

The background of the cover is a photograph of an iceberg floating in a blue ocean under a clear blue sky with a few white clouds. The iceberg's tip is above the water, while its much larger, jagged base is submerged. The water is a deep blue, and the sky is a lighter blue. The entire cover is framed by a white border.

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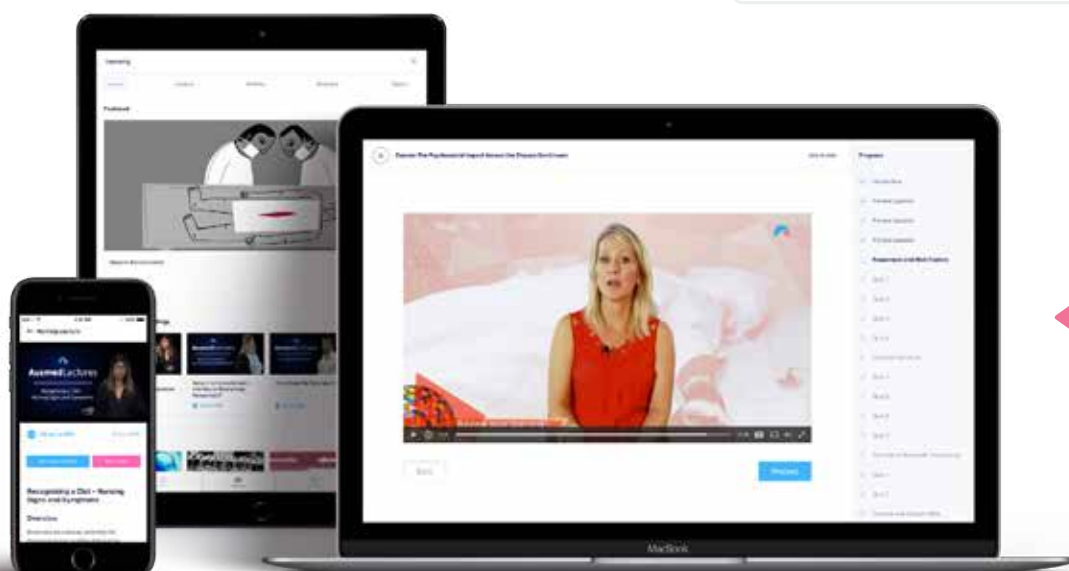
AGENTS OF CHANGE

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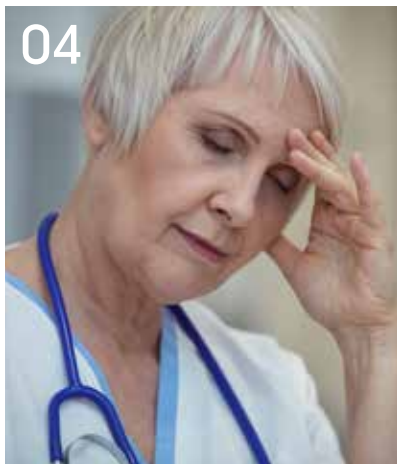
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Editorial

Annie Butler ANMF A/Federal Secretary

On 12 May, International Nurses Day, the ANMF will officially launch its Ratios for Aged Care make them Law. Now! campaign.

A broad advertising campaign of public awareness, already in progress, has been sending a message to all federal politicians and the wider community promoting legislation for staff ratios in aged care.

This includes a series of TV commercials, which began airing late last month to coincide with federal senators returning to Canberra and with mobile billboards circling Parliament House and throughout the city on that day. The voices in the advertising campaign are of aged care nurses, carers and family members telling their stories and calling on politicians to fix the crisis at hand.

The official campaign launch, on International Nurses' Day, could not be more appropriate, given this year's International Nurses' Day theme - *Nurses a Voice to Lead - Health is a Human Right*.

We will be calling on all nurses, midwives and carers across the country to participate in activities on this day. Already some states have organised events. For more information on what's happening in your state or territory go to morestaffforagedcare.com.au and sign up to receive campaign updates.

THE OFFICIAL CAMPAIGN LAUNCH, ON INTERNATIONAL NURSES' DAY, COULD NOT BE MORE APPROPRIATE, GIVEN THIS YEAR'S INTERNATIONAL NURSES' DAY THEME - *NURSES A VOICE TO LEAD - HEALTH IS A HUMAN RIGHT.*

I am pleased to announce that former ANMF Federal Secretary Ged Kearney will be heading to Federal Parliament after claiming victory in the by-election for the Victorian seat of Batman.

The ANMF is delighted that nurses, midwives and carers now have an advocate and voice at this level.

Ged has already pledged to oppose the government's attack on Medicare and to fight for penalty rates. She is also acutely aware of the crisis in aged care and what needs to be done to fix it.

As we prepare to launch our new national aged care campaign we look forward to working with her on this issue. Congratulations Ged!

Before I sign off I want to make mention of another worthy global crusade the ANMF is proud to be part of. The **Nursing Now** campaign, backed by the World Health Organization and the International Council of Nurses, aims to raise the status and profile of nursing so that the profession can work to its full scope to achieve universal health coverage. Launched last month, it will run until 2020. From an Australian perspective, this campaign will focus on access to healthcare. For more information see the news section of the ANMJ.

Annie



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SPOTLIGHT ON THE HARSH REALITY OF SUICIDE IN AUSTRALIAN NURSING HOMES

Almost 150 Australian nursing home residents took their own lives while in care between 2000 and 2013, a confronting new study has revealed.

Nursing home residents who took their own lives most commonly died from hanging (31.9%), falls from height (17%) and plastic bag asphyxia (14.2%).

The majority of these residents were male (68.8%) and had a diagnosed mental illness, primarily depression (66.6%).

Suicides in nursing homes were three times more likely to occur over a holiday period.

Undertaken by a team of researchers from Monash University, the study analysed national records generated by coroners' investigations into the deaths in order to determine an individual's health status, personal circumstances and care history.

It pinpointed major life stressors including health deterioration (79.4%), isolation and loneliness (42.6%) and maladjustment to nursing home life (29.8%) as leading contributors to the rate of suicide in residential care.

The study's co-leader, Professor Joseph Ibrahim from the Department of Forensic Medicine, said researchers focused on suicide in residential care in a bid to form a better understanding of the management of depression and mental health.

"Our question was does this [suicide] ever happen and if it does, how could it?

PROFESSOR JOSEPH IBRAHIM

You don't expect a suicide in a hospital or a school or in an environment where you have a large number of people and professional staff to monitor your behaviour."

Professor Ibrahim labelled the number of suicides "distressing" regardless of the total figure spanning a decade.

He said the findings reflected significant gaps in services across Australia and widespread acceptance about the shortcomings of aged care.

"One of the things people make assumptions about is if you're old, have a disability and live in aged care that it's natural to be sad and depressed," Professor Ibrahim said.

"While we agree there's going to be some type of bereavement response when you move in, no one should be clinically depressed and miserable in a supervised setting."

Professor Ibrahim said the current delivery of aged care was ineffective when it comes to preventing suicides.

Change requires improving the nursing home environment and providing greater access to mental health services and specialist teams, he added.

"[It's about] better attention to social inclusion and making residential care a place that people actually want to live rather than a last resort."

Currently, 170,000 Australians live in nursing homes and the country invests less than 1% on aged care services, ranking it 17th out of 96 globally.

"[IT'S ABOUT] BETTER ATTENTION TO SOCIAL INCLUSION AND MAKING RESIDENTIAL CARE A PLACE THAT PEOPLE ACTUALLY WANT TO LIVE RATHER THAN A LAST RESORT."

Professor Ibrahim believes lifting the overall quality of aged care and curbing suicides represents a shared responsibility, with families, GPs, staff, providers and policymakers all holding a role to play.

He said the release of the study had elicited strong community views but stressed its goal was to improve understanding around quality aged care services.

"[Some] people are using this as a way to argue for euthanasia, which is incredibly disappointing and distressing because the message really ought to be how is it that suicides occur in supervised care and if there are deficiencies in care we should be fixing those.

"But the point of view that seems to come across is I don't want to get old and if I get old I want to make sure I kill myself before I get to residential care."



ENCOURAGING CALD COMMUNITIES TO CONSIDER TISSUE AND ORGAN DONATION

The Federation of Ethnic Communities' Council of Australia (FECCA) is encouraging culturally and linguistically diverse (CALD) communities to make use of updated communication tools about organ tissue donation.

While research has shown more than 67% of Australians are willing to become tissue donors, many Australians of CALD background are not fully aware of what being a donor means or how to go about registering their position, the Chairperson of FECCA, Mary Patetsos said.

"The set of communication tools is part of a community grant received by FECCA from the Organ and Tissue Authority to engage CALD leadership on organ and tissue donation," she said.

The communication tool covers topics such as, religious statements supporting donation, links to resources in multiple languages and when and how to have a discussion on organ and tissue donation.

"We urge people of CALD communities to discover the facts about organ and tissue donation, make an informed decision to become a donor, register that decision- and discuss that decision with people close to you," Ms Patetsos said.

Find the resource at:
<http://fecca.org.au/wp-content/uploads/2018/03/DonateLife-Communication-Tools-for-CALD-Communities-1.pdf>

STRESS AND BULLYING AMONG CHIEF CONCERNS FOR NURSES AND MIDWIVES



Workplace issues including stress, bullying, harassment and burnout have emerged as the leading concerns among the nation's nurses and midwives who accessed the confidential Nurse & Midwife Support (NM Support) service within its first year of operation.

Data collected from the opening 12 months of NM Support providing advice and referrals to nurses and midwives has revealed workplace issues as the biggest concern for 92% of midwives, 74% of nurses and 63% of students who phoned the service.

Stress, followed by bullying and harassment, top the list of concerns.

Launched a year ago, NM Support offers confidential 24/7 assistance and referral to nurses, midwives and students nationally.

As well as central issues such as bullying and burnout, nurses and midwives also called NM Support to discuss physical health problems, with 18% of nurses and 16% of midwives seeking help in this area.

Mental health marked another area of concern, with 28% of nurses and 12% of midwives contacting the service looking for support.

Nurse & Midwife Support Stakeholder Engagement Manager, Mark Aitken, believes the data reflects how the service is successfully reaching out to nurses and midwives across the country in need.

"Whilst it's concerning that Australian nurses are experiencing health issues, it's comforting to know that the service is being utilised across the country, including rural and remote areas," he said.

Mr Aitken spent the past year touring Australia to promote the service and while pleased with its initial uptake he hopes more nurses and midwives will access its expertise as time goes by.

"I would encourage any nurse or midwife who needs our help to call us today. Put our support number in your phone so that it is accessible when you need it. Whether you work in urban or rural location, you are not alone – help is available."

Workplace issues including stress, bullying, harassment and burnout are common within the nursing and midwifery professions and an ongoing concern.

Monash University's Business School began conducting national surveys examining the workplace climate and wellbeing of nurses and midwives in 2010.

Results from its latest survey in 2016 showed almost a third of nurses and midwives have considered leaving the professions due to rising work demands and burnout.

According to the study, increasing workloads, work intensification and budget cuts leading to unrealistic nurse-to-patient ratios formed leading triggers of workplace issues.

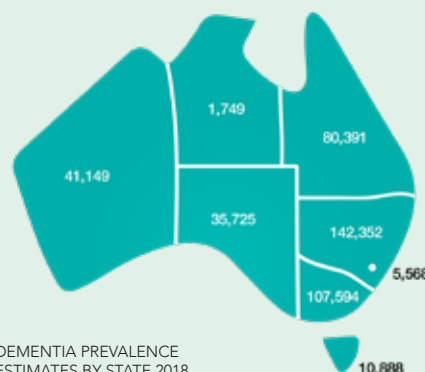
Professor Anne Williams, Chair, Health Research at Murdoch University, regularly presents wellbeing sessions to nurses working in clinical areas.

"When asked what causes them stress at work, responses mostly relate to a lack of time and resources to provide quality care to their patients."

Professor Williams said nurse educators needed to arm undergraduate nurses and midwives with effective strategies to cope with work stress and provide ongoing education to vulnerable healthcare staff.

"Education is key in my opinion. There have been some great advances in our understanding about health and wellbeing over the past 20 years especially in the neuroscience and positive psychology areas. This knowledge now needs to be translated into our healthcare culture to benefit both staff and patients."

SUPPLIED: DEMENTIA AUSTRALIA
THE NATIONAL CENTRE FOR SOCIAL AND ECONOMIC MODELLING
NATSEM (2016) ECONOMIC COST OF DEMENTIA IN AUSTRALIA 2016-2056



DEMENTIA PREVALENCE
ESTIMATES BY STATE 2016

UPSURGE IN PEOPLE LIVING WITH DEMENTIA

Australia's peak body representing people living with dementia is calling on impacted individuals, families and carers to turn to its support services as latest figures show 425,000 people live with dementia nationally and 250 people are developing the condition each day.

Dementia, a collection of symptoms caused by disorders affecting the brain that affect the ability to perform everyday tasks, is the second leading cause of death among Australians and the leading cause of death for women.

There is no cure for the devastating group of disorders but Dementia Australia CEO Maree McCabe said the right support and information could make a life-changing difference to people living with the condition.

The number of Australians living with dementia is expected to soar to 536,000 people by 2025 and more than 1.1 million people by 2056.

People in their 40s and 50s can develop dementia but it is more common amongst those over the age of 65. Early signs can be subtle and vague and include progressive and frequent memory loss, confusion, personality change, apathy and losing the ability to perform everyday tasks.

"Good support services can help people cope better with the uncertainty and changes that come with dementia," Ms McCabe said.

"One significant issue Dementia Australia staff often hear following a diagnosis of dementia is how isolating it can be, which can be devastating and debilitating."

"However, the right services can help people reconnect and re-establish relationships with partners, families and friends which can be so important for their emotional wellbeing. Social engagement and keeping physically and mentally active are also key in contributing to better health and lifestyle outcomes following a diagnosis of dementia."

To contact Dementia Australia call the National Dementia Helpline on 1800 100 500 or visit www.dementia.org.au

GLOBAL NURSING CAMPAIGN AIMS TO EMPOWER NURSES TO MAXIMISE INFLUENCE

Australia's contribution to a landmark three-year global campaign dubbed *Nursing Now* that is striving to improve health and lift the profile of nursing will focus on pushing for greater access to healthcare.

Nursing Now campaign Board member for the World Health Organization's (WHO) Western Pacific Region, Emeritus Professor Jill White said she had begun canvassing the views of nursing groups across the country, including the ANMF, so Australia could develop a collective strategy to support the movement.

"For me, what underpins universal health coverage is good access," Professor White explained.

"That's what I'll be pushing for Australia to pick up on, that notion of access. Because if you talk to a politician in Australia about universal health coverage, quite reasonably they would say 'We've got Medicare'. And we do and it's a brilliant safety net and we're so lucky to have it but if you talk to someone who is in a rural community, or with a mental health problem, whilst they may have financial coverage they don't have access."

The evolution of **Nursing Now** stems from a global nursing review undertaken by the UK's All Party Parliamentary Group on Global Health that produced a report in 2016 titled *Triple Impact*, which concluded strengthening nursing would spark a threefold effect - improving health, promoting gender equity and supporting economic development.

Backed by the International Council of Nurses (ICN) and World Health Organization (WHO), **Nursing Now** was officially launched last month in London and Geneva and will run until the end of 2020 to coincide with the 200th anniversary of Florence Nightingale's birth.

After opening the London event, the Duchess of Cambridge, Kate Middleton, who boasts a family lineage of nurses, will raise awareness about the global campaign as the UK's official patron.

Fundamentally, **Nursing Now** is aiming to raise the status and profile of nursing so that the profession can work to its full scope and enhance its influence in helping achieve universal health coverage.

The campaign's core goals include achieving greater investment in all aspects



of nursing and midwifery, promoting innovative practice in nursing, boosting the influence of nurses and midwives on global and national health policy, ensuring more nurses step into leadership positions, and providing more evidence to policymakers of the contributions nursing can make.

ANMF A/Federal Secretary Annie Butler encouraged nurses and midwives to sign up and pledge their support to the campaign.

"It's time to take action and raise the profile and status of nursing worldwide," Ms Butler said.

"Nurses should be empowered to use their knowledge, skills and expertise to their full scope. As the health professionals closest to the public, nurses and midwives can play a bigger role in driving better health outcomes."

Professor White said the *Triple Impact* report made valid observations about the lack of knowledge regarding what nursing is and what the profession does.

She also praised its view that developing nurses would further economic development.

"Nursing has so often been seen as a cost rather than an absolute investment in the economic growth of the country and I think that's really significant."

Professor White said **Nursing Now** could forge a powerful voice for the profession but stressed it was critical the end goal of

better patient care and access remains at the forefront.

"What we can't afford to do is get people offside by interpreting this as just about nursing self-interest," she said.

"It's always about better healthcare for people. If we don't have the right number of nurses and we don't have nurses paid appropriately and we don't have the right number in the right place, doing the right thing, and educating the right way, we will not have the optimal health for our populations."

Professor White said the success of **Nursing Now** ultimately rested with the professions and their ability to understand the context in which they work, how decisions are made and how they can have greater influence.

"This is up to us. The campaign is about bottom up and top down in lots of ways. It's about trying to educate non-nurses about what nursing can do and garner their assistance and understanding.

"But if nurses don't absolutely take this as a fantastic opportunity to speak about what they do and to try and influence people and think about what might work in their workplace and to agitate about making sure people have a realistic understanding of the job of a nurse – if we don't do our bit we cannot expect others to do anything for us."

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PREGNANCY CARE GUIDELINES UPDATED

A revised version of the *Pregnancy Care Clinical Practice Guidelines* has been released by the Australian Government Department of Health.

The 2018 edition of the guidelines combines Module 1 and 2 of the *Antenatal Care Guidelines*, published in 2012 and 2014 respectively.

A number of chapters have also been reviewed and updated for this edition, in accordance with NHRMC requirements for guideline development.

The guidelines provide evidence based recommendations to support health professionals to provide high quality, safe antenatal care in all settings. They highlight specific approaches to pregnancy care for a range of groups, with a focus on improving the experience of antenatal care for Aboriginal and Torres Strait Islander women, migrant and refugee women and women with severe mental illness.

Among the changes is a new recommendation to encourage routine Hepatitis C testing at the first antenatal visit. Routine testing for Vitamin D status is now discouraged, unless there is a specific indication.

The guidelines recognise body mass index prior to pregnancy and weight gain during pregnancy as important determinants of health for both mothers and babies.

The guidelines are designed for all health professionals caring for pregnant women, including midwives, obstetricians, GPs, Aboriginal and Torres Strait Islander health workers and allied health professionals.

The Pregnancy Care Guidelines can be downloaded at: www.health.gov.au/pregnancycareguidelines

WOMEN IN HEALTH CONNECT OVER LEADERSHIP ASPIRATIONS

A wide cross-section of women working in the health system gathered in Melbourne on International Women's Day last month to build on their leadership skills at the National Health Sector Women's Leadership Summit.

The event is one of many professional development programs run by Women & Leadership Australia (WLA), a national initiative that believes women represent an under-utilised resource and should be supported to take up greater leadership roles.

The 2018 Summit program featured speakers including Libby Lyons, Director of the Workplace Gender Equality Agency, and Ebola fighting nurse Anne Carey, former West Australian of the Year.

A panel discussion running under the theme 'Leading Through Change' offered insights into how several prominent health leaders had steered the ship through times of transformation.

Panellist, Assistant General Secretary of the NSW Nurses and Midwives' Association (NSWNMA) (ANMF NSW Branch), Judith Kiejda, cited the changing demographic of the nursing and midwifery workforce as her most challenging obstacle as a leader over the past 15 years.

"For a very long time we've been aware of the ageing demographic of people we seek to represent but the reality is I know them, I grew up with them, I did my training with them and I am one of them," Ms Kiejda explained.

"The big change has actually been understanding the younger people who are becoming nurses and midwives as well, as newer additions to our internal workforce."

Ms Kiejda told the audience changing times had demanded the union develop innovative strategies around recruitment and retention.

One such example involves a Career Break Scheme, where public health system nurses in NSW can apply to defer 20% of their salary for four years and be paid the deferred salary in the fifth year, taking that year off.

The scheme was devised in response to the view many younger

nurses wish to travel and not necessarily leave the profession.

"We've thought a lot about how we attract them and keep them and thankfully, there's no shortage of people wanting to become nurses and midwives," Ms Kiejda said.

"What there is a shortage of is decent jobs, permanent full-time jobs, for them to go into. However, I would also suggest that there's a cohort of nurse managers out there in hospital land who are hanging on tight to past cultures and that is causing a significant proportion to decide after a few years that this career is not for them."

Ms Kiejda added the union would continue to fight to protect Medicare and health services, illustrating immense pride over recent campaign efforts to stop five public hospitals from changing into private hands.

"One thing is for sure, in a growing industry like health and the constant need to find efficient ways to deliver quality, accessible healthcare, change will be a constant. So leaders need to strap themselves in, take the time to consult, recognise the talents of others and guide their valued team members through all the change developments."

Fellow panellist Vickie Kaminski, Chief Executive Officer of SA Health and a nurse since 1975, spoke about her most recent experience with change as part of the state government's problematic Transforming Health plan of major hospital reforms to cut health costs and improve efficiency.

"I would venture to say now, having been there two years that in fact I don't think we talked to any clinician before we did it. I don't think anybody supported it. I don't think any political party knew what they were buying or why they were doing it. But we had 30,000 staff ready to make a change and to change with us and a number of changes happened."

Despite the shortcomings of Transforming Health, Ms Kaminski said change was inevitable and that leaders needed to stay true to their vision and communicate with the people it affects most.

"I don't think we have change fatigue I think we're just tired. We're working hard, we're working long, we're working tough sometimes and we're tired. If we are tired of change we need to think about what we're doing because what we're doing today isn't what we're going to be doing tomorrow."

"Never underestimate the fact that change is disruptive and that people will move with you if they believe in the vision and understand where they're going."

TIME FOR ACTION ON GENDER PAY GAP

As the world celebrated International Women's Day last month ANMF Federal Vice President Lori-Anne Sharp advocated for workplace gender equality and greater recognition of the economic value of unpaid care at a breakfast held by the Geelong Women Unionists Network to mark the occasion.

Ms Sharp opened her address by highlighting the traits that define a strong woman and reflecting on inspiring female leaders and their achievements.

She then spoke out on why the gender pay gap still exists and growing efforts to tackle workplace gender equality.

According to the Workplace Gender Equality Agency, the national gender pay gap remains stuck at 15.3%, with women earning on average, about \$253.70 a week less than men.

The agency says the gender pay gap favours men in every industry and occupational level, regardless of whether they are male or female-dominated.

The gender pay gap also follows women into retirement, with women, on average, retiring with half the superannuation of men, the shortfall leaving women two and a half times more likely to retire in poverty than men and increasingly vulnerable to homelessness. Ms Sharp said International Women's Day offered the ideal opportunity to help drive progression.



ANMF FEDERAL VICE PRESIDENT LORI-ANNE SHARP AND RN JACKIE KRIZ, VICE PRESIDENT OF GEELONG TRADES HALL.

"WE NEED TO COMMIT TO SETTING CLEAR TARGETS THAT SUPPORT WOMEN HOLDING SENIOR POSITIONS ON BOARDS AND MAKING UP HALF THE NUMBERS IN PARLIAMENT."

"I think it's really important because it reminds people that a gender pay gap exists and that inequality is prevalent but it also brings women and the community together."

Ms Sharp said Australia's efforts to bridge the gender pay gap needed improving, pointing to overseas countries such as England that have mandated laws requiring companies with over 250 employees to publicly declare their gender pay gap.

She highlighted the lack of economic value placed on unpaid care across the system relating to raising children and caring for elderly parents.

Ms Sharp also said married men with children are looked upon more favourably for promotions and career advancement than women with children, who often experience discrimination due to misconceptions they could prove a hindrance.

"Meaningful change must come from government policy," Ms Sharp said.

"We need to commit to setting clear targets that support women holding senior positions on boards and making up half the numbers in Parliament."

As well as pushing for workplace gender quality, Ms Sharp informed the audience about the deepening crisis in aged care and the ANMF's upcoming national ratios campaign, which will lobby politicians in the lead-up to the federal election.

"Safe staffing ratios in aged care are required urgently," Ms Sharp said.

"It's a female dominated workforce. It's hard work and it can be exhausting. Aged care providers are making billions of dollars of profit while there's not enough staff to deliver the adequate care that's required."

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INVESTMENT IN MENTAL HEALTH SERVICES FOR CHILDREN CRUCIAL

Australia must invest more in mental health services for children from birth to age 12 following the release of new data showing increased levels of psychological distress and suicide rates among people during early adulthood.

The National Mental Health Commission made the call in response to the third Australian Research Alliance for Children and Youth (ARACY) report card, which revealed increased levels of high or very high psychological distress among 18-24 year-olds and suicide rates among 15-25 year olds.

The report card uses data from a number of sources across a range of indicators to compare how Australian children and young people are faring across six key areas

including health, learning and positive sense of identity and culture.

Mental health once again emerged as a growing issue, particularly amongst Aboriginal and Torres Strait Islander Youth aged 15-19, with a third experiencing a probable mental illness.

The Commission's chief executive, Dr Peggy Brown, said investment in child and youth mental health must become a national priority to ensure the prevention and early intervention of issues so they do not intensify.

"We know that 75% of all cases of mental illness will occur by the time Australians reach 25 years old," Dr Brown said. "When you're young, the onset of mental illness disrupts every facet of your life – school, family, social life and job prospects – and your future potential."

"There's an estimated 560,000 Australian children and adolescents (4-17 years old) in Australia who have a clinically significant mental health problem and many of them are at increased risk of suicidal behaviour."

Dr Brown said while vital funding had targeted adolescent mental health through initiatives such as headspace, similar investment in children was minimal.

"Many issues which go on to develop into mental health problems in adolescence can be identified, prevented and managed if picked up earlier in childhood," she said.

"The national approach needed is for better coordination and integration of

services among different siloed providers to enable a healthy start to life for children."

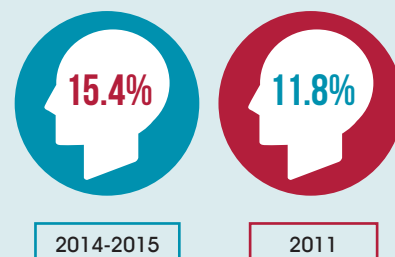
Professor Andrew Cashin, Mental Health Nurse Practitioner and Professor of Nursing at Southern Cross University, stressed any investment into early intervention should not focus solely on formal therapy, but also on promoting a healthy family context and activities that foster community participation and a sense of belonging.

"Intervention needs a broad focus to strengthen families and communities. The school curricula need to be strengthened in the focus on health and building health, and health systems literacy, to promote engagement and capabilities to facilitate positioning of young people at the centre of their own care and health promoting activity."

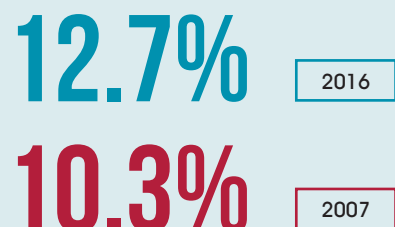
Professor Cashin said nurses could play a significant role in intervention given they work with children, young people and families directly.

"Nurses are arguably the most holistic of health professionals in their focus and mission and are well placed to work with the level of individual, family and community. Nurses are person-centred in their focus with a mandate of service provision across the lifespan, including people with intellectual, developmental and psychological disabilities."

MENTAL HEALTH AND CHILDREN



IN 2014-15 15.4% OF AUSTRALIANS AGED 18-24 YEARS SUFFERED **HIGH OR VERY HIGH PSYCHOLOGICAL DISTRESS**, UP FROM 11.8% IN 2011.



SUICIDE RATES CONTINUE TO INCREASE AMONGST YOUTH AGED 15-24, RISING FROM 10.3% (PER 100,000 POPULATION) IN 2007 TO 12.7% IN 2016

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GED KEARNEY SNATCHES VICTORY IN BATMAN BY- ELECTION

Former Australian Nursing and Midwifery Federation (ANMF) Federal Secretary Ged Kearney is on her way to Federal Parliament after securing an underdog victory for Labor in the Batman by-election last month.

A registered nurse for 20 years and most recently the former president of the ACTU, Ms Kearney secured the inner-city Melbourne seat with a 3.6% swing, capturing 54.63%.

During her victory speech at the Thornbury Theatre, flanked by Labor leader Bill Shorten and overlooking a rapturous crowd of supporters, Ms Kearney declared the win a triumph for "true Labor values" and validation of a campaign that paid attention to schools, healthcare, workers' rights, climate change and national progressive values.

Ms Kearney thanked the community of Batman for engaging with her throughout the campaign and promised to act on their concerns in her new position.

"You were wonderful. You invited me into your homes. You stopped me in the streets to talk. You sat me down in town halls and told me what for. I thank you for putting your trust in me and I won't let you down."

She also thanked the trade union movement and made special mention of her own union, the ANMF, for their ongoing support.

"I want to thank Bill Shorten and the Labor Party for putting their trust in me to run in the seat and guess what everybody? I'm on my way to Canberra," Ms Kearney said proudly.

ANMF A/Federal Secretary Annie Butler congratulated Ms Kearney and said her experience working in the health system meant nurses, midwives and carers finally had a true advocate in Federal Parliament.

Ms Butler said the new leader for Batman

"WE KNOW THAT GED UNDERSTANDS THE WORK OF NURSES AND MIDWIVES AND THE STRUGGLES THEY FACE DAILY IN THEIR EFFORTS TO PROVIDE QUALITY CARE FOR THEIR PATIENTS. SO OUR MEMBERS WILL WELCOME A MEMBER OF PARLIAMENT WHO IS PREPARED TO STAND UP AND FIGHT FOR THEM."

had already pledged support for challenging the federal government's attacks on Medicare, the need to protect penalty rates, and fixing the aged care crisis.

"We know that Ged understands the work of nurses and midwives and the struggles they face daily in their efforts to provide quality care for their patients. So our members will welcome a Member of Parliament who is prepared to stand up and fight for them."

ACTU Secretary Sally McManus said Australia's democracy was richer for Ged's election.

"Ged has been a tireless advocate for working people for decades – in our hospitals, as the national leader of nurses and midwives, as ACTU president and now as the member for Batman," Ms McManus said.

"As working people fight to change the rules so Australia is a fairer and better country, they will have an ally in Canberra in Ged Kearney."

NEW CODES OF ETHICS FOR NURSES AND MIDWIVES

International codes of ethics have come into effect for Australian nurses and midwives.

Leading Australian nursing and midwifery organisations collectively adopted the International Council of Nurses' (ICN) *Code of Ethics for Nurses* and the International Confederation of Midwives' (ICM) *Code of Ethics for Midwives* last month as their guiding documents on ethical decision making across the professions moving forward.

The Australian Nursing and Midwifery Federation (ANMF), Nursing and Midwifery Board of Australia (NMBA), Australian College of Midwives (ACM) and Australian College of Nursing (ACN)

jointly agreed to adopt the codes after a steering group established to review the NMBA's longstanding codes of ethics for nurses and midwives concluded the ICN and ICM documents provided high-level, contemporary leadership on ethical practice and should be accepted.

The ICN's *Code of Ethics for Nurses* states elements that define standards of ethical conduct include nurses demonstrating compassion and integrity and advocating for access to healthcare, nurses maintaining standards of personal conduct that uphold the profession's values, nurses implementing proper standards of clinical practice, and nurses fostering collaborative and respectful relationships with colleagues.

To be effective as an action-based tool, the ICN document says nurses must study and reflect on the code's standards and apply them to everyday nursing and healthcare amid a changing society.

In a similar vein, the ICM's *International Code of Ethics for Midwives* aims to improve the standard of care provided to women, babies and families across the globe through guidelines for midwives on education, practice and research.

The code encourages midwives to support the rights of women and families

to actively take part in decisions about their care, engage with policy and funding agencies to define women's needs for health services, provide culturally respectful care, and ensure the advancement of midwifery knowledge is based on activities that protect the rights of women as persons.

"These mandates include how midwives relate to others, how they practise midwifery, how they uphold professional responsibilities and duties, and how they work to assure the integrity of the profession of midwifery," the code states.

ANMF Federal Vice President Lori-Anne Sharp said the codes of ethics were a welcome advancement.

"Globally recognised standards of ethical conduct is highly relevant and will add strength and guidance to nurses and midwives in all aspects of their work.

"I encourage nurses and midwives to study the codes of ethics and am confident they will prove helpful in providing guidance when facing ethical dilemmas and standards of conduct."

The new codes of ethics are available online at the Professional Standards section of the NMBA's website.

<http://bit.ly/1qW3bKy>



GLOBAL

ICN 2019 SET TO TACKLE GLOBAL HEALTH CHALLENGES

The world's largest international event for nurses will be held in Singapore next year and focus on exploring ways in which the profession can help to achieve universal healthcare and address the social determinants that impact health.

The International Council of Nurses' (ICN) Congress will take place in Singapore in 2019 from 27 June to 1 July.

Running under the theme *Beyond Healthcare to Health* and hosted by the Singapore Nurses Association (SNA), ICN 2019 will examine how nurses can improve global access to health, while also tackling the social determinants of health such as education, gender equality and poverty.

The Congress will also provide opportunities for nurses to build relationships and share knowledge and leadership across different specialities, cultures and countries.

"It's a good opportunity for global nursing leaders to forge valuable networking, gain new insights, create mind-stimulating experiences, inspiration and strategies," SNA President, Professor Lim Swee Hia said.

The Council of National Nursing Association Representatives, ICN's global governing body, will convene prior to the Congress, offering participants who are members of ICN member associations the opportunity to observe global nursing leaders identify the profession's priorities and future directions.



CANADA

NURSING CRISIS REACHES BREAKING POINT

Nurses across the province of Quebec struggling to cope in the face of unsafe nurse-to-patient ratios are demanding change because they can no longer maintain proper standards of care.

Requests to investigate the quality of care and resources have risen by 7% in the past two years amid compulsory overtime becoming the norm and growing fears of increased burnout.

The crisis has become so dire that some nurses have begun reporting themselves to their own order, admitting they can no longer uphold proper standards.

The Order of Nurses of Quebec (OIIQ) has taken a public stance on the issue and is supporting nurses denouncing their work conditions and the push for ratios and quality care.

OIIQ President Lucie Tremblay said urgent action was required.

"The government must immediately implement safe nursing practice conditions and respond to the unprecedented call for help from nurses," she said.

"Too often, they [nurses] are responsible for the extra time required to make up for the lack of solutions. This situation can only rest on the shoulders of nurses. Solutions must be deployed, right now."

Canadian Nurses Association (CNA) board member representing Quebec, Sylvain Brouseau, said nurses deserved to practice in a safe, healthy and humane workplace.

"Whether we're talking about home care, hospitals or other settings, we need to deploy effective multidisciplinary teams that work under reasonable conditions. By doing so, the nursing profession will become more attractive to young people and the rate of absenteeism and turnover will be reduced."

GLOBAL

WHO TACKLES NON-COMMUNICABLE DISEASES (NCDs)

The World Health Organization (WHO) has established a new high-level commission in a bid to come up with bold and innovative solutions to prevent and control deadly non-communicable diseases (NCDs) including heart and lung disease, cancer, and diabetes.

The WHO Independent Global High-level Commission on NCDs comprises heads of state and ministers, leaders in health and development and entrepreneurs.

Globally, seven in ten deaths are caused by NCDs each year, with the main triggers surrounding tobacco use, harmful use of alcohol, unhealthy diets and physical inactivity.

It equates to more than 15 million people between the ages of 30 and 70 dying from NCDs annually, with low and lower-middle income countries increasingly affected.

According to WHO, a collective approach to reducing the main risk factors, as well as early diagnosis and improved access to quality and affordable treatment can help save lives.

"NCDs are the world's leading avoidable killers but the world is not doing enough to prevent and control them," the commission's co-chair President Tabare Vasquez of Uruguay said.

"We have to ask ourselves if we want to condemn future generations from dying too young, and living lives of ill health and lost opportunity. The answer clearly is 'no'. But there is much we can do to safeguard and care for people."

EARLIER PALLIATIVE CARE AT HOME LINKED TO FEWER HOSPITAL ADMISSIONS

Dying patients who receive palliative care earlier at home are admitted to hospital fewer times at the end of their lives, raising questions about time restrictions placed on accessing community-based palliative care in some parts of the world, according to new research led by Curtin University.

The study found offering community-based palliative care to a person in the last six months of their life led to lower rates of unplanned hospitalisations during that period and decreased healthcare costs.

The research examined the care of 16,439 people who died from cancer in Western Australia between 1 January 2001, and 31 December 2011, and accessed community-based palliative care services.

It revealed a marked difference in associated healthcare costs, with \$12,967 (2012) for those who had accessed community-based palliative care before the last six months of life, compared to \$13,959 (2012) for those who accessed it within the six months before death.

Lead author Cameron Wright, from Curtin University's School of Public Health, said the findings were significant given the country's ageing population and increase in many palliative care patients wishing to die at home.

"In some parts of the world, including the US, access to community-based palliative care is restricted to a certain expected time before death but this study suggests there may be a benefit for both the patient and the health system for this support to be provided at home earlier," Mr Wright said.

"As populations age, strategic planning of palliative care will be important to ensure the quality and sustainability of end-of-life care."



OLDER PATIENT SPECIALLING: A CALL FOR A CONSISTENT APPROACH

By Jacqueline J Cook,
Debra Palesy, Samuel Lapkin
and Lynn Chenoweth

People over 65 years of age are now the major consumers of acute health services (Australian Institute of Health and Welfare 2017). This population presents with multiple co-morbidities and is susceptible to further complications during hospitalisation.

Approximately 20% of these patients present to hospital with dementia, 10% will present with an underlying delirium and a further 8% will develop delirium on admission (Australian Commission on Safety and Quality in Health Care 2014).

During hospitalisation, older people can quickly become disoriented, confused and agitated. In these instances, 'specialling', involving close monitoring and observation of the person to prevent accidents, injuries and clinical deterioration is often required (Wilkes et al. 2010). Specialling can be provided either one-to-one, or to a 'cohort' (one nurse for two or more patients). Due to financial constraints, less qualified members of staff, (eg Assistant in Nursing), commonly undertake this role (Dewing 2013).

Despite the widespread practice of older patient specialling, there is no evidence of the best model, or any clear guidelines around the essential requirements for this practice.

To find out exactly what is required for

older patient specialling in hospital, a study was conducted in four aged care wards at a large metropolitan hospital in Sydney. Nine registered nurses participated in a focus group interview, and specialling practices for 12 patients ≥ 65 years were observed.

Observation data around specialling practices indicates that delirium and falls risk were the most common reasons for older patient specialling. More males were specialised than females. The mean age of specialised patients was 84 years. Most specialling was undertaken by Assistants in Nursing and one-to-one specialling was undertaken more frequently than cohorted patient care.

Observation data were confirmed by registered nurses in the focus group interview.

Nurses highlighted concerns around the skills of the nursing staff allocated to specialling: "...junior [staff are] not really equipped to special"; and workload issues when specialling is required: "We are giving one nurse one patient...and then the other two nurses will be dividing the whole ward".

These preliminary findings suggest the need for a consistent approach (eg nursing skills/qualifications required, staff workload) to older patient specialling in acute care settings.

As a result of this study, recommendations and a clinical update to support this approach are currently being developed.

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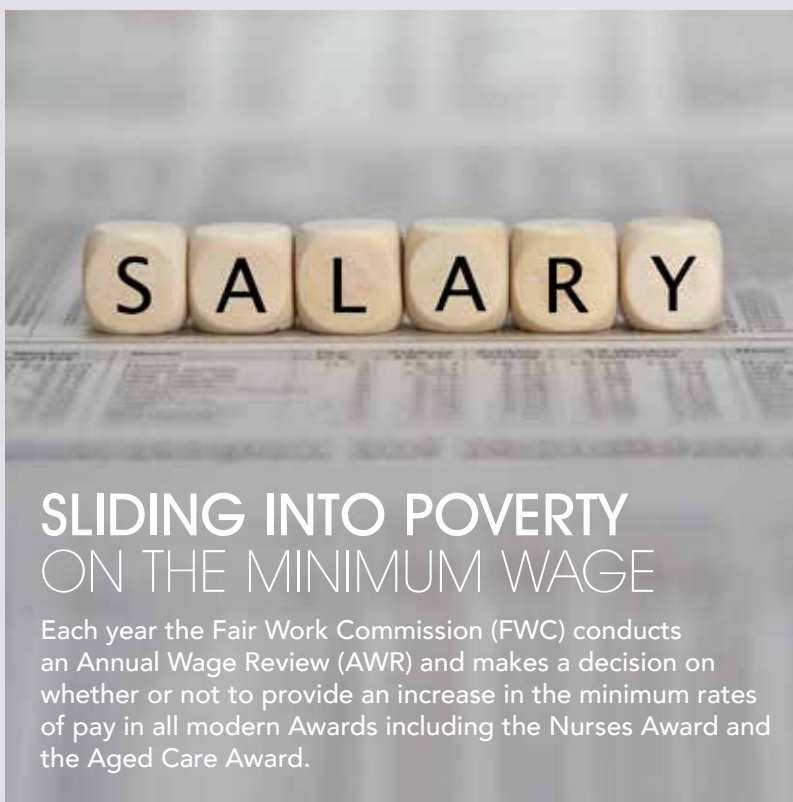
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 **Professor Lynn Chenoweth is a Professor of Nursing at the Centre for Healthy Brain Ageing, Faculty of Medicine, University of New South Wales**



Debbie Richards,
Federal
Industrial
Research
Officer



SLIDING INTO POVERTY ON THE MINIMUM WAGE

Each year the Fair Work Commission (FWC) conducts an Annual Wage Review (AWR) and makes a decision on whether or not to provide an increase in the minimum rates of pay in all modern Awards including the Nurses Award and the Aged Care Award.

The decision also determines the national minimum wage for employees not covered by an Award or enterprise agreement and takes effect from 1 July each year. While the vast majority of nurses, midwives and care workers have their wages and conditions determined in enterprise agreements, some remain on Award rates of pay and depend on the outcome of the AWR for a wage increase.

Although not common in the health and community service sector, some enterprise agreements tie wage increases under the agreement to outcomes of the annual wage review.

“PEOPLE SHOULD NOT WORK FULLTIME AND STRUGGLE TO PAY FOR THE BASICS OF LIFE. WE NEED TO RESTORE A LIVING WAGE”.

It will not surprise anyone that every year employer groups argue that business conditions and the economy can't support an increase, that wage costs are already too high and that any increase will impact negatively on the viability of the business and result in job losses. Last year employer claims ranged from zero increase to 1.8%.

The FWC granted 3.3% providing just 59 cents per hour increase in the minimum wage. This year key employer groups are proposing up to a 1.9% increase.

While the FWC is required to take into account a number of factors and balance the interests of business and the wider community on the one hand, and the interests of workers on the other, minimal increases awarded by the FWC have eroded living standards for the many thousands of employees who rely on award and minimum wages.

To add insult to injury, last year's FWC decision to cut weekend and public holiday penalty rates by between 25 and 50% in the retail and hospitality sectors resulted in actual pay cuts for some already low paid award reliant workers.

This year the ACTU is calling for a 7.2% increase in the minimum wage, about \$1.32 per hour or \$50.00 per week as part of a long-term strategy to restore a 'living wage' where the minimum wage is around 60% of the median adult full time earnings.* Currently it sits at about 53.8% having fallen from 58.4% in mid 2004.

The FWC acknowledged in its last decision that the level of the minimum wage relative to the median wage is an important indicator of relative living standards and wage inequality.

It also observed that about one third of people in poverty were wage earners living in households. In addition, about half of these families had children.

This is surely an unacceptable situation and a strong indicator that our current system for setting minimum wages is failing.

This is the crux of the ACTU's

claim- to stop the slide of more and more people on minimum or low award wages into poverty. ACTU Secretary Sally McManus sums it up by stating: “People should not work fulltime and struggle to pay for the basics of life. We need to restore a living wage”.

The slide in minimum and award wages and low wage growth in general is also contributing to greater income inequality.

Some of the cold hard facts recently published by the ACTU, (see below), paint a grim picture and are a timely reminder that the rules have to work for all in our community not just the privileged few.

The ANMF supports the ACTU campaign to change the rules to bring more balance back to our industrial relations system particularly in relation to the setting of minimum wages, enterprise bargaining and rights of workers to regular and secure employment.

Find out more about the
Change the Rules Campaign:
<https://changetherules.org.au/>

INEQUALITY: SOME FACTS

- Income inequality is greater than at any time in the last 70 years;
- the top 1% have over 22% of total Australian wealth;
- the top 1% own more wealth than the bottom 70% of Australians combined;
- the richest 10% have greater income growth than the poorest half of all Australians combined;
- profits were up 40% to March 2017 – the strongest gains in 15 years, yet wage growth is the lowest on record;
- 40% of Australians are in insecure work;
- over 1 million Australians are underemployed and want to work more hours;

* (The median wage being the wage received by someone sitting in the middle of the income distribution. It is substantially lower than the average wage, which is pushed up by those on high incomes, particularly those in the top 10% of income earners).

HOW MANY MORE AUSTRALIAN HEALTHCARE WORKERS HAVE TO SUSTAIN A NEEDLESTICK INJURY BEFORE SAFETY ENGINEERED DEVICES BECOME ROUTINE?

Dr Cathryn Murphy PhD, Honorary Adjunct Associate Professor, Faculty of Health Sciences & Medicine, Bond University, Queensland.
CEO – Infection Control Plus Pty Ltd.

A decade has now passed since the annual number of needlestick injuries (NSIs) among Australian healthcare workers (HCWs) was identified as more than 18,500 per year.¹ At the same time calls were made for widespread policy reform including routine NSI monitoring and mandated use of safety engineered devices (SEDs).¹

This brief report discusses Australian and international drivers, impediments and progress in prevention of occupational needlestick injury. It also embraces innovation in applications to better understand local NSIs and predict the organisational impact of investing in SEDs.

Australia remains one of the few developed countries without legislation or jurisdictional directives mandating comprehensive adoption and use of SEDs.² Healthcare workers in other similar countries or regions with long-standing infection control and prevention, including the United States³, some Canadian provinces⁴ and Europe⁵ are all protected against NSIs by regulation mandating the use of SEDs. Other Asian countries including Korea⁶ and Japan⁷ have also recognised benefits in adopting SEDs rather than continuing to use traditional sharp needles and objects.

Despite the absence of a standardised national surveillance system for measuring the incidence of NSIs among Australian HCWs, proxy measures such as The Australian Council on Healthcare Standards (ACHS) most recent report of clinical indicator data for 2009-2016 indicate the overall rate of NSIs remains constant. Data over the eight-year period indicate that healthcare organisations have on average reported 4,130 parenteral exposures each year. A parenteral exposure means any piercing of skin or mucous membrane with a contaminated sharp.^{8,9}

In reviewing the ACHS data it is important to recognise that HCWs



consistently underreport NSIs by up to 80%¹⁰. Also, healthcare organisations voluntarily participate in accreditation and submission of annual data to the ACHS. These organisations represent only a proportion of Australian acute healthcare facilities and exclude HCWs using sharps in long-term residential care facilities, first responder roles and commercial outpatient settings such as private specialist and diagnostic procedural rooms. As such it is likely the ACHS report significantly underrepresents the actual incidence of NSIs among all Australian HCWs.

Regardless of the absence of accurate NSI data, it is apparent that without the mandated use of SEDs Australia continues to experience significant numbers of occupational percutaneous exposures including NSIs. Paradoxically, to date many Australian healthcare organisations have resisted the removal of traditional non-safety sharp devices and replacement with SED alternatives.² Ironically, a key argument offered in response to suggestions that SEDs will reduce the incidence of NSIs and associated assessment and follow-up cost is the cost of the SEDs themselves. Typically, SEDs cost more

per-unit than their non-SED equivalent. Calculating the true cost of a NSI is complicated. Experts agree the total cost of NSI postexposure management includes both direct (laboratory, pharmacy, counselling, treatment and administrative) costs and indirect (loss of work time, emotional and psychological impacts) costs.⁶ In fact, work undertaken by The Alliance For Sharps Safety and Needlestick Prevention In Healthcare² and an economic evaluation conducted by the Medical Technology Association of Australia indicate the adoption of SEDs in all Australian hospitals would realise

an average annual cost saving of \$AUD 18.6 million for uncomplicated NSIs and potentially \$AUD 36.8 million if antiviral post-exposure prophylaxis and hepatitis C treatment were included.¹¹

Given the unrelenting number of NSIs occurring among Australian HCWs and the ongoing reluctance of healthcare organisations to adopt SEDs in the absence of legislation mandating their use, it was perhaps always inevitable that innovation would be necessary to help decision-makers better understand, at a local level, the necessary investment and anticipated returns from implementing SEDs. It is therefore with much excitement we await the launch of new, promising applications from other stakeholders committed to making Australian healthcare safer by reducing the incidence and cost of NSIs. Until that time, we again ask: **How many more Australian healthcare workers have to sustain a needlestick injury before SEDs become routine?**

Disclaimer: Assoc. Prof Cath Murphy RN, B. Photog, MPH, PhD, CIC is a consultant to multiple medical manufacturers globally including BD Australia. Views expressed in this article are the author's own.



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THE BROAD VALUE OF PROFESSIONAL INDEMNITY INSURANCE

By Robert Fedele

Professional indemnity insurance is essential for all nurses and midwives.

In 2010, the Nursing and Midwifery Board of Australia (NMBA) set registration standards making it mandatory for all health practitioners in the 14 professions regulated under the *Health Practitioner Regulation National Law Act* to have appropriate professional indemnity insurance (PII) arrangements in place in relation to their practice.

A nurse or midwife may receive appropriate cover through membership of a professional body such as Australian Nursing and Midwifery Federation (ANMF) state and territory branches, or via their employer.

A self-employed nurse or midwife can also obtain cover directly from an insurer or insurance broker.

Associate Professor Lynette Cusack RN, Chair of the Nursing and Midwifery Board of Australia (NMBA), said PII arrangements were essential to help protect the public.

"Nurses and midwives need to assess whether their PII is adequate, given the area/s of practice they work in, their professional experience, the risks involved in their practice and any previous insurance claims made against them."

Appropriate PII arrangements are important when considering the inherent everyday risks involved in the professions.

For example, a nurse or midwife might be sued for negligence or malpractice after administering the wrong medicine or making a clinical error due to workload stress.

Nurses and midwives must not practise unless they have appropriate PII arrangements in place and any practitioner that cannot produce evidence that demonstrates they are covered may have action taken against them.

In a recent example highlighting potential pitfalls, a Registered Training Organisation (RTO) in the Northern Territory who provides clinical training to both registered nurses and midwives reported concerns regarding the PII of some applicants.

The organisation requests applicants provide appropriate PII evidence but last year a number of nurses and midwives were unable to do so, believing their workplace

covered them.

While many employers provide professional indemnity insurance for risks involved at work, arrangements can vary considerably from workplace to workplace and state to state, with some only providing limited cover such as workplace vicarious liability or malpractice insurance.

Most ANMF state/territory branches offer professional indemnity insurance as part of their membership, along with an extensive range of associated benefits including comprehensive industrial, professional and legal advice and representation.

The ANMF (Vic Branch) for example, covers members for professional indemnity (malpractice) up to \$10 million, and provides run off cover that protects nurses and midwives against future claims years after they have stopped working from incidents that took place while they were practising.

However, in New South Wales the majority of nurses and midwives are covered for professional indemnity under NSW Health and state laws.

The legal principle of vicarious liability is reinforced by provisions in the *Employer Liability Act*, whereby an employee cannot be held liable for negligence if their employer is also liable.

Employers are responsible for maintaining a variety of insurances in the event that they may be sued.

ANMF Senior Federal Professional Officer Julianne Bryce said all nurses and midwives must ensure they have full PII cover and can provide appropriate evidence if asked to do so.

If organisations are offering PII at a discounted rate it is important to look at the fine print and understand exactly what kind of support is available.

"Some policies offer limited legal support. You might get access to half an hour for free but then you are paying after that," Ms Bryce says.

"ANMF state and territory branches give members the industrial and professional support they need that accompanies the professional indemnity insurance.

"It's not just a matter of purchasing a product. What you're getting as part of the service that's provided by ANMF branches is the support

you might need should you be in a position to require PII."

Ms Bryce stressed there is a difference between an employer telling nurses and midwives they are covered and them actually providing a certificate that demonstrates the PII that the NMBA demands.

In a 2014 submission to the NMBA during a review of registration standards and guidelines on topics including PII, the ANMF argued that while employers provide vicarious liability cover, they do not usually provide PII cover.

It added that non-members had told ANMF officials they were unsure how their employer's indemnity protects them and experienced difficulty obtaining written evidence of PII to meet NMBA audits.

"Nurses and midwives should not be misled about the provision of PII by employers," the submission stated.



"NURSES AND MIDWIVES NEED TO ASSESS WHETHER THEIR PII IS ADEQUATE, GIVEN THE AREA/S OF PRACTICE THEY WORK IN, THEIR PROFESSIONAL EXPERIENCE, THE RISKS INVOLVED IN THEIR PRACTICE AND ANY PREVIOUS INSURANCE CLAIMS MADE AGAINST THEM."

"The ANMF position remains consistent in that an employer's indemnity policy which is conditional upon the nurse or midwife acting without gross negligence will not provide appropriate and full indemnity to the practitioner."

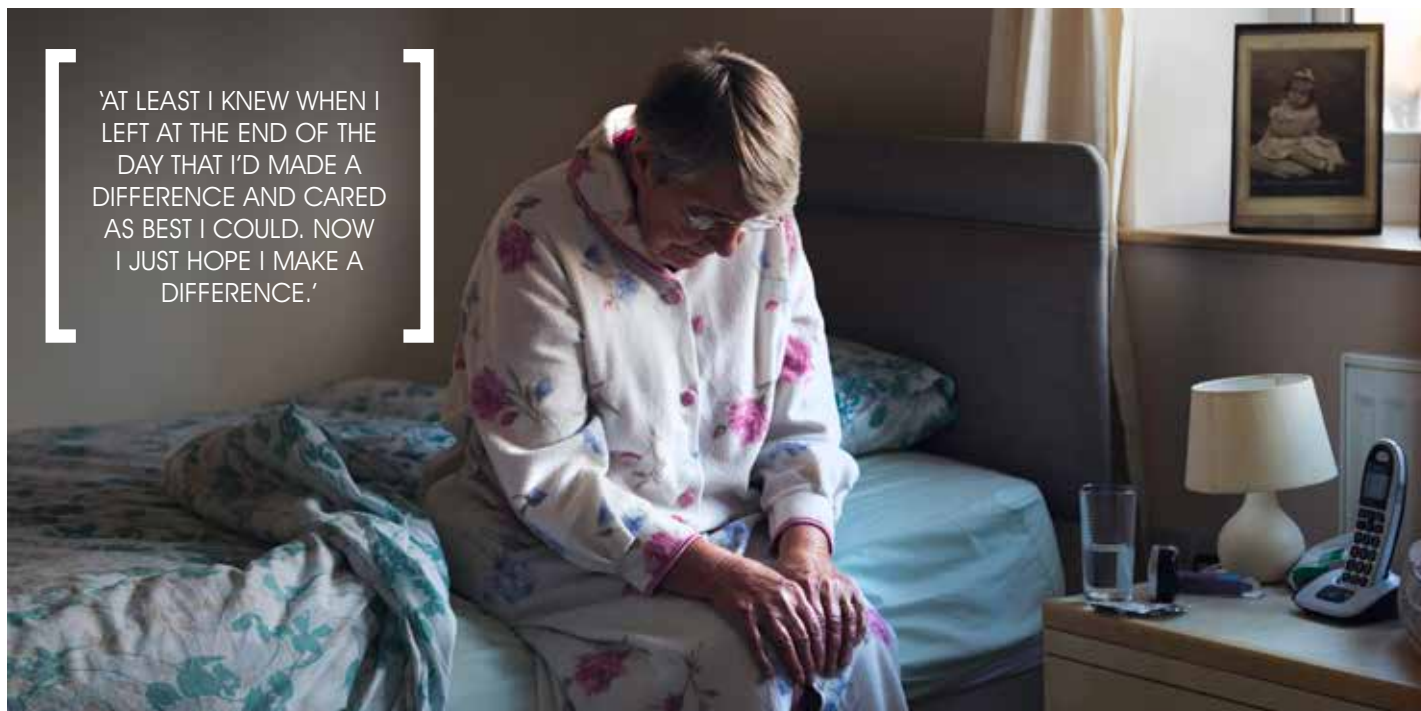
Associate Professor Cusack said any nurse or midwife unsure if they are meeting the Board's standard on PII could access detailed fact sheets online to help them understand the minimum requirements.

"The NMBA is committed to supporting nurses and midwives to practise within their legal obligations while at the same time providing safe care for the Australian community."

FORGOTTEN MEMBERS OF SOCIETY DESERVE BETTER

South Australian carer Brigitte gets emotional at the thought of her residents not receiving the care they pay for and deserve.

‘AT LEAST I KNEW WHEN I LEFT AT THE END OF THE DAY THAT I’D MADE A DIFFERENCE AND CARED AS BEST I COULD. NOW I JUST HOPE I MAKE A DIFFERENCE.’



"You just end up cutting corners on the floor. You don't want to but some care is missed," she says.

"Sometimes I cry. Sometimes I feel like I'm in the wrong job. A lot of us feel the same way. It's not just me. We feel frustrated. Those of us that do care and feel passionately about this, it really bothers us."

Brigitte works across most units at a large not-for-profit aged care facility that holds 185 residents at full capacity.

Residents have varying levels of mobility and care needs, with carers like Brigitte typically allocated around 10 people on a morning shift.

A registered nurse supervises care delivery across three units in the facility and is responsible for up to 100 residents, with one enrolled nurse per unit administering medication to about 35 residents.

If call bells go unanswered in a timely manner, management imposes disciplinary action by requiring enrolled and registered nursing staff to undergo reflective practice sessions, intensifying pressure from nurses on duty.

Brigitte says one of the most upsetting aspects of day-to-day care is being unable to cater to residents' needs properly.

"I hate telling people that they have to wait to go to the toilet when they may not have been toileted since they got up at 7 o'clock in the morning and it's now 1pm and they're busting. I hate telling them to wait because there's only two of us and we are going as fast as we can."

A passionate workplace delegate, Brigitte

has worked in aged care for 15 years and says the crisis facing the sector has reached breaking point.

She believes unsafe staffing levels continue to compromise care and the residents' basic needs.

"I think safe staffing and skills mix is the biggest issue. Ratios need to be legislated and made mandatory," Brigitte says.

"It's important for the residents. It's important for the care we are delivering and to ensure their complex medical and nursing needs are being met correctly. It's so important for all staff who work in this sector."

"But most of all it's important for those dear people who wake up every morning and sit there waiting for somebody to come and help them. There is no time to stop and actually talk to them which is all some of them ask for."

Brigitte, 52, says the aged care workforce is struggling to cope with rising demands and many take sick leave to cope with fatigue and emotional burnout.

"In some of our really high-care areas, because of my age probably, I can manage two or three nights in a row or two or three shifts in a row and then physically my body just won't do it."

Brigitte has two subjects to complete to qualify as a registered nurse after studying at the University of South Australia, and was recently voted onto the ANMF (SA Branch) Council.

In her leadership role, she is hoping to provide a voice for fellow aged care workers rallying against unsafe conditions.

In her early days in the sector, Brigitte recalls having her good days and bad days but always feeling sufficiently resourced and able to provide person-centred care.

Rooms were tidy, residents' fingernails were trimmed, and they were provided with clean glasses and clean clothing.

"You had your good days and your bad days depending on how your residents were but at least I knew when I left at the end of the day that I'd made a difference and cared as best I could. Now I just hope I make a difference."

Brigitte suggests fixing the age care crisis rests with the federal government.

"They used to make facilities accountable for the budget that they were being given. They used to have to be accountable for how they spent that and they used to have to spend that on care. Somewhere along the way, that system was diminished. They don't have to justify that so they don't spend money on care anymore."

"Now it's profits versus people and our residents tell us they have seen the change for the worse and they worry about us."

Despite hurdles, Brigitte remains positive about the aged care sector and says she will continue to fight for residents and the workforce.

"We're becoming an ageing society. I would hate to think that all these beautiful people that have lived and laughed and loved and helped create our nation to where we are now are just going to be these vulnerable members of society that are forgotten and remain voiceless."

RATIOS FOR AGED CARE CAMPAIGN LAUNCH

DATE FOR
THE DIARY
12 MAY

The Australian Nursing and Midwifery Federation (ANMF) will officially launch its unprecedented public awareness campaign calling on federal politicians to legislate staff ratios in aged care as a matter of urgency on 12 May, International Nurses Day.

The ANMF will stand united with members and community supporters at simultaneous events across the nation aiming to draw attention to the crisis in aged care and send a message to all federal politicians to act.

"Our aged care system has been ignored by governments for far too long," ANMF A/Federal Secretary Annie Butler said.

"The nurses and carers working in aged care who are rushed off their feet and struggling to care for their elderly residents see the impact of chronic understaffing.

"They see what happens when there is only one carer to wash and feed 16 residents in just 45 minutes. They see what happens when there is only one RN to manage the overall care of 115 residents."

ANMF state and territory branches will take part in the official campaign launch by holding an activity, such as a rally, targeting federal Labor MPs within key marginal seats in a bid to influence their position on aged care.

The ANMF (Vic Branch) has flagged staging a rally and barbecue in Queens Park, Moonee Ponds, which sits in Labor leader Bill Shorten's Maribyrnong electorate.

Mr Shorten and aged care allies such as Senator Derryn Hinch and new Batman MP Ged Kearney will be invited to attend.

"Ged is acutely aware of the crisis in aged care and what needs to be done to fix it," Ms Butler said.



The New South Wales Nurses and Midwives' Association (NSWNMA, ANMF NSW Branch) will target the McMahon electorate, where shadow treasurer Chris Bowen presides, while the ANMF (SA Branch) will seek support from Labor MP Steve Georganas in the seat of Hindmarsh.

Information about the campaign calling for staff ratios in aged care can be accessed online at www.MoreStaffForAgedCare.com.au, with members encouraged to sign up to help make ratios law now.

"The objective is to get aged care members and community supporters out in force behind the ratios campaign in key marginal seats to show those MPs that aged care is in crisis and ratios must be implemented in aged care immediately," Ms Butler said.

The **Ratios for aged care make them law. Now!** campaign highlights how fewer nurses and carers are expected to care for an increasing number of nursing home residents with complex needs.

Research shows nursing home residents are receiving two hours and 50 minutes of care per day from nurses and carers, well below the four hours and 18 minutes they should be getting.

The media campaign calling for staff ratios in aged care began last month with



a series of TV commercials that aired as Federal Senators returned to Canberra on 19 March.

It also included mobile billboards circulating Parliament House and posts across social media channels.

The voices of the campaign are all involved in the aged care system.

They include a registered nurse (RN), carer, a relative of a nursing home resident, a doctor working in the system, and a community supporter, collectively calling on politicians to fix aged care.

They reveal how in the absence of mandated ratios, inadequate staffing levels are putting the lives of the elderly at risk.

"There's not enough staff and it is extremely stressful. Things are so much worse than people realise," says Cherise, an RN working in aged care who also had her grandmother in a nursing home.

"I feel like sometimes I am on a production line, you don't get enough time to properly care for residents," says Julie, a carer working in aged care.

The ANMF's **Ratios for aged care make them law. Now!** campaign builds on years of activism to improve the sector and protect vulnerable older Australians.

The union's latest federal budget submission included calls for greater accountability concerning the government funding provided to the residential aged care sector and how it is used.

"While care for the elderly gets worse, taxpayer-funded providers increase their profits," ANMF A/Federal Secretary Annie Butler said.

"Last year, owners of aged care facilities pocketed over \$1 billion in profits while cutting staff. It's time elderly Australians get the care they deserve."

Ms Butler said the care of the elderly would continue to be compromised without safe staffing in aged care.

"Nurses and carers are struggling; they're run off their feet. They are doing the best they can but they cannot provide the level of care they want to. It is just not possible.

"It's a national disgrace. It's a crisis that shames us."

JOIN THE CAMPAIGN TO MAKE RATIOS LAW IN AGED CARE


Like our Facebook page –

www.facebook.com/MoreStaffForAgedCare

Visit www.MoreStaffForAgedCare.com.au and sign up to the campaign.

Put 12 May into your diary and take action in your state or territory.





**“MUM WOULD
SOMETIMES
HAVE TO WAIT
AN HOUR BEFORE
THE BUZZER
WAS ANSWERED,
BECAUSE THERE WEREN'T
ENOUGH STAFF.”**

Gabrielle, Daughter

Chronic understaffing in Aged Care homes is leaving thousands of elderly Australians unfed, unwashed or even in soiled pads for hours because there's simply not enough staff. The Federal Government must act now to make staff ratios law for Aged Care. Find out more at [MoreStaffForAgedCare.com.au](https://www.morestaffforagedcare.com.au)

Authorised by Annie Butler, Australian Nursing and Midwifery Federation, 1/365 Queen Street, Melbourne Victoria



Australian
Nursing &
Midwifery
Federation

**RATIOS FOR AGED CARE
MAKE THEM LAW NOW**



CULTURAL SAFETY AND IMPLICATIONS FOR BUILDING STAFF CAPACITY: SNAPSHOT OF FINDINGS FROM A STUDY WITH NURSE ACADEMICS

By Frances Doran and Beth Wrigley

Culturally safe care provides better health outcomes for Aboriginal and Torres Strait Islander people. Nurses and midwives, the largest professional group employed within the healthcare system, have the capacity to contribute significantly to improving Aboriginal and Torres Strait Islander health.

Tertiary institutions are well placed to skill up academic staff and to educate nursing and midwifery students to provide culturally safe care in all health settings including community health and primary healthcare.

The task of building Indigenous knowledge into undergraduate nursing curricula is being articulated and supported by the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), which is the sole representative body for Aboriginal and Torres Strait Islander nurses and midwives in Australia. Both

CATSINaM and the Australian Nursing and Midwifery Accreditation Council (ANMAC) have been instrumental in defining standards for culturally safe practice within the newly released Aboriginal and Torres Strait Islander Health Curriculum Framework (CATSINaM 2017).

Currently there are a low number of Aboriginal and Torres Strait Islander teaching staff at universities and a low number of non-Indigenous staff with the requisite level of knowledge and skills. The authors, both Indigenous and non-Indigenous

Nurse Academics from Southern Cross University participated in workshops conducted by CATSINaM in 2017, designed to support nursing and midwifery academics to meet the Nursing and Midwifery Aboriginal and Torres Strait Islander Health Curriculum Framework (N&M Framework) benchmarks for cultural safety.

Cultural safety provides a decolonising model of practice based on dialogue, communication, power sharing and negotiation, and the acknowledgment of white privilege. These actions are a means to challenge racism at personal and institutional levels, and to establish trust in healthcare encounters (CATSINaM 2017, p11).

An inspiring project emerged from our participation in these workshops. With ethics approval, we surveyed academic nursing staff capability in relation to Cultural Safety at Southern Cross University. We explored their understanding of Cultural Safety, their confidence to teach Cultural Safety and their interest in Cultural Safety training and anti-racism training. Fifteen staff participated and two staff identified as Indigenous Australians. In essence, the results indicated staff were committed to Cultural Safety and interested in further training. This is positive as building staff capacity is fundamental to creating cultural safety (CATSINaM, 2017).

ANMAC have mandated our obligation to provide Indigenous knowledges throughout the curriculum and CATSINaM have worked tirelessly providing solid resources for distribution to implement this knowledge into curricula. The Nursing and Midwifery Board of Australia (NMBA) with support from CATSINaM have just released a new Code of Conduct for nurses and midwives (2018), which for the first time names Cultural practice and respectful relationships as a specific principle. The work has been done within this body by Aboriginal and Torres Strait Islander nurses and midwives themselves who have a sound understanding of what is required. The task ahead is for us to step up and skill up by utilising this readily accessible framework to ensure that this critical work is done in a thorough and respectful way.

Dr Frances Doran is Senior Lecturer in the School of Health and Human Sciences at Southern Cross University

Ms Beth Wrigley is an Indigenous Lecturer in the School of Health and Human Sciences at Southern Cross University



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Nursing and Midwifery Board of Australia. (2018). Advance copy - Code of conduct for nurses. Retrieved from www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx

The Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM). 2017. The Nursing and Midwifery Aboriginal and Torres Strait Islander Health Curriculum Framework: an adaptation of and complementary document to the 2014 Aboriginal and Torres Strait Islander Health Curriculum Framework. Canberra: CATSINaM.



Sue Rodriquez

MY STORY AS A NURSE, AND AS A MOTHER AND CARER OF SOMEONE WITH CRPS (COMPLEX REGIONAL PAIN SYNDROME)

As my beautiful daughter slowly limps up the hallway, I stand and wait for her to reach me so I can hold her in a motherly hug (because, as we all know, a motherly hug can fix most anything), but as she stops in front of me and I reach out to hug her, she flinches and says, "Don't touch me."

My heart drops and I turn away so she cannot see the disappointment in my face.

Today is going to be one of those days where my little girl is locked away from me, locked in her room in the dark with her pain. I know there is little I can do to take that pain away from her. The only thing I can do is be there when she needs my help, whether this is to get in and out of the shower, to dress or undress her, to help her get into or out of bed, to help her get up from the couch, or one of the other many little things she asks of me. On days like these, the only other way I can be there for her is to gently hold her when she needs a hug, even though these hugs are filled with pain for her, or to just sit with her as she lays her head on my lap; sometimes that is all either of us can do.

This all started when she was doing her VCE studies. She was tired, and continually complaining of pain in her right hand and arm. We put it down to stress and all the extra writing she had been doing. A muscle strain was the most likely thing.

She finished school and left home to begin her life, working and running her own home. As her pain and symptoms began to increase and spread further up her arm, going into her shoulder and back, she started to have difficulty sleeping, or to even hold a cup in

her hand.

Many trips to different doctors and multiple, varying tests ensued; and finally, a diagnosis of CRPS. After two years of struggle, she moved home. To regain a degree of independence, we encouraged her to work part time, and to help as she is able.

In researching this condition, I have found a long list of symptoms just as varied as the sufferers themselves. There is more to it than just the painful sensations of burning, stabbing, and stinging pins and needles in the sufferers affected limbs/areas. In some cases, CRPS sufferers can have their condition spread into other limbs. When the condition spreads further throughout the body, other areas may be affected, stomach cramps and nausea to memory loss and cognitive issues.

CRPS sufferers also experience pain that changes in intensity, often feeling worse than may be expected; spontaneous pain that can occur with or without a trigger; muscle spasms; coordination difficulties; loss of fine motor control; loss and impairment of spatial awareness. They can experience stiffness of, and in muscles and joints; changes in hair and nail growth – lack of or excessive hair growth, brittle nails, sometimes with stunted growth – on the affected limb/s; weakness; swelling; the temperature of the affected area can sporadically become cold or hot – for some people this is constant.

This condition is debilitating and complex, with each person exhibiting a different combination of symptoms in varying degrees. Each person having different triggers and tolerance levels to varying stimuli. Because of this, it is very difficult to diagnose and treat. Along with physiotherapy, occupational therapy, and other physical/movement based therapeutic activities, analgesic and nerve pain medications, and anti-depressants are used to treat and manage this still widely unknown condition.

With early diagnosis and a tailored approach to treatment, a sufferer is more likely to go into remission, though many are not diagnosed within the recommended timeframe of six months. Remission or a reduction in pain levels from the right treatment becomes more difficult to achieve the longer someone has CRPS, and is more likely to spread, 'with 35% of those affected, reporting symptoms throughout their entire body.'

The cause of CRPS is still unknown, though it is associated with dysregulation of the central nervous system and autonomic

nervous system. The pain is not just in their head. The constant pain, reduced mobility, and restricted/ altered lifestyle often lead to depression and anxiety. Anxiety is often brought about from the fear of causing more pain, or being in a situation that may trigger more pain. With the increase of pain, there is a decrease in social and physical activities of most sufferers, which can lead to depression and the feeling of isolation; for some sufferers, this can lead to the misdiagnosis of a mental health problem.

UNTIL MORE IS KNOWN ABOUT CRPS, CARERS AND SUFFERERS LIKE MYSELF AND MY DAUGHTER CAN ONLY LIVE DAY BY DAY. WE WAIT, WE CONTINUE TO TALK TO OTHERS, RESEARCH, AND HOPE THAT A CURE CAN BE FOUND FOR SUFFERERS LIKE MY DAUGHTER.

There is no one test for CRPS. It is based on a person's medical history and relevant symptoms in relation to the CRPS 'check list'. Tests can also show what other systems can and are being affected by CRPS.

As not all healthcare professionals are aware of CRPS, or may not fully understand the varying degree of symptoms associated with the condition, there may be a delay in its diagnosis and treatment. Unfortunately, this is to the detriment of some sufferers.

With the right sort of treatment, some people do recover from CRPS, but there are other CRPS sufferers who have ongoing symptoms and pain.


Some sufferers in rare cases, with severe swelling and complete lack of movement look to have the affected limb amputated, as a way of improving their life.

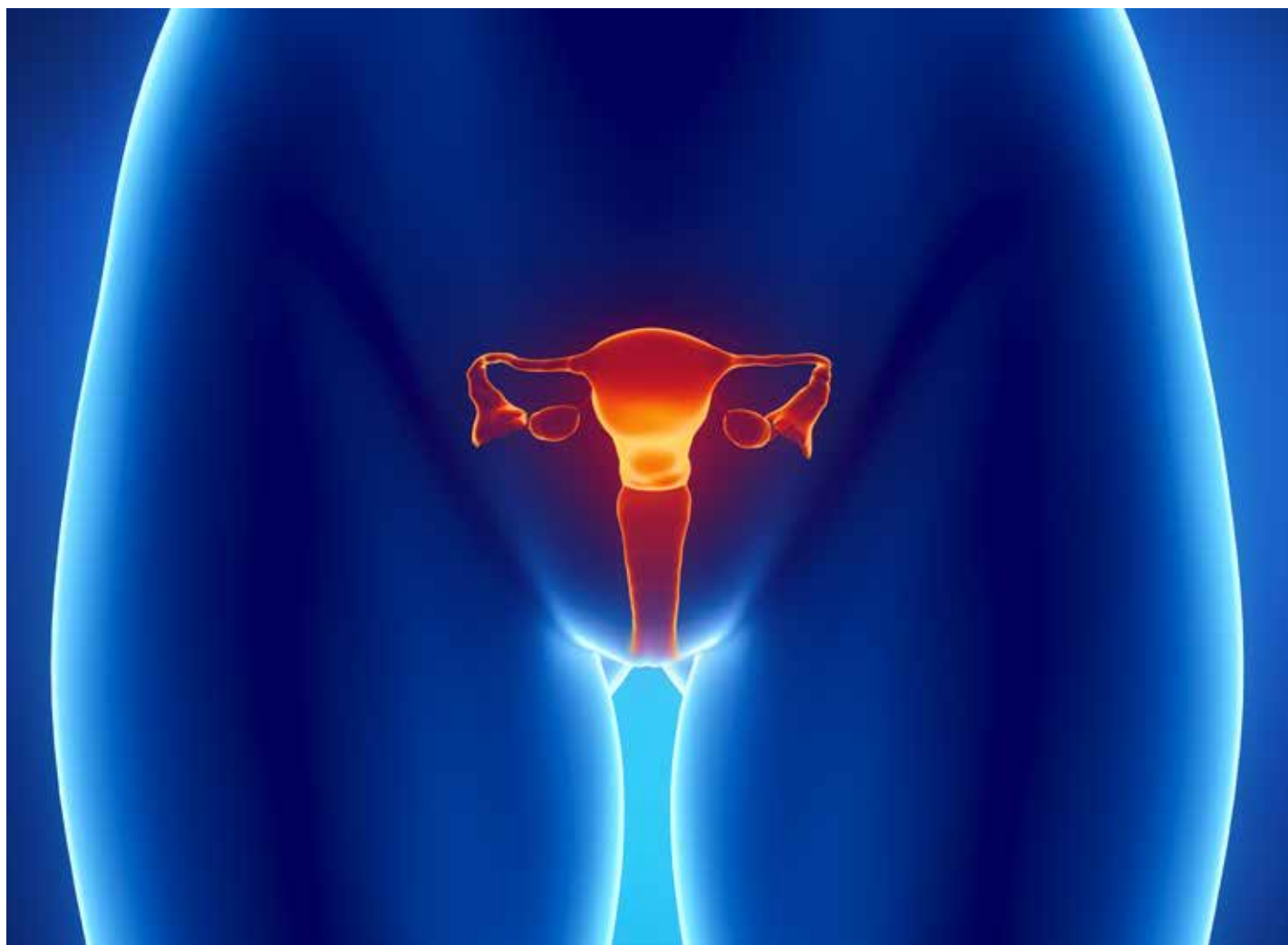
Until more is known about CRPS, carers and sufferers like myself and my daughter can only live day by day. We wait, we continue to talk to others, research, and hope that a cure can be found for sufferers like my daughter.

INFORMATION SITES

www.tpb.org.au
(The Purple Bucket Foundation)

https://en.wikipedia.org/wiki/complex_regional_pain_syndrome

 Sue Rodriquez is an Enrolled Nurse working in residential and acute care in NSW



WOMEN'S HEALTH

The World Health Organization (WHO) defines sexual health as “a state of physical, mental and social wellbeing in relation to sexuality. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence”. There are many facets to sexual health and one of these is women's health.

Women's health includes a wide range of specialties and focus areas, such as: Birth control, sexually transmitted infections (STIs), and gynaecology. Breast cancer, ovarian cancer, and other female cancers, Mammography, menopause and hormone therapy (<https://medlineplus.gov/>).

Women's health nurses play an important role in supporting women by following the Advanced Practice Standards (APS) and the key principles of women's health practice.

When a woman faces problems with her

breasts, vagina or pelvic floor muscles it can have quite a huge effect on her sense of sexuality and even her ability to engage in sex and/or society.

Discussed in ANMF's tutorial on Women's Health, which is available on the ANMF's CPE website (<http://anmf.org.au/cpe/>), are key principles of women's health practice including some of the topics listed above.

The key principles of women's health practice are:

1. encompassing a gendered approach to health;
2. applying a social model of health;
3. enabling clients to make independent health choices;
4. encompassing holistic care practice;
5. emphasising the combination of clinical and advocacy skills;
6. utilising a collaborative approach;
7. providing education to clients;
8. providing accessible affordable and equitable healthcare; and
9. identifying key groups of women.

The tutorial, written by the Australian Women's Health Nurse Association, has a link to their website within the tutorial for more detailed information. The tutorial's content covers a number of topics, including:

- breast health
- cervical screening

- pelvic/bimanual examination
- Human Papilloma Virus (HPV)
- pelvic floor muscles
- female genital mutilation

Each of the topics are addressed keeping the nine key practice principles for women's health in mind, and underpinning these is the National Health and Medical Research Council (NHMRC) guidelines.

Breast health

This section aims to provide you with an understanding of the anatomy and physiology of the normal breast throughout a woman's lifetime.

Protocols for breast examination, breast awareness, breast problems such as: mastalgia, cysts, fibroadenoma's, nipple discharge, nipple inversion, lactational breast abscess, galactorrhoea, galactocoele, duct ectasia, malignant tumours, and mastitis are all discussed in detail.

Investigations such as mammograms and management of the above problems are also conversed.

As breast health can be a very personal topic to discuss with a woman, particularly when there is an issue, the tutorial also addresses communication and counselling skills to assist during interactions with women. A very important topic, early detection of breast cancer, particularly in terms of what to look for when examining a

'WOMEN'S HEALTH INCLUDES A WIDE RANGE OF SPECIALTIES AND FOCUS AREAS, SUCH AS: BIRTH CONTROL, SEXUALLY TRANSMITTED INFECTIONS (STIS), AND GYNAECOLOGY. BREAST CANCER, OVARIAN CANCER.'

woman's breasts, educating the woman on how to undertake regular self-examinations and advising on diagnostic tests are provided within the content.

Cervical screening

This section provides information on the anatomy and physiology of the cervix and recent information on cervical screening. Being able to discuss the need for cervical screening with your female clients may help to encourage them to partake in regular screening.

As of 1 December 2017, the Pap test was replaced by a new Cervical Screening Test. This new test is conducted every five years instead of every two years for the Pap test, and is for women aged between 26-74 years. The new test is more effective as it detects the Human Papilloma virus (HPV).

For women who have previously had a Pap test, the procedure is performed in the same manner and should be conducted two years after the last Pap test.

The Pap test used to look for cell changes in the cervix, whereas the new Cervical Screening Test looks for HPV which can lead to the cell changes in the cervix.

The timeframe for testing has expanded because it is safe for women if the test does not indicate (show) they have a HPV infection to wait five years between tests. Even if the test shows the woman has HPV, it usually takes 10 or more years for HPV to develop into cervical cancer and cervical cancer is a rare outcome of a HPV infection.

Human Papilloma virus (HPV)

The Human Papilloma virus (HPV) is a small double-stranded DNA virus that infects the epidermis and mucous membranes of humans. It can lead to cancers of the cervix, vulva, vagina, and mucous membranes in women and cancers of the anus and penis in men. There are various types of HPV that are regarded as 'high-risk', that are associated with cervical dysplasia. The types of HPV are discussed further in the tutorial content.

Pelvic/bimanual exam

Internal pelvic examinations are performed to check the size and position of the uterus, determine the possibility of fibroids or other irregularities for example, prolapse, discomfort or tenderness when the cervix is rocked.

The tutorial provides detailed information on what is involved in a pelvic/bimanual exam and includes how to perform a pelvic floor assessment.

The floor of the pelvis is made up of

layers of muscle and other tissues. These layers stretch like a hammock from the tailbone at the back to the pubic bone in front. The pelvic floor muscles support the bladder, uterus and bowel. The urethra, vagina and colon all pass through the pelvic floor muscles and help to control the bladder and bowel. They also help with sexual function and sexual sensations.

Therefore, a weak pelvic floor can have ramifications for sexual function and can interfere with a woman psychologically as it may prevent her from socialising due to incontinence and possible embarrassment.

Female Genital Mutilation (FGM)

Female genital mutilation (FGM) comprises all procedures that involve partial or total removal of the female external genitalia and/or injury to the female genital organs for cultural or any other non-therapeutic reasons.

The term 'Female Genital Mutilation' was defined at the International Convention in Vienna in 1993 by Gerard Zwang, a French doctor.

When working with communities affected by FGM this term could be offensive so the term 'female circumcision' is preferred. The communities who practice FGM do not consider it to be mutilation. Although, not all women or young girls consent to FGM being performed even if it is a part of their culture.

The NSW education program on FGM has chosen to refer to women who have undergone FGM as women affected, not victims. The problem is identified as having an overall prevalence of over 130 million cases with an annual incidence of 2-3 million women. It has only recently been acknowledged as a widespread practice with health consequences.

There are four classifications of FGM dependent on the amount of female genitalia that has been removed, and any other procedures that may have been performed. Obviously there are a number of issues surrounding FGM related to both fear and women's sexuality, these include: Lack of choice, marriage partners, reproductive rights, rituals reinforcing womanhood, superstitions based on patriarchal ideology, women's lack of access to resources in the community, economic aspects: income and status for excisor and bride-price, sanctions against women, lack of health education, religious propaganda, lack of government policy and action, illiteracy, and male fears.

Due to increasing numbers of people arriving and settling in Australia from African nations in which FGM is customary, demand for FGM in Australia is present and may be increasing. Australian law clearly prohibits performance or participation of any type of FGM. FGM is also prohibited by the most recent policy of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG). As long ago as 1994, the Family Law Council accepted it was likely that FGM was being conducted in Australia.

Reference:

<https://medlineplus.gov/>

SEEKING AUTHORS

The ANMF Education team are seeking authors to write topics on the website. Please contact education@anmf.org.au if you are interested in contributing to the CPE course suite.



30 MINUTES CPD

Reading this excerpt and reflecting on it will give you 30 minutes towards your annual CPD.

The complete tutorial offers three hours of CPD and includes real life scenarios to help you understand how to best support your clients to receive the care they want and the care they need.

To access the Women's Health tutorial in its entirety, go to the ANMF Continuing Professional Education (CPE) website (<http://anmf.org.au/cpe/>) and follow the links). If you have any questions please contact us via education@anmf.org.au

> anmf.org.au/cpe



FEATURE

AGENTS OF CHANGE

NURSES AND MIDWIVES TACKLE CLIMATE CHANGE HEAD ON

The impact of climate change on the health of Australians and people around the globe are fast becoming evident. Lives are being lost at an increasing rate while adding significant economic burden to already financially crippled healthcare systems. Yet despite politicians stagnating to address the issue, healthcare professionals, including nurses and midwives, are tackling climate change head on, writes **Jessica Gadd**.



Solomon Islands, 2016. A delegation of international guests attending the South Pacific Nurses Forum are shown firsthand the effects of climate change on the small island nation.

A table, traditionally used by the elders for important ceremonial activities, is slowly submerging under the rising ocean. "It had been there for generations, holding a particularly important cultural significance, and that is just being lost," says ANMF A/Federal Secretary Annie Butler, who was one of the delegates at the forum.

"We learnt that, in addition to the physical effects of climate change in the Pacific – that is, villages disappearing under water, there are the mental and psychological effects on culture to take into consideration as well. The ANMF is trying to work with nurses specifically in these areas to try and address this problem with them."

The South Pacific Nurses Forum, the International Council of Nurses, and Global Nurses United are just some of the organisations that the ANMF works with in an attempt to address climate change and its health effects on people around the globe. In Australia, the ANMF works with the ACTU, participating in programs such as 'A Just Transition', which supports a move away from coal fired power towards renewable energy sources, while still maintaining livelihoods.

The ANMF also works with the Climate and Health Alliance (CAHA), which advocates for action on climate change on behalf of the Australian health sector. CAHA recently worked with health stakeholders to produce a *Framework for a National Health Strategy on Climate Health and Well-being* (2017) in an attempt to build understanding among

policymakers and guide action on the issue of climate change and human health.

"Along with CAHA we have written to Australia's Environment Minister and Health Minister, trying to get their support for the *CAHA Framework for a National Health Strategy on Climate Health and Well-being*," Ms Butler says. "They have written back saying, basically, thanks but no thanks, at this stage."

However, Ms Butler says inaction is not an option. The World Health Organization predicts that between 2030 and 2050, climate change is expected to cause approximately 250,000 additional deaths per year, from malnutrition, malaria, diarrhoea and heat stress.

"Hundreds of thousands of people around the world are already dying directly from the effects of climate change," Ms Butler says. "And unfortunately, many of those coping the worst of the effects of climate change, such as the Pacific Islands, frankly, have not caused it."

Climate change is happening now

A glance at global weather events for the first few months of 2018 is telling. In Africa, residents of South Africa's capital city, Cape Town, are grappling with extreme water rations as they face the prospect of becoming the first major international city to run out of water due to drought. In the Pacific Cyclones Gita and Hola in February and March caused severe damage in parts of Tonga, Vanuatu and New Caledonia.

In March the Polar Vortex, a zone of persistent low pressure that typically keeps high latitude cold air constrained to the North Pole, weakened to the point that a blast of icy air brought parts of Europe to a standstill and claimed the lives of nearly 50 people. At around the same time as the 'Beast from the East', as



'We learnt that, in addition to the physical effects of climate change in the Pacific – that is, villages disappearing under water, there are the mental and psychological effects on culture to take into consideration as well.'

A/FEDERAL SECRETARY
ANNIE BUTLER



"When you actually start looking at the data and see how much has already changed just in our lifetime, you can really see that climate change isn't something that's way off in the future – it's actually something we can see is happening now."

PROFESSOR HILARY BAMBRICK,
QUEENSLAND UNIVERSITY OF
TECHNOLOGY FACULTY OF HEALTH

it was dubbed by the UK media, ravaged Europe and the UK, the world's northernmost weather station, at Cape Morris Jesup in Greenland, recorded a temperature of around 6° degrees, which is about 35 degrees above normal for this time of year.

In Australia, a heatwave in January saw South Australian officials shorten the international bike race - Tour Down Under, experts warned players could die of heat exhaustion at Melbourne's Australian Open, and residents of Sydney suburb Penrith swelter through one of the hottest Australian days on record at 47.3°C.

"A lot of people don't realise this, but heatwaves are one of the most deadly effects of climate change, causing the highest numbers of deaths," Ms Butler says.

Australia's Southeastern heatwave in 2009, for example, claimed the lives of an estimated 374 people in just a few short weeks – a 45% increase in the death rate.

It preceded, and contributed to conditions that encouraged, the Black Saturday bushfires, which took the lives of another 173 people.

According to the Climate Council, Australia's worst heatwave, during the 'Angry Summer' of 2013, featured more than 200 record-breaking extreme weather

events driven by climate change, and it resulted in The Bureau of Meteorology adding a new range of 52-54°C to its forecasting chart.

"Heatwaves are happening earlier than they used to, they're lasting longer, and they're more intense," says Queensland University of Technology Faculty of Health Professor Hilary Bambrick, an environmental epidemiologist and bioanthropologist whose research focuses on the health impacts of climate variability and change.

"We don't necessarily pick up on these things ourselves, particularly because Australians are stoic – we're used to drought, bushfire, and all the things that come along with living in a land of extremes. But when you actually start looking at the data and see how much has already changed just in our lifetime, you can really see that climate change isn't something that's way off in the future – it's actually something we can see is happening now."

In January 2018, the Climate Council released a report confirming that the world experienced its hottest five years on record during 2013 to 2017. The report stated that it was 'part of a sharp, long-term upswing in global temperatures, with 17 out of the 18

hottest years on record all occurring in this century'.

Experts predict that unless there are sudden and drastic attempts to curb emissions the current heatwave conditions will be 'the new normal' in 10-15 years' time.

Healthcare impacts of extreme weather

Increased numbers of heat-affected people presents a problem for health services that are not equipped to cope with the increase in hospitalisations, or the increase in mortalities, that come with heatwaves.

"During the 2009 Melbourne heatwave, for example, there wasn't enough room in the morgues and in some cases the bodies had to be kept in refrigerated trucks," Professor Bambrick says.

"We often think of older people as being the ones at increased risk during heat events and that's certainly true, but also there are the emergency and health workers who have to keep working through in those temperatures and are often themselves highly exposed to the extreme weather."

Other climate change related, extreme weather events that will increasingly have acute impacts for healthcare here in Australia, says Professor Bambrick, are

bushfires, severe storms, cyclones, and flooding – including from rising sea levels and storm surges.

Cyclone Debbie in 2017 resulted in 14 lives lost. Australia's deadliest cyclone since Cyclone Tracy devastated the Queensland coast and caused widespread flooding across the border and into NSW.

A less obvious impact of cyclones is the resulting reduction and affordability of fresh food.

"We saw this last year with Cyclone Debbie, which took out a large proportion of important food crops for Australians," Professor Bambrick says. "But food production will also be affected by more chronic things such as drought, and even the changing climate in the sense that you can no longer grow things in particular places. For example, there's concern that our stone fruit areas soon won't be able to produce stone fruit because it's no longer cold enough.

"And if you're thinking about extreme heat, livestock such as dairy cattle are not too comfortable in extreme heat, and their milk production declines quite considerably."

While cows might not enjoy the heat, mosquitos certainly do, and along with increased mosquito numbers comes increased chances for the spread of vector-borne disease such as Dengue Fever.

"In hot and humid weather mosquitos mature much more quickly, which means they are biting earlier than they would otherwise, and they have increased survival, which means more mosquitos are surviving to bite," Professor Bambrick explains.

"In the right weather conditions their metabolic rate is increased, they get hungry more quickly and therefore bite more frequently, so they're more likely to transmit a pathogen that they've picked up. Not only that, the pathogen itself replicates more quickly inside the mosquitos, so there's a shorter timeframe for transmitting that disease."

Professor Bambrick points out that warmer weather also means increased outbreaks of salmonella, a particular concern for people living in aged care facilities, institutional facilities, and childcare facilities.

Climate change is a human health emergency

While many politicians might be slow to make the connection between health and climate change, the health industry certainly is not. In 2015 the world's leading medical journal, *The Lancet*, released a report on climate change and human health that labeled climate change as 'a public health emergency'.

"The scale of the impact that climate change is having on human health in the short, medium and longer term is so immense, and it requires such a comprehensive and urgent response, that it does lead to the assertion that it's an emergency," says Climate and Health Alliance (CAHA) Founder and Convenor Fiona Armstrong.

"The fundamentals that are being impacted are the things that human health and wellbeing are entirely dependent on, such as our access to clean air, soil and water, a safe climate in the sense of a set of conditions that are optimum for human functioning and those are being eroded incredibly quickly."

In 2012, CAHA released a report, *Our Uncashed Dividend*, which explored the largely untapped opportunity to take action on climate change and improve human health at the same time.

This 'co-benefit' approach delivers both human health benefits and economic savings from avoided ill health, and the associated productivity gains.

The improvement in overall respiratory health from reducing emissions from burning fossil fuels and the associated air pollution is a classic example of this, Ms Armstrong says.

"For people living in proximity to either coal combustion or other forms of coal production or coal transport, exposure to coal pollution has very serious health impacts, as it does for all of us who are impacted by the resulting poor air quality. So, obviously moving away from coal-powered energy, which is one of the biggest contributors to climate change globally as an energy source, is a win for the environment and a win for our health."

Ms Armstrong says a 2014 study by the MIT Joint Program on the Science and Policy of Global Change, which provided impact assessments for several different climate change scenarios, has helped to put a dollar value on the health benefits from action on climate change.

"This study looked at different climate policies and what they would deliver in terms of co-benefits for health and economic savings. One of the scenarios they looked at was a nationwide carbon price or emissions

'The fundamentals that are being impacted are the things that human health and wellbeing are entirely dependent on, such as our access to clean air, soil and water, a safe climate in the sense of a set of conditions that are optimum for human functioning and those are being eroded incredibly quickly.'

FIONA ARMSTRONG



CLIMATE AND HEALTH ALLIANCE:

Our Climate, Our Health

As part of its 'Our Climate, Our Health', campaign, CAHA has an online petition through which health professionals can email their local Members of Parliament, and an advocacy toolkit for health professionals to use in lobbying their local MPs for action on climate change.

"The toolkit is designed to help nurses let politicians know that – as health professionals – they are concerned about climate change and want to see a response from political leaders," says Ms Armstrong. "CAHA also has an emerging network of 'climate health champions' who can provide in person support for people who want to meet with their local MPs."

Ms Armstrong says the other thing that nurses and midwives can do is to encourage their hospitals or health service to join the Global Green and Healthy Hospitals Network, if they have not already. Australian and New Zealand member hospitals in the rapidly growing network are demonstrating world-leading initiatives in terms of their impact on reducing emissions.

"There's an online virtual community with tools, resources, and support available 24/7, 365 days a year, so nurses can log in to that network, ask questions and read case studies," Ms Armstrong says.

www.ourclimate-ourhealth.org.au



'Most people are concerned about climate change, but many of them haven't quite recognised the link that the same pollution that causes climate change is the same pollution that causes ill health. So we're showing the healthcare sector how to join the dots - that this great big issue is directly related to how we're practising at work. Addressing this issue is a part of our calling as health professionals, it's a very clear part of our rationale.'

ROS MORGAN, ANMF
(VIC BRANCH) ENVIRONMENTAL
HEALTH OFFICER

trading scheme, and what they found was a national emission reduction scheme of this nature actually delivers health benefits that are ten times the value of the cost of implementing the policy.

"This completely blows out of the water the argument that we can't afford to act on climate change, and it makes the case very strongly that we can't afford not to do something about it."

Nurses take action on climate change

The ANMF (Victorian Branch) has a dedicated environmental health officer, Ros Morgan, who helps run CPD course, *Nursing for the environment: a practical introduction to environmentally sustainable practices*.

Ms Morgan is involved in organising ANMF (Victorian Branch's) annual Environment and Sustainability Conference, headlined this year by Craig Reucassel, presenter of the ABC series *War on Waste*.

ANMF (Victorian Branch) also runs the

highly active and effective Green Nurses and Midwives Facebook Group <http://tiny.cc/greennm>, a space where members can share knowledge and experiences in trying to establish green initiatives.

Ms Morgan says that activity on the page, and her own prior experience as a clinician trying to establish waste reduction schemes in her workplace, made it clear there was a need for a position that could educate about the resources available, and facilitate the uptake of best practice waste management systems in hospitals and healthcare facilities.

"We were aware of a lot of people giving up time and energy, and in a lot of cases reinventing the wheel – often pulling teeth trying to find out answers to questions," Ms Morgan explains. "So the ANMF lobbied the Victorian government on behalf of its members, and in the last Victorian state Budget, secured funding for a new Waste Education Officer. This role will provide a resource base and support members implementing environmentally sustainable

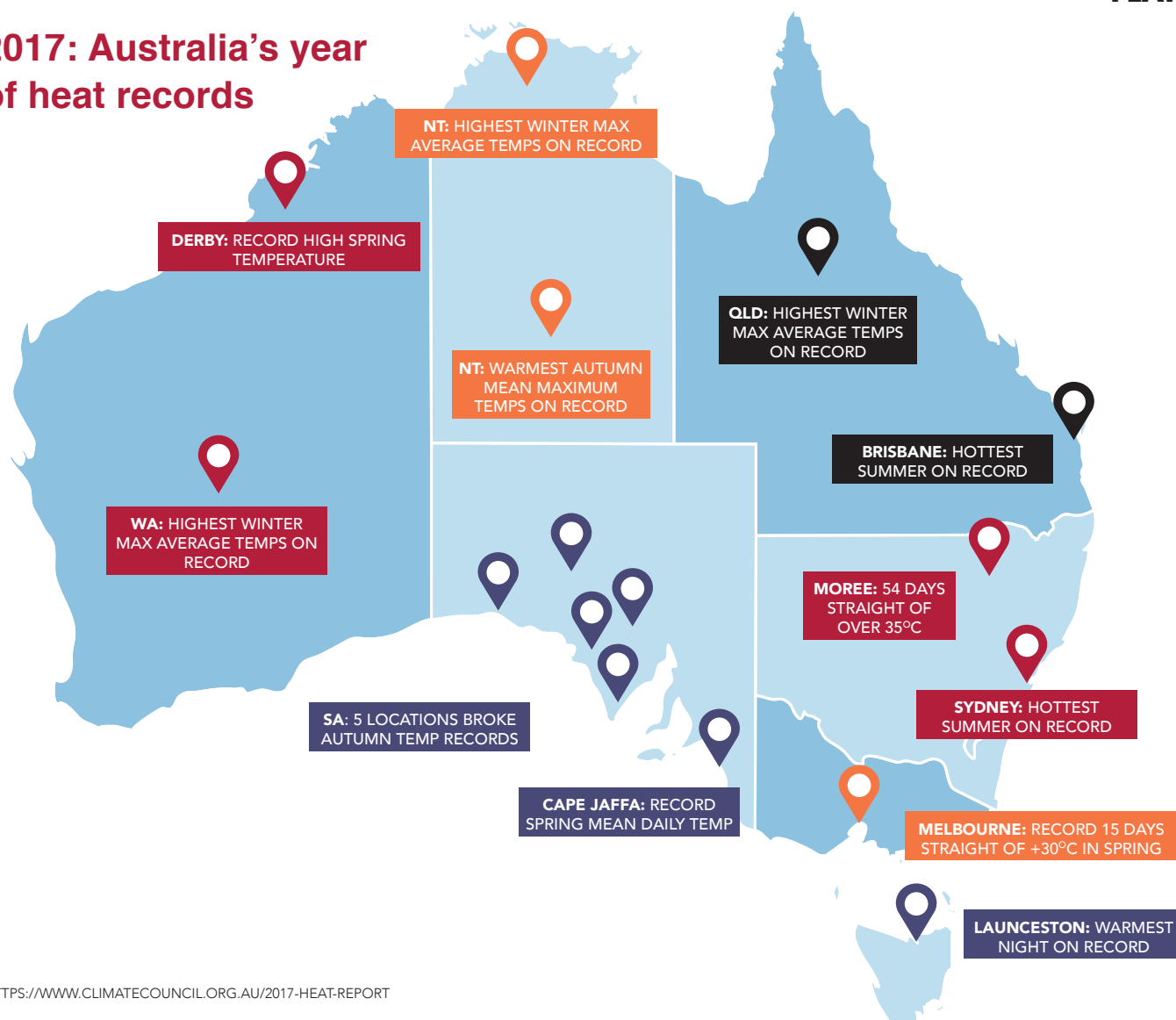
practices."

Ms Morgan says while the appointment is being made, a project working group consisting of representatives from the ANMF (Victorian Branch), Sustainability Victoria, Victorian Human Health Services (VHHS, formerly DHHS), and other senior healthcare professionals is working to furnish the Waste Education Officer with accurate, EPA-endorsed materials.

"We know, for example, that there is often inconsistency with healthcare policy documents because quite often the authors are not sure on how to interpret the guidelines from the EPA," Ms Morgan explains.

"As a direct result of ANMF intervention, we now have an EPA member on that project working group, so that they can endorse the materials that are released by the new Waste Education Officer, with the intention of bringing clarity to some of these areas of confusion. As a result, healthcare organisations can feel confident in developing

2017: Australia's year of heat records



[HTTPS://WWW.CLIMATECOUNCIL.ORG.AU/2017-HEAT-REPORT](https://www.climatecouncil.org.au/2017-heat-report)

or amending some of their protocols."

The Waste Education Officer role will help to create a consistent approach across healthcare facilities and departments, says ANMF (Victoria Branch) Assistant Secretary Pip Carew.

Ms Carew believes that these improved efficiencies, and increased connections with stakeholders, should help to drive behavioural change for best practice in waste management.

"We've had success with government support for this role because improved waste management makes sense from an economic point of view. We can demonstrate a clear value proposition – less waste means less disposal costs."

The ANMF (Victorian Branch) has recently moved into a purpose-built, 5 Star Green Star, award-winning building. The building features solar panels, natural light responsive LED lighting, storm water-fed toilets, smart lifts, onsite high-speed composting, low VOC materials, improved stream sorting for recycling, carefully positioned staircases to encourage people to use the stairs, end-of-trip facilities to encourage walking or riding to work, and an increased number of smaller car spaces.

Ms Carew says it was designed to

support the ANMF's member-driven mandate to reduce emissions and to aid members implementing environmentally sustainable practice.

"As representatives for our members we want to make sure their building has the hallmark of sustainability and is not contributing to harming people," Ms Carew says. "One of the reasons we won our CitySwitch Signatory of the Year (Victoria) award was that in addition to the environmental credentials of the building we've also been able to develop our Nursing for the Environment course to run in the building.

"Nurses wanted structure around advocating in the workplace, so that they could genuinely make a difference in their workplaces. We see it as the project for building our future."

Code of ethics addresses environmental issues

In March 2018 the Nursing and Midwifery Board of Australia (NMBA) adopted the International Council of Nurses Code of Ethics. Ms Morgan says some elements of the code supports nurses addressing environmental issues that might not traditionally have been part of the clinical

sphere. For example, under section 3, *Nurses and the profession*, the code states:

- The nurse practices to sustain and protect the natural environment and is aware of its consequences on health.
- The nurse contributes to an ethical organisational environment and challenges unethical practices and settings.

"The point of view that nurses should not step outside the clinical sphere is sometimes a stumbling block for nurses who want to introduce environmentally sustainable practice," Ms Morgan says. "But waste management is unquestionably a part of the nurse's brief. Is it really acting ethically to mindlessly practice when there are changes that we can make that will have significant impacts?"

"Most people are concerned about climate change, but many of them haven't quite recognised the link that the same pollution that causes climate change is the same pollution that causes ill health. So we're showing the healthcare sector how to join the dots - that this great big issue is directly related to how we're practising at work. Addressing this issue is a part of our calling as health professionals, it's a very clear part of our rationale."



RETIREMENT FROM NURSING: KNOWING WHEN THE TIME HAS COME

By Shirley Allott

There is research on nursing retention and on the value of older nurses in the workforce but how does an older nurse know when the time has come to retire?

This is an important question as a nurse enters into the later fifth decade and sixth decade of life. For me I looked at literature that would guide me in decision making around retirement.

For many older nurses, there is a perception of a need to continue nursing for financial reasons, but if a nurse is experiencing age related body changes, sensory changes, or emotional changes and finding working increasingly difficult, is retirement the best option?

I am a registered nurse aged 65. I started nursing, firstly as an assistant, 45 years ago, then completing my general training and later midwifery. In my forties to my mid-fifties I completed a Bachelor of Nursing and higher degree. I now feel that I am ready to retire.

I looked at research-based evidence that could guide me such as Flinkman, Leino-Kilpi & Salanterä (2010) who reviewed reasons why nurses leave the profession, as well as nursing retention. Within this study, older age was not addressed.

Graham and Duffield (2010) examined ways older nurses can continue working in the face of body changes of ageing such as addressing workloads and having fitness programs for nurses as they age. However, the article suggested many nurses retire at 58 and looks at ways and policy development to retain nurses until 65. Powell (2010) in her study suggested retention rather

RETIREMENT AND
PREPARATION FOR
RETIREMENT ARE IMPORTANT,
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AND SCHEMES SUCH AS
TRANSITION TO RETIREMENT.

than retirement. The study group included nurses over 50. These studies all examined ageism as an issue within nursing.

Schofield & Beard (2005) looked at patterns of retirement of nurses and doctors and suggest that more doctors are working over 60 than nurses- the majority of nurses had retired by 60. It was interesting to note that among nurses, gender was not a factor in retirement patterns.

Jaimet (2013) discussed the need to continue to work for financial reasons and finding the right time to retire with direct quotes such as "As I get older, I've been discovering that the brain is willing, but the body isn't".

She also describes tiredness, and dealing with management and paperwork as factors in retirement. She suggests many older nurses continue to work for financial reasons, sometimes with a partner who cannot work, but suggests there is a need to learn to live on a lower income such as a pension.

Needing to work for financial purposes, and being wanted by

the profession to alleviate nursing shortages, are important reasons to continue to work.

But what if a nurse has arthritis, hearing loss and visual decline. Is it really best or even desirable for the nurse, patients, other staff and management for the nurse to continue to work?

With arthritis, kneeling and bending can be difficult, with hearing loss there is the issue of correctly hearing important communication, and with visual decline, being able to correctly read important documents.

Fragart & Depczynski (2011) discuss the impact of body changes and the impact on nurses. The nurses in this study are over 50 but there does not seem to be information on the actual age range of participants. This study does look at factors that make age related changes that impact on nursing. Musculoskeletal changes make patient care more difficult, and visual and hearing decline impact on the ability to read and understand communication, and there is emotional stress from long years of nursing. This article however looks at how older nurses could be supported to continue nursing. It does suggest the need to reduce hours of work, and the need for work-life balance.

An online article written by staff editor of Nexxt suggests that to heed the voice of the angel on the shoulder that says it is time to retire and suggests there are many post retirement options. Jaimet (2013) also looks at post retirement ideas some nurses have used. The need to fill the time available post retirement is addressed by Jaimet 2013 with the taking up of new activities.

Retirement and preparation for retirement are important, and to understand options for retirement and schemes such as transition to retirement. I started investigating these options at 60 and moved to transition to retirement with my superannuation fund some years ago. I am pleased with the support I have had from the superannuation fund representatives and my workplace. I reduced my hours of work and took my long service leave. My family is also supportive.

After retirement there are many hours to fill but there are also so many possibilities. Some nurses in the literature I read returned to work or took up casual positions after retirement. I took Tai chi, and water aerobics some years ago and more recently joined an orchestra and furthered my knowledge of music and learnt to play new instruments. I cannot say I will never return to paid work because I do not know what the future holds and what opportunities may come up.

SHIRLEY PLANS TO
PLAY THE HARP IN HER
RETIREMENT



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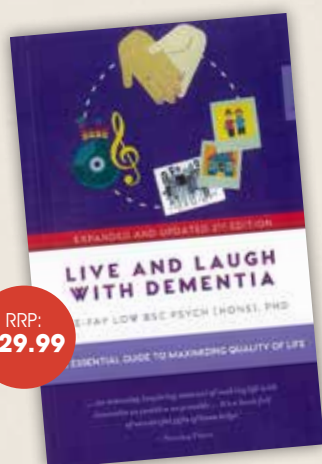
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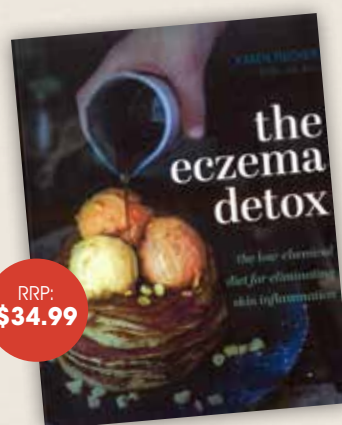


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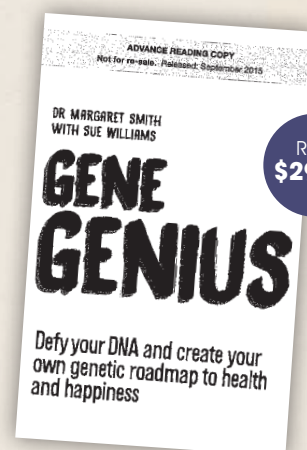


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BY DR MARGARET SMITH WITH SUE WILLIAMS
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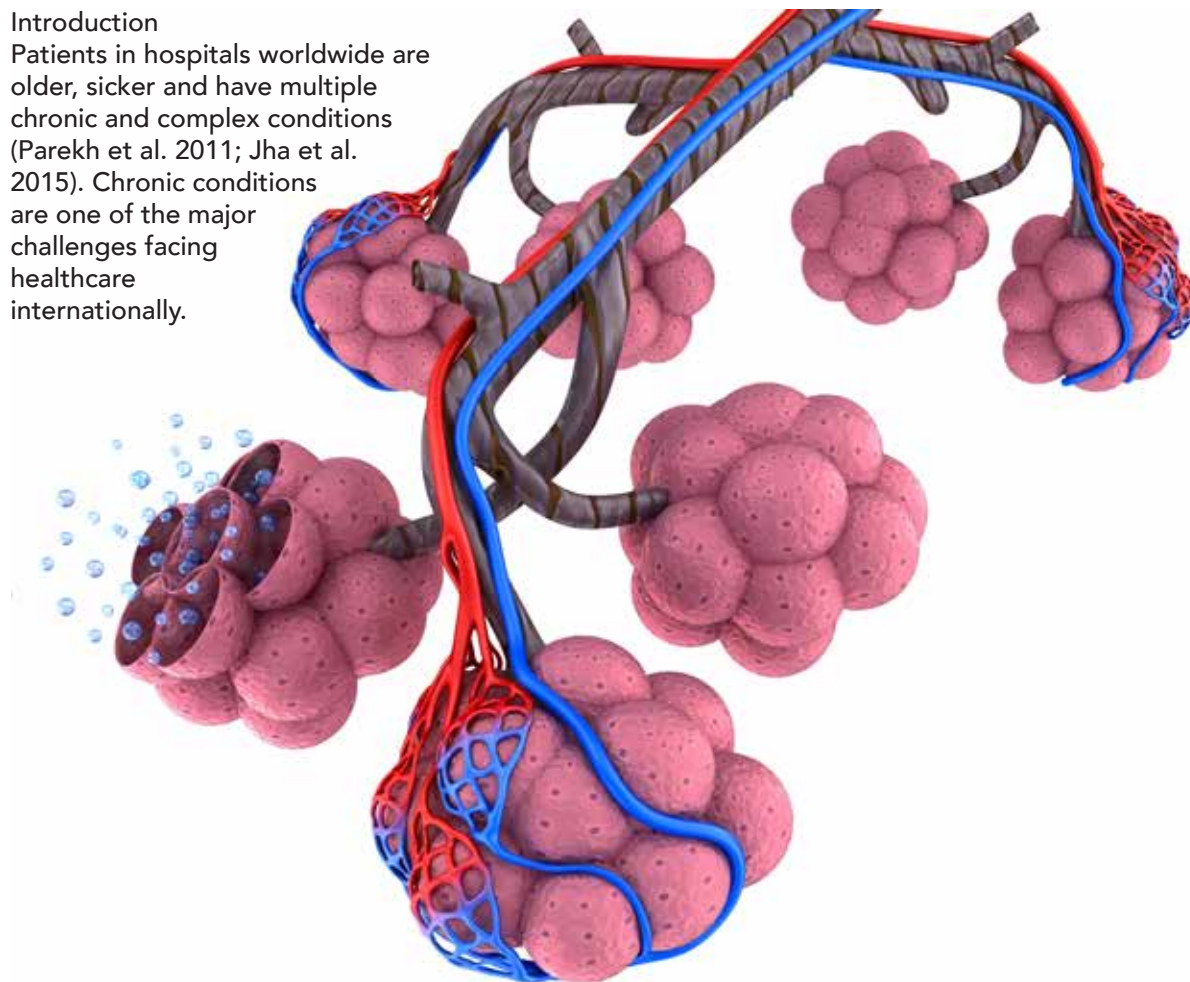
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ASSESSMENT OF BREATHLESSNESS: A CRITICAL DIMENSION OF IDENTIFYING CARDIOVASCULAR DISEASE

Tammy Slater, Martha Abshire and Patricia Davidson

Introduction

Patients in hospitals worldwide are older, sicker and have multiple chronic and complex conditions (Parekh et al. 2011; Jha et al. 2015). Chronic conditions are one of the major challenges facing healthcare internationally.



Commonly, healthcare systems are primarily configured for acute, episodic care and focus on individual clinical conditions. However, many patients experience chronic conditions within the context of multimorbidity and associated social, psychological, cultural and economic factors (Barnett et al. 2012).

An ageing population and the increased prevalence of comorbidity underscore the need for improved skills in clinical assessment, particularly when individuals experience dyspnea.

Breathlessness, otherwise known as shortness of breath or dyspnea is commonly defined as difficulty or labored breathing. The American Thoracic Society characterises breathlessness as a subjective feeling of discomfort associated with breathing that consists of qualitative distinct sensations that fluctuate in severity (Parshall et al. 2012).

Breathlessness is common in

both acute and chronic conditions (Johnson et al. 2016). In a national prevalence study, one in four adults aged 70 and older in the United States experience breathlessness, which is associated with adverse health outcomes including a 60% greater risk of death over the next five years (Smith et al. 2016).

Since breathlessness is a common problem, having a systematic approach to clinical assessment can assist in facilitating diagnosis, relieving symptom burden as well as appropriate treatment.

Due to limited physical space in hospitals, patients are often admitted to clinical areas based on availability of beds, rather than clinical specialty. Nurses are required to provide comprehensive clinical assessment and report on a range of signs and symptoms. Cardiovascular assessment is a crucial dimension of clinical assessment. Gathering a patient's medical, family and social

histories assist with determining their pattern of breathlessness and how it relates to underlying condition(s). Moreover, particularly in older adults, breathlessness can be a manifestation of cardiac ischemia or heart failure (van Riet et al. 2014). This commentary focusses on the initial nursing assessment of breathlessness and how it relates to cardiovascular disease (CVD).

A common scenario in clinical practice

When a patient tells you that they are not able to catch their breath or are unable to take a deep breath, what is your first thought?

The perception of breathlessness is highly subjective, temporal and challenging for clinicians to assess, particularly acutely. As patients age, they may associate shortness of breath with getting older and not necessarily relate this symptom to a new or worsening medical problem.



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Table 1: Summary of medical history relevant to assessment of breathlessnessAdapted from *Bates' Guide to Physical Examination and History Taking*, 12th edn, 2017

System	Related conditions
Cardiovascular	myocardial infarction, angina, heart failure, dysrhythmia, hypertension, hyperlipidemia, congenital heart disease, aortic aneurysm, murmurs, mitral valve prolapse, aortic stenosis
Endocrine	diabetes mellitus, thyroid problems
Respiratory	chronic obstructive pulmonary disease, asthma, obstructive sleep apnea, pneumothorax, pneumonia, tuberculosis
Hematology and Coagulopathy	anemia or bleeding problems, pulmonary embolism, deep vein thrombosis
Infectious, Trauma and Cancer	rheumatic fever/rheumatic heart disease, frequent sore throats, recent infections, recent trauma, cancers
Renal and Hepatology	chronic kidney disease, kidney or liver disorders, hepatitis
Gastrointestinal	dysphagia, gastroesophageal reflux disorder, hiatal hernia, peptic ulcer disease, cholecystitis, pancreatitis

Table 2: Symptom related questionsAdapted from *Bates' Guide to Physical Examination and History Taking*, 12th edn, 2017

Feature of Symptom	Symptom related assessment questions
Onset	<ul style="list-style-type: none"> what are your new symptoms compared to older symptoms you may have had what are your consistent versus progressive symptoms and how frequent do they occur and with what activity what was your activity at onset what is the pattern of your symptoms
Location	<ul style="list-style-type: none"> where is your breathing trouble does it change with movement
Duration	<ul style="list-style-type: none"> how long have you had symptoms how long does each episode last
Character	<ul style="list-style-type: none"> what is the quality of your symptoms have you had burning, pressure, heaviness, tightness, squeeze or crushing associated with your symptoms is there aching, stabbing or a tearing feeling
Relieving/aggravating	<ul style="list-style-type: none"> what makes your symptoms better what makes your symptoms worse
Temporal factors	<ul style="list-style-type: none"> do meals or exertion make your symptoms worse do you awaken from sleep because of your symptoms are your symptoms predictable
Severity 0 (least) to 10 (worst)	<ul style="list-style-type: none"> have your symptoms been annoying or limiting everyday activities do your symptoms change

For nurses, it is essential that we thoroughly evaluate a patient's signs and symptoms by tailoring our history taking and physical assessment skills to appropriately evaluate a new or worsening condition.

Undertaking a clinical assessment

As part of your clinical assessment, you will evaluate a patient's vital signs including respiratory rate and pulse oximetry values. It is important to ask questions related to medical history and key conditions that are summarised in Table 1. This will assist

in determining the situational and temporal context of breathlessness. Since breathlessness is subjective, asking applicable questions will support uncovering vital clues about possible causes for this complaint. Also understanding an individual's social circumstances, medication understanding and adherence, tobacco and illicit drug usage can help gain insight into the patient's history. Additionally, assessing for anxiety is essential given the close association between anxiety and breathlessness (Bailey 2004).

Tables 2 and 3 provide useful

questions to ask that are both general and system specific. Obtaining the patient's health history is crucial when undertaking your detailed physical assessment, which is outlined in Table 4.

Indications of breathlessness related to CVD

Although breathlessness may be associated with many conditions, we will focus on likely manifestations of breathlessness as an indicator of three common cardiovascular conditions: acute myocardial ischemia, heart failure and valvular heart disease.

Acute myocardial ischemia is a

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Table 3: System-specific assessment questionsAdapted from *Bates' Guide to Physical Examination and History Taking, 12th ed, 2017*

System	System-specific assessment questions
Cardiovascular	<ul style="list-style-type: none"> have you had a feeling of: <ul style="list-style-type: none"> impending doom, fainting, nausea/vomiting, sweating, fatigue, decrease in ability to exercise, difficulty breathing overnight when sleeping, palpitations, swelling, or weight gain how many pillows do you need to sleep in bed at night
Respiratory	<ul style="list-style-type: none"> have you had any sputum, and if so, was there blood have you had any wheezing, cough, or fever have you had any flu-like symptoms have you had pain or palpitations associated with breathing
Gastrointestinal & Genitourinary	<ul style="list-style-type: none"> have you had any difficulty swallowing or chewing your food, heartburn, abdominal pain, nausea, vomiting have you had increased frequency with urinating, if so, is it worse overnight
Extremities	<ul style="list-style-type: none"> have you had swelling, pain or cramping in your legs with walking, fatigue, hair loss, cold or numb legs

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Table 4: Focused physical examinationAdapted from *Bates' Guide to Physical Examination and History Taking, 12th edn, 2017*

Examination	Questions and assessment
General appearance	<ul style="list-style-type: none"> is the patient in any distress what is the patient's facial expression are they ill-appearing how are they positioned in bed do they appear to be breathless or have increased work of breathing what is their mentation what is their colouring are they diaphoretic
Vital signs	<ul style="list-style-type: none"> height and weight to calculate body mass index (BMI) temperature, pulse, blood pressure, respiratory rate, oxygen saturation on room air versus oxygen is there positive orthostatic blood pressure, which occurs when the systolic blood pressure decreases greater than 20mmHg when the patient changes position from supine to standing (Dordunoo 2017, pp.583-584)
Inspection of the chest	<ul style="list-style-type: none"> shape of the chest (barrel, sunken) visible scars is there positive jugular venous pressure, which indicates the amount of right atrial pressure often used as a surrogate to estimate the patient's fluid volume status (Bates 2017, p.374)
Palpation of the heart	<ul style="list-style-type: none"> point of maximal impulse is located at the 5th intercostal space of the midclavicular line, is it focal or is it diffuse is there a thrill is there point tenderness
Cardiac auscultation	<ul style="list-style-type: none"> isolate each heart sound <ul style="list-style-type: none"> S1 is heard louder at the apex of the heart S2 is heard louder at the base of the heart are there any extra heart sounds <ul style="list-style-type: none"> gallop murmur prolonged, disrupted blood flow valvular defects rub grating, machine-like, scratchy rubber constant with each heartbeat
Lung sounds	<ul style="list-style-type: none"> are there any absent or adventitious lung sounds <ul style="list-style-type: none"> wheezes crackles or rales rhonchi

precursor to myocardial infarction (MI), which signifies cellular injury or necrosis (Antman et al. 2000). The World Health Organization identifies myocardial infarction as a leading cause of death and disability worldwide and defines the condition based on electrocardiographic abnormalities, elevated cardiac enzymes and patient symptoms (Thygesen et al. 2012). The most common symptoms that have been associated with acute myocardial ischemia are chest pain or pressure and breathlessness (Thygesen et al. 2012). Patients who are women, elderly, or those who have chronic conditions such as diabetes or chronic kidney disease are more likely to present with an atypical pattern of myocardial ischemia such as isolated breathlessness (Puymirat et al. 2016). Because of their uncharacteristic presentation, these patients often experience delayed treatment from onset of symptom identification and are more likely to suffer long-term mortality associated with having an MI (Puymirat et al. 2016).

Breathlessness is the most common reportable symptom in heart failure (Albert et al. 2010). However, many times this could be an initial complaint that is not readily associated with a cardiac etiology. Breathlessness has been found to be more closely related with cardiac mortality than any other symptom including chest pain or pressure (Abidov et al. 2005).

Additionally, other signs and symptoms of heart failure may be present, which at first glance seem unrelated, such as a nagging cough, increased leg swelling, weight gain, extreme fatigue, decreased capacity to perform normal every day activities, generalised anxiety and enlarged abdomen (Albert et al. 2010).

Valvular heart disease (VHD) may resemble heart failure presentation with common symptoms such as breathlessness, angina, syncope, dysrhythmia, palpitation, dizziness, weight gain and fatigue (Durdunoo 2017, pp.580-583).

This is primarily caused by decreased cardiac output and pulmonary congestion, which are also signs of heart failure (Durdunoo 2017, pp.580-583). There are three categories of VHD: stenosis, regurgitation or insufficiency and prolapse (Durdunoo 2017, pp.580-583). A stenotic heart valve is stiff and/or thickened, which narrows the opening and obstructs blood flow (Durdunoo 2017, pp.580-583). Insufficient heart valves cause blood flow to regurgitate in the reverse direction (Durdunoo 2017, pp.580-583). A prolapsed heart valve signifies that the valve leaflets are displaced during systole (Durdunoo 2017, pp.580-

583). The aortic and mitral valves are two of the most commonly affected heart valves with the most common VHD being aortic stenosis especially occurring in older adults (Durdunoo 2017, pp.580-583). Breathlessness, particularly on exertion, may be one of the first symptoms experienced by those with VHD.

Documenting and communicating your clinical assessment

As part of the clinical continuum it is critical to succinctly and clearly document your clinical assessment. The protocol in your institution will dictate documentation practices. If breathlessness is acute and new in onset, particularly in the context of abnormal clinical signs, prompt notification of the treating team is needed. Moreover, beyond acute assessment it is appropriate to implement a reliable and valid assessment tool assessment (Bausewein et al. 2007).

Best practices in communicating your assessment include utilising face-to-face interactions, a hand-off template and focused communication strategies such as SBAR, which stands for situation, background, assessment, recommendation (Riesenberg et al. 2010; Welsh et al. 2010). During hand-off between shifts, oncoming and off-going nurses, who have collaborated at the bedside, are better equipped to problem-solve resulting in less communication errors (Halm 2013). Additionally, a clearly outlined and structured bedside hand-off allows the patient to contribute to their assessment findings and be more informed; thus, enabling them to participate in their overall plan of care. Patient involvement in decision making has been identified as a key component in improving health outcomes as well as patient experiences (Harrison et al. 2016).


Your assessment will be essential in deciding whether to undertake further diagnostic tests, such as electrocardiography, chest radiography and biomarker assessments, such as troponin for myocardial ischemia and brain natriuretic peptide and N-terminal prohormone brain natriuretic peptide to exclude acute heart failure (DeVos and Jacobson 2016). Since the diagnosis of acute heart failure and VHD do not rely on the use of a single clinical parameter, bedside evaluation methods using point-of-care ultrasonography may also be completed. Experienced clinicians can rapidly diagnose the degree and gravity of acute heart failure and VHD using non-invasive, bedside transthoracic echocardiography and lung ultrasound (Pang et al. 2018).


Helping patients self-assess breathlessness

Educating patients regarding symptom management and self-care are crucial aspects in the nursing plan of care. Self-care can increase a patient's awareness of new or worsening symptoms allowing earlier detection of subtle changes, which can prevent complications and lessen severity of disease progression (Park et al. 2017). Active management of self-care principles through the use of a daily symptom diary is associated with longer all-cause survival among rural heart failure patients (Park et al. 2017). Increasingly, patients and clinicians are using electronic web-based and smart phone applications that can track symptoms, schedule follow-up appointments, communicate with providers, improve medication adherence along with adapting techniques for behaviour and lifestyle modification (Voragunti et al. 2017). Patients should be encouraged to track symptoms like breathlessness by using a diary or a smart phone application so that clinicians can aid in identifying patterns of occurrence and target treatment.

Conclusion

Breathlessness is a common symptom across many conditions, both acute and chronic. Undertaking a comprehensive assessment is important in triage, diagnosis and management of breathlessness associated with cardiovascular disease.

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ARE NURSES IN MENTAL HEALTH SETTINGS STILL AVOIDING SEXUAL HEALTHCARE?

By Chris Quinn, Brenda Happell and Chris Platania-Phung

A greater emphasis of the importance of physical healthcare for mental health nursing practice is now generally understood and in some services, has led to the implementation of innovative strategies and solutions.

However, when it comes to the sexual health of mental health consumers, evidence suggests nurses still tend to avoid the topic despite the well documented high sexual health needs that can be experienced by

mental health consumers.

Chris Quinn, Brenda Happell and Chris Platania-Phung from SYNERGY: Nursing and Midwifery Research Centre (University of Canberra and ACT Health) have been exploring the sexual health needs of mental health consumers and the response to these health needs by nurses in mental health services for the past 10 years.

In a recent study, we explored the sexual health service provision of nurses in mental health services for consumers of their services. The study used a survey that was made available to nurses in Australia via the Australian College of Mental Health Nurses. The aims were to gather information on how nurses working in mental health settings respond to sexual health issues within their routine practice, what sexual health issues nurses address during their consultations with consumers, and to explore their views on their role on promoting sexual health for consumers with serious mental health problems.

Over 300 nurses responded to the survey, with 90% working in public health services most of whom had a specialist mental health nursing qualification. There was an even spread with these nurses working in a variety of clinical settings from inpatient care through to community services.

Data analysis shows that over the

past three months, most nurses had not included in their assessments with consumers:


- exploration of the consumer's sexual or gender identity;
- whether consumers were practicing safe sex or using contraception; and
- and did not enquire about sexually transmitted infections.


Other risk issues such as intimate partner violence, sex work or sex trading were also avoided. Problems with sexual function were not addressed which is surprising given the general acceptance that many psychiatric medications can cause alarming sexual side-effects.


Sexual health issues specific to female consumers were also explored, revealing that taking a family planning and fertility history by the nurses was not common. Nurse participants indicated they were even less likely to ask about sexual health for male consumers, meaning that male sexual health issues such as self-checking for testicular cancer and erectile or ejaculating problems were areas of care very rarely attended to.

One of the team's goals is to improve nurses' awareness of the sexual health needs of consumers and to encourage services to explore strategies to improve the response by nurses to these health needs.

The journey continues.

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ABORTION AND REPRODUCTIVE HEALTH IN THE AFTERMATH OF A NATURAL DISASTER: THE CASE OF NEPAL

By Claire Rogers, Sabitri Sapkota and Jaya Dantas

In April and May of 2015, the Himalayan nation of Nepal was struck by two major earthquakes and multiple aftershocks. An estimated 9,000 people died as a result, with UNFPA (2015) estimating around 1.4 million women and girls of reproductive age were affected.

Shortly after the first earthquake, reports of increased numbers of abortion cases began appearing in the news as were reports of women seeking to terminate otherwise wanted pregnancies due to fear that the tremors would cause deformity to the foetus (Sanghani 2015).

To address mounting concerns regarding women's decision making processes around abortion being impacted by misinformation, Marie Stopes Nepal Clinics (having re-opened just days after the first quake), tailored their abortion counselling to ensure women could make informed decisions regarding their choice to terminate their pregnancy. Subsequent qualitative research in the four worst hit areas was conducted to gain contextual understanding and explore

knowledge, attitudes and beliefs of pregnant women during the aftermath of major earthquakes to inform evidence based counselling, program and intervention strategies for crisis settings (Rogers et al. 2017).

The research, presented at the World Congress on Public Health in Melbourne, Australia in 2017 and soon to be published internationally, highlights the sociocultural and religious factors impacting abortion seeking decision making during a crisis. It demonstrates that service providers are not always equipped with accurate information to support women in times of crises. Therefore, it is important to ensure that providers' counselling is evidence based and tailored so that women in need can make informed decisions. While the findings are particularly relevant to countries where safe abortion services are legal, women unable to access accurate information and safe abortion services where laws are restrictive, face even greater challenges to their sexual and reproductive health and rights. The study also showed that it is indeed possible to provide safe abortion services within a crisis setting and that women have a proven desire for these services.

The necessity of providing

WHILE DEVELOPING COUNTRIES CONTINUE TO BEAR THE BURDEN OF NATURAL DISASTERS AND CIVIL CONFLICT, WOMEN WILL CONTINUE TO SEEK UNSAFE MEANS OF TERMINATING PREGNANCIES AND CONTINUE TO LOSE THEIR LIVES.

sexual and reproductive health (SRH) services in humanitarian crisis settings has been gaining greater recognition over the last decade, however, safe abortion services are still rarely provided within this context (McGinn and Casey 2016). In November 2017, the Inter-Agency Working Group on Reproductive Health in Crises (IAWG) included language around safe abortion in the Minimum Initial Service Package (MISP) for Reproductive Health guidelines for the first time (Edwards 2017). While this is a forward step towards achieving the inclusion of safe abortion services in SRH humanitarian response frameworks, sustained political opposition and sensitivity to abortion will continue to derail support for formal inclusion in the MISP. Globally, 25.1 million unsafe abortions occur each year with 97% of these in developing countries (Ganatra et al. 2017).

While developing countries continue to bear the burden of natural disasters and civil conflict, women will continue to seek unsafe means of terminating pregnancies and continue to lose their lives. There is a vital and global need to provide safe abortion services and access to culturally appropriate SRH care to all women.

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SEXUAL ASSAULT AND HARASSMENT IN AUSTRALIAN UNIVERSITIES

By Zach Byfield and Leah East

The recently released 'National report on sexual assault and sexual harassment at Australian universities' (Australian Human Rights Commission 2017) has highlighted the often hidden adversity students can experience during their studies at university.

The report outlines findings made following an investigation by the Australian Human Rights Commission over the latter half of 2016, at the request of 39 universities across Australia.

Made evident within the report was the increased incidence of sexual assault and sexual harassment in the Australian university setting. Whilst the report emphasises the need for higher education institutes to prevent sexual adversity and protect the student population, healthcare professionals including nurses are in prime positions to support individuals and advocate for sexual health and wellbeing.

The nursing profession has a particular interest in sexual assault and harassment. Sexual harassment and assault has a number of negative health outcomes both physically and psychosocially, which nurses understand need to be addressed in a holistic manner (Szalacha et al. 2017). Furthermore, the nurse's social conscious and professional expectation urges them to confront cultural and social issues which may have an impact upon the community's health (Perry et al. 2017). Nurses, both academic and clinical, are in an excellent position to take a leading role in steering future investigations in this field.

Discussion

Sexual assault and harassment can be experienced by any individual regardless of background, age, gender, and ethnicity. Indeed, the report found that while individuals who identify as gay or lesbian were more likely to be sexually harassed or assaulted than individuals who identified as heterosexual, individuals who identified as bisexual or asexual were at even higher risk (Australian Human Rights Commission 2017).

Hidden populations such as gender and sexual minorities need particular attention and focus within policy and intervention to ensure they are not overlooked.

The report also indicated that overwhelmingly women are at a greater risk. Excerpts from participants who were willing to discuss their experiences were dominated by women with minimal excerpts provided by men. Although the report highlights the difficulty men may face in reporting sexual assault due to cultural attitudes and perceived lack of belief, it is apparent that individuals may suffer these experiences in silence regardless of gender identity.

Therefore, it is vital for nurses working in these areas and for our future nurses to educate clients, communities and society at large

that all individuals are at risk, which may promote the breakdown of stigmas and social constructs often associated with sexual assault and harassment, and give voice to those who experience sexual adversity.

Furthermore, although the report is a great step forward in addressing sexual assault and harassment of students within the higher education sector, a greater focus is needed on the detrimental health consequences particularly post assault.

Both sexual harassment and assault can cause significant and ongoing physical, social and psychological health outcomes. For example, sexual assault puts victims at a threefold increased risk of contracting a STI (Van Rooijen et al. 2018). Thus, it is vital for recommendations to be put into place as a result of this report that healthcare professionals, including nurses, are involved in and can follow in order to facilitate effective care, and curb the incidences of both sexual assault and harassment among student populations.


Conclusion

One of the major findings of the report is the recommendation that more needs to be done to address the underlying issues which see such significant incidences of sexual assault and harassment in our higher education institutes. It bears remembering that with such a delicate issue such as sexual assault that has stigma attached, this report needs to be seen for what it is, the tip of the iceberg. A sustained effort will be required to fully realise this issue and put into place strategies to manage, and nursing is in a position to have impact within this effort.

Importance to nurses

Nurses employ a social justice approach in their delivery of healthcare. Nurses, both academic and clinical, will continue to be heavily involved in the issue of sexual assault and harassment both at Australian universities and within the wider national and global context. By fighting stigma and bringing this issue into the open, nurses can influence social change and promote positive health outcomes among individuals and within communities.

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IMPROVING HEALTH LITERACY ABOUT MYCOPLASMA GENITALIUM

By Melissa Power and Donna Tilley

Mycoplasma genitalium (MG) is a relatively new sexually transmitted bacterium infecting the ano genital tract of men and women, and is a cause of urethritis, cervicitis and pelvic inflammatory disease.

Mycoplasma genitalium (MG) Treatment - Moxifloxacin

Your urine or swab test has come back 'positive' and you have been diagnosed with *Mycoplasma genitalium*, sometimes called MG. It is a sexually transmissible bacteria found in the vagina, inside the penis (urethra) or anus. It is passed from one person to another during vaginal or anal sex without condoms.

What is the treatment?
MG is treated with antibiotics. The doctor or nurse will decide which antibiotic is best for you. Sometimes antibiotics do not kill MG bacteria. You might have had antibiotic treatment for another infection. It is important to take antibiotics to treat the MG infection. It is important to take antibiotics to treat the MG infection.

Treatment
My treatment is called: **Moxifloxacin**
Common side effects might include: nausea, stomach pains, diarrhoea, headache, tiredness and dizziness.
If you are worried, please call the clinic.

If you are on other medication
have any health problems, any mental health problems or any allergies, please let your doctor or nurse know. The Consumer Medication Information leaflet that comes with your medication has more safety information for you to read.

It is not common but - if you
unwell, have any yellowing of eyes, dark urine, get a skin rash or blisters, become itchy or any difficulty breathing, stop taking the medication and call your doctor straight away.

What if I don't have treatment?
Without treatment, MG could have ongoing problems.

Do my sexual partners
Any sexual partners if you can, tell any of them. If sexual partners are not told, they could get MG.

When can I have treatment?
You can start having treatment as soon as you have been diagnosed. If not you will need to use condoms.

What do I do?
Talk to a nurse or doctor. NSW Sexual Health Information Line: 1800 046 888

My notes:

Western Sydney Sexual Health Centre
Clinical services
Jeffery House
Level 1
162 Marsden Street
Parramatta
Phone : 9843 3124

Kelly Close Services
Kelly Close
Mt Druitt
Phone: 9881 1206

Please phone for an appointment

Free and confidential
No Medicare card required

Prevalence is estimated up to 3% in the general population and 35% in men with urethral symptoms, and may be increasing and contributing to disease burden (Couldwell and Lewis 2015, pp.147-61). Australian guidelines (Australasian Sexual Health Alliance 2016) recommend testing those with symptoms and contacts of infection. Of concern, is the increasing resistance to first line macrolide antibiotics and emerging resistance to second line antimicrobials (Jensen et al. 2016).

Assessing health literacy is a key part of nurse-patient communication and engagement in care. We know that approximately 60% of Australians have low individual health literacy which can affect their ability to 'understand and use health related information...make well-informed decisions about their health and act on those decisions', resulting in a 'higher risk of experiencing poor health outcomes' (Australian Commission on Safety and Quality in Healthcare 2015). At our sexual health

service in Western Sydney we see patients from diverse socioeconomic and cultural backgrounds, who may have low levels of health literacy.

Over two weeks in June 2017, we undertook a quality improvement project to address the health literacy of patients tested and treated for MG infection. Patient information leaflets (PILs) are a preferred way of accessing sexual health information (Varma et al. 2016, pp. 289-91) and may increase cognitive recall after a consultation. We developed three patient-focused PILs using health literacy quality checklists (Sustersic et al. 2016, pp. 1-12); an 'Information PIL' about MG testing and 'Treatment PILs' about treatment and management of MG using two different antibiotic regimens.

We aimed to recruit 20 patients, who had English as their preferred language from the clinic waiting room to complete questionnaires assessing knowledge and comparing the 'Information PIL' with an MG factsheet available on the NSW Sexually Transmissible Infections Program website, and comparing the 'Treatment PILs' with the relevant antibiotic consumer information medicine (CMI) factsheets.

The PILs were reviewed by 20 patients. Overall 82% preferred our patient-focused PILs. The content in the 'Information PIL' when compared with the existing factsheet increased knowledge about receiving results (70% cf. 60%), informing partners (100% cf. 60%), and how to contact a sexual health nurse (100% cf. 85%). The content of the 'Treatment PILs' when compared with the CMI factsheet increased ease of understanding medication use (89% cf. 53%). Patients remained unsure about whether infection could be cured with an antibiotic course. Over two-thirds (65%) of patients would also use the internet for information.

Implementing patient reviewed PILs may contribute to improved health literacy and patient and public health outcomes by supporting verbal information with additional patient focused written information. The CMI factsheets will also continue to be provided, as required by medicines regulations. We plan to evaluate whether using the PILs supports safe and effective medication use, improves attendance for test of cure and addresses needs of culturally and linguistically diverse patients.

Melissa Power is Clinical Nurse Consultant and Donna Tilley is Transitional Nurse Practitioner. Both are at Western Sydney Sexual Health Centre



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THE IMPORTANCE OF TAKING A SEXUAL HEALTH HISTORY

By Judy Lamb, Louise Holland and Andrew Mahony

The importance of taking a sexual health history cannot be understated. A sexual health history may be confronting to the clinician undertaking the assessment (and the patient), however the information received can be invaluable in many circumstances.

As infectious diseases clinical nurse consultants, we take sexual health histories on most clients referred to our service.

Ideally we would like to see all clinicians take relevant sexual health histories even on busy acute wards, emergency departments, primary and community health services.

A complete sexual health history does not have to occur in every circumstance, and generally can be designed to suit the client. Positive sexually transmitted infection (STI) test results, disclosure of high risk sexual or injecting activities, belonging to a recognised high risk cohort (see below), presentation requesting STI testing, contraception or presenting during pregnancy would be times that would warrant a more detailed risk assessment.

IDEALLY WE WOULD LIKE TO SEE ALL CLINICIANS TAKE RELEVANT SEXUAL HEALTH HISTORIES EVEN ON BUSY ACUTE WARDS, EMERGENCY DEPARTMENTS, PRIMARY AND COMMUNITY HEALTH SERVICES.

High risk cohorts include:

- 15-29 years old;
- individuals who have more than one partner;
- people living with HIV, those with a previous past history of STIs;
- people who are concerned about their partner's behaviour;
- Indigenous people particularly aged 15-29;
- pregnant women;
- people who have changed partners;
- male and female sex workers and their regular partners;
- people who inject drugs;
- men who are clients of sex workers;
- men who have sex with men (MSM);

- People who report unprotected sex or inconsistent condom use with partners;
- travellers who have had sex overseas in high STI prevalence countries; and,
- people who have a history of being incarcerated.

(Australian Society for HIV Medicine [ASHM], HIV, Viral Hepatitis and STIs – A guide for Primary Care Providers, 2014: p 89)

When completing a sexual history questions to ask around sexual practices include:

- Do you consider you might be at risk of HIV or other sexually transmissible infections?
- Have you ever had an STI?
- What type of sexual activity do you engage in with your partner? Vaginal? Oral? Anal?

Useful questions to ask around condom use include:

- Do you or your partner/s use condoms? Always or how often?
- Can you describe the situations in which you don't use condoms?

Useful questions for other transmission risks include:

- Have you ever had tattoos and or piercings, and if yes where were they obtained?
- Have you ever been in jail?
- Have you ever injected drugs and if yes, when did you last inject?
- Have you ever travelled overseas and had sex without a condom?

(More questions can be found at - Australian Society for HIV Medicine [ASHM], HIV, Viral Hepatitis and STIs – A Guide for Primary Care Providers, 2014: p 40)

Case study

A 40 year old female presented to hospital with a recent past history of diverticulitis confirmed on CT scan, however also had acute biochemical hepatitis, which is not typical of diverticulitis.

She had some improvement in abdominal pain after receiving standard empiric antibiotics for diverticulitis but then developed lower abdominal and rectal pain, nausea and vomiting. The surgical team involved ordered a repeat abdominal

CT and diagnosed recurrent diverticulitis, despite no radiological evidence. A differential diagnosis of Fitz-Hugh-Curtis syndrome was not considered as there had been no sexual history taken.

Pelvic inflammatory disease (PID) is an infectious and inflammatory disorder of the upper female genital tract, including the uterus, fallopian tubes, and adjacent pelvic structures. Infection and inflammation may spread to the abdomen, including peri hepatic structures (Fitz-Hugh-Curtis).

Fitz-Hugh-Curtis syndrome is a rare complication of pelvic inflammatory disease involving liver capsule inflammation leading to the creation of adhesions.

The classic high-risk patient is a menstruating woman, often younger than 25 years old who has multiple sex partners, does not use contraception, and lives in an area with a high prevalence of STIs.

Causative organisms include *Chlamydia trachomatis* (predominantly), *Neisseria gonorrhoea*, *Gardnerella vaginalis*, *Bacteroides* species, *E.coli* and *streptococcus*. These bacterial pathogens cause a thinning of cervical mucus and allow bacteria from the vagina into the uterus and fallopian tubes, causing infection and inflammation.

Testing for gonorrhoea and chlamydia via an endocervical swab or low vaginal swab is fast and simple, and not overly invasive if self-collected. Empiric treatment is with Cephtriaxone plus Azithromycin.

The above circumstance reflects why a sexual history is relevant in many differing circumstances, and the potential for missing an appropriate diagnosis.

Judy Lamb is CNC Infectious Diseases Service Bendigo Health

Louise Holland is CNC Infectious Diseases Service Bendigo Health

Dr Andrew Mahony is Infectious Diseases Physician Bendigo Health and Austin Hospital



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LGBTIQ+ EXPERIENCES IN SEXUAL HEALTH SETTINGS

By Alex Robinson

While overall acceptance of the LGBTIQ+ (lesbian, gay, bisexual, transgender, intersex, queer and others) community continues to rise in the wider community, there are still significant barriers for this community to look after their sexual health.

LGBTIQ+ people are underrepresented in attendance at general practice (GP) or specialist sexual health services, but there's also a lot nurses can do to provide a safe, welcoming and supportive space to practice sexual health nursing.

Many in the LGBTIQ+ community do not have a regular GP which makes it difficult for them to access sexually transmitted infection (STI) testing, STI prevention information and methods and other general preventative health care (Koh et al. 2014).

Around 18.6% of Australian women who identify as being attracted to women reported having never had a cervical screening (Pap) test and 34.7% of the same cohort reported having never had a STI test (Mooney-Somers et al. 2017). Also in Australia, 34% of transgender and gender diverse people with cervixes have never had a Pap test in their lifetime (Stardust et al 2017).

In New South Wales in particular, HIV testing in gay and bisexual men continues to increase along with service specific attendance (NSW Health 2017), but these statistics are not reflected in other populations.

There are several barriers to LGBTIQ+ people attending medical and sexual health services, the most significant of these being a fear of potential homophobia and transphobia expressed by health practitioners. Transgender and gender diverse people especially found they had to educate the clinicians on their own needs which takes important time away from receiving services. Approximately 42% of young transgender people have felt their bodies and their experiences weren't understood by the clinicians and 60% felt isolated from medical services (Strauss et al 2017). Clients



who have experienced stigma in the past are less likely to attend the same service, or others, again.

While the design and structure of a service isn't the domain of the average nurse working in sexual health or general practice, there certainly are things nurses can do on an individual basis or take to their management to improve the accessibility of their service to LGBTIQ+ people.

Having multiple gender options on intake forms, at the very minimum an 'Other' box, or a space for patients to write in allows not only better data collection, but for clients to be able to 'see' themselves in the clinic from the get-go. Asking clients what pronouns they use and the language they use around body parts and genitals means all clients can be appropriately addressed. In order to normalise this process, nurses can have that conversation with all clients, regardless of their perceived gender. Nurses can introduce themselves with their pronouns to indicate this clinic as a safe space and further normalise that process.

Consider also that identities do not determine actual lifestyles and acts. Instead of focusing on identities as determining risks and required tests, it's more accurate to use a 'parts and practices' model. For example, a homosexual cisgender man who engages with condomless anal sex is much higher risk for certain STIs than a homosexual cisgender man who engages in hand-to-genital contact only, yet a clinician using the Australian STI Management Guidelines would assume both need the same tests based on their sexual orientation alone. By collecting a thorough sexual history, testing can be personalised to a client's risks and

what a client chooses to be tested for.

Individual nurses can do a lot to make members of the LGBTIQ+ community feel welcome, in the same way nurses work to make all patients feel welcome and respected. By not assuming gender identities and sexual orientations based on appearances, nurses give people room to express themselves as they desire. When nurses are familiar with common terminology and aspects of transition or gender-affirming medicine they can provide better support and take the burden off clients explaining these to a clinician or providing extensive education.

Many LGBTIQ+ clients have had awful experiences with health professionals previously, from overly intrusive questions and outright rejection of gender or sexual orientation to denial of services and verbal abuse. Being able to provide a service where the clinician doesn't require extensive education, doesn't ask unnecessary invasive questions and acts in a welcoming and accepting manner might be the baseline for the best healthcare experience they've had in years.

When people are considered as more than their identities, clinicians are able to take better sexual health histories, better inform their testing and treatment and provide empowering and affirming health care. Members of the LGBTIQ+ community may have specific, different needs as a group, but like anyone attending a sexual health service, it's their individual concerns they've come in to have addressed.

 **Alex Robinson is a Registered Nurse/Sexual and Reproductive Health Nurse**



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SEXUAL HEALTH SERVICE AT THE ROYAL WOMEN'S HOSPITAL, MELBOURNE

By Alison Bean-Hodges, Anne Reid and Suzanne Wallis

The Victorian Women's sexual and reproductive health: Key priorities 2017-2020 detail four priority action areas needing to be addressed.

Priority action area four is:

Victorian women feel confident about accessing respectful and culturally safe sexual health services for testing, treatment and support, regardless of their gender identity, cultural identity, ethnicity, age, sexual orientation, disability or residential location.

The Royal Women's Hospital is well positioned to lead in this area. It is Australia's leading independent specialist hospital for women dedicated to improving the health and wellbeing of women of all ages and cultures, and newborn babies. The Royal Women's Hospital is recognised as a leader in its field, with expertise in maternity services and the care of newborn babies, gynaecology, assisted reproduction, women's health and cancer services.

The Royal Women's Hospital believes health equity for all women is more than a vision - it's a responsibility.

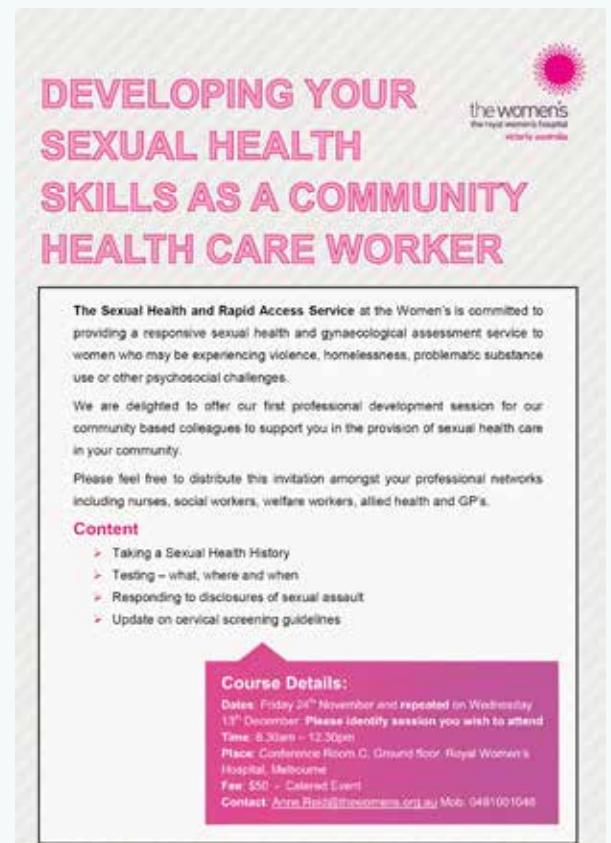
The Sexual Health and Rapid Access Service (SH&RAS) is a specialised, multidisciplinary service which includes sexual health physicians, nurse practitioners and a clinical nurse consultant who provide sexual healthcare to women and their partners and can also facilitate rapid access to broader gynaecological care for women experiencing homelessness, violence or other significant disadvantage.

SH&RAS recognises that for many women facing these challenges, the transition from primary healthcare services to tertiary (hospital) services can be problematic as they may be less able to navigate conventional pathways.

The SH&RAS works in collaboration with those community agencies providing primary health and welfare services to homeless persons, services caring for marginalised women, the Centre Against Sexual Assault and the Victorian Institute of Forensic Medicine.

To facilitate service provision, network development and client assessment, education sessions for community care providers have been delivered by the service's clinicians, with a good response being received and generous feedback. This included more relevant topics of interest and concern, including transgender health that will be addressed in further planned sessions.

Women can be referred to SH&RAS by medical, nursing and allied health clinicians. The aim is to respond to the woman, and her worker, within one week and provide an appointment within a rapid access timeframe, usually within two to four weeks.



DEVELOPING YOUR SEXUAL HEALTH SKILLS AS A COMMUNITY HEALTH CARE WORKER

the women's
the royal women's hospital
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The Sexual Health and Rapid Access Service at the Women's is committed to providing a responsive sexual health and gynaecological assessment service to women who may be experiencing violence, homelessness, problematic substance use or other psychosocial challenges.

We are delighted to offer our first professional development session for our community based colleagues to support you in the provision of sexual health care in your community.

Please feel free to distribute this invitation amongst your professional networks including nurses, social workers, welfare workers, allied health and GPs.

Content

- Taking a Sexual Health History
- Testing – what, where and when
- Responding to disclosures of sexual assault
- Update on cervical screening guidelines

Course Details:

Dates: Friday 24th November and repeated on Wednesday 13th December. Please identify session you wish to attend

Time: 6.30am – 12.30pm

Place: Conference Room C, Ground floor, Royal Women's Hospital, Melbourne

Fee: \$50 – Catered Event

Contact: Anne.Reid@thewomens.org.au Mob: 0481001048

Alison Bean-Hodges and Suzanne Wallis are Nurse Practitioners and Anne Reid is a Clinical Nurse Consultant. All are at The Royal Women's Hospital in Melbourne



Reference

Victorian Women's sexual and reproductive health: key priorities 2017–2020 www2.health.vic.gov.au/about/populations/womens-health

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HIV PRE-EXPOSURE PROPHYLAXIS (PREP) FOR HIV HAS BEEN RECOMMENDED FOR LISTING ON THE PBS

By Cherie Bennett

HIV PrEP is a daily HIV medication that can be taken by HIV negative people to prevent HIV infection.

On 9 February, the Pharmaceutical Benefits Advisory Committee recommended PrEP to be listed on the Pharmaceutical Benefit Scheme (PBS). When PrEP is available through the PBS later this year, GPs will be able to prescribe it to those at high risk, and it will be available to patients through Medicare.

In Australia, PrEP is currently accessible through clinical trials, personal online importation or a private script. Clinical trials are the most common, and affordable option for access in Australia. Nurses have played an important role in these trials.

Nurses can play a role in PrEP uptake and monitoring

A clinician needs to evaluate a patient to determine whether they

are eligible for PrEP, based on specific clinical and behavioural eligibility criteria. The nursing workforce can play a role in identifying patients who would benefit from PrEP, particularly those who may not be aware of their HIV risk, and also provide sexual health counselling and education to patients who are on PrEP.

Once a clinician has prescribed PrEP to a patient, the patient must attend follow-up appointments at a clinic for routine monitoring and assessment. Follow-up appointments include screening for sexually transmitted infections (www.sti.guidelines.org.au/), blood tests to assess renal function, assessment for medication side effects and adherence, and discussions on risk reduction behaviours.

How can I find out more about PrEP


More information about the PrEP



availability in NSW, and on the NSW PrEP trial - EPIC-NSW can be found at <https://epic-nswstudy.org.au/>

The NSW PrEP Guidelines can be found at www1.health.nsw.gov.au/pds/ActivePDSDocuments/GL2016_011.pdf

If you would like to increase your knowledge and skills in HIV and sexual health, NSW Health funds the Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM) to deliver short courses in HIV and sexual health that can be accessed from <http://courses.ashm.org.au/training/>

 **Cherie Bennett is Clinical Nurse Consultant- HIV at the NSW STI Programs Unit**

WORKING IN ABORTION CARE – STIGMA BY ASSOCIATION

By Edna Astbury-Ward

Current literature suggests that those who provide abortion care are targets of stigma, harassment and violence (Harris et al. 2013). The consequences of this are evident in recent figures, which demonstrate that it is becoming increasingly difficult to attract people into abortion care work (Astbury-Ward 2014).

Objectives

To explore the perceptions of staff working in abortion care.

Method

Qualitative methodology using

indepth semi structured face-to-face interviews with doctors and nurses (n=8) working in NHS abortion services in the UK.

Results

Staff working in NHS abortion services in the UK often feel isolated from other medical and nursing colleagues because of their decision to work in abortion care. For some staff, the perceived unpopularity of abortion care work engendered a sense of isolation from other colleagues. Staff linked this to a lack of colleagues working in abortion services with whom they were able to discuss and share their work. Staff 'glossed over' the fact they worked in abortion care, telling others they vaguely worked in women's health or gynaecology. Staff were reluctant to reveal what they actually did, in part because there was acknowledgement that at best they may be vilified or at worst may suffer from violence or attack.

Conclusions

It is argued that staff working in abortion services suffered from the moral taint and fear of consequences of their work. Staff were reluctant to openly share (much less celebrate)

the value and worth of their work, except with those whom they trusted and who they felt understood and sympathised with their decision to work in abortion care. The perception of abortion care as 'dirty work' is as much to do with the narrow definitions held by the general public of what 'nice' doctors and nurses do. It is apparent from the accounts presented here that the threat of social sanctions as a consequence of working in abortion care are felt both within and out of employment situations and may have implications for recruitment.

Several of the staff interviewed indicated that clinical staff were reluctant to join abortion services because of the perceived stigma and unpopularity of the work, and this was a contributory factor to the small numbers of people wishing to join the service. Respondents also noted that because of the shortage of trained staff electing to work in abortion services this affected the level of care which was provided to women. The powerful combination of stigma by association, fear of reprisals (whether actual or perceived) and moral objection is a toxic cocktail for the future of abortion services.



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ACCEPTABILITY AND SATISFACTION OF A PARLOUR OUTREACH SCREENING INITIATIVE IN WESTERN SYDNEY

By Arlie Rochford, Jennifer Walsh and Melissa Power

The NSW Ministry of Health HIV strategy identifies Sex Workers (SW) as a priority population for HIV prevention programs (NSW Ministry of Health 2016, p5).

SWs working in Western Sydney Local Health District (WSLHD) are predominately from culturally and linguistically diverse (CALD) backgrounds, often newly arrived,

have inadequate language skills, may not be aware of available health services and not have access to Medicare (Varma et al. 2015; Western Sydney Local Health District 2017).

CALD SWs are identified as a higher risk population for getting a sexually transmitted infection (STI) (Australasian Sexual Health Alliance 2016).

For several years, Western Sydney Sexual Health Centre (WSSHC) has provided an outreach service for this often transient group, initially health education focused and, more recently, HIV/STI screening focused. The Centre encourages nurses to undertake quality improvement and research initiative to improve client care. As one example of this approach, WSSHC nurses developed, implemented and assessed an outreach screening project among female and transgender CALD SWs in our local health district.

Outreach screening is conducted by registered nurses (RNs) and a Mandarin speaking Multicultural Health Promotion Officer (MHPO) focusing on Chinese SWs. We visit local establishments and speak with SWs about HIV/STI screening and provide culturally appropriate health education. Sex workers are invited to self-complete a brief, confidential sexual history using either English or

Mandarin templates. Participation is voluntary. SWs who choose not to participate are encouraged to attend WSSHC or to test elsewhere at a later date. The workers who have a positive HIV or STI diagnosis are followed up at the WSSHC's main clinic based in Parramatta. Follow-up of positive diagnoses provides further opportunity for education and ongoing engagement with our service.

A quality improvement exercise was undertaken in 2017, to ensure the outreach service was meeting the needs of our local sex workers. Sex workers, who had previously used our HIV/STI screening service, were invited to participate in the anonymous satisfaction surveys in English, Mandarin and Thai. Data were collected from 80 individuals on a number of topics including barriers to getting a checkup and their Medicare eligibility. In addition, participants were asked to rate the outreach service. Survey results indicated that 19% of participants did not know where to go for a checkup and 17% indicated transport difficulties. Additionally 42.5% of SWs were Medicare ineligible, with 90% of participants rating the service as good, very good or excellent.

Responses suggested that outreach screening is an acceptable alternative to the traditional screening setting with culturally appropriate outreach screening improving access by removing language barriers. Relationships formed by our health promotion officer with Mandarin-speaking sex workers and owners of parlours is pivotal, and has built trust and created opportunities for voluntary screening and the provision of health information regarding STIs.

The project was recently awarded the Australasian Sexual Health and HIV Nurses Association (ASHHNA) Poster Prize at last year's 2017 Sexual Health Conference in Canberra with plans for publication of key findings.

Arlie Rochford is Clinical Nurse Specialist, BN. Family Planning Cert in Sexual and Reproductive Health.

Jennifer Walsh is Nurse Unit Manager, RN. Grad Cert in Clinical Management.

Melissa Power is Clinical Nurse Consultant, RN, RM, Grad Cert Community and Primary Health Care Nursing.

All are at Western Sydney Sexual Health Centre

ARLIE ROCHFORD
CNS RECIPIENT OF
AUSTRALASIAN SEXUAL
HEALTH AND HIV
NURSES ASSOCIATION
(ASHHNA) POSTER
PRIZE AT LAST YEAR'S
2017 SEXUAL HEALTH
CONFERENCE IN
CANBERRA.



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THE CREATION OF A SMALL BROCHURE FOR THE USE OF NURSES, MIDWIVES, DOCTORS AND CHILD PROTECTION WORKERS, TO ENABLE CONVERSATIONS ABOUT FGM

these communities.

There are approximately 35,000 people living in Victoria who were born in one of the 29 countries where FGM is traditionally practiced (Costello et al. 2013).

Shepparton is now a leading destination point for new arrivals in Victoria who represent 10% of the locals population. The four main new arrivals (Afghan, Congolese, Iraqi and Sudanese) communities are from countries where FGM is practiced.

Recent research in Shepparton indicated the practice is an issue and community members advise that people travel overseas to access services.

Approach

In early 2015 a Family and Reproductive Rights Education Program (FARREP) Grant was received that enabled:

1. An educational workshop aimed at professionals who may come into contact with women, girls and families affected by FGM.
2. A community development and education program supporting bilingual workers/volunteers to provide education in their own languages.
3. The use of social media and other mediums to disseminate a range of resource materials to the target communities.

Outcomes

Increased knowledge by health professionals and community members with regard to:

1. Negative health impacts of FGM.
2. Legal issues/child abuse.
3. FGM is a cultural practice that dates back thousands of years.
4. Local access to reconstructive surgery.
5. Local access to specialist sexual health and reproductive services.
6. The negative impact of FGM on the woman during labour and child birth.

Betul Tuna is Project Worker, Ethnic Council of Shepparton & District Inc.

Suzanne Wallis is Rural Sexual Health Nurse Practitioner, Goulburn Valley Health, University of Melbourne, Department of Rural Health.

FEMALE GENITAL MUTILATION (FGM) HOW A GRANT HAS MADE A DIFFERENCE

Betul Tuna and Suzanne Wallis

According to the World Health Organization (WHO) sexual health is a state of physical, mental and social wellbeing in relation to sexuality. It requires

a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence (WHO 2018).

Female genital mutilation (FGM) is a practice that involves the partial or total removal of the external female genitalia for non-medical reasons. FGM does not have any health benefits, but may have significant short and long term consequences for the physical and mental health of women and girls (Vaughan et al. 2014).

Nurses and midwives are trusted health professionals who work with immigrant and refugee populations and they are in a position to make a difference to the health and wellbeing of women and girls in



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DR PRADITPORN PONGTRIANG (RIGHT)
AND WILAWAN MAKYOD (LEFT)

THE SIGNIFICANCE OF CONVERSATIONS AROUND SEX IN FAMILIES:

HIV PREVENTION FOR ADOLESCENT MALES IN THAILAND

By Praditporn Pongtriang and Wilawan Makyod

Young Thai males are at risk of contracting HIV. Better communication between family members about sexual issues could lead to HIV prevention.

A qualitative research study, which followed nine young Thai males in undergraduate study, focused on the ways in which the conversation around sex in families is important in preventing HIV.

Social and cultural norms

A representative reflection from one of the participants of the study addresses Thai society and culture and the way in which it influences communication about sex in the family:

"Thai society is considered conservative when it comes to the topic of sex, as people still believe that it's perversion. I feel that my parents brought me up in the Western way. However they will not speak openly about it. They still feel that it's inappropriate to speak with the general public about it. I feel that not many kids know how to use protection properly. This is due to our society that does not provide sufficient information on this issue and people are being told that it's a bad thing to do" (Case 2, 20 years old).

Social and cultural changes, as well as advances in communication technology, in the era of social

networking, have resulted in less communication among family members. Conversations regarding sex among family members is considered sensitive and difficult to communicate about. When sex is a forbidden topic of discussion, teenagers in the family usually search for information via the internet or their friends. This information might not always be correct.

Family roles

Another participant's reflection on the role of the parent and his solution for improving the situation is as follows:

"I think it's necessary because parents are closest to their own children and are the ones that can talk to them the most. However due to the social value, the parents are often feeling awkward when speaking about such topics. Some families do not have limit on which point they should stop or to carry on talking about it, while others might be more uptight. As for myself, the solution is for the parents to be informed about this. There might be meeting or training especially for parents. I think this should help one way or another.

It's not as if parents do not know what they should do, but there is the wall between them and their kids to stop them from being open" (Case 5, 22 years old).

This reflection highlights the importance of communication with parents around issues pertaining to sex. Parents should have the courage to communicate with their children on such topics to reduce the barriers between them. The ability to communicate with their children about sex will assist them to better understand their roles and will provide valuable education that will equip young people to more effectively manage issues and concerns relating to sex.

THESE BRIEF PRELIMINARY RESULTS HIGHLIGHT THAT SUPPORTING PARENTS AND ENCOURAGING THEM TO COMMUNICATE ABOUT SEX WITH THEIR CHILDREN IS A CHALLENGE IN THAI SOCIETY.

Thai society still clings to the idea that sex is a forbidden topic and should not be communicated among family members. There is a perception that conversations around sex will encourage teenagers to have premature sex (Sridawruang et al. 2010). On the contrary, conversations about sex could assist teenagers to learn about the topic informatively and assist in avoiding risky sexual behaviour (Fongkaew et al. 2012).

These brief preliminary results highlight that supporting parents and encouraging them to communicate about sex with their children is a challenge in Thai society. Public health agencies should play a role in supporting adjustments to the perception of parents and to encourage them to open up about sex and have the confidence to communicate with their children.

Dr Praditporn Pongtriang is based at Faculty of Nursing, Suratthani, the Rajabhat University, Surat-Thani, Thailand.

Wilawan Makyod is a registered nurse at Bangkok Hospital Surat, Surat-Thani, Thailand.



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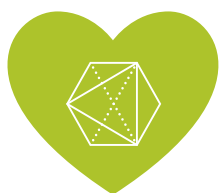
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www.acn.edu.au/membership #ACNtribe



APRIL

National Smile Day

1 April.
<http://www.humourfoundation.org.au/>

Conference - Cultural Competence and the Higher Education Sector: Dilemmas, Policies and Practice

4-5 April, University of Sydney's Charles Perkins Centre. <https://ncccconference.squarespace.com/>

Australian Resuscitation Council Advanced Life Support Level 1 course

8-15 April, Aboard the Royal Caribbean International Explorer of the Seas, seven nights from Sydney to the South Pacific. The course was developed for healthcare professionals in general practice, community health and ward-based facilities. You can also bring your family and friends – you'll have plenty of time to enjoy the ports and experience the onboard entertainment and activities. www.cruiseseminars.com.au/events/080418/

6th Rural and Remote Health Scientific Symposium

11-12 April, Hyatt Hotel, Canberra. <http://ruralhealth.org.au/6rrhss/>

2nd Advanced Nursing Science and Practice

Exploring latest advances in nursing science and practice
12-13 April, Hawaii, USA.
<http://nursingscience.nursingconference.com/>

National Advance Care Planning Week

16-22 April. Plan for tomorrow, live for today. Make your future healthcare preferences known. [acpweek.org.au or #acpweek18](http://acpweek.org.au/#acpweek18)

Lung Health Promotion Centre at The Alfred

Smoking Cessation Course

19-20 April

Respiratory Course

(Modules A & B)

30 April-3 May

Respiratory Course (Module A)

30 April-1 May

Ph: (03) 9076 2382

Email: lunghealth@alfred.org.au

2nd Advanced Nursing Science & Practice

Exploring latest advances in nursing science and practice
20-21 April, Las Vegas, Nevada, USA. <https://nursingscience.nursingconference.com/>

ANMF (Vic Branch) Health and Environmental Sustainability Conference

27 April, Melbourne Convention and Exhibition Centre, 1 Convention Centre Place, South Wharf Victoria. This Conference attracts up to seven hours of CPD, as required by the NMBA for registration renewal. <http://www.anmfvic.asn.au/events-and-conferences>

MAY

17th National Nurse Education Conference

Changing worlds: Synergies in nursing, midwifery and health education

1-4 May, Crown Promenade

Melbourne, Victoria.

www.dccconferences.com.au/nnec2018

Lung Health Promotion Centre at The Alfred

Respiratory Course (Module B)

2-3 May

Spirometry Principles & Practice

7-8 May

Asthma & Allergy Management Seminar

14 May

Ph: (03) 9076 2382

Email: lunghealth@alfred.org.au

Enrolled Nurses' Conference

3-4 May, Melbourne.

www.ausmed.com.au/course/enrolled-nurses-conference

Star Wars Day

May the 4th

International Day of the Midwife

5 May

7th World Congress on Breast Cancer

Pioneering spirit of enriching the lives and wellness of women

10-11 May, Frankfurt, Germany.

<http://breastcancer.conferenceseries.com/>

10th Australian Primary Health Care Nurses Association National Conference

Nurseforce for the future

10-12 May, Brisbane Convention and Exhibition Centre, Qld.

<https://www.apna.asn.au/>

7th World Congress on Midwifery and Women's Health

Caring women and newborns with skill and compassion

11-12 May, Osaka, Japan. <https://midwifery.nursingconference.com/>

International Nurses Day

Theme: Nurses A Voice to Lead – Health is a Human right

12 May. <http://www.icn.ch/publications/2018-nurses-a-voice-to-lead-health-is-a-human-right/>

4th World Congress on Midwifery and Women's Health

Caring women and newborns with skill and compassion

14-15 May, Singapore.

<http://midwifery.nursingconference.com/>

Global Experts Meeting on Neonatal Nursing and Maternal Healthcare

Novel advancement in neonatal nursing & maternal healthcare research

14-16 May, Singapore. <http://neonatal-maternal.nursingconference.com/>

National Dementia Conference

15-16 May, Melbourne.

<https://www.informa.com.au/event/national-dementia-conference/>

3rd World Congress on Nursing Practice & Registered Nurses

Hand in hand creating tomorrow: nursing practice, education and research

16-17 May, Montreal, Canada.

<https://nursepractitioner.nursingconference.com/>

3rd World Congress on Nursing Education & Research

Translate research outcomes into educational practice and policy

16-17 May, Montreal, Canada.

<https://nursingeducation.nursingmeetings.com/>

International Day against Homophobia, Transphobia and Biphobia

Theme: Alliances for solidarity

17 May.

<http://dayagainsthomophobia.org/>

Australian College of Dermatologists Scientific Meeting

19-22 May, The Gold Coast Convention and Exhibition Centre.

<http://www.adna.org.au/events/>

Inaugural Australian Clinical Supervision Association Conference

Clinical 'SUPER'vision – people, passion, purpose

22-24 May, ANMF House, 535

Elizabeth Street, Melbourne. Check out the conference hashtag at: #ACSA18

or <https://www.acsaconference2017.org.au/>

National Sorry Day

26 May

Anniversary of the 1967 Referendum

27 May

Reconciliation Week

27 May-3 June

Reconciliation Day

28 May

JUNE

Mabo Day

3 June

Lung Health Promotion Centre at The Alfred

Respiratory Update Seminar

4 June

Influencing Behaviour Change – a formula

14-15 June

Influencing Behaviour Change – Theory & Practice

14 June

Influencing Behaviour Change – Intensive Workshop/Case Studies

15 June

Paediatric Respiratory Update

21 June

Ph: (03) 9076 2382

Email: lunghealth@alfred.org.au

ANMF (Vic Branch) Annual Delegates Conference

28-29 June, Melbourne Convention and Exhibition Centre. This two day conference will focus both on exploring occupational health and safety issues for nurses and midwives as well as giving delegates the opportunity to vote on resolutions and help shape the direction of their union for the next 12 months. Registration is open to all current ANMF Job Representatives and Health and Safety Representatives. <http://www.anmfvic.asn.au/events-and-conferences>

JULY

Lung Health Promotion Centre at The Alfred

Smoking Cessation Course

26-27 July

Ph: (03) 9076 2382

Email: lunghealth@alfred.org.au

NETWORK

St John of God Hospital Ballarat Past Students reunion

14 April, Ballarat Golf Club. Contact Geraldine Vagg E: gerryvagg@hotmail.com or M: 0418 554 096

Alfred Hospital, Group AP87

31-year reunion

29 April, 12.00pm, Biricchino Café, 100 Scotchmer Street, Nth Fitzroy Vic. Contact Liz Crock E: lizcrock60@gmail.com or M: 0400 833 196

Royal Children's Hospital, Parkville, League of Former Trainees & Associates (including RCH graduate nurses) reunion, Luncheon, AGM, Guest Speaker

19 May, 10.30am for 11.00 am commencement, RACV Club, Melbourne. Contact Sally Mizrahi, Secretary E: sally0307@hotmail.com or Sue Scott E: sue.scott@rch.org.au or M: 0402 092 601 or <http://www.rch.org.au/loft/>

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

23 June. Contact Isabelle E: isabellehenry360@gmail.com

Alfred Hospital Group 3/85, 30-year reunion

20 October. E: cathie@coughlan.id.au or boxvale2@bigpond.com or perilloj@gmail.com

Royal Adelaide Hospital, Group 791, 40-year reunion

January 2019. Past Students register your interest to Margie Hayes (nee Kennedy) E: mdhayes@adam.com.au; Merridee Seiboth E: merridee.seiboth@health.sa.gov.au; Julie Schiller (nee Luders) E: julie.schiller@health.sa.gov.au



Email cathy@anmf.org.au if you would like to place a reunion notice

DISILLUSIONED BY REPORT ON PALLIATIVE CARE IN AGED CARE FACILITIES

I read the report on palliative care services in aged care facilities with grave disappointment as it places many generalisations on the provision of palliative care. Where are the figures in this report coming from? If it is from the ACFI claims as I suspect then the figures are not a true reflection at all.

Most facilities do not even bother trying to claim funding for palliative care unless there is a cancer diagnosis or death is imminent, as it is never supported when you are audited due to the wording being so grey.

No facility wants to have money taken off them so don't claim it even though they are providing the care for all residents which is technically palliative care. This is especially true for those with dementia, as they are suffering a terminal illness, but this is not recognised by the ACFI auditors who want complex pain management and unfortunately emotional distress does not count.

I am growing tired of reports being created by researchers who really have no idea of what the industry is facing.

We are all starting to become disillusioned with negative feedback especially from the media and continual knocking when we work so hard to provide excellent care with insufficient funding.

Cheryl Young RN, Victoria

DEVASTATED FOR AGED CARE

I was saddened to read in March's ANMJ about the conditions nurses and carers are forced to work under in aged care facilities. More so I am devastated for the residents.

I work in acute care, and while conditions can be tough, it would be unbearable not being able to give the care my patients deserve. The whole reason for being a nurse is because of the care that we give. It is why we have pride in what I do. It would be demoralising to practice under such conditions and a struggle to go to work every day.

I feel for all nurses and carers working in aged care. It is time aged care facilities and the government are made accountable for this atrocity that is occurring.

I commend the ANMF for lobbying the government to make meaningful change in aged care and I urge everyone to back the union on this to ensure it happens.

Kate Smith, RN Tas



GOOD JOB ANMJ

I have been meaning to write in for a while to commend you on the excellent job you have been doing in producing the ANMJ.

The balance of clinical, practical and news is spot on. Most of your articles are informative and thought provoking which helps keep me informed beyond the speciality that I work in.

Most importantly, I feel part of a larger community of nurses and midwives, which is integral to our professions.

Thanks for what you do and keep up the good work.

Tara Anderson, RN SA

FEEL FOR NURSES IN AGED CARE

I read with empathy and understanding the brilliant article written in the March 2018 edition of the ANMJ about RN Irene McInerney's experiences working in aged care.

Prior to my retirement in 2014, I worked in aged care and thoroughly agree with everything she said.

As Irene states there is not enough staff to do all that is expected of them.

You would love to be able to spend more time talking with the residents as this impacts on their self worth and wellbeing.

Residents do suffer malnutrition. Apart from some facilities not spending enough on food, staff need more time to assist

their meals as often some residents need a lot of encouragement to eat and drink.

I also think funding the aged care facilities receive is unfair. Facilities get some payment from either the residents, pension or superannuation funds. At the very least I think the interest paid to the facilities from the residents' bond money should be shared with the residents.

Pamela A. Miller, RN (Retired)



The winner of the ANMJ best letter competition receives a \$50 Coles Myer voucher. If you would like to submit a letter to the ANMJ email anmj@anmf.org.au Letters may be edited for clarity and space.



DISSEMINATING RESEARCH INTO THE REAL WORLD

One of ANMF's priorities this year is to boost its research capacity to provide better evidence to influence national health and aged care policy. The ANMF has appointed a National Policy Research Adviser, Dr Micah Peters to help deliver these outcomes. Natalie Dragon profiles Dr Peters and discovers his vision for nursing research.

'THE ANMF WOULD LIKE TO SEE MEMBERS ENGAGING IN RESEARCH AND DISSEMINATING THEIR KNOWLEDGE. NURSES CAN BE LEADERS IN RESEARCH AND EVIDENCE IMPLEMENTATION.'

The aim of research is having a real world impact, says ANMF's inaugural National Policy Research Adviser Micah Peters.

"I am passionate that underpinning clinical practice and decision making is the best available evidence to support effective, safe, affordable and appropriate care."

Dr Peters has led high-profile research projects, including for the Stillbirth Foundation Australia and internationally, as well as having undertaken reviews for the NSW and Victorian health departments. He worked at The Joanna Briggs Institute (JBI) and developed over 200 evidence based recommended clinical practice resources for clinicians.

Dr Peters cites helping a team of nurses in an oncology ward in Shanghai Cancer Hospital develop nurse led evidence based guidelines and strategies to improve outcomes for patients as one of his most rewarding research projects.

"Nurses were caring for patients receiving targeted therapies for cancer which had real side effects. Medical staff were not really managing the side effects or providing information to consumers. The culture in the healthcare system in China is very hierarchical with physicians at the top."

It was a double-edged sword says Dr Peters. Patients who experienced the worst side effects responded the best to the treatment.

"This often meant the treatment was reduced or stopped. Nurses were seeing this gap and identified the need for better management of skin toxicities."

Nurses worked with medical staff and implementation experts and developed evidence based guidelines for nurse led management of targeted therapies.

After three to four months, improvements included decreased incidences of skin toxicities and a reduction in severity of side effects. Patients were more likely to complete treatment. Nurses gained knowledge and confidence.

"It was fantastic to work with a team of nurses taking leadership and getting support from their medical colleagues. Nurses were taking such pride in their work, driving the change and owning it," says Dr Peters.

Dr Peters completed a Bachelor of Health Sciences majoring in psychology. His main interest was mental health, specifically eating disorders.

"I was going to be a clinical psychologist but was particularly inspired by the qualitative approach to research. Why people behave the way they do rather than the mechanistic biomedical approach."

What attracted Dr Peters to the ANMF was the opportunity to work more closely with nurses and midwives, he says.

"Working more closely with nurses and midwives and feeling the impact of their work in the real world. Nurses and midwives and patients are the experts in their own world view. I am not an expert in nursing, I do not have a clinical background. I offer a conduit and tool as a researcher and policy advisor in order to get to know their

perspective to help improve outcomes."

Dr Peters was an Associate Editor at the JBI and has published over 50 articles in peer-reviewed journals.

"There's a lot of focus on output in journal articles which take months, even years to come out. I think it's important to note that there's a lot of research out there, but also a lot of things we can do to get evidence into practice and policy more efficiently."

"There are other effective ways of embedding evidence based knowledge in practice; quality improvement projects do not always need ethics and research approvals."

Nurses as champions for evidence based healthcare

Building the research capacity of nurses and midwives is a key objective of Dr Peters' new appointment at the ANMF.

"The ANMF would like to see members engaging in research and disseminating their knowledge. Nurses can be leaders in research and evidence implementation."

"Look at your own particular workplace and context. Think critically and ask 'What we are doing' and 'why?' 'Maybe we are not doing it as well as we could be.'

"Analyse your context and situation and address those barriers that enable you to provide optimum care. You might talk to your nurse manager in the areas you think can be improved and identify any strategies to do that."

This could developing local resources, such as posters and information sheets, to offering in-service and workshops, says Dr Peters.

"Research supported by professional networks can come out in practical applications for everyday practice: best practice guidelines, information sheets; and resources."

Dr Peters says it's about sharing and disseminating practical knowledge and work among colleagues.

"Measure and evaluate how your activities have led to improvements and why. If not, analyse why you haven't had positive outcomes."

It's about engaging people so that the spread of our footprint, the dissemination of the work is put it out into the real world."

"Any improvements in practice in what you are doing can be shared with other nurses and colleagues who can read or hear about it in newsletters, or at conferences or in-service meetings. Those in a similar context who have the same problem can learn from strategies you've used."

Nurses are strong when they work together, says Dr Peters. It's also about looking for ways to partner with other clinicians, other specialties, researchers and evidence implementation experts, and consumers, he says.

"It's about communication and collaboration. A lot of important work is done in partnerships with nurses and other clinicians and some really passionate consumers engaging in healthcare."

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