



# ANMJ

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## RISE OF HOMELESSNESS

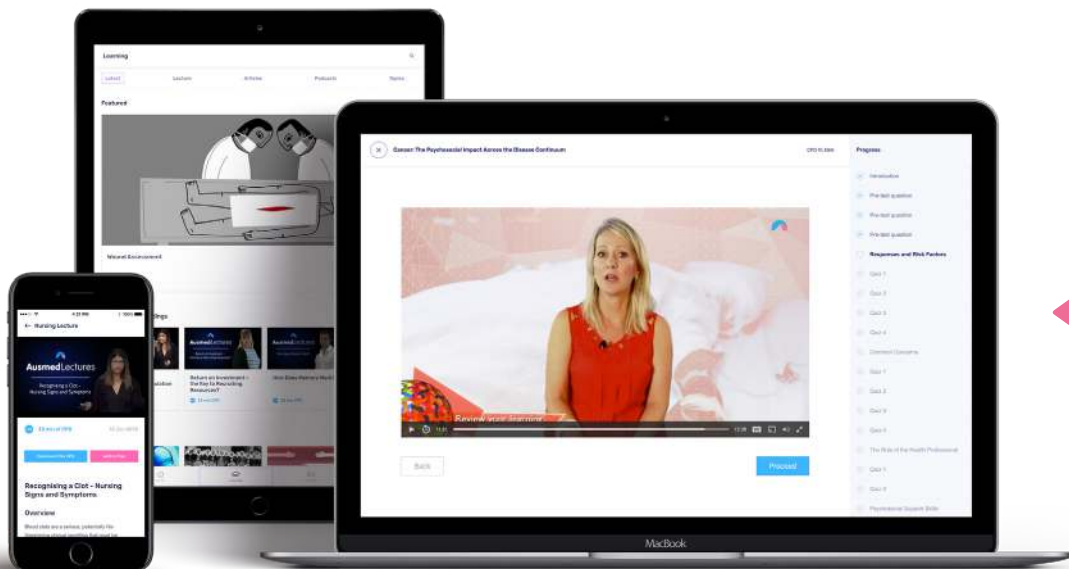
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04



15



## REGULARS

02 DIRECTORY

03 EDITORIAL

04 NEWS

15 WORLD

16 FEATURE: RISE OF HOMELESSNESS

22 VIEWPOINT

Men's preconception healthcare

24 LEGAL

From bedroom to crime scene

25 VIEWPOINT

Reading between the lines of an Adult Sepsis Pathway

26 WORKING LIFE

Late career change pays dividends

28 CLINICAL UPDATE

Care experiences and unmet needs of lesbian, gay, and bisexual people with cancer

31 PROFESSIONAL

Pressure injuries are not inevitable

32 REFLECTION

Remembering nurses who have died in the service of others

33 RESEARCH

34 FOCUS

Education: Part 2

47 CALENDAR

48 VALE

Nursing and midwifery leader never to be forgotten

16

# FEATURE RISE OF HOMELESSNESS



25



28





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## Editorial

Annie Butler ANMF Federal Secretary

With winter truly upon us, most of us, living in the southern part of Australia at least, dare not leave the house without thick coats, woolly hats and scarfs.

Yet as the days become darker and cooler my thoughts are with those living rough on our streets. Disturbingly, on any given morning in all capital cities you will see people wrapped up in sleeping bags and blankets sleeping on the streets and in parks.

According to the 2016 Census, homelessness in Australia has increased by 14% in five years from 2011 to 2016. Women over the age of 55 years are the fastest growing number of people experiencing this.

Low paid jobs and domestic violence are forcing many women out of the private rental market. This is why it is crucial there is a secure and decent minimum wage, a welfare safety net and improved job security in Australia. This month's feature looks into the issues causing homelessness. The article also portrays the tireless job nurses do to help improve the health and wellbeing of those living rough.

Following the launch of ANMF's aged care ratios campaign in May, pressure has been mounting on politicians to fix the crisis in this sector. For example, members from ANMF branches in Queensland, South Australia, Tasmania and Western Australia have been

seeking pledges of support for mandated aged care ratios from political candidates contesting five by-elections later this month. Already the Queensland Nurses and Midwives Union (QNMU, ANMF Qld Branch) has secured a pledge of support for aged care ratios from Longman candidate Labor MP Susan Lamb.

Meanwhile the ANMF has submitted a number of key recommendations to the federal Senate Inquiry into the financial and tax practices of Australia's for profit aged care providers.

The Inquiry, conducted by the Senate Economics Reference Committee, follows a Report commissioned by the ANMF, showing that the top six for profit providers received \$2.17 billion in government subsidies but paid little or no tax at a time when the number of care hours for residents has declined to dangerously low levels.

As a prerequisite for receiving any subsidy there must be proof that government funding is being directly spent on the care of elderly residents.

Signing off I would like to pay my deepest condolences to the family of former QNMU Secretary Gay Hawksworth, who died last month.

Gay led the Branch from 1995 to 2011. She was known as a bold and inspirational union leader, who fiercely advocated for nurses and midwives.

The ANMF will always remember her fondly for her impact on the union movement.

Annie

**LOW PAID JOBS AND DOMESTIC VIOLENCE ARE FORCING MANY WOMEN OUT OF THE PRIVATE RENTAL MARKET.**



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## CANDIDATES URGED TO SUPPORT AGED CARE RATIOS



Members from ANMF branches in Queensland, South Australia, Tasmania and Western Australia have been seeking pledges of support for aged care ratios from political candidates contesting five by-elections due to be held later this month on 28 July.

By-elections will take place in the Queensland electorate of Longman, Mayo in South Australia, Braddon in Tasmania, and Perth and Fremantle in Western Australia.

The unprecedented number of polls set for the same day, dubbed the Super Saturday by-elections, has presented a timely opportunity to judge the level of support for the ANMF's national campaign pushing for an end to chronic understaffing in the aged care sector by legislating aged care ratios.

"These by-elections represent a genuine litmus test regarding the level of political will in addressing chronic understaffing in our aged care sector," ANMF Federal Secretary Annie Butler said.

"We are calling on candidates to support mandated staff ratios in the aged care sector to ensure vulnerable elderly Australians living in nursing homes have access to safe quality care."

The Queensland Nurses and Midwives Union (QNMU, ANMF Qld Branch) has already made inroads, securing the pledge of support for aged care ratios from Longman candidate, Labor MP Susan Lamb.

Ms Lamb met with QNMU Secretary Beth Mohle and ANMF aged care ratios campaign face Cherise last month to seal her support for minimum staff ratios in the sector.

In South Australia, the ANMF (SA Branch) held meetings with candidates for the seat of Mayo last month, seeking support for aged care ratios from both the Centre Alliance's

Rebekha Sharkie and Liberal Candidate Georgina Downer.

Officially launched 12 May, International Nurses Day, the ANMF's national aged care ratios campaign is calling on federal politicians to stand up and support the legislation of ratios and ensure aged care providers are held accountable for the billion in government subsidies they receive.

A recent report prepared by the Tax Justice Network Australia on behalf of the ANMF showed the country's top six for-profit aged care providers received over \$2.17 billion in government subsidies – 72% of their total revenue – and made profits of \$210 million during 2016 and 2018 by using a range of loopholes to minimise the amount of tax they pay.

The report triggered a Senate Inquiry into the financial and tax practices of for-profit aged care providers that will investigate the use of tax avoidance or aggressive tax minimisation strategies and the associated impacts on the quality of care in the sector.

The ANMF's submission makes several key recommendations, including requiring any company receiving government funding over \$10 million to file complete audited annual financial statements with the Australian Securities and Investments Commission and residential aged care companies publicly and transparently disclosing the staff of all aged care facilities.

## PEAK BODY ESTABLISHED TO COMBAT RISK OF ELDER ABUSE

A new peak body established to protect vulnerable older Australians from elder abuse will focus on developing a national plan to counter the growing problem.

Attorney-General Christian Porter launched elder Abuse Action Australia (EAAA) last month on the eve of World Elder Abuse Awareness Day on 15 June.

He called the abuse of older Australians "tragic" and said the federal government was committed to working with key stakeholders to develop solutions to address the issue.

"EAAA has been established to work in partnership with government to promote the safety, dignity, equality, health and independence of older Australians through education, capacity building, data gathering and research," the Attorney-General said.

Developing a national plan to combat the issue will form a key role of the alliance.

Funding of \$500,000 has been provided

by the federal government through Budget initiatives to help EAAA contribute to policymaking and system design that prevents and addresses elder abuse.

EAAA will also investigate developing a central knowledge hub so older people, their families, carers and support staff, and allied professionals can access the information and training necessary to curb elder abuse.

A national plan emerged as a key recommendation from the 2017 Australian Law Reform Commission's Report: *Elder Abuse – a National Legal Response*, which highlighted numerous examples of physical abuse, financial abuse, neglect and exploitation of older people.

"As Australia's population ages, with the proportion of those aged 65 or over rising from 15% of the population in 2014-15 to 23% by 2055, we need to address the risk of abuse that faces people as they age.

"The Council of Attorneys-General agreed to work towards the establishment of a national register of Enduring Powers of Attorney as a key step to provide protection from financial abuse of older Australians."

On World Elder Abuse Awareness Day, the Australian Nursing and Midwifery Federation (ANMF) voiced its opposition to the abuse and suffering inflicted on older people around the globe and called out the systematic mistreatment and neglect of the nation's elderly living in residential aged care due to chronic understaffing.

The ANMF's current national aged care campaign is calling on federal politicians to

legislate minimum staffing numbers and an appropriate mix of registered and enrolled nurses and carers to residents.

"This level of mistreatment continues to occur across Australia with little recognition or response. But it is an issue that's affecting the health, wellbeing and basic human rights of our elderly and needs urgent attention now," ANMF Federal Secretary Annie Butler said.

The ANMF encourages nurses and carers working in aged care to report any concerns they have about the possible abuse of nursing home residents or others in the community to the Aged Care Complaints Commission.





## AUSTRALIAN NURSE CHOSEN TO LEAD INTERNATIONAL COUNCIL OF NURSES (ICN)



Australian remote area nurse turned research academic Dr Isabelle Skinner will represent more than 20 million nurses worldwide after being appointed the new chief executive officer (CEO) of the International Council of Nurses (ICN) last month.

Founded in 1899, ICN is a federation of over 130 national nursing associations, including the Australian Nursing and Midwifery Federation (ANMF), striving to advance the profession globally, influence health policy and improve health outcomes.

Currently a senior research fellow with James Cook University's Mount Isa Centre for Rural and Remote Health in north-western Queensland, Dr Skinner said she felt

humbled by the opportunity to take the reins of the world's top nursing job.

"It's quite unbelievable really," she said.

"Not only is it an honour but it's also a huge privilege because the thing that I'm really passionate about is rural and remote health and when we look at where all the ICN's key priority areas are, they've really focused very heavily on public health, universal health coverage, non-communicable diseases (NCDs), all of the things that actually speak to what I'm passionate about."

A past president of the professional body representing remote health professionals, CRANaplus, Dr Skinner is a registered nurse and midwife with extensive experience in remote area nursing, education, research and nursing leadership.

Looking back, she trained to become a nurse at age 17 at the Royal Brisbane Hospital and took up her first post at Cloncurry Hospital, near Mount Isa.

Not long after, while visiting a friend in Papua New Guinea, Dr Skinner discovered an interest in working in improving health in developing countries and upon returning to Australia realised she did not have to head overseas and could instead make the same impact in her own backyard.

Dr Skinner worked clinically for 15 years as a remote area nurse in areas such as the Katherine region in the Northern Territory and the Kimberley in Western Australia.

"In the 80s and 90s Aboriginal health was a different beast to what it is now. There wasn't so much non-communicable disease. We were still dealing with very high rates of infectious diseases, of childhood illness. We were having a huge problem with our immunisations. We were not managing the culture very well."

Over time, the mammoth health challenge out bush inspired Dr Skinner to move further into policy work where she was involved in projects such as establishing nurse practitioner (NP) legislation in Western Australia and working in university departments of rural health to impact remote health in an entirely different way.

Her venture into academia began in 2002 when she started working with the university

department of rural health in Western Australia and she has never looked back.

At her current post at JCU's Mount Isa Centre for Rural and Remote Health, Dr Skinner supports the nursing program and works on research, particularly rural based research.

"The whole objective of my career is to actually improve access to specialist health services for people living in rural and remote Australia and actually now around the world."

Dr Skinner's association with ICN extends to previously being part of its Telehealth, Advance Practice and Nurse Practitioner Networks, as well as attending ICN's major conferences.

She said what appealed to her most about the CEO role was the chance to engage and work together with national nursing organisations from around the world.

Dr Skinner said ICN's greatest challenge remained maintaining core relationships with national nursing organisations and getting everyone working together to create a learning community of nurses rather than a competitive environment.

"I am a trained manager so I can certainly bring good financial management skills.

I'm an innovator, an entrepreneur, so I can bring those skills to the ICN and I am used to looking at things from a different perspective and I think that will be a useful tool to bring to the ICN."

Dr Skinner will begin her new role in August and relocate to Geneva.

She encouraged all nurses to work on building relationships with their patients and getting the most out of their careers.

"I think for all nurses you need to find the part of nursing that actually really lights your fire," she said.

"For some people it's working in the emergency department, other people it's working in operating room nursing and for other people it's mental health and for people like myself it's been primary healthcare and remote area nursing.

"The thing that you love doing is the thing you read about, the thing you learn about and the thing that really takes your career forward."

## CHRONIC DISEASE NURSES LEAD TELE-MONITORING SERVICE IN COUNTRY SA

A trial of an innovative nurse-led home tele-monitoring service for country people with chronic disease has been launched in South Australia.

The Virtual Clinical Care (VCC) Home Tele-Monitoring Service monitors people with chronic diseases including respiratory, cardiac and diabetes allowing them to measure their clinical signs on a daily basis from home.

The VCC program enables people to monitor their own condition for a period of 12 weeks and respond to any changes quickly before their condition deteriorates.

As part of a four-month trial, dedicated chronic disease nurses will monitor patient information in a secure database known as the Virtual Clinical Care Hub.

"When abnormal clinical signs are identified by the system, the patient's care team and GP are notified and begin an action plan to manage their condition,"

Country Health SA Executive Director of Medical Services Dr Hendrika Meyer said.

The use of dedicated chronic disease nurses to monitor the database would allow more patients to be monitored by the service, Dr Meyer said.

"This initiative not only provides patients with the ease of being monitored at home, but could have the potential to save lives.

"The expansion of this program will benefit the community greatly, allowing many more people to manage their chronic conditions themselves, with support close at hand."

Clinicians will assess the outcomes of the VCC monitoring model at the end of the trial. [sahealth.sa.gov.au/countryhealthsa](http://sahealth.sa.gov.au/countryhealthsa)

## MINIMUM WAGE INCREASE A STEP IN THE RIGHT DIRECTION

More than 2 million workers will receive a pay boost after the Fair Work Commission announced a 3.5% increase, or \$24.32 per week, to the minimum wage last month.

The commission is tasked with conducting a review of the national minimum wage each year and its 2017-18 Annual Wage Review will see 2.3 million workers on modern awards receive no less than \$719.20 per week.

Nonetheless, the 3.5% increase falls well short of the 7.2% called for by unions.

Australian Council of Trade Unions (ACTU) Secretary Sally McManus said the latest increase was a step in the right direction to the union's goal of 60% of the median wage but would still leave some full-time workers struggling.

The minimum wage should not leave people in poverty but should provide a comfortable life for low-paid workers, she added.

"The minimum wage should be pegged at 60% of the median wage," Ms McManus said.

"This is the level set by the OECD – that



is what's required to ensure that every full-time worker in Australia can survive on their wage."

In reviewing the minimum wage annually, the FWC takes into account a range of considerations including promoting social inclusion through increased workforce participation, relative living standards and the needs of the low paid and various economic issues.

Ms McManus said the 3.5% increase equated to \$26.71 more per week for a hospitality worker and \$24.33 for a horticulture worker.

"All Australians need a pay rise, but none more so than the 2.3 million people who are now award reliant," she said.

"We have to change the rules on the minimum wage. People who have been

forced into poverty by the inadequacy of this wage should not have to wait every year to see if they will be saved by the Fair Work Commission. The minimum wage should be set to keep pace with wages."

Ms McManus reinforced that moving towards a Living Wage would help mitigate widening income and wealth inequality.

A poll conducted by the ACTU shortly before the FWC announcement asked 1,502 respondents to decide which of two statements better represented their view.

More than 64% agreed that "increasing the minimum wage will increase the amount people have to spend, creating demand that will create jobs" while just 35.8% agreed "increasing the minimum wage will increase the costs on small business, cost jobs and force small businesses to close".

## DIGITAL HEALTH SET TO TRANSFORM AUSTRALIA'S HEALTH SYSTEM

Publicising data that allows patients, their carers and future consumers to compare residential aged care facilities based on health outcomes and patient experiences was among the key recommendations identified in a new expert report.

The report also declared Australia is poised to roll out a digitally enabled health system that could transform care services.

Developed following an expert roundtable initiated by the Consumers Health Forum (CHF) and the George Institute for Global Health, the report states "the time is now ripe" to support the expansion of digital health technology in vital areas including

chronic care and residential aged care.

The report is based on discussions held by about 40 consumers, clinicians, academics, government and industry supported by the Australian Digital Health Agency.

Roundtable attendees considered four sectors – chronic care, residential aged care, emergency care and end of life care and what is wanted from digital health, the current state of digital health in that sector and how to meet goals in the future.

The report said major progress was being made with My Health Record, e-prescriptions, patient registries, shared care portals, state-based digital health strategies and linked hospital patient information systems.

The report sets out clear recommendations regarding what is needed to enable people to take more control of their own health needs and make informed choices about their care.

The recommendation identified for chronic care involved trialling virtual care teams to support patients with high care needs and a 'Patient Like Me' platform to enable patients with chronic and complex care needs to safely connect and share experiences with one another.

In residential aged care, the recommendation pinpointed ensuring

residents' health and social services information is readily available in a single location, on a platform easily accessible by consumers and providers anywhere, anytime on any device.

It was also suggested to collate and publicise data that allows patients, their carers and future consumers to compare residential aged care facilities based on health outcomes and patient experiences.

"The time is now ripe to leverage this maturing digital health capacity in ways that are meaningful to both consumers and providers," CEO of Consumers Health Forum, Leanne Wells, said. "If done well, it has potential to be transformative for Australia's health system bringing about rapid enhancements in quality, safety, accessibility and efficiency."

Ms Wells said the health system had lagged behind other sectors in embracing the power of digital disruption.

"For Australia to embrace health and benefit from its huge potential, we need national leadership. The COAG National Digital Health Strategy provides a foundation but what is needed is stronger, coordinated direction from the federal, state and territory governments."



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## WOMEN READY TO CHANGE THE RULES

Women are more supportive of the ACTU's Change the Rules campaign, recent polling shows.

The Australian Council of Trade Unions (ACTU) campaign includes restoration of a living wage and penalty rates, a fairer and more independent workplace umpire, more equitable working arrangements and changes to superannuation to ensure no one retires in poverty.

ACTU Secretary Sally McManus said recent polling showed the campaign strongly resonated with female voters. "Women are ready to change the rules because they are being hit harder by our broken workplace rights."

The ACTU survey found 63% of women were opposed to cuts to penalty rates compared to 50% of men. More than half of women (54%) polled considered cutting penalty rates would result in businesses



making more profits, not employing more people or delivering wage rises, compared to 47% of men.

The polling found women fared worse than men in the current industrial climate. A total of 67% of women reported not having had a pay rise in the past 12 months compared to 61% of men. Only 31% of women had a wage rise in the past year compared to 39% of men. And 52% of women considered it harder to get a wage rise that covered the cost of living compared to 45% of men.

Both men and women had similar levels of concern around the levels of insecurity they felt in their work.

While women were hardest hit by Australia's current crisis of insecure work and stagnant wage growth, they stood to gain the most from changes the ACTU was fighting for, Ms McManus said.

"We need to change the rules for women in work. We need action on the gender pay gap, penalty rates, secure jobs and flexible work arrangements."

[changetherules.org.au/](http://changetherules.org.au/)

## NURSES HAILED IN QUEEN'S BIRTHDAY LIST

Nurses around the country were awarded for their extraordinary work in the Queen's Birthday Honours List 2018.

Nurses highlighted their breadth and scope of practice in all facets and contexts in Australia

— from clinical to management, politics and history to social welfare and community, and from metropolitan to rural.

Nurses recognised in this year's honours list included:

- **Terry Ann Cramwell (AM)**: Parliament and politics in QLD, and to women in rural and regional communities
- **Anne Therese Cross (AM)**: community through social welfare organisations in the government and not-for-profit sectors, and to women
- **Phyllis Mary Davis (AM)**: nursing through clinical, administrative and international advisory roles, and to nurse education
- **Cheryl Ann Norris (AM)**: nursing, particularly to neonatal paediatrics, as a

clinician and administrator, to education, and to the history of nursing in Tasmania

- **Julienne Florence Feast (OAM)**: the community of Mount Gambier
- **Elizabeth Mary Fraser (OAM)**: community
- **Jane Mary Griffith (OAM)**: nursing
- **Blanche Lynette Mulligan (OAM)**: community through a range of organisations
- **Michael John Oates (OAM)**: psychiatric nursing
- **Julienne Tyers (OAM)**: nursing, and to international eye-health programs
- **Jane Elizabeth Gallagher (PSM)**: outstanding public service in the areas of nursing services to veterans

## NEW HIV CASES ALMOST HALVED IN GAY AND BISEXUAL NSW MEN

New HIV diagnoses among gay and bisexual men in NSW have almost halved over the past five years, new figures shows.

It comes as the state moves closer towards its aim of ending HIV transmission by 2020.

The latest NSW Health data showed the number of new HIV diagnoses in Australian-born men who have sex with men dropped by 48% in the first three months of 2018.

There had been an overall 14% decline in new HIV diagnoses across NSW in January to March 2018 compared to the same period in the previous five years.

NSW Chief Health Officer Dr Kerry Chant said the results showed more testing, higher uptake of treatment in people with HIV and the addition of the new HIV prevention tool PrEP alongside condom use were having an impact.

"NSW Health is working hard to reach the

goal of eliminating HIV transmission over the next two years."

While the first quarter results in 2018 were encouraging, there was still more work to be done, Dr Chant said. "Nearly 70% of men who have sex with men who were diagnosed with HIV in January to March 2018 had their previous HIV test more than 12 months prior to their diagnosis, and 20% had never previously tested for HIV."

Small numbers of HIV notifications through heterosexual contact still persisted in NSW, she said. Of the people diagnosed in NSW in January to March 2018, 15% likely acquired their infection through heterosexual sex.

## STUDY INVESTIGATES HEALTH OF LOW-PAID AGED CARE WORKERS

A new study is examining how employment conditions affect the health of carers and other low-paid workers in the aged care sector.

The research, which is being undertaken in partnership by the University of Melbourne and the Brotherhood of St Laurence, aims to explore the connections between health and work among the cohort in response to Australians being forced to work longer and the pension age tipped to reach 70.

Researchers are currently recruiting 20 older workers aged over 50 from different life situations.

Qualitative interviews will delve into people's family situations and caring responsibilities, work roles and whether they feel valued, their financial situation, health issues and experiences of ageing.

The study is due to be completed by April 2019, and is one component of five studies that form a larger Australian Research Council Linkage Project titled "Working longer, staying healthy and keeping productive".

The project seeks to inform policy development regarding older workers and their workplaces.

A researcher working on the study, Dr Aaron Hart, said the focus on the aged care sector presents an opportunity to



contribute to current discussions surrounding regulations and workforce issues.

Dr Hart listed poor health as the most common reason for involuntary retirement, saying research shows poor health is associated with work characteristics such as hectic and psychologically demanding roles, lack of autonomy and decision-making and physically demanding work.

"We are interested in the psychosocial and physical quality of work in the aged care sector, and any ideas people might have about making the work less stressful on their body and on their mind."

Dr Hart said the pension age increase to 67 and plans to lift it to 70 presented genuine social equity issues, particularly for people who do not own a home or do not have large superannuation nest eggs.

Dr Hart suggested the current push to make Australians work longer would likely affect women more than men, with many tending to occupy lower-paid roles that will

be the subject of the study.

"As we wind out the working age and require people to work longer it's going to be people in the lower skilled, lower-paid roles that are going to be most disadvantaged."

Dr Hart acknowledged that aged care staffing levels could emerge as a significant issue in the findings.

"We'll be all ears and if the workers are telling us that this is one of the biggest issues, that they don't get time to rest or practice their care roles properly and that makes them feel stressed and it lowers their job satisfaction because there's just too much caring to do and not enough carers to do it, if that's the message then we'll certainly reflect that in our findings."

If you are interested in taking part in the study complete this survey [surveymonkey.com/r/working-well](https://surveymonkey.com/r/working-well)

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## PUSH FOR TARGETED ANTI-SMOKING CAMPAIGNS IN RURAL AUSTRALIA

Governments must address “alarming rates” of smoking in rural Australia by implementing targeted anti-smoking campaigns to help curb the problematic health issue, according to Dr Adam Coltzau, President of the Rural Doctors Association of Australia.

Australians living in rural areas are the biggest smokers in the country, with one in five people living in outer regional or remote areas smoking daily, and therefore vulnerable to numerous related illnesses causing death.

Smoking is the largest preventable cause of death and disease in Australia and linked to heart disease, stroke, asthma, renal disease and cancer.

Dr Coltzau said while smoking rates across Australia had fallen in recent years, rural Australians, particularly those living remote or very remote, continued to smoke at “alarming rates”.

“Anti-smoking initiatives have been effective in reducing smoking rates in many areas of Australia but they have not worked



as well in the bush,” Dr Coltzau said.

“It’s time for targeted campaigning, aimed specifically at reducing smoking rates in our rural population, to help manage this ongoing health crisis.”

Dr Coltzau said the damage triggered by smoking was multifaceted and included negative impacts on household budgets, costs to the health system of billions of dollars, and most importantly, loss of life.

Dr Coltzau acknowledged ongoing

funding aimed at reducing indigenous smoking rates, but said there was no program targeted at tackling smoking rates in the broader rural and remote community.

“While the federal government will be raising more than \$11 billion a year from tobacco taxes, there has been no national media campaign to reduce smoking since 2012, and yet again there is no allocation for one in the most recent federal Budget.”

## AUSTRALIA'S HEALTHY STAR RATING SYSTEM UNDER REVIEW

The effectiveness of Australia’s health star rating system will be under review amid the federal government’s push to make the ratings mandatory.

The Australian Government introduced the world-first Health Star Ratings system to promote healthy eating in 2014.

The voluntary health star rating system was aimed to rate the healthiness of packaged food.

It was specifically designed to assist shoppers to quickly pick the healthiest food options, said Dr Sateesh Seenivasan of Monash University’s Business School.

“When faced with two boxes of cereal – one with a rating saying it is healthy, one with a less favourable rating – do you pick the healthier option?”

The two-year Monash University project will use actual consumer purchase data to assess whether the ratings have had any effect.

There was no current research about how people’s actual purchasing habits had changed since the ratings, Dr Seenivasan said.

“What we will do is look at people’s whole shopping baskets and analyse how the healthiness of their baskets have changed since the health star labelling was introduced.”

“We also want to see whether making Health Star Ratings mandatory will make them more effective or change people’s shopping behaviour more.”

The Australian government has undertaken a five year, large scale review of the health star ratings system before looking to make the system mandatory.

The success of the system has been questioned due to it being voluntary and that it is not designed to compare products across different categories, eg. comparing chips to cheese.

Australia’s health star ratings are currently most prominent on cereal boxes with stars displayed on many products.

“But when we look across a whole basket of goods their effects are not evident because the system is still voluntary and not many companies have adopted them,” Dr Seenivasan said.

This was changing with Coles and Woolworths adopting the ratings across their private labels, he said. “I think there is an expectation that these ratings will become mandatory and so these large producers want to be seen as early adopters of them.”

Several retailers in the United States use health labels and a Canadian supermarket chain has also introduced a health rating system.

“We believe what happens in Australia on these indicators may inform the rest of the world on whether nutrition summary indicators such as health star ratings can help change behaviours,” Dr Seenivasan said.

The study will also involve collaborators from the University of Melbourne and Deakin University. Results will be submitted to Health Star Ratings Advisory Committee as part of the government’s review.



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NIP: National Immunisation Program; MMR: measles, mumps, rubella; HibMenC: *Haemophilus influenzae* type b and *Neisseria meningitidis* serogroup C; Hib: *Haemophilus influenzae* type B

Please review full Product Information before prescribing. Product Information is available on request on 1800 675 229 or at [www.pfizer.com.au](http://www.pfizer.com.au)

**References:** 1. Australian Government Department of Health. National Immunisation Program Schedule. Available at: <https://bit.ly/2EkXr3l> (accessed: June 2018). 2. Australian Government Department of Health: Australian Technical Advisory Group on Immunisation. Public consultation on the infant pneumococcal vaccination schedule. Available at: <https://bit.ly/2lcQ9WF> (accessed: June 2018). 3. Australian Government Department of Health: Australian Technical Advisory Group on Immunisation. Public consultation on changes to the recommended use of meningococcal and *Haemophilus influenzae* type B vaccines. Available at: <https://bit.ly/2Gf9cd7> (accessed: June 2018). 4. The Pharmaceutical Benefits Scheme. March 2018 PBAC Meeting – Positive Recommendations. Available at: <https://bit.ly/2li8ulc> (accessed: June 2018). <sup>™</sup>Trademark, <sup>®</sup>Registered trademark. Pfizer Australia Pty Limited, Sydney, Australia. PP-NIM-AUS-0051 S&H 06/18 PFPFSH0168/ANMJ

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## NEW MIDWIFERY STANDARDS FOR PRACTICE

The Nursing and Midwifery Board of Australia (NMBA) is asking all midwives to view new standards for the profession and reflect on how they relate to their practice.

The *Midwife standards for practice* replace the existing *National competency standards for the midwife*.

Seven interrelated standards are framed within a woman-centred approach and contain criteria that specify how the standard can be demonstrated.

All midwives in Australia will need to ensure their practice meets the new standards from 1 October 2018.

NMBA Chair Associate Professor Lynette Cusack said the new standards provided a framework for midwifery practice in all contexts.

"The *Midwife standards for practice* are evidence-based and have been tested across midwifery settings, including clinical,

community and governance applications."

The standards had been thoroughly researched and widely consulted on, Ms Cusack said. "They will help midwives to ensure their practice meets the contemporary standards of their profession and the trust women place in them."

The standards reflected the midwife's continuous woman-centred professional relationship that may extend from preconception to the postnatal period acknowledging the role midwives play across the health system, she said.

The standards can be viewed on the professional standards section of the NMBA website.

[nursingmidwiferyboard.gov.au/](http://nursingmidwiferyboard.gov.au/)

## NURSE-LED MODEL OF COLORECTAL CANCER SURVEILLANCE IMPROVES OUTCOMES

A nurse-led model of colorectal cancer surveillance has shown improved patient outcomes, research shows.

Under the nurse-led model compliance with guideline recommendations increased to 97%, with a reduction in the number of unnecessary colonoscopies and in the

number of cases that progressed to cancer.

Screening and surveillance guidelines increase the effectiveness of colorectal cancer (CRC) prevention. Surveillance intervals generally range between one and five years.

However compliance with those recommendations is poor. The research highlighted that as many as 89% of patients receive inappropriate surveillance – usually a colonoscopy before the recommended date. About one third of those were usually due to patient symptoms or faecal occult blood test results.

South Australia's Flinders Centre for Innovation in Cancer (FCIC) compared two models of CRC surveillance. One nurse-led in two public hospitals, where nurses make recommendations based on NHMRC guidelines which are confirmed by a physician. The other physician-led in four private hospitals where the specialist physician manages the whole process. Both models of care were audited over three months.

In the nurse-led model 97.1% compliance with surveillance guidelines was achieved

compared to the physician-led model of 83%.

FCIC Senior Scientist and lead researcher Dr Erin Symonds said that having a process in place that allowed for long-term compliance with surveillance guidelines promoted optimal healthcare, as procedures performed too frequently could increase risks to patients, were expensive, and lengthened waiting lists.

"Continuous monitoring of and education about colonoscopy surveillance intervals for patients at elevated risk of CRC promotes adherence to recall guidelines and efficient use of limited endoscopy resources."

ANMF Senior Federal Professional Officer Julianne Bryce said registered nurses were well placed to undertake CRC screening, particularly the recall and reminder process.

"Registered nurses have the theoretical knowledge and understanding that underpins the decision-making required for CRC surveillance. This includes decision-making where colonoscopy is appropriate or unnecessary in line with evidence-based recommendations."

## POSTAL CODE AFFECTS LGB HEALTH

Lesbian, gay and bisexual Australians suffer more health problems in areas where most people voted against same-sex marriage, research shows.

University of Queensland (UQ) researchers attributed stigma against those who identified as lesbian, gay and bisexual (LGB) as a key factor in explaining the disadvantage in health status.

The UQ study was the first of its kind conducted outside the United States and involved data from 15,000 people to electorate level same-sex marriage postal vote results.

"LGB people living in electorates with higher percentages of 'no' voters in the 2017 postal survey reported poorer general health, mental health and life satisfaction than LGB people living elsewhere," UQ Institute for Social Science Research's Dr Francisco Perales said.

The study found heterosexuals had better health and wellbeing overall. However those differences reduced or dissipated in electorates with higher rates of support for same-sex marriage.

The results indicated that a lack of social support available for LGB



people in some parts of Australia played a crucial role, Dr Perales said. The findings had significant implications for developing social policies aimed at improving the outcomes and social standing of Australian LGB people.

"Our results highlight the need for interventions that reduce the complex discrimination faced by LGB people and increase the social support available to them."

The study was published in journal *Social Science & Medicine*.



## DISADVANTAGE DURING CHILDHOOD SHAPES DEVELOPMENT

Almost one third of Australian children experience some form of disadvantage that can have a lasting impact on their development, research has found.

The study of more than 5,000 children, titled Changing Children's Chances, identified patterns in children's experiences of disadvantage between birth and age nine and how these affected children's development at ages 10–11 to measure any long-lasting impact.

The researchers from RMIT University and Murdoch Children's Research Institute specifically looked at how four types of disadvantage – sociodemographic factors, geographic environments, health conditions and risk factors – influenced critical childhood development including interpersonal and motor skills, literacy and numeracy.

Using data from the Longitudinal Study of Australia's Children, researchers found 41% of children who had experienced disadvantage sat in the bottom 15% of NAPLAN literacy and numeracy test scores.

The study's co-author, Dr Hannah Badland, from the Healthy Liveable Cities Group based at the RMIT Centre for Urban Research, said living in a neighbourhood lacking amenities such as local parks, libraries, and quality early education and primary schools, causes long-term impacts on children's health and development.

"When people hear the word disadvantaged, they often think about how wealthy someone is, how much power they have, how much prestige they have," she said.



"For children, disadvantage manifests in the circumstances in which they live, learn and develop."

Dr Badland said children's exposure to disadvantage generally widened over time.

"Those who started out in the most advantaged neighbourhoods became more advantaged over time, while those who started in the most disadvantaged neighbourhoods became more disadvantaged."

However, Dr Badland highlighted that change was possible, with something as simple as the establishment of a community library just one example of providing excellent benefits to a child's development.

PBS information: These products are listed on the National Immunisation Programme (NIP) for children only and are not listed on the PBS. Refer to the NIP Schedule.

### **NIMENRIX. Minimum Product Information. NIMENRIX™ Meningococcal polysaccharide serogroups A, C, W-135 and Y conjugate. Powder for IM Injection.**

**Indications:** Active immunisation of individuals from the age of 12 months through 55 years against invasive meningococcal disease caused by *Neisseria meningitidis* serogroups A, C, W-135 and Y. **Contraindications:** Hypersensitivity to the active substances or excipients. **Precautions:** Avoid intravascular, intradermal or subcutaneous administration; appropriate treatment and supervision must be readily available in case of a rare anaphylactic reaction; postpone administration in acute severe febrile illness; syncope can occur following/before any vaccination; consider the risks of I.M. injection in thrombocytopenia or coagulation disorders; does not protect against other serogroups or other organisms; protection may not be conferred in 100% of patients; adequate immune response may not be elicited in immunisation of individuals with immunodeficiency or receiving immunosuppressive treatment; safety and immunogenicity not assessed in patients with increased susceptibility to meningococcal infection (such as terminal complement deficiencies and anatomic/functional asplenia); does not replace routine tetanus immunisation; in patients with increased risk of MenA exposure and who received first dose of Nimenrix more than one year prior, a second dose of Nimenrix may be considered; subjects previously vaccinated with a plain polysaccharide meningococcal vaccine and received Nimenrix 30–42 months later had lower immune response (Clinical relevance of this observation is unknown); safety during pregnancy or lactation not established. See PI for details. **Interactions with other Medicines:** Can be administered concomitantly with several other injectable vaccines at separate sites. Should either be co-administered or administered at least one month before a TT-containing vaccine. See PI for details. **Adverse Effects (Very Common/Common):** Lost appetite, irritability, drowsiness, headache, fever, swelling, pain and redness at injection site, fatigue, gastrointestinal symptoms and injection site haematoma. See PI for details. **Dosage and Administration:** For intramuscular use only. 0.5 ml as a single dose of reconstituted vaccine. Booster may be given if previously vaccinated with a plain polysaccharide meningococcal vaccine. The need for a booster dose in subjects primed with Nimenrix has not been established. Use should be in accordance with official recommendations. See PI for details. V11217.

**PREVENAR 13. Minimum Product Information. Prevenar 13® suspension for IM injection. Indications:** Active immunisation for the prevention of disease caused by *Streptococcus pneumoniae* serotypes 1, 3, 4, 5, 6A, 6B, 7F, 9V, 14, 18C, 19A, 19F and 23F in adults and children from 6 weeks of age. **Dose:** 0.5 mL I.M. **Infants 6 weeks to 6 months of age:** 3 doses at least one month apart. A single booster should be given in the second year, at least 2 months after the primary series. **Previously unvaccinated children:** Varies with age at first dose, see full PI. **Children previously vaccinated with Prevenar (7vPCV):** Children 12 months to 5 years who have completed primary infant immunisation with 7vPCV and children 6 to 17 years who have received one or more doses of 7vPCV may receive 1 dose, at least 8 weeks after the final dose of 7vPCV. **Adults:** 1 dose. **Special Populations (higher risk, e.g. HIV, SCD):** 1 dose. HSCT: 4 doses. If sequential administration of Prevenar 13 and 23vPPV is considered, give Prevenar 13 first. **Contraindications:** Hypersensitivity to any component of the vaccine, including diphtheria toxoid. Allergic or anaphylactic reaction following prior administration of 7vPCV. **Precautions:** Do not administer intravenously, intravascularly, intradermally or subcutaneously. Avoid injecting into or near nerves or blood vessels. Do not inject into gluteal area. Postpone administration in acute, moderate or severe febrile illness. Only protects against *Streptococcus pneumoniae* serotypes included in the vaccine and may not protect all individuals from pneumococcal disease. Consider the risks of I.M injection in infants or children with thrombocytopenia or any coagulation disorder. Appropriate treatment and supervision must be readily available in case of a rare anaphylactic event. Prophylactic antipyretic medication is recommended for children receiving concomitant whole-cell pertussis vaccines, and for children with seizure disorders or history of febrile seizures. Consider the potential risk of apnoea when administering to very premature infants. **Very Common/Common Adverse Effects:** *Children 6 weeks to 5 years:* Injection site reactions (redness, pain, swelling), fever, diarrhoea, vomiting, decreased appetite, drowsiness/increased sleep; restless sleep/decreased sleep, rash, irritability. *Children and adolescents 5 to 17 years:* Irritability, injection site reactions (redness, pain, swelling), somnolence, poor quality sleep, injection site tenderness (including impaired movement), fever, decreased appetite, vomiting, diarrhoea, headaches, rash. *Adults:* Diarrhoea, vomiting, nausea, chills, fatigue, injection site reactions (redness, pain, swelling), limitation of arm movement, fever, new or aggravated joint or muscle pain, decreased appetite, headaches, rash. Adults >65 years reported fewer adverse effects than younger adults. Adverse effects were generally most common in young adults 18 to 29 years. See full PI. (V10516).

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## BRING NURSES TOGETHER FROM AROUND THE GLOBE

By ANMF Assistant Federal Secretary Lori-Anne Sharp

I was fortunate to represent the ANMF at the International Council of Nurses (ICN) Triad meetings in Geneva, Switzerland in May this year.

Every two years ICN hosts a meeting of its member organisations in Geneva in advance of the World Health Assembly. These meetings bring together national nursing and midwifery organisations, chief government nursing and midwifery officers, regulatory bodies and the World Health Organization (WHO).

Over 80 countries were in attendance representing 20 million nurses worldwide.

The ICN's theme this year was health is a human right.

The four-day Triad meetings focused on ways to support and strengthen nursing and midwifery leadership at national, regional and international levels in the broader context of health workforce, health systems and global health priorities.

Countries shared their stories on recruitment and retention, impact of burnout, social determinants of health, and effects of climate change, universal health coverage and the high percentage of deaths globally attributed to non-communicable diseases.

ICN presented two stories of how nurses from around the globe are achieving the WHO Sustainable Development Goals.

I was both delighted and impressed to hear that one of the case studies chosen was from Brisbane's outreach service "homeless to healthcare", demonstrating how nurses are working to break the poverty cycle in their delivery of healthcare to those experiencing homelessness.

Co-chair Lord Nigel Crisp gave an update of the Nursing Now! Campaign which, launched in February 2018. The campaign is a three year global campaign being run in collaboration with the ICN and WHO, ending on 12 May 2020 on Florence Nightingale's 200th birthday.

The campaign's vision is to improve health globally by raising the profile and status of nurses worldwide. It seeks to build a global movement influencing policy makers and supporting nurses to leadership positions. ANMF Federal Office will be talking more about the Nursing Now! Campaign at the upcoming annual delegates' conferences.

It was very interesting to hear from representatives from the Korean Nurses Association (KNA) who addressed the



ANMF ASSISTANT FEDERAL SECRETARY LORI-ANNE SHARP WITH NEWLY APPOINTED WHO CHIEF NURSING OFFICER ELIZABETH IRO

meeting and shared a video of two Austrian nurses, who spent 43 years taking care of leprosy patients on Sorokdo Island in South Korea. The KNA has established a petition calling for the recommendation of these two nurses for the Nobel Peace Prize.

The KNA has asked the ANMF to share their petition with our members in Australia. I encourage all nurses and midwives reading to offer their support for such an incredible story of commitment and dedication. The KNA is seeking one million signatures. To find out more, the online petition can be found at [mm.kna.or.kr](http://mm.kna.or.kr)

I left the Triad meetings grateful to have experienced this unique opportunity and the chance to share knowledge, network and learn from other health professionals around the globe. I was often reminded how lucky we are here in Australia, compared with many other countries- while not losing sight that there is still much work to be done here, especially in the areas of aged care, mental health, addressing inequality and raising the status of nurses and midwives in supporting them to lead change.

At the conclusion of the four-day meetings, participants signed up to the 2018 Triad statement. The link to the statement can be found here: [who.int/hrh/nursing\\_midwifery/TriadStatement\\_18MayFinal.pdf](http://who.int/hrh/nursing_midwifery/TriadStatement_18MayFinal.pdf)

**WE LEARNT THAT 70% OF HEALTH WORKERS GLOBALLY ARE WOMEN AND THAT THERE IS A PREDICTED GLOBAL SHORTAGE OF NINE MILLION NURSES BY 2030.**



# NURSES TO TACKLE NON-COMMUNICABLE DISEASE GLOBALLY

The World Health Organization (WHO) has recommended nurse-led models of care as crucial in tackling non-communicable disease (NCD) in a latest report.

A WHO independent global commission on NCDs made six key recommendations in its final report. The commission was established to identify ways to curb the world's biggest causes of death and extend life expectancy.

NCD kills 15 million people aged 30-69 each year. Low and middle income countries are particularly affected by NCD; almost 50% of premature deaths from NCD occur in these countries.

The sustainable development target is for a one-third reduction in premature NCD deaths by 2030. This includes political efforts to accelerate action on cardiovascular disease, cancers, diabetes and respiratory disease; and to reduce suffering from mental health and the impacts of violence and injuries.

The WHO report recognised many nurse-led models of care which enabled nurses to work to their full scope of practice.

"Within a multidisciplinary health workforce, nurses have especially crucial roles to play in health promotion and health literacy, and in the prevention and management of NCDs.

"With the right knowledge, skills, opportunities, and financial support, nurses are uniquely placed to act as effective practitioners, health coaches, spokespersons, and knowledge suppliers for patients and families throughout the life course."



International Council of Nurses President Annette Kennedy, who serves on the NCD Commission, said she welcomed the recommendation to mobilise and invest in nurses to make substantial progress on addressing NCD.

"Recognising, investing and mobilising the nursing workforce will lead to real and lasting change in individual and population health wellbeing."

Nurses as the largest group of healthcare professionals were the key providers of NCD prevention, treatment and management, she said.

"Nurses, as the first point of contact, are well positioned to detect, treat and refer patients with NCDs as well as to provide information, education and counselling to the public on prevention of NCDs."

For more information, visit [icn.ch](http://icn.ch)

# PATIENTS TO SUFFER UNDER CASH-STRAPPED AND UNDERSTAFFED NHS

Nurses working in the public sector in England cared for more patients than ever before in the last financial year.

Figures released by the National Health Service (NHS) showed unprecedented demand with record numbers of patients attending accident and emergency coupled with high vacancy rates.

At the end of the year there were 92,694 staff vacancies; nursing accounted for 35,794 of those. While 95% of nursing vacancies were filled with agency or bank staff, it cost the NHS £976 million.

The increase in demand for services contributed to the NHS having a deficit of

£960 million at the end of 2017-2018.

Royal College of Nursing (RCN), Chief Executive Janet Davies said the figures revealed a cash-starved NHS forced to run without enough staff to treat people safely.

"The number of nurses missing from England's NHS remains stubbornly high – hospitals cannot afford to recruit and inadequate numbers are being trained too."

The figures were released as the RCN warned that nurses were being made to choose between paperwork and patient care because of staff shortages. The RCN surveyed 30,000 nursing staff. In its report, the RCN described the profession as "on the brink" with 43,000 vacant fulltime nursing

posts across the UK which hampered their ability to do the job. Nurses' main concerns were lack of time to provide personal and patient care, including time to wash patients or get them back to bed.

For as long as hospitals remained £1 billion in the red, patients would pay a heavy price, Ms Davies said.

"Whether the Chancellor announces extra funding in time for the NHS anniversary this summer or waits until the Autumn Budget, it must be both substantial and genuinely new money.

'It would not be enough just to wipe these deficits – health and care budgets must be boosted to reflect genuine demand. Anything less exposes patients to unacceptable risks and leaves care increasingly unsafe."



# RISE OF HOMELESSNESS

Despite being a wealthy country, homelessness in Australia is on the increase. According to the latest Census older women and young people are the most vulnerable, while growing overcrowding in group accommodation is becoming commonplace. As winter hits, Cathy Beadnell examines the reasons for homelessness and the significant work nurses are doing to address the issue.

When now retired nurse Chiew Ung Tan (CU) moved from Singapore to Melbourne in 2003 to work at a large private hospital, she was unprepared for how difficult it would be to find a home. CU had lived and worked in Sydney and Melbourne for 10 years as a graduate nurse in the 1980s but returned to Singapore to care for her ailing mother in 1991.

"I did my training in England but moved to Australia with some friends to start my career as a graduate nurse. I trained as a midwife, so I was keen to work in this area when I arrived in Sydney. I was told there was no work for me in midwifery and I was placed in a special baby care unit."

CU resigned from her job in Sydney after being moved into the ICU department of the infant special care unit after only a few weeks in the role.

"When they moved me into ICU I was out of my depth professionally and I told the DON I wasn't comfortable or qualified, but she insisted I remain in ICU. One day I came back from a break and a baby turned blue. A doctor and I resuscitated the baby, but it gave me a real scare, so I resigned from the job and moved to Melbourne," she says.

"I loved my work in Melbourne. I ended up in gynaecology at the Royal Women's and really enjoyed it. I was offered a job in midwifery but decided I was learning a lot in gynae and it was an experience I knew would be useful if I ended up back in midwifery."

After 10 years at the Royal Women's in a job she loved CU returned to Singapore when her mother fell ill.

"By the time I arrived back in Singapore my mother had improved. I told her I would stay on for a few months to make sure she was ok and then I would return to Melbourne for work. Somehow I ended up staying on in Singapore and after five years my permanent residency status in Australia was cancelled."

CU spent the next 12 years in Singapore working as a midwife and nurse. In 2003 she attended a recruitment seminar in Singapore run by an Australian firm. She signed up for a two-year contract to return to Australia to work as a midwife. In 2003 she returned to Melbourne having lost many of the connections she had made during her previous stay.

"I arrived in Melbourne without a great network and stayed briefly with a friend, but I didn't like it because it was too crowded. I ended up sleeping on the floor- there just wasn't enough room. I was paying rent but didn't have my own space."

After living with her friend for three months and sleeping on the floor, CU moved into a boarding house in Richmond. "It was a very anxious and lonely time. I didn't have any family and quite a few of the other women who lived in the boarding house had mental health and drug and alcohol issues," CU says.

"I stayed at the boarding house for five years because I couldn't find a decent place to live on my own. It was too expensive to rent my own place as a single woman on a part-time salary."

Two significant factors occurred in 2010 that resulted in CU being at risk of







CHIEW UNG TAN (CU) AND CAE TEACHER CHRYSANNE FERGUSON WHO ASSISTS COMMON GROUND RESIDENTS WITH GARDENING AND COOKING

**“IT WAS A VERY ANXIOUS AND LONELY TIME. I DIDN’T HAVE ANY FAMILY AND QUITE A FEW OF THE OTHER WOMEN WHO LIVED IN THE BOARDING HOUSE HAD MENTAL HEALTH AND DRUG AND ALCOHOL ISSUES,” CU SAYS.**

homelessness. One of the women who lived at the same boarding house experienced a psychotic episode and accused CU of stealing her belongings. The situation escalated, and CU was physically assaulted.

A week after this incident the rooming house owners where CU was living announced they were closing for renovations. As luck would have it a new affordable housing project was opening in Elizabeth Street in Melbourne when CU found herself in desperate need of a new home.

“I saw an advertisement for a new affordable housing development in the CBD and decided I would look into it,” she says. “Some of the housing support workers that came to help us find new homes when the rooming house was closing also mentioned Common Ground as an option and a few of us took up this opportunity and moved in.”

Elizabeth Street Common Ground (ESCG) is based on a model that includes a mix of permanent, supported accommodation co-located with independent affordable housing units. The model, founded in New York, has

proved successful in delivering long term, safe and secure housing for people who have experienced chronic homelessness and those at risk of homelessness.

There are common ground housing developments across Australian cities now. CU was one of the first tenants to move in to ESCG when it opened its doors in 2010.

“I think 12 of us from the rooming house applied and two of us are still here,” CU says.

“Living here has been a great experience – it is a secure home for me. I continued working part-time as a nurse until I was 67. Since I retired in 2014 I have more time to help out in the rooftop garden and make other tenants feel welcome.”

Women, like CU, who are over 55 years of age are the fastest growing group of people experiencing homelessness according to the 2016 Census. On Census night in 2016, 6,866 women over 55 were homeless, an increase of 31% from the previous Census in 2011.

Overall homelessness in Australia increased by 14% in five years from 2011 to 2016. The ABS homelessness statistics,

published in March 2018, revealed people living in ‘severely’ crowded dwellings (defined as needing four or more extra bedrooms to accommodate the people who usually live there) was the greatest contributor to the increase in national homelessness (up by 23.5%).

Dr Paul Jeffs, ABS General Manager of Population and Social Statistics, said while there had been an overall increase in the number of people experiencing homelessness in Australia, the numbers are made up of ‘various distinct groups, each telling a different story’.

“On Census night, 8,200 people were estimated to be ‘sleeping rough’ in improvised dwellings, tents or sleeping out,” Dr Jeffs says. This figure represents a 20.4% increase between 2011 and 2016.

An increasing number of younger and older Australians also experienced homelessness between 2011 and 2016. Younger people aged 20 to 30 accounted for 25% of the 116,427 people who experienced homelessness in 2016.

Social commentators attribute family violence and economic insecurity as key factors at play in the rise of homelessness among older women. Launch Housing Deputy CEO Dr Heather Holst says women who have been in low paid jobs and those leaving family violence have increasingly been priced out of the private rental market.





## DR HEATHER HOLST SAYS WOMEN WHO HAVE BEEN IN LOW PAID JOBS AND THOSE LEAVING FAMILY VIOLENCE HAVE INCREASINGLY BEEN PRICED OUT OF THE PRIVATE RENTAL MARKET.

"Despite all of the talk about how great our economy is we have seen a steady increase in the casualisation of work and many older women on low incomes who can no longer afford to stay in private rental. Add to that the fact that you might also experience family violence and be forced to leave home with little or no financial backing and you're really in trouble."

CU certainly didn't expect to find herself at risk of homelessness while working part-time as a nurse, but even when she arrived in Melbourne to start her new job in 2003 she was unable to find affordable housing.

"I look back at the time I spent living in the boarding house and I feel I was lucky because I had a place to live, but it was hard. I had my own room, but I had to share a kitchen, bathroom and toilet. It was difficult because if someone was having a bad day and they were using drugs or alcohol you didn't feel safe."

Nurses throughout Australia play a vital role in delivering healthcare services and treatment to people who are sleeping rough on any given night of the year. In Victoria nurses partner with homelessness services like Launch Housing and the Salvation Army as part of the Melbourne Street to Home program.

Bolton Clarke (formerly RDNS) Homeless Persons Program (HPP) cared for around 2,500 people in 2017. The nurses provided a total of 36,451 visits in 12 months, assisting people with visits to medical practitioners, dentists and other allied health services. They also advocate for people in the housing sector.

Liz Tuddenham is six months into her outreach job as part of the Melbourne Street to Home team. She waited five years to join the team after doing a placement with the then RDNS Homeless Persons Program in her graduate nursing year in 2012.

"I was so impressed by the work the nurses did in HPP. I remember going to see clients who had a health appointment booked and when we arrived to take them they would say they weren't going. The nurses would just sit down (sometimes on the floor if there were no chairs) and chat for five or ten minutes and then say, 'how about that appointment'. Usually the client would turn around and agree to go," she says.

Mary-Anne Rushford heads up the HPP team in Melbourne. She says nurses who join the team need at least five years general nursing experience. "We say five years' experience because it's a tough job. You're working with very complex clients, so you've got to have a level of resilience. It

### A 2013 STREET COUNT IDENTIFIED THE FOLLOWING HEALTH CONDITIONS IMPACTING 124 PEOPLE SLEEPING ROUGH:

- 15% – Heart disease
- 32% – Hepatitis C
- 27% – Liver disease
- 84% – Substance use
- 61% – Mental Health
- 70% – Any serious medical condition
- 32% – Asthma
- 52% – Victims of attack

can be really hard working all day with rough sleepers then going home to your nice house listening to the rain on the roof and not think about the people who are out there with no shelter."

Liz says nurses working with people experiencing homelessness rely heavily on a multidisciplinary team approach. "We really need to work collaboratively with a whole range of services, particularly our housing workers because the accommodation issues will be a priority for most of our clients," she says.

"Until someone has their housing situation sorted out they can't really fathom the idea of going to the dentist or having a blood test or speaking to someone about their uncontrolled diabetes or whatever the health concern is."

Housing workers who team up with nurses in services like Melbourne Street to Home quickly realise the value of the health services provided to people experiencing chronic homelessness according to Mary-Anne.

"Some of the housing workers have commented on the difference it makes to have a nurse on the team. They say, 'I thought I knew how to do health but now that we have nurses on the team I can see I didn't really'. Our skills are being able to navigate the system," she says.

"We know who to ring and how to get appointments. We have connections in hospitals and local community health

### CAUSES OF HOMELESSNESS

#### Family breakdown

Family violence/abuse  
(physical, sexual, emotional)

#### Loss of social supports or networks

#### Poverty/unemployment

#### Lack of affordable housing

Disability  
(physical, cognitive or psychiatric)

#### Alcohol or other drug use

#### Gambling

#### Chronic illness

centres, with dental and optometry services. We've built these connections up over years so that we can call up and say we have a person experiencing homelessness who needs an appointment. Our contacts will prioritise our clients and ensure they get quick access to really vital Healthcare."

Liz and Mary-Anne both agree that people experiencing homelessness still face discrimination in mainstream healthcare services.

"I remember taking a man who was rough sleeping to hospital a while ago. He was jaundiced and had a massive ascites. It took me a couple of days to engage with him and he finally agreed to visit the hospital," Mary-Anne says.

"The nurse got him triaged quickly and the doctor said he would be admitted. When I knew he was being looked after I went to let the nurse on duty know I was leaving and she asked if they had my number to call me when my client was ready to leave. I told her I understood he was being admitted. She replied, 'well he might be jaundiced but he's just an alcoholic'. It was a really judgemental statement and suggested he didn't have the right to be cared for in hospital because of his alcohol use."

Liz says she has learnt a lot from the people she cares for in the Melbourne Street to Home program. "What you realise working with rough sleepers is that it is really commendable if someone just gets out of



BOLTON CLARKE HPP NURSES (LEFT TO RIGHT)  
LIZ TUDDENHAM AND MARY-ANNE RUSHFORD

**“UNTIL SOMEONE HAS THEIR HOUSING SITUATION SORTED OUT THEY CAN’T REALLY FATHOM THE IDEA OF GOING TO THE DENTIST OR HAVING A BLOOD TEST OR SPEAKING TO SOMEONE ABOUT THEIR UNCONTROLLED DIABETES OR WHATEVER THE HEALTH CONCERN IS.”**

LIZ TUDDENHAM

bed in the morning given what they’ve been through in the last 10 or 20 years. The people we work with carry on even if things don’t go their way. They will often make a joke about it and move on. If I was in their situation I’m not sure I would have that level of resilience.”

Launch Housing’s Dr Heather Holst says the role of nurses in street homelessness teams is essential. “Nurses are really important because of what they can quickly achieve in identifying the health needs of people experiencing homelessness,” she says.

“They can quickly connect people up with hospitals and allied health services – make longer term health plans and help people engage with and keep those plans going. The other really important thing about nurses is that people are more trusting of nurses and regard them as really practical and non-threatening people.”

Dr Holst says nurses make connections in the mainstream healthcare system that generalist housing workers can’t always navigate. “In terms of engaging with people who have experienced real barriers in accessing service generally, including health, that kind of trust is golden. Nurses remove barriers to healthcare for people sleeping rough and that often equates to saving lives.”

While rough sleeping accounts for around only 7% of homelessness in Australia, it is the most devastating manifestation of our housing crisis and it is on the rise.

“We have seen a dramatic rise in rough sleeping in recent years, not just in capital cities but also in suburbs and regional centres around the country,” says Dr Holst.

“In Victoria the state government has been responsive and invested in resources for services like Melbourne Street to Home.

They released a rough sleeping strategy in January this year and we hope to see some announcements that fund more nurses in outreach teams that can reach people in more locations.”

ANMF Assistant Federal Secretary Lori-Anne Sharp has first-hand experience as a HPP nurse having worked with the RDNS program for a decade. She would like to see a more robust political response to homelessness across all layers of government.

“The first thing we need on a national level is the re-instatement of a dedicated Federal Housing Minister. I would also like to see secure funding in the state-led systems for nurse led services. We often see funding for nursing services in this area attached to pilot funding that can run out after a 12-month period, it would be really great to see more commitment to funding that was ongoing,” she says.

Lori-Anne says having a decent minimum wage, welfare safety net and improved job security in Australia would also help reduce the national homelessness rate.

“We have to look at reversing some of the bad policy that has led to job insecurity, lower wages and casualisation in the workforce – all of which contribute to low paid workers being priced out of the housing market,” she says.

“We also have to deal with the issues around income disparity in Australia. You have people struggling to live on Newstart allowance which is below the poverty line. If you are on Newstart you often don’t have enough money to pay rent, buy food, pay for medicines, use public transport – all things many of us take for granted,” Lori-Anne says.

“It’s essential we address the problems that lead to homelessness at a public policy and political level. Look at issues like the minimum wage, availability of affordable housing stock and the social and economic







supports we provide to people who are falling through the cracks. What's the good of boasting about being an international economic success if we measure that by the number of millionaires we have instead of how we care for the most vulnerable."

Nurses like Liz Tuddenham see the human face of homelessness everyday as they go about their work. While the job can be difficult and sometimes traumatic, there are also good outcomes for clients who find housing and receive the healthcare they need.

"I recently worked with a delightful gentleman who really struggled with his mental health. You could have a great conversation for about 20 minutes and then things would decline," she says.

"When I first met him, he was living in a supported residential service that was in pretty bad shape. The place was riddled with bed bugs and he really needed some secure housing. A place came up at Common Ground (Elizabeth Street Common Ground in Melbourne) and we had the chance to attend an interview.

"We went into the interview and it started

off really well. He was coherent for the first 20 minutes and then he started to say things like, 'Oh, can I bring drugs on the premises' and he didn't even use drugs. The workers were great and explained that he couldn't use drugs in the common areas but that there was a 24-hour concierge service to ensure everyone was safe."

When Liz and her client left the interview, she was worried that he wouldn't be accepted into the service. "I was sweating profusely thinking he might have ruined his chances of getting a place. All of these

things he was saying as we were having a tour of the property that might jeopardise his chances," she says.

"Thankfully when we were near the end of the tour and the support workers were with us the client turned to me and said, 'There are a lot of rules here, but I understand because it gives structure and it's important to keep people safe. I think I can do really well here'. I was so relieved – my heart melted a little when he said this. I got a phone call a couple of days later that he was accepted so that was fantastic."



**LORI-ANNE SHARP SAYS HAVING A DECENT MINIMUM WAGE, WELFARE SAFETY NET AND IMPROVED JOB SECURITY IN AUSTRALIA WOULD ALSO HELP REDUCE THE NATIONAL HOMELESSNESS RATE.**





# MEN'S PRECONCEPTION HEALTHCARE

By Anthony O'Brien

While engaging all men in a meaningful conversation about health is important, to target men when they are younger and before they start a family, is perhaps more advantageous and opportunistic.

A focus on men's health in the context of preconception health and primary healthcare, promulgates a different approach to drawing male attention to their preconception and overall health (Courtenay 2002; Frey 2010; Frey et al. 2012; Warner & Frey 2013; Wenitong 2002).

Reproductive problems are usually identified at the point where there is difficulty in conceiving, thus leading to fertility investigations.

Nonetheless, men's preconception health is important in terms of family planning and fertility, enhancing pregnancy outcomes, improving the reproductive health of female partners, preparing men psychologically for fatherhood, and improving men's general health through fostering access to primary healthcare (Frey et al. 2012; Garfield 2018; Warner & Frey 2013).

There is evidence that most men are aware of the importance of their own health prior to conception, and that they would prefer to receive advice and information about preconception healthcare from their family physician (Frey et al. 2012).

Indeed, Bodin et al. (2017) have coined the phrase 'procreative consciousness' which relates to the process of men becoming aware of their procreative potential. For example, male factors alone, or in combination with female factors, contribute to about 50% of causes of infertility (Esteves et al. 2012). However the focus on fertility and reproductive health has traditionally been about the woman and not the man.

Beyond preconception health, impacts surrounding smoking, alcohol consumption, poor diet, lack of exercise, mental health, cardiovascular and respiratory health, obesity and chronic disease, and other causes of morbidity are all serious male health concerns (ABS 2016).

Despite this, the 2017 Australian Institute of Health and Welfare report (AIHW 2017) indicated that for self-assessed health status nearly three in five Australian men in 2014-15, rated their health as excellent, or very good, with expected variation based on age.

While this outcome is promising, and Australian men are living longer than in previous years, they have still not reached the levels of overall longevity that Australian women enjoy. Compared to women, men continue to have higher mortality rates for suicide (Smith et al. 2018), accidents and injury, and for the leading causes of death: tobacco smoking, hypertension, obesity, cholesterol abnormality, and alcohol abuse (ABS 2006; AIHW 2017; ABS 2014).

Inner regional and very remote areas fare much worse for mortality rates in men, compared to the major cities (Department of Health and Ageing 2010). In addition, Australian Aboriginal and Torres Strait Islander (ATSI) men have measurably poorer health outcomes than Australian non-Indigenous men (ABS, 2014).

Yet, since the advent of the Australian Men's Health Policy (Ageing 2010), the focus on Australian men's health generally seems to be increasing. Groups like Andrology Australia, Australia's leading agency on male reproductive health: [andrologyaustralia.org](http://andrologyaustralia.org), the Jean Hales Research Unit: [med.monash.edu.au/sphpm/jean-hales/](http://med.monash.edu.au/sphpm/jean-hales/), Varta (The Victorian Assisted Reproductive Treatment Authority) [varta.org.au](http://varta.org.au) and the Robinson Institute: [adelaide.edu.au/robinson-institute](http://adelaide.edu.au/robinson-institute) for example, have formed a coalition called 'Your Fertility'.

Partnerships such as these are evidence of the increasing motivation and clinical need to collaboratively be more inclusive of men in fertility and reproductive counselling. The Commonwealth Department of Health funding of the Australian Men's Shed Association (AMSA), with 1000 men's sheds, focussed on improving the health and wellbeing of its male members (AMSA 2018), is further evidence that men's health is now firmly, if not pervasively on the health agenda.

It is not always easy to engage men in a conversation about health however. Some practical tips provided by Andrology Australia when engaging the male service user are to be concise and direct, but friendly, demonstrate professional competence, use humour thoughtfully, be empathetic and resolve health issues promptly. If the health service environment is also male friendly this can help men to feel more welcome (Andrology, 2007).

Despite very few examples of any primary healthcare services in Australia addressing men's preconception health promotion and prevention, the clinical ground for working with men to improve preconception health status, but also male health overall, is fertile.

As the momentum on men's health surveillance gathers, it is timely to remind nurses and GP's to engage males on every occasion, and perhaps opportunistically in the context of reproductive health, about their general health.

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Linda Starr

## FROM BEDROOM TO CRIME SCENE

The media and professional literature continue to raise concerns regarding the care of older Australians, particularly vulnerable adults.

There have been many calls for improved staff ratios in residential aged care, better funding, improved access to services and allied health and better protection for vulnerable adults from perpetrators of abuse. The current campaign to legislate staffing ratios in aged care is gaining some traction.

However, along with an increase in staff ratios recent events such as Oakden (an Inquiry into the abuse of vulnerable adults in SA) have revealed the need to review the knowledge base needed to provide quality care to vulnerable adults – particularly those who cannot speak for themselves.

This article highlights the need for those working in aged care (and other health professionals) to have some knowledge of fundamental forensic principles in healthcare including 'basic evidence identification and collection, crime scene preservation, working with police and appearing in court as a witness' (Starr 2016).

This would come at a cost. However, these costs are small compared to the safety, protection and justice this could bring to vulnerable adults such as Dorothy Baum.

Ms Baum was 93 years of age when she died on 31 May 2012. The cause of death determined by the forensic pathologist and accepted by the Coroner was 'blunt trauma with head injury on a background of ischaemic heart disease' (Inquest into the death of Dorothy Baum 2018).

Another resident, Ms Setalo, using a plastic chain with magnets at each end, inflicted the injuries.

On this shift there were six staff for 100 residents – three permanent staff and three agency staff – one RN and five carers which the Coroner found to be insufficient given the layout of the nursing home.

### The incident

The evidence as to what happened on this shift came from three staff members, two carers, Kamal and Irvine and RN Latz.

In summary, around 0130hrs, Ms Setalo was angry and violent, pushing her walking frame into and swinging a plastic chain at Kamal and Latz. She also assaulted another resident before she was restrained until the police and ambulance arrived and transferred her to hospital at approximately 0300hrs.

Latz completed an incident report. No staff made an attempt to check on

the other residents' safety after Setalo left the facility. It was not until they commenced their round at 5am that Ms Baum was discovered and they saw 'blood everywhere' (p 9) from what they claimed were self-inflicted injuries.

In fact, Latz in her incident report wrote:

*'Found in bed with multiple? skin breaks? self-inflicted due to agitation (p 12).'*

Around 0400hrs Ms Baum was taken to hospital where it was noted that she had multiple lacerations and haematomas. Photographs of her injuries taken at the hospital were described by the Coroner as:

graphic and distressing [that] ... demonstrate in a way that words cannot, how traumatic the injuries sustained to this frail, elderly, defenceless lady must have been. It is particularly distressing to see wounds exposed to reveal fat and subcutaneous tissue, bone and tendons.

This is a stark comparison to the words of Latz (above) highlighting the value of photographs as supplemental documentation to enable accurate reporting and recording of patient injuries and where necessary become demonstrative evidence.

### The scene

Staff at the nursing home did not notify the police believing that the injuries were self-inflicted. Hence, it was nearly 12 hours after the attack that police were alerted to the incident by the hospital staff.

By this time the crime scene was severely compromised. The bedding had been removed along with the pooling of blood it contained - crime scene investigators were unable to find the sheets in the laundry. To some extent the room had been cleaned although fortunately crime scene examiners were able to obtain some 'cast off' blood splatter on the walls and curtains of the deceased's bedroom. Police believed this blood splatter was caused by the deceased being struck with the plastic chain - DNA analysis of the blood on the chain confirmed it was that of the deceased. Although police were treating this as a murder investigation, ultimately the Deputy Director of Prosecutions determined that it would not be in the public interest to prosecute due to the mental state of the accused who had died since the event.

However, at the time Ms Baum's room was a crime scene highlighting the need for healthcare professionals to be skilled at recognising what could be a crime scene and understanding how to protect any evidence it may contain until police rule otherwise.

The Coroner was concerned about the staff's interpretation of Ms Baum's injuries given that investigating officers and medical staff were of the view that it was highly unlikely that these were self-inflicted.

After careful consideration the Coroner concluded that Latz, Kamal and Irvine had deliberately represented the injuries this way to avoid taking responsibility for their failure to check on the resident's wellbeing.

On this point, he found it to be a 'deplorable state of affairs' that Ms Baum was left 'untreated and undiscovered for a minimum of two and quarter hours' (p 21), concluding that overall there had been a 'gross dereliction of proper management' of this incident.

This case highlights not only a failure of the staff to manage this incident appropriately, but the value in staff having some understanding of the fundamental principles of forensic healthcare that could assist them to distinguish between accidental and non-accidental injuries, the benefits of photo documentation and knowledge on how to recognise and preserve a crime scene. All of which is a crucial step in the investigation of and potential prosecution of perpetrators.



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## READING BETWEEN THE LINES OF AN ADULT SEPSIS PATHWAY: WHY AND HOW NURSES CAN INITIATE CHANGE

By Gladis Kabil, Dr Evan Alexandrou, Deborah Hatcher and Stephen McNally

Nurses are acclaimed critical thinkers practising in numerous specialties such as emergency departments where patients regularly present with life threatening conditions requiring timely intervention by nurses.

While many milestones have been achieved in the critical thinking journey of nurses, some low performance areas make us consider why and what barriers stop nurses from initiating treatment. A relevant example is the timely initiation of intravenous fluids (IVF) in patients with sepsis or severe infection. Studies show lack of adherence to early fluid resuscitation (Bentley et al. 2016; Leung et al. 2017).

Severe sepsis can quickly progress to multi organ failure if adequate IVF are not commenced within the recommended timeframe of 30 minutes (Miller 2014). Despite compelling evidence of urgency, application of this recommendation seems lacking.

Although protocols have remarkably improved the time to commencing intravenous antibiotics in sepsis, time to commencing IVF has only improved by half the time (Hayden et al. 2016). This leads one to consider why nurses have successfully improved practice with antibiotic administration but not an equally important aspect of the same protocol. A paucity of literature exists exploring this question despite the number of studies exploring antibiotic administration and the sepsis pathway (Tipler et al. 2013; Roberts et al. 2017) and this raises several questions.

Could this lack of attention to IVF administration be a reason for the delayed urgency? Are nurses

merely practising based on what's expected to be done by the clinicians around them? Are priorities based on expectations? Is this evidence of nurses reverting back to traditional 'follow the crowd' practice found before the era of evidence-based practice?

Some studies support the benefits of initiating IVF early regardless of the patient's medical background (D'Amore et al. 2017; Leisman et al. 2018), and some suggest that there are controversies regarding IVF management based on patient's comorbidities.

Indecision is common among treating physicians (Marik, 2015).

Does this indecision among doctors influence the initiation of IVF by nurses? Are nurses relying purely on the decision-making skills of doctors in making such 'complex' and controversial decisions? Does an 'invisible hierarchy' exist in clinical decision making preventing nurses from voicing their concerns? Or is there lack of foundational knowledge among nurses to identify the need for IVF in sepsis? Does the experience level of nurses influence their decision-making skills? Is there a lack of confidence preventing nurses from initiating IVF?

The current sepsis pathway used widely in Australia relies heavily on the treating physician's IVF orders to start acting. The possibility of empowering emergency nurses to initiate IVF would change the early practice of managing sepsis.

This quest for inquiry has led to the development of a research study aiming to explore all of the issues identified and modify the Sepsis Pathway which will mean a world of difference to the patients with sepsis.

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# LATE CAREER CHANGE PAYS DIVIDENDS

By Robert Fedele

Remote Area Nurse Greg Smith was nearing 50 when he was retrenched from his long-time job in the IT industry and suddenly found himself searching for a new career.

Healthcare seemed like an expanding field so he applied for several university places and “fell into nursing”.

“I really didn’t know what a nurse did or what the job entailed but after a couple of weeks in the course I thought it was fantastic.”

Greg went on to complete his graduate year at the Alfred Hospital in Melbourne, then worked there until 2010 in general medical and mental health.

His journey to remote area nursing traces back to when he was still working in IT and travelled across outback Australia with his family visiting Aboriginal communities.

“I found the people were really genuine and engaging and just looked really interesting,” he recalls.

When an opportunity emerged to work as a remote area nurse in Maningrida, an Indigenous community in the heart of the Arnhem Land region of the Northern Territory, Greg grabbed it with both hands.

Maningrida has a population of about 3,500 people, mostly Aboriginal, who speak 13 different languages.

Greg has worked at the Maningrida Health Centre for more than eight years and says the community experiences several health issues.

“Chronic disease is very prevalent in Maningrida – diabetes, heart disease and lung disease as well as skin disease and rheumatic heart disease,” Greg says.

“Rheumatic heart disease is a Third World problem. It doesn’t exist in any First World Country. The rate of rheumatic heart disease in remote Aboriginal communities is just as bad as a lot of Third World countries, which is a disgrace really.

“There’s a lot of people dying here too young and the longer I’ve been here the more I’ve got to know the people that are dying.”

While working in Maningrida, Greg has undertaken several research projects that involved consulting with the community on how they would like their healthcare delivered.

The feedback suggested the community wanted service delivery to be more culturally secure and better designed to foster relationships.

Greg’s efforts in leading health promotion in Maningrida and conducting research geared towards helping to close the gap in health outcomes for residents led to him being recently named the Northern



**“I’M REALLY EXCITED ABOUT GETTING THE AWARD BECAUSE IT SHOWS THE IMPORTANCE OF DELIVERING PATIENT CENTRED CARE, WHICH MEANS IN OUR CONTEXT, DELIVERING CARE THAT’S CULTURALLY SENSITIVE.”**

Territory’s 2018 Nurse/Midwife of the Year.

“I still can’t get over the shock. It’s an absolute honour to be recognised. I’m really heartened that through my research I’ve been recognised. I think it really shows how much we do value research.

“I’m really excited about getting the award because it shows the importance of delivering patient centred care, which means in our context, delivering care that’s culturally sensitive.”

Greg says undertaking research has allowed him to understand the community better through engagement.

“What keeps me going is the sense of community and the wonderful people that I work with,” he says.

“We need to be encouraging our service to develop relationships with people so we


can get better engagement because we know that strong relationships do result in better engagement with people’s health.

“So being able to attract the right workforce, people that are interested in learning about culture and forming long-term relationships and working side by side with Aboriginal colleagues is really what we need to be doing.”

Reflecting on his late career change and pathway to remote area nursing, Greg says he feels thankful for the opportunity to work daily in a vibrant health centre as part of a collaborative team of health professionals.

“I just can’t believe how lucky I’ve been to be where I am now. I think winning the award was just something totally unexpected and I guess validation of the direction I’ve taken.”





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

Gabrielle, Daughter

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

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



Australian  
Nursing &  
Midwifery  
Federation

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



# CARE EXPERIENCES AND UNMET NEEDS OF LESBIAN, GAY, AND BISEXUAL PEOPLE WITH CANCER: SYSTEMATIC REVIEW SUMMARY\*



By Dr Micah DJ Peters,  
Dr Karolina Lisý, Professor  
Penelope Schofield and  
Professor Michael Jefford

## Introduction:

Nurses provide a significant proportion of clinical care for people who are affected by cancer and are also important sources of information, non-clinical care, and support. Following a cancer diagnosis, distress, uncertainty, depression, and anxiety may impact upon peoples' lives. For particular segments of the community, however, the negative experiences associated with cancer and its treatment can be amplified by other social and cultural factors.

While sexually and/or gender diverse people including lesbian, gay, bisexual, transgender, intersex, queer people (LGBTIQ+) are estimated to account for around 11% of the community, they can face discrimination, marginalisation, and inequitable treatment both in society at large and within healthcare contexts. It is known that compared with heterosexual cisgender people, those who identify as sexually and/or gender diverse are more likely to experience

worse psychosocial outcomes following a diagnosis of cancer.

Our team conducted a systematic review of qualitative evidence to identify and explore the experiences of people who identify as LGBT and to develop recommendations for clinical practice and policy. The systematic review has been published in the latest issue of *Psycho-Oncology* (Lisy, Peters, Schofield and Jefford; 2018), and Micah Peters is presenting this work on behalf of all authors at the upcoming Multinational Association for Supportive Care in Cancer (MASCC) Annual Meeting on 30 June in Vienna, Austria.

The review provides up-to-date information regarding how LGB people experience cancer care as well as evidence-based guidance that nurses can use to offer appropriate, informative, and supportive care for LGB people. Many of the recommendations can also be transferred beyond cancer care.

### Systematic reviews of qualitative evidence:

Systematic reviews of qualitative evidence identify and synthesise qualitative research that focusses upon people's experiences. We adhered to a protocol and inclusion criteria registered with PROSPERO and sought English language primary research from PubMed, PsycINFO, and Google Scholar published before 22 March, 2017. The quality of relevant studies was assessed, data extracted, and thematic analysis and synthesis methods used to bring together relevant evidence from included articles.

### Included evidence:

Our review included 15 articles from Australia, USA, Canada, and the UK. Ten were published in the last five years and none before 2002, highlighting that this is an emerging area of qualitative investigation. The studies were of moderate-high quality, scoring between five and nine of the Critical Appraisal Skill Programme (CASP) nine-point checklist.

While LGB people were represented, no transgender people were identified in the articles. Breast and prostate cancers were the most common cancer types. Gynaecological, skin, bowel, and lymphoma cancers were experienced by some people. Some articles also included male partners, however their experiences were beyond the scope of this

work. Further research should investigate experiences of a broader range of cancer as well as the experiences of transgender and bisexual people.

### Thematic analysis:

Twenty-eight recurrent themes were identified within the articles, and thematic analysis and synthesis resulted in six overarching themes (see Figure 1).

### Disclosure

LGB people could feel uncomfortable or uncertain revealing their sexual orientation to healthcare professionals. Some felt that it was the responsibility of the healthcare professional to create suitable opportunities for disclosure, while others felt that their sexual orientation was private and irrelevant to their care. Some people regretted not telling their healthcare professionals about their sexual orientation.

### Homophobia

Disclosure of sexual orientation was commonly associated with both fear and experiences of homophobia or discrimination regarding poorer treatment or care, both actual and anticipated. Some people did preliminary screening of their healthcare team to detect their attitudes towards LGB people and knowledge of issues particular to LGB people.

### Healthcare professional behaviour

Some people experienced rudeness, neutrality, discomfort or dismissiveness from healthcare professionals. This was experienced negatively and felt to be associated with sexual orientation. Many people felt healthcare professionals were reluctant or unprepared to discuss issues particular to LGB people, while some people experienced hurtful remarks or disinterest. LGB people appreciated when healthcare professionals made efforts to answer questions or seek relevant support or resources. It was considered very important that same-sex partners were acknowledged, treated respectfully, and included.

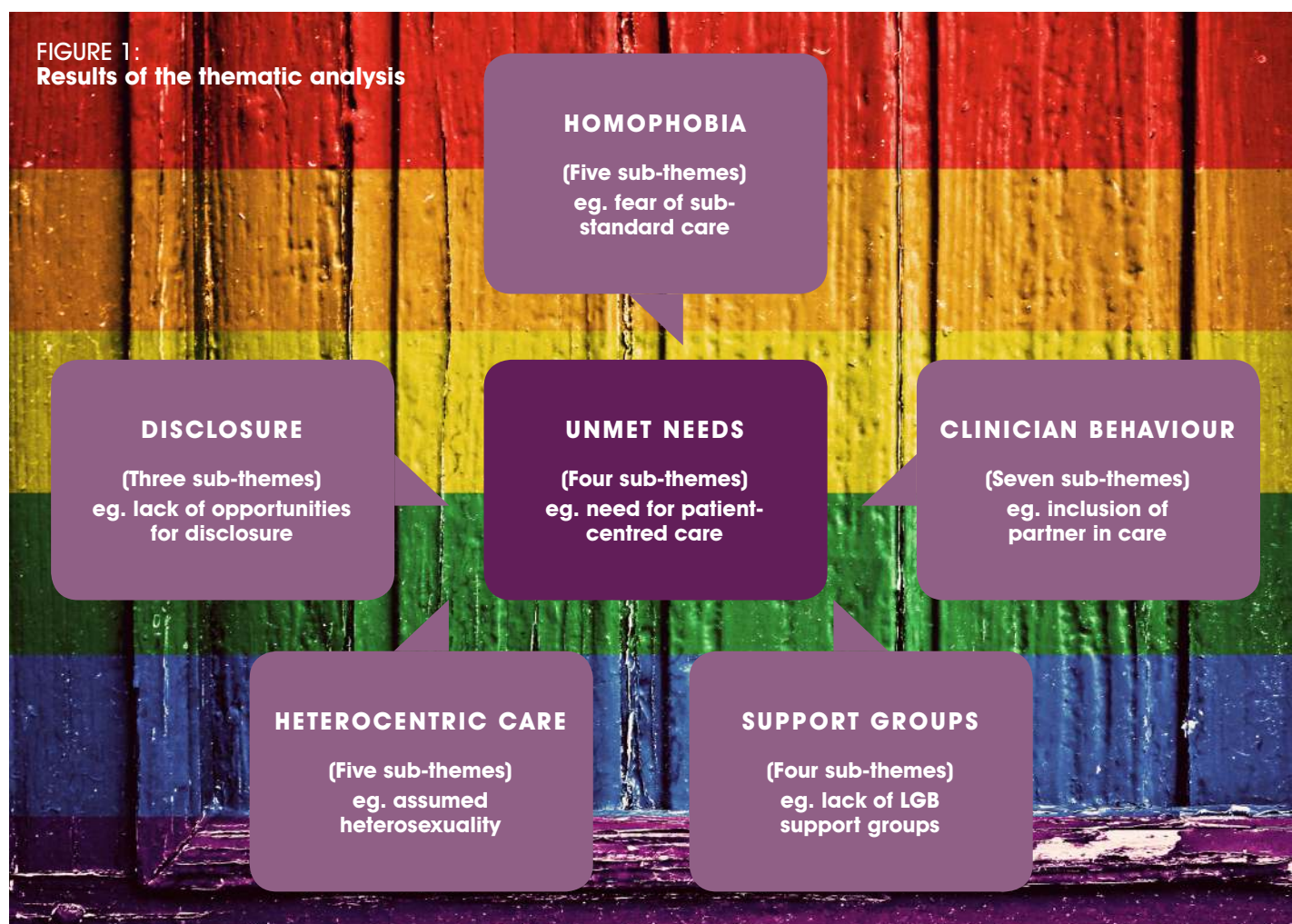
### Heterocentric care

Experiences of heterocentrism included assumed heterosexuality (such as assuming a patient's partner was the opposite sex). Many people felt invisible and that they were being treated with a 'one-size-fits-all' attitude despite their particular and specific information and care needs. Lack of specific information for LGB people and inappropriate or irrelevant information was commonly identified in peoples' experiences.

### Support groups

LGB people reported an absence of relevant support groups that they or their partners could turn to following a cancer diagnosis.

FIGURE 1:  
Results of the thematic analysis





### BOX 1 Domains of unmet information needs for LGBT people

LGB-specific information regarding sexuality and relationships

- Side effects of treatment that are relevant to LGBT people
- Different treatment options (eg. options for declining breast-reconstruction)
- Psychological impacts of cancer treatment
- Open discussions regarding relevant sexual matters and wellbeing

Support groups were seldom specific or inclusive of LGBT people and were felt to have only limited benefit, especially when LGBT people felt they could not disclose their sexuality or the issues they faced with confidence. LGBT-specific support groups were felt to be safe spaces to discuss relevant issues and seek emotional support.

#### Unmet needs

Unmet needs appeared within each overarching theme above but were also specifically raised. LGBT people spoke of the need for structured and ongoing supportive care and the desire for better patient-centred decision making. The absence of LGBT-appropriate information could lead to anxiety and frustration (see Box 1). Many felt that it was the responsibility of the healthcare professional to be able and willing to discuss LGBT sexual matters (see Box 1).

#### Appropriate, inclusive, and equitable care for LGBT people

The overarching themes from this review were clearly interlinked; fear of homophobic reactions or discrimination may lead to anxiety regarding disclosure and discomfort. Decisions to not disclose

### BOX 2

#### Evidence-based recommendations for providing care for LGBT people

- Use LGBT-inclusive language and information
- Don't assume heterosexuality
- Sensitively and respectfully enquire about sexual orientation
- Respond to disclosed LGBT identity in a positive and reassuring manner
- Participate in cultural awareness training to develop competence in discussing sexual matters with LGBT people
- Provide or refer to LGBT-relevant services and information
- Respectfully and courteously include same-sex partners in care
- Provide tailored information in response to individual needs
- Recommend appropriate support groups
- Display LGBT-inclusive images, logos, and other materials
- sexual matters and wellbeing

one's sexual orientation could in turn lead to feelings of invisibility, experiences of heterocentric care, inadequate or irrelevant information and support, and ultimately unmet needs and potentially inequitable care and treatment. While disclosure was usually experienced as being beneficial when healthcare professionals were felt to be positive, understanding, and equipped to deal with LGBT-specific issues, decisions to disclose sexuality as well as preferences for care and support are entirely individual. Indeed, some people did not wish to disclose or discuss their sexuality. It is the healthcare professionals' responsibility to ensure people receive care that is appropriate and suited to their unique needs and preferences, rather than based upon assumed preferences.

#### Implications for nurses and recommendations

Because they provide a significant proportion of the clinical and non-clinical care of people affected by cancer, nurses are well-positioned to take the lead in ensuring that LGBT people, as well as other sexuality and gender diverse people, are cared for in an inclusive, sensitive environment

and receive care and information that is relevant and specific to their needs. An absence of healthcare professional knowledge regarding the specific concerns and issues faced by LGBT people in relation to cancer care appeared linked to many unmet needs and we have developed succinct recommendations for providing care (see Box 2).

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# PRESSURE INJURIES ARE NOT INEVITABLE

ANMF Professional Officers Julianne Bryce, Elizabeth Foley and Julie Reeves

Hopefully by now you are aware the ANMF is running a national campaign to have staffing ratios established across the aged care sector – public and private residential facilities.

The publicity for this campaign has flushed out a range of comments from aged care providers, nurses, care workers, elderly people (both those in care and potential consumers of aged care), and informal carers (family/friends).

Much of this feedback has been positive, recognising that elderly people in residential facilities are there because they require 24 hour care and a skills mix that meets their care needs. Some comments, however, have led us to provide information to correct misconceptions.

A particular case in point, just as the title signifies, is that pressure injuries are not inevitable. While our members will know this fact, we provide the following to arm you with information so that you can refute this fallacy should you encounter it in your workplace.

A pressure injury (PI) is a localised injury to the skin and/or underlying tissue, usually over a bony prominence, resulting from sustained pressure, including pressure associated with shear. The most common bony prominence is the sacral area (the area at the base or bottom of the spine) and heel, but they can develop anywhere on the body (National Pressure Ulcer Advisory Panel 2014).

Pressure injuries are a major contributor to the care needs of people in aged care, but this does not have to be the case. Most pressure injuries are preventable if appropriate measures are implemented, and this is the crux of the issue. To implement these strategies effectively, evidence from large-cohort studies undertaken

on quality of care clearly shows there must be sufficient numbers of staff and the right skills mix of those staff (Aiken et al., 2016).

While immobility can cause pressure injuries, risk factors are not restricted to decreased mobility. Other factors include: poor nutritional status, skin integrity, age and the level of oxygenated blood supply to pressure points. A pressure injury can occur in a person with any or all of the associated risk factors and can commence in any setting and in people of any age.

Nurses in all health and aged care settings are well aware of the strategies to prevent pressure injuries, which involve:

- initial and ongoing risk assessment of all persons in care;
- implementation of prevention strategies including comprehensive skin inspection and repositioning of the person at regular intervals;
- early identification and analysis of causal factors in the event of pressure injury development; and
- immediate intervention including selection of appropriate pressure relieving devices.

Some aged care providers suggest anyone can use available risk assessment tools to identify and rate a person's potential for pressure injury and implement treatment. However, while such tools may assist decision making, they can not be relied on in isolation of knowledge and clinical assessment conclusions.

This is precisely where the importance of having the right skills mix in aged care comes into play.

Research commissioned by the ANMF in 2016, in conjunction with Flinders University and the University of South Australia, provides evidence that a skills mix of registered nurses – 30%, enrolled nurse – 20% and personal care workers – 50%, is the minimum requirement “to ensure safe residential and restorative care” (Willis et al. 2016).

Registered nurses are equipped with the knowledge, backed by an evidence base, to undertake a comprehensive assessment of potential for pressure injury and commence appropriate preventative measures, and/or, to institute required wound management systems for established pressure injuries.

It is essential that aged care providers acknowledge and implement evidence-based pressure injury prevention and management strategies. Registered nurses are qualified to be the clinical leaders for determining the complex care required to prevent and manage pressure areas, including co-ordinating and monitoring care management plans in conjunction with enrolled nurses and delegating aspects of care to personal care workers.

Instigating solutions and monitoring for compliance with best practice requires ongoing education and an awareness of all risk factors associated with pressure injuries.

Pressure injuries will undoubtedly occur without the right skill mix and number of registered nurses, enrolled nurses and carers. To prevent this from happening we need: Ratios in Aged Care – Make them Law Now.



Julianne Bryce



Elizabeth Foley



Julie Reeves

**ANMF Federal Professional Officers**



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## REMEMBERING NURSES WHO HAVE DIED IN THE SERVICE OF OTHERS

By Jennifer Manning and Linda Shields

November 2018 marks the centenary of the end of the First World War. There have been many commemorations already this year for those who have lost their lives, with women leading the Anzac Day marches. In Bathurst, New South Wales (NSW), a commemorative service held in February honoured and remembered nurses who have lost their lives in the service of others.

The aim of the service was to remember nurses, both military and civilian. It is estimated that 104 Australian defence force nurses have died since the South African War (Boer war) (Newell 2010). Yet the records concerning civilian nurses who have died whilst serving others are limited, as it is difficult to gather information about civilian nurses.

Some we know include Rose Adelaide Wiles (aged 28) and Cecilia Elizabeth Bauer (aged 22), who, in 1905, in Maryborough in Queensland, died when they volunteered to care for the victims of pneumonic plague. More recently, in 2016, a remote area nurse, Gayle Woodford, was killed while she was on duty in South Australia.

The service was held on 18 February. This date was chosen as it coincided with the anniversary of the sinking of *SS Vyner Brooke* on 14 February, 1942. She was a British freighter, or cargo ship, and one of the last ships to take evacuees of various nationalities from Singapore before it fell to the Japanese, whose planes bombed the ship, and she sank within 30 minutes. On board were approximately 228 passengers (crew, nurses, soldiers, and civilians - largely women and children) the most passengers she had ever carried (Shaw 2010 p. 3; Australian War Memorial, n.d).

Sixty-five Australian Army nurses reluctantly boarded the *Vyner Brooke* as she left Singapore harbour. They were caring for Australians wounded in battle (Shaw 2010, p. 4), and once aboard, the nurses continued

to care for them. When *SS Vyner Brooke* was sinking, the nurses helped others off the ship first, and if they survived the sinking, protected the injured, either on life rafts, in the water or on pieces of debris (Jeffrey 1947).

Some nurses were killed during the air attack, 12 drowned, and some floated away on life boats or debris. One who died at sea was Sister Mary Dorothea Clarke of 2/13 Australian General Hospital, Singapore, who was from Rylstone, NSW (not far from Bathurst). Of the survivors, 21 nurses reached land. On Radji Beach, Banka Island, Matron Irene Drummond and her team were massacred. Only one, Sister Vivian Bullwinkel, survived. The commemorative service was centred on the *Vyner Brooke* nurses.

The service was especially touching as there were members of the Clarke and Drummond families present – a moving tribute. The families were very grateful to have been involved and their relatives remembered with such honour.

The service was attended by His Excellency General the Honourable Sir Peter Cosgrove AK MC (Retd), Governor-General of the Commonwealth of Australia, and His Excellency Mr Kwok Fook Seng, Singapore High Commissioner to Australia, and Mrs Pearl Kwok, as well as many other military and civilian dignitaries, politicians and leading nurses and other health professionals, including Mrs Coral Levett, President, NSW Nurses and Midwives' Association (NSWNMA, ANMF NSW Branch).

Co-hosts included All Saints' Anglican Cathedral, Bathurst, Charles Sturt University, Bathurst Hospital, Australian College of Nursing and the Centaur Memorial Fund for Nurses.

The attendance of the Governor-General and Mr Kwok, as well as the military and civilian leaders of the nursing profession, and other dignitaries, confirmed the importance of this event. Such services are a fitting tribute to those who have given their lives caring for others. They are not about glorifying conflict, rather about paying due respect to those who paid the ultimate sacrifice while they were serving others. The commemorative service was one of dignity and respect and this was felt by the over 600 people who attended and came to pay their respects. Lest we forget.



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## LACK OF NURSES THE KEY FACTOR IN PREVENTABLE DEATHS IN HOSPITALS

Inadequate nursing numbers and skill mix is having a direct impact on thousands of preventable deaths across Australian hospitals each year, new research has revealed.

Undertaken by Charles Darwin University lecturer Dr Melanie Underwood, a former nurse, the study investigated the causes of system failure, finding that nurse numbers were the key to more than 25,000 preventable deaths in hospitals annually.

Dr Underwood's PhD research analysed 101 coronial reports to pinpoint nurse-related adverse events that resulted in the death of patients.

She modified a system originally used by the US military to analyse failures in adverse events called the "Human Factors Analysis and Classification System" (HFACS), taking into account 99 variables such as nursing shift, type of death, specific types of unsafe acts and environmental factors.

"I found that almost all variables that led to the deaths in each case were foreseeable and therefore often preventable," Dr Underwood said.

"In the majority of cases, the number or skill mix of nurses was related to the unsafe act occurring."

Dr Underwood said the research highlights an ongoing issue that needs addressing.

"The research has confirmed that unsafe acts are not single, isolated events but the result of an error trajectory with influencing factors at all levels of an organisation.

"The factors contributing to an error can be identified and mitigated, which can then prevent deaths from occurring."

## CONSUMERS WANT CONTROL OF PERSONAL HEALTH DATA

Australians want control of their health data and to be asked for consent when government, private companies or researchers use the information, according to a new study published by the Consumers Health Forum and NPS MedicineWise.

The *Engaging Consumers in their Health Data Journey Report* involved qualitative interviews, literature reviews, discussions with consumer representatives and a national survey of 1,013 Australians.

Survey results found 96% of Australians believe they should have access to their own health data, with 90% of respondents saying they should be asked for permission if either a government department or private organisation wants to use the information.

Two thirds (62.5%) of survey respondents said they would give the government permission to share their data if they knew how it would be used and what potential benefits existed in supporting healthcare providers to improve outcomes.

The report also found consumers are more willing to share their data when it is for public or individual good, rather than commercial gain.

Dr Lynn Weekes, CEO of NPS MedicineWise, said developing models of consent acceptable to both consumers and research and health communities presented a key challenge.

"The onus is on organisations to put in place clear, transparent, open and two-way communication about how and by whom their data will be used, along with the benefits and any risks," Dr Weekes said.

## CALLS FOR JUNK FOOD TO CARRY GRAPHIC WARNINGS

Graphic warnings on junk food packaging, similar to cigarettes, would prove an effective deterrent to consumers when deciding what to eat, new research suggests.

Conducted by the University of Melbourne and Cancer Council Victoria, the findings bolster calls for mandatory health warnings on unhealthy food in a bid to improve diets and combat rising rates of obesity-related chronic diseases.

In the study, 95 hungry participants were shown colour pictures of 50 different snack foods ranging from chips, chocolate bars and biscuits to nuts, fruits and vegetables.

After being asked to rate on a scale how much they would like to eat each food at the end of the experiment, participants were then shown several different health warnings and asked to rate a similar set of 50 snack foods.

Results found negative text combined with images was twice as effective at changing people's choices as messages that had negative text-only content or those with images combined with positive text.

The study also found warning labels prompted participants to exercise more self-control rather than act on impulse.

"The study shows that if you want to stop people choosing fatty and sugary packaged foods, health warnings actually work," University of Melbourne researcher and co-author Stefan Bode said.

"It sheds light on the mechanisms in the brain that underlie the effects of health warning messages on food processing."

## PUBLIC HOSPITAL ADMISSIONS RISING FASTER THAN PRIVATE HOSPITAL ADMISSIONS

Admissions to public hospitals are growing faster than admissions to private hospitals, a new report from the Australian Institute of Health and Welfare (AIHW) shows.

The report, *Admitted patient care 2016-17: Australian hospital statistics* reveals that of the 11 million hospital admissions in 2016-17, 6.6 million were in public hospitals and 4.4 million were in private hospitals.

Admissions rose by 4.3% on average each year for public hospitals and 3.6% for private hospitals between 2012-13 and 2016-17, greater than the average growth in population of 1.6% over the same period.

In 2016-17, the majority of admissions to



public hospitals (83% or 5.5 million) were for public patients.

However, about one in seven (14% or 912,000 admissions) were for patients who used private health insurance to fund all or part of their admission.

Public hospitals accounted for the majority of emergency admissions (92%), medical admissions (77%) and childbirth admissions (76%) in 2016-17.

By contrast, 59% of admissions for surgery took place in private hospitals.

The proportion grew if the surgery was elective, with 67% of elective surgery admissions taking place in a private hospital.

Regarding safety and quality of care delivered, the report showed in 2016-17 there were more than 186,000 hospital-acquired complications or 2.2% of 8.6 million in-scope admissions.



# HIV – IS THAT STILL A THING? NURSING WORKSHOP SAYS “YES!”

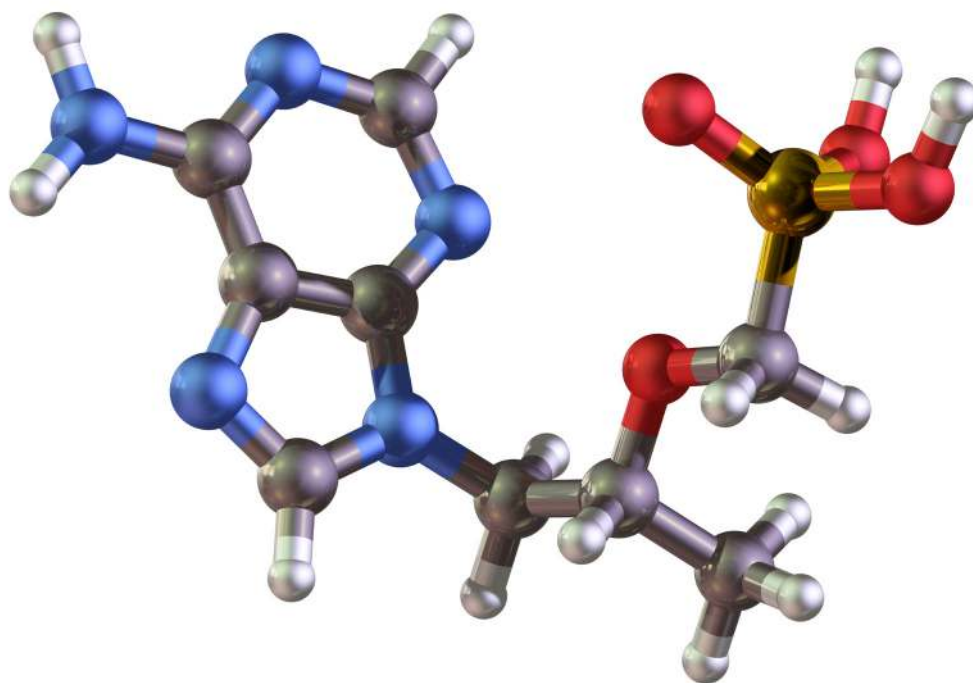
By Maggy Tomkins, Denise Cummins and Maggie Smith



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The HIV Nursing Practice Workshop began in 1996 by a group of nurse educators and consultants who realised that most of the available HIV education was at a basic level, aimed at reducing stigma and ensuring nurses understood risks of transmission and prevention through Standard Precautions. Nothing was available for specialised nurses caring for people with HIV.

Over the last 22 years, the workshop content, with the exception of basic immunopathology, has changed significantly. Initially emphasis was on treatment adherence and end of life issues. Ten years ago, the challenges were complexities due to comorbidities, complicated treatment regimes, and the increase in community rather than hospital management.

In the last few years treatments have changed significantly leading to different medical and psychosocial issues and information on biomedical prevention now includes information on HIV pre and post exposure prophylaxis (PrEP and PEP).

With NSW Health promoting the 'goal of virtually eliminating HIV transmission by 2020' (NSW Ministry of Health 2015), there is a perception that HIV is no longer a challenge. However, as people with HIV who are well controlled on treatment now have a near-normal life expectancy,

most nurses will at some time encounter patients with HIV.

Because of treatment success, along with increased rates of cardiovascular and other diseases due to HIV, people with HIV are engaging with mainstream health services as they age. Therefore, now more so than ever, it is important for all nurses to understand about HIV prevention, care and treatment.

Although HIV prevalence in Australia is low (0.13%) compared to other countries in the region, by the end of December 2016 there were an estimated 26,444 people living with HIV in Australia (The Kirby Institute 2017).

Currently the four day workshop is conducted annually with sessions on Immunopathology, opportunistic infections, pharmacology, HIV associated neurocognitive disorder, ageing, mental health, biomedical prevention, sexuality, sexual health, transgender health, women, children, multicultural issues, legal issues, nutrition, substance use, co-infection with hepatitis C, ongoing maintenance and psychosocial issues.

Participants have come from different services including inpatient HIV, sexual health, mental health, drug and alcohol, infection control and aged care; from rural and metropolitan regions; and from other states in Australia and other countries in the Pacific.

Strengths of the Workshop are the breadth of topics, that each session is facilitated by a recognised expert, mainly nurses, and that it is managed by a steering committee of nurses with extensive HIV experience.

The final word goes to some of the 542 participants who have attended the workshop and their answers to the evaluation question: "What will you say to colleagues about this course?"

- Overall very worthwhile attending. Good networking and sharing different experiences.
- It was worthwhile. So many lovely informed CNCs – how inspiring!
- Wonderful! Informative! Interesting!
- Just do it!

For further information:  
[education@thealbioncentre.org.au](mailto:education@thealbioncentre.org.au);  
(02) 9332 9720; [thealbioncentre.org.au/education-training](http://thealbioncentre.org.au/education-training)

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# RESEARCH INTO MIDWIFERY MENTORSHIP THE CHALLENGE OF EXPLORING RELUCTANT MENTORS' PERSPECTIVE OF THEIR ROLE

By Michelle Gray

Midwives have a professional responsibility to support midwifery students and facilitate learning opportunities, which enable them to grow in confidence and competence.

However, the desire to be a midwife does not automatically mean that a midwife possesses the pre-requisite enthusiasm for teaching and supervision. Skills for mentorship are not taught during initial training and thus teaching and assessment are not universal skills acquired from the initial entry to practice curriculum. Therefore, how is one expected to acquire such skills to facilitate the learning of others? Currently, there is limited research knowledge around the perspectives of midwives and their role as mentors.

Research evidence suggests that midwifery students are experiencing negative interactions with unhelpful and unsupportive midwifery mentors (Longworth 2013; Hughes & Fraser 2011; Licqurish & Seibold 2008).

Midwifery students have reported mentors have made them feel inadequate; mentors have 'taken over' and not allowed students space for 'hands-on' practice (Hughes & Fraser 2011).

It is tempting to blame the mentor for acting unprofessional in regards to failing in their responsibility to provide mentorship to students. However, without evidence we cannot establish if there are unexposed issues at the heart of their behaviour, and what the issues are from the mentor's perspective. The reality of the clinical placement environment means that the majority of the midwifery workforce is casual, or on part time contracts, which means that midwifery mentors often see

a different student every shift; with different behaviours and qualities. For midwifery mentors the opportunity to provide consistent mentorship to the same student is non-existent. This is potentially problematic because it makes it difficult to scaffold learning, or make reliable assessments on the student's abilities over time.

As a profession that strives to provide evidence based practice it is important that we endeavour to investigate issues that can inform us of matters that affect how we facilitate the student/mentor relationship. While the research literature reports the student's experience, and the positive experiences of midwifery mentors, there is a distinct lack of research to explain the experiences and perspectives of midwives who are reluctantly mentoring students. To address this problem ethical approval has been granted (A/17/1003) to conduct an online national research study.

Volunteers are needed to complete an anonymous survey to collect the perspectives of midwifery mentors who undertake mentorship of midwifery students. Researchers are looking for midwives who would like to share their experiences of the challenges and difficulties they face within the role.

If you or a colleague would like to participate, please type this address into the web browser of your computer: [survey.usc.edu.au/opinio/s?s=6905](http://survey.usc.edu.au/opinio/s?s=6905)

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# TOWARD KINDER PLACES

By Joy Penman and Gulzar Malik

True education is defined as the congruous development of all domains of learning, namely the cognitive, psycho-motor and affective dimensions (Bastable & Alt 2014).

All faculties are active, including the development of the mind, skillful hands, and building of character and values that ultimately translate to actions. When applied to nursing, cognitive refers to the knowledge in nursing, psychomotor to the doing, and affective to the feelings and emotions involved in nursing.

This definition is our understanding of what it means to prepare nurses for practice until a colleague tells us a story about a 76-year-old female patient who says to her nurse, "You might have done my sugar test, inserted my catheter, and given me my pills, but you are not really helping me. You did not make me feel good..." The nurse was astonished by this comment. After much reflection, she concluded that "It's not enough to know the theory behind my care plan, nor to be skilled and competent; what seems important and relevant is how I make my patients' feel!"

True nursing education is well-balanced and takes a broad, holistic scope. The emphasis is not only on the pursuit of a particular specialty of study, nor performance of sophisticated skills but also has a higher aim. Agreeably, various constructs such as the culture, education, experience, position and expertise all come into play in

determining the ethical values nurses hold (Rassin 2008).

However, equal emphasis must be given to the inculcation of values such as human dignity, integrity, autonomy, altruism, and social justice (Fahrenwald et al. 2004), and respectfulness, responsiveness, compassion, and trustworthiness (ICN 2018). The Code of Ethics (ICN 2018) is clear as to the values nurses must hold dear – high quality nursing care, respect of rights, values and beliefs of individuals, a culture of safety, ethical management of information, meeting the health and social needs, and equal access to healthcare.

How might these values be inculcated? One way is emphasising more a values-based education. This type of education means developing a program that stresses and promotes the core values in nursing. Students are exposed to processes of values clarification and exchange, and these values are integrated into clinical practice. It also helps them to meet challenges they may encounter. Values-based education gives meaning and fulfilment to nurses, highlights a sense of person and community, guides behaviour, and develops positive self-esteem and care for others. The new nursing education paradigm must be learning to create safer and kinder places for clients, caregivers and health professionals. Values education must be accentuated because nursing is relational, as it is performance-based.

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## IODINE SUPPLEMENT USE DURING PREGNANCY AND LACTATION IN THE ILLAWARRA BORN STUDY

By Catherine Jane Lucas, Karen Charlton, Michelle Townsend, Jordan Stanford, Megan A Kelly, Mercy Baafi and Brin F S Grenyer

In Australia, bread contains iodised salt to prevent mild iodine deficiency, however this is insufficient to meet increased requirements during pregnancy and lactation.

It is therefore recommended that women take a supplement containing 150µg of iodine throughout pregnancy and whilst breastfeeding (NHMRC 2010). Cross-sectional studies conducted in the Illawarra, NSW show an improvement in the iodine status of pregnant women from 2008 to 2012, following the introduction of mandatory fortification and supplementation recommendations (Charlton et al 2013). However, supplementation rates remain sub-optimal with 30-40% of women not taking iodine-containing supplements (Charlton et al. 2013; Lucas et al. 2014).

We explored supplement use as part of a small birth cohort pilot study in the Illawarra. Pregnant women attending the major public hospital within the region were invited to participate in the study from April-December 2014. Information on participant demographics and supplement use was collected at 22 weeks gestation via a computer-based survey. Maternal supplement

use and breastfeeding status was measured at six months post-partum via a structured telephone interview. Ethical approval was obtained for this study (HE13/377).

Data was obtained from n=41 women. Most women (n=36) were born in Australia and had tertiary education (n=33). The mean ± SD age of women was 31 ± 4.6 (22-41). It was the first pregnancy for n=25 participants, and n=32 indicated their pregnancy was planned.

At 22 weeks, 83% (n=34) women reported taking a supplement, 78% (n=32) were taking a supplement containing folic acid and 73% (n=30) were taking a supplement containing both iodine and folic acid. Less participants (66%, n=27) were taking a supplement that contained the recommended amount of iodine. Only 34% (n=14) participants reported taking a folic acid supplement pre-conception.

At six months post-partum 48% (n=12) women out of the 25 women who were still breastfeeding were taking a supplement, 40% (n=10) of which were taking a supplement containing iodine. Women who gave reasons for ceasing supplements (open-ended question, n=5) stated

they stopped taking supplements as they 'felt like didn't need it anymore' (n=3), were tired of taking them (n=3), or were too costly (n=1).

This research adds to the growing body of evidence that iodine supplementation rates are sub-optimal in pregnant and breastfeeding women.

Midwives and practice nurses working in clinics delivering antenatal shared care can play an important role in educating women about iodine supplements for pregnancy and lactation.

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# LOOKING BACK TO UNDERSTAND WHAT LIES AHEAD: STUDENTS' VISUAL JOURNEY

By Helena Anolak, Vanessa Tilbrook and Lyn Gum



Learning through reflection allows nursing and midwifery students the opportunity to identify knowledge deficits leading to greater clinical competency (Embo et al. 2014; Mamede & Schmidt 2004).

The use of creative arts within this reflective process aids in the exploration process of knowing, identifying feelings and

reflecting on the impact of 'self' (Warne & McAndrew 2010; Hall & Mitchell 2008).

As part of the first year Flinders University midwifery curriculum, students are required to participate in learning that focuses specifically on effective communication. Within this topic, each student was provided with a blank fabric square and asked to visually reflect upon their feelings towards becoming a registered midwife. Accompanying this the students' submitted a short written reflection. This exercise allowed students to celebrate their journey of self-discovery by tapping into existing knowledge and critiquing it artistically, cognitively and meta-cognitively (Newton & Plummer 2009). The collated squares were compiled into a vibrant travel rug that was later displayed at the Australian College of Midwifery's National Conference in Adelaide.


Conversation surrounding this travel rug project focused on critical analysis of its benefits, limitations and implications of this type of activity. Arguably, the students who were given the opportunity to visually reflect as part of this project gained an increased


awareness of self, gained further knowledge of the midwifery profession as well as a greater understanding of the constraints of the environments they are entering into. Self-reflection assists future nurses and midwives with the 'ability and skills to analyse and reflect in, on, and about their practice.'




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## BEYOND A TEXTBOOK: USING LIVED EXPERIENCE OF RECOVERY FROM MENTAL ILLNESS AS A TEACHING TOOL

By Julia Bocking, Brenda Happell, Brett Scholz,  
Chris Platania-Phung

Mental health nursing continues to struggle to be seen as a valuable and rewarding career choice. It's been described as the 'brussel sprouts' course; often unpalatable to students, despite its importance.

Nursing students, like the rest of the public, tend to hold stigmatised views towards people diagnosed with mental illness. These discriminatory attitudes deter students from pursuing a career in mental health nursing and negatively impact on nursing practice. Together these circumstances contribute to poorer health outcomes for mental health consumers. This is simply not good enough for a profession that prides itself on holism as the central principle to practice.

There is a growing support for including lived experience perspectives from consumers of mental health services in nursing education. Research indicates this generates more positive attitudes towards mental illness and even increases interest in mental health nursing as a career.

SYNERGY: Nursing and Midwifery Research Centre is part of an international research project involving the implementation and evaluation of teaching by people who have accessed mental health services. The Coproduced Mental Health Nursing

Education (COMMUNE) project referred to these educators as Experts by Experience. The learning outcomes for the COMMUNE module were coproduced by Experts by Experience and mental health nursing academics from Iceland, Finland, Ireland, the Netherlands, Norway and Australia.

Julia Bocking brought her expertise gained from her recovery from mental illness and service use, academic background and experience in consumer-based workforce roles, to teach nursing students. This project was extensively evaluated through surveys administered before and after the unit and focus groups with students and members of the teaching team.

The survey results were very positive. Students showed significant improvements in attitudes and knowledge about mental illness. They were less anxious about working in mental health. We were particularly pleased to see an increased interest in mental health nursing as a future career. Not all graduates will ultimately pursue a career in mental health. However, their positive attitudes are vital as people can experience mental distress in all areas of the healthcare system.

Student feedback from focus groups and course assessments demonstrated the profound impact the Expert by Experience

had on their learning, so eloquently described as:

*having that insight into Julia's story it'll make us better practitioners...a lot of skills of listening to people and...understanding of other people's experiences...it does make me I'd like to think a better person...*

Other lessons learned from this project included the importance of respecting lived experience as autonomous and distinct from clinical and academic knowledge. Its inclusion enhances mental health nursing education and promotes person-centred care. A desire for uniformity was expressed by the teaching academics: "That team approach is really, really important, so that we're consistent." Going forward we need to question the need for consistency and consider its likely negative impact on the promoting the consumer voice in mental health nursing education.

The project was funded by Erasmus+

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**Agnes Higgins**  
Professor in Mental  
Health, Trinity  
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**Dameyon Bonson**  
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# DIABETES, PALLIATIVE AND END OF LIFE CARE: INFORMATION TO SUPPORT SHARED DECISION-MAKING

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

## Introduction to the issue

The Victorian Medical Treatment Planning and Decisions Act 2016 and the National Safety and Quality Health Service Standards (NSQHS) (2017) highlighted the importance of planning for end of life care.

Diabetes reduces life expectancy by 12 years for those with type 1 and eight years for those with type 2 diabetes diagnosed before age 40 (Roper et al. 2001). Diabetes is the underlying/associated cause of deaths due to cardiovascular disease, cancer, stroke and renal disease (AIHW 2014). Most current diabetes care guidelines do not encompass guidance about palliative/end of life care.

The diabetes trajectory consists of periods of deterioration and recovery (stable and unstable diabetes) (Dunning 2018). Care initially focuses on achieving 'tight blood glucose control' to prevent long term complications. The focus needs to change to a palliative approach as complications develop, periods of instability become more frequent and treatment-related adverse events such as hypoglycaemia occur.

Palliative care focuses on managing unpleasant symptoms and promoting quality of life and can be implemented at any time (WPCA/WHO 2014). It can be combined with usual diabetes care but is often overlooked until the late stages of life. These points are important, because tissue-damaging hyperglycaemia and glucose variability are often present before type 2 diabetes is diagnosed and complications are often present at diagnosis.

Nurses and other clinicians are ideally placed to discuss values and care preferences and help people with diabetes document an Advance Care Directive (ACD). Many such opportunities are missed (Claessen et al. 2013). It is essential to start discussions while the person is able to make autonomous decisions. ACDs that clearly document the person's values and preferences reduce decisional uncertainty for nurses/clinicians, family members and Medical Emergency Teams (MET). They enable them to make decisions consistent with the person's values in emergencies when the person is unable to decide for themselves.

## A potential solution to enhance ACD

An advisory group of older people with diabetes and an interdisciplinary clinician advisory group, including nurses, helped us:

- Develop and evaluate an evidence-based suite of information to help key stakeholders recognise the 'right time' to discuss palliative and end of life care.
- Evaluate the suite of information through public consultation and use the feedback to refine the information.
- Subject the penultimate versions to review by international diabetes, palliative care, geriatrics and communication experts. These experts reviewed the information independently using the Well Written Information for Consumers Guide (2000) and the AGREE II Instrument

(Agree Collaboration) to assess relevance, acceptability, usability, readability, design appropriateness and the likelihood the information will be used in practice.

- Assess the information to ensure it is consistent with current care recommendations:
  - The Medical treatment Planning and Decisions Act 2016
  - NSQHS Standards 2017
  - Palliative Care Australia Standards 2018
  - NHMRC Guidelines for a Palliative Approach in Residential Aged Care 2006
  - National Statement on Health Literacy.

The research was funded by The Diabetes Australia Research Program. The information is from: [dropbox.com/sh/pgc0pnpmylc0pi/AAC0SR6qG7mnHnYx8-Fys2jsa?dl=0](https://www.dropbox.com/sh/pgc0pnpmylc0pi/AAC0SR6qG7mnHnYx8-Fys2jsa?dl=0) and iBooks from the iTunes store on: [itunes.apple.com/us/book/id1370224743](https://itunes.apple.com/us/book/id1370224743)

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Planning palliative and end of life care with older people with diabetes: information for health professionals



Palliative and end of life care: information for families caring for older relatives with diabetes



Palliative and end of life care: information for older people with diabetes



# THE INFLUENCE OF INTERNATIONAL NURSING PLACEMENTS ON CULTURAL COMPETENCE AND CAREER PLANNING

By Shelley Gower, Jaya A R Dantas, Ravani Duggan and Duncan Boldy

International clinical placements are being increasingly included in undergraduate nursing programs in universities to prepare nurses to work with diverse cultures within their own country, and globally (Turale 2015). However little is known about their enduring impact.

Using an exploratory longitudinal approach this mixed methods study examined the influence of an international clinical placement of up to four weeks in developing countries on cultural competence and career planning in undergraduate nursing students from four Western Australian universities. Qualitative data were collected using semi-structured interviews and quantitative data through administering the Inventory for Assessing the Process of Cultural Competence-Revised at pre-and post-international placement and again 12 months after return.

Our analysis revealed challenges and opportunities during the placement had enhanced students' appreciation for Australian nursing education and practice, and confirmed their capacity to engage in positive cultural interaction in diverse settings. However some participants were confronted by what they perceived to be a lack of

compassion in host country nurses, which they struggled to reconcile with the resource-poor environment and political context (Gower et al. 2017).

Whilst overall cultural competence scores increased immediately post-placement, and were maintained for 12 months, there was a surprising and significant drop in Cultural Skills (ability to communicate and ask questions of culturally diverse patients), Cultural Awareness (understanding of own biases and beliefs) and Cultural Desire (the willingness to become culturally competent) immediately post placement. This reflected the negative reactions in some of the qualitative findings. Scores in all three constructs returned to pre-placement levels 12 months after returning home, possibly reflecting greater feelings of self-efficacy and confidence once participants were able to apply their skills in the Australian setting.

Participants retained their pre-placement interest in career roles which offer variety and excitement, including international work. There was increased interest in roles requiring development of relationships with clients, including midwifery. However, students

were realistic about the constraints imposed by competing realities on their return to Australia, such as employment availability and family commitments.

Results documented that sending supervisors with in-country experience and support to explain how socio-economic, cultural and political factors contribute to health system priorities and nursing practices in the placement country enhances educational outcomes. This can help mitigate the sometimes confronting nature of placement encounters, and help students integrate their experience into post-placement practice.

Targeted learning activities are needed to ensure international clinical placements positively influence the global perspectives of students and highlight the importance of nursing and midwifery roles. This is important in the current climate of global migration of refugees, economic migrants, students, and health professionals. Activities need to target Cultural Desire in particular, as this is the basis upon which cultural competence is built.

**Shelley Gower, Lecturer; Associate Professor Ravani Duggan and Professor Duncan Boldy are all in the School of Nursing, Midwifery and Paramedicine at Curtin University in WA.**

**Professor Jaya A R Dantas, International Health Programme in the School of Nursing, Midwifery and Paramedicine at Curtin University in WA.**



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# CAPABILITY IN NURSING

By Patricia Bromley

Registered Nurses in Australia must meet the Nursing and Midwifery Board of Australia (NMBA) professional standards. These standards define the practice and behaviour of nurses and midwives in Australia. Standard 3 states the Registered Nurse 'Maintains Capability for Practice' (NMBA 2016). However, the NMBA Standards do not define Capability.

Research recognises that capable graduates not only have a high level of technical competence, but personal, interpersonal and cognitive capabilities (Scott et al. 2010). Bromley's (2017) research into capability in nursing students of the Postgraduate Certificate Neonatal Intensive Care (PG Cert NIC) concurs with similar studies into capability; synthesising the underpinning concepts of capability into professionalism, interpersonal interactions and, knowledge and skill. These concepts are interdependent, like cogs in a wheel (Figure 1).

Bromley (2017) identified that mentors of the PG Cert NIC students appraised capability not only through the neonatal nursing students' application of knowledge and technical abilities, but were also alert to the students' skill in navigating the complexities of the work context. This was evident in clinical practice through the students' verbal and non-verbal behaviours.

Nurse mentors interpreted the students' behaviours within the clinical context, to evaluate their abilities in managing the situation, which in turn informed their ideas on the students' overall capability for future situations. Appraising capability allowed the mentors to make decisions about the student's potential.

This concept of capability has been conceptualised into a Capability Wheel (PG Cert NIC) (Figure 2). The Gears of Capability (Figure 1), are in the centre of the wheel, which propel capability forward. Continuing this analogy, the spokes on the wheel revolve around the geared hub. In this analogy, the spokes, which incorporate essential capability requisites, play an important

function in maintaining the strength of the wheel. In Bromley's (2017) research, the spokes are the 20 PG Cert NIC Capability Requisites, essential to functional capability. The specific capability requisites are powered through the Gears of Capability (Figure 1), in other words, the interaction of professionalism, interpersonal interactions, and knowledge and skills.

The spokes also connect to the tyre, which is the interface with the road. In this analogy, this is the interface with practice, this is how capability is seen, or demonstrated, in practice. Nursing students in practice are being appraised on their ability to work in familiar and unfamiliar environments; their justified confidence, in themselves and their clinical decisions; how well developed their clinical reasoning skills are, through devising solutions to unfamiliar problems. This is the evidence the student provides of capability in practice; literally, this is where the rubber hits the road.

As each part of the wheel is dependent on the other to be functional; straight spokes, well-greased gears, and good rubber on the tyre, so too is each part of the Capability Wheel dependent on the other. The Capability Wheel moves the nurse forward, along the path of capability, as a wheel continues, capability continues.

The Capability Wheel (PG Cert NIC), embodies the capable neonatal nurse, from which the following definition of the capable neonatal nurse emerged:

The neonatal nurse demonstrates capability through their professionalism (problem solving, analytical thinking), their interpersonal interactions (ethical behaviour, presenting and applying information and interactive skills), and their knowledge and skills (effective time management, recognising incomplete praxis and ongoing learning needs). The capable neonatal nurse can be relied on to work just as well in familiar and unfamiliar environments, with a justified confidence in her or his clinical decision making, with well-developed clinical reasoning skills providing the means to devise novel solutions to unfamiliar problems.

The PG Cert NIC Capability Wheel is specific for the neonatal specialist area. However, the concept can be extended to other post-registration and pre-registration nursing courses in Australia. It would also be valuable to explore if capability is culturally bound, and to broaden the research to consider other social contexts, other countries, including societies where English is not the first language.

FIGURE 1

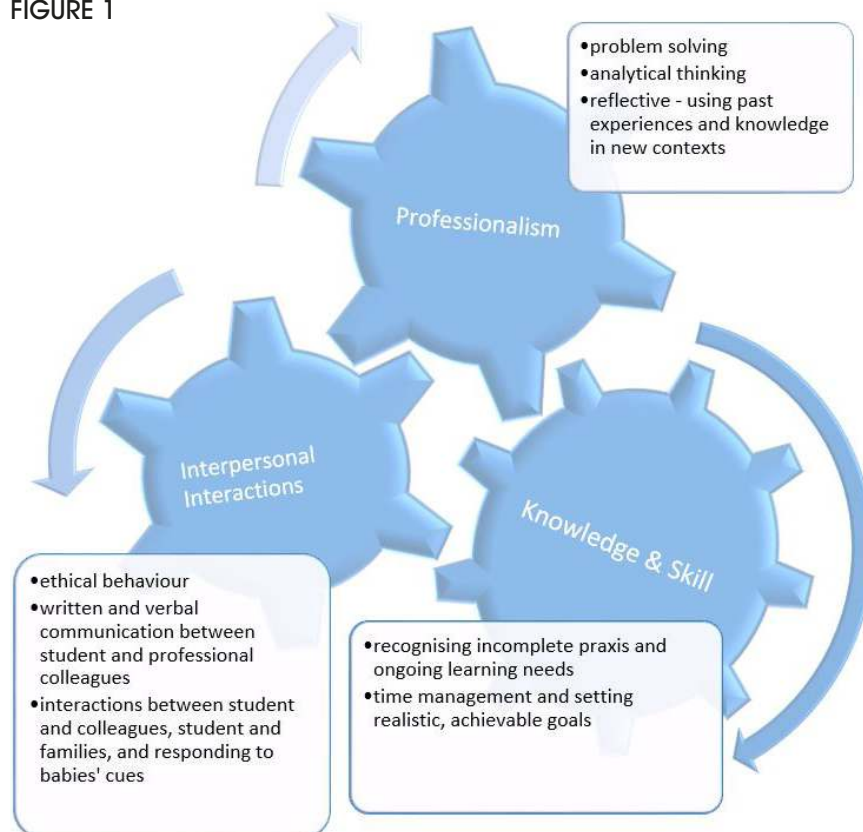


FIGURE 2



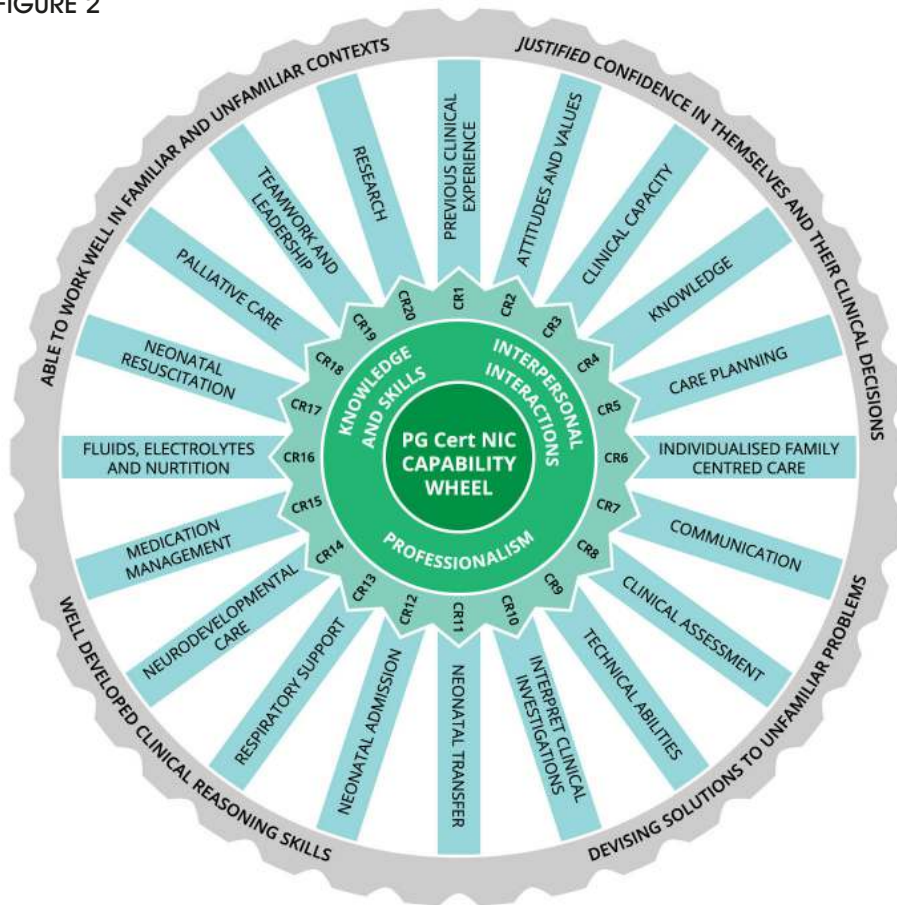
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**Patricia Bromley is a Lecturer, Nursing & Midwifery in the School of Health Sciences, College of Health and Medicine at the University of Tasmania**



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# HOLD HIGH THE STANDARD

By Joy Penman and Josie Tighe

One of the challenges faced by nursing students is learning medical/nursing terms. These terms are unfamiliar, formal, technical, and complex (Strube, Thalluri, & Kokkinn, 2004). Learning them however is imperative because the majority of the study of nursing consists of learning new words.

Words matter a great deal in nursing. Terminology is paramount for ensuring clarity, conveying exact meanings, and avoiding confusion. Correct use of words signifies good understanding, enhances professional communication, and high-quality documentation.

With the growing expansion of topics to cover in preparing student nurses, discussion about medical/nursing terminology is sometimes forgotten or omitted. It is important however to re-emphasise the importance of correct use of terminology and abbreviations if nurses are to communicate effectively within the interprofessional healthcare environment. Thus, we propose that beginning student nurses do not memorise the terms, but understand their construction instead. The secret to unravelling the mysteries of the medical/nursing jargon, is to collapse the words into the Latin or Greek root words or stems, prefixes or suffixes or both (Walker, Wood & Nicol, 2013; Colman, 2015).

Drawing from a number of resources (Medical Terminology for Cancer, 2013; Concise Medical Dictionary, 2015), some examples are provided. For instance, the term 'dysphagia' is collapsed to the root

word and combining form phag(o) (which means swallow), combined with a prefix dys- (which means difficulty), to mean 'difficulty in swallowing'. The term 'cardiomegaly' is collapsed to the root word and combining vowel cardi(o), which means heart, combined with the suffix -megaly (which means enlargement), to mean 'enlargement of the heart'. Utilising both prefix and suffix could be added to the root word as in the case of hemiglossectomy. The root word is gloss(o) (meaning tongue), combined with prefix hemi- (meaning half) and suffix -ectomy (meaning removal), to produce the meaning 'removal of half the tongue' or a tongue resection.


Nurses should be careful with words. Inappropriate use of words may completely alter the intended meaning of the information being conveyed, can reflect muddled, incorrect, ambiguous thinking, and show minimal control of the subject. Learning new terms should not be a stumbling block for nurses. Novice nurses can work to strengthen their professional vocabulary by looking up word meanings, practicing the use of the medical/nursing terms, using only correct and accepted abbreviations, linking words and phrases to real-life

events, and even maintaining a personal dictionary. And while we are at the subject matter, please avoid vague, colloquial and inaccurate language; describing clients for example as 'yukky', 'not very nice' or 'He's okay!' (Polectick & Holly, 2010). Let's aim to hold high the nursing standard of effective communication (Nursing and Midwifery Board of Australia, 2008).



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 **Dr Joy Penman (Senior Lecturer) and Ms Josie Tighe (Lecturer) are lecturers from Monash University, Nursing and Midwifery.**



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# IMMINENT BIRTH EDUCATION PROGRAM

By Jane Connell

Most women in Queensland give birth in hospitals with maternity services, however, given the nature of birth and with contracture of birthing in many rural and remote services, some women present to hospitals when birth is imminent and where staff may not have had education or training to respond safely.

These clinicians need to be able to recognise labour and provide safe and effective care to the woman until qualified help arrives and/or she is transferred to a birthing facility. The Imminent Birth Education Program was developed to address this need, a collaboration between the Statewide Rural and Remote Clinical Network and the Statewide Maternity and Neonatal Clinical Network.

The program consists of an online component and a four-hour face-to-face workshop developed with the input of a steering committee of midwives. The course is available through the Pathways to Rural and Remote Orientation and Training (PARROT) platform and contains four modules:

- Introduction
- Working in rural and remote areas
- Physiology of pregnancy and birth
- When problems arise

The modules contain many resources and interactive activities and takes participants with no prior knowledge regarding birth eight to ten hours to complete. The face-to-face workshop is scenario-based and designed to be delivered by a midwife.

More than 400 people have completed the online course since it went live in February 2017. The majority are registered nurses, approximately 75%, with the next largest group being enrolled nurses, about 12%. Other cadres of health workers who have completed the course include assistants in nursing, Indigenous health workers, midwives, medical officers and students of nursing and medicine. Although aimed at non-midwives in rural and remote settings the Imminent Birth Education Program is available to all and has attracted interest from health staff in many contexts. Nearly 18% of online completions are health workers from non-rural and remote areas of Queensland.

Feedback about the course has been generally positive with comments such as, 'Easily able to navigate course, well set out', 'content very applicable to practice', and 'I cannot believe how much I enjoyed it. Outstanding'. One participant added 'Cannot wait for the face to face, I have a million questions'. Some feedback for development has related to technical issues and personal preferences.

The face-to-face workshop train-the-trainer has been made available to all Hospital and Health Services (HHSs) in the state and been embraced by midwives and nurses in their various health facilities. Participants in the workshops have really appreciated the opportunity to practice what they learned online. Feedback included 'Scenarios are very helpful', '.... great fun & learning' and 'Face to face follow up post online very good to reinforce learning'. The non-midwifery participants also commented on the midwives who facilitated the workshops with comments such as 'Presenters were excellent & very knowledgeable in their field, fabulous teachers' and 'The educators were ... approachable & put us at ease – Hands on was excellent'. One participant commented, 'Being a dedicated ED nurse I have never been interested in Obstetrics, you have changed my mind, and now I want to go and spend a little time with the midwives'.



The face-to-face workshop has been rolled out with train-the-trainer workshops around the state for local midwives who will continue to provide the workshop for their non-midwifery colleagues. It is now being provided in 13 of the 16 HHSs in the state with another to complete the train-the-trainer workshop by the end of June 2018.

To access the online Imminent Birth Education Program go to [ilearncatalogue.health.qld.gov.au/course/495/parrot-c-mc51-imminent-birth](http://ilearncatalogue.health.qld.gov.au/course/495/parrot-c-mc51-imminent-birth) and for more information contact Jane Connell, CNC Project Officer – Imminent Birth at [jane.connell@health.qld.gov.au](mailto:jane.connell@health.qld.gov.au)

**Jane Connell is CNC Project Officer – Imminent Birth, Health and Wellbeing Service Group, Townsville Hospital and Health Service in Qld.**

# JULY

Australian Women's History Network Symposium  
2 July, Canberra.  
[auswhn.org.au/awhn-conference/](http://auswhn.org.au/awhn-conference/)

NAIDOC Week  
Theme: Because of her, we can!  
8–15 July.

20th Asia Pacific Diabetes Conference  
Therapeutic approaches for diabetes management and endocrine complications  
9–10 July, Sydney, NSW.  
[diabetesexpo.com/asiapacific/](http://diabetesexpo.com/asiapacific/)

5th Annual Congress on Emergency Nursing & Critical Care  
Exploring the innovations in emergency nursing and critical care  
16–17 July, London, UK.  
[emergency.nursingmeetings.com/](http://emergency.nursingmeetings.com/)

50th World Congress on Men in Nursing  
Exploring the role of men in advancing global health  
16–17 July, Rome, Italy.  
[men.nursingmeetings.com/](http://men.nursingmeetings.com/)

5th World Congress on Hospice and Palliative Care  
Refinement and renovation of medicate with hospice palliative care  
16–17 July, Melbourne, Victoria.  
[hospice-palliativecare.conferenceseries.com/](http://hospice-palliativecare.conferenceseries.com/)

49th International Congress on Nursing Care Plan & Health  
Nursing care plan – A practical guide to medicine  
16–18 July, Rome, Italy.  
[nursingcareplan.nursingmeetings.com/](http://nursingcareplan.nursingmeetings.com/)

21st World Nursing Education Conference  
Technology innovations in nursing education  
16–18 July, Melbourne, Victoria.  
[nursingeducation.nursingconference.com/asia-pacific/](http://nursingeducation.nursingconference.com/asia-pacific/)

**Lung Health Promotion Centre at The Alfred**  
Smoking Cessation Course  
26–27 July  
Ph: (03) 9076 2382  
Email: [lunghealth@alfred.org.au](mailto:lunghealth@alfred.org.au)

HIC Digital Health Conference  
29 July–1 August, International Convention Centre Sydney. Australia's premier digital health, health informatics and ehealth conference and expo. [hisa.org.au/hic/](http://hisa.org.au/hic/)

# NETWORK

**St Vincent's Public Hospital, Melbourne, August '78 group 40-year reunion**  
11 August, from 5pm, Pumphouse Hotel, 128 Nicholson Street Fitzroy. For information contact St Vincent's August 78 nurses reunion on Facebook.

**St Vincent's Graduate Nurses Anniversary Lunch**  
30 August, 11.30 to 3.00pm, Park Hyatt Melbourne.  
E: [stvgna@gmail.com](mailto:stvgna@gmail.com)

# AUGUST

**Lung Health Promotion Centre at The Alfred**  
Asthma Educator's Course  
1–3 August  
COPD – From Diagnosis to Management  
9–10 August  
Spirometry Principles & Practice  
13–14 August  
A Practical Management Approach of Non Invasive Ventilation & Sleep Disorders  
16–17 August  
Sleep: the how, why & the what – skills for your toolkit  
16 August  
The Pressure to Breathe – the skills for success with NIV  
17 August  
Respiratory Course (Modules A & B)  
20–23 August  
Respiratory Course (Module A)  
20–21 August  
Respiratory Course (Module B)  
22–23 August  
Ph: (03) 9076 2382  
Email: [lunghealth@alfred.org.au](mailto:lunghealth@alfred.org.au)

National Aboriginal & Torres Strait Islander Children's Day  
4 August

A5M Anti-Ageing and Aesthetics Conference  
Connecting inner and outer health  
4–5 August, Sofitel Hotel Melbourne.  
[a5m.net/conference-information/a5m-annual-conference](http://a5m.net/conference-information/a5m-annual-conference)

19th International Mental Health Conference  
Our treatment. Our environment. Our strategies  
8–10 August, RACV Royal Pines, Gold Coast.  
[anzmh.asn.au/conference/](http://anzmh.asn.au/conference/)

International Day of the World's Indigenous Peoples  
9 August

Hyperbaric Technicians and Nurses Association and Australia New Zealand Hyperbaric Medicine Group  
26th Annual Scientific Meeting  
16–18 August, The Bandha Hotel and Suites, Legian, Bali, Indonesia.  
[htna.com.au/index.php](http://htna.com.au/index.php)

47th World Congress on Nursing & Health Care  
Nursing: Education, healthcare and research in practice  
20–21 August, Tokyo, Japan.  
[nursingcongress.nursingconference.com/](http://nursingcongress.nursingconference.com/)

**Alfred Hospital Group**  
3/85, 30-year reunion  
20 October.  
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)

**Royal Adelaide Hospital, Group 791, 40-year reunion**  
January 2019. Past Students register your interest to Margie Hayes (nee Kennedy)  
E: [mdhayes@adam.com.au](mailto:mdhayes@adam.com.au); Merridee Seiboth E: [merridee.seiboth@health.sa.gov.au](mailto:merridee.seiboth@health.sa.gov.au); Julie Schiller (nee Luders) E: [julie.schiller@health.sa.gov.au](mailto:julie.schiller@health.sa.gov.au)

49th Annual Nursing Research and Evidence Based Practice Conference  
22–23 August, Tokyo, Japan.  
[evidencebasedpractice.nursingconference.com/](http://evidencebasedpractice.nursingconference.com/)

Australasian Diabetes Congress  
22–24 August, Adelaide Convention Centre, SA.  
[diabetescongress.com.au/](http://diabetescongress.com.au/)

**19th Asia-Pacific Prostate Cancer Conference 2018**  
22–25 August, Brisbane Convention and Exhibition Centre. The program will involve locally advanced and metastatic prostate cancer, research, diagnosis and management with nursing and allied health specific sessions over the three days.  
[prostatecancerconference.org.au](http://prostatecancerconference.org.au)

# SEPTEMBER

Indigenous Literacy Day  
5 September

Anniversary of the UN Declaration on the Rights of Indigenous People  
13 September

Congress of Aboriginal & Torres Strait Islander Nurses & Midwives (CATSiNaM) Professional Development Conference  
17–19 September, Hilton Adelaide, SA.  
[catsinam.org.au/](http://catsinam.org.au/)

International Rural & Remote Nursing & Midwifery Conference in conjunction with CRANaplus  
36th Annual Conference  
Leading primary healthcare in a challenging world  
20–22 September, Pullman Cairns International Hotel, Qld.  
[cranconference.com/](http://cranconference.com/)

# OCTOBER

51st World Nursing Leadership & Management Conference  
Exploring the leadership practices in nursing and management  
4–5 October, Moscow, Russia.  
[nursingleadership.nursingmeetings.com/](http://nursingleadership.nursingmeetings.com/)

33rd Euro Nursing & Medicare Summit  
Accelerating Innovations & Fostering Advances in Nursing and Healthcare  
8–10 October, Edinburgh, Scotland.  
[europe.nursingconference.com/](http://europe.nursingconference.com/)

**Royal Adelaide Hospital, Groups 793/4, 40-year reunion**  
May 2019. Past students register interest with Julie Hoyle (nee Lloyd)  
E: [djhoyle@bigpond.net.au](mailto:djhoyle@bigpond.net.au) or Andrew Booth  
E: [andrew.booth@sa.gov.au](mailto:andrew.booth@sa.gov.au)

**Western General Hospital**  
60th PTS reunion  
16–23 June 2019, Port Vila, Vanuatu.  
Contact Wendy  
E: [Wendyflahive@gmail.com](mailto:Wendyflahive@gmail.com)

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

42nd International Hospital Federation World Hospital Congress  
10–12 October, Brisbane Convention & Exhibition Centre, Qld. <http://event.icebergevents.com.au/whc2018>

19th South Pacific Nurses Forum hosted by Cook Islands Nurses Association Aotearoa  
Transforming leadership – Nurses as change agents for non communicable diseases in the Pacific  
15–19 October, Rarotonga, Cook Islands. [spnf.org.au/2018/19th\\_SPNF\\_Registration\\_Form.pdf](http://spnf.org.au/2018/19th_SPNF_Registration_Form.pdf)

21st Australian College of Nursing National Conference  
Coming of age  
15–18 October, Crowne Plaza Perth.  
[midwives.org.au/](http://midwives.org.au/)

4th Australian Association of Nurse Surgical Assistants Conference & AGM  
Discover the difference  
20–21 October, Launceston, Tas.  
[aansa.org.au/](http://aansa.org.au/)

44th International Mental Health Nursing Conference  
Mental health is a human right  
24–26 October, Pullman Cairns International, Cairns, Qld.  
[acmhn2018.com/](http://acmhn2018.com/)

**Lung Health Promotion Centre at The Alfred**  
Asthma Educator's Course  
31 October–2 November  
Ph: (03) 9076 2382  
Email: [lunghealth@alfred.org.au](mailto:lunghealth@alfred.org.au)

# NOVEMBER

Melbourne Cup Day  
6 November

2018 Nursing Summit - Eastern Caribbean  
The Latest Advances in Healthcare Delivery and their Implication for Nursing Practice.  
10–18 November. The content will be both relevant and of interest to Nurses working in the acute hospital setting, community health, public health, aged care, and doctor surgeries. As well as those Nurses working in the area of policy development, health education, and Nursing research. We will explore a number of different ports and you will spend time with fellow Nurses in an exclusive setting, on one of the most exceptional ships sailing in the Caribbean – the Harmony of the Seas. [nursesfornurses.com.au/events](http://nursesfornurses.com.au/events)

Remembrance Day  
11 November

**Lung Health Promotion Centre at The Alfred**  
Smoking Cessation Facilitator's Course  
15–16 November  
Spirometry Principles & Practice  
22–23 November  
Ph: (03) 9076 2382  
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# NURSING AND MIDWIFERY LEADER NEVER TO BE FORGOTTEN

Gay Hawksworth: 24/03/1947 – 01/06/2018

Tributes have poured in for beloved and fearless union leader Gay Hawksworth after her sudden death last month.

Friend and colleague Beth Mohle, current Secretary of the Queensland Nurses and Midwives Union (QNMU, ANMF Queensland Branch), described Gay as an inspirational and courageous nurse unionist and leader.

"She was a true and fierce advocate for nurses and midwives and as Secretary she positioned our union strategically so it grew to become the largest union in Queensland," Beth said.

"Gay was also a magnificent comrade, friend and mentor. I often sought her wise counsel on many issues and she was always keen to hear the latest news.

"I can't thank her enough for all she did for nursing, midwifery, the union movement and to improve the health of the wider community. I will miss her dearly."

Gay began working for the then Queensland Nurses Union (QNU) in 1989 when nurses were campaigning for university education and rose to become Secretary of the QNU, a position she held from 1995 to 2011.

Over more than two decades, Gay worked tirelessly to advance the professions and was duly recognised as a strong and inspiring leader and activist who shaped positive change.

As QNU Secretary, she oversaw the introduction of many policies now embedded in the professional lives of the workforce, including the public sector EB process, an enforceable workloads management clause for public sector nurses, a national Nurses Award (2010), and the first research investigating the work/life balance of Queensland nurses and midwives.

Gay also spearheaded the QNMU's fight against the federal government's WorkChoices legislation during the Your Rights at Work campaign, and squared up to the state Beattie Labor government during EB5 bed closures.

It led to one of the memorable moments, the Chunder Bucket Express, which saw nurses and midwives travel down the coast from Cairns to Brisbane to take part in a massive protest outside Parliament House.

Members closed hundreds of beds across the state because of unsafe workloads while languishing among the nation's lowest paid nurses and midwives.

However, the next agreement, EB6, ultimately saw Queensland nurses become amongst the highest paid as well as the ground-breaking introduction of professional development leave and professional development allowance.

Fittingly, Gay was awarded a Medal of the Order of Australia (OAM) in 2010 for her service to industrial relations, particularly through leading the QNU.

Australian Nursing and Midwifery Federation (ANMF) Federal Secretary Annie Butler said the national nursing and midwifery community was shocked and saddened by Gay's death.

"Gay was a bold and inspirational union leader who will be sorely missed by our professions," Ms Butler said.

"Her enduring legacy on the QNMU is unmistakable and her impact on the union movement will never be forgotten."

Gay's niece Sarah Sheehan recalls regularly seeing her aunty on television or

hearing her on the radio advocating for better conditions for nurses or improved health services.

She describes her as a force with an "incredible presence" who was kind, compassionate and family oriented.

"Aunty Gay was soft, but incredibly strong. She had a huge heart and came from an exceptionally close family. She enjoyed the important things in life. She kept up our family tradition of freshly baked scones for morning tea at my grandparents' house every Sunday, long after my Nanna passed away. Nanna and Pop's tiny kitchen would be filled with our family, and generations of families of neighbours who had lived in the street since the 1950s."

Sarah says Gay's entire family feels immensely proud of her passion and advocacy for nurses.

"The public reaction to her passing and the messages that my cousin Jimmy has read about the legacy his mum left has really comforted him and filled him with enormous pride," Sarah says.

"When she retired, I remember our former premier Anna Bligh said, 'Gay Hawksworth never raised her voice or banged on tables, but she was one of the fiercest negotiators I have ever come across'.

"I can't tell you how proud I was when I heard those words and I remember looking over at my Pop, who was in his 90s, and seeing tears of pride streaming down his face, even though he had probably watched that retirement video a thousand times before."



GAY HAWKSWORTH – QNMU SECRETARY 1995–2011



GAY HAWKSWORTH AND BETH MOHLE

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# Global Obstetric Update 2018



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Professor Kjersti Aagaard,  
Baylor College of Medicine, Texas

Recording fetal movements – does this matter?  
Professor Jane Norman, University of Edinburgh

A closer look at the risk factors for stillbirth  
Professor Gordon Smith, Cambridge University

Evidence based approach to controlling blood  
pressure that is a little high, or scarily high  
Dr Jenny Myers, The University of Manchester

The lifelong health consequences for mothers  
who have had preeclampsia  
Professor Mark Brown, past president of  
the International Society for the Study of  
Hypertension in Pregnancy

Monitoring the growth restricted fetus  
and deciding when to deliver  
Dr Edward Johnstone, The University of Manchester

“Common” fetal malformations and what to  
do with them: A guide for the generalist  
Professor Jon Hyett, University of Sydney

An update on cholestasis of pregnancy  
Dr Amanda Henry, University of New South Wales

Managing PPH – a closer look at the evidence  
behind each step to turn off the tap...  
Professor Michael Permezel, University of  
Melbourne, past president of RANZCOG

The race to develop an artificial placenta  
Dr Matthew Kemp,  
University of Western Australia

Dealing with a placenta accreta –  
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Dr Michael Rasmussen,  
Mercy Hospital for Women

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