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AUSTRALIAN NURSING & MIDWIFERY JOURNAL
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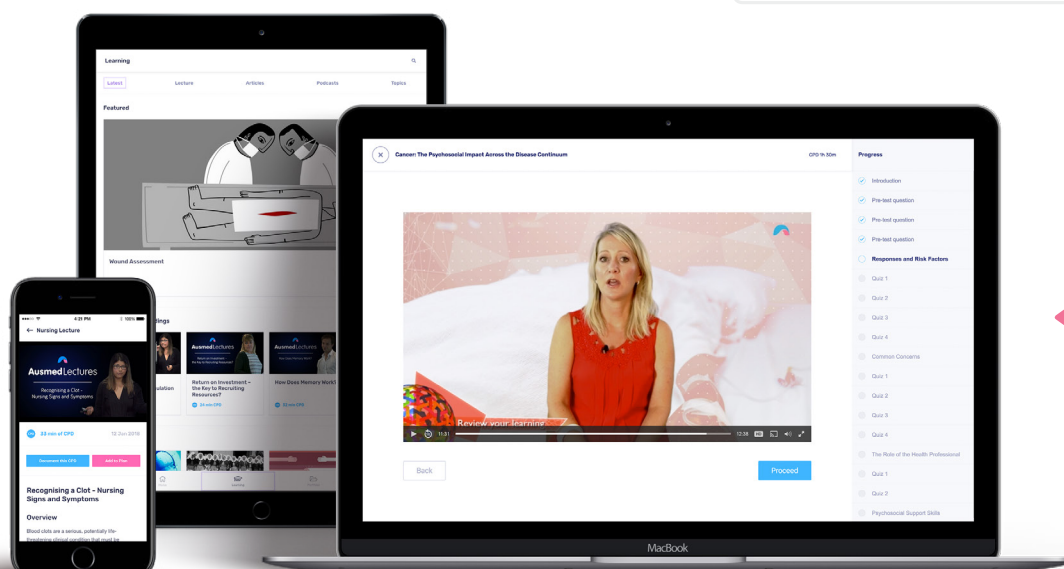
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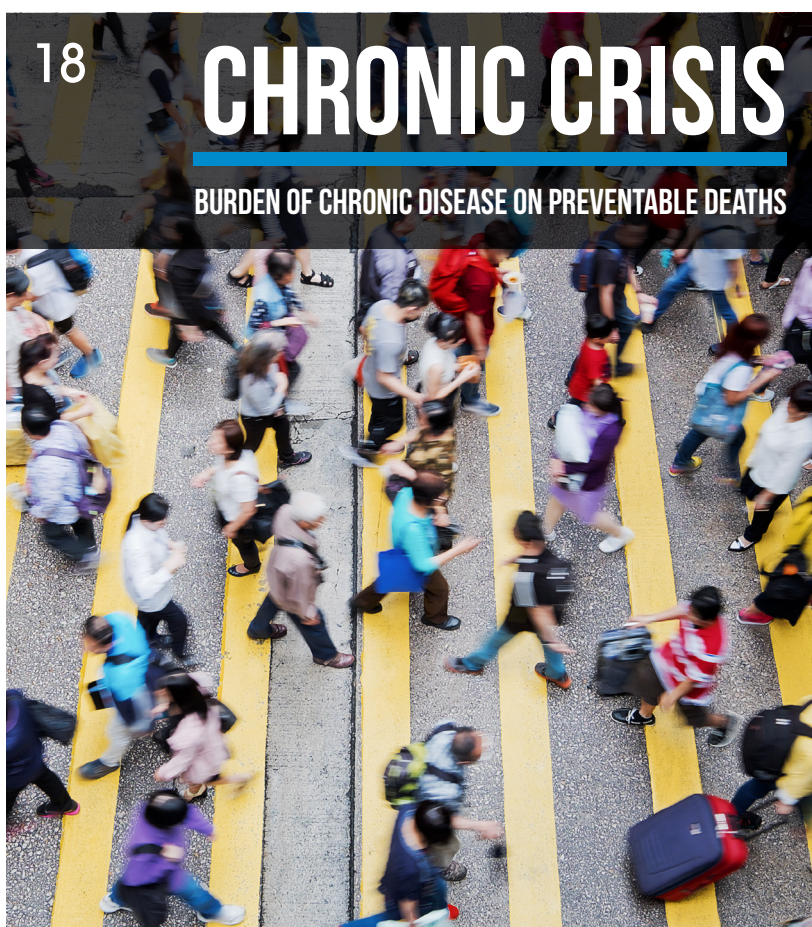
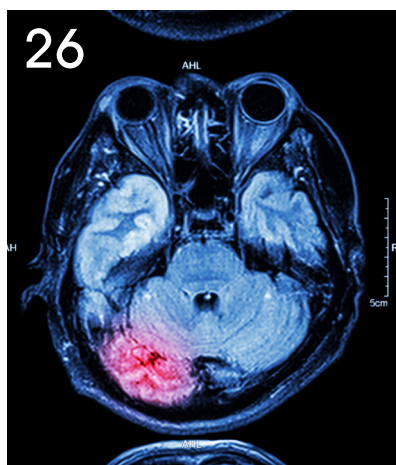
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Editorial

Annie Butler ANMF A/Federal Secretary

The ANMF has had a busy month campaigning to fix the crisis in aged care.

On International Nurses Day, thousands of nurses, midwives, carers and members from the community gathered at events around the nation, calling on federal politicians to legislate staffing ratios in aged care.

I attended the ANMF Vic Branch Rally in Queens Park, Moonee Ponds, where it was pleasing to see not only union members but also concerned families and members of the community, showing their passionate support for nurses and carers in nursing homes who are struggling to cope as a result of chronic understaffing.

Speaking to an inflamed crowd, ANMF Vic Branch Secretary Lisa Fitzpatrick, recently elected federal politician Ged Kearney, Senator Derryn Hinch and I expressed our disgust at the shameful state of the sector and our determination to fight for vulnerable older Australians.

Media coverage of events around the country continued to fuel an angry community and within hours of the national events, thousands of people had signed up to support ratios in aged care on the ANMF website.

Additionally this month the ANMF released a report prepared by the Tax Justice Network Australia on tax avoidance by for-profit aged care companies.

The data showed the country's top six for-profit providers received over \$2.17 billion in government subsidies - 72% of their total revenue – and made profits of \$210 million during 2016 and 2018.

As a result of the report a Senate Inquiry into the financial and tax practices of for-profit aged care providers was announced. The Inquiry will see the Senate Economics Reference Committee investigate for-profit aged care providers' use of tax avoidance or aggressive tax minimisation strategies, the associated impacts on the quality of care and sustainability of the sector, whether providers are accountable for their use of taxpayer money and if current practices meet public expectations. The news section in this month's *ANMJ* outlines this report.

Despite the momentum of the campaign, it was disappointing that the recent federal Budget 2018-19 delivered nothing to alleviate the chronic understaffing in the aged care sector.

The only way to ensure safe staffing levels is to tie government funding to the provision of care, yet this budget indicates the government is currently not prepared to guarantee this.

This, however, has not deterred us in the least. We will continue to fight until the government mandates minimum staff ratios in aged care.

It is important everyone backs this campaign. You can do this by signing up for campaign updates and signing the petition: anmf.org.au/campaign/entry/ratios-for-aged-care

Your invaluable support will make all the difference to nurses and carers working in aged care, older Australians living in aged care facilities, families and loved ones.

Annie

WE WILL CONTINUE TO FIGHT
UNTIL THE GOVERNMENT
MANDATES MINIMUM STAFF
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SOUTH AUSTRALIANS RALLIED FOR AGED CARE RATIOS

FIGHT FOR AGED CARE RATIOS LAUNCHED ACROSS NATION

Aged care workers and community advocates turned out in force at rallies across the country last month as the Australian Nursing and Midwifery Federation (ANMF) officially launched its national campaign pushing for mandated staff ratios in the sector.

At Victoria's rally on International Nurses Day, 12 May, ANMF A/Federal Secretary Annie Butler said the campaign's launch across the country marked the beginning of collective action to address chronic understaffing so nurses and carers could provide proper care to elderly residents.

Ms Butler called on federal politicians to legislate ratios and ensure aged care

providers are held accountable for the billions in government subsidies they receive.

"The only thing that will meet our expectations is when we know every single elderly nursing home resident has access to safe quality care and we know the only way to do that is for the government to mandate staff ratios," she told the crowd in Queens Park, Moonee Ponds.

High profile aged care allies in former ANMF Federal Secretary and recently elected Federal Labor MP for Batman, Ged Kearney, and Victorian Senator Derryn Hinch pledged to back the campaign, with Hinch promising to introduce a tougher ratios Bill into Parliament later this year after his private member's Bill failed to gain support last September.

Aged care worker Sam said she attended the rally because she felt compelled to help fix the crisis.

"I just feel proud that all these people have come out today," she said.

"This [ratios] is what we've got to fight for. This should have happened many years ago before it got this bad."

Across in South Australia, hundreds rallied for aged care ratios outside the office

of Federal Labor MP Steve Georganas in Glenelg East, with nurses, carers and community advocates chanting "Ratios for aged care make them law now!"

Former nurse and South Australian Labor MP Nat Cook, who began her career in aged care, was among those who addressed the crowd and committed to fighting for the nation's elderly.

"In aged care I provided care. I gave personal hygiene. I fed them [residents]. I helped people put their makeup on. I dressed them with dignity. We took them for walks. People don't have the time to do that these days. It's not care anymore and people don't enjoy their jobs because of it."

The Queensland Nurses & Midwives' Union (QNMU) began their campaign activities for the national launch with a march for aged care on Labour Day, 7 May, across the state that saw scores of nurses, midwives and carers support their aged care colleagues.

Then on 12 May, International Nurses Day and national launch day, the QNMU conducted a secret audit that involved surveying 70 aged care facilities across 30 federal Queensland electorates.

RATIOS FOR AGED CARE CAMPAIGN LAUNCH

The audit found 79% of aged care staff surveyed said facilities were dangerously understaffed, 82% reported residents who called for help had to wait, and 68% said chronic understaffing meant they were unable to properly clean residents.

The audit also found 75% of aged care staff were not qualified nurses, with many aged care residents regularly left without a registered nurse on staff overnight.

Tasmania's campaign launch involved a community gathering on the Clarence City Council lawns in Rosny and included speeches from ANMF (Tas Branch) Secretary

Emily Shepherd and Federal Labor MP for Franklin Julie Collins.

"Chronic understaffing in nursing homes in Tasmania means that nurses and carers are being placed under enormous pressure and elderly, vulnerable residents aren't getting the care they need and deserve," Ms Shepherd said.

Elsewhere, the ANMF (ACT Branch) held a sausage sizzle in Lennox Gardens, Yarralumla, on 12 May, while the ANMF (NT Branch) called for action on 7 May in Darwin and Alice Springs with nurses, midwives and carers marching for legislated ratios in aged care.

In NSW, drizzly weather did little to dampen spirits at the NSW Nurses and Midwives' Association (NSWNMA) rally in Parramatta Park, which featured numerous speakers including aged care workers and supportive politicians.

"Nurses and care staff are doing the very best they can, often in impossible circumstances," NSWNMA General Secretary Brett Holmes told the crowd.

"They are run off their feet and they can't provide the level of care they want to. There simply isn't enough staff."



REPORT TRIGGERS INQUIRY INTO TAX AVOIDANCE BY FOR-PROFIT AGED CARE PROVIDERS

A Senate Inquiry into the financial and tax practices of for-profit aged care providers was announced just a week after an explosive report revealed the nation's largest for-profit nursing home companies are using a range of loopholes to minimise the amount of tax they pay despite receiving billions in taxpayer funded government subsidies.

The Inquiry will see the Senate Economics Reference Committee investigate for-profit aged care providers' use of tax avoidance or aggressive tax minimisation strategies, the associated impacts on the quality of care and sustainability of the sector, whether providers are accountable for their use of taxpayer money and if current practices meet public expectations.

The launch of the public examination last month emerged directly after the release of a report prepared by the Tax Justice Network Australia on behalf of the Australian Nursing and Midwifery Federation (ANMF) titled *Tax Avoidance by For-Profit Aged Care Companies: Profit Shifting on Public Funds*.

The data showed the country's top six for-profit providers received over \$2.17 billion in government subsidies - 72% of their total revenue - and made profits of \$210 million during 2016 and 2018.

The report found the largest of these providers, Bupa, recorded \$7.5 billion in total income in Australia in 2015-16 yet paid just \$105 million in tax on a taxable income of \$352 million.

Australian aged care business netted \$663 million in 2017, with 70% (\$468 million) coming from government funding.

The second biggest, Opal, half-owned by under fire AMP, registered a total income of

\$527.2 million in 2015-16 but paid only \$2.4 million in tax on a taxable income of \$7.9 million.

Another leading provider, Allity, paid no tax in 2015-16 despite a total income of \$315.6 million, while Opal paid no tax in 2014-2015.

ANMF A/Federal Secretary Annie Butler welcomed the Inquiry and thanked Senators for listening to the issues raised in the report.

"Companies that receive millions of dollars via Australian government subsidies should be required by law to meet higher standards of transparency in financial reporting," Ms Butler said.

"Proof of government funding being directly spent on the care of elderly residents' needs to be mandated as a pre-requisite to receive a subsidy."

Examining financial data, corporate structures and practices sourced from the statements and reports of aged care providers, the Tax Justice Network Australia report found for-profit companies were employing various methods to avoid paying tax such as stapled securities and discretionary trusts in a bid to maximise profits.

However, the report said it was difficult to obtain a complete picture of the extent to which the top six for-profit companies, who operate over 20% of residential aged care beds in Australia, were implementing tax minimisation strategies.

The report made several recommendations focused on improving transparency to ensure government funding reaches care.

They include legislation requiring aged care companies that receive more than \$10 million in government funding any year to file complete audited annual financial statements with the Australian Securities and Investments Commission (ASIC) and making public and private companies disclose all transactions between trusts or similar parties that are part of stapled or similar corporate structures.

Ms Butler said Australia is facing an aged care crisis typified by chronic understaffing and missed care for vulnerable elderly residents and that the report revealed these for-profit providers

did have the financial capacity to fix these issues.

She said evidence within the report would help bolster the ANMF's national aged care ratios campaign, launched last month on 12 May, International Nurses Day.

"There are currently no rules to ensure that the \$2.17 billion in government subsidies given to for-profit aged care providers is spent directly on care for their residents," Ms Butler said.

"As a result, care is being missed. There's simply not enough staff to feed, wash, toilet, change or give them their medication.

"The bottom line is big for-profit providers continue to generate massive profits at the expense of taxpayer funding which should be going directly towards the care of elderly Australians."

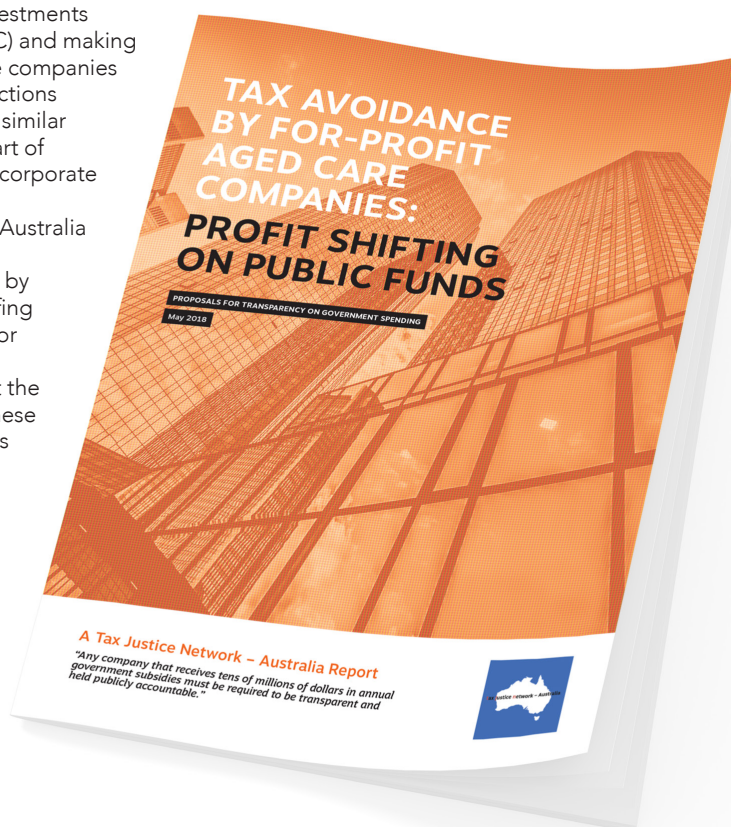
The report's author, Jason Ward, from the Tax Justice Network Australia, said the study confirmed many for-profit aged care providers were using "a variety of loopholes" to avoid paying tax and increase their profits.

He said stricter legislation would ensure providers were held accountable.

"Australian law is not currently strong enough to ensure that their financial records and accounting practices are publicly available and fully transparent."

Following the report's release, the ANMF launched a national online petition calling for greater transparency and accountability in government funding for the for-profit aged care sector.

To sign the petition visit,
bit.ly/2roUJqe



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BITTERSWEET: BUDGET 2018–19

What can health and aged care expect as a result of federal Budget 2018-19? While some investment into health was welcomed, the ANMF was deeply disappointed safe staffing in residential aged care was ignored. Read ANMJ's Budget summary below.

STAFFING CRISIS IN AGED CARE IGNORED

The ANMF has expressed disappointment the federal government has failed to address the urgent need for safe staffing in residential aged care in its latest Budget.

"Our members are pleased the government has allocated funding into additional home care packages and palliative care services, but they know that this will do nothing to ensure safe and timely care for elderly Australians already in residential aged care and those who will need it soon," ANMF A/Federal Secretary Annie Butler said.

The Budget delivered nothing to alleviate the chronic understaffing in the aged care sector, which has led to dangerous workloads for nurses and carers, Ms Butler said.

"We know that from 2003 to 2016, there's been a 13% reduction in qualified nursing staff working in aged care. Over the same period, there's been a 400% increase in preventable deaths in residential aged care. Yet the Government is still not prepared to guarantee safe staffing levels in residential aged care."

The only way to guarantee safe staffing levels is to tie government funding to the provision of care, Ms Butler said. "And the best way to achieve this is through mandated minimum staff ratios."

AGED CARE FUNDING LONG OVERDUE AND NOT ENOUGH

The aged care sector has cautiously welcomed the \$5 billion investment into aged care, largely for in-home care. The \$1.6 billion funding towards 14,000 high-level home care packages to enable older Australians to stay at home has been lauded as long overdue.

More than 104,000 people were on the waiting list for home care packages to meet their needs, with 78% needing higher Level 3 and 4 packages, according to latest government figures.

"It's simply unacceptable that waiting lists have blown out to this point, with thousands and thousands of people waiting more than a year for the care services they need to remain in their home," ANMF A/Federal Secretary Annie Butler said.

The federal opposition described the aged care package as a "pathetic insult

to older Australians" which did nothing to address the aged care crisis.

Funding just 14,000 new in-home aged care packages over four years was a "cruel hoax", Shadow Minister for Ageing and Mental Health Julie Collins said. "Made even worse by the fact that funding is coming from within the existing aged care budget to pay for it."

National Seniors Australia had called for double the number of Level 3 and 4 home care packages, to allow people to stay in their own homes and out of residential aged care. "We know that if people can remain in their own homes, they have better health outcomes and it is more cost efficient, so it's hard to understand why more resources haven't been allocated to home care," Chief Advocate Mr Ian Henschke said.

"Further work is needed to address the support needed for the remaining tens of thousands of Australians who will remain on the waiting list," Dementia Australia CEO Maree McCabe said.

NURSING INITIATIVES TO IMPROVE ACCESS

A range of nursing initiatives announced in the federal Budget aiming to help improve

access to healthcare for many Australians have been welcomed by nursing and health stakeholders.

A \$550 million Stronger Rural Health Strategy will provide for more than 3,000 nurses in rural, regional and remote areas.

"Aboriginal and Torres Strait Islander peoples, low income families, those who live outside our major metropolitan cities, or people who are new to Australia, do not always have the same access to best practice care that many of us take for granted," Australian College of Nursing Adjunct Professor Kylie Ward said.

"By investing in and supporting our nursing workforce, the Australian community can feel confident that nurses will be available to provide care now and into the future."

Funding for enhancing the role of nurse practitioners in frontline service delivery to improve patient care and keep pace with increasing demand for services was also announced.

Australian College of Nurse Practitioners CEO Mark Monaghan said this would raise greater public awareness of the role and skills of NPs.

"This will assist in raising the profile of



NPs and will help attract more nurses to undertake extra study to become a NP."

"Among a range of measures in rural health, the government will strengthen the role of nurses in primary healthcare, including a greater awareness of the role and skills of nurse practitioners, who are integral to the delivery of specialist palliative care," Palliative Care Australia CEO Liz Callaghan said.

The Consumers Health Forum (CHF) urged for longer-term primary healthcare reforms to remain on the radar.

The CHF remains concerned about people's ability to access the care they need due to expense, CEO Leanne Wells said. "While the additional funding for hospitals, Medicare, aged care and medicines is welcome, there is a strong case for greater emphasis on primary healthcare that focuses on local health services to respond to local need for integrated care, particularly for chronic illness."

FUNDING INJECTION FOR MENTAL HEALTH

The mental health sector has welcomed substantial investment to improve mental healthcare services for vulnerable Australians in this year's federal budget.

The federal government will invest \$338 million in the sector over the next four years across a range of initiatives, including suicide prevention and ensuring older Australians in residential care receive adequate mental health support.

The budget included \$20 million in funding to The Australian College of Mental Health Nurses (ACMHN) to co-design a pilot service for people living in the community aged over 75 at high risk of experiencing mental health issues due to social isolation and loneliness.

"We are very pleased the Commonwealth Government has recognised that substantial action needs to be taken to improve the mental health and wellbeing of older members of the community," ACMHN chief executive Kim Ryan said.

The National Mental Health Commission said its annual increase in funding would strengthen its objective to identify the strengths and weaknesses across mental health services and provide advice to government and the community.

"This includes monitoring and reporting on the implementation of the Fifth National Mental Health and Suicide Prevention Plan and aspects of the National Disability Insurance Scheme relating to psychosocial disability," the Commission's CEO, Dr Peggy Brown said.

Mental Health Australia described the funding focus on suicide prevention, older Australians and mental health research as a positive step toward an improved system that delivers better care.

"These budget measures are welcome, but this doesn't mean we won't stop working tirelessly to seek further investment next year, and every year that follows, until the current gaps in the mental health system are finally closed," Mental Health Australia CEO Frank Quinlan said.

\$5 BILLION AGED CARE PACKAGE MORE CHOICES FOR A LONGER LIFE

14,000 high-level home care packages

13,500 new residential aged care places and 775 short-term restorative places, plus \$60 million for capital investment

\$40 million to support aged care providers in regional, rural and remote

More than \$105 million to culturally safe aged care services in remote Indigenous communities

Establishment of an Aged Care Quality and Safety Commission with \$50 million for implementation

\$61.7 million for MyAged Care, and \$7.4 million to trial navigators

\$32.8 million for palliative care in residential aged care

\$5.3 million for innovations in managing dementia

\$102.5 million for mental health programs for older Australians

FEDERAL HEALTH BUDGET 2018-19

\$4.8 billion in Medicare funding

\$5 billion More Choices for a Longer Life aged care package

\$2.4 billion for new medicines

\$30 billion in public hospital funding

\$6 billion for health and medical research sector

\$3.9 billion for Indigenous Health

\$550 million Stronger Rural Health Strategy

\$338.1 million in mental health funding

\$77.9 million in infant and maternal health

\$230 million in sport and physical activity initiatives

NURSING INITIATIVES FUNDED INCLUDE

3,000 extra nurses in rural, regional and remote areas

Exploring nurse models of healthcare delivery to primary healthcare to support the nursing workforce

An independent review of current nursing preparation and education that affect nurses entering the nursing workforce

Funding for frontline service delivery by nurse practitioners

\$20 million for a mental health nurse led service for over 75s

MENTAL HEALTH FUNDING BOOST

\$338 million in mental health funding

\$83 million for psychological services in residential aged care

\$20 million for a mental health nurse-led service that will aim to address social isolation and loneliness among older Australians aged over 75 living in the community

\$125 million over 10 years for the Million Minds Mission from the Medical Research Future Fund

\$33.8 million towards Lifeline to boost its telephone service

\$37.6 million to beyondblue to provide care following a suicide attempt

\$20.4 million to the Royal Flying Doctor Service to enhance their mental health outreach services



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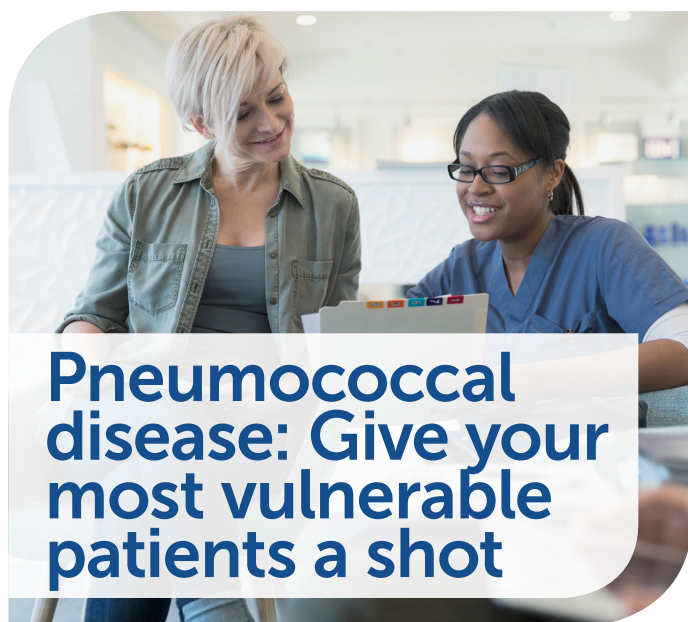
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BEFORE PRESCRIBING, PLEASE REVIEW THE PRODUCT INFORMATION AVAILABLE IN THE PRIMARY ADVERTISEMENT IN THIS PUBLICATION.

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Pfizer Vaccines



Pneumococcal disease: Give your most vulnerable patients a shot

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Adults become more susceptible to infections like pneumococcal disease when they have conditions which compromise their immune system.³

The Australian Immunisation Handbook (AIH) is the most informed resource for identifying at-risk patients and understanding which vaccines are recommended.¹

The AIH defines conditions associated with the highest risk of invasive pneumococcal disease (IPD) as **Category A conditions**:¹

Asplenia e.g. splenectomy	HIV/AIDS
Functional asplenia e.g. sickle cell disease	Solid organ transplant
Haematopoietic stem cell transplant	Congenital or acquired immune deficiency
Chronic renal failure or relapsing/persistent nephrotic syndrome	Immunosuppressive therapy (including corticosteroid therapy ≥ 2 mg/kg per day of prednisolone or equivalent for > 1 week) or radiation therapy, where sufficient immune reconstitution for vaccine response is expected
Intracranial shunts	Cerebrospinal fluid (CSF) leak
Haematological and other malignancies	Cochlear implants

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- Telephone reminders +/- face-to-face reminders⁶
- Electronic health record reminders⁷
- Pre-visit care planning for preventative health⁷
- Standing orders^{8,9}

Growing evidence shows a combination of interventions integrating vaccination checks into routine clinical care increases vaccination uptake.^{6,9,10}

A combination of strategies can help protect your most vulnerable patients against pneumococcal disease

You can:

- Use your patient management system to **screen and identify** your patients with Category A conditions.
- Use the **PneumoSmart Vaccination Tool** to help navigate the pneumococcal vaccine recommendation pathway. Input patient information via www.pneumosmart.org.au/clinicians/vaccination-tool/ to determine what pneumococcal vaccine they need, and when.
- Integrate this into your **recall/reminder systems** to ensure pneumococcal vaccination status is discussed at their next appointment.
- Document vaccines administered in the **Australian Immunisation Register (AIR)**. For patients with compromised immune systems and multiple touchpoints within the health system it's critical their records are up-to-date.

Nurses are in an ideal position to help protect vulnerable adult patients against pneumococcal disease. Using a multicomponent, collaborative approach in advocating pneumococcal vaccination is helpful – by establishing systems in your practice to prevent patients falling through the cracks, updating all practice staff on vaccine recommendations, administering the vaccines, documenting in the AIR and in providing patient education.

This article is supported by Pfizer.



For PBS information refer to the primary advertisement in this publication

BEFORE PRESCRIBING, PLEASE REVIEW THE PRODUCT INFORMATION AVAILABLE IN THE PRIMARY ADVERTISEMENT IN THIS PUBLICATION.

Limited safety and immunogenicity data on PREVENAR 13 are available for patients with sickle cell disease, allogeneic haematopoietic stem cell transplant, or HIV infection, and are not available for other immunocompromised patient groups. Efficacy/effectiveness has not been established. Vaccination should be considered on an individual basis. Immunocompromised individuals or individuals with impaired immune responsiveness due to the use of immunosuppressive therapy may have a reduced antibody response to PREVENAR 13. Immunisation schedules for PREVENAR 13 should be based on official recommendations. **References:** 1. Australian Technical Advisory Group on Immunisation (ATAGI). The Australian Immunisation Handbook 10th Ed (2017 Update). Canberra: Australian Government Department of Health, 2017. Available at www.immunise.health.gov.au. Accessed September 2017. 2. PREVENAR 13® Approved Product Information. 3. National Centre for Immunisation Research and Surveillance, Adult Vaccination factsheet. Available at http://www.ncirs.edu.au/assets/provider_resources/fact-sheets/adult-vaccination-fact-sheet.pdf. Accessed September 2017. 4. Serre J, et al. *Eur J Intern Med*. 2017; pii: S0953-6205(17)30220-0. 5. Byrnes P, et al. *Aust Fam Physician*. 2006; 35(7):551-2. 6. Chan SS, et al. *Int J Nurs Stud*. 2015; 52(1):317-24. 7. Wright WL, et al. *J Am Assoc Nurse Pract*. 2017; 29(7):384-391. 8. Rhew DC, et al. *J Gen Intern Med* 1999;14:351-356. 9. Rittle C and Francis R, *American Nurse Today* 2016; 11(9):42-43. 10. Koch JA, *J Gerontol Nurs*. 2012; 38(2):31-9. ©Registered trademark. Pfizer Australia PTY Ltd. Sydney, Australia. PP-PNA-AUS-0105. S&H 05/18 PFPFSH0138/ANMJ

DEMANDING A FAIR GO



Thousands of trade unionists joined forces at a series of rallies across the country last month during 12 days of national action seeking to Change the Rules and restore workers' rights.

Spearheaded by the Australian Council of Trade Unions (ACTU), the Change the Rules campaign is calling for an overhaul of Australia's broken workplace laws in a bid to create better job security, secure meaningful pay rises and implement fairer working conditions.

Last month's rallies represented the largest mobilisation of working people since the Your Rights at Work campaign over a decade ago in response to Work Choices legislation.

An estimated 100,000 people flooded Melbourne's CBD alone during the Victorian leg of the nationwide rallies, the masses hollering chants like "Hey hey, ho ho, Malcolm Turnbull's got to go".

Beginning at Victorian Trades Hall, a diverse cross-section of trade union members carrying banners and flags, including a strong presence from the Australian Nursing and Midwifery Federation (Victorian Branch), listened intently to speakers before marching as one to the Magistrates Court, then down Swanston Street and up to Flinders Street.

Addressing the crowd, ACTU Secretary Sally McManus said big business had too much power and that the Change the Rules movement was aiming to fight record inequality, including rising insecure work and low wage growth.

Ms McManus said the trade union movement had shaped the ideal of "the fair go", including rights such as the

eight-hour day, living wage, Medicare and superannuation, but that those hard fought wins were increasingly under threat.

"It's time to stop defending and start advancing," she said.

"Change doesn't happen by sitting on the sidelines and watching. Change happens by us making it happen. Rules change because we insist they change. We know power never gives in without a demand. We must insist on that."

ANMF Federal Vice President Lori-Anne Sharp (pictured centre) marched at the rally, describing walking side by side with fellow trade unionists to fight for a common goal as "empowering".

"The situation has been getting worse for a long time. There's an increase of casual work, attacks on penalty rates and a lack of secure work meaning many people are living under the poverty line," Ms Sharp said.

"The pendulum has swung too far in favour of big corporations. We must collectively fight for a fair and just society for the next generation and beyond. Doing nothing is not an option."

Ms Sharp said the **Change the Rules** campaign aligned well with the ANMF's current campaign pushing for mandated aged care ratios.

"We need to change the rules in aged care to legislate aged care ratios and support our chronically understaffed workforce that cannot deliver the care they are capable of and that residents deserve."

ROSEMARY BRYANT FOUNDATION LAUNCHED



On 17 May, the Rosemary Bryant Foundation was officially launched at the South Australian Nursing and Midwifery Research Symposium.

- ADJ ASSOCIATE PROFESSOR ELIZABETH DABARS AM, CEO/SECRETARY OF THE ANMF (SA BRANCH)
- DR ROSEMARY BRYANT AO, CHAIR OF THE ROSEMARY BRYANT FOUNDATION
- PROFESSOR CAROL GRECH, HEAD OF SCHOOL AT THE SCHOOL OF NURSING AND MIDWIFERY AT THE UNIVERSITY OF SOUTH AUSTRALIA

The Foundation has been established with the support of the ANMF (SA Branch) in order to fund high quality, translatable research that can be quickly adopted and embedded into practice.

The Foundation has been named in honour of Dr Rosemary Bryant AO – Australia's first Commonwealth Chief Nurse and Midwifery Officer and a renowned South Australian champion of the nursing profession.

"The Foundation will pave the way in ensuring Australia has the evidence it needs to make informed healthcare decisions, said Dr Bryant.

"It will be integral in the translation of new research discoveries into practice to better equip nurses and midwives, and the broader healthcare system, to provide the best possible care for the community."

In recent history nursing and midwifery care has evolved immensely. Nursing and midwifery are now established and respected professions in which best practice care is informed by high-quality evidence based research. It is important, however that the profession continues to develop and grow into the future and it is clear that research is integral to improving care provided to the community.

ANMF (SA Branch) Chief Executive Officer/Secretary Adjunct Associate Professor Elizabeth Dabars AM explains evidence is crucial to achieving change.

"Evidence in healthcare is vital – not only in clinical practice but also to policy,

management and, critically, systems development and funding," she said.

"Most importantly, it has to relate to real and improved outcomes for the nursing and midwifery professions and the people they care for through the course of their work."

Dr Bryant, who chairs the Foundation agrees.

"There is a large gap in the evidence on the nursing and midwifery professions' essential contribution to the bottom line of our health system, but more importantly, the quality of care and health outcomes of the population," Dr Bryant said.

Adjunct Associate Professor Dabars states supporting the establishment of an independent research foundation is the next logical step following the significant amount of work that has already been undertaken to drive evidence-based research with a focus on partnerships.

"The Foundation builds on the role we have played in implementing and advancing evidence-based practice through leadership of the Best Practice Spotlight Organisation program – an initiative now being implemented in three of the five Local Health Networks in the South Australian public health system.

"We understand that in order to accelerate our learnings and improve best-practice care, more funding for research is required which the Foundation can address," she said.

People can learn more and support the Foundation by visiting rbf.org.au or by emailing info@rbf.org.au

LEADERSHIP AND RESILIENCE: A PEACEKEEPER'S PERSPECTIVE

One of Australia's most decorated women in military history urged nurses to step up and lead at the Australian Primary Health Care Nurses Association national conference held in Brisbane last month.

An inspiring address by retired Major Matina Jewell left a teary 550-strong delegation on their feet with a standing ovation.

"We are all leaders, Major Jewell said. "We do not necessarily think of ourselves as leaders unless it is in our job roles. Yet the most effective teams are those that have leadership at every level."

In 15 years of army service, Major Jewell worked alongside US Navy Seals blockading the Persian Gulf. She dodged Israeli bombs while being a United Nations peacekeeper in the 2006 Lebanon war which earned her eight military service medals.

Major Jewell said it was natural and 100% normal to feel fear in intense circumstances. The challenge was to try something new, she said.

"To 'just have a crack'. To drop the boundaries and limitations we place on ourselves. You might be surprised what you might achieve. We learn the most from our failures. We remember them and learn from them for a very long time."

Major Jewell was stationed at what was considered the most dangerous UN peacekeeping patrol base just inside South Lebanon when the war erupted in 2006.

"I hadn't seen anything more dangerous in my 15-year career. It was the most terrifying and challenging time in my life, that tested my skills and abilities unlike any other situation previously where I had to lead my team to safety."

Sometimes as leaders we have to think outside the box and find a solution to our problems, Major Jewell said. It meant having critical processes in place.

"Have a plan and back-up plan and practice them before you get in to a crisis situation. It's really important for us to be able to identify skills that we might need such as training and education, upskilling in technology, whatever it is in nursing we might encounter in the future. Going on the front foot to have that ability to rapidly change in any given situation."

While commanding a UN convoy to

safety, Major Jewell became a casualty of the Lebanon war breaking five vertebrae. She endured lying on a tiled floor for two days without pain relief before a 20 hour boat ride to Cyprus to receive medical treatment.

Major Jewell found out 15 days later via CNN News that her entire team had been killed when a laser guided bomb hit the unarmed UN base in South Lebanon.

"I hit absolute rock bottom. It was not one single thing but compounding factors. I was extremely fit and now I was bedridden and immobilised. I had battles with the government for health cover for my injuries on the battlefield. I lost my career in a split second and had no say in it. I lost my teammates and I had survivor guilt."

It was how we handled adversity that shaped our development, both professionally and personally, Major Jewell said.

"I was consumed by darkness and negativity. I had the most amazing support network. But first I needed to tap into my own inner fighting spirit. Life isn't fair. It doesn't always go to plan. We all have moments that define us."

"We are all who we are as a result of the experiences we have in our lives. Ask 'what is your purpose?' 'What is in your organisation, work, life that is worth fighting for?' "Don't ever underestimate the role you have. Our voices can be a ripple that goes on to be a tidal wave of change."

PROTECTION FOR ADULTS TOO¹



Prevenar 13[®]
Pneumococcal polysaccharide conjugate vaccine, 13-valent adsorbed

PBS Information: This product is listed on the National Immunisation Programme (NIP) for children only and is not listed on the PBS. Refer to the NIP Schedule.

Please review full Product Information before prescribing. Product Information is available on request on 1800 675 229 or at www.pfizer.com.au

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 for details (V10516). References: 1. PREVENAR 13[®] Approved Product Information. ©Registered trademark. Pfizer Australia PTY Ltd. Sydney, Australia. PP-PNA-AUS-0060. S&H 05/18 PFFFSH0138/ANMJHPA

ANMF PARTICIPATES IN NATIONAL RECONCILIATION WEEK



Faye Clarke, a Gunditjmara, Wotjaboluk and Ngarrindjeri woman and ANMF Aboriginal Nurse Adviser joined in the ANMF Federal Office activities during National Reconciliation Week 2018 earlier this month. Ms Clarke said this year's National Reconciliation Week theme *Don't Keep History a Mystery* was fitting.

"Everyone in Australia is just waking up: 'Oh that happened'. People still don't know about it. Everybody needs to know the history of this country. There needs to be acceptance that this is what happened and that it hasn't been an easy trip for Aboriginal people since colonisation and it continues not to be easy."

It's about connecting dots, said Ms Clarke. "To get people to understand that the history of this country has an impact on Aboriginal people and their state of health."

One of the small things we can do as nurses and midwives is to acknowledge, pay homage or show respect to Aboriginal and Torres Strait Islander people as the First Nations peoples, said Ms Clarke.

Doing a Welcome to or Acknowledgement of Country when participating or attending conferences or meetings is an initial base step, she said.

A Welcome to Country and Acknowledgement of Country are two different things. A Welcome to Country occurs at the beginning of a formal event and can include song, dance, and smoking ceremonies.

A Welcome to Country is delivered by Traditional Owners or Aboriginal and Torres Strait Islander people who have been given permission from Traditional Owners to welcome visitors to their Country.

"I could not do a Welcome to Country if I am not from this Country. Where it's done well, often an organisation has the right connections with the right elders, particularly if they have an existing relationship with the elders and continually work together. For national events held from capital city to capital city that's not always the case," Ms Clarke said.

The difference in quality of a Welcome to Country can rely on time, preparation, relationship with the Traditional Elders, and the delivery. "It comes down to the planning and forethought. This includes if the elder is given a briefing about the conference and/or understands what the conference is about," said Ms Clarke.

Whereas anyone can do an Acknowledgment, she said. "It used to be that any Aboriginal person present could be asked to do it. Thankfully that's lessening. It is much more respectful and honouring if the MC of an event or the person chairing a meeting does the Acknowledgment. As an organisation we are honouring the Traditional Owners this way."

What people do themselves when they stand up and acknowledge the Traditional

Owners and land is their own personal view and expression, said Ms Clarke.

"It does mean something more personally. They are saying: 'I am with you'. You can as a health professional encourage and role model by showing that respect."

By doing an Acknowledgement, it means you've thought about it and even better if you add depth, said Ms Clarke. "As nurses and midwives we can acknowledge the disparities around health."

A big essence of the Welcome to Country or Acknowledgement is the permission to come on to land.

"We welcome, acknowledge and pay respect to that. What we are doing is thanking the traditional owners. In the day, you did not just come on to someone else's country unless you had permission. Those people would have to grant permission and be welcomed by the elders," Ms Clarke said.

Historically it was on the borders of the country, generally the hilly parts or the rivers or landmarks identified as the borders.

"If people came on to country on top of a hill they would light a night fire and someone would go up to see them and invite them to country. Generally it was a fire to signal their arrival and seeking permission to come on to country. It might be for trade, connections, or relations with neighbouring tribes."

It's the equivalent of what we do today, Ms Clarke said. "We do not drop in to the neighbour's house, we knock on the door."

There is also the strong spiritual side of the Welcome to and Acknowledgement of Country.

"We come in and have a very strong awareness that our ancestors are with us and are still watching over their own land. When going to a different country Aboriginal people will acknowledge in their minds or silently to themselves and perhaps perform a physical act - throw a bit of dirt, toss some soil in to the water or some method to acknowledge they are on someone else's country. Some way of honouring the land and the ancestors," said Ms Clarke.

MY HEALTH RECORD OPT-OUT DATE LOOMS

Australians will have until October to opt out of a My Health Record before having one created for them.

The government's online health summary originated several years ago in a bid to give people and their healthcare providers shared access to key information such as allergies, medical conditions and pathology tests.

Now, every Australian will get a My Health Record unless they opt-out during a three-month period running from 16 July to 15 October.

If they choose not to, they will have an online health record created for them by November.

However, Australians can cancel their My Health Record at any time after the opt-out period or sign up again if they opt out and change their mind.

The government will roll out a national communications strategy to inform Australians about the opt-out process and promote the benefits of digital health.

People who do not want an online health record will be able to opt-out by visiting the My Health Record website or by contacting the Australian Digital Health Agency via phone.

Currently, 5.7 million Australians use a My Health Record to access their health information online.

The government's announcement was widely welcomed by health organisations who consider the move a positive step towards making consumers an active partner in their own care.

"For too long, healthcare has lagged behind in exploiting the clear benefits of information technology to provide prompt, secure and precise patient information," Consumers Health Forum CEO Leanne Wells said.

"For these benefits to be realised and a consumer-centred and digitally enabled healthcare system to become a reality, consumers will need to be involved in using and improving innovations such as My Health Record."

Health Minister Greg Hunt encouraged all Australians to utilise My Health Record for its benefits to patients, including reduced duplication of tests, better coordination of care and more informed treatment decisions.

National Rural Health Alliance (NRHA) Chairperson Tanya Lehmann strongly supported the benefits of a digital health record in helping to improve outcomes for those living in rural and remote areas.

A NIGHT OF NIGHTS FOR NURSES: THREE OUTSTANDING WINNERS TAKE HOME A HESTA AUSTRALIAN NURSING & MIDWIFERY AWARD

Three remarkable nurses have been celebrated at the 2018 HESTA Australian Nursing & Midwifery Awards.

More than 300 people attended the awards presentation, held on Thursday 10 May at Pullman Melbourne on the Park and hosted by writer, broadcaster and presenter Yumi Stynes.

In its 12th year, the national Awards are Australia's most prestigious recognising nurses, midwives, nurse educators, researchers and personal care workers who excel in their area of expertise or service provision across the three categories: Nurse or Midwife of the Year, Outstanding Graduate and Team Excellence.

Proud Awards sponsor ME – the bank for you, generously provided the \$30,000 prize pool, divided among the three winners.

HESTA CEO Debby Blakey said this year's winners demonstrated an outstanding commitment to the nursing profession. "We are proud to recognise the winners of this year's Awards, who have shown leadership in advocating on behalf of their patients for improved access to health care, whilst also providing meaningful solutions to overcome these challenges," Debby said.

"Their work has had a profound impact on the lives of many Australians."

Nurse of the Year: Gail Yarran Derbarl Yerrigan Health Service Aboriginal Corporation

Gail was awarded for her work in improving and advocating for better delivery of health care services to Aboriginal and Torres Strait Islander peoples living across Western Australia.

With a nursing career spanning more than 50 years, Gail is a prominent Aboriginal

healthcare leader and nurse ambassador. Her work includes holding multiple advisory roles, as well as developing clinical research projects and pilot programs designed to meet the specific needs of Aboriginal and Torres Strait Islander patients.

Gail's tireless work continues to help Aboriginal people living across Western Australia reach health parity.

"I know I can't close the gap, but I can do my little part to make a difference," said Gail. "Currently I work in maternal child health doing screening, child health checks and immunisations. By doing this I would like to see better health outcomes for Aboriginal and Torres Strait Islander women and their babies."

Gail said she would like to use the prize money to explore how to improve antenatal health services and make them more accessible for women. She is also a nurse ambassador with The Heart Foundation in Perth, and said she would like to put some of the prize money towards researching Aboriginal women's heart health.

Team Excellence: The Kombi Clinic, Hepatitis Queensland

Awarded for designing a mobile medical clinic to provide life-saving treatments to people living with hepatitis C across South East Queensland, the Kombi Clinic's innovative service is a one-stop-shop for hepatitis C testing, treatment, and information. Run by a team of health professionals, including Outreach Fibroscan Nurse Mim O'Flynn, the clinic treats patients with life-saving medication following an initial consultation which includes blood tests and fibroscan.

Mim said the clinic is unique and different to other services because it brings medical care directly to people who are most vulnerable, enabling them to easily access treatment. "The Kombi Clinic is a team of

passionate people who want to eliminate hepatitis C by 2030," Mim said "Our patients often haven't spoken to anyone about their hep C status and we offer them a safe environment and the opportunity to seek treatment free of judgement."

She said the teams plans on using the prize money towards new technology which does point-of-care testing, enabling on the spot diagnosis.

Outstanding Graduate: Veronique Murphy, Alfred Health Melbourne

Veronique was awarded for improving the care experience of patients who have difficulty communicating by developing a process to facilitate the record keeping of patient likes, dislikes and interests, enabling easy communication of a person's preferences between team members.

Believing each person has the potential to positively or negatively influence a patient's experience, the 'patient preferences prompt sheet' was designed by Veronique to ensure vital nonclinical information could easily be communicated between staff, aiding them in providing compassionate, quality care.

"The more we know about the patients, the more easily we can guide them through the times when they're struggling to communicate," said Veronique. "The sheet was designed to help those patients, whether they are experiencing delirium or have dementia."

Veronique plans to use the prize money from her award win to help pay for a Master's degree in nursing, in addition to funding work experience in under-resourced parts of Australia and the world.

See all the night's action at: hesta.com.au/awards/nursing-midwifery-awards.html

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HESTA NURSING & MIDWIFERY AWARDS L TO R MC YUMI STYNES HESTA CEO DEBBY BLAKEY KOMBI CLINIC MIM O'FLYNN DERBARL YERRIGAN GAIL YARRAN ALFED HEALTH VERONIQUE MURPHY WITH ME BANK MARNIE FLETCHER

ENGLAND

NHS NURSES CONSIDER IMPROVED PAY DEAL

Nurses in England are casting their vote on whether to accept their largest pay rise offer in a decade following an agreement reached between NHS unions, the Department of Health and Social Care and NHS Employers.

The pay boost emerged after the Royal College of Nursing (RCN) led a successful campaign last year calling on the government to scrap its 1% cap on public sector pay rises.

The enticing three-year deal will deliver 1.3 million workers on the NHS Agenda for Change contract a pay rise worth at least 6.5% by 2020.

The pay rise will see nurses receive more than a 6.5% increase, with a registered nurse three years into their career set to be about £6,000 a year better off by 2020/21.

Importantly, an increase in starting salaries and allowing individuals to reach

the top of their pay band sooner is likely to improve the recruitment and retention of nurses.

RCN has endorsed the deal and if members approve it, higher payments will begin in July.

"Today's deal is neither a magic wand nor a blank cheque but commits significant government cash to overlooked NHS staff without making any unpalatable demands in return," RCN Chief Executive and General Secretary Janet Davies said.

"There are 40,000 unfilled nursing jobs in England alone and this should begin to make the profession attractive again."

IRELAND

NURSING AND MIDWIFERY STUDENTS CONTEMPLATE LEAVING COUNTRY

Over 70% of final year nursing and midwifery students in Ireland are considering leaving the country to work abroad, a survey by the Irish Nurses and Midwives Organisation (INMO) has revealed.

The recruitment and retention of nursing and midwifery graduates in Ireland has been a serious concern for some time, reflected by sliding numbers working in the Irish Public Service.

The INMO's survey of 2018 4th year students examining their plans post-graduation also found 60% were considering leaving the public health service to work in the private sector, 57% had already been approached by overseas nursing companies and 76% said staffing levels were not adequate to support learning and training of student nurses in clinical settings.

The findings listed an increase in pay, improved staffing levels and working conditions, and access to funded postgraduate education as the leading incentives that could influence graduates to stay within the public health service.

INMO Student and New Graduate Officer Neil Donohue said current uncompetitive rates of pay and overcrowded and understaffed workplaces made it difficult to attract nurses and midwives.

"The offer of a permanent contract for an extremely low paid job with poor working conditions is simply not attractive for nursing and midwifery interns. The shortage of skilled and experienced nurses and midwives to support the education of students will also mean there will be further deficits going forward."

INMO General Secretary Phil Ni Sheaghda said the results painted a grim picture of an issue that needed urgent addressing so improved services and better staffing and skills mix can roll out nationwide.

GLOBAL

NURSES CRITICAL TO COMBATTING VACCINE-PREVENTABLE DISEASES

The International Council of Nurses (ICN) has implored health systems globally to mobilise their nursing workforces in an effort to combat vaccine-preventable diseases.

Highly effective against the threat of emerging diseases and the eradication of scores of illnesses in high and middle-income regions, vaccines are still inaccessible for more than 19 million people worldwide due to a lack of funding, policy constraints that prevent nurses from administering vaccination and misconceptions around the intervention.

"Vaccination is still one of the most successful and cost-effective treatment to guarantee the health and wellbeing of our populations and, as the frontline

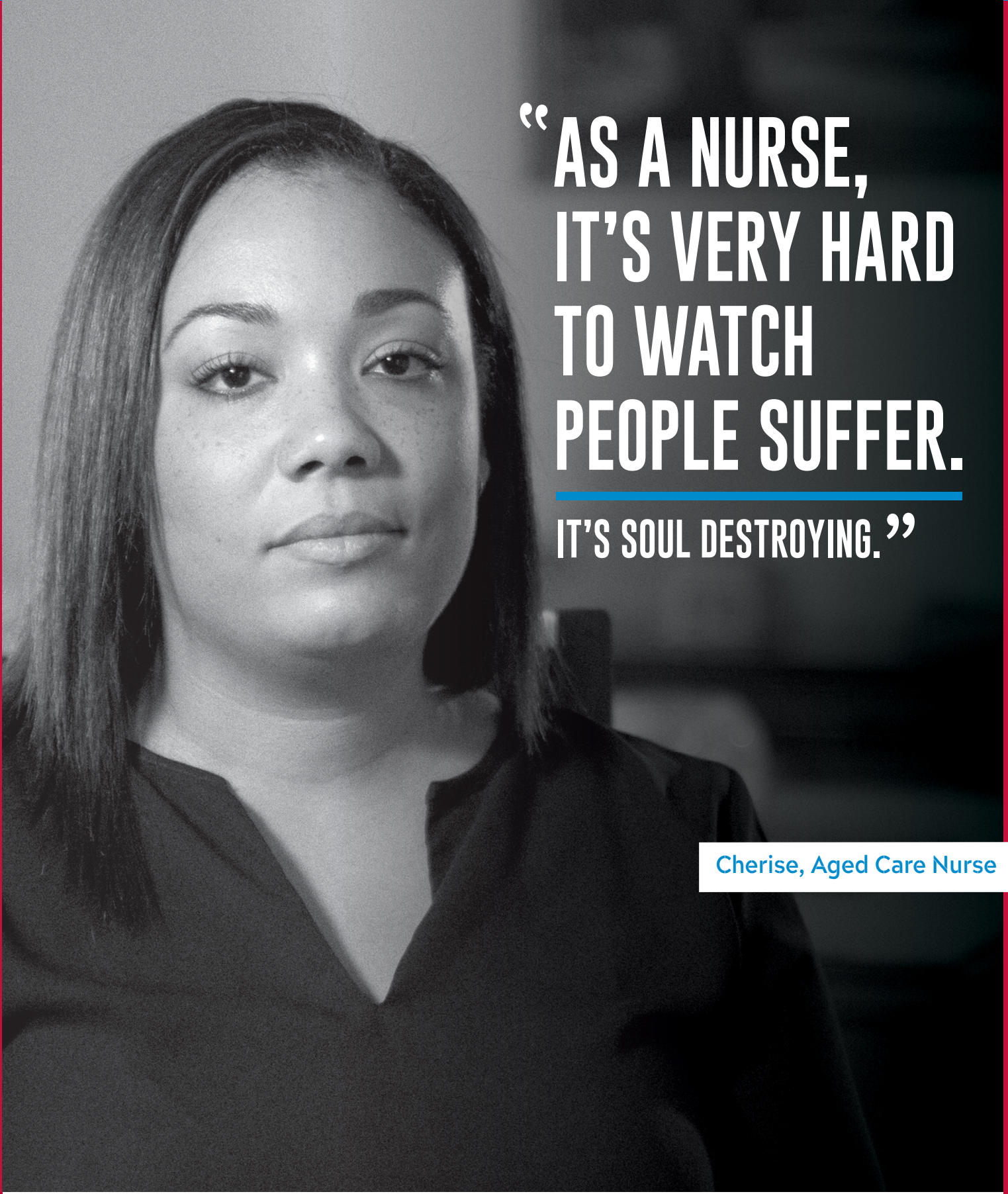


of healthcare, nurses are ideally placed to lead the way to ensure effective immunisation practice and coverage."

The ICN said by providing nurses with adequate training and competencies, as well as broadening their autonomy, countries can extend the reach of prevention programs to their most vulnerable in remote and deprived areas serviced solely by nurses.

Utilising the person-centred approach of the profession allows nurses to identify the needs and factors that result in poor immunisation systems and implement tailored strategies to educate patients and advocate for the sick.

As one of its priority areas, ICN is strongly involved in advocating for immunisation and continues to work to support and strengthen immunisation programs by enabling nurses to play a critical role in the administering of treatment.



**“AS A NURSE,
IT’S VERY HARD
TO WATCH
PEOPLE SUFFER.
IT’S SOUL DESTROYING.”**

Cherise, Aged Care Nurse

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

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



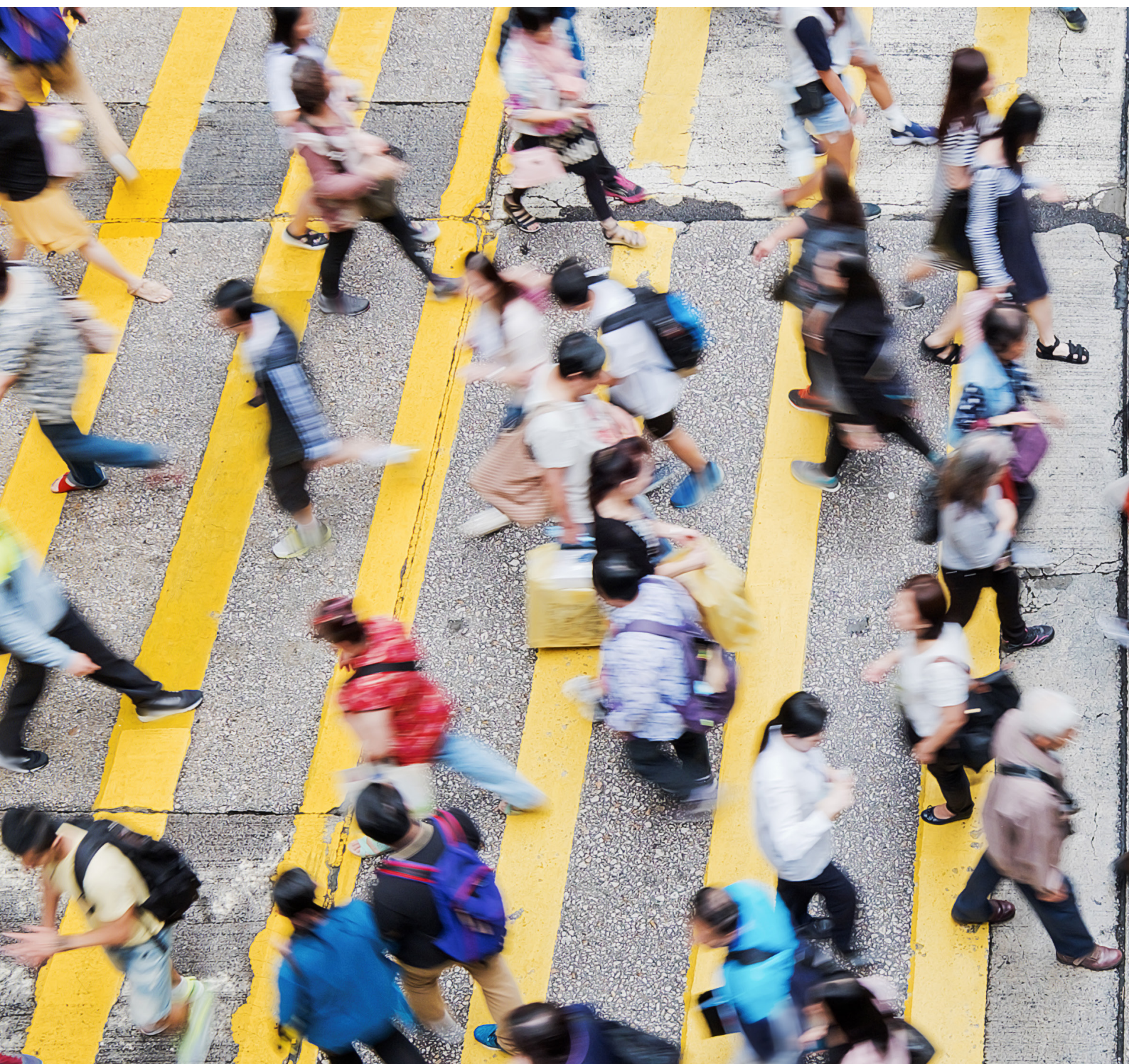
Australian
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Federation

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

FEATURE

CHRONIC CRISIS

BURDEN OF CHRONIC DISEASE
ON PREVENTABLE DEATHS



Despite being a wealthy, developed country, Australia's levels of chronic disease, amongst its population, is soaring, devastating millions of lives, and potentially crippling the health system. Yet a great deal of this disease burden is preventable. **Jessica Gadd** investigates what lifestyle changes can significantly reduce the chance of developing chronic diseases, and what nurses are doing to assist in disease prevention.

A quick health check for our nation reveals a few disturbing truths. According to the Australian Institute of Health and Welfare, half of us have at least one long-term, 'chronic' or 'non-communicable' disease, such as cancer, obstructive pulmonary disease, diabetes, or a mental health disorder.

One quarter of Australians, have two or more chronic diseases – the most common combination being cardiovascular disease

and arthritis. Moreover, around seven in 10 deaths (73%) in Australia are due to chronic disease.

In addition to the obvious, devastating effects, these diseases have on individuals and their families, many of them have the potential to stretch Australia's health system beyond its capacity.

Diabetes, for example, is increasing at such a rate that Diabetes Australia has labelled the disease as a silent pandemic.

They state it is 'the biggest challenge confronting Australia's health system', with 280 Australians being diagnosed with the disease every day. That's one diagnosis every five minutes, adding up to a total of around 1.7 million people with diabetes. This includes all types of diagnosed diabetes (1.2 million known and registered) as well as silent, undiagnosed type 2 diabetes (up to 500,000 estimated). As a consequence Diabetes costs the healthcare system an estimated 14.5 billion every year.

Grouped together, chronic conditions are responsible for around three quarters of Australia's total 'burden of disease' – a set of statistical techniques used to measure the impact that diseases, health conditions, injuries and various health risk factors have on the population.

Yet most concerning is that chronic diseases are responsible for the shortening





PROVIDING INFORMATION TO HELP PEOPLE MAKE HEALTHIER CHOICES IS AN IMPORTANT STEP TOWARDS SOLVING THE OBESITY CRISIS

MICHAEL MOORE AM,
PUBLIC HEALTH ASSOCIATION
AUSTRALIA CEO AND
FORMER ACT HEALTH MINISTER

of lives. According to the *Australian Burden of Disease Study: impact and causes of illness and death in Australia 2011*, released by the Australian Institute of Health and Welfare, Australians lost a staggering 4.5 million years to premature death or living with illness.

Australia's top health concerns and risk factors

In Australia, the leading causes of death in 2016 were ischaemic heart disease, dementia (including Alzheimer's disease), cerebrovascular diseases, cancer of the trachea, bronchus and lung, and chronic lower respiratory diseases.

The greatest public health burdens were cancer, cardiovascular disease, mental and substance abuse disorders, and musculoskeletal conditions and injuries, which accounted for 66% of the total burden of disease in Australia.

"Unquestionably, health in Australia and premature mortality is dominated by the non-communicable diseases," says University of Melbourne Laureate Professor Alan Lopez, co-author of the *Global Burden of Disease Study*.

This study is the world's most comprehensive observational epidemiological study, describing and examining mortality, morbidity injuries and risk factors, and enabling an understanding of global health challenges.

Professor Lopez says the rise of chronic disease in Australia is part of a worldwide trend.

"The key thing to note is that the global epidemiological environment, as measured

by the burden of disease, suggests that the main causes of health loss in the world today are not measles, diarrhoea and pneumonia, as important as they are, but non-communicable diseases like stroke, cancer and ischaemic heart disease."

What is more, one third of this chronic disease, including cardiovascular disease, stroke, dementia and some cancers is preventable.

While this might seem a staggering claim to some, it is backed up by numerous studies, including the *Global Burden of Disease Study*, which has found many chronic diseases have avoidable risk factors, most commonly: smoking, alcohol, obesity, poor diet and a lack of exercise.

The Australian Institute of Health and Welfare estimates that 31% of Australia's burden of disease could have been prevented, by reducing exposure to modifiable risk factors such as these.

"Let's look at cancer, for example," says Professor Lopez. "If you take populations of people who smoke and people who don't smoke, and you follow them through, then of the deaths from cancer in those populations, about one-third of them will be due to smoking. You can calculate that epidemiologically. So, using these fractions as a frame of reference, we can legitimately say that one third of these cancer deaths are preventable – because you don't need to smoke."

Obesity – a growing problem

Smoking and alcohol consumption are the leading disease risk factors, but obesity, having tripled in the past 30 years, is not far behind them. Obesity is estimated by the Grattan Institute to cost Australia more than \$5 billion a year in welfare expenditure, healthcare costs and lost income taxes.

"Obesity is a big issue in Australia," says Professor Lopez. "It's not clear that it's leading to massive premature mortality in itself, but it is certainly leading to various illnesses like diabetes and some of the cancers, and many of the musculoskeletal conditions are directly related to people being obese."

Professor Lopez says, despite the clear health hazard presented by obesity, it's been difficult to find population-level interventions that work in reducing levels of excess body fat and obesity in the Australian population.

"There's possibly reasons for this relating to the promotion of sugar in the population and the fast food industry," Professor Lopez says.

"So, there's definitely still a big agenda there for prevention in Australia around diet, around better food choices and also to be aware that it's not all about exercise. I'm sure the fast food industry would like us to think 'Oh I'll just exercise more' – well, you need to exercise an awful lot just to burn off one ice cream."

Make the healthy choice the easy choice

This sentiment is echoed by Public Health Association Australia CEO and former ACT Health Minister Michael Moore AM, who

argues providing information to help people make healthier choices is an important step towards solving the obesity crisis. He says there are two obvious ways to do this – either by restricting junk food marketing to children, or at least matching it with an equal amount of healthy message advertising.

"The government is really reluctant to interfere with that kind of marketing, but the reality is that if they want people to make reasonable and informed decisions, then they should be hearing messages from both sides. None of us want taxpayers' money spent on the latter, so the government has a responsibility to enact that kind of restriction, which doesn't cost very much money, and is therefore not a budget issue."

A 2017 report from Deakin University revealed that 'big food' lobbyists have significant influence on Australia's health policies, swaying public policy decisions with political donations – and by emphasising the importance of the big food industry's economic contribution. Moore says that for this reason, transparency of political donations is critical.

"I think that if we want to see a healthier society we really need, in the broadest possible way, to look at our democracy. A healthy democracy equals a healthy society," Mr Moore says. "For example, just look at how industry has had an influence around the sugar tax. We do have to keep in mind that one of the big influences on this government is the rural sector, and we have seen a small number of electorates in Queensland, in particular, that are really dependent on sugar."

Calls to introduce a sugar tax on sugary drinks in Australia, which would work in much the same way as the tax on cigarettes, have repeatedly met with political resistance.

A press release from Health Minister Greg Hunt in February 2018 states: "Obesity and poor diets are complex public health issues with multiple contributing factors, requiring a community-wide approach as well as behaviour change by individuals. We do not support a new tax on sugar to address this issue."

Yet a tax on sugary beverages has been successful in reducing sales of sugary drinks in around 20 countries. Mexico, for example, introduced such a tax in January 2014, and saw sugary drink sales drop by 6% by the end of the year, and a further 6% in 2015.

"Picture a family and grandparents sitting around a table, and the child spooning eight teaspoons of sugar into its cup of tea," Mr Moore says. "Just imagine the frowns on the adults' faces, and yet every time we give a child a can of soft drink, they're getting at least that much sugar. But when it's in a can nobody frowns. And then we wonder why our kids are becoming obese!"

Mr Moore is encouraged by recent government announcements regarding a new focus on preventative health, but he points out that at just 1.6%, Australia's spending on preventative health has a long way to go to catch up to countries such as New Zealand and Canada. These nations devote about 6% of their health budgets to prevention, and reap the results in terms of lower overall health costs per capita than Australia.



Prevention is better than cure

The good news is avoiding these risk factors increases your chances for good health and avoiding chronic disease. It can also prolong your life – significantly.

According to a recent American study published in US journal, *Circulation*, 50 year olds who avoid these risk factors and keep healthy habits, maintaining a moderate level of exercise, healthy body-mass index and healthy diet, and avoiding cigarettes and too much alcohol – typically live 12 to 14 years longer than 50 year olds who don't.

Rosemary Calder, Director of Victoria University's Australian Public Health Policy Collaboration, argues that Australia needs to make a substantial shift, turning the focus from treatment of disease to the prevention of it.

"Most chronic diseases are related to our national lifestyle, the way in which we live and work, and they have, in many ways, the same capability of being prevented and or minimised as we've discovered in infectious diseases," Ms Calder says.

"We no longer have hospitals overwhelmed by infections, because we have built early intervention strategies such as improved sanitation and vaccination programs. We haven't taken the same logic to chronic disease and yet the evidence is very strong that prevention and early intervention works. We haven't yet seen chronic disease as a critical health policy issue requiring the same approach to prevention."

The difference with chronic disease is that the impacts are gradual, and it doesn't have the same, immediate impact, Ms Calder says.

"I think that is why we are complacent about this issue. But, we also know that people with multiple chronic diseases are more likely to die earlier than others, by a significant margin, and that ought to be a matter of national concern."

Ms Calder considers one solution is for general practices to become genuine primary healthcare providers, with practice nurses,

dietitians, and social workers being able to provide health management including diet and physical activity related interventions.

This model is slowly being adopted by general practices, particularly by practice nurses. In 2008 the Australian Health and Welfare Institute reported there were around 10,000 practice nurses working in 60% of Australia's general practices.



THE BIGGEST BARRIER TO MAKING LIFESTYLE CHANGE IS OFTEN MOTIVATION, AS WELL AS FINANCIAL CONCERNS

JACKIE EYLES, PRACTICE NURSE



THE RISE OF CHRONIC DISEASE IN AUSTRALIA IS PART OF A WORLDWIDE TREND

PROFESSOR ALAN LOPEZ,
CO-AUTHOR OF THE GLOBAL
BURDEN OF DISEASE STUDY

Practice nurse Jackie Eyles says that the bulk of her day-to-day work is around health promotion, chronic disease management, and emotional and mental health support. She says that the biggest barrier to making lifestyle change is often motivation, as well as financial concerns – such as the cost of medical appointments, gym memberships, and a perception that healthy food costs more.

"I think that people have an awareness of risk factors, to a certain extent, and often that's the reason why they're presenting, because they want to make changes, but they don't know how," Jackie says.

"People often struggle to stay motivated because of the cost involved, so a big part of my role is coming up with ideas that might support better healthy choices within their friendship groups that don't necessarily have to cost money, such as going for a walk with friends, rather than meeting them at a bar or a café."

Jackie says making healthy lifestyle choices can be complex.

"I'm in a small rural community where the focus is on red meat and dairy because it all has an impact on farming and local incomes. So if people decide to go dairy free, or reduce their red meat intake, then often there's the view that you're not supporting that community's, or your family's way of life. And there's the flow on effect from that. If people pack up and go, then we lose health services; if we lose numbers at the school, then we lose teachers, and so on."

Jackie says it often takes an illness in a friend, family member or prominent community member to alert people to the importance of their own health. "I see that immediately, because someone will get sick, and then other members of the community start coming in to say: 'I'm a bit worried about this, because I've also been a regular at the pub for 30 years', or whatever the relevant lifestyle choice might be."

Blaming the individual is not the answer

But Jackie is cautious about using the term 'lifestyle disease', because it shifts the focus to the individual, which can have negative effects on people's self-esteem and mental health thus compounding the problem and discouraging positive outcomes.

"As a practice nurse, I want to help improve the patient's life – to have an open conversation about that person's wellbeing as a whole, so they're able to be on the planet longer, to make better health choices, and be part of that positive lifestyle change."

Rosemary Calder would also like to see a shift away from blaming individuals.

"We have this attitude in Australia, which gets too much airplay, that it's your choice; it's your fault. But if you're a mum on a low income, and you don't have access to a car, unfortunately you will find that fast food is cheaper and more accessible for you than chicken and fresh vegetables. You can get it delivered. You possibly could live in a small flat, so there is nowhere for your children to exercise, either.

"Now, that is not a choice that's made. It's not a fault. It's not a failure – it's a problem that we as a nation should be concerned about, because that's all leading to preventable chronic disease. And preventable chronic disease is everybody's business."

In 2016 the Australian Health Policy Collaboration released *Getting Australia's Health on Track*, a report that outlined a series of 10 priority policy actions designed to reduce preventable illness and disability in the population. The organisation says that failure to address this issue will result in ongoing increases in the burden on health services, with soaring hospital admissions for conditions with preventable causes.

"I'm not arguing for new money, I'm arguing for a better use of existing money," Ms Calder says. "The proposals outlined in

this report are all affordable, feasible, and implementable now. And if taken together, like a prescription, they would start to make a significant difference to the nation's health.

"Particularly for the vulnerable populations – that's the 10 million Australians who have income and socioeconomic status in the lower 40%. It's in that part of our community for whom chronic disease has its worst impact. For the most recent four-year period, that 40% experienced 49,000 more deaths from chronic disease than the wealthiest 40% of Australians. Now that's an awful road toll."

Anti-smoking – a preventative health success story

Ms Calder sees Australia's road safety and smoking campaigns in the 1970s and 1980s as examples of really effective preventative health campaigns. She says that, had we not addressed those two major issues when we did, Australia's health landscape would look very different today.

"People were dying from tobacco-related cancers and people were dying from road trauma, and the health professionals whose business was to repair the carnage could see that it had to stop.

"So public health strategies, initiated by concerned clinicians, started addressing both those areas, and Australia's measures were really effective – they led the way, worldwide. If that hadn't have happened our hospital system these days would be absolutely dominated by rehabilitation hospitals, and our social welfare would be dominated by disability support."

Both Professor Lopez and Michael Moore agree, citing also taxation, restrictions around smoking in public spaces, and the introduction of plain packaging as successful tobacco prevention strategies.

"The Australian government uses Global Burden of Disease data to monitor program impact in key areas of population health, including tobacco control," says Professor Lopez. "

In men in the 1970s and 1980s, tobacco was the cause of about one in three deaths in middle age. Because of the immense tobacco control efforts in Australia, that fraction has declined dramatically, and it's probably now under one in 10 deaths in middle age.

"But in Australia, we can't take our eye off tobacco – we haven't won that one yet. It's still a significant cause of disease burden at around 10–12%. In other words – the Australian population would be 10–12% healthier if no one had ever smoked in Australia. But we can certainly say that those bold public policy anti-smoking interventions are now paying off and saving thousands of lives"





CRUNCHING THE NUMBERS ON AUSTRALIA'S TOP HEALTH CONCERNS

CANCER

is Australia's biggest killer, weighing in at 19% of Australia's total burden of disease. It accounts for an average of 131 deaths every day, that's nearly 48,000 deaths a year, with lung, bowel, prostate, breast and pancreatic cancer being the leading causes of cancer deaths. Cancer costs the health system more than \$4.5 billion every year, which is 6.9% of overall health expenditure.

CARDIOVASCULAR DISEASE

(including heart disease and stroke) accounts for 15% of Australia's burden of disease. Mortality rates from this disease are nearly as high as that of cancer, with an average of 120 deaths every day, or 43,963 a year. Cardiovascular disease accounts for \$5.48 billion every year; that's about 11% of Australia's health care expenditure. Cardiovascular disease is more prevalent in Australians aged over 55.

SUICIDE

is the leading cause of death for younger Australians – about eight Australians aged between 15 and 44 die by suicide every day (3,000 a year). The total cost of suicide and non-fatal suicide burden in 2014 was estimated at \$6.73 billion.

MENTAL HEALTH

conditions overall affect one in five Australians each year; and one in two Australians during our lifetimes. In 2016, the Australian Government National Mental Health Commission put the cost of mental ill-health at about \$60 billion every year.



**AUSTRALIA
NEEDS TO MAKE
A SUBSTANTIAL
SHIFT, TURNING
THE FOCUS FROM
TREATMENT OF
DISEASE TO THE
PREVENTION OF IT...
AND PREVENTABLE
CHRONIC DISEASE
IS EVERYBODY'S
BUSINESS.**

ROSEMARY CALDER,
DIRECTOR OF VICTORIA
UNIVERSITY'S AUSTRALIAN PUBLIC
HEALTH POLICY COLLABORATION



ENGAGING NURSES AND MIDWIVES WITH EVIDENCE-BASED HEALTHCARE

By Dr Micah D J Peters

At the February 2018 Australian Council of Australian Governments (COAG) meeting, state and territory leaders met to discuss future national public hospital funding and healthcare reform. Key strategic areas were focussed on including the need to drive best practice and performance in healthcare using data and research.

It is widely recognised that safe, effective, affordable, appropriate, and efficient healthcare should be underpinned by rigorous research evidence and high-quality data.

Likewise, assumptions of benefit within each of these domains should be tested carefully both prior to entering 'real world' settings, and then on an ongoing basis as they are evaluated for continued suitability and sustainability.

Research supports continuing advancements in healthcare and in the way that healthcare professionals, including nurses and midwives, carry out their work and are educated and trained.

As pervasive as its impact is in healthcare practice, research can sometimes appear to occur in a world separate to everyday clinical work and be conducted by a select few.

Indeed, historically, medical doctors have dominated healthcare research and notwithstanding the significant developments and benefits this has brought healthcare, has meant that nursing and midwifery research can be further from one's mind when thinking about the research evidence.

Nurses and midwives account for the greatest proportion of Australia's healthcare workforce, and while nurses and midwives use the results of research evidence every day, comparatively few are directly involved in its conduct and reporting.

For some, engagement with research work may have been most evident during education and again when encountering training opportunities, but otherwise may not be embedded in professional life. Nurses have been involved in research for much longer than many might assume, with Florence Nightingale (1820–1910) pioneering early developments in the framework of evidence-based healthcare (McDonald, 2001).

The contribution that nursing and midwifery research has made, and continues to make, is considerable and must continue to grow.

Nurses' and midwives' contemporary clinical application, coupled with tertiary knowledge and expertise provides a foundation to foster nurse and/or midwifery led research.

Due to the nature of nurses' and midwives' work, they have strong engagement with healthcare consumers, family members, and other healthcare professionals; often as the coordinators of care.

THE CONTRIBUTION
THAT NURSING AND
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This means they are optimally placed to make important contributions to the growth and translation of research evidence in Australia. Nurses and midwives can rapidly and accurately recognise issues in the delivery of care and have a wealth of insight and practical knowledge regarding possible approaches and practical strategies for improving clinical practice and health consumer outcomes.

Evidence-based healthcare itself is a process of problem-solving, where nurses and midwives can reflect on their knowledge of research evidence to inform decisions they make when providing care for their patients. This process is also influenced by knowledge of what the patient or their support person find appropriate or suitable to meet their needs, as well as the nurse or midwife's own expertise and experience and knowledge of the context within which they are delivering care (Sackett and Haynes, 1998). Getting evidence into practice through implementation science is a

field where nurses and midwives can advance care delivery and outcomes considerably (Van Achterberg, Schoonhoven, and Grol, 2008).

There are known barriers to engaging with research (KoeHN and Lehman, 2008). However, it takes considerable time to sift through vast quantities of research, and knowledge and skills are required to be able to confidently assess the quality and reliability of research evidence and to skilfully synthesise this with one's own ingrained understanding of the local context and situation, and the consumer's wishes.

Australia's healthcare sector and nursing and midwifery professional practice must be supported by the collection, sharing, linkage, analysis, implementation, and evaluation of high quality data and evidence from research as well as expert and consumer sources. Nurses and midwives can and should have a key role in these processes.

Over the coming months, a series of short papers will be published in the ANMJ addressing some of the challenges that nurses and midwives face in engaging with research evidence and enabling the research to be applied effectively in everyday practice. The intention of these papers will be to stimulate readers' interest in engaging with research and evidence – both in terms of potentially carrying out research – or implementation work themselves, strategies to progress research, or in reading and critically reflecting upon the outputs of research and applying them effectively in practice.

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ANMJ is launching a new website.



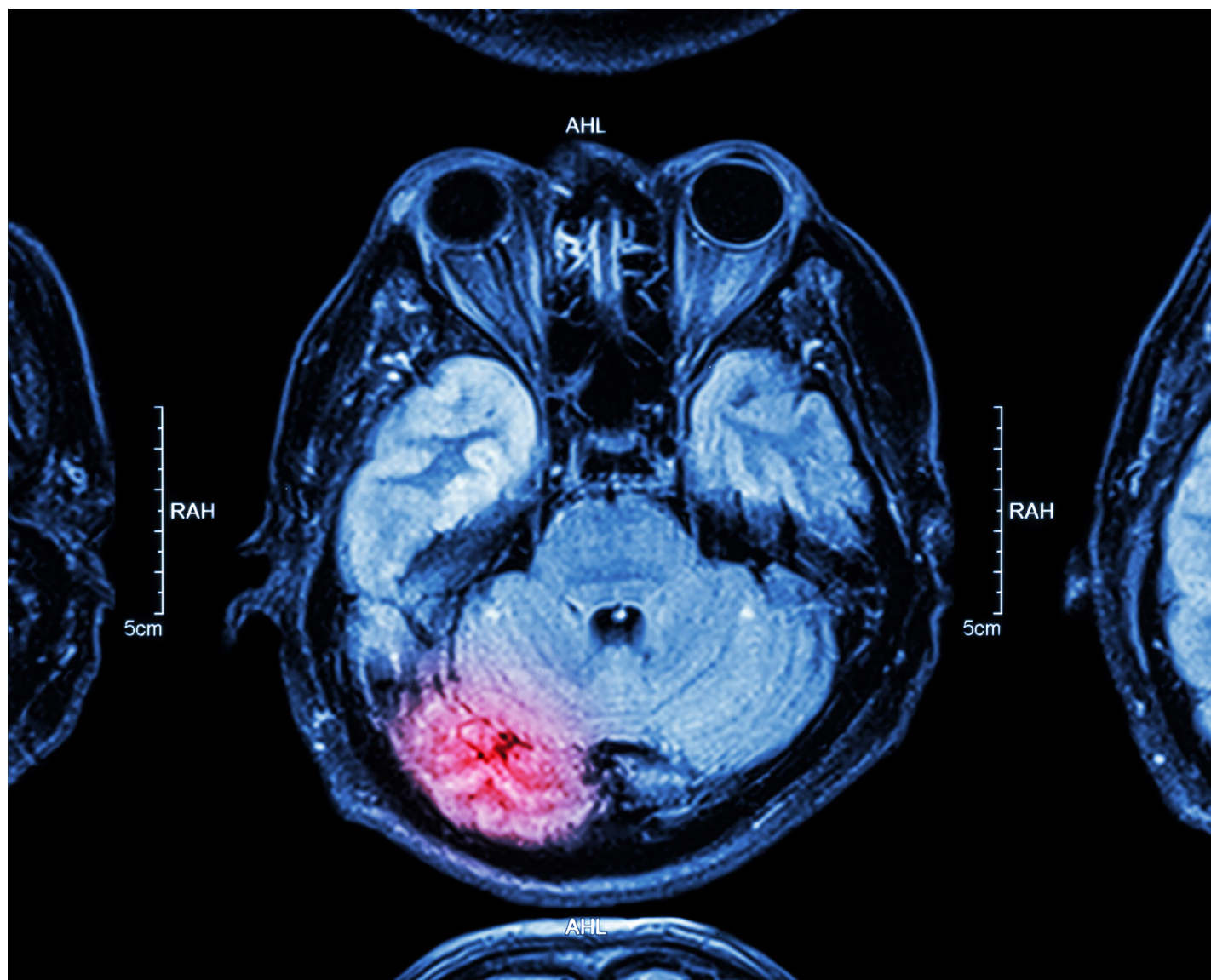
From 1 July nurses, midwives, carers and students can go online to access relevant news, views, helpful tips and information.

To help celebrate the launch, ANMJ is giving away 100 Goody Bags to the first 100 people to sign up to our new fortnightly newsletter.

Worth over \$50, the ANMJ Goody Bags are not to be missed.

Be sure to sign up from 1 July to be in with a chance to win.

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STROKE (CEREBROVASCULAR ACCIDENT)

A stroke occurs when there is a sudden loss of blood flow to one or more blood vessels in the cerebral circulation. This then disrupts oxygen supply to brain tissue.

In 2015, strokes accounted for 6.8% of the deaths in Australia making it the third leading cause of death in older adults following heart disease and cancer.

In 2017, there was approximately one stroke every nine minutes, or in other words, almost 56,000 new and recurrent strokes occurring during the year.

There was also more than 475,000 people living with the effects of a stroke, and this number is expected to exceed one million people by 2050. The financial cost of a stroke in Australia each year is estimated to be five billion dollars.

As strokes are a leading cause of death and disability in the Western world, stroke prevention is a major health focus and therefore there has been a lot of education strategies implemented to inform the public about stroke and stroke prevention.

This education empowers people to alter known risk factors for stroke, to encourage them to seek medical advice and ensure any pre-existing conditions that are considered risk factors for stroke are managed appropriately.

Beside the known risk factors for stroke, social factors have also been found to play a part in an individual's predisposition to medical conditions such as strokes.

Often those who are more socially disadvantaged, have limited access to healthcare, a lower level of education, and are not as informed regarding health decisions have an increased overall risk of having a stroke or developing other medical conditions.

There is also a gender difference with individuals suffering a stroke with men 1.3 times more likely than women to suffer a stroke. It is unknown why this occurs but it

is thought that it could be related to men being less likely to access healthcare for checkups and to also follow up on health related conditions and stroke risk factors with medical care.

Some preexisting conditions such as diabetes and Atrial Fibrillation (AF) can also be risk factors for stroke.

With AF, this condition has a tendency to produce emboli as there is increased turbulence in the atria; these emboli are then often pushed into the path of least resistance which is often the aorta and carotid arteries where they lodge in an arterial vessel causing a stroke. This is why patients with AF also require anticoagulation therapy as part of their treatment to decrease their risk of a stroke.

There is also a relationship between diabetes and stroke with elevated blood

glucose levels found in at least 30% of diabetic stroke victims admitted to hospital. And, if untreated, hyperglycemia can be further linked to brain oedema which then increases the infarct expansion area and causes more damage.

Many of the risk factors for stroke are preventable conditions. As a consequence of this, and the number of people worldwide who are affected by strokes, stroke prevention is an international health priority.

Stroke screenings can be successful in identifying those who are at a higher risk of having a stroke and then educating them about prevention strategies to any modifiable risk factors for stroke which they have, such as:

- hypertension (this is one of the major risk factors and controlling hypertension is the key to preventing stroke);
- cardiovascular disease;
- high cholesterol levels;
- obesity;
- elevated haematocrit;
- diabetes;
- oral contraceptive use (increases risk especially with coexisting hypertension, smoking and/or high oestrogen levels);
- smoking;
- drug abuse (especially cocaine); and
- excessive alcohol consumption.

There are two main types of strokes, these are: Haemorrhagic and Ischaemic

A thrombotic stroke is the most common type of stroke and is classed as an ischaemic stroke. Although this is the most common type of stroke, mortality is generally low with only 8% of ischaemic strokes resulting in death within 30 days.

This type of stroke is associated with atherosclerosis, which causes narrowing of the lumen of the arteries. A thrombus is then formed in one of the cerebral arteries that occludes the vessel and results in cerebral ischaemia.

An embolic stroke is another type of ischaemic stroke and occurs when an embolus, which may have been part of a thrombus, fat or another substance, is transported to the brain and then occludes a cerebral blood vessel causing cerebral ischaemia.

Overall there are five different types of ischaemic strokes, these are:

- **Large artery thrombosis.** These are due to atherosclerotic plaques in the large vessels in the brain, which then occlude resulting in the ischaemia and infarction.
- Small penetrating artery thrombosis also known as **lacunar strokes**. These affect one or more vessels and are the most common type of ischaemic stroke.
- **Cardiogenic embolic.** These are associated with cardiac arrhythmias, most commonly atrial fibrillation.
- **Cryptogenic.** These strokes are those that have no known cause.
- Other causes such as illicit drug use.

Normally there are auto-regulatory mechanisms that help to maintain cerebral circulation when an artery becomes blocked. However if the artery remains blocked for more than a few minutes or the compensatory mechanism becomes overworked, then the blood flow remains impaired to that region of the brain and infarction of that tissue can occur.

The chain of events that occurs from a disruption in blood flow is sometimes referred to as the ischaemic cascade.

Transient Ischaemic Attacks (TIA)

A Transient Ischaemic Attack or TIA can sometimes be a warning sign of an approaching thrombotic stroke. They are neurological attacks or episodes that can last from seconds to hours and usually resolve within 24 hours.

The symptoms that are associated with an attack then disappear and normal function returns.

The individual will display symptoms that are associated with neurological dysfunction and include:

- double vision;
- slurred speech;
- uncoordinated or staggering gait;
- unilateral weakness or numbness;
- unilateral loss of vision; and
- dizziness.

An attack can also be associated with a fall due to the onset of leg weakness.

TIAs are thought to be caused from a micro-emboli or arteriole spasm.

Nearly 20% of people who have had a TIA will go on to have a stroke within one month, but this number will peak during the first 72 hours following the TIA.

Haemorrhagic Stroke

When a haemorrhage is the cause of a stroke, impaired cerebral perfusion causes infarction because the blood itself takes up extra space within the skull. This type of stroke is often associated with hypertension with rupture of an artery often seen as a result of degenerative changes in the arterial wall, or from an anatomical defect such as an aneurysm.

Individuals can also have intracerebral haemorrhages that are associated with arteriovenous malformations (AVM), intracranial aneurysms or certain medications such as anticoagulants and amphetamines.

Although haemorrhagic strokes only account for approximately 10–20% of all strokes, over 50% of people with a haemorrhagic stroke will die.

An intracerebral haemorrhage is most common in patients with hypertension and cerebral atherosclerosis due to degenerative changes from these diseases causing rupture of the blood vessel. It is usually arterial and occurs most commonly in the cerebral lobes, basal ganglia, thalamus, brain stem and cerebellum.

Arteriovenous Malformations are a tangle of arteries or veins in the brain without a capillary bed. This absence of a capillary bed

often then leads to dilation of the arteries and veins and eventual rupture. They are a common cause of haemorrhage in young people and usually develop due to an abnormality during embryonic development or trauma.

A subarachnoid haemorrhage is when the haemorrhage occurs in the subarachnoid space as a result of either an arteriovenous malformation, intracranial aneurysm, trauma or hypertension.

During a haemorrhagic stroke, in order to try and maintain equilibrium, blood pressure will increase which then increases intracranial pressure to force out cerebrospinal fluid to restore the balance.

Sometimes if the bleed is small only minor neurological deficits may be present, however if the bleeding is heavy, then intracranial pressure rises faster and perfusion to brain tissues stop, and even when the pressure returns back to normal, many cells have died.

This excerpt is from a new tutorial to the CPE suite of topics, authored by, Sally Moyle, BNurs, MNurs, RN, CNS.



30 MINUTES CPD

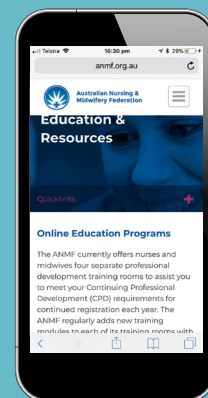
Reading and reflecting on this excerpt gives you 30 minutes towards your annual CPD.

Completing the tutorial, assessment and reflection provides three hours of CPD and covers signs and symptoms, diagnosis, treatment, management, nursing management, rehabilitation, discharge and recovery.

The tutorial is \$7.70 for ANMF and NSWNMA members and free for QNMU members.

For further information contact the ANMF Federal Education Team at education@anmf.org.au

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Andrew McCarthy
Federal
Industrial
Officer

CHANGES NEEDED TO EMPLOYMENT LAWS

Two recent decisions of the Fair Work Commission demonstrate the need for significant changes to employment laws in Australia. While in both decisions the tribunal made improvements to employment conditions for working people, it was prevented by the existing rules from providing more than marginal gains.

In March 2018 the Commission rejected a union movement claim to provide for a right for parents and carers to access family-friendly working hours.

As working people (especially women) have to juggle work and caring responsibilities, the Australian Council of Trade Unions (ACTU) sought the right for an employee to work part-time if their existing position is full-time or on a reduced hours basis if their existing position is part-time or casual.

The claim also included a right for the employee to revert to their previous hours when their child reaches school age and for carers to do the same after two years on family-friendly hours.

While the Commission accepted most of the union arguments including that there is a significant unmet employee need for flexible working arrangements, the tribunal rejected the claim for a *right* to obtain flexible working arrangements on the basis that the claim provided no means for employers to refuse requests.

Instead the Commission decided that awards, which provide minimum wages and conditions for employees (including nurses) across Australia, should be amended to provide parents and carers only with a right to request flexible working arrangements.

An employer would be able to refuse requests on 'reasonable business grounds'.

The decision provides marginal improvements on an existing right to request under the Fair Work Act. Before refusing any request, an employer will have to confer with the employee and genuinely try to reach agreement regarding a request, and must provide more detailed written reasons if a request is refused.

One of the biggest problems regarding the existing legislative right to request is that an employee cannot challenge an employer refusal to grant a request. While the tribunal accepted that the Act lacks an effective enforcement or appeal mechanism, it was unable to override the Act, which prevents it from deciding whether a particular refusal based on 'business grounds' is reasonable. Thus the right to request remains largely unenforceable.

ONE OF THE BIGGEST PROBLEMS REGARDING THE EXISTING LEGISLATIVE RIGHT TO REQUEST IS THAT AN EMPLOYEE CANNOT CHALLENGE AN EMPLOYER REFUSAL TO GRANT A REQUEST.

The other recent decision by the Fair Work Commission related to family and domestic leave provisions. In July 2017 the tribunal rejected a union movement claim for 10 days paid family and domestic violence leave to be included in all awards, however decided to create an entitlement to *unpaid* leave instead.

In March 2018, the tribunal made a further decision regarding the details of this entitlement. Awards will be varied to include a new entitlement to five days unpaid leave for employees experiencing family and domestic violence.

Regular casual and part-time employees will also have access to the full five day entitlement, ie. the entitlement is not pro-rated. The five days will be available in full on the commencement of employment and the start of each year thereafter, however the entitlement does not accumulate.

The leave will be available in the event that the employee needs to do something to deal with the impact of family and domestic violence and it is impractical for them to do it outside their ordinary hours of work. This is expected to include such things as the need to attend court appointments or police services, meet with lawyers, arrange alternative housing and make care arrangements for a dependant.

The tribunal will review the operation of the entitlement in 2021 including the issue of whether *paid* leave should be introduced.

On the same day as the tribunal decision, the federal government announced that it would legislate to include five days *unpaid* leave in the Fair Work Act, which would extend the benefit of the decision to more employees.

While the decision (and the proposed legislation) is a step in the right direction, the difficulty lies in the fact that the entitlement is unpaid and therefore does not address the issue that employees will need to forego pay to access the entitlement.

Given the pervasiveness of domestic violence and that two thirds of the 400,000 plus people (mostly women) who experience domestic violence each year are workers, it is time that the rules were changed to introduce paid leave as has occurred in Queensland, which introduced 10 days paid leave in 2016. The federal Greens also introduced a Bill for 10 days paid leave in February 2018, which the federal ALP has previously stated it would support. At the time of writing, the Coalition government has made no commitment to supporting paid leave.



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MITIGATING INFLUENZA

By Louise Kemme

WHAT IS INFLUENZA?

Influenza is a contagious respiratory virus. The virus, which has the greatest impact during winter, causes time off work for many Australians. It can also lead to hospitalisation, resulting in deadly consequences for some.

As it can affect any population in any setting, it is important for all nurses to understand how it is spread, diagnosed, treated, and prevented. This article highlights our current understanding of influenza and what the Australian healthcare system can do to mitigate this seasonal illness.

The flu versus a cold

Both influenza (the flu) and colds are caused by viruses that share similar signs and symptoms. This makes it near impossible to diagnose without laboratory testing. The key differences are that colds tend to be less severe, whereas the influenza virus can result in serious associated complications, particularly in those who are most vulnerable (Center for Disease Control and Prevention [CDC] 2018). Although people are contagious from day one, symptoms can develop one to four days post-exposure (CDC 2018).

Deadly influenza

Although influenza is uncomfortable, it does not generally require hospitalisation unless there are complications. These complications can include sinus infections, ear infections, bronchitis, myocarditis, encephalitis, rhabdomyolysis, and sepsis. Pneumonia is also a complication that can develop, which may be caused by the virus alone or by a co-infection of the influenza virus and



bacteria. The influenza infection can also exacerbate chronic illnesses such as asthma or congestive cardiac failure (CDC 2018).

Influenza preventions

There are two methods to reducing the risk of catching influenza - good hygiene and vaccination. Good hygiene in the nursing workplace entails compliance with the general principles of hand hygiene and frequent cleaning of shared surfaces such as keyboards and door handles. It also includes proper use and disposal of personal protective equipment (PPE) when providing care to infected patients.

Vaccination is highly recommended for all vulnerable populations, including families and caregivers associated with these populations. The Australian government offers free flu vaccines to all vulnerable people (Department of Health 2018). This includes:

- Children aged six months to less than five years (new for 2018 in select states);

COLD VIRUSES

FEVER (mild)

HEADACHE (mild)

GENERAL ACHES (mild)

FATIGUE (mild)

STUFFY NOSE

SNEEZING

SORE THROAT

COUGH

INFLUENZA VIRUSES

FEVER (high)

HEADACHE (intense)

GENERAL ACHES (severe)

FATIGUE (severe)

STUFFY NOSE

SNEEZING

SORE THROAT

COUGH

VOMITING (more common in children)

DIARRHOEA (more common in children)

- Aboriginal and Torres Strait Islander people aged six months to five years;
- Aboriginal and Torres Strait Islander people aged 15 years and older;
- Pregnant women;
- Aged 65 years and older; and
- Anyone aged six months and older at risk of influenza complications due to chronic disease such as chronic respiratory conditions, cardiac disease, impaired immunity and other chronic illnesses such as diabetes.

Australians are able to receive the influenza vaccine at general practice clinics and pharmacies. Often healthcare settings will offer free influenza immunisation for staff.

Vaccine effectiveness

Virus composition continuously changes from one season to the next, therefore requiring people to obtain vaccinations annually. The Australian Influenza Vaccine Committee, in consultation with the World Health Organization (WHO), determines which vaccine strains (type A and B strains) will be included in the seasonal vaccine.

This is based on global data collected by the WHO that monitors changing strains and vaccine effectiveness around the world. This year there are two strains of type A and two strains of type B influenza that will be included in the vaccine (Department of Health 2018). There is always at least one circulating type A and one circulating type B virus each season. The vaccine aims to protect against both strains of influenza. Unfortunately, between vaccine development, distribution, administration and a prolonged flu season influenza strains can change, resulting in reduction of vaccine match. Vaccine match is the degree of similarity between circulating virus and the virus found in the vaccine.

Catching the flu post-vaccination

You can catch the flu despite having received the influenza vaccine. The most obvious reason is if there is poor vaccine match. Even with good vaccine match, the effectiveness of vaccines varies from person to person, with older children and younger adults experiencing the most benefits. This year,

the Australian government has developed an enhanced flu vaccine aimed to generate a stronger immune response among people over age 65 (Department of Health 2018).

After receiving the vaccine, it can take two weeks for a body to develop antibodies to influenza. During this two-week period a person is still susceptible to catching influenza from others or they may already be unknowingly hosting the virus as it can take one to four days for symptoms to appear (World Health Organization (WHO) 2015; CDC 2018).

Other times people may think they have caught influenza, when they actually have an influenza-like illness (ILI). ILI are pathogens that are not classified as influenza, but which present with similar symptoms. The only way to confirm someone does not have the influenza virus is by laboratory testing (symptom diagnosis is not recommended).

The vaccine only contains weakened virus, therefore making it impossible to catch the flu from the vaccine itself. However, the body's natural immune response to the vaccine has been known to cause minor symptoms such as low-grade fevers and muscle aches for one to two days. This is nothing like the more severe, lengthy symptoms experienced by those who catch the live full-strength influenza virus.

EXAMPLE CASE

Day 1: Nurse Karly is unknowingly exposed to a stranger in the elevator who has influenza, but is not yet symptomatic.

Day 2: Karly is now contagious and inadvertently spreads influenza to her vulnerable patients and to her children at home. Since she is still feeling healthy, she receives the influenza vaccine offered at work.

Day 4–10: Karly begins to develop the severe symptoms of influenza and takes a week off work. She may believe that she caught the flu from the vaccine, but this would be incorrect.

Day 15: Karly is now immune thanks to the vaccine she received two weeks ago. It is unfortunate she did not get the vaccine sooner.



What happened in 2017?

During 2017, there was the highest rate of infected people since 2009, particularly on the east coast of Australia. The influenza season was more intense, with a longer duration and lower vaccine effectiveness. This resulted in a greater number of cases but not severity. Vaccine effectiveness was lower this year, which may have been due to genetic diversity among the predominant A strain, resulting in poor vaccine match (Department of Health 2018). While there was a higher reported number of deaths due to more people infected, the mortality rate was consistent with other influenza seasons.

If there is poor vaccine match, should you still get the vaccine?

The WHO recommends getting the vaccine despite poor match. If the strain in the virus is similar to other circulating viruses, it can prevent influenza-like illnesses or reduce influenza severity. It is also important to remember that there are three to four virus strains incorporated into the vaccine to combat the two predominant strains of Influenza A and Influenza B that circulate among the population; even if the match is poor for one strain, the vaccine may still be effective against the other circulating strain (WHO 2015).

Influenza diagnosis

Symptom-based diagnosis of the flu is not recommended due to similarities among ILI and cold viruses. There are two predominant methods of influenza diagnosis: the rapid diagnostic test and respiratory cultures. The rapid diagnostic test was developed for remote locations and healthcare facilities that do not have access to laboratory services. Although results can be obtained at the patient's bedside within 30 minutes, these tests are known to have low sensitivity and produce false negatives. They are also ineffective four days post-symptom onset due to decreased viral shedding. The rapid diagnostic test is recommended only in

conjunction with other testing methods (WHO 2010a).

From a nursing perspective, even if a rapid diagnostic test comes back negative, it is important to continue treating the patient as contagious. This is because the test result could be a false negative or the patient may have a different contagious infection such as an ILI. Ultimately viral cultures are considered the gold standard for influenza diagnosis and should be used to determine whether a patient is contagious (WHO 2010a).

Isolation precautions

In the clinical setting, if a patient is suspected of having influenza or an ILI, they should be placed on droplet isolation precautions. This entails all staff wearing a surgical mask, gloves, and disposable gown when in the vicinity of the patient. The influenza virus is spread via droplets - up to one metre when a patient is talking or five metres when coughing. The virus can also survive on air droplets for several hours or on hard surfaces for 24 hours (Greatorex 2011). Cold viruses are equally contagious and require the same droplet precautions. If leaving the isolation room, the patient should wear a mask. Droplet precautions can be taken down once the patient is determined to be symptom-free for seven days, excluding a residual cough. Patients may have a residual cough for two to three weeks post-influenza infection (CDC 2018). Healthcare professionals and supervisors should be aware that if employees have caught influenza, they can still be contagious for up to a week after feeling better. Returning to work too early can place other co-workers and patients at risk.

Treatment

Oseltamivir is the most common treatment for influenza. However, it is important to recognise that it does not cure influenza. It can only prevent symptoms or reduce their duration. Research shows that in adults Oseltamivir can reduce the overall

length of influenza symptoms on average by 16.8 hours (Jefferson et al. 2014). There is conflicting data as to whether it can be used prophylactically to prevent influenza infection.

The WHO recommends that all higher risk patients or complicated cases presenting with influenza be treated with Oseltamivir within 48 hours of symptom onset, as it may reduce risk of influenza complications (WHO 2010b). It could also have a minor impact up to five days post-symptom onset, and therefore can be given to patients who have had symptoms for longer than 48 hours (Jefferson et al. 2014).

Often doctors may prescribe antibiotics to individuals diagnosed with influenza. This is an adjuvant treatment for when they have also contracted an opportunistic bacterial infection, such as pneumonia. Symptomatic treatment, using antipyretics, antihistamines, and analgesics, are the only other alternatives to treat influenza (WHO 2010b).

Prepare for 2018

As frontline healthcare workers, it is important for all nurses to be knowledgeable about influenza. With a strong understanding of influenza diagnosis and treatment, nurses will be able to advocate for their vulnerable patients. Together they can promote prevention, reduce infection transmission, and educate the public. Hopefully this year, nurses can help reduce the intensity of the upcoming influenza season.

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AN EXPERIENCE WITH OPEN DISCLOSURE

By Bethaney Martin

I had been familiar with the Australian Charter of Healthcare Rights that outlines the rights of healthcare consumers, such as the right to receive open and timely communication (ACSQHC 2012) for many years. However, I had little knowledge of National Standard 1 Governance for Safety and Quality in Health Service Organisations, Criterion 1.16 and its expectation that the clinical workforce is trained in open disclosure (ACSQHC 2012, pp. 20).

It was not until I had the opportunity to work with my organisation's clinical governance department that I began to understand what open disclosure is and appreciate the important role it plays in clinical incident management.

Open disclosure is talking to your patient about any clinical incident that resulted in harm while they were receiving healthcare (ACSQHC 2013 pp. 4).

Other terms for open disclosure include error disclosure, reconciliation and clinician disclosure (Moore and Mello 2017; QLD Health 2014; Cole et al. 2013; QLD Health 2011).

The goal of open disclosure is to acknowledge the incident; provide an explanation of what occurred and what is being done to prevent reoccurrence of the event; and to help re-build trust in the health service (Moore and Mello 2017; Lamb 2004). The open disclosure conversation should be characterised by openness, honesty, timeliness and the delivery of an apology or expression of regret (Moore and Mello 2017; ACSQHC 2013; Lamb 2004).

Open disclosure after clinical incidents is an ethical, moral and professional responsibility that is important for error reduction and establishing the human connection between patient and clinicians (Moore and Mello 2017; ACSQHC 2013; Cole et al. 2013; Walton 2009; Lamb 2004).

Despite the undisputed opinion that open disclosure is a necessity in healthcare, there is reluctance from clinicians to perform open disclosure (Moore & Mello 2017; Cole et al. 2013; Walton 2009; Lamb 2004).

Barriers to engage in this patient-centred and quality improvement activity include fear of litigation; the confidential and time-consuming nature of clinical incident investigations; lack of organisational support; increasing costs of medical malpractice insurance; fear; and that open disclosure is too difficult (Moore & Mello 2017; Cole 2013; Pinto et al. 2012; Lamb 2004).

The Australian Open Disclosure Framework (ACSQHC 2013, pp. 16-17) states all clinical incidents require open disclosure of either a higher-level response or a lower-level response dependent on the severity of harm. Incidents that require a higher-level response are those incidents that result in "death or permanent loss of function; permanent or considerable lessening of

body function; significant escalation of care / change in clinical management; major psychological or emotional distress; or at the request of the patient" (ACSQHC 2013, pp. 16); therefore, all other incidents require a lower-level disclosure response. It is this lower-level open disclosure response that concerns frontline clinicians.

Clinician disclosure is often identified as the term relating to lower-level open disclosure where the treating clinician has identified a low harm incident and engages in an initial discussion with the patient to inform, support and offer an apology (Quick 2012; Qld Health 2011).

A STARS communication tool is an instrument that has been developed to provide clinicians with a pathway for the open disclosure conversation:


- S – sorry;
- T – tell me about it;
- A – answer questions;
- R – response; and
- S – Summarise (QLD Health 2014; QLD Health 2011).

While most nurses will never be involved in a clinical incident resulting in death or permanent harm, all nurses at some stage will observe or be involved in a low harm clinical incident that, according to the Australian Open Disclosure Framework (ACSQHC 2013), still requires open disclosure.

In a complicated and dynamic healthcare environment, clinical incidents are inevitable. Did your patient fall and sustain a skin tear? Did your patient accidentally receive a meal resulting in delayed surgery? Did you fail to administer insulin resulting in elevated blood glucose levels? Did you double dose a medication? Was there an equipment failure that resulted in a delayed detection of an abnormal result that required treatment? Was the venepuncture blood specimen placed in the wrong tube requiring a re-bleed of the patient?

Our patients trust us to provide safe, quality care and we all go to work with the best intentions. However, if you identify a clinical incident it is your professional and moral obligation to respond. After all, "families can suffer in two ways, first from the incident itself and second from the way it is handled by the healthcare organisation concerned" (Pinto et al. 2012, pp. 1001).

As such, we all need to be aware of our local clinical incident management policy and training in open disclosure. After appropriate escalation of the clinical incident, advocate for an early open disclosure response. If the clinical incident resulted in low harm take the leap and initiate an apology or expression of regret; this does not imply fault, it simply communicates to your patient that you care.

 **Bethaney Martin is a Clinical Nurse with the Acute Pain Service at Mackay Base Hospital, QLD.**



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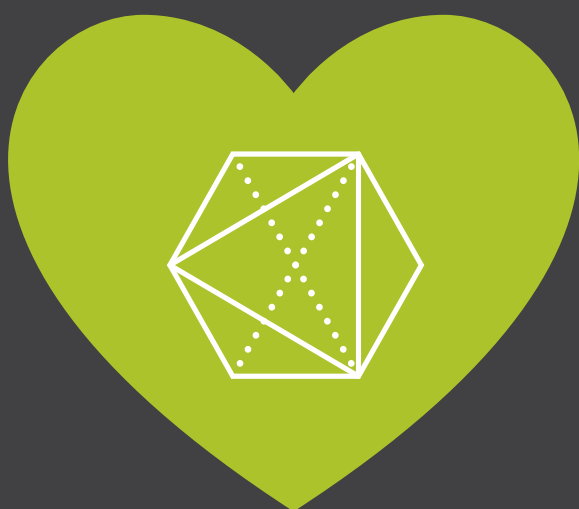


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CONCERN OF OLDER PEOPLE FALLING

By Seng Giap Marcus, Amanda Wilson and Anthony Paul O'Brien

Carers' falls concern is an important psychological factor associated with the care recipients' falling. Further, 90% of carers of older people are concerned about them falling again (Faes et al. 2011).

Few studies have been conducted to determine the impact on carers when older people fall, such as their physical, psychological, social health, and burden of care (Ang et al. 2018).

Besides these impacts, carers' concern about falls are also significantly associated with the older person's perception of fall risk (Ward-Griffin et al. 2004), and the strategies used to prevent falls (Ang et al. 2018).

Due to the complex nature of carers' falls concern and limited understanding about this phenomenon, it is not commonly included in falls prevention programs. Carers' concerns about the older person falling have however, been associated objectively with caregiving burden (Dow et al. 2013; Kuzuya et al. 2006). This burden indicates that after the older person falls, carers can experience stress, anxiety and continuously worry about their care recipients falling again (Faes et al. 2010; Davey et al. 2004).

Excessive falls concern on fall risk

While carers' concern is associated with a sense of caution and fear of falling among community-dwelling elderly (Ward-Griffin et al. 2004), excessive concerns can lead to needless restrictions of older people's activities, including restricting access around the home. In a systematic review on restraints use in older people receiving home care, between 5 and 24.7% were subject to various types of restraint including body vests, seat belts, psychotropic medication, and seclusion (Scheepmans et al. 2017).

Another study found that carers who were less confident of their care recipients' balance were more likely to be over-protective and felt that they needed to provide more support to their care recipients (Honaker and Kretschmer 2014). These actions arguably lead to older people becoming increasingly dependent and

potential functional decline (Honaker and Kretschmer 2014).

A qualitative study on carers looking after family members with dementia identified strategies such as 'blocking' with furniture to restrict care recipients' movement in attempts to prevent further falls (Buri and Dawson 2000). Such strategies, although used with the best intention, may instead lead to increased falls risk due to physical deconditioning. Physical deconditioning is defined by a decreased level of physical fitness due to inactivity (Verbunt et al. 2003). Decreased functional ability due to deconditioning among patients restrained was identified in a study of professional carers looking after older people with dementia in long-term care units (Fitzgerald et al. 2009). Inappropriate physical restriction can also cause psychological trauma and physical injury to the care recipients (Scheepmans et al. 2017).

Lack of falls concern about fall risk

Carers who underestimate falls risk can inadvertently jeopardise the safety of the care recipient. One study found many carers of people with Parkinson's disease felt it was normal for their care recipients to fall as the disease affects gait and balance (Abendroth et al. 2012). Families did not act to prevent the older person falling if they did not sustain any injury (Abendroth et al. 2012). However, when they sustained severe injuries from the fall, they often had to go into long-term care via an emergency department assessment and hospital admission (Abendroth et al. 2012).

Implication to practice

It is important for healthcare professionals to help carers in the home develop a realistic appraisal of their older people's fall risk, and to educate them on falls prevention

strategies. Research is needed to increase the understanding of carers' falls concern and this should not just be limited to people with diseases like Parkinson's disease, or dementia, which are associated with a higher risk of falling. A validated uniform measurement for carers' falls concern is required to determine the level of both accurate and unfounded concerns about falling. Effectively addressing the range and scope of carers' falls concern could lower the burden of care, as well as preventing premature institutionalisation for the people they care for.

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WORKING WITH GRIEF



EXPERIENCES OF NURSES WORKING IN ACUTE HOSPITAL SETTINGS AFTER THE DEATH OF A PATIENT IN THEIR CARE

By Nikki Meller, Deborah Hatcher, Deborah Parker and Athena Sheehan

The majority of nurses enter into the healthcare profession on the premise that they contribute to alleviating patient pain, suffering and preventing death. But when faced with a patient who has died, a nurse's clinical goals and expectations are potentially unmet, and can lessen the opportunity for personal and professional growth (Papadatou 2009).

Sometimes the death of a patient is inevitable, especially in an acute hospital setting, with just over half (52%) of the Australian population dying in this particular healthcare area (Australian Commission on Safety and Quality in Health Care 2013). Grief is a common and natural response when faced with a loss, especially if the loss is represented by death. For a job related loss though, inherently trying to make meaning of the grief process, nurses may fluctuate from experiencing grief to avoiding or suppressing the grief they may feel (Papadatou 2009). Grief reactions of nurses often involve a change in a person's physicality, cognition, social interaction, emotions and behaviours (Kain 2013; Vachon 2012). In acute care settings where death is frequent and expected such as palliative care, factors that can contribute to the grief response a nurse may have after the death of a patient include previous death experiences, personal grief history, professional nursing ethos

and the impact of the workplace environment (Papadatou 2009). Even though there may be less frequency of patient death in other clinical areas within an acute hospital setting, it doesn't discount the impact the death of a patient may have on the nurse caring for them, or the possibility that the nurse may be actively grieving the loss of the patient represented by the patient death.

Theoretically, grounded research identifying psychological and sociological aspects of grief from a nurse's perspective is an area that needs further attention and awareness. Current literature explores nurses' grief experiences in palliative care, paediatric nursing or oncology settings, but to date, there is limited research identifying or exploring grief experiences of nurses working in other clinical areas in the hospital setting after the death of an adult patient in their care. The "Working with Grief" research project is centred on exploring

this gap in understanding how nurses who work within an acute hospital setting, experience and manage their own grief after the death of a patient in their care. The findings of this study may present an opportunity for changes in best practice and individual self-care strategies for nurses who may be grieving after the death of a patient. It also has the potential to increase a nurse's awareness of the emotional variables when nursing dying patients as healthcare professionals in this setting. If their own grief has been recognised and managed appropriately and timely within the workplace, it may increase a nurse's capacity to provide better quality patient care to future patients. If you are interested in hearing more about this study, please contact Nikki Meller, PhD candidate, Western Sydney University School of Nursing & Midwifery.



References

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NURSING STUDENTS' CLINICAL PERFORMANCE ON PLACEMENT: VOICES FROM CLINICAL FACILITATORS

By Jacqueline Rojo and Leanne Hunt

The clinical learning environment experienced by undergraduate nursing students during clinical placements form an integral component of nursing education (Bisholt et al. 2014), to connect theory with practice, and develop the clinical skills necessary to transition into graduate practice as a registered nurse (Cooper et al. 2015). The clinical facilitator, also known as clinical instructor, supervisor or preceptor plays a pivotal role in this learning experience by supporting, supervising and monitoring students' clinical capabilities by benchmarking against industry standards and expectations.



While clinical placements are an essential component of all nursing education programs, the voice and perspectives of clinical facilitators supporting these students are underrepresented in the literature. In contrast, there is a substantial amount of information reporting the negative experiences of students while on clinical placement (Cooper et al. 2015; Vijayanathan et al. 2016).


In order to bridge these gaps in the literature, the Concerns during Nursing Clinical Placement (CONDUCT) project was developed with the aim to identify suboptimal performance issues and behaviours from the perspective of the clinical facilitator within an Australian nursing education context. In addition, the project will also examine if there were student-related factors that

may be associated with suboptimal clinical performance resulting in course attrition.

The initial phase of the research project that involved a review of the literature revealed that issues identified by clinical facilitators regarding the underperformance of undergraduate nursing students were related to:

- inadequate knowledge;
- lack of proficiency in clinical skills;
- difficulty in applying theory to clinical practice;
- inability to perform drug or medication calculations; and
- lack of professional integrity (eg. dishonesty) – attributes that are crucial for professional practice as a Registered Nurse, and essential for patient safety (Tanicala et al. 2011; Luhanga et al. 2008).

Early identification and addressing these concerns is essential to ensure that undergraduate nursing students are delivering optimal and safe clinical care while practising in the clinical learning environment.

 **Jacqueline Rojo is Associate Lecturer and Leanne Hunt is a Lecturer and Deputy Director Clinical Education (Nursing). Both are in the School of Nursing and Midwifery at Western Sydney University**

L T O R JACQUELINE ROJO, JENNIFER KYRILLOS AND JENNY ZAYAT
A FACILITATOR SUPERVISING A STUDENT DURING A PHYSICAL ASSESSMENT PHOTOGRAPHER SHARON JACOBS



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NEW SIMULATED HOSPITAL ENVIRONMENT FOR STUDENTS

A new nursing and midwifery campus based at Deakin University's School of Nursing and Midwifery Geelong campus will provide students with state-of-the-art simulated hospital wards and other clinical spaces.

Interim Head of School Professor Nikki Phillips said the purpose-built simulation centre provided a safe, supportive and realistic environment for students to develop core clinical nursing and midwifery skills.

"The simulated learning spaces replicate hospitals and community environments, familiarising students with these settings, the equipment in them, safety related issues, and potential challenges, enhancing their decision making in order to prepare students for what they will encounter when they go out on clinical placement," Professor Phillips said.

"An important part of the new centre is a high-fidelity simulation area, where staff control state-of-the-art advanced human simulators via a separate control room to create a variety of emergency and critical scenarios that students have to recognise and respond to.

"The advanced human simulators can be programed to simulate a variety of situations that students may encounter in the clinical environment including changes in a patient's condition, such as vital signs and heart rhythm, sweating, groaning, convulsing, and even crying.

"Through wireless technology, the patient's condition can be remotely altered to respond to interventions performed by students with the added advantage of a live voice response from the patient generated by a staff member in the control room.

"This adds another level of realism with students gaining authentic experiences in more challenging and stressful interactions with patients and families."

Professor Phillips said a new dedicated community space provided the opportunity for students to develop the specific adaptive skills

required when nursing people in their home and when caring for women and their babies in their home.

"Home care creates numerous additional challenges including the need to adapt to a non-hospital environment," she said.

"This space has a lounge room area, kitchen, bathroom and bedroom so students can think critically about how they would work safely in a home environment to deliver safe and quality care.

"Each week, the environment can be changed to reflect different risks students may face in a community nursing environment."

Professor Phillips said midwifery students would also be introduced to state-of-the-art equipment in the new centre, including a high-fidelity newborn simulator and high-tech premature simulator, and birthing simulators to provide a realistic experience.



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CLINICAL PLACEMENTS IN NURSING & MIDWIFERY – CHALLENGING THE STATUS QUO

By Debbie MacLean, Judy Morton, Melanie Birks, John Smithson, Wendy Smyth and Cate Nagle

Demand for undergraduate nursing and midwifery placements and provision of quality clinical experience is an ongoing issue within Australia (Anderson et al. 2016; HWA 2014). In tackling this issue, Townsville Hospital and Health Service (THHS), accepted the challenge co-designing an innovative model in partnership with James Cook University to develop a sustainable supportive clinical supervision model that rethinks how and where clinical placement support is provided. The new model was underpinned by a deliberate move away from a facilitated student model.

What are the features of the new model?

The 'Clinical Partnership Program', model has been designed to improve the students' experience of placement, provide high-value support for registered nurses/midwives supervising students and expand student placement capacity. Students are assigned a clinical partner RN/RM for the duration of placement. Features include:

- students mirroring the shift pattern of their assigned clinical partner working the same roster for the duration of placement;
- developing leadership capability of nurses and midwives with the focus on 'at the elbow' education;
- supports and develops the educational capacity of RN/RM staff focussing on their role in training future nurses/midwives; implementation of 'clinical coach' roles to provide leadership and support to RN/RM clinical partners at the point of care; and
- shift the culture to recognise teaching and education as a core component of all clinicians' roles.

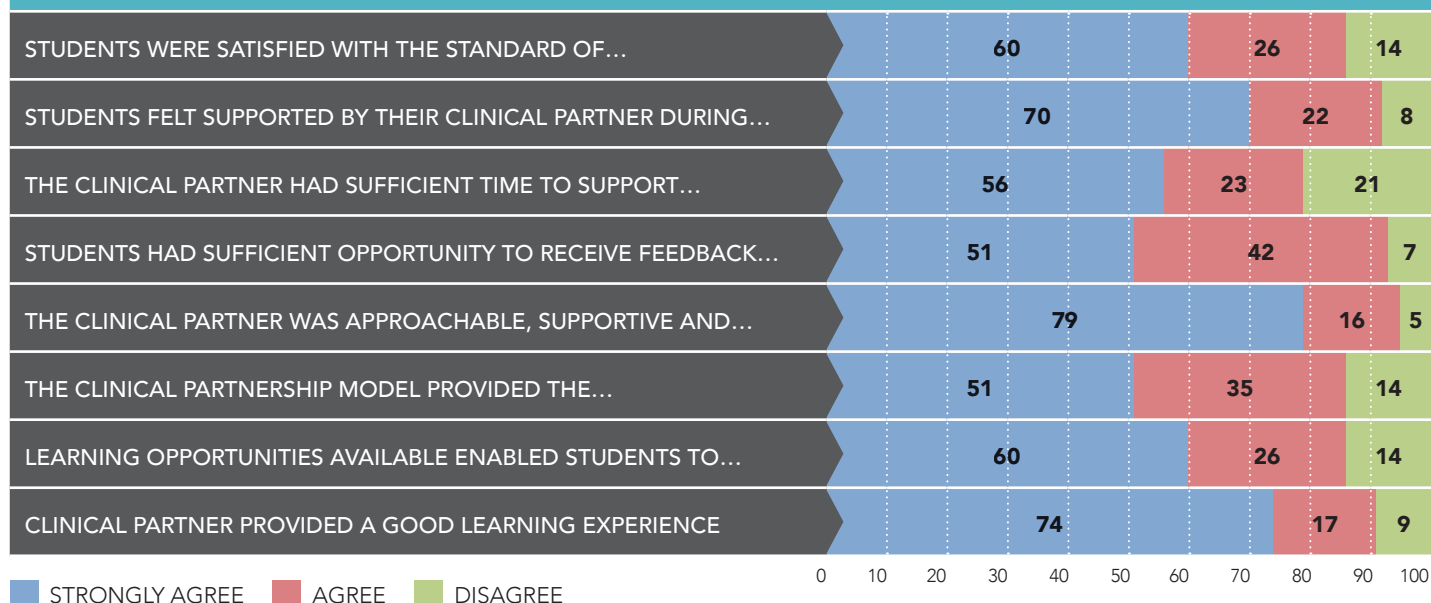
What are the outcomes?

Innovative changes to student supervision models at THHS have tripled the capacity for undergraduate clinical placement training days. Initial student feedback was encouraging with 70% of a small sample of 89 students indicating they preferred the clinical partnership model over the old facilitated model. Students reported:

- "I was continuously presented with opportunities to support my learning needs..."
- "...clinical partners shared their years of knowledge, making my learning experience so much more exciting"
- "I felt like they were invested in my experiences and learning..."
- "Each week my patient workload increased. This was an effective way of preparing me to be a nurse."

Identified barriers included participating in shift work and reliance on the previous clinical facilitator for support/coordination with assessments. Current research is focused on the experience of the nursing and midwifery clinical coaches, and the

Student responses to Clinical Placement Experiences (%)



impact of this new model on organisational culture.

What is the significance of this project?

This program enhanced collaboration with local education partners to provide an innovative and sustainable clinical placement model that is contemporary and reflective of student, education provider and health service needs. It has been successful in improving and expanding access to clinical placements and improving support for both students and clinicians. Learning experiences in the practice environment have

improved by developing well-prepared, experienced clinical partners who demonstrate mutual respect and shared responsibility for achieving student learning outcomes.

Debbie MacLean (BNSc, MHSc (ED)) is Nursing Director, Education and Judy Morton (BSc, MBA, RN) is Executive Director of Nursing and Midwifery. Both are at Townsville Hospital and Health Service in Qld.

Melanie Birks (PhD, RN) is Head, Professor of Nursing and Midwifery and John Smithson (PhD, BNSc) is Deputy Head, Nursing and Midwifery. Both are at James Cook University in Qld.

Wendy Smyth (PhD, RN) is a Nurse Researcher and Cate Nagle (PhD, RN, RM) is Professor of Nursing and Midwifery. Both are at Townsville Hospital and Health Service and James Cook University in Qld.



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FACTORS IMPACTING ON THE SUCCESS OF CLINICAL LEARNING – A STUDENT AND NURSE EDUCATOR PERSPECTIVE

By Sinead Barry and Chris Martin

Clinical placement provides an opportunity for student nurses to consolidate their clinical skills and apply their theoretical knowledge into practice (Siggins Miller Consultants 2012).



Several factors have been identified that impact on a student's experience while on placement. These include the length of placement, their sense of belonging while on placement and the attitude of clinical staff they are working alongside (BPCLE 2016).

Undergraduate nursing students undertake a significant amount of clinical hours under the direct or indirect supervision of nurse educators throughout their degree. Nurse educators are responsible for assessing students' competency and supporting their clinical learning. The success of students' learning and their perception of a 'good' placement however are influenced by a number of factors extending beyond the current standards of competency.

In an attempt to understand factors that impact on clinical learning La Trobe University undergraduate nursing students and Melbourne Health clinical nurse educators were invited to participate in a qualitative research project. The project was facilitated at The Royal Melbourne Hospital (RMH) in the latter half of 2017. Undergraduate nursing students from first, second and third year who


were undertaking clinical placement at the RMH and clinical nurse educators who were employed with the principle role of undertaking clinical supervision of undergraduate nursing students were invited to participate. Participants chose to complete an anonymous qualitative evaluation survey or undertake an individual face-to-face interview.

The project explored undergraduate nursing students and clinical nurse educators' perspectives of factors that impact on students' clinical learning whilst undertaking clinical placement at The Royal Melbourne Hospital.

The purpose of the research project was to identify factors (both positive and negative) that impact upon clinical learning. The project has provided a valuable dual insight into the unique challenges faced by nursing students, in addition to challenges clinical nurse educators perceive impact upon students' learning from a clinical perspective. The significance of the findings drawn from this research provides the opportunity to consider both higher education and health service

providers' perspective on ways to improve the clinical learning experience. This project demonstrates the value of collaboration and partnership between higher education institutions and health service providers to work towards improving nursing education.

Potential benefits of such research extend to improving the future of clinical nursing education by bringing to the forefront current factors impacting clinical learning. Consideration of ways to improve clinical learning has the potential to positively influence the skills and performance of future nursing students to help deliver safer patient care.

 **Sinead Barry is a Lecturer in Nursing and PhD Candidate at La Trobe University in Melbourne**

 **Chris Martin is Entry to Practice Program Coordinator at The Royal Melbourne Hospital**



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CYNTHIA WELLINGS

Registered nurse Cynthia Wellings started up Ausmed Education for nurses and midwives over 30 years ago. The business has gone from strength to strength, educating nurses and midwives across the country. The following is an interview with Cynthia.

You've run Ausmed Education for over 30 years now, what gave you that initial inspiration to start a company?

Starting Ausmed Education was really an accident. There was no great master plan- it just fell into place. It all began when I wrote a book with a geriatrician on the topic of urinary incontinence. At that time, incontinence was seen as a natural part of the ageing process. We wanted to change this view and enable people to see that it was not normal and that the condition warranted more attention. I self-published the text and the rest is

history. The book turned out to be a huge success and Ausmed is now known to nurses around the world.

You have been described as an entrepreneurial nurse. What is your message to other nurse entrepreneurs out there looking to follow a less traditional career path in nursing?

I think the deeply ethical nature of nursing combined with our self-regulatory discipline gives us a particular edge when we run a business. Companies thrive when governance is good and nurses seem to really get this. A key skill is financial literacy. Business is much more complex now compared to when I first started Ausmed in 1987. This is because there are ever increasing compliance issues, which can be costly and time-consuming. Nurses are well placed to overcome these hurdles, though. Nursing is such a broad profession that it offers huge scope for self-employment. In my daily work, I come across a lot of entrepreneurial nurses who work in their own business.

How do you assess the current approach to continuing professional development (CPD) in Australia?

I think this is an incredibly important question. It seems obvious that measurable outcomes will drive all education funding going forward. We achieved accreditation with distinction from the American Nurses Credentialing Center's Commission on Accreditation – the educational equivalent of Magnet status – for our Ausmed Education Learning Centre. This intervention was absolutely significant to us and caused us to change the way we viewed and provided education. Now we continually ask the question, 'So what? Is this education effective in the short and long term? What will change as a result? How will patients benefit?' CPD needs more research

and data to establish its efficacy. For instance, we have discovered the emergence of significant patterns across large data sets in Australia in regards to barriers affecting translation of new knowledge to practice (Wellings, Gendek & Gallagher 2017).

Nursing is clearly a profession for which you have a great passion. What drives this ongoing passion?

I have had a remarkable love affair with nursing for more than 40 years. This is because I always believed in the importance of what we do. Nurses professionalise compassion. What an immensely important thing to do. At a time when the world is so caught up with friction and chaos, we have managed to wrap our profession around the vulnerable and the scared. What would the world be like if we did not exist?

I think there are huge challenges facing the nursing profession in the next several decades and I fear nurses may not have a great deal of control over their destiny. I, for one, do not intend to let this happen. This makes me passionate. We need to ensure we remain relevant and are not entirely displaced by a soulless technology with no ethical insight. I see many roles emerging where nurses are currently underutilised - health promotion and advocacy come to mind. There are so many reasons why nursing matters. I just need to live to 120 to realise some of these dreams.



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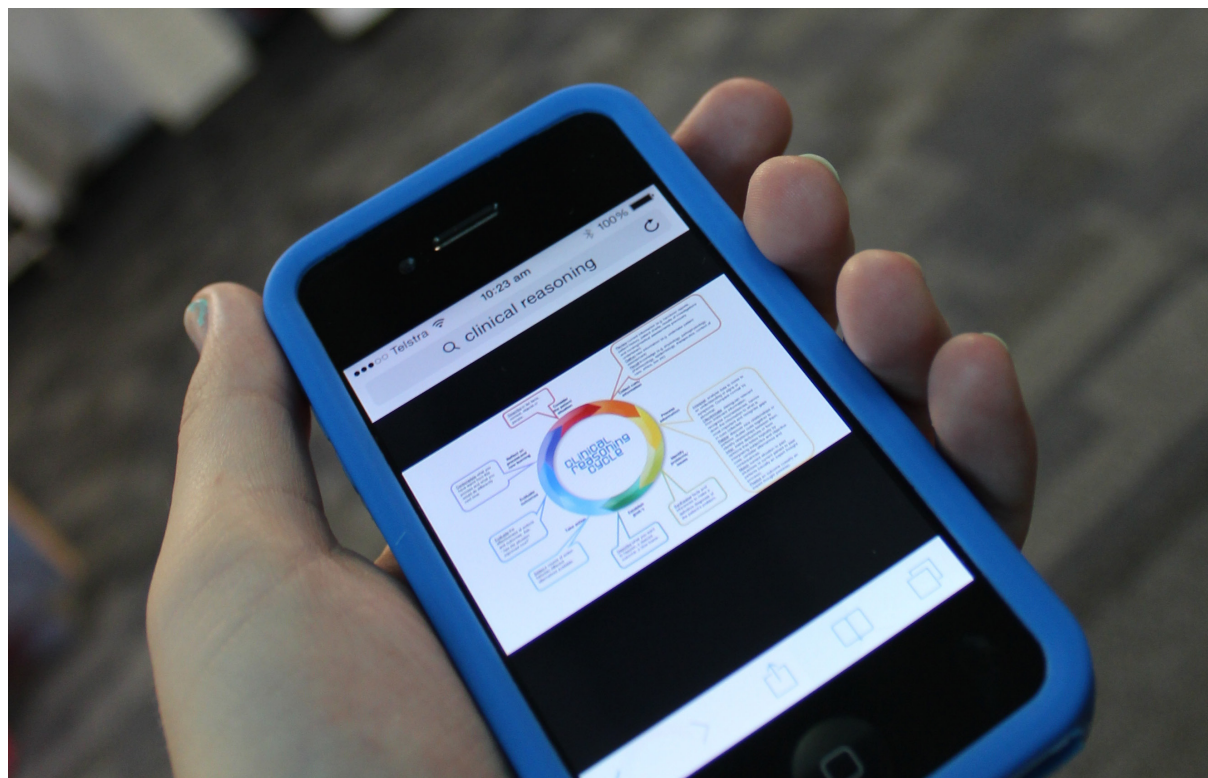
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PREPARING THE NURSING WORKFORCE FOR MOBILE LEARNING AT POINT OF CARE

By Carey Ann Mather, Elizabeth Ann Cummings and Fred Gale

The growth of mobile technology in healthcare environments in Australia has outpaced the governance arrangements related to accessing and using mobile devices for learning at point of care (Mather et al. 2017).

The inability of nurses to gain real-time access to convenient health information using mobile technologies to enhance care and improve patient outcomes has created a 'mobile learning paradox' within the profession (Mather & Cummings 2015).

Recent research has focused on gaining a better understanding about how nurses and nursing students can harness mobile technology for informal learning and continuing professional development in the workplace.

Surveys, focus groups and interviews with undergraduate nurses, nurses, nurse supervisors and with representatives of nursing professional organisations revealed that the nursing profession do understand there are deficiencies in governance regarding access and use of mobile technology.

The research pinpointed to several challenges, risks, and barriers that need to be overcome before mobile learning can become a legitimate nursing function. Opportunities exist within the Health Informatics and Health Technology Explanatory Note (ANMAC 2014) and review of the Registered Nurse Accreditation Standards (2017) for nurses and their students to embrace mobile learning within healthcare environments.

Additionally, the recent release of the Australian National Digital Health Strategy (Australian Digital Health Agency 2017) provides further opportunities to resolve the paradox by enabling the current nursing workforce to develop and model digital professionalism to their peers, colleagues and to the

next generation of nurses. Notably, Strategy 6 (ADHA 2017) indicates that confident use of mobile technology to deliver health and care will be an imperative by 2022. This research provides strong support for inclusion early in the undergraduate nursing curriculum. Modelling, especially in simulated environments where pause and reflect, and debriefing activities can enable students opportunities to develop the knowledge, skills, attitudes and behaviours that will enable them to be engaged, safe and competent users of mobile technology, when undertaking nursing practice within healthcare environments. Ensuring on-campus learning is authentic will facilitate the development of digital professionalism that can be modelled during work integrated learning. Developing the digital literacy of the nursing workforce simultaneously through on and off campus support will promote the profession of nursing in maintaining the capacity to deliver safe, contemporary and effective nursing care.

Carey Ann Mather is a Lecturer and Elizabeth Ann Cummings is Associate Professor. Both are in the School of Health Sciences, College of Health and Medicine at the University of Tasmania

Fred Gale, PhD is Associate Professor in the School of Social Sciences, College of Arts, Law and Education at the University of Tasmania



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Influencing Behaviour Change – a formula
14–15 June
Influencing Behaviour Change – Theory & Practice
14 June
Influencing Behaviour Change – Intensive Workshop/Case Studies
15 June
Paediatric Respiratory Update
21 June
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48th World Congress on Advanced Nursing Research
To promote excellence in nursing research
14–15 June, Dublin, Ireland.
nursingresearch.nursingmeetings.com/

World Elder Abuse Awareness Day
15 June.
elderabuseawarenessday.org.au/

Protecting the rights, choices and freedoms of older people living in residential aged care facilities Seminar
15 June, 9am–5.15pm, Village Roadshow Theatre, State Library Victoria, 328 Swanston Street, Melbourne. tinyurl.com/yc4pqzw2

June Solstice: Longest and Shortest Day of the Year
21 June

Renal Society of Australasia Annual Conference
Lighting the path to success
21–23 June, Adelaide, SA.
renalsociety.org/education/2018-annual-conference/

21st Cancer Nurses Society of Australia Annual Congress
Science, symptoms and service delivery
21–23 June, Brisbane Convention and Exhibition Centre.
cnsa.congress.com.au/

24th World Nurse Practitioners & Healthcare Congress
Reconciling the Recent Trends and Innovations in Nursing
25–27 June, Dubai, UAE.
globalhealth.org/event/24th-world-nurse-practitioners-healthcare-congress/

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

JULY

Australian Women's History Network Symposium
2 July, Canberra.
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/

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/

50th World Congress on Men in Nursing
Exploring the role of men in advancing global health
16–17 July, Rome, Italy.
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/

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

21st World Nursing Education Conference
Technology innovations in nursing education
16–18 July, Melbourne, Victoria.
nursingeducation.conference.com/asia-pacific/

Lung Health Promotion Centre at The Alfred Smoking Cessation Course
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HIC Digital Health Conference
29 July–1 August, International Convention Centre Sydney.
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Australian Cardiovascular Health and Rehabilitation Association Annual Scientific Meeting
Create, Collaborate, Grow
30 July–1 August, Hotel Grand Chancellor Brisbane, Qld.
acra.net.au/acra-2018-asm/

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

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

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

International Day of the World's Indigenous Peoples
9 August

17th International Congress of Circumpolar Health
12–15 August, Copenhagen, Denmark.
icch2018.com/

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

Vietnam Veterans' Day
18 August

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

49th Annual Nursing Research and Evidence Based Practice Conference
22–23 August, Tokyo, Japan.
evidencebasedpractice.nursingconference.com/

Australasian Diabetes Congress
22–24 August, Adelaide Convention Centre, SA.
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

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. http://catsinam.org.au/

OCTOBER

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

NETWORK

Western General Hospital 60th PTS reunion
16–23 June, Port Vila, Vanuatu.
Contact Wendy
E: Wendyflahive@gmail.com

Prince Henry's Hospital, Group 2/78, 40-year reunion
2 June, 12:30 Duke of Wellington Hotel, Melbourne. Contact Jenny Pendrich (nee Jende)
E: jenny.pendrich@hotmail.com

Alfred Hospital, Group 3/68, 50-year reunion
23 June. Contact Isabelle
E: isabellehenry360@gmail.com

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.

Alfred Hospital Group 3/85, 30-year reunion
20 October. E: cathie@coughlan.id.au or boxvale2@bigpond.com or perilloj@gmail.com

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

EDUCATING CARERS ABOUT NEEDLE-STICK INJURIES

Dr Cathryn Murphy noted the under-reporting of needlestick injuries (NSI) in her article in the April ANMJ.

NSI's are further under estimated because many people with diabetes check a friend or relative's blood glucose level using their own finger-pricking device. Some change the lancet but many don't, especially if testing a direct family member. As nurses we can make a difference by reminding people with diabetes not to share needles... they just might be sharing more than they realise!

Jayne Lehmann RN CDE, Diabetes Nurse Specialist, SA



NO TIME TO ANSWER BELLS

I am an enrolled nurse in a not for profit aged care facility and like every other nurse and carer, we can see that aged care is in crisis.

The Ratios for Aged Care, Make them Law campaign advertisement in the April ANMJ of a daughter stating her mother waited one hour before the buzzer was answered, is sadly an everyday reality. While management undertake audits on call bell times, their outcomes are that staff need to manage their time better and be more aware of how long call bells have been on for. Consequently, it's now become common practice for staff to attend to the call bell and then turn it off and return later if they get a chance.

For better nursing care, ratios are needed now. We have one carer per 10 to 12 residents. With ACFI funding we are supposed to be assisting residents with walking, assisting with feeding, toileting, showering and dressing. For one resident that's four meal services on the am shift, a few toilet breaks, and all day walking for some residents, yet the carer still has 11 other residents to look after that have the same needs. It's impossible to give that level of care for that many residents.

It is mandatory to report elder abuse. Without ratios in aged care, elder abuse is occurring on every level, every day in every aged care facility.

Lisa EEN, Victoria

DEMAND FOR RATIOS IN AGED CARE

I commend the ANMF for taking up the cause to improve aged care through demanding ratios.

Why the government is not acting on what is required to address this issue comes down to ageism and a disrespect of human rights. Older Australians are being neglected. They deserve better than that.

Give aged care nurses the opportunity to provide the care that they want to, and should give.

I support this campaign 100% and call on all ANMF members to back the union on this cause, for the sake of our parents, grandparents and all Australians.

Sue Cox RN, NSW

WHEN THE TIME IS RIGHT TO RETIRE

I respond to Shirley Allott's article published in the April 2018 ANMJ.

Recently, I retired as a Maternal and Child Health Nurse, two months short of 69 as I just sensed it was time to retire – despite still enjoying my work, feeling just as knowledgeable and capable as always, and my given goal of working until aged 70.

I did not find ageism ever to be a factor in my place of work. In fact, the opposite was true, as clients and management valued my vast experience.

Any hearing and visual loss can easily be rectified with the use of hearing aids and glasses and should pose no barrier to continued work.

Community work, rather than a hospital setting, is easier for those with arthritis and general physical decline, as is a reduction of hours of work. Clinical supervision is invaluable in addressing the stressful and emotional aspects of nursing, as well as the clinical.

It is important that any person should keep fit and healthy and have a good work-life balance in situ well before retirement beckons. Interests and hobbies, I feel, should also be taken up before retirement, so there is no sense of just filling in the time post retiring. It is essential for a retiree's wellbeing that they still retain a sense of purpose and of usefulness.

In my case, I am a volunteer penguin guide at St Kilda, help at Braeside Park, and with a friendship group fundraiser for East Timor and Days for Girls. I have time to relish reading, table tennis,

sorting out years of photos, playing Scrabble and doing more bushwalking and travelling than before, plus seeing more of my grandchildren. I love being retired although there is sadness at relinquishing my registration soon.

Perhaps try it out first by using your annual and long service leave if still unsure it is for you.

Helene Rogers RN, RM, Bachelor of Nursing, Grad. Dip. Public Health (Maternal & Child Health), Victoria



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



IT'S TIME TO CHANGE THE RULES

Lori-Anne Sharp,
ANMF Vice President-
Assistant to the Federal
Secretary

'Where you see wrong or inequality or injustice, speak out, because this is your country. This is your democracy. Make it. Protect it. Pass it on.'

THURGOOD MARSHALL

As my children have grown into teenagers, I have encouraged them to seek part-time work that fits around their schooling, so I was pleased when my eldest daughter found a part-time job last year. Casual wages for a fifteen year old in the food retail industry are low, but the appeal of working on the weekends to obtain weekend penalty rates was attractive and the hours conveniently fit in with school commitments.

Unsurprisingly, she was angered to hear that from 1 July penalty rates will be cut back even further, and from 1 July 2019 cut again.

The government's attacks on penalty rates for low paying industries such as hospitality and retail demonstrates how out of touch they are with the average worker and shows one of the many reasons why we must stand up to change the rules.

The **Change the Rules** campaign is led by the Australian Council of Trade Unions (ACTU) of which ANMF is an affiliated member.

The campaign seeks to rectify the imbalance of power between the large corporations and the ordinary worker.

We know that nationally four million people are in insecure work, inequality is at a 70 year high and wage growth is at record lows.

We must all act by standing up to fight for a fairer and more just society for the next generation and beyond. We must seek to reverse cuts to penalty rates, address inequality, raise the minimum wage and seek fairer industrial laws. It is not an option just to do nothing.

We also need to change the rules in aged care. Many are aware of the crisis in residential aged care, and with it's chronic understaffing and inadequate staff skill mix, our elderly are suffering. Our dedicated nurses and carers are often overstretched and lament that they simply can't give their residents the care they need and deserve because there are just not enough staff.

The basics of care- to feed, toilet, wash, give medication and provide pressure area care are being left unattended.

People in residential aged care, who rely on others to have their needs met, are being put in unsafe situations and are having their dignity eroded. ANMF and its members are determined to improve conditions in aged care and are working hard to seek reform to the **Aged Care Act 1997** that will include mandated staff to resident ratios.

Our national campaign launched on 12 May will continue to pressure politicians in the lead up to the next federal election. We will be asking them to commit to mandating safe staff to resident ratios in nursing homes. To commit to ensuring our vulnerable older Australians are able to be cared for safely, appropriately and with the dignity and care that everyone deserves.

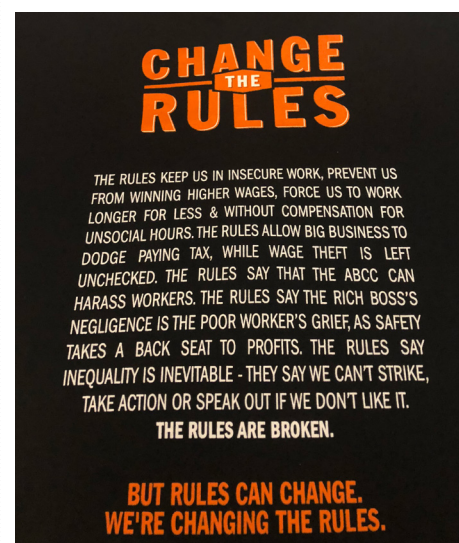
At a time when we are hearing alarming stories in aged care, such as having one RN in charge of 100 residents, or carers being expected to shower up to 16 residents in 45 minutes, we also know that some of our big for-profit providers are benefiting from large

government subsidies to run their business and using complicated corporate structures to minimise their taxable income.

A recent report commissioned by the ANMF and conducted by the Tax Justice Network Australia shows that six of the largest aged care for-profit providers received \$2.17 billion in government subsidies last year, with reported profits of over \$210 million. As a result of this report a new Inquiry into these tax avoidance practices has recently been announced by the Senate Economics Reference Committee.

They are scheduled to report in August. Currently, there are no rules to ensure the \$2.17 billion in government subsidies given to for-profit providers is spent on direct care of elderly residents. This needs to change. We need greater accountability and transparency to ensure that our tax-payer money is used to care for the elderly by ensuring adequate staff and skill mix and not just to increase company profits.

Led by the ACTU, union members, their families and members of the community across the country recently took to 12 days of action to change the rules, culminating on 9 May at a rally in Melbourne where over 100,000 people attended. Many sectors were represented and the large contingent of nurses, midwives and carers marched with pride and determination. Together we will fight to Change the Rules and together we will win.



THE LAWS MUST CHANGE, AND AS MEMBERS OF THE LARGEST UNION IN THE COUNTRY, IT IS IMPORTANT THAT WE DRAW ON OUR COLLECTIVE STRENGTH TO INFLUENCE THE LAW-MAKING DISCUSSIONS THAT PROTECT THE RIGHTS OF THE WORKER, THE RIGHTS OF THE ELDERLY AND TO FIGHT FOR LAWS THAT ARE FAIR AND PREVENT FURTHER EROSION OF OUR RIGHTS.

Help people with diabetes **stay on top** of their condition



Services



Support



Information



Products



The National Diabetes Services Scheme (NDSS) offers a huge range of information, support and education for people with diabetes.

Register a person with diabetes with the NDSS today and give them the basic building blocks they need to keep healthy and stay on top of their condition.

Go to ndss.com.au for more information.



ndss.com.au | NDSS Helpline 1300 136 588

ndss
national diabetes services scheme

diabetes
australia

The National Diabetes Services Scheme is an initiative of the Australian Government administered with the assistance of Diabetes Australia.



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that acts in my
best interests."**

Sarah Tooke,
Midwife

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