards, clinics, general practice, operating theatres, nursing homes, to the sick kids and the dying, no matter where we nurse them.

In an increasingly pressurised, disconnected and digitalised world, being aware of, and practicing culturally sensitive touch and presence is the way that nurses can keep healthcare human.



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