

# ANMJ

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## ANMF PRIORITIES 2018

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## Editorial

Annie Butler ANMF A/Federal Secretary

Welcome not only to the first issue of the *ANMJ* for 2018 but also to my first editorial as A/Federal Secretary.

Late last year we said farewell to ANMF Federal Secretary Lee Thomas, who is currently seeing out her well-earned long service leave and will retire as federal secretary thereafter. We thank Lee for her years of service to the Australian Nursing and Midwifery Federation and wish her well in her newly chosen career of law, where we know she'll be a dynamo.

Lori-anne Sharp, who was the ANMF's Vice President, will now join the Federal Office as A/Assistant Federal Secretary. Along with the staff at the Federal Office both Lori-anne and I are excited and eager to meet the challenges that 2018 brings.

Already we have set a priority list of critical issues we plan to address. This list will be challenging but we are confident our goals are achievable for the benefit of nurses, midwives, carers, patients and the community.

On top of our list is to fix the crisis in aged care. We plan to launch an unprecedented national campaign in pursuit of ensuring funding is directed into care, legislated ratios and proper skills mix, to ensure missed care is a thing of the past and better conditions for aged care workers.

As we boldly raise awareness about these core issues, we will be putting politicians on notice to address this crisis immediately.

Campaigning about the adverse health impacts of climate change will also be high on the priority list for the ANMF. It is essential we transition to zero-emissions energy sources to avoid dangerous and irreversible

environmental and health impacts. Not only will we be lobbying politicians on this, but we will be calling on nurses and midwives to communicate with their communities and workplaces about climate and health and participate in the broader climate change debate.

To ensure the ANMF is placed as a key player in influencing the government's agenda in national health and aged care policy, we will be boosting our research capacity to provide better evidence. Our expanded research platform will include analysis of the impact of federal health and aged care policies, including workforce analysis, funding shortfalls and improving the capacity for nurses, midwives and carers to deliver the best care they can.

Throughout 2018 the ANMF will be supporting the Australian Council of Trade Unions (ACTU) national **Change the Rules** campaign to provide fairer working conditions. This includes a just tax system, protected penalty rates for nurses and midwives in all sectors and fairer rules for aged care workers.

Another major priority for the ANMF will be streamlining the way we communicate with members. We want to make news and information more accessible and relevant to the readership. This includes the *ANMJ* having a greater online presence through a digital news site, while reducing the frequency of the paper version of the journal. By introducing these changes we will continue to provide you with your favourite columns, as well as up to date real time news.

More details of all of these priorities can be found in this month's journal.

It is going to be a busy year for the ANMF but we are ready and willing to take on these challenges and any other issues that arise.

We look forward to working with you and for you as we grow from strength to strength as Australia's biggest union dedicated to nurses, midwives and personal care assistants.



Annie



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## ANMF TASMANIAN BRANCH MOVING FORWARD

Recently elected ANMF Tasmanian Branch Secretary Emily Shepherd is passionate about ensuring all nurses, midwives and care workers feel valued in their work.



"Ensuring that members interests across all sectors are represented equally is really important to me and will be a priority, as well as achieving positive outcomes for individual members and the wider nursing and midwifery teams into the future".

Ms Shepherd was elected ANMF Tasmanian Branch Secretary last November. A Registered Nurse (RN) with broad experience in the public, private and aged care sectors, she has worked across medical, surgical and oncology specialties, in education and leadership.

"Certainly, having an understanding of the public, private and aged care sectors has, and will continue to be, beneficial in the Secretary position particularly in being able to understand and effectively advocate for the individual nuances between the sectors."

Ms Shepherd, who has a Masters in Clinical Nursing and has worked as a Nurse Unit Manager, Clinical Nurse Educator and Clinical Facilitator, has a passion for nursing education, and safety and quality.

Following her time as an active Workplace Representative Ms Shepherd joined the ANMF Tasmanian Branch Council in 2012; and after 12 months became Branch President, a position she held for five years.

"Joining Branch Council was a culmination of a desire to combine my nursing experience with my passion for supporting my nursing colleagues, the

nursing and midwifery professions and most importantly fighting for transparency and equity in the Tasmanian health system," Ms Shepherd says.

Ms Shepherd was an active workplace representative in the public sector, at a time of massive state budget cuts.

"The government had demanded cost cutting and so the decision was made by management to close down a ward. It was a time of great uncertainty and everyone felt disempowered. Particularly those staff who were on fixed term contracts.

"However, at a time of turmoil ANMF along with staff were proactive and held a huge campaign and community rallies. Unfortunately, it didn't reverse the decision to close the ward but with the support of the ANMF it allowed all members the chance to have their voices heard and enabled the opportunity to pursue every avenue to stop the closures and support patient care."

As ANMF Tasmanian Branch President Ms Shepherd worked closely alongside the then Tasmanian Branch Secretary Neroli Ellis in lobbying federal politicians and "demanding that they listen to our members concerns".

"There was mixed opinions about the federal assistance package to Tasmania and politically it was a contentious issue.

"We really lobbied for an injection of funds for Tasmania's health system following

"CERTAINLY, HAVING AN UNDERSTANDING OF THE PUBLIC, PRIVATE AND AGED CARE SECTORS HAS, AND WILL CONTINUE TO BE, BENEFICIAL IN THE SECRETARY POSITION PARTICULARLY IN BEING ABLE TO UNDERSTAND AND EFFECTIVELY ADVOCATE FOR THE INDIVIDUAL NUANCES BETWEEN THE SECTORS."

the state budget cuts. It was a huge win which bolstered the Tasmanian health system."

Following the ANMF President role, Ms Shepherd took up an internal position as ANMF Professional Officer in 2016. She says during that time there were key wins for all nurses and midwives across all sectors, such as additional public sector beds, recurrent state funding for the John L Grove Centre and the retention of the Paid Parental Leave (PPL) scheme. Significant priorities across all sectors lie ahead, she says.

The ANMF Tasmanian Branch is currently consulting with members in the lead up to the new public sector Enterprise Agreement in March 2018. There is great concern that the state government's wages cap would continue with a 2% pay rise. "This would leave Tasmanian nurses and midwives by the end of the year the lowest paid in Australia, and the Tasmanian nursing and midwifery professions at risk," says Ms Shepherd.

There are already currently over 240 vacancies in the public sector. "In Tasmania recruitment and retention is absolutely essential to both the public and private health sectors. We want to keep our current nurses and midwives and recruit more graduates in Tasmania and even potentially from interstate."

The ANMF Tasmanian Branch also secured in principle agreement in 2016 from the state government to explore a nurse to patient staffing ratio model and remains a priority for the ANMF Tasmanian Branch to see this improved workload model implemented.

Similarly, workloads in the private sector are a predominant concern, says Ms Shepherd. "We want to ensure that there is appropriate levels of staffing that allows members to be able to deliver quality care."

Ms Shepherd said the Tasmanian ANMF Branch will be part of the Federation's national aged care campaign in 2018. "The Tasmanian ANMF Branch will be joining in the national campaign to ensure it is a federal election priority and that aged care is not ignored. The priority is for legislated mandatory minimum staffing levels across all of aged care and for greater transparency around funding. We need to offer the aged care workforce as much support as we can "as it is members desire in aged care to provide the highest level of quality care but it is incredibly challenging when you may be the sole RN for 80 residents and beyond."

## BULLYING COMMON AMONG NURSES SAYS RESEARCH

About half of hospital-based nurses have faced bullying in the workplace, with some going through the ordeal several times per week, a new Australia-wide study has revealed.

However, the problem was less prevalent in hospitals where managers displayed strong leadership typified by positive social behaviours and open and honest dialogue.

Undertaken by Professor Stephen Teo from Edith Cowan University's Centre for Work and Organisational Performance, the study found 48% of the 230 nurses surveyed had been a target of bullying in their workplace, while 59% recounted being a witness to bullying.

Of those who reported being victims of bullying, 39% encountered the situation from time to time, while 12% suffered the ordeal several times per week.

Professor Teo suggested the study's findings partly reflected the nature of the sector.

"In healthcare, those in charge usually make promotion choices based on a person's technical skills – related to treating patients – while soft skills such as managing people and relationships are secondary," Professor Teo said.

"The pressure of the medical field can expose weaknesses, so a manager may react abruptly and be snappy, and if that isn't addressed it can become normal.

"This has a trickle-down effect on how those around them act."

The research examined the impact of incivility, which Professor Teo said encompassed behaviours subtler than workplace bullying such as rudeness, creating feelings of exclusion, unfair work distribution and negative body language.

It found nurses who witnessed or experienced incivility were 52% more likely to suffer psychological stress, which can lead to health problems, turnover and decreased efficiency.

Yet in workplaces where line managers demonstrated authentic leadership, nurses' perception of incivility was 37.5% lower, helping to reduce stress.

"Authentic leaders model positive social behaviours while being self-aware and open and honest," Professor Teo said.

"They embody the organisation's professed values, even if they aren't perfect.

"Overall, our research suggests healthcare organisations need to put more emphasis on training to provide line managers with skills and tools to navigate the human side of work."

## 10 YEARS OF ETHICS AND LAW FOR ANMJ

2018 marks a decade of dedicated coverage to ethics and the law in the *ANMJ*.

Since the inaugural ethics and legal columns in 2008, they have informed, prompted letters, promoted discussion and fuelled debate. Our columnists have not shied away from the controversial, including the plight of refugees in detention, elder abuse, assisted dying, abortion, and climate change.

Of her almost 60 articles published, Professor Megan-Jane Johnstone, who retired at the end of 2017, considers amongst her favourites: 'Caring about the unbefriended elderly' (Apr 2014); 'Justice as a basic human need' (Sep 2009); 'On the matter of human kindness' (Feb 2010) and 'Moral panics and asylum seekers' (Sep 2015).

Legal columnist Professor Linda Starr says health has a higher profile in the media than ever before.

"It's bringing the reality of the potential for legal issues to mind for everyone. We also have a developing area in health law, and so there are always new and novel issues to address – like now we have euthanasia in Victoria, the new push for advance care directives, greater awareness of mental health issues associated with Ice and the law, and the increasing professional boundary issues and criminal matters involving practitioners – much more than we would have seen 10 years ago."

Standards of practice and the wide variation in what is seen as 'acceptable practice' is another issue, says Professor Starr. "Just looking at some of the Coroners' cases, there seems to be some complacency at times."

The columns have provided an opportunity to inform others of the issues that are occurring in health, according to Professor Starr who says she was both daunted and inspired when first asked to write for the *ANMJ*. "It has been a great privilege to write for the journal, something I have valued dearly."

"I hope the *ANMJ* and the ANMF have found the column worthy," Professor Johnstone said.

## AUSTRALIA'S FIRST POST-TRAUMATIC STRESS RESEARCH CENTRE LAUNCHED

The country's first Post-Traumatic Stress (PTS) Research Centre dedicated to improving the mental health of veterans has commenced in South Australia alongside the recently opened \$15 million Jamie Larcombe Centre.

The Australian Centre of Excellence for Post-Traumatic Stress gives researchers working on interventional therapies the chance to work closely with patients and staff.

It also provides an opportunity for local and international researchers to work collaboratively and undertake studies that will improve the health and wellbeing of veterans.

The new research centre is supported by The Road Home, an affiliate of The Hospital Research Foundation, responsible for raising awareness and funds to support health and wellbeing research and programs into conditions such as PTS experienced by the nation's veterans, emergency service personnel and their families.

The Jamie Larcombe Centre opened in November last year, named in honour of Sapper Jamie Ronald Larcombe, who was born in Kingscote, Kangaroo Island and was killed in action in February 2011, during a deployment to Afghanistan.

The Centre includes an ambulatory service incorporating outpatient treatment areas, 24 single rooms with private ensuites, consulting rooms and a gymnasium.

"Our veterans deserve nothing short of the best possible care and this new research initiative cements Jamie Larcombe Centre's reputation as a Centre of Excellence for Post-Traumatic Stress and other related conditions," SA Health Minister Peter Malinauskas said.

"It will allow clinical treatment and research activity to integrate, ensuring we continue to improve care, innovate and develop a best practice model for veterans' mental health."





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A 3-day program covering the latest advances in asthma care, management & delivery, enabling professionals to work effectively to improve health outcomes. (21 CPD hrs)  
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### Smoking Cessation Course

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19 – 20 April / 26 – 27 July / 15 – 16 November

### Spirometry Principles & Practice

This 2 part course is for individuals who want to be able to accurately perform & interpret spirometry tests. It comprises face to face training, written & practical assessment. (14 CPD hrs)  
1 – 2 March / 7 – 8 May / 13 – 14 August / 22 – 23 Nov

### Asthma & Allergy Seminar

This update is designed for health professionals who want to improve their understanding of & update their knowledge in the current management of asthma & allergy. (7 CPD hrs)  
14 May

### Respiratory Course

A 4-day program, split into 2 modules over a week, for those wanting to update & develop their skills & knowledge of respiratory care & the holistic management of respiratory illness. (28 CPD hrs)  
30 April – 1 May (Module A) / 2 – 3 May (Module B)  
20 – 21 August (Module A) / 22 – 23 August (Module B)

### COPD – from Diagnosis to Management

A 2-day course for health professionals to improve their understanding & knowledge best practice, diagnosis & management of COPD. (14 CPD hrs)  
8 – 9 March / 9 – 10 August

### Paediatric Respiratory Update

This update is designed for health professionals who want to improve their knowledge & skills in the current assessment and management of childhood respiratory illnesses. (7 CPD hrs)  
21 June

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## NEWS

### NURSE LED TRIAL TO IMPROVE PHYSICAL HEALTH OF MENTALLY ILL

A nurse led initiative aiming to improve the physical health of people with mental illness is being trialled in the ACT this year.

The three-year SYNERGY project, a partnership of the University of Canberra and ACT Health, will trial a Physical Health Nurse Consultant (PHNC) within the ACT Community Mental Health Service.

"It's a nurse led initiative assisting with improving the physical health outcomes with those diagnosed with mental illness," Project Leader University of Canberra Professor Brenda Happell said.

"Research shows the physical health in people diagnosed with mental illness is poorer than that of the general population, however there is not much around the solution."

Consumers of mental health services with psychosis were two to three times more likely to have comorbid cardio-metabolic illnesses such as heart disease, diabetes or stroke and die 10-25 years prematurely compared to the general population, Professor Happell

said. Despite this, they often received very low rates of cardio-metabolic care as part of standard care, she said.

The PHNC service was developed to provide a coordinated, nurse led intervention to improve physical health care, Professor Happell said. The service will be offered alongside usual mental health care.

The PHNC will provide cardio-metabolic assessment, risk management and care coordination. There would be a whole gamut of observations and assessment, including physical health and activity and diet, Professor Happell said.

"The intervention group will work positively with the physical health of people with mental illness. It's not a one-size-fits-all approach, people will have an individual plan around what might work best for them. If something hasn't worked for them, then we can look at what's happened and alternatives. If something has been helpful then we can further work on that. It's dynamic."

Professor Happell said she hoped the results of the project demonstrated the cost-effectiveness and positive outcomes of a nurse led initiative to improve the physical health of people with a mental illness.

"We will look for improvements or no further deterioration in physical health, for some that may be the best possible outcome."

The service will measure improvements in the burden of disease risk factors, consumer experience of care and cost-effectiveness.

The outcomes are also aimed to help inform health policy with the area outlined a priority issue for the National Mental Health Commission.

### MYEFO COULD DERAIL CAREER PATHWAYS OF FUTURE NURSES AND MIDWIVES

The next generation of nurses and midwives could find it harder to enter tertiary education or pay off their student loans earlier in the wake of Mid-Year Economic and Fiscal Outlook (MYEFO) papers released recently.

The warning issued by the ANMF is among a range of issues it believes could have a negative impact on the healthcare system, nursing and midwifery workforce and hip pocket of Australians.

"Higher education reforms could lead to capping student places without regard to workforce planning, especially in rural areas," A/Federal Secretary Annie Butler said.

"Nurses and midwives who are lucky



enough to graduate could also be hurt by the push for HEC repayments to kick in at \$45,000 instead of the current \$55,000 threshold."

Ms Butler said the federal government's bid to improve its bottom line would simply hurt those from lower socioeconomic backgrounds the most and inflate the poverty line.

"The Minister is also reaping savings from cuts to welfare payments and this is totally unacceptable while corporations continue to pay little or no tax," Ms Butler said.

"Further, using the Medicare Benefits Schedule Review to create savings has resulted in Australians paying more for their health from the start of this year, with no signs of changes to the Medicare Freeze."





## THOUSANDS OF AUSTRALIANS TAP INTO SUPER TO PAY FOR MEDICAL BILLS

A review of the longstanding rules governing early access to superannuation is underway amid release of new data showing a growing number of Australians are dipping into their retirement nest eggs to pay for medical procedures such as weight loss surgery and IVF.

People can currently tap into their super in order to assist with medical treatment, palliative care, modifications necessary for a family home or motor vehicle due to severe disability, and in the event of financial hardship including preventing foreclosure of a mortgage.

Over time, medical treatment has emerged as one of the leading categories for approving early release applications, with latest Treasury figures revealing 15,000 people dipped into their super to pay for varying procedures during 2016-17.

The Treasury review indicates a large number of recent applications stem from medical costs incurred because of weight loss surgery, with a smaller number attributed to IVF treatment.

From July to September 2016, about 56% of approved medical ground applications lodged were in order to undergo weight loss surgery.

Most applications approved were on the grounds the surgery would treat a life-threatening illness or alleviate chronic pain.

The spike in using super to pay for medical treatment is one of the core reasons behind the federal government's new review, which is examining current thresholds to determine whether the rules need tightening.

In the public spotlight, the issue has generated robust debate concerning what limitations should apply going forward.

Financial Services Minister Kelly O'Dwyer believes only Australians suffering severe financial hardship or a serious medical condition should gain access to early superannuation.

Other stakeholders suggest the rapid increase in the use of superannuation for medical treatment is a symptom of high out-of-pocket expenses and waiting lists and demands greater government health funding for these conditions.

ANMF A/Federal Secretary Annie Butler cautioned Australians looking to access their superannuation early for medical procedures to be mindful of the hidden costs and full

range of fees that may apply, as well as the financial impact on future retirement savings.

Ms Butler acknowledged the need for greater transparency surrounding medical costs but also raised the need for more funding towards preventative health strategies.

"THE REALITY IS THAT ACTUAL MEDICAL FEES FOR ALMOST ALL MEDICAL PROCEDURES FAR OUTSTRIP THE BENEFITS PAID BY MEDICARE AND EVEN WHEN PEOPLE HAVE HEALTH INSURANCE, THEY CAN STILL FACE GAPS OF THOUSANDS OF DOLLARS."

"The Medicare system is meant to ensure the community has access to quality and affordable healthcare contingent on clinical need. Unfortunately, high out-of-pocket medical costs have become the norm and we fully support trying to restore a level playing field."

Consumers Health Forum of Australia CEO Leanne Wells said the rising use of superannuation funds to meet high medical bills underlined genuine challenges facing the system.

"High out-of-pocket costs, running into the thousands of dollars for many patients, are contributing to the widening gap of two-tiered medicine where access to medical treatment is dependent on your means rather than need.

"The reality is that actual medical fees for almost all medical procedures far outstrip the benefits paid by Medicare and even when people have health insurance, they can still face gaps of thousands of dollars."

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## VICTORIA PASSES VOLUNTARY ASSISTED DYING LAWS

Victorians living with a terminal illness will have the right to end their own lives legally from 2019 after the state's Parliament passed historic legislation late last year.

Approved last November following weeks of tense debate that sparked several amendments, the Voluntary Assisted Dying Bill will come into effect in June next year following an 18-month implementation period to ensure a robust system is put into operation.

To be eligible to access the new law a person must be over 18, have lived in

Victoria for at least a year and be diagnosed with a terminal disease causing intolerable suffering that is expected to cause death within six months.

Amendments to the Bill included people with a mental illness needing to see a psychiatrist before using the law and informing the coroner of voluntary assisted dying deaths.

The Australian Nursing and Midwifery Federation (ANMF), together with the ANMF (Vic Branch) have long campaigned for voluntary euthanasia laws that give people suffering terminal illnesses the right to choose to die with dignity in a manner acceptable to them.

ANMF A/Federal Secretary Annie Butler commended the Victorian government for listening to the community and health professionals at the centre of the complex ethical debate.

"Politicians have shown courage and compassion in supporting laws that will give terminally ill Victorians who make a voluntary assisted dying request greater control in shaping the end of their lives with the

protections and safeguards they need.

"Victoria marks the first state to pass voluntary assisted dying laws and the ANMF is confident it can pave the way for similar legislation across Australia in the near future. Every Australian deserves access to the same choice when it comes to deciding the timing and manner of their death."

The new legislation is the result of almost three years of extensive consultation and engagement with politicians, the community, health professionals, and legal sectors, including the Parliament's Legal and Social Issues Committee's Inquiry into End-of-Life Choices and the Expert Ministerial Advisory Panel.

ANMF Victorian Branch Secretary Lisa Fitzpatrick said the new law had listened to the voices of dying Victorians and has the support of most nurses.

"This has been a difficult ethical debate and while the majority of our members support terminally ill Victorians' right to choose voluntary assisted dying those who don't will be able to conscientiously object to any involvement."

## AUSTRALIANS PAY TRIBUTE AND CALL FOR NATIONAL GAYLE'S LAW

A groundswell of community support has followed the passing of *Gayle's Law* in SA Parliament with many Australians calling for the federal government to enact similar national legislation.

Under the new SA legislation, a two-person minimum is mandatory for after-hours callouts to prevent remote area nurses from working alone.

Community and nurses and midwives took to social media after Gayle's husband, Keith Woodford posted on online petition website Change.Org on 20 December.

"The family are pleased that Gayle's Law will now be implemented here in South Australia. We now hope the federal government takes note."

Mr Woodford extended an emotional heartfelt thank you to the Australian community.

"We would sincerely thank all those who have helped make this possible. There are a lot of people behind the scenes that have worked extremely hard and we are grateful."

South Australian Labor MP and former RN Annabel Digance, and strong



advocate for the new law, took to Twitter to congratulate the family.

"Gayle's Law just passed in Parliament of South Australia – all tribute to Keith Woodford for your commitment and legacy in Gayle's memory."

Many Australians followed suit in paying tribute to Keith Woodford and his family.

"A true injustice that Gayle paid with her life, for a protection that should come before the tragedy. That her family tributes her by channelling their grief into making substantive and permanent change hopefully eases some of their pain. Congratulations," Cassandra Barford wrote.

"So sorry for your loss but you have now helped keep other RANs safe," posted Helen McNiven.

"May the dreadful thing that happened to Gayle, be prevented from ever happening again by this law," wrote Barbara Vincent.

It is more than a year since remote area nurse Gayle Woodford was murdered. Many in the community expressed sadness

and anger that such a tragedy occurred.

"It's taken a long time to implement what should have been done automatically in place for nurses like Gayle. Nurses... have a right to be protected when going about their work," Irene Hudspeth wrote.

Federal Health Minister Greg Hunt indicated broad and unanimous support for *Gayle's Law* in other states and territories after the last COAG Health Ministers' meeting in November. Many Australians called directly on the federal government to introduce national law to protect RANs.

Audrey Aspelting worked as a RAN in WA and SA, said she was devastated by what happened to Gayle. "Thank you to all who helped get this law passed and hopefully this can be done throughout Australia because this is vital to those who live in the outback."

"This should be law throughout Australia. Everyone should be entitled to a safe workplace no matter where that is," posted Sue Sutherland.

"Come on Commonwealth MPs. No excuses acceptable. Sussan Ley failed, you need to remedy this situation," wrote Adrian Bell.

However remote area health organisation CRANApplus CEO Christopher Cliffe told the ANMJ late last year that any one piece of legislation was unlikely to fix the problem. A wide range of strategies to address the complex issue was required, he said.

RN Rachel Quayle recently did a placement at Imanpa, NT.

"There were no callouts unless an Elder, or a community representative attended as well. This way the community also takes responsibility for the safety of the nursing staff."



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# NURSES UNITING TO BETTER HEALTHCARE GLOBALLY

By Annie Butler,  
A/Federal Secretary

The Australian Nursing and Midwifery Federation (ANMF), along with three of its branches, the ANMF Victorian Branch, the Queensland Nurses and Midwives' Union (QNMU) and the New South Wales Nurses and Midwives' Association (NSWNMA), are founding members of Global Nurses United (GNU).



5TH ANNUAL MEETING OF GNU



QUEBEC NURSES PROTESTING

Formed in 2013 by 14 nurses' and healthcare workers' unions across the world, the GNU's stated aims are to unite in the fight against austerity measures, privatisation and cuts to health services; to fight for universal healthcare as a human right for all; safe patient care; mandated safe nurse-to-patient ratios and safe healthcare workplaces.

Today, GNU is now made up of 21 member countries: Australia, Brazil, Canada, Costa Rica, Dominican Republic, Guatemala, Greece, Honduras, Ireland, Israel, Kenya, New Zealand, Paraguay, Peru, Philippines, South Africa, South Korea, Spain, Taiwan, United States and Uruguay.

On behalf of the ANMF, NSWNMA Assistant General Secretary Judith Kiejda and I attended the 5th annual meeting of GNU, hosted by the Fédération

Interprofessionnelle de la Santé du Québec (FIQ) in Quebec, on 1-2 December 2017.

At this meeting we discussed progress on critical issues and re-affirmed our commitment to economic and social justice, our opposition to the adverse effects of income inequality, poverty, maldistribution of wealth and resources, attacks on public workers, and the ravages of climate change.

Together, the GNU members considered the devastating impacts of climate change and environmental degradation for our patients and our practice around the globe. The World Health Organization currently estimates more than seven million people worldwide die every year from air pollution while the number suffering the effects of droughts, extreme temperatures, increases in vector-borne diseases, flooding, rising sea levels, bushfires and 'super' storms is growing exponentially.

We agreed climate change and environmental degradation currently posed a grave threat to public health, which requires an urgent and a radical response. We resolved to advance the following collective agenda:

- raise awareness of the environmental/ climate emergency among our members and in our communities, with an emphasis on public health;
- engage our organisations and involve our members in local, regional and national campaigns for environmental and climate justice;
- build alliances and stand in solidarity with frontline communities, including indigenous peoples and right to culture;
- continue to support climate 'first response' work in the aftermath of extreme weather events; and
- engage in international forums and campaigns as GNU to elevate the progressive voice of nurses, build international solidarity, and collectively demand climate action at the inter-governmental level.

Workplace violence against nurses, the attack on nurses' rights to organise and bargain effectively and the fight for optimal nurse staffing for safe patient care were also main topics for discussion. All GNU member countries grapple with these issues, many dealing with much worse situations than those we face in Australia.

I reported on the progress we had made on these issues in Australia. This included Victoria's 10 Point Plan to End Violence and Aggression; the achievement of legislated ratios in Queensland, Victoria and in NSW's public health system nurses' and midwives' Award; and, while under considerable recent attacks from conservative governments, the right for nurses and midwives to organise and bargain through their union.

As I gave my report and listened to the reports from other countries, I had cause to reflect on how significant nurses' and midwives' achievements in Australia have been, and how fortunate, living in this country, we are.

Many other countries face situations that,

truly, we can't even begin to imagine. In some Central and South American countries, they have nurse-to-patient ratios of 1:20, 1:30 and even 1:40 in their major acute hospitals. They deal with horrific levels of violence both within their communities and directed at healthcare workers – Guatemala reported five nurses and doctors had been killed in their main emergency department because a member of an organised crime gang was being treated in the department. Many reported they were under threat of physical violence from their own governments for being union leaders and activists defending the safety of their patients.

Honduras was not able to attend the meeting because of the terrible situation in their country, but the GNU signed a statement of support denouncing the violent repression of the Honduran people by the armed forces and military police following a presidential election in late November.

The 'elected' administration had abolished hard-won labour rights of public sector nurses with the intention of limiting their ability to care and advocate for their patients with deleterious impacts on the health of Hondurans. Dozens of human rights defenders including nurses protesting these threats to Honduran health and democracy have been killed in targeted assassinations.

Listening to these accounts, including the struggle US nurses have with Trump seeking to remove Obamacare and nurses in Quebec being threatened with dangerously low staffing in their mental health units, I wondered what contribution I could possibly be making to improve their situations.

Though, I must admit when I reported on Australia's situation in aged care, there were much stronger parallels with the stories of many other countries.

I had cause to reflect again – just how shameful our aged care situation is. That we could be treating our elderly so disgracefully in a country as fortunate as ours, so safe and prosperous, where nurses and midwives are genuinely setting the benchmark for the rest of the world in terms of the delivery of safe and quality care. I was reminded – we still have much to achieve.

My GNU colleagues were interested in this, although, comparatively, we have achieved so much, Australian nurses, midwives and carers still have work to do. They were interested in understanding how we had achieved staffing ratios, safer workplaces, and stronger union rights and how we intended to pursue further achievements. I realised this was the contribution we, the ANMF, could make.

By sharing our successes and how we achieved them, especially the struggles it took, and standing in solidarity with our global colleagues we could aim to make improvements for nurses and midwives everywhere.

Because that is our aim as a member of GNU, to confront and work to overcome our challenges at a local level and to support our international colleagues, especially those less fortunate than ourselves, to do the same to make a global difference.





## SHARING SKILLS AND TRAINING IN A DEVELOPING COUNTRY

By Sally Hogan

**After winning a trip to Mentawai Islands through a charity auction we eagerly decided to add to our holiday adventure by teaching basic first aid to some of the locals who were learning English.**

My partner (Gav) is a retired paramedic, an avid surfer and has considerable water rescue experience. I am a registered nurse; currently teaching in the Bachelor of Nursing at Griffith University and we both hold advanced First Aid and Certificate IV TAE qualifications.

Our adventure began from the Gold Coast where we flew to Padang via Kuala Lumpur and caught the fast ferry (3 ½ hours) to the Mentawai Island of Sipora.

On arrival the first thing that hit me was the motorised scooters that transport everyone and everything. Road rules give way to some sort of understanding of etiquette creating organised chaos to the eyes of the newcomer.

The second thing that profoundly struck me was the plastic rubbish littering every street, beach and natural waterway. Plastic bottles, plastic thongs, plastic wrapping, every imaginable plastic item litters this beautiful paradise. I had to remind myself that we were not here to solve all of the problems that erupt as western culture invades the developing east.

Meeting us in Sipora for our volunteering experience was Karen and Tom who ran the Perfect Wave Foundation Education and Conservation Centre in the small village of Mapaddagat.

Two of the main challenges at this village

we experienced but also anticipated were cultural and language differences.

Poor health remained an issue on this island with tuberculosis and malaria high on the list of common illnesses.

Food was cooked using open flames and hot oil and village life remains primitive comparative to Australia.

The local health clinic, run by approximately 30 nurses and three doctors, provided immunisations, maternity and early childhood care as well as some emergency care. There is still a considerable belief in black magic and evil spirits which impacts on the local understanding of illness and the need for treatment by western medicine.



We travelled with a basic CPR mannequin (pictured above) who came to be known as Harry by all of our students. We were able to teach basic first aid (relevant to the local community and available supplies) and CPR to eight young adult students of the education centre and seven of the nursing staff from the health clinic. Gav also taught basic first aid and surf safety and rescue to six of the young local surfers.

Karen assisted with translation for the English students, as we do not speak Indonesian. Two of these students then translated for the other two classes, proudly demonstrating their ability to speak and understand English and their excellent comprehension of the first aid concepts we

had taught.

While the heat was oppressive, the classroom boasted three fans and the students eagerly participated in the practical CPR training.

I was interested to hear from the nurses at the clinic that they were taught basic First Aid and CPR in their nursing course in Padang, but did not update their skills or knowledge thereafter. They expressed surprise when I told them that all Australian nurses needed to refresh their CPR skills every year.



The local clinic has minimal supplies and basic sterilising equipment. Single use, disposable items would be of little benefit to this community, as they have no way of disposing of rubbish beyond burning in open fires. This was a timely reminder that as health professionals, we have to view the whole picture and consider financial cost as well as environmental cost when introducing modern medicine to the developing world.

These trips are not for the faint hearted or the ill prepared. Conditions are primitive (we were excited to have a western toilet), there is no hot water, the food is very basic, water must be boiled before drinking, malaria and dengue are a genuine risk in the wet season and there is no internet access.

It is oppressively hot and everyone works to island time. However, the people are incredibly friendly and welcoming, our room was simple but clean and comfortable and we had one of the most relaxing yet rewarding weeks of our life.

We thoroughly enjoyed our interaction with the community and hope that we may have had a small, positive impact on health outcomes.

The public health and sanitation issues are well beyond two travellers on a one-week trip and all praise goes to Karen and Tom and others who make this their life. The feeling of giving back, even just a little is something that must be experienced to be understood.

We hope to go back next year and would encourage any other health professionals to consider an immersion trip, sharing their skills with those in developing cultures.

**Sally Hogan, RN is a Lecturer in the School of Nursing and Midwifery at Griffith University in Qld**



**Andrew McCarthy**  
Federal  
Industrial  
Officer



## DOMESTIC VIOLENCE LEAVE – WHAT ARE THE ENTITLEMENTS?

One in three women experience family and domestic violence. ABS figures show that two thirds of the 400,000 plus people (mostly women) who experience domestic violence each year are workers.

Family and domestic violence is the greatest preventable contributor to death, disability and illness among women aged 15-44 years, greater than cancer or heart disease, yet Australian workers have limited access to family violence leave. Domestic and family violence is the principal cause of homelessness for women and their children and the estimated cost of family and domestic violence to the economy is \$12.6 billion per year.

In July 2017 the Fair Work Commission (FWC) decided to create an entitlement to unpaid family and domestic violence leave in awards, which provide minimum wages and conditions for employees (including nurses) across Australia.

**WITHOUT PAID LEAVE, WOMEN ARE FORCED TO CHOOSE BETWEEN THE FINANCIAL SECURITY OF THEIR PAID EMPLOYMENT AND THEIR ABILITY TO UNDERTAKE THE ACTIVITIES ASSOCIATED WITH MAKING SAFE ARRANGEMENTS FOR THEMSELVES AND THEIR CHILDREN.**

The decision came as a result of a union campaign, led by the Australian Council of Trade Unions (ACTU), for a paid entitlement. Domestic violence leave has only relatively recently become a condition of employment for some employees, with unions pushing for and obtaining the entitlement in particular workplaces through enterprise agreements, and some companies introducing it via

policy. The entitlement has however been patchy, hence the union claim to make it a community standard.

The ACTU claim was for 10 days paid family and domestic violence leave to be included in all awards and to apply to permanent and casual employees. The tribunal rejected the claim for paid leave however formed a provisional view that awards should include an unpaid entitlement.

The decision importantly recognised the pervasiveness of family and domestic violence and the devastating effects it has on those experiencing it. It accepted the ACTU's argument that family violence is a social and workplace issue with widespread impacts, that it disrupts workforce participation, that it disproportionately affects women and that it requires a workplace response. It found that lack of family and domestic violence leave leads to financial hardship, job insecurity and ultimately safety risks for families and people affected. The Commission also applauded the ACTU for being an agent of 'social utility'.

The FWC found that workplace rights must keep pace with community expectations and that domestic and family violence leave should therefore be part of the safety net of minimum conditions for employees across the country.

A disappointing aspect of the decision was the failure to provide for paid rather than unpaid leave. Employer groups had opposed the union claim, and the decision was not

unanimous with one tribunal member rejecting the claim.

At the time of writing, the Commission is yet to hand down a further decision on the details of the entitlement including the amount of leave that will be available and the circumstances in which the entitlement will arise. For example leave may be required to attend court appointments, meet with lawyers, arrange alternative housing or make care arrangements for a dependant.

Since the decision, the union movement has also commenced a campaign to obtain *paid* leave directly through the legislated National Employment Standards, which currently provide for other minimum entitlements such as annual leave, personal leave and redundancy.

Paid leave is necessary because of the economic costs imposed on those who experience family and domestic violence. Without paid leave, women are forced to choose between the financial security of their paid employment and their ability to undertake the activities associated with making safe arrangements for themselves and their children. For working people who are living with violence, paid domestic violence leave is important at several stages. It is necessary while they are living with violence (before they leave), at the time they make the decision to leave and after a person leaves a violent relationship. In fact the ability to take time off work can be a major reason why a person makes the decision to leave.


The federal ALP and Greens have both recently announced that they support legislating 10 days of paid leave and the Greens will soon introduce a Bill into Parliament implementing this. At the time of writing, the Coalition government has made no commitment to supporting paid leave.



Further detail on the union campaign to obtain paid family and domestic violence leave can be found here:

[www.facebook.com/AustralianUnions/videos/1705504652881484/](https://www.facebook.com/AustralianUnions/videos/1705504652881484/)





**Brent Lang**  
Clinical Nurse Manager  
Royal Darwin Hospital

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ANNIE BUTLER A/FEDERAL  
SECRETARY AND LORI-ANNE SHARP  
A/ASSISTANT FEDERAL SECRETARY



## ANMF PRIORITIES 2018

# TIME FOR ACTION

As 2018 moves into full swing, the Australian Nursing and Midwifery Federation (ANMF) is poised to tackle wide-ranging issues confronting the health and aged care sectors that directly impact nurses, midwives and carers as well as the broader community.

Chief among this year's priorities sits fixing the mounting crisis in aged care, in addition to advocating and protecting the nursing and midwifery professions, championing societal issues such as climate change and maintaining and strengthening the ability of the nursing and midwifery workforce across all levels to practise to their full scope and provide quality care.

Crucially, the ANMF will fight to improve a declining aged care sector and launch a powerful and defining national campaign demanding legislated ratios.

As the biggest union in Australia with a growing membership of more than 270,000, the ANMF represents a dedicated and resilient workforce and is committed to safeguarding the professions well into the future.

Late in 2018 ANMF's Federal Secretary Lee Thomas stepped down to pursue a career in law but is starting the year seeing out her well earned long service leave.

Annie Butler takes the helm as Acting Federal Secretary, supported by newly appointed Acting Assistant Federal Secretary Lori-anne Sharp; with the pair now spearheading

the union's leadership arm moving forward following backing at a recent meeting of the ANMF's federal executive.

Queensland-based nurse Sally-Anne Jones maintains her role as ANMF Federal President.

Ms Butler said the year ahead presented numerous challenges as the union strives to draw attention to critical issues and lead the way in demanding change through targeted campaigns.

"As the country's largest union the ANMF is once again primed to use its voice to improve the working lives of nurses and midwives and drive better health outcomes for the broader community," she said. "The political landscape changes frequently but the collective capacity of the ANMF is equipped to confront and deal with current and emerging challenges facing our professions."

The 2018 priorities include:

- Aged care: safe staffing
- Health impacts of climate change
- Making things fairer: Change The Rules
- Influencing national policy
- Better communication with ANMF members



# AGED CARE

The crisis facing aged care has undoubtedly reached breaking point.



ANNIE BUTLER AT THE BUPA AGED CARE RALLY IN MELBOURNE LAST YEAR

Over time, a lack of accountability within the aged care sector has resulted in for-profit providers allowing sub-standard care in a bid to maximise profits.

The ripple effect has created a state of play where aged care workers across the country are increasingly fighting an uphill battle to provide the level of expert care their elderly residents require and deserve.

Under the current Aged Care Funding Instrument (ACFI) model, aged care providers receive funding based on the assessed care needs of their residents, within a range of categories.

About 70% of the funding aged care providers collect comes from the taxpayer, with the remainder generated by resident fees.

But, the system lacks transparency making it unclear if funding is being used to meet the needs of residents or being siphoned into profits.

Already in a number of aged care facilities across the country nursing hours have been significantly cut resulting in dangerously low staffing and subsequently missed care.

Fighting back, the ANMF Victorian Branch took unprecedented action against aged care provider Bupa aiming for better pay and conditions and ultimately better staffing across its nursing homes in Victoria during their enterprise bargaining negotiations.

However, A/Federal Secretary Annie Butler said the only way to ensure funding is directed into care is to make ratios in aged care law.

"Without legislated ratios in aged care, there's nothing to ensure aged care providers such as Bupa are complying with guidelines to provide the level of service they sign up for. Taxpayers' money is being squandered and inadequate care means our most vulnerable residents are sadly suffering due to the pursuit of profit margins."

Despite a plethora of reviews and Inquiries examining the aged care sector over the past two decades no genuine action has been taken to address the issues, Ms Butler said.

The inaction has also remained despite the ANMF actively lobbying governments and key decision-makers to deal with the problem instead of shifting blame and responsibility.

At the 13<sup>th</sup> ANMF Biennial National Conference in Hobart held in October last year, delegates unanimously passed a resolution calling on the union to bring aged care to the fore as a key strategic national priority.

The plan underscored the need for a nationally steered aged care campaign demanding legislated ratios, proper skills mix and fair pay and working conditions for those working in the sector.

On the back of the delegates' resolutions, the ANMF will be launching its critical campaign to address these core issues.

"We are going to take this aged care campaign to a whole new level to ensure action is taken before more damage is done," Ms Butler said.

"The campaign, will involve raising awareness about core issues and putting politicians on notice that enough is enough for once and for all."

Ms Butler said the ANMF had collected solid evidence underlying why aged care is failing and put forth strategic solutions required to trigger meaningful change.

She said the ANMF plans to add to its body of research by examining the money trail behind aged care funding and seeking accountability. "We need to know where the money is going and aged care nurses and their residents definitely need to know," Ms Butler said.

"If the money is not going to care then where is it going?"

"We need to be sure that our money, taxpayers' money is spent on safe quality care for our elderly."

Ms Butler said the government must work with the ANMF to find solutions to fix the sector. "A meaningful aged care strategy can only occur utilising the knowledge of nurses and carers at the coalface of aged care."

# MAKING THINGS FAIRER: CHANGE THE RULES

In 2018, the ANMF is supporting the Australian Council of Trade Unions (ACTU) national 'Change the Rules' campaign that aims to address inequality by pushing for amendments to the Fair Work Act and shifting power back to working people



ACTU SECRETARY SALLY  
MCMANUS



Launched last year, the campaign seeks to bring together all Australian unions in a bid to change the rules and bring fairness back to the nation's workplaces so unfair laws can no longer hold everyday working people to ransom.

The campaign draws attention to widespread inequality, a broken tax system that rewards big business, employers deliberately underpaying workers, weak industrial rights, rising insecure work arrangements, abuse of the temporary overseas working visa system, and concerns over the restrictive rules surrounding enterprise bargaining often used to exploit workers.

The campaign also addresses cuts to penalty rates for 700,000 hospitality and retail workers and raises genuine fears the attacks will extend to other industries such as nursing and midwifery in the near future.

The campaign reveals thought-provoking evidence that paints a bleak picture illustrating how far the pendulum has swung in favour of big business.

Evidence includes:

- income inequality is greater than any time in the past 76 years;
- in 2014-15, the top 10 companies that paid no tax at all had a combined revenue of \$33 billion;
- too many hurdles involved in industrial action, with employers able to threaten heavy penalties while workers can do little to stop them;

- widespread wage theft across Australia, including one third of workers being underpaid super entitlements;
- restrictive rules around enterprise bargaining, with bosses increasingly exploiting them by employing tactics including outsourcing, offshoring, terminating agreements and avoiding paying fair wages;
- penalty rates cuts for 700,000 hospitality and retail workers, with some losing up to \$77 per week;
- the increasing casualisation of the workforce, with employers using insecure work arrangements to improve their bottom line;
- the gender pay gap stubbornly hovering between 15 and 19% for the past two decades; and
- the government refusing to ensure job opportunities for local workers while allowing dodgy employers to exploit overseas workers.

Many of the issues targeted in the 'Change the Rules' campaign mirror resolutions endorsed by ANMF delegates at the union's 13<sup>th</sup> ANMF Biennial National Conference last year.

This includes to maintain the fight to protect penalty rates for nurses and midwives in all sectors; to campaign for a fairer tax system; and perhaps, most of all, to 'change the rules' for aged care for our nurses and carers working in the sector and

mostly for the residents living in aged care.

ANMF A/Federal Secretary Annie Butler said the union stood together with the ACTU and unions across Australia in fighting to turn the tide back in favour of the worker.

"The ANMF fully supports the 'Change the Rules' campaign and we are confident it can ultimately lead to fair and decent working conditions for all Australians," Ms Butler said.

"The current system is flawed and unfair. The rules must now be re-written to ensure working people regain their rights and power is taken back from employers driven by boosting profits.

"I call on all nurses and midwives to join the fight in bringing fairness back. Change doesn't come easy but with collective action real progress can be achieved."



[www.australianunions.org.au/  
change\\_the\\_rules](http://www.australianunions.org.au/change_the_rules)



# HEALTH IMPACTS OF CLIMATE CHANGE

Treatment of climate change-related health conditions are adding to the burden of an already stretched healthcare workforce.



Nurses, midwives and aged care workers contend with the increasing fallout of bushfires, heatwaves and floods. Unprecedented incidents last year included the thunderstorm asthma event in Victoria and the 'Ash Fly Crisis' in South Australia.

"Nurses and midwives and assistants in nursing are increasingly concerned about the health implications of climate change and global warming," says ANMF A/Federal Secretary Annie Butler.

"These adverse climatic conditions continue to pose significant risk to the health and wellbeing of the community, particularly in those who are most vulnerable like the elderly and Indigenous people in remote and rural areas."

The 2017 Biennial National Conference (BNC) requested that Federal ANMF continue to campaign about the adverse health impacts of climate change and the need to transition to zero emissions energy sources urgently to avoid dangerous and irreversible impact on the environment and health.

The BNC called on Federal ANMF to advocate for a meaningful and consistent renewable energy target such as Victoria's 40% renewable target by 2025 to meet Australia's Paris commitment to limit global warming to 1.5 degrees or well below two degrees.

Australia only ratified its commitment to reduce its emissions to 26-28% on 2005 levels by 2030, in 2016. The UN's Sustainable Development Goals will be extraordinarily difficult to meet given the apathy to date of countries to act swiftly,

according to climate experts.

In the latest blow, the Turnbull government recently scrapped the Clean Energy Target (CET) which the ANMF warns will lead to an increase in carbon emissions.

"This means that Australia will now struggle to achieve its Paris targets under the new National Energy Guarantee, putting the health of all Australians further at risk," says Ms Butler.

Ms Butler says it was shameful the government capitulated to conservative climate-change sceptics and walked away from plans to cut emissions from the CET.

"The politically motivated policy move to support coal fired power at the expense of support for renewable energy risks causing further harm to our community's health."

Both the federal and Queensland governments' support for the \$16.5 billion Adani Coal Mine in the Carmichael Basin has drawn widespread condemnation from not only green activists and high profile Australians but growing community opposition nationally.

The ANMF has called on the government to focus on a genuine emissions reduction scheme through the greater use of renewables.

While Australia lacks a national strategy on climate change, all three major political parties jointly hosted the launch of a proposed framework for a national strategy last year. It was followed by a health leaders roundtable convened in October.

Any national strategy will need to support nurses, midwives and assistants in nursing to implement sound and viable

climate change initiatives, says Ms Butler.

"As the largest component of the healthcare workforce, they are at the forefront of providing care to communities affected by climate change.

"Nurses and midwives are well placed to develop policy and influence practices in their workplace to improve energy and water efficiency, procurement and waste management practices."

The ANMF Victorian Branch Health and Environmental Sustainability conference held in Melbourne in 2017 showcased the efforts of health services and individual nurses and midwives to reduce their environmental impact. Individuals and organisations' strategies include: energy efficiency; water and waste management; recycling, including PVC; use of solar PV; and service procurement and design.

The ANMF supports the Global Green and Healthy Hospitals (GGHH) worldwide network for the health sector to reduce its environmental impact. Globally there are almost 800 members with a reported 25,000 hospital and health services signed up.

Nurses and midwives are in a position of advocacy - to communicate within their communities and their workplaces about climate change and health, says Ms Butler.

"As members of the community, nurses, midwives and assistants in nursing need to participate in the broader climate change debate, using their networks to communicate with politicians, the media and the community on the importance of reducing carbon emissions."

## INFLUENCING NATIONAL POLICY

The ANMF will boost its research capacity in 2018 to provide better evidence to influence national health and aged care policy and to deliver better outcomes for our members and our communities.

An expanded research platform will include analysis of the impact of federal health and aged care policies, including on workforce, funding and the capacity for nurses and midwives to deliver the best care they can, Ms Butler says.

"We want to evaluate the impact of current policies in health and aged care; and contribute to and influence new national policy."

The ANMF will do this by building policy research networks and collaborations with major stakeholders including developing relationships with research institutes, think tanks, policy makers, government departments and other organisations, Ms Butler says.

"We want to be seen as a key player in influencing the government's agenda in health and aged care.

"We will do this by providing rapid responses to critical reviews and put forward our own evidence to support the nursing and midwifery professions in government consultations, submissions and roundtables."

The ANMF aims to develop a broad program of health and aged care research in population and public health, health systems, workforce planning and reform, safety and quality, clinical practice and patient outcomes.

"We want to build a resilient, sustainable and collaborative nursing, midwifery and aged care workforce," Ms Butler says.

"We want a health system that supports nurses, midwives and aged care workers to deliver high quality care and that is adequately resourced."

Research conducted by the ANMF has bolstered the union's position on penalty rates, paid parental leave and conditions in aged care.

The ANMF's national workforce survey in aged care this year revealed the true extent of cuts to care hours in residential facilities nationwide.

The ANMF National Aged Care Staffing and Skills Mix Project was the first of its kind in Australia, which collected evidence that demonstrated the need for a staffing methodology that considered both staffing levels and skills mix for residential aged care.





# BETTER COMMUNICATION WITH ANMF MEMBERS

The ANMF will streamline its communications in 2018 to make information and news more accessible and relevant to the membership.



The ANMF's flagship publication the *ANMJ* will undergo a revamp in response to the members' needs gauged through a survey late last year.

In line with the ANMF's policies on sustainability and reducing its environmental imprint, the *ANMJ* will move to fewer hard copies. The move will be supported with a new online digital presence, says Ms Butler.

"The *ANMJ* has already been free online since last February making it more accessible for all members," says Ms Butler.

"The ANMF is now keen for improved online delivery of the *ANMJ* through a digital news site. A digital website will allow for breaking news and ANMF updates to members as the frequency of the *ANMJ* is reduced."

The member survey revealed the majority of you read the *ANMJ* and that you would like to see more nursing and midwifery related news, healthcare news and tips to help you in the workplace.

"You told us how busy you are and you want more timely information. – and we are responding," Ms Butler says.

The *ANMJ* will continue to provide industrial, professional, clinical and education articles relevant to the nursing and midwifery professions. In between, more immediate and 'snack-able' content will be available online to members.

"This is an exciting time for us to provide more timely information to our members as well as move forward with how our members want to access their *ANMJ*," Ms Butler says.



# USE OF POINT OF CARE OUTCOMES DATA FACILITATES QUALITY IMPROVEMENT IN PALLIATIVE CARE

Sarah Aranha, Claire E Johnson, Jane Healey, Pippa Blackburn, Sam Allingham, Ann Yeomanson and Margaret Bird

## Overview

The Supportive and Palliative Care Unit (SPCU), Eastern Health is the largest in-patient palliative care unit in Victoria, with 32 beds and a diverse interdisciplinary team.

The unit provides specialist palliative care for an average of 800 patients with a life-limiting diagnosis annually. In 2016, the Supportive and Palliative Care Unit (SPCU) at Eastern Health identified an opportunity to review the SPCU's clinical assessment processes and utilise the benchmarked reports provided by the Palliative Care Outcomes Collaboration to report patient outcomes.

The Palliative Care Outcomes Collaboration (PCOC) is a national, voluntary quality improvement program that supports individual person-centred care through point-of-care data collection.

Regardless of the care setting, patient measurements define the quality of care. PCOC supports continuous improvement in palliative care through using standardised, validated, clinical assessment tools to systematically measure, report and benchmark patient and family outcomes (Clapham and Holloway, 2014).

Patients are systematically assessed using five assessment tools:

- the Palliative Care Phase (PC Phase)- a measure of the clinical need of the patient and their family and carers (Masso et al. 2015);
- the Palliative Care Problem Severity Score (PCPSS) - clinician assessed severity of problems in each domain (ie. pain, other symptoms, psychological/spiritual and family/carer) (Masso et al. 2016);
- the Symptom Assessment Scale (SAS) - used to capture the patient's perspective on the degree of individual symptom distress (Aoun et al. 2011);
- the Resource Utilisation Group Activities Daily Living (RUG-ADL)- measures motor function with activities of daily living (ie. bed mobility, toileting, transfer and eating) (Fries et al. 1994), and;
- the Australian Karnofsky Performance Scale (AKPS)- overall performance or ability to manage activities of daily living (Abernethy et al. 2005).

Each service collects and reports data biannually to PCOC and receives a consolidated report of outcome measures for the preceding six months. Reports describe how each service has performed against nationally agreed benchmarks to help identify areas where improvements are needed (Currow et al. 2015). PCOC provides training in the use of the tools and support services to embed their use in routine practice. A quality improvement facilitator helps services to interpret their reports and respond to the issues raised.

A PCOC quality improvement facilitator, working collaboratively with the SPCU in April 2016, provided structured feedback on benchmarking outcomes from the 2015 reports. Four areas for improvement were identified:

- levels of distress across three indicators (pain, dyspnoea, family/carer stress);
- discord between clinician and patient rated scores of key symptoms;
- higher than average rate of deaths outside the terminal phase; and
- inconsistent application of clinical tools.

Although the SPCU had been undertaking clinical assessments for more than four years using the tools provided by PCOC, there were several process issues identified in relation to the way in which the assessments were conducted, data were entered and a lack of interdisciplinary engagement with the use of PCOC assessments (nursing led). Nursing staff had completed education during the initial implementation of PCOC into the service, though no ongoing education had occurred for either nursing or interdisciplinary staff. This in turn led to assessments being undertaken inconsistently. The PCOC assessments and language were not embedded throughout the interdisciplinary team and the focus was to collect and enter the data rather than using the clinical information the assessments provided, in real time, to inform and plan patient care.

The SPCU leadership team identified that there needed to be a shift in focus for staff to understand the clinical assessment tools, and have systems and processes in place to use the information these assessments provided to plan care and improve outcomes. A further requirement was for the systems and processes used to collect and record the assessment for benchmarking purposes to be enhanced to improve data integrity.

The SPCU responded by planning a quality improvement project which aimed to embed the PCOC clinical assessments throughout the interdisciplinary team. An important factor was to improve clinician knowledge and use of the assessment tools across the interdisciplinary team and to integrate these assessments into clinical practice to facilitate decision making and care planning. It was anticipated that these changes would lead to improved patient assessment, earlier recognition of changes in patients' condition and prompt action to manage moderate or severe symptoms for our patients and their families.

## Method

The SPCU leadership team used a PDSA (plan, do, study, act) continuous improvement methodology to implement changes (Gillam and Siriwardena 2013). The work was further enabled by a connection with a formal inter-professional project to revise the SPCU model of care that was occurring simultaneously. The project was guided by use of 'A3' process improvement tools, (Kimsey 2010) as well as Eastern Health's improvement methodology and performance excellence systems. The Model of Care project's scope extended to all phases of the inpatient journey, and included:

1. access
2. initial needs identification and assessment
3. consent and goal-setting
4. care-planning and implementation
5. transition and discharge



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The Model of Care project provided an environment in which all clinical processes and tools across the whole inpatient journey were under simultaneous inter-professional review. This meant that changes to workflows that would enhance the use of PCOC assessment could be built-in to all aspects of the new model, including incoming referral management systems, the unit's daily timetable, clinical care forms, clinical meeting formats, and task delegations.

The SPCU leadership team identified the following areas for improvement and implemented changes in a stepped process over a period of months.

1. Data entry was reallocated to administration roles instead of clinical team members. Education was provided to administrative staff to ensure consistent practices in data entry. Real-time data reviews by nursing management were introduced to ensure clinical assessments were in keeping with the patient symptoms and phase of care.
2. There was a refocus on education and training of all staff about the purpose and intended clinical use of the PCOC assessments, and to ensure all staff were confident in conducting and using the PCOC assessments to plan clinical care. This included a full PCOC training day for nursing staff and biannual PCOC training requirements being incorporated into position descriptions to emphasise the expectation to regularly undertake refresher training. All other staff were offered the opportunity to attend a PCOC training day, as well as shorter in-services within the SPCU run by the collaborative quality improvement team.
3. The structure and frequency of SPCU clinical meetings was identified as an area for improvement as part of the unit's Model of Care A3 project. Team meetings were held weekly, all patients were discussed, using a team meeting tool that had been implemented prior to the unit undertaking PCOC assessments. The interdisciplinary team identified the strengths and weaknesses of the current process and collaboratively redesigned the ward meeting schedules (changed to bi-weekly) and clinical documentation tools. The new regimen was pilot-tested and revised (PDSA method). The newly designed team meeting tool incorporated reviews of patients' function and symptoms as assessed by the PCOC tools and assisted in decisions to refer to

allied health. PCOC assessments were further embedded at the daily inter-disciplinary clinical handover where informal care planning was undertaken. Patients' phase of care and any moderate or severe symptoms were identified to prioritise clinical care. A particular focus was to identify patients who were receiving terminal care, with staff empowered to change a patient's phase of care when a patient met the clinical criteria for this change.

4. Clearly defined escalation pathways for moderate or severe symptoms were developed and introduced. The PCOC assessment tools were augmented to provide suggestions for clinician interventions and an escalation pathway to medical (including after hours) and allied health staff when primary interventions did not improve symptoms.
5. The consultant roster was restructured so that there was a senior medical presence six days each week to support the recognition of and responsiveness to patients with complex or uncontrolled symptoms.

The implementation of changes were discussed weekly by the SPCU leadership team and at the Model of Care project meetings by the wider inter-disciplinary team. These meetings focused on reviewing and revising the clinical meeting tools and the development and pilot testing of a symptom assessment and management tool with defined escalation pathways. Staff were encouraged to provide feedback via a 'feedback' log or face-to-face with the SPCU leadership team. The PDSA cycles continued over 12 months, with modifications occurring throughout this period.

Patient outcomes were reviewed six-monthly with the receipt of a consolidated report from the PCOC program. Here we report the changes in PCOC results against the 12 benchmarks and the patient and clinician-reported case-mix adjusted outcomes (ie. patients in the same phase who started with the same level of symptom referenced to the baseline national average as at Jan-June 2014) prior to intervention and eight months post-intervention. Case-mix scores greater than zero indicate outcomes better than the national reference period (Eagar, Green, and Gordon 2004). The 12 benchmarks identified by PCOC are:

**BM 1.** Timely admission to service: 90% of care commences the day of, or the day after the person is ready for care.

**BM 2.** Responsiveness to urgent needs: 90% of patients who are in

an unstable condition only remain unstable for three days or less.

**BM 3.** Change in symptoms and problems-

- 3.1 90% of patients with absent or mild pain (clinician rated) at the beginning of a phase, pain remains absent or mild at the end of the phase.
- 3.2 60% of patients with moderate or severe pain (clinician rated) at the beginning of a phase, pain becomes absent or mild at the end of the phase.
- 3.3 90% of patients with absent or mild distress from pain (patient rated) at the beginning of a phase, pain remains absent or mild at the end of the phase.
- 3.4 60% of patients with moderate or severe distress from pain (patient rated) at the beginning of a phase, pain becomes absent or mild at the end of the phase.
- 3.5 90% of patients with absent or mild distress from fatigue (patient rated) at the beginning of a phase, distress from fatigue remains absent or mild at the end of the phase.
- 3.6 60% of patients with moderate or severe distress from fatigue (patient rated) at the beginning of a phase, distress from fatigue becomes absent or mild at the end of the phase.
- 3.7 90% of patients with absent or mild distress from fatigue (patient rated) at the beginning of a phase, remains absent or mild at the end of the phase.
- 3.8 60% of patients with moderate or severe distress from breathing problems (patient rated) at the beginning of a phase, distress from fatigue becomes absent or mild at the end of the phase.
- 3.9 90% of patients with absent or mild family/carer problems (clinician rated) at the beginning of a phase, family/carer problems remain absent or mild at the end of the phase.
- 3.10 60% of patients with moderate or severe family/carer problems (clinician rated), at the beginning of a phase, family/carer problems become absent or mild at the end of the phase.

## Results

Between January and June 2015, the SPCS cared for 400 patients and families, compared to 330 in the same period in 2017. The average length of episode was 12.3 days in 2015 compared to 11.5 days in 2017. Patient characteristics post-intervention were similar to those prior with the exception that fewer patients had a cancer diagnosis in the



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**Table 1: Patient characteristics in January to June 2015 and 2017**

	Jan – June 2015		Jan – June 2017	
	n	%	n	%
<b>Age (years) (by episode of care)</b>				
<55	21	(4.7)	24	(6.2)
55-64	51	(11.4)	40	(110.3)
65-74	98	(21.8)	83	(21.3)
≥75	279	(62.1)	243	(62.4)
<b>Country of Birth (by patient)</b>				
-Australia	250	(62.5)	214	(64.3)
-Other	150	(37.5)	119	(35.6)
<b>Diagnoses (by patient)</b>				
-All malignant diagnoses	298	(74.5)	228	(68.5)
-Stroke	14	(3.5)	5	(1.5)
-Cardiovascular disease	2	(0.5)	19	(5.7)
-Respiratory Failure	1	(0.3)	22	(6.6)
-Other non-malignant	81	(20.4)	64	(19.2)
<b>End of episode mode (by episode)</b>				
-Death	280	(65.0)	246	(66.1)
-Discharge to community	136	(31.6)	118	(31.7)
-Discharge to another hospital	3	(0.7)	8	(2.2)
-Discharged to acute care	11	(2.6)	0	(0)

NB: Some patients had more than one episode of care

2017 period (table 1).

Prior to the intervention, the SPCU met one of 12 PCOC benchmarks, ie. timeliness of care, where 90% of patients must have their episode commence on the day of, or the day following date ready for care. Post-intervention, the SPCU met nine of the 12 PCOC Benchmarks (table 2).

The extent of improvement varied between symptoms. Both clinician-rated and patient-rated concerns improved for all items with the exception patient-rated nausea (casemix adjusted) (figure 1).

### Discussion

Using a plan, do, study, act quality improvement methodology, the SPCU made important changes to the work structures and conducted targeted education about the use and embedding of clinical assessment and escalation pathways into routine practice. This which resulted in improvements in patient and clinician-reported symptom outcome measures - achieving the national benchmark for nine of 12 nationally reported measures where they had previously met only one

benchmark.

This project resulted in significant changes in the way the PCOC program was viewed and used in the SPCU. Throughout the implementation of changes, staff were engaged to provide feedback. As with any PDSA cycle, the implementation on one change may have an intended or unintended consequence to other processes in place. The main challenges posed were around moving the benchmark data entry from clinicians to administrative staff, which meant that



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**Table 2: Met and unmet benchmarks in January to June 2015 and 2017**

BM Ref	Outcome measure	Jan – June 2015		Jan – June 2017	
		%	BM met?	%	BM met?
1	Timeliness of care	98.8	Yes	96.6	Yes
2	Response to urgent needs	75.8	No	96.8	Yes
<b>Anticipatory care (absent / mild remaining absent / mild)</b>					
3.1	Pain (PCPSS)	88.3	No	93.8	Yes
3.3	Pain (SAS)	84.7	No	94.1	Yes
3.5	Fatigue (SAS)	82.2	No	94.2	Yes
3.7	Breathing problems (SAS)	95.4	No	96.2	Yes
3.9	Family / carer (PCPSS)	89.9	No	96.6	Yes
<b>Responsive care (moderate / severe becoming absent / mild)</b>					
3.2	Pain (PCPSS)	53.8	No	65.3	Yes
3.4	Pain (SAS)	49	No	56.8	No
3.6	Fatigue (SAS)	35.1	No	57.2	No
3.8	Breathing problems (SAS)	36	No	56.2	No
3.10	Family / carer	45	No	64.7	Yes

BM: Benchmark



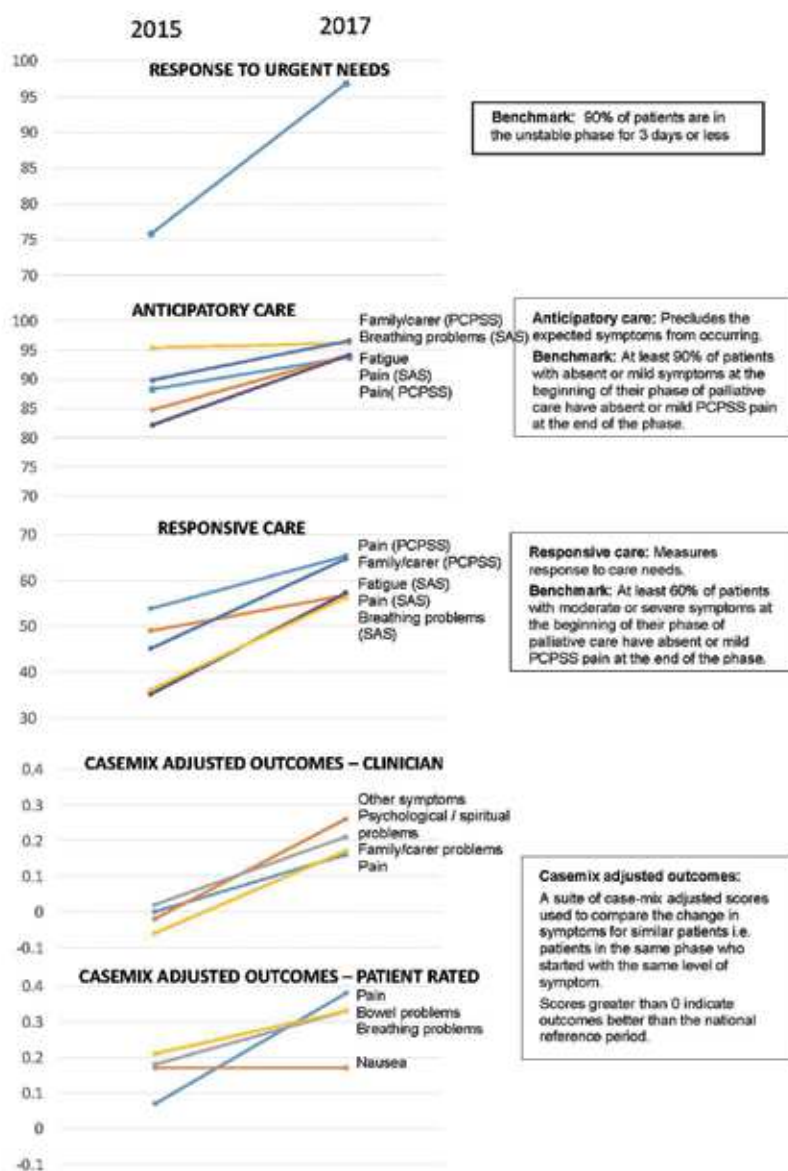


FIGURE 1: THE PERCENT OF PATIENTS MEETING BENCHMARKS AND CASEMIX ADJUSTED CLINICIAN-RATED AND PATIENT-RATED OUTCOMES BETWEEN JANUARY TO JUNE IN 2015 AND 2017

data cleaning at the point of entry was lost. However rather than this being a barrier, it became a strong determinant in embedding the review of PCOC assessment in clinical meetings which in itself provided many benefits.

Healthcare services are expected to prioritise continuous service improvement in order to ensure safe and effective patient care and therefore patient outcomes (Australian Council on Healthcare Standards (ACHS) 2012).

Outcome measurement has a major role in describing patient populations and the efficacy of interventions, as well as improving the quality, efficiency and availability of palliative care. Measuring outcomes strengthens the learning capacity of services and organisations through identifying areas for improvement and performing

meaningful and targeted quality improvement activities. Justifying continuation or expansion of services to secure resources for current and emergent needs can be informed by descriptive data and outcome measurement. When used in conjunction with clinical processes of care and existing statistics on expenditure, outcome measures can inform government policy on achieving better value care (Bausewein et al. 2011; Coulter 2017; Selman and Harding 2010). There is a growing international trend towards the need to develop and analyse comparative outcome measures to guide health reform. The *Next Generation Health Reforms [2017]* statement by Health Ministers from the Organisation for Economic Co-operation and Development (OECD) ratify this trend (OECD Health Ministerial Meeting 2017).

Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREM's) are recognised as the "new currency for comparative performance assessment..." and "...may have an even more important role in clinical care" (Coulter 2017, pp 2).

The PCOC program has enabled the palliative care sector to measure trends in patient outcomes in Australia since 2009. There has been a consistent improvement over time in patient outcomes, timely access to palliative care services (in community, inpatient and consult settings) and improved family and carer outcomes (Currow et al. 2015). During July to December 2016, 113 palliative care services throughout Australia participated in PCOC of which 83 services provided care in an inpatient hospital or hospice such as the SPCU at Eastern Health. This project demonstrates how a mature palliative care service can use regular patient reported outcome measures to inform their service development and quality improvement.

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## DIGNITY AND RESPECT IN AGED CARE

The Australian Nursing and Midwifery Federation's Aged Care Training Room (ACTR) recently added a much-anticipated topic to their suite of learning activities – **Dignity and Respect in Aged Care**. This topic addresses: the principles of Consumer Directed Care (CDC), the rights of older people as members of society, and how healthcare workers can support and provide dignity in the provision of care of older people.



The tutorial discusses older peoples' right to independence; their right to choice and decision-making and how to support the older person receiving aged care services to make a complaint. The following is an excerpt from the tutorial.

Dignity and respect must include; emotional support and sensitive care in service delivery such as understanding the impact of loss and grief and the adjustments the older person must make. The planning of service delivery, management of client

information and trust and reliability are all components of providing dignity and respect to your older clients.

Diversity in relation to protection from discrimination, the diverse needs of clients such as their preferred areas of interest, relationships and social engagement, sexual identity and cultural and linguistic diversity are vital components of providing care based on dignity and respect of the older person.

Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) people are now included

as a special needs group under the Aged Care Act. The National LGBTI Ageing and Aged Care Strategy and changes to the Sex Discrimination Act provide clear information about aged care workers' obligation to provide inclusive, safe and appropriate care and services that best meet the needs of older LGBTI people.

Similarly, many aged care clients come from diverse cultural and linguistic backgrounds. Often they will have strong beliefs, customs, traditions, culture and

religion. The freedom to have beliefs, practice religion and be part of the culture of your choice is a basic human right according to the Universal Declaration of Human Rights. This tutorial helps to give understanding to aged care workers of how best to support clients to remain involved in their beliefs.

For far too long aged care services have made assumptions about what may be of interest or enjoyment for their clients. This tutorial will assist you to work with your clients to support their involvement in activities of their choice, even though some may include a level of risk.

### Sensitive care and service delivery

Chronic illness and disability are risk factors for depression and anxiety disorders. Your client's emotional or mental health needs should be included in their initial assessment and be part of ongoing care.

Having to accept help with personal care, home care or other activities can often cause distress. Your client, carer and others in their lives may show a range of emotions including anger, sadness and fear when help is required.

Your client's emotions, way of thinking and behaviour at this time may be very concerning for them and others. In the early stages of assessment, care planning and receiving care may require minor or major adjustment for your client. You need to think about how your client is coping with needing help. They may be relieved and very happy to get some help. They may feel embarrassed and believe that needing help means they can no longer care for themselves. It is normal for new clients to feel grief as they adjust to the loss of health or ability and coming to terms with needing help, care or assistance.

Emotional support is a very important part of your client's care at all times. Their mental health and feelings of self-worth, can be promoted through respectful interactions and a professional relationship.

Try and imagine what it might feel like if you could no longer look after yourself and do things how and when you used to.

Your health problems make you feel weak and you are often in pain. Most things that you want to do have to be planned. You need other people to take you places at the times that may not always be best for you.

Your family have other commitments (kids, jobs) and they can't give you all of their time. They feel guilty and you feel lonely. You can no longer do the things you used to enjoy.

Then, the decision is made that you need to accept home care and other community services. You are not happy with this. It makes you feel embarrassed and angry. You think about how hard you have worked in your life and everything that you have been through, but you know that without some help, your health will get worse.

Let's imagine you overhear your family talking about 'nursing homes'. All you can think of is your best mate, your dog. You

wonder if you could go on without him/her. However, you feel like you have no choice but to accept some help.

Now, the home care and support you have been receiving are no longer adequate to meet your needs and you will be going to live in an aged care facility. It makes you feel embarrassed and angry. All you can take with you is a small piece of furniture, some photos and a few personal belongings. The only facility available is a 50 minute drive from your family!

Older people often say they are 'overwhelmed' by their feelings of grief.

Everybody feels grief in their own way, there are no rules about how you should feel or how long the feelings will last.

Your client may show feelings of sadness and be withdrawn. They may have feelings of anger or their behaviour may seem to be demanding. Their family may not understand what is happening and react in ways that are not helpful for your client.

### You can help your client by:

- being patient;
- giving them the chance to talk about thoughts and feelings but also respect they may want to keep their feelings private;
- explain many people feel confused, upset or even angry about having to accept care and services; and
- giving carers/family and others time to talk. They may also be feeling grief. It is common for carers and family to feel guilty about not being able to provide all the care that is needed for their loved one.

Your client/carer's emotional needs should also be considered when making assessments in planning care.

### Simple questions like:

"How can we best help you" or statements like: "People often feel frightened or upset when they can't do all the things they used to be able to do" may help.

Your clients' need to be reminded that it is their right to get the help that they need in the way that is best for their physical and mental health.

If your client knows about their right to privacy and confidentiality they will be more likely to tell you what they really think and feel.

### Emotional support can be offered by:

- involving your client in every part of service or care planning;
- finding out about the things they really like or enjoy, and their dislikes;
- finding out about special needs and making sure that services are inclusive and do not discriminate based on a person's identity, culture, religious beliefs and practices, language, customs, family traditions and rituals; and
- ask permission from your client to pass on information to your supervisor if you think it will improve the quality of their life and care.



## 30 MINUTES CPD

Reading this excerpt 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 client's to receive the care they want and the care they need.

This tutorial is available on the ANMF ACTR website via an annual subscription (over 60 aged and community care specific courses) for ANMF, NSWNMA and QNMU members as well as non-members. The ANMF Continuing Professional Education (CPE) website will soon offer this course and others as part of a new section for aged and community care healthcare workers.

If you have any questions please contact us via [education@anmf.org.au](mailto:education@anmf.org.au)

> [anmf.org.au/cpe](http://anmf.org.au/cpe)







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**Megan-Jane Johnstone is a retired Professor of Nursing who now writes as an independent scholar. Internationally renowned for her work, she has published extensively on the subject of nursing ethics and is the author of the widely acclaimed book *Bioethics: A Nursing Perspective*.**

## NURSING, ETHICS AND THE MEANING OF LIFE

In 2012, Brighton based Vasey RSL Care in Melbourne identified that 67% of its residents felt their lives 'lacked meaning and purpose' (O'Keeffe 2016, p38). It further identified that the residents' perspective was due largely to their experiences of loss (eg. of home, neighbours, job, ways of caring for family) following their admission to the facility.

Recognising the need to do something about this situation and improve residents' quality of life, a new lifestyle program was developed. Drawing on the views of residents, which identified various types of meaning and purpose (eg. achievement and contribution, involvement, freedom, expression and wisdom), the program offered a range of activities designed to meet residents' need for a meaningful life. Introduced over an 18 month period, by 2016 the percentage of residents feeling despondent had reduced significantly to 10%, with 90% of residents being able to identify and engage with more than eight types of meaning and purpose activities (O'Keeffe 2016).

### A question of nursing ethics

Aged care residents are not the only ones who may question the meaning and purpose of their lives. Others across life's spectrum may also find cause to ask 'What's it all about?' especially when facing the tragedies and travesties of life eg. the death of a loved one, losing one's job, being diagnosed with a life-threatening illness, being prematurely coerced into early retirement, losing faith in God. Yet, even in the most challenging of circumstances, people do somehow manage to cultivate meaning in their lives. But what is a 'meaningful life'? And why does such a question merit attention by the nursing profession?

### Meaning of a 'meaningful life'

Attempts to answer questions concerning life's meaning have invariably turned on questions like 'Around what purposes should I order my life?' 'What confers value on my life?' and 'What makes my life worthwhile and not irredeemably futile' (Seachris 2013, p4). These queries have led to a further set of related yet distinct philosophical questions eg. about human existence, the value, worth and significance of life generally – particularly in the face of our inevitable mortality (Klemke 2000; Seachris 2013).

In attempting to answer these

PEOPLE ARE LONGING FOR GENUINE MEANING AND PURPOSE IN THEIR LIVES BUT DO NOT KNOW WHERE TO LOOK FOR IT.

'big life questions', it is generally contended that the meaning of and in life encompasses at least two conduct guiding categories: *happiness* (self-interested concern for one's own flourishing) and *morality* (other-interested concern about human welfare and wellbeing, eg. 'making the world a better place to live in'). Some contend, however, that *meaningfulness* is neither of these things since neither are reducible to morality or happiness (one can be happy yet not have a meaningful life). Wolf (2010), for example, contends that what underlies *meaningfulness* is that which is achieved through the personal fulfillment of something *one deeply cares about* both at a subjective and objective level (termed respectively as 'the Fulfilment View' and 'the Larger-than-Oneself View'). She contends that while happiness and morality can work successfully as guiding categories for a 'good' life, the inclusion of *meaningfulness* as a third category will enable moral goals to be achieved more often (Wolf 2010).

### Relevance to nursing

Questions concerning the meaning and purpose of life are fundamental to the profession and practice of nursing in several ways.

Most notably they underscore the need to explore and understand what it is nurses should care about and why eg. what goals the profession should pursue, why the ethical responsibilities of nurses matter (eg. to promote health, prevent illness, restore health, and alleviate suffering), what makes the profession's projects worthwhile, why life matters, what makes life valuable, what makes life meaningful,

what makes life meaningless (eg. is it necessarily a life of 'endless purposeless'?), what attitudes should we have toward the prolongation or willful ending of life, in what sense do those wishing to die have 'nothing to live for'?

### The importance of purpose

Questions concerning the meaning of and in life cannot and should not be ignored. The need for meaning and to have a purpose in life is not some fluffy ill-defined unscientific fancy. Rather, as researchers are finding, having a purpose – a sense of direction in life informed by one's core values functions by making a person's life worth living and, in turn, guides their daily behaviour (Burrell 2017, p30).

Having a purpose has also been found to influence health outcomes in unique ways – including reducing depression, reducing the risk of heart attacks, promoting resilience in the face of adversity, and even increasing longevity.

### The failure of education

In recent decades subjects and modes of teaching that would otherwise offer students the opportunity to explore life's big questions have been gradually squeezed out of nursing curricula to make way for the ideals of research driven practice and the courses they inform. This has left graduates of nursing programs under-prepared for responding appropriately to the fundamental questions raised by the conundrum of life's meaning and the implications that answers to this conundrum might have for the nursing profession. It has also left nurses and their ideals vulnerable to being hijacked for political ends – the presumed justification of nurses' support for euthanasia is an example.

In several respects we currently find ourselves living in an age characterised by a crisis in meaning. People are longing for genuine meaning and purpose in their lives but do not know where to look for it. Perhaps the first step is to fully engage with the big questions of life and sincerely examine the things that *really matter* and what it *really means* to authentically live a meaningful life.



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## STUDY WILL ASSESS HEALTH AT CONCEPTION AND RISK OF DISEASE

Pregnant women and those planning a pregnancy are being encouraged to take part in a NSW study looking at whether the first 1,000 days of conception influence the risk of developing chronic disease in later life.

The BABY1000 study – Before, during and beyond the baby years study is being conducted by the University of Sydney's Charles Perkins Centre.

"At the time of conception, the health and lifestyle of the parents, including their diet, body weight, stress levels and whether or not they smoke, play an important role in the development of the foetus and in determining the future health of the child," said Project Leader and neonatologist Dr Adrienne Gordon.

The study aims to recruit 500 women less than 13 weeks pregnant or those planning a pregnancy, and their partners over the next two years.

Participants need to attend study visits at the Royal Prince Alfred clinic at the Charles Perkins Centre before, during and after pregnancy. Participants receive two extra free ultrasounds later in their pregnancy. General information on lifestyle, nutrition, body composition, pregnancy weight gain and mental wellbeing, as well as biological samples will be collected.

"Ultimately we want to raise awareness that preconception health is more important than currently understood, and that intervening before pregnancy is key to improved outcomes for mother and baby," Dr Gordon said.

For more information, visit: [cpc.baby1000@sydney.edu.au](mailto:cpc.baby1000@sydney.edu.au)

## HOME-TESTING HIV KITS TO TACKLE LATE DIAGNOSIS

**Home-testing kits for HIV should be used in Australia to address the increase in cases among people born in sub-Saharan Africa and South East Asia, according to new research.**

A Curtin University study found over the past decade there had been an increase in the number of HIV notifications among people born in sub-Saharan Africa and North East and South East Asia. Just under half of these notifications occurred at a late stage – or more than four years after HIV had been acquired.

Curtin University School of Public Health lead author Corie Gray said barriers to accessing HIV testing included lack of awareness of at-risk groups, or a fear of

offending patients among GPs; patients not requesting tests; language or cross-cultural difficulties; and HIV-related stigma.

The research made several recommendations including home-testing kits approved by the Therapeutic Goods Administration; universal access to HIV testing for those ineligible for Medicare; and expansion of rapid HIV testing beyond gay and bisexual men.

"The research also recommends encouraging more positive conversations about HIV and regular testing in the community to address the stigma, encouraging GPs to offer HIV testing as part of general health check-ups, pop-up testing sites, and ensuring international students are provided the relevant information," Ms Gray said.

The report is available at: <https://sirent.org.au/project-overview-barriers-to-hiv-testing/>

## FUNCTIONAL FITNESS MORE EFFECTIVE THAN BODY IMAGERY

**Functional fitness campaigns may have a greater impact on motivation to exercise than aspirational body images.**

Images of fit, toned bodies on social media that claim to provide fitness inspiration could be having the opposite effect, according to Flinders University Health and Exercise Sciences Senior Lecturer Dr Ivanka Prichard.

Researchers compared the effects of exposure on women of two high profile media campaigns *This Girl Can* and *#jointhemovement* with that of idealised body imagery of perfectly toned bodies.

The study, also conducted with the University of the Sunshine Coast and Burnet Institute, found that the functional fitness campaigns produced higher appearance satisfaction and exercise intentions than the control video of idealised fitness imagery.

"These results...suggest that women benefit from campaigns that feature



non-idealised depictions of women exercising," Dr Prichard said.

The two functional fitness media campaigns improved satisfaction of women's appearance and physical functionality, exercise intent, and protecting them against exposure to idealised imagery.

Previous research had shown body satisfaction even decreased and negative mood increased over time following exposure to 'fitspiration' images, Dr Prichard said.

The research was published in journal *Body Image*.

## ONLINE PRIVACY BEYOND CONTROL

**Australians are seriously concerned about their online privacy, with many people worried about government and corporate violations, research shows.**

A University of Sydney report found while 67% of Australians have taken steps to protect their privacy online, only 38% said they felt in control.

Almost half (47%) of those surveyed

worried about government violating their privacy. Almost 80% of Australians wanted to know what information of theirs was being accessed, by whom and how to report and correct inaccuracies. Report co-author Professor Gerard Goggin of the University of Sydney said lawmakers, technology elites and corporate boards had failed to keep up with digital rights and governance.

"Data hoarding and seemingly opaque decision-making has given rise to community concern and an urgent need for our digital rights to be clearly laid out by the government," Professor Goggin said.





# WHY ARE WE STILL RELUCTANT TO TALK ABOUT END OF LIFE CARE?

By Vicki Cope

Quality end-of-life care (EOLC) and decision making has been prominent in the literature over recent years with EOLC having a significant bearing on the process of dying and effect upon family and significant others during this time (Raijmakers, 2013, Caswell et al. 2015).

The call has been to move beyond a 'death denying culture' but rather to a more open communication by people and health professionals (Whiting, 2016). Undeniably grief and bereavement counselling prior to and at EOL helps to prepare patients for a good death and can benefit patient, family and care-givers before and after the death of their loved one (Sealey et al. 2015).

Dying is inevitable. Every human understands the cycle of life and death and most people have considered their own death and their hopes and plans for a good

death and EOLC care. Nowadays, discussion with friends and relatives and the treating doctor perhaps concerning organ donation and EOLC may have also occurred (Stoebe and Boerner 2015). Yet a recent study titled, *Factors influencing medical decision-making for seriously ill patients in the acute care hospital* has shown that health professionals involved in EOLC remain reluctant to talk about palliation and persist in pursuing curative care to circumvent the difficult discussions to prepare patients, family and significant others to accept terminal care (Hendricks et al. 2017).

Truthfully, many patients and families do not want to have the 'death and dying' conversation or feel ill-equipped to involve themselves in those discussions, however, what remains shocking is that health professionals are unwilling to involve themselves in discussions concerning medical decision making and death and dying with patients and indeed nurse researchers (Hendricks et al. 2017).

While some patients may elect for interventions aimed at prolonging life, contemporary research has indicated that the most central consideration in EOLC is keeping the patient comfortable via pain and symptom management. The least important consideration is the comfort of health professionals and caregivers and the futile delaying of an inevitable death (Raijmakers 2013).

It is true that communication of bad news is difficult and debate on how and what to say to all involved

continues to be an issue for health professionals (Bélanger et al. 2014). Further, some people do not wish to discuss death and prefer to believe that they will not die. Others plead to be told the truth whilst they can 'get their affairs in order' and to plan for death.

The conduit for these difficult conversations is Advance Care Planning (ACP). People with plans in place are more likely to receive the EOLC they wish for and the family members and friends concerned experience less stress, anxiety and depression (Detering et al. 2010).

In addition, Bernacki and Block (2014) and Sealey et al. (2015) suggest a checklist for difficult conversations to aid health professionals, offering a guide for discussion and documentation regarding EOLC to reduce the likelihood of missed needs.

The call for more patient-centred care surely includes care at time of approaching death and dying. The continued reluctance of health professionals to engage in those conversations with not only their patients but with researchers raises alarm. Transparent discussions for a dignified death and justifiable medical decision-making at EOLC would provide better quality care of our patients.

**Vicki Cope is Associate Professor Nursing, Academic Chair in the School of Health Professions at Murdoch University in Western Australia**



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EXERCISE PROMOTES  
PSYCHOLOGICAL  
BENEFITS



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## EXERCISE AND PSYCHOLOGICAL BENEFITS FOR OLDER PEOPLE

By Rebekkah Middleton, Lorna Moxham and Dominique Parrish

The literature establishes that older people benefit not only physically, but cognitively and socially from being engaged in community recreational activities. Community recreational activities support healthy ageing (Young et al. 2015 p2), and allow older people to maintain cognitive abilities, improve self-belief, and quality of life indicators (Balducci et al. 2014).

The author's research explored the meaning that older people with diabetes attribute to being involved in a community health promotion program. A qualitative phenomenological methodology was implemented to gather information.

Participants spoke of how being a part of the program made them feel good about themselves, how they felt more 'positive' during the program. This concept is discussed in literature as realistic optimism and enables older people to adapt and continue to experience good health (Song and Kong 2015).

Participants verbalised that they felt, 'so much better about myself'. This then led to 'coming along the next time' as 'doubt' was left behind and 'positivity' replaced it. This was often attributed to personal effort and control: 'doing something for my own wellbeing'.

Older people with chronic diseases who are more physically active commonly express more positive thoughts than negative ones. This is particularly connected to their disease management and that they are more likely to be engaged in other

aspects of their health, such as diet and nutrition. The participants spoke of the positive outcomes; the 'pros' of doing the program and how they 'loved going'.

Such positivity resonated in all participants, many of whom expressed they were 'sorry when it ended' as they didn't feel the same level of positive emotion and thoughts. After cessation of the program, the psychological benefits were not present anymore to the same degree according to participants.

People with higher levels of physical activity report enhanced mental health (Law et al. 2014), greater quality of life (Apostolopoulos et al. 2014), and improved cognitive function (National Institute for Health and Clinical Excellence 2014). Participants in this research talked about feeling more 'clear minded' and 'less stressed' while undertaking the program. Exercise and health programs can help older people to engage in strategies that improve memory, that promote positive attitudes, and that assist in emotional awareness and care which can

promote an increased quality of life (Fogarty et al. 2014).

Since physical activity has been demonstrated to improve psychological resilience and thereby reduce and manage stress, as RNs/RMs delivering care, we have a responsibility to ensure it is included and encouraged in the older people we care for. We should be promoting and referring to health programs to sustain the psychological benefits of exercise in the older person. Results from this research, can lead to better understanding of how engagement, for older people, in health promotion and exercise programs can and should be enhanced.

**Dr Rebekkah Middleton is Senior Lecturer and Lorna Moxham is Professor in Mental Health in the School of Nursing at the University of Wollongong**

**Dominique Parrish is Associate Dean Education in the Faculty of Science, Medicine and Health at the University of Wollongong**

# POSITIVE AGEING ON OUR MIND – AN INITIATIVE CALLED AFIA (AGE FRIENDLY ILLAWARRA ALLIANCE)

By Lorna Moxham

Ageing is everyone's business, after all, none of us are getting younger. This assertion is reflected in the nursing workforce with the Department of Health telling us that the overall ageing workforce is reflected in both the increasing average age of nurses from 44.3 years in 2009 to 44.6 years in 2012 and the increasing percentage of those aged 55 years and over from 19.8% in 2009 to 23.1% in 2012.

Given the statistics above, if we care about our own profession we need to start taking a closer interest in caring about older people and not from deficit model but rather from a strengths perspective. Despite the fact that we are all getting older, ageism and social beliefs about older people being 'unhealthy' and 'unable' appears to be rife. To combat ageism and to illustrate the important role that older people have in society, AFIA was established in the Illawarra region of NSW.

AFIA is made up of education, business, government and community organisations working to drive improvements to social, civic and employment participation and access to transport, housing and support services by Illawarra seniors (defined as those ≥ 55 years of age).

AFIA members are the University of Wollongong, the IRT Foundation, Edmiston Jones GBB, Illawarra Pilot Joint Organisation, Healthy Cities Illawarra and NSW Family and Community Services. The Age-Friendly Illawarra Alliance is governed by a steering committee of representatives from each of the member organisations, which is inclusive of a nurse academic.

Nurses are aware that working

	2013	2016
Age group	Total employed	Total employed
0-19	116	100
20-34	72,162	85,760
35-44	68,362	68,182
45-54	83,922	80,751
55-64	61,499	68,891
65-74	8,843	11,109
75-99	273	344

Source: NHWDS 2016 Fact Sheet - <http://data.hwa.gov.au>

with and for older people needs to involve more than a focus on medical issues and should also include proactive social and cultural projects. To achieve this holistic approach the role of the individual members of the Age-Friendly Alliance Steering Committee includes:

1. Advocating for the vision, mission and strategic objectives of AFIA, their organisation, industry sector and the broader community.
2. Playing an active role in achieving the strategic objectives of AFIA.
3. Having a broad understanding of the barriers to and opportunities for active ageing in their local government area or industry sector.
4. Representing the interests of their member organisation/sector and its stakeholders.

In its aim to present older people as worthwhile contributors to society, AFIA's vision is for people aged over 55 years to be enabled to lead active, engaged lives and contribute positively to Illawarra Shoalhaven communities.

This focuses on active ageing which the World Health Organization defines active ageing as "the process of optimising opportunities for health, participation and security in order to enhance quality of life as people age" allowing people to "realise their potential for physical, social and mental wellbeing throughout the life course". AFIA's mission then, is for the people of the Illawarra to prosper socially and economically in an age-friendly region. To do this, AFIA is committed to driving region wide age-friendly initiatives across the focus areas of:

- communication, connection and

THIS FOCUSES ON ACTIVE AGEING WHICH THE WORLD HEALTH ORGANIZATION DEFINES ACTIVE AGEING AS "THE PROCESS OF OPTIMISING OPPORTUNITIES FOR HEALTH, PARTICIPATION AND SECURITY IN ORDER TO ENHANCE QUALITY OF LIFE AS PEOPLE AGE"

- collaboration;
  - older perspectives and perceptions; and
  - government and regulatory.
- A three year delivery plan will see AFIA:

Year 1: Develop infrastructure and make connections

Year 2: Leverage resources and deliver events

Year 3: Influence and Advocate

A focus on healthy ageing will change social perceptions and create opportunities that maximise the quality of life of older people, make the most of their contribution to society and minimise costs to health and care providers including family members.



**Dr Lorna Moxham is Professor of Mental Health Nursing in the School of Nursing at the University of Wollongong and Steering Committee Member – AFIA**



# IMPROVING THE LIVES OF RURAL RESIDENTS USING NURSE-LED TELEMONITORING IN COMMUNITY AGED CARE

By Alison Devitt

At a time when our health system is being challenged to improve the treatment and management of older people living with chronic and complex health issues, nurse-led telemonitoring is emerging as an approach that improves patient outcomes (Celler et al. 2016; Lorentz 2008).

Telemonitoring is a relatively new and developing role for nurses in Australia. It involves using easy-to-use technology installed in patients' homes, which enables remote monitoring of vital signs and access to timely health coaching. Since 2015 I have been employed by LiveBetter (a rural community aged-care provider) as a 'telehealth nurse' to undertake several telemonitoring projects. Working in partnership with universities, we have learned much from evaluating these projects. Our findings support the growing body of evidence demonstrating that telemonitoring helps older people to actively manage their own health, prevents unplanned hospital presentations and improves quality of life (Burmeister et al. 2016; Celler et al. 2016).

These benefits are highlighted in the telemonitoring story of one of my patients, Ron.

Prior to partaking in the trial, he was plagued by anxiety due to relatively low levels of awareness about managing his multiple chronic conditions. After six months of taking his Telemonitoring readings, he showed significant improvement in health literacy and self-management with a subsequent reduction in anxiety, reduced social isolation and fewer hospital presentations. Most importantly for Ron was the impact on his quality of life. For the first time



in many years he had the confidence to travel interstate to visit his son, knowing that he could manage his health effectively while he was away.

Similar findings have been consistent across the patient cohort, demonstrating the multiple benefits of telemonitoring for community aged care (Burmeister et al. 2016). So where to next? Innovation in telemonitoring and wearable technology is surging ahead, primarily led by private businesses. However its use by the healthcare system is being hindered by policy and funding which has not yet caught up to models of chronic disease management that

embrace technology. For example, Medicare Benefits Schedule (MBS) items specific for the needs of telemonitoring services are required.

Nursing, as the largest group of health professionals, are well placed to advocate for these changes. May Ron's story challenge us to pave the way to an improved quality of life and better healthcare experience for our older community residents.

**Alison Devitt is Telehealth RN LiveBetter and Lecturer in the School of Nursing, Midwifery & Indigenous Health at Charles Sturt University in NSW**

ABOVE: ALISON DEVITT, LIVEBETTER TELEHEALTH RN WITH THE MONITORING EQUIPMENT

BELOW: LIVEBETTER'S TELEMONITORING MODEL OF CARE

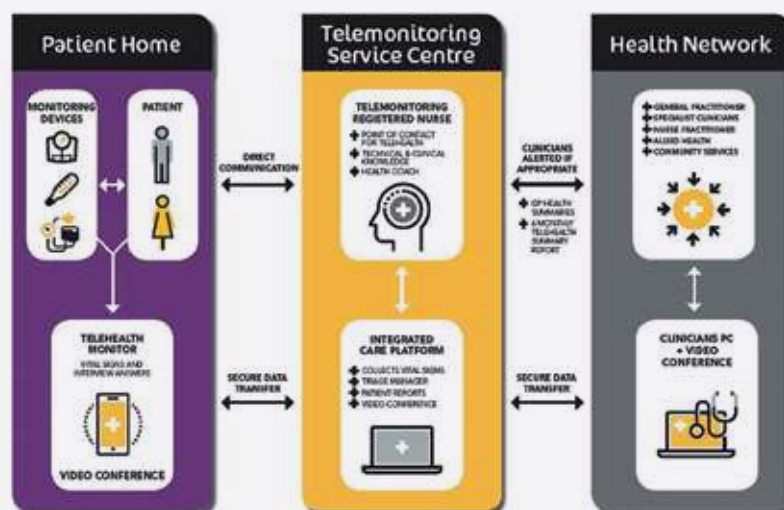


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# REGISTERED NURSES AND DELIRIUM RECOGNITION IN OLDER PEOPLE IN HOSPITAL: A CLINICAL NURSE CONSULTANT WORKPLACE STUDY

By Miriam Coyle, Victoria Traynor and Pippa Burns

Delirium is a serious and acute condition commonly experienced by older people in hospital with broad ranging impacts on the individual, their social networks and on healthcare costs.

Delirium causes health and safety issues for the older person, such as falls, pressure areas, long-term functional and cognitive damage resulting in a deteriorating quality of life and an increased risk of death beyond the day of hospital discharge. Prevention using non-pharmacological methods is currently evidenced as the most effective strategy for delirium care, however, it is concerning that despite the availability of screening tools delirium continues to be under-recognised at

rates of 60% (Oh et al. 2017). The Dementia Delirium Clinical Nurse Consultants (CNCs) working in NSW Health hospitals fulfil an important role in educating and raising awareness about dementia and delirium, contributing to improved outcomes for older people and their families. The purpose of this paper is to report on a study undertaken by a Dementia Delirium CNC working in regional NSW focused on delirium recognition.

The study provided a means to engage registered nurses (RNs) in a reflection on their clinical practice and give a voice to their understanding about the barriers and enablers they experience in recognising delirium in older people during a hospital admission (Coyle et al. 2017).

Set in a large teaching hospital this qualitative study collected data via semi structured group interviews with Registered Nurse participants. Findings by thematic analysis revealed a dichotomy in the clinical practice of participants and opportunities to improve RN capacity in delirium recognition. This prompted a review of educational methods in delirium recognition among RNs. Development of Objective Structured Clinical Examinations (OSCEs) in delirium recognition became an effective focus to further clinical competence and empathy in RN practice in the local setting (Traynor et al. 2016). Adhering to best practice in busy and complex hospital environments requires cultures of care which value older people and reject stereotyping to ensure assessments are competent and care compassionate (El Hussein & Hirst 2015). Collaboration and linkage with national and state-wide initiatives, along with educational interventions, will promote adherence to best practice and ensure older people are screened for delirium.





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# IS WORKING IN AGED CARE BECOMING MORE ATTRACTIVE?

By Judith Anderson

Australia, like many other countries worldwide is experiencing an ageing population (Australian Bureau of Statistics 2013). Many aged care facilities report shortages of staff, frequently registered nurses (National Institute of Labour Studies 2012).

In Australia, efforts have been directed towards improving student registered nurse attitudes towards working in aged care, (Anderson et al. 2017) and towards graduate nurse programs which assist the newly graduated registered nurse to develop skills and knowledge appropriate to working in aged care (Willets et al. 2017). These developments have described some successes.

Several countries (Australia, United Kingdom and United States) which are struggling to staff

aged care facilities are employing overseas born workers. Despite their struggles with language and communication, these staff often indicate that the meaning they associate with their work is a motivating factor and many intend to stay in the sector. Supportive and flexible workplaces were associated with the intention to stay (Gao et al. 2015). This resonates with other studies where supportive management was linked to an intention to continue working in aged care (Backman et al. 2016).

In the United Kingdom nurses are beginning to view aged care as having a career path and generally a more appealing proposition for working in than was previously the case. They value the autonomy of the work and the encouragement to 'get to know' a resident rather than attempting to discharge them as soon as possible (Houchin 2016).

An improved vision of aged care by managers, staff, residents and the community would be beneficial to everyone in ageing populations, attracting the best staff and ensuring that they stay. Hopefully, such a change is beginning.

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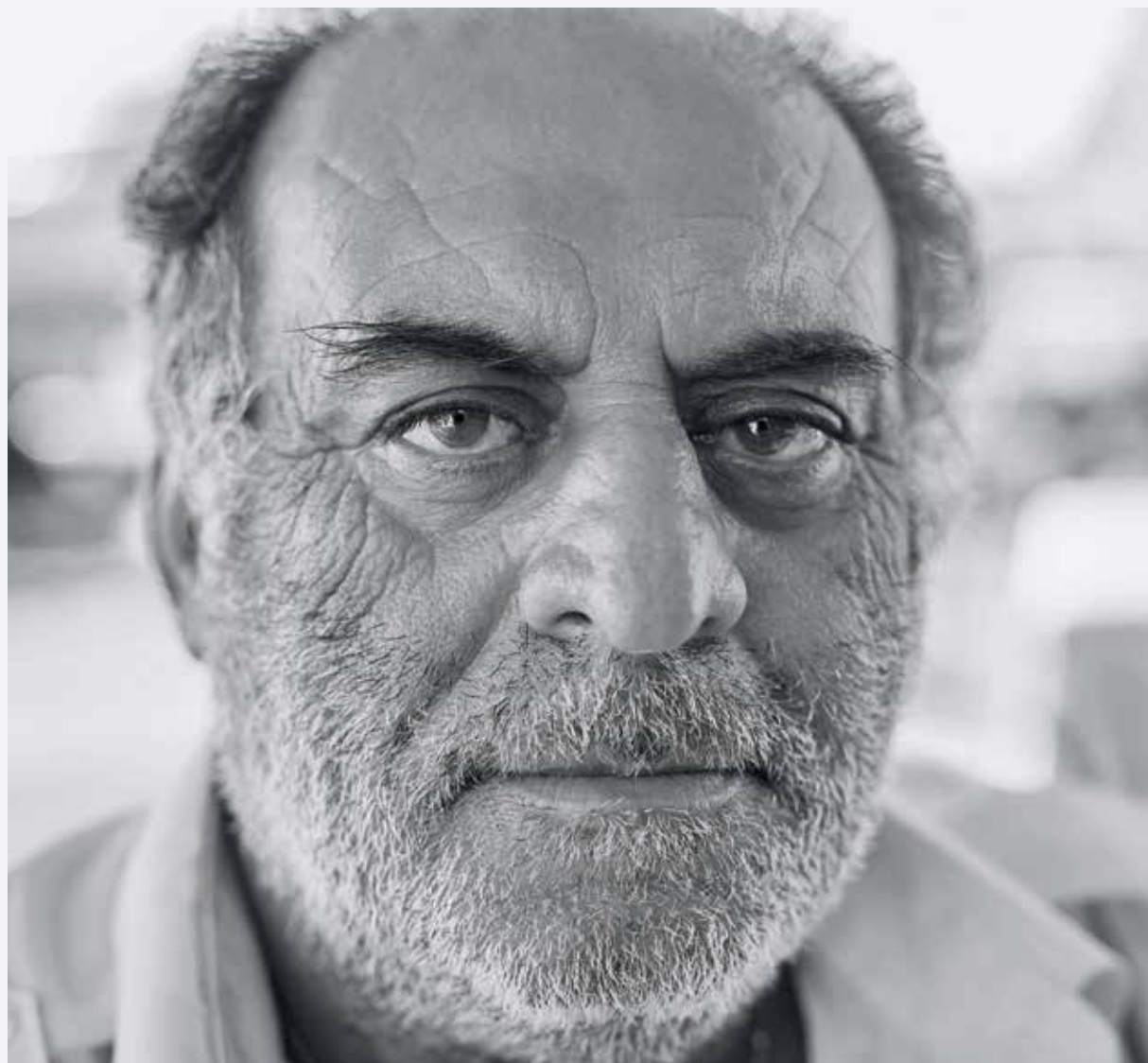
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## GREEK OLDER PEOPLE AND LATER LIFE DEPRESSION AND ANXIETY

By Georgia Tziros and Maree Bernoth

Later life mental health issues specifically depression and anxiety lack community acknowledgment and recognition; older people and welfare staff together lack this awareness (Greenlee & Hyde 2014). A review of literature was undertaken to explore the causative factors of depression with, social factors especially significant.


Social factors were considered to be

influenced by the social world and the quantity and quality of social interactions (Santini et al. 2015). An interesting facet lacking insight is connection to culture of origin, experience of migration and later life depression and anxiety. As a second generation Greek migrant, I am aware that culture, language and the stories of migration are heavily embedded in identity. Taking this into account, it is clear to me that isolated older Greek people who, are unable to have social connections could at times experience strong feelings of disconnect, sadness and anxiety.

Although there is a strong Greek community in Melbourne there are still pockets of isolation which can result in unaddressed later life mental health issues. The literature suggests that social connections plays a pivotal role in reducing onset of depression and anxiety. It was found that these factors included social structures and perspectives, quality of relationships, gender and ethnicity (Green & Benzeval 2011). Regarding ethnicity it was found that minority groups within communities usually experienced

more later life mental health issues due to inadequate social connectivity (Yoon & Jang 2014). Awareness of correlating factors with depression is necessary to effectively plan and implement early intervention and awareness among older Greek adults.

This is an area of practice which needs to be examined further and practical solutions such as community education, healthy ageing initiatives and education for health professionals and welfare staff must be conducted with cultural lenses to fill the clear deficit in ageing in older Greek migrants.

 **Georgia Tziros is a Family Reunification Practitioner in the Department of Health and Human Services and is completing a Doctor of Health Science (DHLthSc) with the focus being older Greek migrants**

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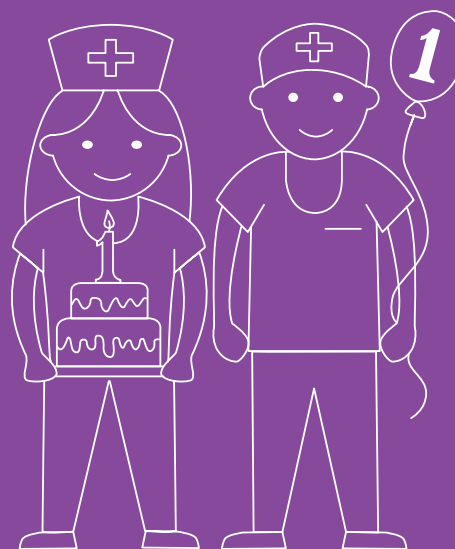
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# LEARNING ABOUT MANAGEMENT OF A DETERIORATING PATIENT THROUGH SIMULATION

By Krishna Lamber, Deborah Magee and Nicole Ward

Learning through simulation has been a well-established teaching and learning modality in practice based disciplines for over 40 years. Literature suggests at undergraduate level nursing simulation as a teaching modality is just as effective if not more so than traditional methods (Baillie & Curzio 2009; Shin et al. 2015).



MOULAGE OF BURN ON HAND

The School of Nursing, Midwifery and Indigenous Health at Charles Sturt University is using simulation to prepare third year Bachelor of Nursing students for managing the clinically deteriorating patient.

Simulation techniques such as role playing, high/low fidelity mannequins and computer assisted instruction were incorporated in a theoretical scenario, 'Mrs Wells'. Over five weeks of clinical simulation classes Mrs Wells' condition evolves; from her initial presentation of chest pain and cardiac arrest through to multi-system organ failure and death. The expected learning outcome was students being able to comprehensively assess, plan, implement and evaluate the care provided to Mrs Wells and through clinical reasoning, respond appropriately to clinical deterioration in team context.

The authenticity of a scenario provides the students with an opportunity to "suspend disbelief" (Waxman 2010 p29) and to actively engage in their learning. To achieve authentic and creative simulation

it was vital that academic and technical staff collaborated. The theoretical case study of Mrs Wells was developed by the teaching team and brought to life by the technical staff. This was achieved through the replication of injuries and disease processes, such as a laceration to Mrs Wells' forehead following a fall and a second degree burn on her hand. These visual cues also challenged the students to think critically about the priorities of care. For example, we found the students would become focussed on wound care rather than addressing Mrs Wells' chest pain.

Debriefing was a vital component of this learning experience (Shinnick et al. 2011). During debriefing students reflected on facets of the scenario such as the strengths and areas for improvement in individual and team performance, the physical processes related to changes in Mrs Wells' condition, and students emotional response to participating.

Mrs Wells enabled students to experience caring for a critically ill older person with complex,

evolving problems. The simulation space was a safe environment for students to develop relevant clinical skills, be challenged in the application of evidence to clinical practice, and demonstrate critical thinking and clinical reasoning in their decision making (Bucknall et al. 2016). Collaboration between academics and technical staff ensured authenticity, where students could experience Mrs Wells not as a mannequin, but as a person.

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# THE THERAPEUTIC LIE: A REFLECTIVE ACCOUNT ILLUSTRATING THE POTENTIAL BENEFITS WHEN NURSING AN ELDERLY CONFUSED PATIENT

By Tom Moncur and Andrew Lovell

## Situation

The circumstances involved an extremely anxious, frustrated and distressed man named John, with a severe cognitive impairment. John was an inpatient on a dementia ward in a mental health hospital in the southwest of England, who wanted to use the telephone to contact his long-deceased mother.

One of the author's works as a staff nurse on the ward, who after recognising that John was disorientated to time, place and person, lacked capacity around his health and wellbeing, and had no insight into his own confusion, wondered whether a therapeutic lie might be employed, both to effectively engage with and minimise his distress and preserve his dignity.

## Background

John was detained under Section 2 of the Mental Health Act (2007) whilst the extent of his cognitive impairment and probable dementia was assessed and determined. His family and friends were struggling to maintain his safety and happiness at home, where he had been increasingly endangering himself and telephoning emergency services regularly and inappropriately. This was compounded by his regular ventures into the local community where he had invariably got lost, was confused, had no money, was

looking for his mother, and required police support until relatives could be contacted.

Consequently, John was admitted into hospital and had spent the last few weeks on the ward. While on the ward he was continually requesting to use the telephone to contact his mother and was unable to accept explanations from both staff and family as to why this was not possible. Anxiolytic medication was being utilised during the weeks of his admission to alleviate his distress when circumstances became extreme. There appeared, as is so often the case in dementia, to be no logic to his repetitive fixation.

## Assessment

The rationale for the therapeutic lie and associated ethical issues were discussed by the multidisciplinary team, and a consensus was reached to take a positive risk. It was decided that when distress was not reduced by other interventions, John would be offered the opportunity to telephone one of his daughters, whilst telling him he was calling his mother. The ward advocate, an independent party, was involved in the decision, so to ensure that John's best interests were being sought and to promote the individuality of the situation. His daughters were familiar with him telephoning and believing he was speaking with his mother. Once the situation had been thoroughly discussed and a decision made that the truth about his mother's death many years earlier was counter-therapeutic, a care plan was accordingly constructed by the author and colleagues. John would be given the opportunity to telephone his mother on request, and many distraction techniques were also built-in to the care plan, essentially expanding the therapeutic lie to accommodate excuses for why it was not possible at certain times to telephone.

## Discussion

According to the NMC Code of Conduct, it is imperative for nurses to: Prioritise people – Practise effectively – Preserve safety – Promote professionalism and trust. There is clearly an ethical issue here relating to professionalism and trust, since a lie is being told to the patient, irrespective of it being regarded as therapeutic. The use of a therapeutic lie to alleviate John's distress and anxiety is contextualised by his lack of mental capacity, which is unlikely to be regained, except for brief periods. The situation is complicated further by Turner et al. (2016's) observation that staff belief in therapeutic lying under certain circumstances might

THE USE OF THE THERAPEUTIC LIE MUST BE IN THE BEST INTERESTS OF THE PATIENT, SHOULD BE RISK ASSESSED, AND BASED ON A CONSENSUS OF PROFESSIONALS, FAMILY AND ADVOCATE

result in inconsistent care delivery and confused communication strategies. This practice of deliberately deceiving John for reasons considered to be in his best interests, the definition of a therapeutic lie (Sperber 2015), is conceptualised in this way because of the desire both to eliminate any harm potential but also control behaviour (Rahman 2017). Unfortunately, there are currently no formal published guidelines in the UK justifying the use of the therapeutic lie with people with dementia, yet the approach is sometimes justifiable and perhaps pervasive (Culley et al. 2013). It is not uncommon, for example, to avoid telling people that their relatives are dead (Mental Health Foundation 2014), but there is a clear absence of consistency, with contradictory qualities, such as openness and honesty, regularly accentuated (NMC 2008).

## Conclusion

The use of the therapeutic lie must be in the best interests of the patient, should be risk assessed, and based on a consensus of professionals, family and advocate. Once it has been integrated into the person's care plan, the approach can genuinely reduce distress, anxiety and behavioural psychotic symptoms of dementia. Finally, it might be fruitful to engage the person with dementia during the early stages of the condition to contribute to an advanced directive in relation to future risks and care needs.

*\*The patient's name has been changed and Nursing & Midwifery Council (NMC) confidentiality guidelines and procedures fully observed.*

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# EXERCISE FOR INDIVIDUALS LIVING WITH DEMENTIA IN RESIDENTIAL AGED CARE FACILITIES: A NEGLECTED ISSUE

By Lindsey Brett and Victoria Traynor

Most health professionals working in residential aged care facilities (RACFs) will agree that physiotherapy and exercise for individuals living with dementia is a neglected area, even though there is evidence that demonstrates numerous benefits.

A systematic review found studies demonstrated significant improvements in cognition, agitation, mood, mobility and functional ability for individuals living with dementia in RACFs when they participated in exercise (Brett et al. 2016b). Recent Australian studies have also demonstrated the feasibility of physiotherapy and exercise for individuals living with dementia in RACFs, as well as improvements in functional ability and behavioural and psychological symptoms of dementia (Brett et al. 2017; Brett et al. 2016a; Neville et al. 2014; Henwood et al. 2015). Best practice dementia care guidelines recommend nonpharmacological interventions, such as physiotherapy and exercise, be the first approach utilised by healthcare practitioners when helping individuals living with dementia manage their symptoms.

The Accreditation Standards for Australian RACFs promote independence and exercise, in line with current evidence. In contrast, the Aged Care Funding Instrument (ACFI) focuses on dependency levels of individuals living in RACFs. Although it might be an unintentional outcome, RACFs become financially dependent on assessing the dependency of individuals in their care rather than promoting independence (Chan et al. 2014). None of the ACFI domains include funding for exercise interventions (Australian Physiotherapy Association 2016). Physiotherapy is only considered in a restricted role as part of pain management. The rigid ACFI guidelines impede physiotherapists using their clinical reasoning skills to provide interventions, such as

exercise as part of chronic pain management. Instead, ACFI guidelines prescribe the type and frequency of pain management treatment, unsupported by current evidence (Australian Physiotherapy Association 2012). A recent review of ACFI found it was no longer fit for purpose because it does not reflect a contemporary understanding of the aged care sector, or the characteristics of individuals living in RACFs (McNamee et al. 2017).

Evidence supports the use of exercise to maintain function, independence and reduce pain for individuals living with dementia in RACFs. In contrast, ACFI appears focused on assessing dependency levels, rather than assessing care needs which would prevent, maintain or promote the capacity and function of individuals living with dementia in RACFs. More needs to be done to enable RACFs to adopt a reablement model of care which would, inevitably, include a focus on promoting exercise and physiotherapy among individuals living with dementia. To facilitate changes, issues with policies and practices, such as ACFI need to be addressed, or perhaps a new evidence-based funding tool needs to be developed.

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## LIVE BEHIND THE ORANGE DOOR – THE EFFECTS OF CHANGING SUITE DOORS FOR INDIVIDUALS LIVING WITH A DEMENTIA

By Alexandria Varshawsky and Victoria Traynor

Dementia friendly designs are important in residential care homes but an aspect that remains neglected is the potential positive role of door designs on individuals living with a dementia.

For most individuals living with a dementia, the typical long corridors and repetitive styled doors created in residential care homes cause confusion and frustration. A pilot study in NSW, Australia, tested the effects of unique room door designs for a small group of individuals living with a dementia in a residential care home. Internal doors were transformed using a giant adhesive poster created by a commercial graphic designer. The poster replicated the look of traditional front doors,

including a range of bright bold colours and architectural features, such as brass doorknockers, letterboxes and door guards.

The well validated Revised Algase Wandering Scale (RAWS) was used to identify the effects of introducing the doors on individuals living with a dementia. A total of nine individuals living with a dementia participated in the project. The post-intervention data demonstrated that there was a reduction in persistent walking (63 to 50%) and eloping behaviours (54 to 43%). In addition, ongoing anecdotal evidence found that participants continued to seek out others to showcase their unique door. The host aged care organisation, Warrigal, extended this project and more residential care homes are transforming their internal room doors for individuals living with a dementia.

# THE IMPORTANCE OF INTEGRATING CULTURAL AND SPIRITUAL CARE INTO ABORIGINAL AGED CARE

By Nina Sivertsen, Ann Harrington and Mohammad Hamiduzzaman

**Aged care for Aboriginal people needs to be understood within the social and historical context of colonisation, dispossession of land and culture, and economic exclusion.**

Health conditions associated with ageing often affect Aboriginal people earlier than other Australians (DTA 2017; AIHW 2011). This outcome is reflected in the Australian government policy to provide Aboriginal people access to culturally appropriate aged care services from 50 years old, in comparison to 65 years for the broader population (Australian Aged Care Quality Agency 2014).

Despite this policy initiative, those who work with older Aboriginal people remain sceptical of whether aged care services provided are optimal. Fundamental issues such as lack of Aboriginal care workers and lack of access to technology presents a barrier - notably the reliance on the internet and the 1800 phone number. Hermant (2016) points out that many Indigenous people do not have landlines and use mobile phones sparingly to conserve credit.

The Federal Government National Aboriginal and Torres Strait Island Flexible Aged Care Program report found that although aged care services are largely delivered effectively to Aboriginal people, the ageing of Australia's population and growing diversity among older people, are placing pressures on the depth and agility of Australia's aged care system. This pressure brings about challenges in ensuring Aboriginal peoples' access to culturally appropriate care (Australian National

Audit Office 2017; DTA 2017). Culture and spirituality are important determinants of Aboriginal health (Dudgeon et al. 2014), and nurses and carers can play a pivotal role in integrating cultural and spiritual care into the general care for Aboriginal people (Sivertsen & Harrington 2016).

Similar to Australia, other nations with Indigenous populations struggle to achieve positive health outcomes for their older generations. In New Zealand, many Māori experience a compromised quality of life and reduced lifespan relative to non-Māori, and there is much scope to enhance positive ageing strategies that includes Whanau (family) so that they can support older Māori people to achieve their own self-defined aspirations (Edwards 2010). In Norway health professionals often have limited Sámi language skills and knowledge of Indigenous Sámi culture (Sivertsen 2010), which limit their ability to anticipate, assess, and communicate about the possible needs, particularly of the older Sámi patients (Blix et al. 2013). In Canada First Nations elderly on-reserve do not receive the home care and ongoing support that they need to stay in their communities (Health Council of Canada 2013). Overall, consideration of the issues of self-aspiration, cultural competency of carers, and domestic support are important to provide high quality, sustainable, culturally appropriate, and accessible aged care and disability services, in remote centres as well as cities and large regional centres, where more than half of Aboriginal people in Australia live. This care includes close involvement with local Aboriginal community-controlled health services.

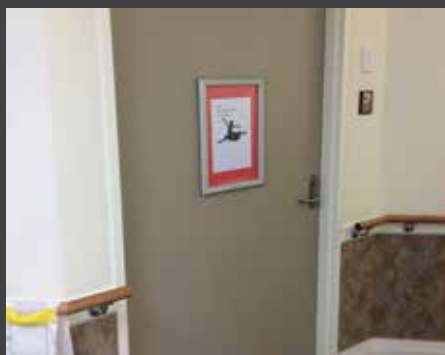
A research project to discover how culture and spirituality can be integrated into residential aged care is being conducted through Flinders University. This study is currently in its final stages and has captured the voices of Aboriginal residents and care workers, findings to be reported at its conclusion.

**Dr Nina Sivertsen is a Lecturer and Associate Professor Anne Harrington are both in the College of Nursing and Health Sciences at Flinders University in SA**

**Mr Mohammad Hamiduzzaman is a PhD candidate in the College of Nursing and Health Sciences at Flinders University in SA**

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SAMPLE 'BEFORE' DOOR DESIGN



NEW DOOR DESIGN

**Alexandria Varshawsky, MSc (Gerontological and Rehabilitation Studies), Bachelor of Exercise Science (Health Professions), Community Facilitator, Warrigal**

**Victoria Traynor, PhD, BSc (Nursing Studies) Hons, Professor, University of Wollongong**

# INDIGENOUS AUNTIES: DEMENTIA AND DANCE

By Darcelle Douglas,  
Victoria Traynor and  
Pippa Burns

## Background

Our study adopted an innovative approach to explore the different facets of wellbeing among Aboriginal and Torres Strait Island peoples. The historical significance and social determinants of health has complicated the health and wellbeing of Indigenous Australians by causing unequal opportunities and entrenched disadvantage.

These experiences are magnified for older populations who are often the most vulnerable population group in most societies. The focus of this study was on the wellbeing of a group of Indigenous Aunties living with a dementia in a nursing home for Aboriginal communities.

Currently within Indigenous Australian populations, the prevalence of dementia is greater compared to non-Indigenous Australians and therefore warrants special attention by aged care providers.

## Objective of the study

The objective of the study was to explore the impact of a dance intervention on the wellbeing of Aboriginal and Torres Strait Islander women living with a dementia in nursing homes. One of the authors, Darcelle Douglas, is of Aboriginal descent from North Queensland, now living in New South Wales. As a member of an Aboriginal community, she loves and cares for the Elders and her passion for dance, led her to embark on a journey incorporating dance for Aboriginal and Torres Strait Islander Aunties living with a dementia.

## Design

Darcelle delivered a weekly dance intervention lasting one hour over eight weeks. The participants were Indigenous Aunties living with a dementia in a nursing home. What was crucial for the research to be undertaken was that approval from

Aboriginal and Torres Strait Islander Community, Aboriginal Health and Medical Research Council and the University of Wollongong ethics committee was gained. This process took several months and was only possible because Darcelle is a respected Aboriginal woman in her community. An observational ethnographic research approach was adopted with observations made up of digital video recordings and a structured check sheet completed by hand at the end of each dance session.

The researchers viewed and reviewed the digital video recordings to develop an understanding about the meaning of the dance intervention for the Indigenous Aunties and the observation check sheet data were used to explain the impact of the social interaction generated through the dance intervention on the Aunties.

## Results


The overall experiences of the Indigenous Aunties were overwhelmingly positive. Themes were generated to explain why and how the dance intervention provided positive benefits for the Aunties. Participants, self and others included, participants and self-worth through movement, participants' interactions with each other and participants and reminiscence. Participants and dance included, participants choosing their performance song, participants saying the dance steps with the dance instructor out loud, participants dancing, participants and musical appreciation (movies, musicals and Broadway musicals) and participants' Broadway and movie musical knowledge overall increasing physicality and social interactions.


## Conclusion


The study provided powerful evidence about the positive benefits of dance on wellbeing from an Indigenous perspective and demonstrated the importance of social interaction on the wellbeing of Indigenous Aunties living with a dementia. This study provided new understanding for Aboriginal and Torres Strait Islanders and also adds to mainstream knowledge about the value of dance for individuals living with a dementia.

The study demonstrated how dance can benefit Indigenous Australians emotionally and socially. The authors are extending their research and working with community to explore how dementia services within Indigenous populations can be improved. This work is especially valuable because it is being led by an Aboriginal woman with and for her community.

THE STUDY PROVIDED POWERFUL EVIDENCE ABOUT THE POSITIVE BENEFITS OF DANCE ON WELLBEING FROM AN INDIGENOUS PERSPECTIVE AND DEMONSTRATED THE IMPORTANCE OF SOCIAL INTERACTION ON THE WELLBEING OF INDIGENOUS AUNTIES LIVING WITH A DEMENTIA.

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# BETTER EQUIPPING HEALTHCARE PROFESSIONALS IN PAIN MANAGEMENT OF PEOPLE WITH DEMENTIA

By Hui Chen (Rita) Chang, Vanathy A David, Nicole Britten, Loren De Vries

Pain management for individuals living with a dementia is one area of nursing care which needs better management. As a dementia progresses, verbal language skills can deteriorate and individuals rely more on non-verbal ways of communicating.



It can become difficult, if not impossible, for individuals living with dementia to use words to explain their pain to someone else. Individuals living with a dementia then become at high risk of living with chronic pain. And, not unsurprisingly, this has a negative effect on their quality of life which in turn causes a further deterioration of an individual's dementia and high levels of stress for family and healthcare professionals providing care.

It is estimated up to 80% of older people living in nursing homes experience chronic pain and in Australia more than half of these older people (52%) have a diagnosis of dementia while two in three (67%) require high-level care to manage distress situations (Gibson 2007; Zwakhalen 2006). We can therefore assume that a high proportion of people with chronic pain also have cognitive impairment and will have difficulties in verbally expressing their pain.

The Australian Pain Society (2005) reported that individuals living with a dementia who experience pain have their pain left untreated at higher rates than those without dementia. In one study, pain was detected in just 31.5% of cognitively-impaired residents compared to 61% of cognitively-intact residents, despite both groups being equally afflicted

with potentially painful disease (Proctor & Hirdes 2001).

This situation can be avoided using close observation of non-verbal expressions of pain and responding to the other signs of pain. For those individuals living with dementia who cannot clearly verbalise their pain there is a 'Gold Standard' observational pain assessment tool known as the 'Abbey Pain Scale'. The Abbey Pain Scale can be used to assess levels of pain and develop a pain management plan for individuals living with dementia. Despite the abundant evidence of the effectiveness of the Abbey Pain Scale for detecting and managing pain it remains largely unused in everyday clinical practice. The Aged and Dementia Care Health Research and Education (ADHERE) team at UOW wanted to address this gap and developed an Abbey Pain Scale filmed vignette educational resource. Three videos demonstrate a nurse practitioner providing education to a family carer and registered nurses in acute care and nursing home settings on how to use the Abbey Pain Scale.

If a person with dementia experiences unexplained changes and/or shows signs of distress, healthcare professionals should assess whether the person is in pain but without a tool like the

Abbey Pain Scale this is difficult to achieve. The Abbey Pain Scale filmed vignettes to demonstrate how to assess pain experienced by individuals living with a dementia in their own home, in hospital and in a nursing home. The videos can be used to assist healthcare professionals learn how to better detect and manage pain experienced by individuals living with dementia who cannot easily express their pain verbally.

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**Health District**

DEMONSTRATING THE  
USE OF THE ABBEY  
PAIN SCALE AT HOME



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# DEVELOPING GERONTOLOGICAL NURSING COMPETENCIES: AN E-DELPHI STUDY

By Nicole Britten, Victoria Traynor, Tracey Osmond and Lynn Chenoweth

## Background/Aim

In Australia, a total of 13% registered nurses (RNs) (40,443) work in aged care and therefore deserve special attention. Understanding the specific contribution of RNs in aged care is limited and aged care employers report that a "lack of specialist knowledge" among RNs is the main reason for unfilled RN vacancies (Deloitte Access Economics 2016).

This paper presents the findings from a study to develop Gerontological Nursing (GerNurs) Competencies for RNs for use across Australian nursing homes and community care. A literature review of gerontological nursing competencies found that the only widely used competencies were published in the United States and irrelevant to the Australian care context. A group known as the Nursing in Aged Care Collaborative (NACC), made up of five not for profit aged care providers, undertook the study with the help of two universities to develop the GerNurs Competencies (Figure 1).

Figure 1

NAME	ORGANISATION	POSITION
Kristene Rice	Anglicare	GM Quality and Service Support
Tracey Osmond	Scalabrini Village	Director, Clinical Governance and Quality
Jolan Stokes	HammondCare	Hammond College Manager, Health and Hospitals
Linda Justin	Uniting	Director of Practice and Quality
Carolyn Moir	BaptistCare	Care Improvement Consultant
Donna Lennon	BaptistCare	Care Improvement Consultant
Mary McConachie	Anglicare	Quality and Compliance Manager – Residential
Melissa Jansson	Anglicare	Nurse Educator, Quality and Service Support
Elaine Griffin	Scalabrini Village	Director, People, Learning and Culture
INVITEES		
Victoria Traynor	UoW	Professor
Nicole Britten	UoW	Project Manager
Lynn Chenoweth	UNSW	Professor of Nursing, Centre for Healthy Brain Ageing

## Methods

This study was undertaken using an e-Delphi with a snowball sample made up of just over 400 participants. The e-Delphi technique was used successfully when dementia care competencies were developed by this same

research team (Traynor and Britten 2015). This e-Delphi started with 11 core competencies with 36 domains of practice generated from a literature review and workshop with senior practitioners working in aged care.

The e-Delphi consisted of five rounds of online consultation: Reviewing the wording of each core competency and its associated domains of practice (round one and two) and creating levels of practice (round three to five) for each of the domains of practice.

Content analysis of qualitative comments provided in the e-Delphi informed the final wording of the competencies and descriptive statistics were used to record percentage levels of agreements among the participants about the wording of the competencies and domains of practice.

## Findings


The participants were clinicians (57%) and managers (30%) and academics (13%) from 10 countries (90% Australia). By round two, the final set of 11 core competencies and 36 domains of practice (Figure 2) generated a 98% (SD±2) level of agreement among the participants. By round five, two levels of practice were created to explain the competence in each of the domains of practice for RNs working with older people and their families- essential and enhanced (minimum level of 60% agreement achieved across the domains of practice).


Figure 2

CORE COMPETENCIES	
1	Living well for older people across communities and groups
2	Maximising health outcomes
3	Communicate effectively
4	Facilitating transitions in care
5	Facilitating choices within legal and ethical frameworks
6	Partnering with family carers
7	Promoting mental health and psychological wellbeing
8	Providing evidence based dementia care
9	Providing optimal pain management
10	Providing palliative care
11	Enabling access to technology


## Conclusion

The GerNurs Competencies were endorsed through a wide consultation activity using the e-Delphi technique. Currently, a pilot implementation of the competencies across the NACC organisations is being undertaken to test the accompanying documentation to help RNs and their managers implement the GerNurs Competencies. During the implementation RNs and their managers were completing online surveys to evaluate the accompanying documentation to ensure it is appropriate for aged care in Australia. One RN implementing the GerNurs Competencies said it was, "Long overdue and will be of great value in development of future aged care leaders". The GerNurs Competencies and accompanying documentation will be available by 2018 on an accessible website for use by individuals for their professional development and organisations to support implementation of their strategic plans.

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# EVALUATING THE EFFECTS OF A PHYSICAL ACTIVITY PROGRAM ON AGITATION AND WANDERING EXPERIENCED BY INDIVIDUALS LIVING WITH A DEMENTIA IN CARE HOMES

By Victoria Traynor, Nadine Veerhui and Shiva Gopalan

We know that exercise is good for us but in nursing homes it is common for older people, including individuals living with a dementia (Devries & Traynor 2012; Brett et al. 2015), to live very sedentary lifestyles.

The aim of this study was to provide evidence about the positive benefits of exercise for individuals living with a dementia in nursing homes.

This study evaluated the implementation of a structured physical activity (PA) program for individuals living with a dementia in care homes. More specifically, test the effects on the behavioural and psychological symptoms of dementia (BPSD) using the Cohen-Mansfield Agitation Inventory and Algate Wandering Scale. The study was undertaken over 16 weeks using a quasi-experimental design.

Registered nurses,

physiotherapists, assistants in nursing and physiotherapy aids from one aged care organisation in NSW, Australia undertook the study with academics.

## Major findings

A total of 72 individuals living with a dementia from four care homes participated. Implementation of the structured PA program generated statistically significant findings with reductions in agitation ( $p < .001$ ) and eloping ( $p = .001$ ) achieved for individuals living with a dementia in care homes.

## Conclusion

Physiotherapists and exercise physiologists can complement nursing focused care teams and contribute to a holistic model of care for individuals living with dementia in care homes. The study demonstrated how a structured PA program positively affected the levels of agitation and wandering experienced by individuals living with a dementia. Individuals living with a dementia in care homes who participated in a structured PA experienced positive outcomes from the program.

The findings demonstrated that they benefited from the program and PA should be promoted for this group just as it is for other population groups, including general populations of older people.

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# MODELS OF CARE FOR AGED CARE – SOCIAL OR BIOMEDICAL?

By Joan Ostaszkievicz, Trisha Dunning and Susan Streat

## Implications for the workforce

By 2050, Australia will need almost one million aged care staff (The Productivity Commission 2011). Under the *Aged Care Act 1997*, their education and training will be a shared responsibility between government and industry (2015-16 Report on the Operation of the Aged Care Act 1997).

Aged care service providers, policy makers and researchers are currently grappling with the question of how to grow and sustain the workforce to provide aged care services and support for older people to meet their care needs in a variety of settings, including but not limited to residential aged care. We argue that the development of an aged care workforce strategy should be underpinned by a contextually appropriate model of care and informed by data about older peoples' complex and changing care needs.

## Residents' health profiles

People admitted to Australian aged care facilities are older and frailer than ever before. Their average age at admission is 85 years of age, half stay less than two years, and the annual mortality rate is 32%. Around 50% of residents have a diagnosis of dementia (2015-16 Report on the Operation of the Aged Care Act 1997). Hence, most residents have complex chronic conditions that require significant multidisciplinary team input from healthcare professionals with gerontological expertise. A key challenge for aged care providers is to provide care that addresses the combined biological, psychological and social factors that influence residents' health and wellbeing. Whilst traditional models of healthcare are structured on a biomedical model characterised by workforce specialisation and professionalisation, aged care has seen an increased emphasis on social models of care and a corresponding reduction in professional knowledge and skills in gerontology.

## The difference between biomedical and social models of care

Models of health or care are 'conceptual frameworks' or ways of thinking about health. They offer a shared vision for achieving common goals and a way to evaluate performance on an agreed basis. They also guide the nature of the workforce structure and associated workforce competencies.

*'The biomedical model is based*

*on the assumption that each disease or ailment has a specific cause that physically affects the human body in a uniform and predictable way, meaning that universal 'cures' for people are theoretically possible. It involves a mechanical view of the body as a machine made up of interrelated parts, such as the skeleton and circulatory system' (Germov 2009. p11).*

The biomedical model does not accommodate the social and psychological dimensions of a person's illness.

*'The social model focuses on societal factors that are risk-imposing or illness..., and in particular highlights the health inequalities suffered by different social groups based on class, gender, ethnicity, and occupation, to name a few' (Germov 2009. p17).*

## The effect of the biomedical and social models in aged care

The adoption of a biomedical model to the exclusion of a social model places many residents at risk of being viewed solely through the lens of their medical diagnoses. As such, behaviours such as resistance to care or incontinence are likely to be 'pathologised'.

Sociological studies about ageing highlight the dangers of relying on medical understanding to explain and subsequently dismiss patients' behaviours and/or symptoms (Dupuis et al. 2012; Kitwood 1997; SixSmith et al. 1993). Another limitation of relying on the biomedical model to guide care in aged care facilities is that many residents have intractable conditions that cannot be 'fixed'.

Arguably, the adoption of a social model with its focus on the social and psychological aspects of illness to the exclusion of a biomedical model is equally dangerous, as it could result in a situation in which a resident's potentially treatable conditions go undiagnosed and therefore, remain untreated. Moreover, a wellness and self-management approach may not meet the needs of residents with multiple interacting chronic conditions, or those who require end-of-life care, or are unable to

self-manage. Whilst people have long argued the need to move beyond biomedical approaches and incorporate a social model of health, we believe the complexity of residents' health and illness warrants elements from both models. Furthermore, we argue that residents' subjective wellbeing should be the key criterion of successful ageing and of quality care. These factors can be accommodated with the adoption of a biopsychosocial model of care.

## The biopsychosocial model

Within a biopsychosocial model, it is recognised that disease, illness and health are all affected by a combination of biological, psychological or behavioural, and social factors. The biopsychosocial model is attributed to George L. Engel (1977; 1980), a psychiatrist who voiced concerns about what he and others perceived were the limitations of biomedicine and a need for a different perspective. The model provides a person-centred and comprehensive framework for understanding disease, illness and health (Hatala 2012). We suggest service providers, policy makers and researchers consider the relevance of the biopsychosocial model of care as they deliberate on how to develop and maintain workforce competency to respond to the increasingly complex care needs of older Australians.

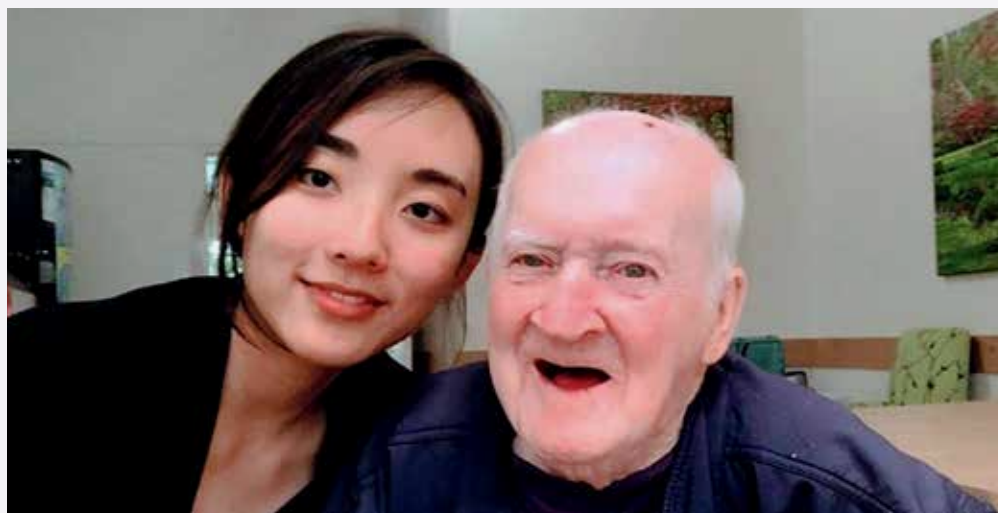
**Dr Joan Ostaszkievicz is a Research Fellow, Professor Trisha Dunning is Chair in Nursing and Ms Susan Streat is Research Assistant. All are located in the Centre for Quality and Patient Safety Research – Barwon Health Partnership, School of Nursing and Midwifery, Faculty of Health at Deakin University**



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# ORAL HEALTH IN RESIDENTIAL AGED CARE: ARE NURSES BEARING THE BRUNT OF A MULTIDISCIPLINARY SOLUTION?

By Amy R Villarosa, Dong Wang and Ajesh George

Older people in residential aged care (RAC) experience some of the poorest oral health in Australia (Australian Institute of Health and Welfare 2007). Poor oral health can have a significant impact on quality of life due to pain, altered appearance, impaired speech, eating difficulties and malnutrition (Slade and Spencer 1994).

Increasingly, poor oral health is being linked to many chronic diseases including diabetes, cardiovascular disease, renal disease, rheumatoid arthritis, aspiration pneumonia and cognitive decline (Galgut 2010).

A national training program for nursing staff endorsed by the Australian government was implemented to address poor oral health in residential aged care facilities (Lewis et al. 2015). Despite this implementation, oral health remains an issue in RAC (Webb et al. 2015), and nursing staff persist to bear the primary responsibility of providing oral healthcare to residents, hence, also taking the blame for their poor oral health (Lewis et al. 2015). Yet, oral health is a multifaceted issue that extends into the scope of many other health professions (Coleman 2005), therefore the role of other health professionals in this multidisciplinary model of care is paramount.

Several multidisciplinary models of care involving dental professionals have been successfully implemented into RAC facilities (Fallon et al. 2006; Wallace et al. 2016). The need for such models of care involving dental professionals in Australian RAC facilities, is underpinned by residents' limited access to oral health services and support from dental professionals (Slack-Smith et al. 2015).

Other allied health professionals, including dietitians also have a potential role in the oral healthcare for aged care residents (Slack-Smith et al. 2016). As the primary health professionals responsible for the management and prevention of malnutrition in RAC, dietitians have a vested interest in promoting oral health in residential aged care (Touger-Decker and Mobley 2013). In fact, a recent joint statement

between the Dietitians Association of Australia and Dental Health Services Victoria highlighted that as part of their practice in institutional settings, it is the dietitians' role to perform oral health screening, promotion and education (Dietitians Association of Australia and Dental Health Services Victoria 2015). However, there is little evidence to suggest that this is currently being implemented.

With the successful implementation of multidisciplinary oral health models in other settings (George et al. 2016), this unmet need in aged care becomes increasingly evident. If the oral health of older Australians is going to be ensured, other health professionals should share the burden of oral health.

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REGISTERED NURSE  
ASSISTING AGED  
CARE RESIDENT WITH  
DENTURE CARE



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# FEBRUARY

**Ovarian Cancer Awareness Month**  
<https://www.womenscancerfoundation.org.au/>

**World Cancer Day**  
 4 February. [www.worldcancerday.org/](http://www.worldcancerday.org/)

**Anniversary of the Apology (2008)**  
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**Ash Wednesday**  
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**Teal Ribbon Day for Ovarian Cancer**  
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**Lung Health Promotion Centre at The Alfred**  
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 8-9 March  
 Asthma Educator's Course  
 14-16 March  
 Ph: (03) 9076 2382  
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# MARCH

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[www.cleanupaustraliaday.org.au](http://www.cleanupaustraliaday.org.au)

**5th International Conference Global Network of Public Health Nurses**  
 5-7 March, Safari Park Hotel and Casino, Nairobi. [www.icn.ch/](http://www.icn.ch/)

**International Women's Day**  
 8 March.  
[www.un.org/en/events/womensday/](http://www.un.org/en/events/womensday/)

**National Health Sector Women's Leadership Summit**  
 8 March, Melbourne. The Summit is focused on connecting, celebrating and developing women leaders across Australia's health sector. More information: <https://www.wla.edu.au/healthsectorsummit.html>

**Australian Cardiovascular Nursing College Annual Conference**  
 9-10 March, Mercure Hotel Sydney.  
<http://www.acnc.net.au/>

**22nd Otorhinolaryngology Head & Neck Nurses Group National Conference**  
 Brave New World  
 9-11 March, Crown Perth Convention Centre. <http://www.ohnng.com.au/>

**23rd Commonwealth Nurses and Midwives Federation Biennial Meeting and the 4th Commonwealth Nurses and Midwives Conference**  
 Leading the way: Nurses and midwives for a safe, healthy and peaceful world  
 9-11 March, London UK.  
[www.commonwealthnurses.org/](http://www.commonwealthnurses.org/)

**10th Asia Pacific Global Summit on Healthcare**  
 In pursuit of high quality public health and healthcare  
 12-14 March, Singapore.  
<https://healthcare.global-summit.com/>

**National Close the Gap Day**  
 15 March

**Australian College of Nurse Practitioners 'Innovations in Practice Symposium'**  
 16 March, 9.00am-4.30pm, Carson Centre, ANMF House, 535 Elizabeth Street, Melbourne. Further information E: [sarah.brophy@acnp.org.au](mailto:sarah.brophy@acnp.org.au)

**St Patrick's Day**  
 17 March

**24th Global Registered Nurse and Nurse Practitioners Conference**  
 Dredge into the advanced approaches of nursing  
 19-20 March, Bali, Indonesia.  
<http://registerednurse.nursingconference.com/>

**International Day of Happiness**  
 20 March. <http://www.dayofhappiness.net/#join>

**Harmony Day**  
 Celebrates the country's cultural diversity. It coincides with the United Nations' International Day for the Elimination of Racial Discrimination  
 21 March. <https://www.harmony.gov.au/>

**4th International Health Care Reform Conference**  
 Moving care from hospital to community: Navigating the bumps  
 21-23 March, InterContinental Sydney Double Bay, NSW. <http://ihcrc-2018.wyrd.currinda.com/#>

**20th Global Nursing Education Conference**  
 Current challenges and innovations in nursing education  
 21-23 March, New York, USA.  
<http://nursingeducation.nursingconference.com/america/>

**Australian Healthcare Week Expo**  
 21-23 March, International Convention Centre Darling Harbour. <http://bit.ly/2u8H0dS>

**Nurse Practitioners - Pharmacology and Prescribing Conference**  
 Ausmed's annual conference for Nurse Practitioners  
 22-23 March, Melbourne. Go to [ausmed.com.au](http://ausmed.com.au) or call 1300 AUSMED to register

**Working Hours, Shift & Fatigue Conference, presented by the ANMF (Vic Branch)**  
 23 March, ANMF Vic Branch, Carson Conference Centre, 535 Elizabeth Street, Melbourne. This Conference attracts up to six hours of CPD, as required by the NMBA for registration renewal. <http://www.anmfvic.asn.au/events-and-conferences>

# APRIL

**National Smile Day**  
 1 April.  
<http://www.humourfoundation.org.au/>

**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: [enquiry@lunghealth.org](mailto:enquiry@lunghealth.org)

**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

**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: [enquiry@lunghealth.org](mailto:enquiry@lunghealth.org)

**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/>

# NETWORK

**Royal Women's Hospital student midwives, March group 1983-1984 reunion**  
 Contact Maureen Boston (nee McFadden) E: [maureen\\_boston@hotmail.com](mailto:maureen_boston@hotmail.com) or M: 0428 552 475

**NDSN Bendigo School 71, 50-year reunion**  
 Seeking students from Bendigo, Castlemaine, Echuca, Swan Hill and Mildura. Contact E: [margie\\_coad@hotmail.com](mailto:margie_coad@hotmail.com) or M: 0427 567 511

**St John of God Hospital Ballarat Past Students reunion**  
 14 April, Ballarat Golf Club.  
 Contact Geraldine Vagg E: [gerryvagg@hotmail.com](mailto:gerryvagg@hotmail.com) or M: 0418 554 096

**Alfred Hospital, Group AP87 31-year reunion**  
 29 April, 12.00pm, Birichino Café, 100 Scotchmer Street, Nth Fitzroy Vic.  
 Contact Liz Crock E: [lizcrock60@gmail.com](mailto: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](mailto:sally0307@hotmail.com) or Sue Scott E: [sue.scott@rch.org.au](mailto: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**  
 June. Contact Isabelle E: [isabellehenry360@gmail.com](mailto:isabellehenry360@gmail.com)

**Alfred Hospital Group 3/85, 30-year reunion**  
 October TBC. E: [cathie@coughlan.id.au](mailto:cathie@coughlan.id.au) or [boxvale2@bigpond.com](mailto:boxvale2@bigpond.com) or [perilloj@gmail.com](mailto:perilloj@gmail.com)



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

# HOMELESSNESS IS EVERYBODY'S BUSINESS

Lori-anne Sharp, ANMF Assistant Federal Secretary



*"The true measure of any society can be found in how it treats its most vulnerable members."*

MAHATMA GHANDI

Reflecting on my ten years working with our society's most marginalised and disadvantaged and delivering healthcare to those experiencing homelessness, I have consistently admired the courage, strength and resilience of those individuals confronting extreme hardship.

As an outreach nurse, I frequently witnessed the daily frustrations, emotional pain, unfair judgements, social isolation and all too often the feelings of hopelessness felt by clients I was working with. More often than not, many individuals experiencing homelessness feel ignored, unheard and invisible.

Working in this specialised field, it is key to have a non-judgemental approach and the ability to develop rapport easily whilst maintaining professional relationships of trust.

Homelessness is often misunderstood, even by health professionals and community health nurses, and cannot be simply defined as the absence of a stable home.

It may include sleeping rough, couch surfing, living in a car, a caravan park, rooming houses, or transient and crisis accommodation. Individuals experiencing homelessness typically lack the social supports and safety net of family and friends that many of us depend on, which can exacerbate feelings of social isolation, loneliness and exclusion.

Circumstances that lead an individual to becoming homeless are often complex and can include; family violence, physical or intellectual disabilities, mental illness, past history of trauma, intergenerational abuse, death of significant other or relationship breakdown, loss of job or precarious employment, acquired brain injury or substance abuse issues. It is not uncommon for people to experience a combination of these events, and to have their detrimental

effects multiplied by their living situation.

When you are homeless you have very few choices. I recall assisting a couple, Steve and Kate,\* who were both reliant on the Newstart allowance. Steve's mother had died when he was eleven, while his father was an alcoholic and had been physically abusive. He had also been a victim of institutional sexual abuse. Having little supports to rely on, Steve disengaged from school early and had been living on and off the streets since he was sixteen. Kate came from a loving family, but experienced behavioural problems at school and also left early. She suffered chronic pain from injuries sustained in a motor car accident, hearing impairment and likely undiagnosed alcohol foetal spectrum disorder. All these factors combined, made it extremely difficult for Kate and Steve to find, afford and sustain housing, let alone their basic needs.

When I met Steve and Kate they had been homeless for more than eight years. They had two children in foster care, and despite their extraordinarily tough circumstances they had managed to maintain some regular contact visits with their children.

On one occasion, I assisted Steve and Kate to relocate to a rooming house. Previously a two bedroom, weatherboard, it had been modified to accommodate five-bedrooms divided by chipboard walls, with shared bathroom and kitchen. With no bond or references this was the best option available to them. I remember attending a medical appointment with Steve and Kate and on the way home we stopped at the supermarket to get some basic food supplies. Even this small task was a challenge for them, as it was necessary to choose food that could last without being refrigerated. The rooming house was already overcrowded and they feared that if their food was kept in the communal kitchen it could be gone the next day. As we went together to buy our few items, the cashier requested to check Steve and Kate's bags, but did not request to check mine. Without hesitation the couple showed the contents of their bag while I stood with them angered and saddened by this blatant discrimination.

There is a common misconception that some individuals actually choose homelessness. I have never found this to be the case, although I acknowledge that some people may choose to not pay 85% of their welfare allowance towards often substandard, unsafe and overcrowded accommodation. Currently, the Newstart allowance is \$290 per week. Typically once rent is deducted this means trying to live on less than \$60 per week, which leaves very little money for food, medication and transport costs, not to mention luxuries like a phone, a haircut, a cup of coffee or a trip to the movies. Generally, if individuals are offered a safe, affordable, permanent

dwelling, very few would decline.

Safe, permanent, and affordable housing is a fundamental human right. Nationally, we are seeing a shortage of affordable housing, resulting in an increased number of individuals experiencing homelessness. It is essential we do not turn a blind eye to those who are most vulnerable. We need all levels of government to show leadership on this issue, and persist on tackling this devastating and widespread problem.

Our communities and health services have an important role to play in addressing this problem, but so do we as individuals. Homelessness deserves a well-coordinated and thoughtfully delivered response from government and community groups. Does your workplace have a policy on dealing with those experiencing homelessness? Make it your mission to find out, and be a force for the good fight against homelessness.

\*Real names not used.



Witnessing homelessness can be confronting for many. There are tough questions that a lot of good people ask themselves. Frequently I have been asked "What causes a person to be homeless?" and "When I see a person begging, is it right to give them money?" It is important to not lose sight of those most marginalised or ignore individuals facing extraordinary circumstances. Acting with compassion, kindness and respect will always win over. As a decent society, and as nurses and midwives it is important to have an awareness of what leads people to homelessness and to know that it is ok to say 'hello' or offer money to demonstrate some understanding. If you are uncomfortable offering money, you could consider offering to buy them a hot drink or providing them with a snack or meal. If that is too confronting, consider a charity or service that will make a difference to those experiencing homelessness. Over the year I have supported charities such as Orange Sky Laundry, Smith family and regularly support The Big Issue vendors. Many of my family and friends enjoyed receiving The Big Issue calendar for Christmas recently.



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