

# ANMJ

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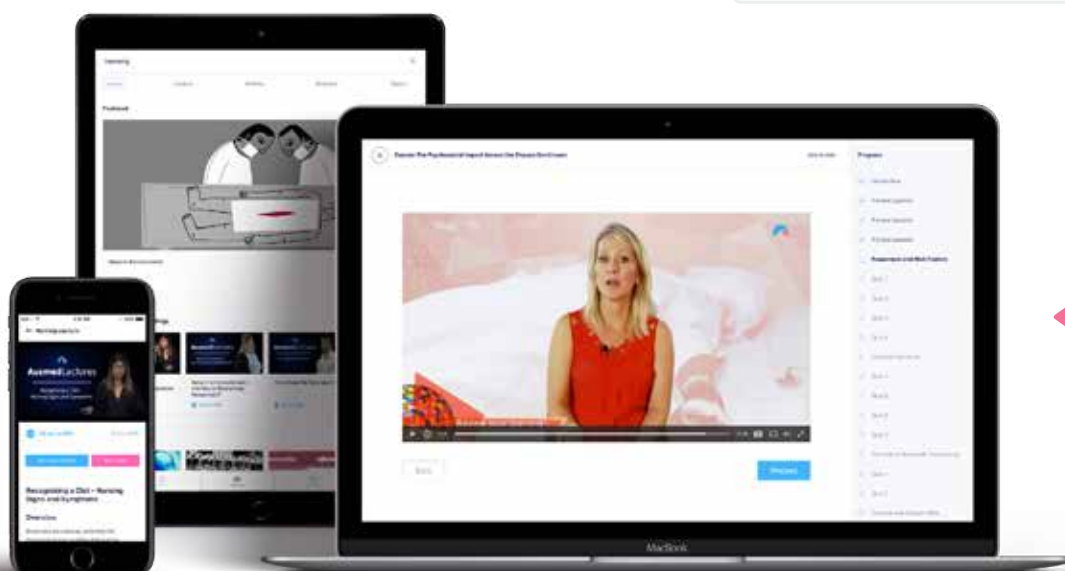
## THE WAY FORWARD

Expanded prescribing roles for nurses and midwives

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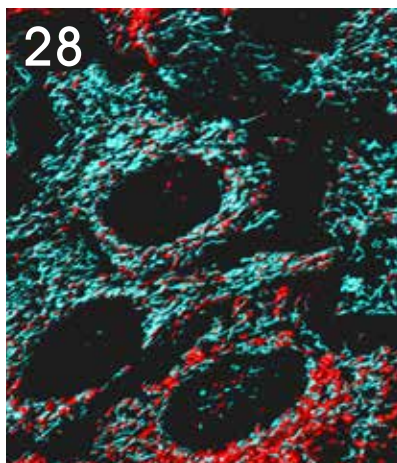
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08



28



16



# THE WAY FORWARD

Expanded prescribing roles for nurses and midwives

32



26



## REGULARS

### 02 DIRECTORY

### 03 EDITORIAL

### 04 NEWS

### 10 ISSUES IN AGED CARE

Residents suffer most as aged care crisis deepens

### 11 ISSUES IN AGED CARE

Relentless, demanding and unappreciated

### 13 LEGAL

Negligent care leads to manslaughter convictions

### 14 PROFESSIONAL

Codeine – more harm than good

### 16 FEATURE

The way forward: Expanded prescribing roles for nurses and midwives

### 22 REFLECTIONS

Student cultural experiences and revelations – A nursing tour to Taipei Medical University, Taiwan

### 24 WORKING LIFE

Tackling the challenges of Autism

### 25 ISSUES

Medical association campaign to abolish nuclear weapons wins Nobel Peace Prize

### 26 RESEARCH

### 28 CLINICAL UPDATE

Changes to the National Cervical Screening Program

### 32 FOCUS

Primary/Community Health Care

### 44 WORLD

### 45 MAIL

### 46 CALENDAR

### 48 WORKING LIFE

A passion for maternal and child health

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## Editorial

Annie Butler ANMF A/Federal Secretary

**With every passing moment cracks in the aged care system widen leaving vulnerable older Australians in an increasingly deplorable position.**

Last month alone research revealed some nursing home providers were spending a measly \$6.08 a day for three meals per resident. The study also found that last year half of aged care residents suffered from malnutrition, with nursing home providers cutting their spend on food by 30 cents per resident.

Recently, I joined nurses, carers and members of the public concerned about the state of aged care at an aged care reform rally in South Australia.

On the steps of the state's Parliament House I spoke about the urgent need for more staff in aged care and emphasised the need for transparency and accountability in all aged care facilities to ensure funding is directed into care rather than providers' profits. As I declared my position, my argument resonated with the passionate crowd who want aged care fixed as a matter of priority so their loved ones can get the care they deserve.

Speaking out and uniting as a collective was a powerful force. The energy that reverberated from the crowd in Adelaide that day was nothing less than awe-inspiring and will go a long way towards putting politicians on notice to fix aged care.

It's imperative we keep this momentum alive. It is our responsibility as nurses, carers, midwives and concerned family members to band together and speak out for older Australians until this crisis is resolved.

This month's journal contains stories about aged care which clearly show the extent the system has reached. It is at breaking point. I urge you to read these accounts to gain a better understanding of what the sector is really facing.

ANMJ's feature this month looks at expanded prescribing roles for nurses and midwives. Late last year the Nursing and Midwifery Board of Australia (NMBA) released a discussion paper and held a symposium on expanding the endorsement of registered nurses and midwives to supply medications under protocol. The proposed standard has gained strong support from the clinical, research and management sectors. The NMBA and the Australia and New Zealand Council and Chief Nursing and Midwifery Officers are now working together to facilitate the development of potential future models of prescribing, and these are detailed in the feature.

The ANMF supports this initiative. Enhancing nurses and midwives' roles to prescribe gives opportunity to improve access to medicines and better health outcomes for much of the community.

ANMJ news this month includes a story about early career nurse Thomas West who is about to start his transition program at Sydney's St Vincent's Hospital.

Thomas shares his feelings and excitement about embarking on his new career. We wish Thomas and all other early career nurses and midwives who have recently started practising in their professions the very best in their transition year and welcome them to our wonderful profession.

Annie



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## MIDWIVES DUTY-BOUND TO PROVIDE CARE 'FREE OF BIAS AND RACISM'

Midwives must provide care that is free of racism or bias and take responsibility for improving the cultural safety of health services for Aboriginal and Torres Strait Islander people under a new code of conduct that comes into force this month.

The new code of conduct for midwives, developed by the Nursing and Midwifery Board of Australia (NMBA), promotes care that is "holistic, free of bias and racism".

The code states midwives should advocate and facilitate access to quality and culturally safe health services for Aboriginal and Torres Strait Islander peoples and recognise the importance of family, community and collaboration in healthcare decision-making.

It also demands midwives understand how their own culture, values, attitudes, assumptions and beliefs may influence their interactions with people, families, the community and colleagues.

The new code further calls on midwives



"THERE ARE PEOPLE OUT THERE ADVOCATING AND PROVIDING EXCELLENT CARE. AS REGULATORS WE WANT EVERYONE TO BE DOING THIS."

Janine Mohamed

to acknowledge social, economic, cultural, historical and behavioural factors that affect health and accordingly to use their expertise to actively address health disparities and improve outcomes for the community.

"The code makes it very clear that racism or bias is not acceptable," NMBA Chair Associate Professor Lynette Cusack said.

"I am aware of some educators, administrators and midwives who are very passionate about Aboriginal and Torres Strait Islander healthcare.

"There are people out there advocating and providing excellent care. As regulators

we want everyone to be doing this."

A glossary accompanying the new codes of conduct for nurses and midwives drew on insight from the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM).

It notes that the concept of cultural safety emerged in a First Nations' context and contends that the recipient of care – rather than the caregiver – deems whether care is culturally safe.

CASTSINaM CEO Janine Mohamed (pictured) said the new code illustrated the NMBA's strong stance on establishing cultural safety across the health system.

She suggested midwives were in a powerful position to help shape better outcomes for Aboriginal and Torres Strait Islander people across the nation by embedding cultural safety into their practice.

Associate Professor Cusack stressed the new code was just a small component of a larger focus on improving cultural safety across the health system in a bid to trigger meaningful change.

## CLOSING THE GAP SHOWS MIXED PROGRESS

Three out of seven Closing the Gap targets are on track in a sign of moderate progress a decade on from the government's commitment to addressing Indigenous disadvantage.

Last year's Closing the Gap report card, where just one of seven targets was on track, painted a bleak snapshot of the widening disparity between Indigenous and non-indigenous Australians when it came to critical areas including health, life expectancy and employment.

In 2018, the 10th Closing the Gap snapshot revealed three of seven key targets were on track to be met by 2020 including reductions in childhood

mortality and boosts to early childhood education.

However, the remaining four targets continue to fall short. They include the target to close the 10-year gap in life expectancy by 2031; improve school attendance and to halve the gap in reading and numeracy by 2018; and the target to halve the gap in employment by 2018.

As four of the existing Closing the Gap targets are set to expire in 2018 the report suggested it may be time for a fresh approach.

"There is a view that we need to move beyond addressing inequalities in education, employment and health and ask what needs to be done to create a thriving and prosperous environment in which Aboriginal and Torres Strait Islander people can choose to pursue the lives they value for themselves, their families and their communities," the report states.

Reflecting on the report, National Aboriginal Community Controlled Health Organisation (NACCHO) Chair John Singer said all governments must increase funding to provide the comprehensive services needed to fill the gaps and work collaboratively with Aboriginal and Torres

Strait Islander people in order to reduce health disparity. He said an urgent and radically different strategy was required to close the gap.

"The Close the Gap strategy has never been fully implemented. There has been a decrease in funding over the past five years to Aboriginal and Torres Strait Islander health services; the biggest impact has been to our members and affiliates. The Close the Gap refresh being considered by the Council of Australian Governments (COAG) provides an opportunity to reflect upon and reform current policy settings and institutionalised thinking."

Aboriginal and Torres Strait Islander rights organisation ANTaR slammed the government over its inability to listen and respond to the voices of Indigenous people in efforts to close the gap.

"Of course it's good to see some progress against those targets but three out of seven targets is a failure. We're a wealthy country, absolutely capable of addressing the disadvantage experienced by 3% of the population, but to do so, government must listen and act with First Peoples."



## PUSH TO MAKE PAID DOMESTIC VIOLENCE LEAVE THE NORM

In recent years Australian Nursing and Midwifery Federation (ANMF) branches across the country have led the way in attaining paid family and domestic violence leave for their workforces and now new legislation introduced by the Greens is seeking to make it the norm for employees nationally.

Instrumental wins achieved by the ANMF's state and territory branches date back to 2011, when the NSW Nurses and Midwives' Association (NSWNMA) broke new ground to insert a clause into the Public Health System Nurses' and Midwives' (State) Award 2010 allowing nurses and midwives to use family and carer's leave and sick leave entitlements for matters relating to family violence.

It included access to an additional five paid days per year if carer's leave and sick leave entitlements were exhausted and a range of workplace support measures such as flexible work hours and changing telephone and email where appropriate.

More recently, the ANMF (Victoria Branch) secured its public

sector nurses and midwives access to 20 days per year of paid special leave in the event of family violence for purposes such as counselling, medical appointments and legal proceedings under the Nurses and Midwives (Victorian Public Health Sector) (Single Interest Employers) Enterprise Agreement 2016-2020.

Similarly, a successful campaign by the Queensland Nurses and Midwives Union (QNMU) helped achieved a minimum 10 days of paid domestic and family violence leave as a core condition across the public sector. While in South Australia, the ANMF (SA Branch) locked in 15 days of paid domestic violence leave for its public sector nurses and midwives and the potential for a further 15 days under special leave with pay provisions.

In a sign of national support for change, Greens MP Adam Bandt last month introduced a private members' Bill into the House of Representatives that would give all workers 10 days paid domestic violence leave each year as part of amendments to the National Employment Standards.

The Greens' Bill underlines widespread calls to tackle the issue, including a pledge by Opposition Leader Bill Shorten that a future Labor government would implement 10 days of paid domestic violence leave for workers.

The push builds on momentum triggered by an Australian Council of Trade Unions (ACTU) campaign that resulted in the Fair Work Commission (FWC) last year ruling that unpaid domestic violence leave should be standard for all workers under modern awards.

Mr Bandt said family and domestic violence was an ongoing problem Australia needed to address immediately.

## Current access to paid domestic violence leave shaped by ANMF state and territory branches

### VICTORIA

Employees experiencing family violence have access to 20 days per year of paid special leave (pro rata for part-time employees) following family violence and for related purposes including counselling, medical appointments, legal proceedings or appointments with a legal practitioner and other related activities. **Nurses and Midwives (Victorian Public Health Sector) (Single Interest Employers) Enterprise Agreement 2016-2020)**

### QUEENSLAND

Queensland introduced 10 days of paid family and domestic violence leave for public sector workers in 2016 after the government passed the new **Queensland Industrial Relations Act**.

### SOUTH AUSTRALIA

Employees suffering from or escaping domestic and family violence have access to up to 15 days paid leave and potential for a further 15 days under special leave with pay provisions. **Nursing/Midwifery (South Australian Public Sector) Enterprise Agreement 2016)**

### TASMANIA

Up to 10 days family violence leave per year in order to attend medical and legal appointments, organise safe housing or childcare and to maintain support networks with children, family and significant others.

In addition to family violence leave, employers should consider additionally supporting the employee through measures including increased workplace security, flexible work arrangements and counselling. **Nurses and Midwives (Tasmanian State Service) Award**

### ACT

Employees experiencing domestic violence have access to a maximum of 20 days paid leave per year to allow them to be absent from the workplace to attend counselling appointments, legal proceedings and other related activities. **ACT Public Service Nursing and Midwifery Agreement 2013-2017)**

### WESTERN AUSTRALIA

Victims of family and domestic violence have access to 10 days paid leave, reinforced flexible work arrangements and safety plan agreements and ongoing access to confidential counselling services provided by employers.

### NEW SOUTH WALES

Entitlements provided for sick leave and family and community services leave can be used by staff members experiencing family violence. If these leave entitlements have been exhausted, the employer shall grant up to five days special leave at full pay to cater for absences from the workplace to attend matters arising from family violence situations. **Public Health System Nurses' & Midwives" (State) Award 2017**

### NORTHERN TERRITORY

Northern Territory Public Sector (NTPS) nurses and midwives have access to domestic and family violence leave through the government's **By-law 18 – Miscellaneous Leave**. Under the clause, supportive measures include leave with pay, flexible work options and access to an Employee Assistance Program (EAP). The ANMF (NT Branch) is about to start negotiations on a new Enterprise Agreement (EA) and is requesting 20 days per year of paid family and domestic violence leave.



## MORE SA PREMMIE BABIES SURVIVING EARLY ARRIVAL

More low-birthweight babies are being born in South Australia and more are surviving prematurity.

Of all 2015 births, 9.6% were preterm compared to 5.5% in 1981, according to the latest Pregnancy in Outcomes in South Australia report.

The number of low birthweight babies, born weighing less than 2500 grams increased to 7.6% of all births. The survival rate for premature babies also improved, with 35 neonatal deaths, a mortality rate of 1.7 per 1,000 live births. There were 153 stillbirths and three maternal deaths.

The report shows a gradual increase in preterm and low-birthweight babies over the past 36 years; and a significant reduction in risk factors. The proportion of women smoking at the first antenatal visit dropped from 25% in 1998 to 10.1% in 2015. In addition, 2.8% of women had quit smoking before the first antenatal visit in 2015.

"We are seeing that women are realising the dangers of smoking during pregnancy with that rate declining to 10.1%, but it's important to continue reinforcing that message so that rate declines further," Epidemiology Director Dr Katina D'Onsie said.

The report also revealed a drop in teenage pregnancy rates - the number of teenage women giving birth from 7.8% in 1981 to 2.8% in 2015.

The average age of women giving birth was 30.1 years, an increase from 26.5 years in 1981.

## PREP LISTED ON PHARMACEUTICAL BENEFITS SCHEME (PBS)

Game-changing HIV prevention treatment Pre-Exposure Prophylaxis (PrEP) has been added to the Pharmaceutical Benefits Scheme (PBS) in a move hailed as a major step towards ending new HIV transmissions in Australia.

The Pharmaceutical Benefits Advisory Committee (PBAC) gave PrEP, a medication taken daily by HIV negative people to decrease the chances of HIV transmission, the tick of approval last month.

It will now be subsidised by the Australian government under the PBS, bringing the cost of the drug down from \$10,000 per year to \$39.50 per script.

More than 1,000 Australians are diagnosed with HIV each year with rates increasing in some parts of the country.

Alarming, the rate of new infections among Aboriginal and Torres Strait Islander communities is now above the Australian average for the first time.

Making PrEP more accessible is expected to lead to critical change and achieving goals to eliminate HIV infections in coming years.

The Labor Party has promised \$53 million in funding to step up the fight against the disease, including a focus on targeting hidden populations who are not currently reached by existing health promotion drives.

## ACTION PLAN ON AGED CARE ACCESS FOR (CALD) GROUPS

The Australian government's Aged Care Sector Committee Diversity Sub-group is developing an action plan to address specific barriers and challenges faced by older people from culturally and linguistically diverse (CALD) groups when accessing aged care and is seeking input from consumers and carers.

The action plan will sit under the Aged Care Diversity Framework launched in December last year by Aged Care Minister Ken Wyatt in a bid to create a more inclusive future for aged care services.

The Diversity Framework seeks to embed diversity in the design and delivery of aged care to support actions that break down perceived or actual barriers to consumers accessing equitable and quality aged care.

To inform the action plan, the Federation of Ethnic Communities' Council of Australia (FECCA) has consulted a range of stakeholders from (CALD) backgrounds.

It is now calling on consumers, carers and providers to have a say and participate in the aged care design process.

The consumer survey is available in eight languages, Chinese, Arabic, Vietnamese Greek, Italian, Serbian, Croatian and Bosnian. To take part in the survey visit [www.surveymonkey.com/r/DRWNLCB](http://www.surveymonkey.com/r/DRWNLCB) for consumers or [www.surveymonkey.com/r/DRN38SY](http://www.surveymonkey.com/r/DRN38SY) for providers by the cut-off, 18 March.

## HOSPITAL SAFETY UNDER THE SPOTLIGHT

New evidence showing wide variation in complication rates across Australian hospitals has called for a collective lift in safety performance and informing patients about the best and worst performing hospitals so they can make decisions about where they are treated.

The Grattan Institute report - *All complications should count: Using our data to make hospitals safer* - found one in every nine patients who go into hospital in Australia

suffers a complication, with the chances of something going wrong rising to a one in four risk if the patient stays overnight.

Complication rates vary considerably from hospital to hospital, with the report concluding there is significant scope to boost safety across the board and that 250,000 more patients would leave hospital each year free of complications if improvements can match the best 10% of Australian hospitals.

Complications are wide-ranging and involve everything from falls to surgical errors or a patient receiving the wrong drug.

Hospital safety statistics are currently collected but remain hidden from patients, doctors and hospitals.

The report claims removing "the veil of secrecy" over data would enable greater transparency and highlight the gaps so poorer performing hospitals could learn from the best. Its recommendations include all Australian hospitals publishing reports on excess complications by speciality and

institution, and enabling hospitals and clinicians to interrogate state hospital data.

ANMF Acting Assistant Federal Secretary Annie Butler said the report underscored a timely opportunity for a system-wide response to reducing patient harm yet warned creating a blame culture could inadvertently shift the focus away from underlying issues.

She said the current quality and consistency of data collection and analysis needed improving before information was widely circulated for comparison.

"The importance of collecting data that presents a comprehensive picture of hospital safety performance is unquestionable but going down the path of exposing where complications occur could trigger a destabilising blame game," Ms Butler said.

"This report marks an opportunity for an organisation to review its systems and to ensure the health professionals it employs are appropriately supported to deliver safe and quality care."



## NURSES OUTPRICED IN SYDNEY'S HOUSING MARKET

Nurses are being forced to move outside Sydney due to skyrocketing housing prices risking the viability of key services to the city.

In the 10 years leading up to 2016, key areas in Sydney lost up to 20% of nurses, teachers, police and emergency service workers to outer and regional areas.

The University of Sydney's Urban Housing Lab report last month warned that key workers were being driven out of metropolitan areas and living hours away from their workplaces.

The nature of nursing and other essential workers' shift work together with long distances away from their workplaces with inadequate public transport meant 77.4% drove to work. Only 5% used public transport to get to work, compared with 12.7% of the general population.

The study is the first of its kind in Australia, providing detailed analysis of declining levels of housing affordability across greater and metropolitan Sydney for key workers: nurses, teachers, firefighters, police, ambulance drivers and paramedics.

The closest area to live for an entry level enrolled nurse was Cessnock in the Hunter Valley – about 150km from any hospital in Sydney's city, a 300km round trip per day.

Between 2003 and 2016, the median price of established homes in Sydney more than doubled from \$400,000 to around \$900,000.



Soaring rents have heightened the crisis, making a 20% home loan deposit out of reach for many key workers. A single key worker would need 13 years to save for a deposit for a property in Sydney's inner ring, at the 2016 median price of just over \$1 million.

Clinical Nurse Educator Martin Gray left Sydney for Newcastle with his wife, also a nurse, and two children aged six and three last September. He worked for 15 years at the Prince of Wales Hospital in Sydney's inner east.

"We have been looking for the past two years where we could move to outside of Sydney to live - around Queensland, Coffs Harbour and then Newcastle. I definitely would have stayed in Sydney if we could have bought there."

Mr Gray commuted from Hurlston Park, in Sydney's inner west to work at the Prince of Wales Hospital. "I was a classic example. I caught the 370 bus which

goes everywhere, all the main spots but it stopped running after 10pm. That's no good when you are working a late shift."

Mr Gray said many staff commuted to work at the Prince of Wales for about two years and then left.

"Most people who work there are young people who have just qualified. You get a lot of graduate nurses who then move back to where they come from. I cannot see how the hospital can sustain its staffing – unless you've already bought in the area you can't afford it."

NSW Nurses and Midwives' Association Acting General Secretary Judith Kiejda said the union was very concerned about the increasing trend of nurses and midwives travelling considerable distances to and from work, due to the shortage of affordable housing. "This increases risks not only to their health, especially given shift-work requirements, but also places additional stress on family relationships."

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## ENTERING INTO A NEW CAREER

Early career nurse Thomas West will formally join the profession in April when he clocks on at St Vincent's Hospital in Sydney to undertake a year-long transition program aiming to arm him with the skills and knowledge required to forge a successful career.

"I'm confident that I'll be ready," the 26-year-old says, despite admitting to understandable nerves.

"I'm not scared as such but like all new grads I just have to take the plunge and jump in and learn from my experiences."

Thomas grew up with Type 1 diabetes, and the condition shaped his motivation to work in the health sector.

After finishing high school, he worked in the digital media space for several years before turning to nursing, venturing along to an open day at Australian Catholic University (ACU) where he was inspired by the scope of career opportunities.

"I definitely wanted to get into an industry where I felt like I could help people and could get something from a job rather than just working the normal 9-5 cycle."

A mature-age-student, Thomas believes settling on nursing as a career later in life allowed him to pinpoint the right pathway and develop greater emotional maturity.

During a three-year degree at ACU he completed numerous placements but none more defining than a stint at St Vincent's working in an outpatient clinic focusing on areas including sexual health, hepatitis and haematology.

"I was the first student they had and I had such a great experience. I loved the team working there and it's something I'm quite interested in pursuing once I get out beyond the graduate year."

Thomas says the profession demands a cluster of qualities.

"You definitely have to have compassion. You also have to be able to set aside all those little prejudices that we all have, put them aside to the table and actually listen to your patients and get better outcomes.

"You also need to treat them as part of a team and take into consideration all of their wishes in terms of treatment and how they're treated as well because if you don't have the patient on board, no one is happy."

Thomas adds that nurses must continually evolve and keep absorbing knowledge if they are to remain contemporary and progressive.

After completing his studies, he applied for an early career position through NSW Health and successfully landed his first preference, the Registered Nurse Transition Program offered by St Vincent's Hospital in Darlinghurst.

The 12-month program aims to equip early career nurses with the skills and confidence required to carry out safe, effective nursing care within a supportive learning environment.

It includes extended ward orientation, weekly CPD sessions, rotation across two clinical areas, extensive education and fortnightly clinical supervision/debrief sessions with a nurse educator.

Fortuitously, several of Thomas' classes throughout his nursing degree were held at ACU's clinical school, based at St Vincent's, which now gives him a sense of familiarity due to existing relationships.

"I'm glad it's at St Vincent's so I can continue the relationships that I've built but a number of people I know didn't get positions, which was a massive blow to their self-confidence. However, they have been able to work on whatever they felt like they weren't successful in and have been given positions in the private sector.

"St Vincent's, because they are in such a unique area and have a unique catchment, there's quite a wide range of patients that come through the doors. There's very wealthy and there's the poor and vulnerable."

Thomas will begin his career as a nurse working in anaesthetics in perioperative care.

Looking long-term, he considers intensive care an appealing fit.

"ICU has always been a big interest for me because you have more autonomy and you have to use your critical evaluation skills. It involves more of a learning process and a lot more background knowledge, which I really enjoy developing.

"Life's not predictable [as a nurse]. Although you might think it's just another day on the ward doing the routine, something always comes up that makes you think about your skills or about your knowledge or go somewhere else to find out what you need to know and interact with people constantly so you've got to be constantly on the go."



"YOU DEFINITELY HAVE TO HAVE COMPASSION. YOU ALSO HAVE TO BE ABLE TO SET ASIDE ALL THOSE LITTLE PREJUDICES THAT WE ALL HAVE, PUT THEM ASIDE TO THE TABLE AND ACTUALLY LISTEN TO YOUR PATIENTS AND GET BETTER OUTCOMES."



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# RESIDENTS SUFFER MOST AS AGED CARE CRISIS DEEPENS

After clocking off from her routine night shift at one of Australia's typical nursing homes carer Yvonne (not her real name) heads back to her house and invariably collapses from exhaustion.

The problematic aged care sector - plagued by understaffing, low rates of pay and insufficient investment - is challenging work yet like many aged care workers, Yvonne says it's residents who bear the brunt.

"It makes you feel frustrated because you cannot give the care that you know the residents deserve and what you are capable of giving," Yvonne explains.

Yvonne has worked in the aged care sector as a carer for over a decade.

The current facility she works at houses 93 residents who require both low and high care, and includes a dementia wing.

Working nights under the supervision of a registered nurse, Yvonne and one other carer look after all the residents' needs.

Standard duties include general rounds to make sure residents are safe and in bed, changing incontinence aids and toileting.

Yvonne says delivering aged care in this environment is demanding and unpredictable.

"The aged really don't have a recognition of time. They are up and down all night. It's your responsibility as a carer to make sure that they're safe all the time."

Yvonne says the aged care sector is falling short when it comes to providing quality care.

Last year, the ANMF released its

National Aged Care Staffing and Skills Mix Project, revealing nursing home residents should receive an average of over 4 hours a day of care instead of the current 2.84 hours.

The study found a skills mix of registered nurses (RN) 30%, enrolled nurses (EN) 20% and personal care workers (PCA) 50% was the minimum skills mix required in nursing homes.

"Every nursing home needs more staff. It is a major problem wherever you go and some places are worse than others are," Yvonne says.

"The place I worked before coming here, in my area I had about 56 residents. I worked with the RN and the RN was always running around elsewhere. I was doing double the amount of work on my own because there were no staff to help me and that's a danger to yourself and your residents."

Along with her day job, Yvonne is in the final stages of completing her studies to become an enrolled nurse.

Advancing her skills was a decision she made in part because at 47 years of age she felt working in the aged care sector was taking too much of a toll.

Once a qualified EN, she will reluctantly contemplate leaving the sector.

Yvonne says nursing homes operate

24-hours a day and believes that the workforce, in particular carers, are vastly undervalued.

"You never feel appreciated. You have to put up with the abuse from the residents themselves, and then you have to put up with the abuse from senior staff and managers.

"We're doing the best we can do in the circumstances that we are put in."

Yvonne followed the footsteps of her mother to work in aged care.

In a seemingly poor reflection on the sector, her now elderly mother plans to avoid entering the system at all cost.

"She worked in a nursing home for 45 years. She is now 90 years old and she swears to us kids, she's got 13 children, that the day she's got to go into a nursing home she will overdose on her medication."

Yvonne says the level of quality in aged care depends on the facility and what investment it injects into staff and resources.

In recent years, Yvonne says the qualifications that carers require have slackened, with many new staff entering the workforce after as little as three months training.

Despite the pitfalls in aged care, Yvonne is proud of the resilient workforce and continues to front up day in day out to keep the residents safe.

"That's why I go to work; for my residents. I make sure I give them my 100%, which is what they deserve and what they pay for.

"I absolutely love my job. I love the residents. I love that I can help them. Some of them do not see their family. I love how some of them regard you as their family."



# RELENTLESS, DEMANDING AND UNAPPRECIATED

Last year RN Irene McInerney swapped to working nights in the residential aged care facility where she works. She felt she was no longer able to do the job properly on the day shift.

"There had been a change in staffing. We had eight carers to 84 residents, where we used to have at least nine. Everyone was running ragged. Call bells were being left unanswered for who knows how long. People were left incontinent in their beds until we could get to them – that's the sad reality."

However while somewhat better working nights Irene says the stress and pressure due to skeleton staffing and demanding workloads is relentless.

"Every night shift I dread going in, hoping there's going to be four staff on, not three. We need a full pairing up - we pair up and do rounds of turns and pad changes, it takes four hours. You just hope nothing out of the ordinary happens."

"I had two palliative care residents last week. I was giving them sub cut morph and thinking I hope this lasts them because I don't think I'll have time to come back for the whole shift. It's incredibly stressful."

There is a lack of continuity of care, rostering is inconsistent and staff numbers are unpredictable. It's the residents who suffer, Irene says.

"We don't want to provide care that's factory fashioned but we have to be systematic if we're to get through the work. We start our rounds at 3.30am, waking people to do their pads so that four staff can get through 84 residents. There's a mixture of low and high care but two thirds would need some care at least whether that's toileting or other care."

Irene has worked in aged care for 30 years. She says the problems plaguing the sector have gone from bad to worse.

"My passion is aged care but it's hard to enjoy it when it's that stressful. It's no longer

about doing the job because you enjoy it, it's about money and survival."

"There is low morale, people feel unappreciated, let alone underpaid. Facilities are crying poor to pay us, yet making multimillion dollar profits and building brand new facilities."

Irene says staff don't feel supported from management who are directed by a profit-driven Board. "We are made to feel that we can't manage our time. We're all in the same boat. And no one wants to rock the boat."

Irene came down to Tasmania from Queensland to be her father's carer more than four years ago. She says the conditions are comparable across states and territories. "It's no better across those corporate private facilities. I am in contact with others I worked with in Queensland and they say it's no better up there either."

She says staff in residential aged care are working in a climate of risk.

"Our staffing is inadequate, there are not enough pairs of hands to go around."

We leave residents unattended hoping they'll wait long enough. There is increasing falls and pressure sores because we cannot do things in a timely manner.

"They talk about preventative care but we are at the bottom of the cliff day in day out. My worst fear is people dying alone. We had a resident who died, we didn't know who last saw him alive."

Irene says it's going to take federal government commitment to fix the crisis in aged care. "Staffing ratios are what we need to fix this. It's not going to be right until we have mandated ratios at the federal level."

Not only has there been increased casualisation of staff, but shorter shifts



"I HAD TWO PALLIATIVE CARE RESIDENTS LAST WEEK. I WAS GIVING THEM SUB CUT MORPH AND THINKING I HOPE THIS LASTS THEM BECAUSE I DON'T THINK I'LL HAVE TIME TO COME BACK FOR THE WHOLE SHIFT. IT'S INCREDIBLY STRESSFUL."

introduced to pare down staffing to an absolute minimum, says Irene.

"They've reduced the hours of shifts so that we are down to skeleton staffing. ENs on the afternoon shifts help with the medication rounds but they don't do full shifts – four hours or so and finish at 1pm."

"People are leaving because of job insecurity or to find other work because they don't have enough hours. Then people call in sick and there's no one to replace them."

"Staff are having mental health days, some are off on compo. We do our best but we are exhausted. People are leaving in droves, staff are tired."

Irene says many staff have worked in aged care for 20-30 years and are passionate about their work. "The residents make up for it, if we leave who cares for them? We're talking about people's lives here. Aged care residents deserve better. So we do our best even though it's not enough."

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Linda Starr

## NEGLIGENT CARE LEADS TO MANSLAUGHTER CONVICTIONS

A recent decision made in the Courts in England convicting a doctor of manslaughter has enraged many medical officers both in England and Australia; raising concerns that the court failed to look at the realities of practice in the public health system and the systemic wide failings that add pressure to an overworked and understaffed healthcare workforce.

However, when exploring this case it became apparent that it was not only one medical officer but also two nurses, also working in such conditions, who faced criminal charges following the avoidable death of a six year old boy.

Jack Adock had Down's Syndrome and a heart defect which had been successfully managed since his birth. He was described as a lively and energetic boy who attended a local primary school. On 18 February 2011 around 10:30am he was admitted to hospital with symptoms of diarrhoea, vomiting and breathlessness. At 9:30pm the same day he died of systemic sepsis.

That his death was premature was supported by evidence of a paediatric intensive care consultant who believed that '.... had he been properly diagnosed and treated, he would not have died at the time and in the circumstances which he did.' and, that '... any competent junior doctor would have realised Jack's condition.' (General Medical Council v Dr Bawa-Garba, 2018).

Following his death Dr Bawa-Garba a trainee paediatrician, and an agency nurse Isabel Amaro were charged and convicted of manslaughter by gross negligence. A third nurse Theresa Taylor was acquitted.

The Court determined that the level of care Jack was given was "woeful" and "truly, exceptionally bad". As such, rather than the care simply falling short of the required standard, it was determined that it fell so far short that it reached the threshold of gross negligence and so, the threshold of criminality where a custodial sentence was appropriate for both accused who received a 24 month suspended sentence (General Medical Council v Dr Bawa-Garba, 2018). Professional disciplinary hearings followed where both practitioners were 'struck off' the register.

It was alleged that Bawa-Garba breached the standard of care expected of her when she failed to adequately assess Jack; failed to respond to clinical findings from laboratory tests indicating his deterioration and the need for reassessment; failure to keep proper clinical notes; and to refer to a consultant for further advice.

Furthermore, Bawa-Garba confused Jack with another patient who was 'DNR' ("do not resuscitate") and stopped his CPR until this view was corrected by another doctor and CPR was recommenced approximately two minutes later.

However, this matter was not given any causative weight in Jack's death, although it was argued that it was indicative of the overall level of care attention given to him.

It was also argued that Amaro had failed to undertake and record regular readings of Jack's vital signs and oxygen saturation levels and, despite Jack being given IV fluids failed to keep the proper fluid balance record necessary for a deteriorating patient. In fact, her record keeping was described as 'woefully incomplete'.

It was further argued that she failed to escalate her concerns regarding Jack's deteriorating condition to senior nursing and medical staff which delayed his urgent reassessment and initiation of further treatment. Overall it was held that this significantly contributed to the deficiencies in his care and his subsequent death.

Each accused put forward a number of mitigating factors in both the criminal and disciplinary hearings as to why they should not be found guilty of gross negligence or struck off the registrar. These included, failings of the nurses and consultants, a shortage of medical and nursing staff, IT systems failures leading to abnormal blood test results not being highlighted, handover deficiencies, data availability at the bedside, high workloads and heavy reliance on agency staff.

While these were taken into consideration, they did not dissolve the responsibility of the practitioners. It is in part the failure to give consideration to these issues that has elicited the response from the medical profession and raised concerns that ordinary mistakes in practice will end careers.

From a disciplinary perspective, both practitioners were found to be impaired – not only because of public safety reasons but also '.... because the conviction for manslaughter by gross negligence meant that public confidence in the profession would be undermined if no finding of impairment were made, and because a finding of impairment was required

to promote and maintain proper professional standards' (Ouseley J).

The High Court in deciding that suspension was an insufficient penalty for Bawa-Garba concluded that in these circumstances where the conduct had been described as exceptionally bad because of a series

ON 18 FEBRUARY 2011  
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of failings where a patient died, due weight must be given to the verdict of the jury when imposing a sanction. As such, given that the verdict of manslaughter by gross negligence concerned a serious departure from the principles of "Good Medical Practice" and was fundamentally incompatible with being a doctor a sanction of erasure, was appropriate.

The Nursing and Midwifery Council also concluded that the appropriate and proportionate sanction to satisfy the public interest was a striking off order for Amaro concluding that the manslaughter conviction represented '...a fundamental departure from the relevant standards, that public confidence in the nursing profession and in the NMC as its regulator would be undermined were the panel not to impose a striking-off order' (NMC v Amaro 2016).

It is not surprising there has been such a response to these findings as many health professionals feel the pressure of working in overloaded systems, and many consumers are demanding more accountability for adverse outcomes.

Once again we are reminded of the need to consider what issues may be impacting on our own ability to deliver the necessary standard of care to meet our professional obligations and what we can do individually and collectively to minimise such risks.



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Council v Amaro (2016)

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Elizabeth Foley



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## ANMF Federal Professional Officers



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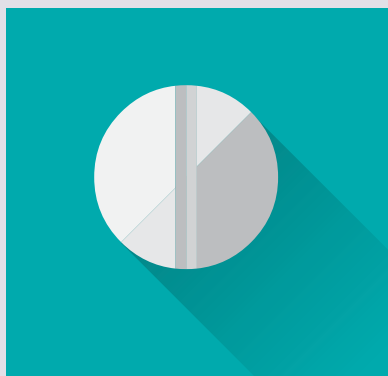
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## CODEINE – MORE HARM THAN GOOD

From 1 February 2018, medicines containing codeine are no longer available without a prescription.

No therapeutic product is ever completely free of risk. Some risks may be known when a medicine is first placed on the Therapeutic Goods Register. Others only become apparent after more people use the products.

In 2010, the Therapeutic Goods Administration (TGA) reviewed the availability of codeine in response to reports of misuse and toxicity. This review resulted in the removal of the pharmacy-only (Schedule 2) listing for codeine-containing analgesics and restricted pack sizes to five days' supply (Roberts and Nielson 2018).

Codeine is widely used in Australia, often in combination with other medicines. In 2013, more than 27 million packs of codeine-containing analgesic products were supplied by pharmacies, and 56% of these sales were over-the-counter without a prescription (Gisev et al. 2016).

National sales data show that over-the-counter codeine-containing analgesics account for 37% of all opioid purchases in the community (Degenhardt et al. 2016).

Codeine is metabolised to morphine but there is marked variability in each individual's metabolism resulting in considerable differences in analgesic effects. Due to the opioid effects of codeine, people can become dependent with regular use (Roberts and Nielson 2018).

Use of medicines containing codeine, for example for chronic pain, has led to some people becoming addicted to codeine without realising it.

Research shows that current over-the-counter low-dose (<30 mg) medicines containing codeine for pain relief offer very little additional

benefit when compared to similar medicines without codeine. The use of such medicines however, is associated with high health risks. Codeine can cause opioid tolerance, dependence, addiction, poisoning and, in high doses, even death. In addition, side effects of long term use of combination codeine medicines containing paracetamol and non-steroidal anti-inflammatory drugs (NSAIDs), are also potentially life threatening (Australian Government Department of Health Therapeutic Goods Administration).

In December 2016, after more than 18 months of consultation, the Australian Government Department of Health TGA made the final decision to reschedule all codeine-containing products to prescription only (Schedule 4).

Submissions to the TGA during the consultation that supported rescheduling included: addiction specialists reporting increasing numbers of people presenting with codeine dependence; pharmacists reporting the challenge of dealing with people demanding codeine; and members of the public speaking of families being devastated by codeine addiction.

These groups identified the ready availability of codeine over-the-counter as a contributing factor. Those arguing against codeine rescheduling included: people using codeine regularly; people with limited access to GPs; and community pharmacists (Therapeutic Goods Administration 2016).

Through the extensive consultation activities that were undertaken, stakeholders indicated that an education and awareness campaign would be critical for health professionals and consumers to support changes in codeine scheduling.

In May 2017, the Australian Nursing and Midwifery Federation (ANMF) received an invitation to participate on the Nationally Coordinated Codeine Implementation Working Group (NCCIWG), established to inform and educate all affected stakeholders of the upcoming changes to the availability of low-dose codeine containing medicines. The NCCIWG, which continues to meet monthly, includes representatives from state and territory health departments, and peak professional bodies representing consumers, pharmacists, doctors, nurses and midwives. The purpose of the NCCIWG has been to facilitate a coordinated and consistent approach to the drafting and delivery of key messages and education material to all affected stakeholders.

Through the NCCIWG, the ANMF

has assisted the TGA to draft the *Nurses and Midwives Fact Sheet: Talking to people about changes to codeine access*. This document is available through the TGA Codeine Hub at:

[www.tga.gov.au/codeine-info-hub](http://www.tga.gov.au/codeine-info-hub)

People will still be able to access codeine-containing medicines through prescription, if and when they need them, by consulting with a health practitioner with prescribing authority.

Nurse practitioners and midwives with scheduled medicines endorsement are authorised prescribers and can prescribe codeine-containing medicines when appropriate, consistent with their scope of practice.

In some jurisdictions, registered nurses in rural and remote areas can supply codeine-containing medicines in specific circumstances, under protocol.

A list of codeine-containing products previously available over-the-counter that are still available with a prescription from 1 February 2018 is available at: [www.tga.gov.au/community-qa/current-list-scheduled-codeine-containing-products](http://www.tga.gov.au/community-qa/current-list-scheduled-codeine-containing-products)

It is anticipated that pain relief will be a key reason for people seeking prescriptions for codeine or other opioids. As is always the case, the assessment of pain requires a thorough history and examination before any prescribing should occur. It's possible that a benefit of rescheduling codeine is that it will direct attention to the clinical assessment and management of pain and the risks associated with the use of opioids. Clear messages from health professionals about the relative effectiveness of non-drug options and non-opioid analgesics available over-the-counter may also help address people's concerns (NPS MedicineWise).

Preparing for the changes to codeine availability in 2018 is as critical for health professionals as it is for people using codeine-containing products. As qualified health professionals and the largest part of the health workforce, nurses and midwives are well placed to discuss the changes to codeine access. Head to the TGA Codeine Hub for all the information you'll need.



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# THE WAY FORWARD

## Expanded prescribing roles for nurses and midwives

I WILL NEVER FORGET TRAVELLING WITH MY NIECE OVER A DECADE AGO FROM MELBOURNE TO SYDNEY AFTER SHE HAD RECEIVED A B-CELL INFUSION TO TREAT A CHRONIC ILLNESS.

By Catherine Beadnell

**T**he new treatment was exciting because it promised to provide more targeted relief than the oral chemotherapy and steroidal treatments she had received for many years.

Several hours after her treatment we set off for Sydney and she mentioned not feeling well. By the time we arrived at my sister's home in the western suburbs my niece was in extreme pain.

We drove a short distance to the emergency department of a major tertiary hospital and the triage nurses attended to her quickly. As we waited her pain levels worsened, and she became increasingly distressed. This was a young woman who never complained about her illness or the chronic pain she suffered, so we knew things weren't good.

After what seemed like a very long time, a registrar came to examine my niece. An amazing nurse had been checking in while we waited, and she returned during the doctor's examination. By now my niece was crying in pain and the registrar was going to prescribe Panadol while some tests were ordered.

I looked across at my sister in exasperation, I'm not medically trained but it seemed something a little stronger might be considered in this situation.

The nurse asked the doctor if she could speak with him and they left the cubicle. A few minutes later the nurse returned with

a much stronger pain medication. She was an experienced emergency nurse, and it turns out a great patient advocate, who collaborated with the registrar to ensure my niece received an appropriate response to her level of pain.

I have never forgotten that incident and the enormous gratitude I felt for the nurse as my niece's pain subsided. It turns out she was allergic to the penicillin administered following her infusion in Melbourne. She remained in hospital overnight until the symptoms subsided.

While the nurse who cared for my niece didn't prescribe her pain relief she clearly intervened to advocate for her patient and the registrar respected her advice and ordered a more appropriate medicine. It made perfect sense because the nurse was with my niece for a good hour before the doctor arrived and was able to assess her pain levels and advise on the best pharmaceutical response.

### Prescribing by nurses well established

There is nothing new about nurses prescribing medicines. *The Health Practitioner Regulation National Law Act* allows the endorsement of registered nurses and midwives as qualified to prescribe, supply or use scheduled medicines if they meet the requirements of their registration standards.

The introduction of the Nurse Practitioner (NP) role in Australia in 2000 allowed autonomous prescribing by endorsed nurses with Masters' level education in a speciality area. In 2010 endorsed midwives could also prescribe autonomously under the *Registration standard: Endorsement for scheduled medicines for midwives*.

Many countries around the world have expanded nurse and midwife prescribing models in place. The United States introduced nurse practitioner roles in the 1960s. In addition to the United States, independent or collaborative prescribing models for nurses and midwives exist in Sweden, the United Kingdom, Canada, Ireland, New Zealand and more recently Australia.

Dr Rosemary Bryant recently joined NPS MedicineWise, representing the nursing and midwifery professions. Dr Bryant was Australia's first Commonwealth Chief Nursing Officer and is passionate about advancing nursing and midwifery professions.

### Changes to prescribing models 'timely'

Dr Bryant says moves underway to expand the prescribing rights of nurses and midwives are timely and essential for the future of the Australian healthcare system.

"We are certainly not the first country



to look at this issue. Countries like the US, UK, Ireland and many others have had expanded prescribing roles for nurses for many years.

"In many ways we are catching up with international trends and it is clear primary healthcare has received a lot of attention in recent years. One of the main reasons for this is that we have an ageing population and all of the complexity that comes with that. A lot of nurses work in primary healthcare and could be doing a lot more to improve health outcomes for people in our communities."

Dr Bryant says there are multiple reasons for developing new models for nurse and midwife prescribing in the Australian context.

"It makes sense for so many reasons," she says. "It would be more convenient for patients and it would also help decrease the cost of healthcare in the federal budget."

"If you could have a nurse, with the appropriate level of skill and education, seeing patients and providing continuing

scripts for existing conditions for example it would be very convenient for the patient. They may not be initiating medications, but it would be great if they could renew existing scripts."

### Improving access to healthcare

ANMF Senior Professional Officer, Julianne Bryce agrees and says nurses already leave their undergraduate programs with a level of preparation for administering nurse initiated medicines under protocol.

"What happens when you're working as a nurse is that you might have a standing order from a doctor that allows you to choose between different levels of pain relief. We are not technically prescribing but certainly making decisions about appropriate medication."

"Nurses also already make a lot of decisions around the amount of medication that is administered within a sliding scale. So, we currently have a number of pathways within standing orders and protocols that allow nurses to use their initiative."

Ms Bryce says the current review of prescribing rights by the Nursing and Midwifery Board of Australia (NMBA) and the Australian and New Zealand Council of Chief Nursing and Midwifery Officers (ANZCCNMO) is an opportunity to address future challenges in the healthcare system.

"This really is an opportunity to improve scope of practice for nurses and midwives across all healthcare settings. We think that acute care is less of an issue because there are lots of doctors in the system. But the reality is a lot of people wait for care due to the availability and access to doctors."

"It's really important that we have nurses and midwives working to their full scope of practice as the demands on our healthcare system increase. We have an ageing population with increased acuity and nurses are well placed to respond to their needs. Nurses focus on person centred care and it makes sense that we are better equipped to manage medications to prevent delays and deterioration in a person's health."



## Reaching out to people in need

Gabrielle Bennett is a registered nurse who has spent most of her working life delivering healthcare to people who struggle to access the same level of care that most of us take for granted.

She has worked in remote locations, with people experiencing homelessness and with refugees.

Gabrielle's current role is Victorian Viral Hepatitis Educator, based at St Vincent's Hospital in Melbourne.

She supports expanded prescribing roles for nurses and midwives and says new models will potentially improve access to quality healthcare within disadvantaged communities.

"Nurses are already doing this in some areas under arrangements with doctors and nurse practitioners because we have trusting, collaborative relationships. I think it would be good to formalise these arrangements."

She says hepatitis nurses are already working in collaborative arrangements to provide new, curative drugs with few side effects to people with hepatitis C.

"We've got nurse led models happening in prisons and doing outreach to places where people with hepatitis C are attending like needle syringe programs and homelessness services for example."

"We know nurses are doing this work in collaboration with medical specialists and making decisions around which particular drugs people need. Nurses tend to go to places where there are few doctors, like the services I mentioned earlier."

Gabrielle says the new models of prescribing will extend nurses ability to provide essential healthcare service to people in need. Nurses often communicate on a different level and can spend more time building rapport, finding out what is most important to the client.

"We need to formalise arrangements that are already happening and acknowledge that nurses have the skills and capacity to improve our healthcare system. Particularly in areas of existing disadvantage."

## Symposium identifies strong support for enhanced prescribing roles

A symposium hosted by the Commonwealth Department of Health, on the future of nurse and midwife prescribing was held in Canberra in March 2017. The event attracted over 120 representatives from the clinical, management, nursing research, professional and third sector.

In the final outcomes report in May 2017, Chief Nurse and Midwifery Officer Debra Thoms said the symposium, "identified strong support for enhancing the role the professions currently play in the management of medicines by expanding the ability to prescribe."

"Participants highlighted many ways nurse/midwife prescribing will enhance access to medicines for Australian communities and contribute to improved

health outcomes, particularly for underserved populations such as rural and remote and indigenous communities," she said.

CRANAp<sub>plus</sub> Director of Professional Services, Geri Malone is a registered nurse and midwife who has worked extensively in rural and remote communities in Australia. In her capacity as part of the rural and remote healthcare workforce and with CRANAp<sub>plus</sub>, she is well positioned to see the benefits of new and expanded prescribing rights for nurses and midwives.

Ms Malone says CRANAp<sub>plus</sub> has been advocating for enhanced nurse and midwife prescribing roles for many years.

"This kind of reform is vitally important, particularly for the remote workforce. Access to quality healthcare and medicines for people who live in remote areas is impacted by workforce issues," she says. "The ability for nurses on the ground to provide better healthcare will definitely improve access and healthcare outcomes in remote areas."

Ms Malone says any reforms around expanding nurse and midwife prescribing rights must focus on national standards in relation to education, clinical governance, safety and harmonisation of poisons legislation.

"Innovation is usually born of necessity and while we certainly think the reforms will improve access there needs to be a nationally consistent approach. You currently have jurisdictional based drugs and poisons Acts and this has been highlighted as a barrier for some time."

"Our [CRANAp<sub>plus</sub>] position is very much about safe, quality access to medicines for consumers. And we're aware of the challenge that presents, particularly in remote and rural settings," she says.

"We support moves that allow nurses and midwives to work to their full scope of practice within guidelines that ensure safe access. It has to be a national approach that makes it easier for a very mobile remote workforce. We have nurses and midwives doing the same work across state and territory borders with different drugs and poisons Acts. These barriers have to be removed by harmonising the laws."

In its submission to the NMBA/ANZCCNMO public consultation on registered nurse and midwife prescribing, the ANMF also identified the need for a harmonised approach to any new models of nurse and midwife prescribing in Australia. It proposes:

Before a model of independent prescribing for registered nurses could be considered, there would need to be a nationally agreed mechanism by which it is possible to determine that the registered nurse is working as an advanced practice nurse. A national framework to support advanced practice needs to be established as the foundation for a move to broadening independent prescribing...

Once this advanced practice framework is in place, benefits to expanding the



**"WE ARE CERTAINLY NOT THE FIRST COUNTRY TO LOOK AT THIS ISSUE. COUNTRIES LIKE THE US, UK, IRELAND AND MANY OTHERS HAVE HAD EXPANDED PRESCRIBING ROLES FOR NURSES FOR MANY YEARS."**

Dr Rosemary Bryant



**"WE KNOW THAT A LARGE NUMBER OF PEOPLE WITH MENTAL HEALTH ISSUES AREN'T RECEIVING ADEQUATE TREATMENT. I THINK THE PROPOSED CHANGES WILL RATIONALISE THE APPROACH TO PRESCRIBING INCLUDING CEASING SOME MEDICATIONS. WE COULD PROVIDE BETTER ACCESS, NOT ONLY TO MEDICINES, BUT TO THE RIGHT MEDICINE AND THE RIGHT DOSE".**

Andrew Cashin



"IT'S REALLY IMPORTANT THAT WE HAVE NURSES AND MIDWIVES WORKING TO THEIR FULL SCOPE OF PRACTICE AS THE DEMANDS ON OUR HEALTHCARE SYSTEM INCREASE. WE HAVE AN AGEING POPULATION WITH INCREASED ACUITY AND NURSES ARE WELL PLACED TO RESPOND TO THEIR NEEDS.

Julianne Bryce




"NURSES ARE ALREADY DOING THIS IN SOME AREAS UNDER ARRANGEMENTS WITH DOCTORS AND NURSE PRACTITIONERS BECAUSE WE HAVE TRUSTING, COLLABORATIVE RELATIONSHIPS. I THINK IT WOULD BE GOOD TO FORMALISE THESE ARRANGEMENTS."

Gabrielle Bennett

## SUMMARY OF KEY OUTCOMES

### REGISTERED NURSE/MIDWIFE PRESCRIBING SYMPOSIUM 2017

- Overall support for extending capacity for some form of prescribing across the nursing and midwifery professions beyond that currently held by NPs and endorsed midwives.
- Potential benefits in the use of nurse/midwife prescribing across various aspects of healthcare delivery including:
  - Improved access
  - Health outcomes and cost effectiveness
  - More effective use of resources
  - Greater contribution to the quality use of medicines
  - Improved patient experience
- All healthcare settings were seen to benefit from a new model of prescribing with community, aged care and rural and remote settings scoring slightly higher than others.
- Majority of responses (n=68) said the ability for nurses and midwives to prescribe would enhance access to medicines by increasing the opportunity for individuals to obtain the medicines they require and by reducing the time, effort and cost it might otherwise take for them to do so. (Source – *Registered Nurse/Midwife Prescribing Symposium: Final outcomes report May 2017*) Note: Based on Commonwealth of Australia (Department of Health) material



model of independent prescribing for registered nurses could be realised and the advantages would include: person-centred care; reduced wait times; system efficiency; cost effectiveness; workforce flexibility; job satisfaction; and improved workforce retention.

This expanded model of independent prescribing would have immense potential to improve timely access to high quality, safe healthcare...

State and Territory Drugs and Poisons legislation and regulations must enable or be amended to support partnership prescribing by registered nurses.

Julianne Bryce says safety, person-centred care and national consistency are issues at the core of the ANMF's approach to expanded prescribing rights for nurses and midwives in Australia.

"It is vital that we get this right and put the safety of the people whom we provide care for at the core. We're not suggesting every nurse and midwife is going to have access to the entire PBS. There are some situations where shared care arrangements are essential.

"State and territory health departments operate different frameworks and apply different legislation within their local health workforce settings. Because of this you might be a nurse working across a state border in a remote setting who isn't able to provide continuity of care across jurisdictions. This is why the various Drugs and Poisons laws should be harmonised."

New nurse and midwife prescribing models will certainly impact on nursing specialties and as already mentioned have the potential to improve access to improved healthcare across the board.

The current NMBA/ANZCCNMO discussion focusses on three models of prescribing for nurses and midwives in future (the three levels of prescribing model is supported by the ANMF):

#### **Level 1 – Structured prescribing (NMBA Model 3)**

Prescribing occurs where a prescriber with a limited authorisation to prescribe medicines by legislation, requirements of the national Board and policies of the jurisdiction or health service, prescribes medicines under a guideline, protocol or standing order.

#### **Level 2 – Partnership prescribing (NMBA Model 2)**

Prescribing occurs where a prescriber undertakes prescribing within their scope of practice in partnership with an authorised independent prescriber. The partnership prescriber has been educated to prescribe and has a limited authorisation to prescribe medicines by legislation, requirements of the national Board and policies of the jurisdiction, employer or health service. The partnership prescriber recognises their role in the healthcare team and ensures appropriate communication occurs between team members and the person taking the medicine.

#### **Level 3 – Independent prescribing (NMBA Model 1)**

Prescribing occurs where a prescriber undertakes prescribing within their scope of practice without the approval or supervision of another health practitioner. The prescriber has been educated and authorised to independently prescribe in a specific area of clinical practice. Although the prescriber may prescribe independently, they recognise the role of all members of the healthcare team and ensure appropriate communication occurs between team members and the person taking the medicine. This model of prescribing is currently within the scope of practice of nurse practitioners and midwives with scheduled medicines endorsement.

Andrew Cashin is a Nurse Practitioner specialising in mental health and a Professor of Nursing at Southern Cross University.

Professor Cashin supports an expanded prescribing role for nurses and midwives under supervision, akin to the NMBA Model 2 outlined above.

"It would be great to have registered nurses expanding their roles in prescribing in partnership. I say that because autonomous prescribing requires the advanced clinical skills and diagnostic reasoning in the nurse practitioner scope of practice. Having registered nurses prescribing in partnership with nurse practitioners for example would be great for improving access to and quality of healthcare," he says.

"I make mention of the quality angle because nursing is largely a person-centred model. Patients talk about how nurses spend more time with them and understand their healthcare needs. As long as registered nurses complete further education and work in partnership with autonomous (or independent) prescribers it will certainly make a difference."

People experiencing mental health issues face a lot of barriers in accessing treatment and lack confidence in the system, according to Professor Cashin. Expanded roles for mental health nurses and partnership prescribing models with nurse and medical practitioners could improve both access and quality of care.

"We know that a large number of people with mental health issues aren't receiving adequate treatment. I think the proposed changes will rationalise the approach to prescribing including ceasing some medications. We could provide better access, not only to medicines, but to the right medicine and the right dose".

"Another important aspect of this is allowing nurses an expanded role in mental health from a person-centred care approach. Nurses have a great role to play in preparing people to be at the centre of their own care and educating them in medication management. In mental health you think about issues like choice to take medication and adherence to medicines. Nurses can work with people to action quality medication choices and save a whole lot of unwanted side effects and it will also save the country money."



# STUDENT CULTURAL EXPERIENCES AND REVELATIONS – A NURSING TOUR TO TAIPEI

By Tanya Silva, Nicole D Ellis, Julie Moxam, Jean Jorel Alvarez, Erine Miclat, Belen Torres, Kuei-Ru Chou and Anthony Paul O'Brien

The University of Newcastle's School of Nursing and Midwifery in combination with the Colombo Mobility Project and Taipei Medical University (TMU) College of Nursing, supported six second year nursing students during a 14-day study tour of the Taiwanese healthcare system and culture (DFAT 2017).



The visiting program, delivered by TMU College of Nursing, top 15 in the world, offers high quality Masters' degrees, a Doctoral program and Bachelor of Nursing (Shanghai Global Ranking of Academic Subjects 2017 – Nursing). The Bachelor's program is a four-year degree.

TMU nursing academics and hospital staff provided students a series of lectures on Taiwan's National Health Insurance (NHI), long term care, assistive devices, Traditional Chinese Medicine (TCM), postpartum care and disaster management, amongst other talks.

Students toured and conducted clinical observations in the three TMU 1,000 plus bed hospitals, Shuang Ho, Wan Fang and Taipei Medical University hospital.

TMU nursing college students and academic staff shared cultural values and beliefs, nursing education experiences and healthcare system approaches.

Taipei is an exceptional densely populated bustling Asian city, bursting with scooters and buses and an amazing metro rail system. The people are very kinship orientated, with the young supporting the old and openly showing respect for their elders and seniors. The markets are open each day and night selling fresh fruit and vegetables, meat and fish, and cultural dishes.

To buy from the markets is a daily ritual for Taipei people, who live in city high-rise accommodation. People speak Mandarin and some English and it is a relaxed place to visit.

## The Taiwan healthcare system

The Taiwanese healthcare system

is inclusive of Chinese medicine, very accessible, has wide coverage, short waiting times, and low out of pocket expenses. Taiwan uses a national health card enabling health professionals to quickly access patient medical records.

Patients are able to download their health records and laboratory results from an app. Visitors to the hospitals can also take their own blood pressure, as well as measure their weight, height and BMI in the foyer of the hospitals.

Taiwan is not alone in the global ageing crisis and has one of the lowest birth rates in the world. This results in fewer taxpayers to support the increasing ageing healthcare burden. The animated passion Taiwanese show for their National Health Insurance (NHI) is contagious. NHI is government sponsored and regulated, compulsory for all and funded by taxes, tobacco sales and lottery profit (Chen 2017; NHIA 2017).

## Nursing and healthcare

Taiwan healthcare is innovative and has a practical grasp on the use of technology to improve the delivery of healthcare systems. Such innovations include Da Vinci robotics for microsurgery (Oldani et al. 2017), the development of rehabilitation programs utilising motion-sensor technology (Chang et al. 2011); and the use of assistive devices to help maintain quality of life for elderly Taiwanese citizens. The integration of Chinese Traditional Medicine (TCM) with Western medicine is a widespread and accepted practice among Taiwanese people. An example, is using TCM in conjunction with chemotherapy to aid liver

function (Mei-Ling et al. 2011).

Traditional postpartum practice in Taiwanese culture demonstrates a commitment to holistic health for the mother and newborn. Postpartum confinement for one month is an important cultural approach to ensure the health and safety of both the mother and baby (Chien et al. 2006). The traditional Chinese belief is that the woman by nature is cold (Yin), and therefore vulnerable. As the woman becomes more vulnerable after childbirth, it is stipulated that a month of confinement will improve her health by increasing her body's inner heat; allowing her to recover faster (Chmielowska and Shih 2015). These are important things to remember if a nurse is caring for a Taiwan woman giving birth in Australia.

## The value of cultural immersion

The kindness shown by the Taiwanese to the students was very gratifying. The hospital tours to the large hospitals provided students with a great appreciation for the passion of Taiwanese nurses. Taiwanese nurses have much larger patient to nurse ratios than their Australian counterparts and employ some different procedures. The nurses utilise electronic records, priority care systems, and scanned electronic medication administration (each medication pack is bar coded) (Tsai et al. 2010). Something Australia is yet to completely emulate.

**Tanya Silva, Nicole D Ellis, Julie Moxam, Jean Jorel Alvarez, Erine Miclat and Belen Torres are all second year Undergraduate Bachelor of Nursing students at the University of Newcastle, School of Nursing and Midwifery, Faculty of Health and Medicine.**

**Kuei-Ru Chou, RN, PhD, is Professor and Dean of College of Nursing, Taipei Medical University**

**Anthony Paul O'Brien RN, PhD is Professor of Nursing, School of Nursing and Midwifery, Faculty of Health and Medicine at the University of Newcastle**

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# TACKLING THE CHALLENGES OF AUTISM

By Robert Fedele

**Mental Health Nurse Practitioner Professor Andrew Cashin helps people with autism and their families tackle challenges head on.**

Following his endorsement as a Mental Health Nurse Practitioner in NSW in 2003, Professor Cashin established an autism clinic focusing on counselling and psychotherapy services for people with autism and their families, based on the Central Coast and from 2009 at Southern Cross University (SCU) in Lismore.

Professor Andrew Cashin originally chose nursing because he wanted to make a difference in people's lives.

While completing his undergraduate degree he developed an interest in mental health, specifically working with people with autism spectrum disorder (ASD) and the behavioural challenges and mental health issues it triggers.

After graduating, he joined a mental health team and later developed a chief interest working within community crisis teams on the Central Coast region.

After advancing his education in mental health, he entered the sector and worked across various settings, including as a family counsellor with Autism Association of NSW, now Autism Spectrum Australia (Aspect), the country's largest national service provider for people on the autism spectrum.

Professor Cashin describes autism as a fascinating field due to its complex layers and the potential for clinical intervention to improve lives.

He began investigating autism decades ago when there was little support for people experiencing the disorder and their families.

The clinic Professor Cashin runs has established aims to help people with autism navigate complex social situations by reducing their anxiety and increasing their resilience.

Professor Cashin most commonly treats children or adolescents, as well as an increasing number of teenagers transitioning from high school to tertiary study, but does provide services across the age spectrum.

"When I first began working with people with autism professionals largely only recognised autism in people with co-morbid intellectual disability," he says.

"Of course since that time and the notion of Aspergers, which helped people raise their vision to see that people right across the spectrum can have autism, there was a broadening of understanding of how it affects people in the community in general and who we work with."

At the clinic, Professor Cashin helps support people with autism to confront

daily challenges, in addition to increasing the knowledge of their families.

Anxiety and depression often steers people to the clinic, with Professor Cashin adopting a modified narrative therapy technique to help patients manage their daily problems and systematically deal with future ones.

"So perhaps by the time they reach early adulthood they're able to recognise cues that they're having some sort of difficulty and can actually use this formulaic or scaffolded approach to problem solving so the problems are able to be broken off into concrete workable chunks rather than the world being seen as overwhelming."

In this vein, Professor Cashin's recent research studied restrictive and repetitive behaviours (RRBs) in ASD and the challenges they bring people, their parents and caregivers.

RRBs comprise a wide range of behavioural manifestations that persist over time, such as obsessions, ritual and insistence on sameness, which can derail the ability to cope.

Professor Cashin's contention suggests a heuristic model, based on identifying declining structure in a patient's routine and making interventions, can help clinicians make improved decisions that reduce anxiety and improve outcomes.

He says people with autism can retreat into RRBs and experience greater anxiety without the necessary tools to deal with their problems.

"That's where that clinical approach is vital. If you can give people a formula or approach to have a way of actually identifying, exploring what the problem is and having an active approach to working on it and evaluating if what they're doing is successful, it can actually have a big impact in terms of their adaptation and their success in whatever that is - whether it's work, study, speaking to a family member or enjoying social contact in the community."

The findings have sparked a new research project where Professor Cashin will delve into people prone to developing RRBs and whether it is possible to induce them to form pro-social fixations such as playing a musical instrument like the ukulele.

Professor Cashin says working in the autism space as a Mental Health Nurse Practitioner provides an ideal fit.

"Working with people with intellectual and developmental disability is the perfect spot for nurses and a really high congruence between the capabilities of RNs and NPs and the needs in terms of support and treatment of co-morbidities that are commonly associated with intellectual and developmental disabilities."



THE UNIVERSITY IS ABOUT TO OFFER A NEW GRADUATE DIPLOMA IN MENTAL HEALTH NURSING AND IS ALSO EXPLORING THE DEVELOPMENT OF FURTHER EDUCATION FOR NURSE PRACTITIONERS AIMED AT ADVANCING LEADERSHIP AND PRACTICE DEVELOPMENT.

Professor Cashin currently splits his time between the autism clinic and his main role as Professor of Nursing at Southern Cross University in Lismore.

The university is about to offer a new graduate diploma in mental health nursing and is also exploring the development of further education for nurse practitioners aimed at advancing leadership and practice development.

Professor Cashin believes nursing faces many challenges in coming years.

"I think the challenge for nursing is to continue to articulate its scope of practice and the autonomous nature of the profession within rapidly changing healthcare contexts," he says.

"Whilst nurses embrace collaboration, the collaborative nature of our endeavours is often overshadowed. I think other healthcare disciplines are quick to claim nursing in an assistant role and I think the challenge is to articulate our role and have the community understand the things RNs can do and the other extensions on that such as the roles as NPs."



Professor Cashin's research into RRBs:  
<http://bit.ly/2EKfvZ>



# MEDICAL ASSOCIATION CAMPAIGN TO ABOLISH NUCLEAR WEAPONS WINS NOBEL PEACE PRIZE

By Amanda J Ruler

The International Campaign to Abolish Nuclear Weapons (ICAN), founded by the Medical Association for Prevention of War (MAPW) in Melbourne 2006, was recently awarded the Nobel Peace Prize for 2017 following its successful campaign for the landmark Treaty on the Prohibition of Nuclear Weapons (TPNW). The Treaty was adopted on 7 July 2017 by 122 countries at the UN.



The aim of establishing ICAN was to specifically focus attention on the prevention of nuclear war through the complete abolition of nuclear weapons.

This Treaty prohibits the development, testing, production, possession, stockpiling, use or threatened use of nuclear weapons.

Nurses, doctors and public health professionals around the world (represented by the International Council of Nurses, the International Physicians for the Prevention of Nuclear War, the World Medical Association, and the World Federation of Public Health Associations) have welcomed the Treaty as a significant step forward towards the elimination of these weapons that pose risk of nuclear war and the destruction to humanity.

Australian health workers in particular have a lot to be proud of, with ICAN being founded in Australia by a concerned medical community.

Nuclear weapons are indiscriminately and catastrophically destructive. Their production of ionising radiation kills people from radiation sickness, while radioactive contamination of the environment causes cancers, chronic diseases, birth defects and genetic damage.

There are no winners in a nuclear war. A nuclear exchange will eradicate the physical and social infrastructure required for recovery from conflict, making a meaningful humanitarian response to aid the immediate survivors impossible.

Nuclear weapon detonations in cities would likely have extreme impacts on climate, with widespread disruption of agricultural productivity.

It has been estimated that detonation of less than 1% of the 15,000 nuclear weapons in the world today would cause a massive and widespread famine, putting two billion people around the world at risk of starvation.

There would also be a high likelihood of a refugee crisis with the potential of millions of people being displaced.

The dangers posed by nuclear weapons are unacceptable. These weapons must be prohibited and completely eliminated. More countries must be persuaded by their citizens to sign onto and support the newly concluded Treaty on the Prohibition of Nuclear Weapons.

The massive and expensive nuclear rearmament programs underway in nuclear armed states are recklessly endangering our collective security. The Treaty, represents a new and explicit legal, moral and political norm, comparable to the treaty prohibitions that already apply to chemical and biological weapons, antipersonnel landmines and cluster munitions. It closes a legal gap and makes it unequivocal that no state has a legitimate claim to possess, build, test, deploy, use or threaten to use nuclear weapons.

A minority of countries, especially the nuclear armed states and US allies, including Australia, object to a ban treaty because they

believe that nuclear weapons make them more secure.

However these weapons are the greatest threat to the security of all people, including those nations that possess them. All governments must show the courage and determination that smaller, non nuclear states have demonstrated and act on behalf of the future of humanity and the people they purport to represent.

With the Nobel Peace Prize being awarded last year to an Australian initiative, ICAN, that was founded by health professionals, it is only fitting that Australian health professionals continue to campaign for the Australian government to support the TPNW. Eliminating nuclear weapons is of the highest priority if life as we know it is to survive. As nurses, we must not fail to act and support this agenda.

Please see Medical Association for Prevention of War at [www.mapw.org.au](http://www.mapw.org.au) and ICAN at [www.icanw.org.au/](http://www.icanw.org.au/) to support our campaign or email [amanda.ruler@mapw.org.au](mailto:amanda.ruler@mapw.org.au)

**Amanda J Ruler is a RN with BA(Hons), Grad Dip Gerontological Nursing, PhD and is SA Branch Coordinator and National Vice President, Medical Association for Prevention of War**

## MIDWIVES SAFELY SELECT FOR WATER BIRTH

Midwives are choosing the appropriate women to labour and birth in water, Western Australian research shows.

The Curtin University and King Edward Memorial Hospital research found 80% of WA women who planned to give birth in water experienced a normal, uncomplicated vaginal birth.

A total of 502 women at WA's sole tertiary public maternity hospital, King Edward Memorial Hospital (KEMH) were surveyed between July 2015 and June 2016. Of the 303 women who went on to labour in water, 59% birthed in water and 41% did not.

Lead author Dr Lucy Lewis, who has a joint appointment at Curtin's School of Nursing, Midwifery and Paramedicine and KEMH, said not all women who set out to labour and/or birth in water achieved their aim.

"The main reason women who used water for their labour and did not end up having a water birth was the fact they experienced an obstetric complication. This suggests the midwives at KEMH are following water birth guidelines by responding appropriately in the event a



complication arises during labour."

The research, published in *Australian and New Zealand Journal of Obstetrics and Gynaecology* found that women who were identified and approved to undertake labour in water were less likely to be transferred to KEMH's main birth suite.

"This suggested the labour had fewer or no complications, and they were more likely to have a normal or spontaneous water birth," Dr Lewis said.

The finding was supported by the

low caesarean rate among the cohort of women surveyed.

"Given the international concern surrounding the rising caesarean birth rate, our most encouraging finding relates to the small number of women who experienced caesarean birth – just 6%," Dr Lewis said.

The study recommended the collection of water birthing data across Australia to help inform women; and establishment of a national body to collect and publish water birth data.

## BETTER STROKE REHABILITATION FOR ABORIGINAL PEOPLE

New research is aiming to help Aboriginal people rehabilitate with better quality of life after stroke.

A Stroke Foundation research grant will assess implementation of Australia's first large trial aimed to improve rehabilitation services and quality of life for Aboriginal people affected by stroke and traumatic brain injury.

Project Leader, University of Western Australia Senior Research Fellow Dr Judith Katzenellenbogen said the funding had the potential to strengthen the rehabilitation trial by "fine-tuning" how it is applied, promoted and measured. Health programs often suffered from implementation failure, she said.

"This is particularly true in Aboriginal health where factors like patient recruitment, staffing, training, cultural knowledge, vast distances and rigid systems can cause road blocks."

Stroke Foundation WA State Manager Jonine Collins said Aboriginal people were over represented in stroke statistics.

"They are twice as likely to be hospitalised with a stroke and 1.4 times as likely to die from a stroke, than non-Indigenous Australians. Too many people are dying or being left with an ongoing disability as a result of stroke."

## WHOOPING COUGH VACCINATION VITAL IN PREGNANCY

New baseline research confirms the importance of pertussis vaccination during the third trimester of pregnancy.

The Queensland research by the Menzies School of Health Research was recently published in prestigious Cambridge University press *Epidemiology & Infection Journal*.

Queensland was the first state in Australia to recommend and fund pertussis vaccination in pregnancy in 2014. The vaccination is now funded by every state and territory. The research assessed 53,901 cases of pertussis from 1997 to 2014 – prior to introduction of the vaccination pregnancy program in QLD in 2014; followed nationally in 2015.

The high disease burden both in early infancy and among women of childbearing age suggested both groups would benefit from a maternal pertussis vaccination program, lead author, Menzies researcher, Lisa McHugh said.

"From 1997 to 2014 we found notifications were highest in infants younger than four months of age and the highest annual notification rates in infants younger than one month of age.

"We found that among Aboriginal and Torres Strait Islander infants younger than one month of age, this rate almost doubled. Six infant deaths were identified, all younger than two months of age."

The control of pertussis was a high public health priority, in particular prevention of severe disease in infancy, Ms McHugh said.



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Anne Dabrow Woods,  
DNP, RN, CRNP, ANP-BC, AGACNP-BC, FAAN  
Chief Nurse of Wolters Kluwer,  
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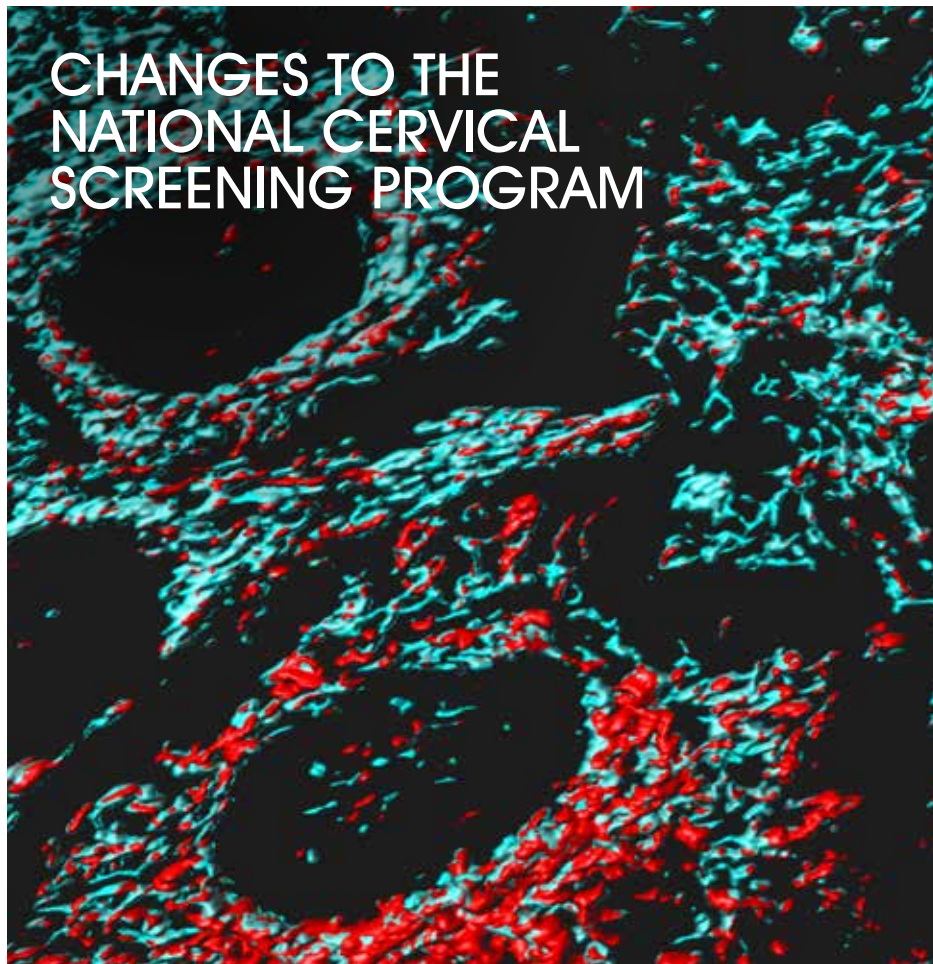


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# CHANGES TO THE NATIONAL CERVICAL SCREENING PROGRAM



Australia has established a new cervical screening process based on recommendations by Australia's independent Medical Services Advisory Committee (MSAC).

The new Cervical Screening Test has replaced the existing Pap test. MSAC recommended that the new screening test will be conducted every five years instead of every two for people aged 25 to 74 years.

This clinical update provides information on the changes to the National Cervical Screening Program (NCSP) for healthcare providers from 1 December 2017.

## From 1 December 2017

A five yearly Cervical Screening Test will replace the two yearly Pap test.

- Women who are already having Pap tests should have their first Cervical Screening Test when they are next due for a Pap test (this is usually two years after their most recent Pap test for those women with a normal screening history)
- Women who have ever been sexually active should have a Cervical Screening Test every five years
- Women will be invited to start cervical screening from the age of 25 and continue screening until they are 74 years
- Women should have an exit test between 70 and 74 years of age
- Women who have been vaccinated

against human papillomavirus (HPV) need to have regular cervical screening as the vaccine protects against some high-risk types of HPV, but does not protect against all oncogenic types

- Healthcare providers will still perform a vaginal speculum examination and take a cervical sample, but the sample medium is liquid-based for partial HPV genotyping
- The new Cervical Screening Test will be supported by a new National Cancer Screening Register that will send invitations and reminder letters to women when they are next due, and follow up letters when women have not attended further investigations or tests

## The link between HPV and cervical cancer

Nearly all cervical cancers are caused by a HPV infection. HPV is easily transmitted via skin contact during sexual activity. It is extremely common in men and women who have ever been sexually active, with most people being infected with at least one type of HPV at some point in their life. While HPV infections are normally cleared naturally by the immune system, sometimes they cause cervical cells to become abnormal. The body is usually able to rid itself of HPV and the abnormal cells, but in some cases this doesn't happen and the abnormal cells develop into cervical cancer. The time from HPV infection to cervical cancer is usually 10-15 years.

## What is the new cervical screening test?

The Cervical Screening Test detects infection with human papillomavirus (HPV). Partial genotyping is used to determine the type of HPV into one of two groups: oncogenic HPV 16/18 or oncogenic HPV types other than 16/18 as a pooled result.

Reflex liquid-based cytology (LBC) is applied to all HPV positive samples and is used to triage women who test HPV positive for types other than 16/18.

## Based on the test result

- **women who test negative for HPV** will be invited to screen again in five years (low risk)
- **women who test positive for high-risk HPV (types 16 and/or 18)** are referred to colposcopy regardless of their reflex LBC result (**higher risk**)
- **women who test positive for other types of HPV**, the reflex LBC result is used to determine management as follows:
  - a possible or definite high-grade squamous intraepithelial lesion (HSIL) and/or any possible or definite glandular abnormality will be referred to colposcopy (**higher risk**)
  - negative cytology or a possible or definite low-grade intraepithelial lesion (LSIL) will be referred for a repeat Cervical Screening Test in 12 months (**intermediate risk**)

## Why are the changes taking place?

Between 2012 and 2014, MSAC assessed an extensive range of clinical evidence and modelling of potential screening pathways. MSAC made a recommendation for the new Cervical Screening Test and pathway.

## The New Cervical Screening Test and pathway

- The new Cervical Screening Test every five years is more effective than and just as safe as, a Pap test every two years
- The new Cervical Screening Test and pathway is a risk-based approach to management of women participating in the program. Women are managed according to their risk of developing cervical cancer which is determined by the Cervical Screening Test results
- HPV testing for cervical screening is more sensitive than cytology (Pap tests) and detects the potential for progression to high-grade lesions earlier, thus preventing more cervical cancers
- The Cervical Screening Test detects infection with human papillomavirus (HPV). Partial genotyping is used to determine the type of HPV into two groups: oncogenic HPV 16/18 or oncogenic HPV types other than 16/18 as a pooled result
- If HPV is detected the laboratory will automatically, on the same sample, conduct a cytology test to determine if any cervical cell abnormalities are present. This assists in determining

the person's risk rating and triaging for colposcopy.

### Cause of cervical cancer

Cervical cancer is a rare outcome of persistent infection with high-risk HPV types. Infection with a high-risk HPV type is necessary, although not sufficient, for the development of cervical cancer. HPV types 16, 18 and 45 are most predominantly associated with cervical cancer, with types 16 and 18 detected in 70–80% of cases in Australia.

The time from HPV infection to cervical cancer is usually 10–15 years.

### What do I say to women who ask about cervical cancer not caused by HPV?

More than 99% of cervical cancers are caused by HPV, which includes squamous cell and adenocarcinoma. A third type of cervical cancer is called neuroendocrine or small cell cervical cancer. These are often more aggressive, but account for less than 1% of cervical cancers. Neither the Pap test nor the new Cervical Screening Test effectively detects neuroendocrine cancers.

### Cervical Screening Test

HPV testing for cervical screening is more sensitive than cytology (ie. Pap tests) and detects the potential for progression to high-grade lesions earlier, thus preventing more cervical cancers.

Screening using HPV testing also has the potential to improve detection of adenocarcinoma and its precursors.

While self-collection of samples is possible in some circumstances, it is not recommended for routine screening, as it is not as effective as clinician-collected screening.

### How should women transition to the new screening pathway?

Most women will be due for their first Cervical Screening Test two years after their last negative Pap test. Women who are undergoing follow-up investigation or treatment should transition to the new screening pathway as outlined in the 2016 Guidelines found at [www.cancer.org.au](http://www.cancer.org.au)

Women under 25 years of age will be invited at 25 years of age for their first Cervical Screening Test.

### How do I explain why women who have had the HPV vaccine still require cervical screening?

HPV types 16 and 18 cause more than 70% of cervical cancers in Australia. The HPV vaccine protects against both these types; however, it does not protect against other oncogenic types of HPV known to cause cervical cancer. Therefore, vaccinated women are still at risk of cervical cancer from these other high risk HPV types and need to participate in regular cervical screening.

### Screening interval

Due to the high negative predictive value of HPV testing, a screening interval of five

years is safe for women who are HPV-negative.

### What do I say to women who want to screen more often than every five years?

The Cervical Screening Test is more effective at preventing cervical cancers than the Pap test. Cervical cancer usually takes 10 to 15 years to develop from an HPV infection, so it is very unlikely that cancer will develop in the five years following a negative Cervical Screening Test. Studies have shown that the chance of developing high-grade cervical abnormalities after a negative Cervical Screening Test is lower than the chance of developing them after a negative Pap test.

### Age range

Because Australia has an effective national vaccine program, the prevalence of HPV in young people 18–24 is very low.

Cervical cancer in young women (under 25 years of age) is rare, and screening has not changed the rates of incidence or mortality from cervical cancer in this age group. Commencing screening at age 25 will reduce the investigation and treatment of common cervical abnormalities that would usually resolve by themselves in women under the age of 25. In addition, the HPV vaccine has been shown to reduce cervical abnormalities in young women.

Sending an invitation for women to have a final HPV test between the ages of 70–74 years, rather than 64–69 years, is expected to reduce the incidence of cervical cancer by 4%, and mortality from cervical cancer by 7%.

Women of any age with symptoms, such as unusual bleeding or spotting, will be able to have a Cervical Screening Test.

### What do I say to women who are nervous about waiting until 25 to screen?

Screening women younger than 25 years has not reduced the number of cervical cancer cases, or deaths from cervical cancers, in this age group. Cervical cancer is rare in women younger than 25 years.

While HPV infection and cervical abnormalities are common in women younger than 25, both usually clear up without needing treatment. Treatment of these common abnormalities can increase the risk of pregnancy complications later in life.

### What if I'm concerned that a woman is engaged in sexual activity at a very young age?

For women who experienced their first sexual activity at a young age (before age 14) and had not received the HPV vaccine before this, a single Cervical Screening Test between the ages of 20–24 years could be considered on an individual basis.

### How will women know when they are due for their Cervical Screening Test?

The new National Cancer Screening Register (NCSR) will provide an invitation,

## KEY MESSAGES

Cervical screening is largely preventable through regular screening

From 1 December 2017, the Pap test will be replaced by a new cervical screening test

The new test is more effective because it detects the human papillomavirus (HPV)

The new cervical screening test is expected to protect up to 30% more women from cervical cancer

Women who have received the HPV vaccine still need to be regularly screened as the vaccine does not protect against all types of HPV infection known to cause cervical cancer

reminder and recall system to prompt women to book an appointment, supporting and promoting timely participation in cervical screening.

### The new National Cancer Screening Register (NCSR)

The NCSR will be a national database of cancer screening records, including Cervical Screening Test results.

Data collected by the NCSR is protected by legislation and cannot be used for purposes other than to support the operations of the cervical screening program, inform ethics-approved research projects, and report on outcomes at a population level.

### How will the NCSR support the NCSP?

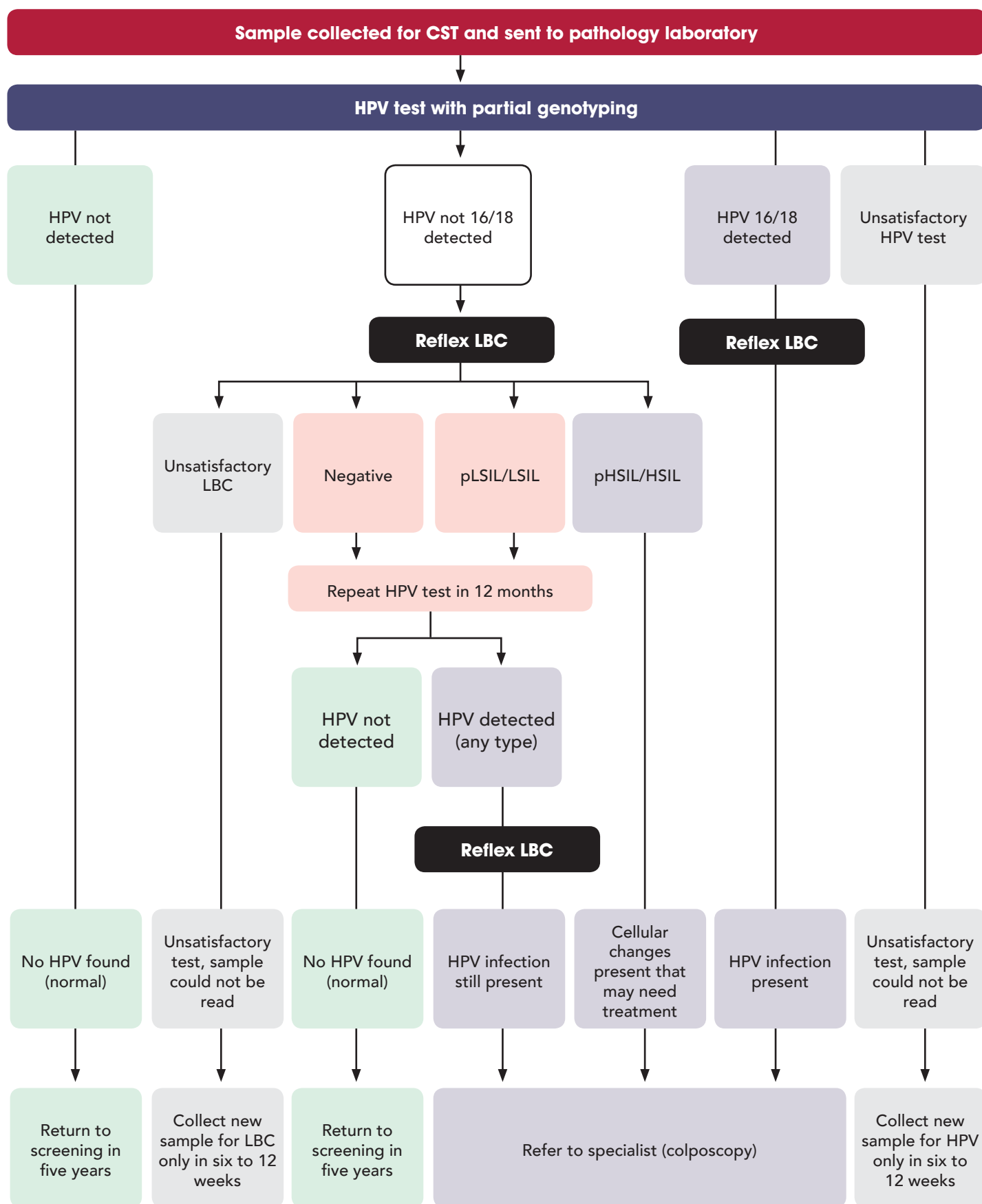
The NCSR will support the NCSP by:

- inviting women to commence screening when they turn 25 years
- reminding women when they are due and overdue for cervical screening
- providing a woman's cervical screening history to laboratories for comparison with current results
- providing a 'safety net' for women who have positive test results and who have not attended further testing, by prompting them to have follow-up tests

### What do the changes mean for healthcare providers?

#### Patient reminder and recall systems

Healthcare providers will need to update their practice patient reminder and recall systems in line with the new pathways and screening intervals.



Definitions CST – Cervical Screening Test

HPV – Human papillomavirus

LSIL – low grade squamous intraepithelial lesion

HSIL – high grade squamous intraepithelial lesion

LBC – liquid based cytology

Diagram adapted from Cervical Screening Guidelines 2016



### Changes to the Cervical Screening Test

Healthcare providers will still perform an examination using a vaginal speculum and take a sample, but the sample medium is liquid-based and will be tested for the presence of HPV. For the participant, if they have ever had a Pap test before, the way the test is done will feel the same.

For patients that may have refused to screen, an alternate method of collection is available but patients must meet the eligibility criteria; be over 30 years of age and be overdue for their screening test by two years or more.

### Changes to MBS items

The Pap test is no longer covered under the Medicare Benefits Scheme (MBS) and will be replaced with the new Cervical and Vaginal Testing and accompanying MBS item numbers. Healthcare providers will need to know the differences between the MBS items and provide as much information on the pathology request form as possible. This will avoid the wrong pathology test being performed on the sample and may result in the patient being charged incorrectly for a test.

Healthcare providers should not write Pap test or smear on the pathology request form, otherwise their patient will be charged. To assist with completing the pathology request please refer to the *Pathology test guide for Cervical and Vaginal testing* available on the Australian Department of Health website.

### How can I get across the changes?

#### The new screening pathway

The new Cervical Screening Test and pathway is a risk-based approach to the management of HPV and cervical cancer, as recommended by the MSAC. Patients are managed according to their risk of developing significant cervical abnormalities within the next five years, which is determined by their Cervical Screening Test result.

The new Cervical Screening Test is more accurate than cytology alone (ie. Pap tests) as it detects the presence of HPV and the potential for progression to high-grade lesions earlier, thus preventing more cervical cancers. Screening using HPV testing has the potential to improve detection of adenocarcinoma and its precursors.

For clinician collected specimens, reflex LBC can be performed on the same cervical specimen (without requiring an additional request) and the pathology lab will issue the HPV test result, LBC test result and overall screening risk rating as a combined report. Self-collection of a vaginal sample can only be tested for HPV. A new pathology request will be required for the clinician collected specimen for reflex LBC testing only. The pathology lab will then issue a combined report with the initial self-collect HPV test, LBC test result and overall screening risk rating as a combined report.

If any glandular abnormalities are detected on a screening test, healthcare providers should follow up according to the

2016 Guidelines.

There are four result categories:

- Return to screen in five years
- Repeat the HPV test in 12 months
- Refer to a specialist
- Unsatisfactory sample (HPV or LBC) retest within 6-12 weeks

#### Return to screen in five years

This result means oncogenic HPV was not detected. Patients with this result will be invited to screen again in five years. These patients are at low risk of developing cervical cancer and can safely return for a Cervical Screening Test in five years.

We cannot assure patients that they are at 'no risk' because they may subsequently acquire an HPV infection or have a latent infection that becomes active.

#### Repeat the HPV test in 12 months

This result means an HPV infection was detected. It is not associated with high-grade cell changes that require treatment.

A reflex LBC conducted on the same sample showed that the patient has negative or possible low-grade squamous intraepithelial lesion (LSIL), or LSIL abnormal cervical cells.

These patients will be invited to return for a repeat HPV test in 12 months. This is to check if the body has cleared the HPV infection.

#### Refer to a specialist

This result means the patient has received one of two possible results:

- **HPV is detected, but not types 16 or 18**

A reflex LBC will be conducted on the same sample. If possible high-grade squamous intraepithelial lesion (HSIL) or HSIL on cytology has been detected, the patient should be recommended to a specialist to have a colposcopic assessment because they are at a higher risk of cervical cancer. A colposcopy will determine if a biopsy is needed and treatment is required.

- **HPV types 16 or 18 have been detected**

HPV types 16 and 18 are associated with approximately 70% of cervical cancers. These HPV types are more likely to progress to cervical cancer than other oncogenic HPV types. Regardless of the reflex LBC test result, the patient should be recommended to have a colposcopic assessment because they are at a higher risk of cervical cancer. The LBC will inform the colposcopic assessment.

#### Unsatisfactory sample (HPV or LBC) retest within 6-12 weeks

This result means the sample collected was unsatisfactory. If the HPV test was unsatisfactory, the patient should return within 6-12 weeks for a repeat HPV test. If the LBC test was unsatisfactory, the patient should return within 6-12 weeks for a repeat LBC test.

The four pathways are shown in the

diagram opposite.

### More information for healthcare providers

#### Healthcare provider information pack

An information pack has been sent to healthcare providers. It contains the essential information about the changes to the National Cervical Screening Program and materials which you can use to explain the changes to your patients.

Alternatively, you can order resources from the publications and resources section of the Australian Department of Health website.

#### Online training modules

Online training modules to help you understand the new test and Clinical Pathways are available on the NPS MedicineWise website. [www.nps.org.au](http://www.nps.org.au)

This training will be recognised as continuing professional development hours with RACGP, ACRRM, ACN, ACM and APNA.

Training covers information about the changes to cervical screening, including:

- The difference between the new Cervical Screening Test and the Pap test
- New results categories and clinical pathways
- Managing people transitioning to the new clinical pathway who have test results and are under clinical management
- Practical advice and videos to help you engage with patients from culturally and linguistically diverse communities and patients with an intellectual disability

The training was developed by the Department of Health and NPS MedicineWise.

#### Resources available for healthcare providers

Guidelines for the management of screen-detected abnormalities, screening in specific populations and investigation of abnormal vaginal bleeding are available on the Cancer Council Australia wiki website: [wiki.cancer.org.au/australia/Guidelines:Cervical\\_cancer/Screening](http://wiki.cancer.org.au/australia/Guidelines:Cervical_cancer/Screening)

#### The Clinical Guidelines for the National Cervical Screening Program

Health providers should regularly check for updates in the 2016 National Cervical Screening Program: *Guidelines for the management of screen-detected abnormalities, screening in specific populations and investigation of abnormal vaginal bleeding*. The latest version is available on the Cancer Wiki platform

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[http://wiki.cancer.org.au/australia/Guidelines:Cervical\\_cancer/Screening](http://wiki.cancer.org.au/australia/Guidelines:Cervical_cancer/Screening)



## 'PRESCRIPTION' OF EXERCISE FOR PEOPLE WITH DIABETES

By Rebekkah Middleton

Physical activity is vital in providing positive health improvements in people with diabetes. Balducci et al. (2014 p13) states however, that medical officers and/or general practitioners rarely prescribe exercise as a 'therapy' for people with diabetes.

Given that pharmacological and dietary interventions are regularly prescribed as tailored aspects of care and treatment for people with diabetes, so too, a physical activity program could be prescribed. Schneider et al. (2014) advocate that general practitioners need to be capitalising on the interactions they have with patients as opportunities to encourage engagement in physical activity programs.

Grandes et al. (2011) conducted research with general practitioners where exercise was prescribed by practitioners for people they assessed as not meeting the minimum physical activity

recommendations.

Over four years, the research team found significant differences in engagement in exercise for those for whom it was 'prescribed'. They concluded that general practitioners have capacity and influence to increase the level of physical activity among their patients.

These studies highlight that 'prescription' of exercise by general practitioners could be particularly beneficial given that exercise has been shown to have the greatest impact on glycaemic control, along with benefits to blood pressure and cardiovascular risk (Nicolucci et al. 2012).


Balducci et al. (2014) assert that exercise programs are also not likely to lead to adverse medication effects, which pharmacological interventions could, and hence could be potentially more cost effective than drug interventions.

In a person-centred approach however, 'prescription' of exercise alone may not be the best approach for the person with diabetes. Particularly when considering long term engagement and maintenance of exercise behaviours. Exercise should only be 'prescribed' in conjunction with the person's values

and goals (Ryan et al. 2008).

This then promotes intrinsic or autonomous motivation where the individual engages in the behaviour(s) and action(s) because they are important to them (Ryan et al. 2008). Autonomous motivation is exemplified when a person with diabetes exercises because they value being healthy. Autonomous self-determined exercise and healthy eating motivation leads to more positive outcomes, such as improved diabetes self-management. Exercise is more likely to be sustained when motivation for exercise and healthy eating are intrinsic (eg. enjoyment), rather than extrinsic (eg. general practitioner advice) (Tulloch et al. 2013).

'Prescription' of exercise may be beneficial then as an adjunct to working with people individually and co-designing interventions that will enhance and encourage their behaviour(s) and action(s) to ensure exercise and lifestyle choices are enjoyable and consistent with what is important to them.

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## GENERAL PRACTICE NURSES AND MENTAL HEALTHCARE: ARTICULATING THEIR ROLE

By Lorna Moxham, Liz Halcomb, Susan McInnes and Christopher Patterson

Primary healthcare is the frontline of Australia's healthcare system, encompassing a large range of providers and services across the public, private and non-government sectors with services including health promotion, prevention and screening, early intervention, treatment and management (Department of Health 2018).

Within primary care, general practice nurses (GPNs) are recognised as one of the fastest growing health workforces in Australia (APNA 2014).

In 2016, the number of GPNs working in Australian general practice rose to 13,240 and 84.7% of General Practitioners (GPs) now report working with a GPN (Britt et al. 2016).

This has largely been driven by workforce demands brought about by an ageing population who have increasing healthcare needs, and the growing prevalence of

enduring conditions that are now largely treated in the community (Commonwealth of Australia 2010) with GPNs at the forefront of care. This care includes the provision of nursing practice to people who have a mental illness.

In 1996 the federal government recognised the importance of psychological wellbeing of Australians and declared mental health to be an Australian national health priority area. It is now considered that 1:4 Australians will have a mental health issue in their lifetime and with the increasing number of people requiring treatment for mental illness, costs associated with the provision of mental health related services has concomitantly increased.

While GPNs have a long history in the management and screening of physical health conditions, their role in recognising and managing mental illness is less well established (Halcomb et al. 2008). This is despite the National Mental Health Policy (2008) recognising that primary care is the linchpin in the delivery of mental healthcare. Currently, there is a disproportionate focus on the care and management of severe mental illness requiring the intervention of mental health nurses and nurse practitioners, rather than mild to moderate mental health conditions that comprise the largest burden of illness likely to be seen by GPNs.


Providing a prepared and competent GPN workforce with the skills to deliver a consumer centred approach to the planning and delivery of mental health services is integral to mental health recovery. This approach will help ensure that tailored primary mental healthcare services are provided in the community at the right time by the

most appropriate health professional for people presenting with a spectrum of mental illness.

Primary care and mental health nurse researchers from the University of Wollongong are currently undertaking a project, funded by the Australian College of Mental Health Nurses, to identify the role of general practice nurses in mental healthcare and develop a document to define GPNs practice in this area.

Phase 1 of the project consists of a comprehensive examination and contextual analysis of national and international literature that includes an overview of the history and evolution of primary care nursing and the current trends and issues which impact on primary care nurses in relation to mental health. Phase 2 will use an action research approach inclusive of stakeholder consultation, with the aim to improve the quality of mental healthcare by optimising GPN mental health activities. Such role development has the potential to improve the quality of mental healthcare in general practice and enhance mental health outcomes.

The team of interdisciplinary nurse authors are looking forward to completing the project and disseminating the outcomes. Watch this space!

 **Professor Lorna Moxham is Professor of Mental Health Nursing; Professor Elizabeth Halcomb is Professor of Primary Health Care Nursing, Dr Susan McInnes is Lecturer in Primary Health Care Nursing and Christopher Patterson is Lecturer in Mental Health Nursing. All are in the School of Nursing, Faculty of Science, Medicine and Health at the University of Wollongong in NSW**



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## GRASSROOTS NURSING IN THE TOP END DELIVERING CARE TO ABORIGINAL WOMEN AND CHILDREN

In her native New Zealand, Registered Nurse Anna Curtin (pictured) worked across a variety of settings including aged care and an acute surgical ward.

In 2016, on the hunt for a new challenge, Anna decided to take the plunge and move to Australia in search of fresh opportunities.

She had already gained accreditation with Remote Area Health Corps (RAHC), an Australian Government funded program that actively recruits urban-based health professionals to boost limited primary healthcare services across remote Indigenous Northern Territory communities.

Anna's first call-up as part of RAHC saw her head to Tennant Creek in March 2016.

"I had to Google Tennant Creek because I hadn't heard of it before,"

she recalls.

"The staff at RAHC had said it was a nice place to go for the first time; it's a big clinic and not incredibly remote."

Tennant Creek is the fifth largest town in the NT and situated about 1,000 kilometres south of Darwin.

It boasts a stunning landscape and half of its population identifies as Indigenous.

"My first impression getting off the plane was it's very hot and this adventure is really about to begin," Anna says.

"I felt really excited. I felt I had made a good decision and I was keen to have a look around and understand where I was. It's obviously very different to Christchurch. It was a bit confronting."

The demands of the role included wound care, chronic disease care, children's health, women's health, renal treatment and health promotion, and even dealing with a meningococcal outbreak.

"You need to build trust and gain rapport," says Anna.

"People are very interested to know what your story is your background. It's how they work out if they trust you or not."

Anna says the clinical and educational opportunities afforded her were unique and valuable.

"It's an honour working with and learning about another culture. It blows you away. It's very special."

Following her initial short-term placement, Anna took on a full-time position focused on women's health and delivering care to the Aboriginal



women and children of Tennant Creek.

She reveals witnessing a variety of problematic issues, including many young women battling drug and alcohol issues, but says with support change can occur and that some have undergone rehab and come out the other side to find employment and turn their lives around.

"One thing I really like, that I'm really passionate about is educating and empowering women."

"There's lots of domestic violence and sexual violence. It's important to educate women that this isn't normal and shouldn't occur."

After working in the community for almost two years, Anna says she remains alarmed by the ongoing health disparities between Aboriginal and Torres Strait Islander and non-Indigenous Australians.

"I understand the issues are multi-faceted, but it's very confronting. I was blown away when I first got here that there are people younger than me who have heart failure, or are on dialysis and waiting for transplants."

"It's not good enough and I hope to see and be a part of the change during my time here."

Anna says moving to Australia reignited her nursing career and she hasn't looked back.

"I enjoy the country life and fun that comes with it. There's nothing more amazing than the desert sky, day or night."

"It's amazing just how much there is to be involved in; sports, arts, culture and community."

Anna, who credits her initial short-term placement through RAHC with giving her an insight into Tennant Creek's issues and challenges, encouraged health professionals looking for a change to give it a try.

"Just do it, live your life, enjoy new challenges and adventures. Prepare to be challenged clinically, learn a lot about yourself and make some unforgettable memories along the way."

For more information on Remote Area Health Corps (RAHC) visit:

[www.rahc.com.au](http://www.rahc.com.au)

# GENERAL PRACTICE NURSE PERCEPTIONS OF THEIR COMMUNICATION ON LIFESTYLE RISK

By Sharon James, Elizabeth Halcomb, Jane Desborough and Sue McInnes

Lifestyle risk factors from behaviours such as smoking, poor nutrition, harmful alcohol intake, inadequate physical activity and being obese or overweight are modifiable, but responsible for 80% of preventable mortalities and at least 31% of the chronic disease burden (Australian Institute of Health and Welfare 2016).

Within general practice, patient demand and general practice nurse (GPN) involvement in chronic disease management is increasing (Dennis et al. 2008). To assist patients in managing lifestyle risk factors, behaviour change communication, such as motivational interviewing, is known to be effective, (Noordman et al. 2012), however, little is known about nurses' views and communication regarding lifestyle risk factors.

Sharon James is currently undertaking a PhD Project, under the supervision of Professor Liz Halcomb, Dr Susan McInnes and Dr Jane Desborough in the School of Nursing at the University of Wollongong to explore this issue. This project aims to investigate the perceptions of lifestyle risk communication by GPNs in the South East New South Wales and Australian Capital Territory primary health networks. The research methods being used are innovative in that they

are combining video observation of in-practice consultations and semi-structured interviews. Video recording of approximately three GPN-patient consultations is undertaken using small cameras, each facing the nurse and patient. These cameras are generally mounted on or near the computer monitor. Ms James' experience as a GPN has informed the conceptualisation of the study.

At the time of writing 10 GPNs have video recorded 29 consultations and also participated in semi-structured interviews.


It is through understanding GPN communication regarding lifestyle risk factors that patient outcomes and service delivery can be improved. It is envisaged that study outcomes will also assist in the development of nurse education, policy and clinical practice.


The project is still recruiting nurses across South East New South Wales and Canberra and we would love to

hear from any GPNs in these areas who would like to be involved.

Ms James can be contacted on [sjames@uow.edu.au](mailto:sjames@uow.edu.au)

 **Sharon James is Lecturer and PhD Candidate**

 **Professor Elizabeth Halcomb is Professor of Primary Health Care Nursing**

 **Sue McInnes is a Lecturer / PhD Candidate.**

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 **Dr Jane Desborough is Post Doctoral Fellow in the Department of Health Services Research and Policy, Research School of Population Health, College of Medicine, Biology and the Environment at the Australian National University**



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## FREE FLU JABS FOR NSW KIDS THIS YEAR

Children in NSW will be eligible for free flu jabs from April, following last year's horror flu season.

The NSW government announced in January, investment of \$3.5 million for an influenza vaccination program for children between six months and five years.

It followed a similar announcement by the Queensland government late last year.

Last year's flu season was the most severe in NSW since the 2009 pandemic, with more than 12,000

confirmed cases in children under five.

"NSW, like the rest of the country, was subjected to a horror flu season last year. The program will target more than 400,000 children and ensure better protection for them and the wider community," NSW Premier Gladys Berejiklian said.

The vaccine will cover four strains of influenza virus – two A strains and two B strains – likely to be circulating this winter.

Children who have never had a flu vaccination will need two doses, one month apart.

Vaccines will be available from community health centres, Aboriginal Medical Services and their GP.

NSW Minister for Health Brad Hazzard said NSW childhood vaccination rates increased by 6.3% since 2010 to 93.9% in 2017.

The Royal Australian College of General Practitioners (RACGP) welcomed the NSW government's announcement for children but called for further commitment.

"Ideally, every Australian will have access to a free influenza vaccination in the lead up to this year's flu season," RACGP President Dr Bastian Seidel said.

A government-subsidised flu vaccination program would cost far less than the economic losses from the 3,000 deaths a year, mounting hospital and health bills, and lost productivity, Dr Seidel said.

"We are seeing the same story over and over again – on average, 3,000 deaths a year, 18,000 hospital admissions and 350,000 Australians affected by the flu."



## IMPROVING BLOOD PRESSURE CONTROL IN PRIMARY CARE: THE IMPRESS STUDY

By Catherine Stephen

Hypertension effects over one third of all Australian adults (National Heart Foundation of Australia 2016). While effective treatment is available, up to 60% of those living with hypertension struggle

to keep their blood pressure under control and are at increased risk of renal failure, cardiovascular disease and premature death (Cadilhac et al. 2012; Australian Institute of Health and Welfare 2015).

Given that many of these individuals seek help within General Practice, nurses in this setting have a key role to play in supporting self-management and lifestyle risk factor reduction.

The ImPress study seeks to build on our previous pilot study (Zwar et al. 2017; Stephen et al. 2017) and test the impact of an innovative general practice nurse (GPN)-delivered intervention for patients with uncontrolled hypertension. The Clinical Audit Tool (CAT) will be used to identify patients who are at high risk of cardiovascular disease (National Vascular Disease Prevention Alliance 2012) and whose blood pressure is uncontrolled. These patients will be offered six face to face consultations and telephone support with the GPN over six months. During these consultations GPNs work in partnership with the patient and GP to provide tailored lifestyle advice, action planning, health monitoring and motivational counselling. Participants will also have GP input to optimise their medication in line with best practice. The primary outcome measure will be blood pressure and secondary outcomes will include lifestyle risk factors such as smoking, nutrition, body mass index and medication adherence.


This randomised controlled trial will be undertaken by Ms Catherine Stephen in her doctoral program at the University of Wollongong,

School of Nursing. The research will be supervised by Professor Elizabeth Halcomb, Professor Nicholas Zwar and Dr Sue McInnes. We are currently recruiting 20 general practices who employ a registered nurse across Central Sydney and South Western Sydney Primary Health Networks. Once recruited practices will be randomised to either the intervention or the control group.

The ImPress intervention not only enhances the nurses' role within general practice to the top of their scope, but also has the potential to improve health outcomes for individuals with hypertension. Results from this study will provide important evidence about the impact of a nurse-delivered intervention on health outcomes in those with uncontrolled hypertension. This has the potential to change the way hypertension care is organised and delivered within Australian General Practice.

### Further Details

The ImPress study has been approved by the UOW Human Research Ethics Committee. If you would like any further information or details on how you can participate contact Catherine via email at: [cms793@uowmail.edu.au](mailto:cms793@uowmail.edu.au)

 **Catherine Stephen is a PhD Candidate in the School of Nursing at the University of Wollongong NSW**

  
IMPROVING BLOOD PRESSURE



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## THE REAL COST OF SUGAR

The Public Health Association of Australia (PHAA) is advocating for a health levy on sugar sweetened beverages as a way to influence consumer purchasing behaviour away from unhealthy drinks.

"There is much more awareness now of the damage which sugary drinks inflict on consumers' health, such as the direct correlation with obesity and the development of Type 2 Diabetes. While there has been an attempt at the message of consuming these discretionary foods and beverages in moderation, it has been ineffective in significantly reducing excessive consumption of sugary drinks," PHAA's CEO Michael Moore said.

Mr Moore said 26 other countries had already implemented a health levy on sugary drinks. "A similar approach would be a substantial step forward for Australia to tackle soaring rates of obesity and associated non-communicable diseases."

In a response to the 2017 National Health Budget in May last year, the PHAA called for an increase in prevention funding, which currently sits at 1.5% of overall health expenditure.

"There is an estimation that a price increase on sugar-sweetened beverages in Australia would generate more than \$500 million a year. If this was targeted directly toward prevention health measures aimed at improving nutrition and physical activity levels among Australians, it would save lives," Mr Moore said.

## A TRANSITION TO PRACTICE PILOT PROGRAM FOR NURSES IN PRIMARY HEALTHCARE

By Lisa Collison

Australia's health system faces significant challenges due to the growing burden of an ageing population, workforce pressures, chronic disease, and unacceptable inequities in health outcomes and access to services (National Primary Health Care Strategy 2013).



This increased demand for healthcare services sees a growing need for a knowledgeable and skilled primary healthcare nursing workforce within the multidisciplinary team, who are enabled to work to their fullest capacity and better

contribute to positive patient outcomes.

Recruitment and retention of nurses in the primary healthcare workforce will play an increasingly important role in ensuring our healthcare system can meet the complexities of ever increasing demands. Analysis conducted by (the now defunct) Health Workforce Australia projected a shortfall in the 'other nursing sector' workforce (which includes primary healthcare nurses working in general practice) of 27,000 by 2025; one of the highest shortfalls of any nursing sector (HWA 2014).

With this in mind, innovative strategies are needed to address recruitment and retention issues in the primary healthcare nursing workforce to ensure our communities continue to receive high quality care from a well supported and engaged nursing workforce. Transition to practice programs are one strategy for promoting recruitment and retention if appropriate support frameworks are provided.

Over the last two years, the Australian Primary Health Care Nurses Association (APNA) has developed, tested and is modelling an accessible, flexible and structured process to increase the confidence, skills and knowledge of nurses commencing work in primary healthcare settings, with funding from the Australian Government Department of Health under the Nursing in Primary Health Care Program. The anticipated outcome of the program is to improve employment opportunities, recruitment and retention of nurses in primary healthcare settings.

APNA's Transition to Practice Pilot Program has been developed as a 12 month workplace-based program to facilitate transition into practice and involves assessment of knowledge and skills, tailored formal education and both professional and clinical guidance. The Program is being delivered in two tranches over two years within two cohorts – nurses recently graduated from Australian universities, and experienced nurses from other healthcare settings who are seeking to successfully integrate into primary healthcare work environments.

Tranche two of the Transition to Practice Pilot Program commenced in April 2017 and includes 27 recently graduated and experienced nurses transitioning into primary healthcare and 20 external clinical and professional nurse mentors who are supporting them.

This tranche will contribute to the evaluation of what influences and contributes to the future development of an effective and confident workforce. Read more about this Program at [www.apna.asn.au/transitiontopractice](http://www.apna.asn.au/transitiontopractice)



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**Lisa Collison is Project Manager, Transition to Practice Pilot Project at Australian Primary Health Care Nurses Association (APNA)**



## HEPATITIS A PROGRAM

A free vaccination program for men who have sex with men (MSM) was recently launched to combat a recent outbreak of hepatitis A in Victoria.

The program, which began in January 2018, will run to 31 December 2018.

The two-dose course of Hepatitis A vaccine is available to MSM in Victoria and people who have injected drugs in the past 12 months.

There have been 27 confirmed cases of hepatitis A in Victoria linked to the outbreak. All cases are male, with many reporting MSM sexual activity and who have not travelled overseas. Some cases are also people who inject drugs.

Hepatitis A is spread through person-to-person transmission, including sexual activity, and is not limited to MSM.

Transmission can occur while sharing injecting equipment such as needles, and through consumption of contaminated water.

Victoria's Deputy Chief Health Officer Dr Brett Sutton said it was important to hand and body wash after sex to help stop the spread of hepatitis A. "Make sure you're using condoms between any sexual activity," he said. "We also advised any confirmed cases with Hepatitis A against engaging in any sexual activity that could increase the spread of the virus.

"Vaccination is safe, effective and provides the best protection against serious diseases. I urge all MSM to get vaccinated without delay."

## EDUCATING ABORIGINAL YOUTH ON HEALTH

A sexual health and life skills program for Aboriginal children in Western Australia has been granted a \$514,654 funding boost by the state government.

The Mooditj program, delivered by state wide Aboriginal Educators, is designed to inform and empower Aboriginal children between 10-14 years about their sexual health, emotions and feelings, goal setting, puberty and sense of personal identity. The grant will be used to expand on the Mooditj program with the trial and evaluation of new modules in social, emotional and mental wellbeing, resilience and respectful relationships.

"This is an interactive program that engages young Aboriginals in ways that are culturally appropriate and creative, using real life scenarios and discussion on serious topics including alcohol and drugs, family and domestic violence and respectful relationships," State Minister for Health Roger Cook said.

## PROMOTING EVIDENCE BASED PRACTICE AND IMPROVING CARE QUALITY FOR COMMUNITY PATIENTS WITH LOWER LEG ULCERS

By Sue Randall, Panagiota (Pat) Avramidis, Naomi James, Alanda Vincent and Rebecca Armstrong

There are times in community nursing when working 'on the front line' can raise questions. This happened with the community wound specialist nurses (WSN) in a metropolitan local health district.



Their concerns were about the number of patients with lower leg ulcers (LLU) and how many of this group of patients was receiving optimal treatment. Data were not easily available, so a university academic suggested completing an audit that aimed to describe the profile of a sample of LLU patients, including prevalence, incidence and diagnosis, influence of geographical

centre to which patients were attached and influence of community WSN involvement in care.

It was hypothesised that gaps in care would be identified. Audits are commonly used in nursing to promote evidence-based care and to improve quality of care (Christina et al. 2016). Additionally, quality improvement and research collaborations of this nature can be beneficial for all parties (Gallagher et al. 2013).

Extracted data, from a snapshot of 25% of LLU patient records (n=62) available in February 2017, was entered into an excel spreadsheet in July 2017. Subsequently data was cleaned and entered into SPSS 24 for analysis. Undertaking a retrospective audit provided evidence to support the concerns of the community WSN. Patients with LLU accounted for 28% of the District Nursing caseload. Care was positively influenced if

patients were seen by a WSN and this increased referrals to vascular specialists. A gap was identified in the process of referral and diagnosis of LLU patients.

Undertaking the audit was time consuming and extracting data from the Electronic Medical Records was cumbersome. However, audits provide a factual platform which offer evidence of what is done effectively and identifies where there are gaps in care provision. Therefore, it is a useful tool to empower clinical nurses who seek change and a robust base for managers to improve quality. The next step, following our audit, is to suggest changes and create new protocols, which should improve equity and access to diagnosis for patients with LLU in line with primary healthcare principles (WHO 2008; 2003; 1978).

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**Rebecca Armstrong is Clinical Nurse Consultant Wound Care at Sydney District Nursing, Redfern Community Health Centre**



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# NATIONAL SCHOOL NURSE STANDARDS FOR PRACTICE

The ANMF invites all nurses who practice in school nurse settings to participate in reviewing the revised draft National School Nurse Standards for Practice.

In 2009 the Victorian School Nurses Special Interest Group of the then Australian Nursing Federation (Victorian Branch) published a set of professional practice standards specifically for nurses working within a school setting. Following a request

from the authors of those Standards, the Australian Nursing and Midwifery Federation (ANMF) Federal Office used the Victorian document as a base for adapting the Standards for national applicability. School nurses from across the country participated in a period of consultation during 2010/11, with the resulting *National School Nursing Professional Practice Standards* being published in 2012.

In 2015 the ANMF began a process of review of the *National School Nursing Professional Practice Standards*. Extensive feedback from school nurses suggested significant change to the national professional standards for contemporary applicability, reflecting the diversity of school nurse roles and settings across the country.

Professional standards developed by different groups within the nursing and midwifery professions sit alongside the mandatory registration

standards issued by the Nursing and Midwifery Board of Australia (NMBA). The NMBA has moved in recent years to use the terminology of 'standards for practice' for all previous competence standards documents, for example, *Registered Nurses Standards for Practice*. The draft revised standards document developed by the ANMF from school nurse feedback has, therefore, been titled *National School Nursing Standards for Practice*.

The ANMF is wanting as many school nurses as possible to review the revised draft National School Nursing Standards for Practice and provide your feedback. A SurveyMonkey questionnaire has been developed to make it easy for you to do this and submit your response – [www.surveymonkey.com/r/schoolnursestandards](http://www.surveymonkey.com/r/schoolnursestandards). Please encourage your school nurse colleagues to complete the survey.

# PROMOTING HEALTH ACROSS THE LIFESPAN: INVOLVING OLDER PEOPLE AS TEACHERS

By Clarissa Hughes,  
Denise Winkler and  
Maree Bernoth

It is estimated by 2020, an additional 250,000 workers will be required in residential aged care and community services across Australia, to care for the growing numbers of older people.

These care workers - including nurses, nursing assistants and support workers – will require initial and continuing education that equips them to promote optimal health for the older person and learn for themselves about how to age well. Older people and health workers need to learn ways to relate to each other with compassion, respect, understanding and in a culturally safe way. This presents an ongoing challenge for nursing education and related fields, but also provides a unique opportunity to involve those with experience of ageing in teaching others about ageing.

A multidisciplinary team from Charles Sturt University is undertaking an innovative project called OPTEACH (Older Persons Teaching and Empowering Aged Care Health Students), funded by a Liveable Communities Grant from the NSW government. The project is developing a suite of resources for teachers, lecturers, administrators, and older people and their carers, to assist them to utilise a participatory approach to planning, delivering or being involved in education sessions. The development of the resources has been informed by indepth interviews with educators, facility managers, and older people living in residential aged care and the community.

The central ethos of the project is valuing the lived experience of older people and empowering them to be 'co-creators' of knowledge by speaking about their struggles and triumphs in their own words (Bernoth & Winkler 2017).

OPTEACH emphasises the need to respect the rights, relevance and unique contribution of older people. All participants are encouraged to reflect on their own assumptions and stereotypes, with the aim of building understanding, tolerance and more inclusive communities.

The OPTEACH resources will be available free of charge and will include printable checklists, document templates, policy examples, video and audio recordings, and other support materials to assist educators in a variety of settings to involve older people in educating the next generation of healthcare professionals. This 'toolkit' will

provide universities, hospitals, TAFE, registered training organisations and residential aged care facilities with practical tips and specific resources for running education sessions that are both engaging for all participants and aligned with the relevant learning outcomes.

The authentic, person-centred approach to learning encouraged by OPTEACH supports students to learn both from and with older people, hear and reflect on real-life stories and situations, and maximise opportunities to ask questions to enhance their learning. This not only benefits students of all ages, but also builds community connectedness (see Burmeister et al. 2016, Hocking et al. 2017) and enhances the self-esteem of older people as they play a tangible and meaningful role in educating the aged care workforce of the future.

Anyone interested in finding out more about the project is encouraged to contact Associate Professor Maree Bernoth at [mabernoth@csu.edu.au](mailto:mabernoth@csu.edu.au)





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# MONITORING NURSING TRENDS

By Stephanie Hille and Shanthi Gardiner

In 2017, 1,073 primary healthcare nurses were surveyed in the Australian Primary Health Care Nurses Association's (APNA's) annual Workforce Survey. Outside of hospitals, there is a burgeoning world of nursing that is progressively more recognised and increasingly integral to the healthcare sustainability agenda.

Here is a snapshot of what they told us.

## High levels of job satisfaction

Over 80% of respondents are satisfied or very satisfied with their current role and intend to continue with a nursing or midwifery career in primary healthcare for the foreseeable future.

Some of the most satisfying aspects of working as a primary healthcare nurse were reported as:

- The provision of care to patients and their families including continuity of care
- Contributing to patient satisfaction and positive health outcomes
- Collaboration and effective team-based care
- Being a valued member of the primary healthcare team by staff and patients.

## Primary healthcare nurses could be better utilised in the workplace

Many respondents felt that their education, training and qualifications are not used to the full extent in their current role. Approximately 29% felt they could do more and 11% of respondents indicated that most of the time they don't get to use their knowledge and skills to the full extent.

Less than half of the respondents (48%) suggested to their employer or manager that they could undertake more complex clinical activities or extend their role in the workplace within their scope of practice.

Of these nurses who suggested to their employer or manager that they could do more complex activities within their scope of practice, less than half (47%) were able to negotiate more complex tasks or extended roles.

A number of common reasons for the lack of change to more complex tasks or extended roles included lack of support by the broader healthcare team and financial and resourcing challenges.

## Working conditions

Lack of time and financial remuneration were the most commonly reported factors impacting

on respondents' ability to carry out their roles.

In the last two years, 50.44% did not have or were not sure if they had a formal and documented appraisal of their work performance and 31% of respondents have never been offered a pay increase.

Primary healthcare nurses working to their full scope of practice as part of an interdisciplinary team can enable more integrated, efficient and accessible healthcare.

So how can we empower and recognise the role of nurses working across primary healthcare settings, like correctional health, general practice, residential aged care, school nursing, refugee health, community health, and so many more?

Nurses intending to access education to assist them in working to their full capacity are often hindered due to financial constraints.

This doesn't just include not being able to afford the education itself but also the fiscal impact of time away from work to attend and complete professional development. Support for nurses to achieve their 20 hours of CPD required per year might include paid educational leave, employers covering course costs, and being paid to attend conferences and education events with the reward being fed back to the workplace by an upskilled and invigorated nurse.

Transition to practice programs are seen as valuable in supporting both the graduate nurse's professional adjustment into nursing as well as facilitating the experienced nurse's movement from one clinical setting or specialty to another. Many nurses have reported that these programs, such as APNA's Transition to Practice Pilot Program, increase role clarity and their job satisfaction. This supports improvements in clinical and non-clinical areas of care – competence, confidence, knowledge, skills – all required when determining an individual's scope of practice.


Nurse clinics are innovative models of care which provide an opportunity for primary healthcare nurses to strengthen and optimise their scope of practice. APNA is currently working with 11 pilot sites

MANY RESPONDENTS FELT THAT THEIR EDUCATION, TRAINING AND QUALIFICATIONS ARE NOT USED TO THE FULL EXTENT IN THEIR CURRENT ROLE. APPROXIMATELY 29% FELT THEY COULD DO MORE AND 11% OF RESPONDENTS INDICATED THAT MOST OF THE TIME THEY DON'T GET TO USE THEIR KNOWLEDGE AND SKILLS TO THE FULL EXTENT.

across general practice, aged care, community health and corrections to improve care delivery and patient health outcomes across a range of clinical areas, including diabetes, dementia, mental health and hepatitis. The broad range of nurse clinics being implemented demonstrates the breadth and scope of the primary healthcare nursing role.

Tools like **MyNursingFuture.com.au** aim to improve the perceived value and professionalism of the nursing role in primary healthcare. It also provides a platform to promote and describe the breadth of the primary healthcare nursing role.

The primary healthcare nursing profession in Australia has come a long way, but still has a long way to go if we are to get the best out of our workforce. Developing and utilising the full potential of this workforce will help ensure we can deliver high quality, accessible and affordable primary healthcare to our community into the future. Find out more at [www.apna.asn.au](http://www.apna.asn.au)

 **Stephanie Hille is Communications and Policy Manager and Shanthi Gardiner is Policy Adviser. Both are located at Australian Primary Health Care Nurses Association (APNA)**



# A MODULAR APPROACH TO ESTABLISHING A NURSE CLINIC

By Linda Govan

With the increasing demands of an ageing population and the subsequent burden of chronic illness, nurse clinics in primary healthcare settings provide opportunities for nurses to contribute more actively, by working to their full scope of practice through the introduction of innovative service delivery models.

As part of raising awareness of the potential benefits of nurse clinics, the Australian Primary Health Care Nurses Association's (APNA's) Enhanced Nurse Clinics project – supported by funding from the Australian Government Department of Health under the Nursing in Primary Health Care Program – has developed a suite of resources, with the primary focus on increasing the level of knowledge and understanding of nurse clinic models, to support nurses and employers in their establishment.

A human-centred design approach was used to engage and consult with nursing and non-clinical (eg. practice managers) primary healthcare stakeholders to elicit information and understanding of the key components and knowledge required in the establishment of nurse clinic models of care. The human-centred design process is an effective approach to ensure engagement and buy-in for potential users of the nurse clinic resources.

Consistent throughout the findings were a number of major themes impacting on the awareness and uptake of nurse clinics. Most significantly, a majority of stakeholders expressed their concern that the opportunities provided by nurse clinics as an alternate model of care were not well understood in the sector. This was influenced by a preference for the familiarity of established systems and processes, a lack of knowledge regarding funding and sustainability and lack of clarity regarding the level of clinical expertise required by the nurse to operate a nurse clinic.

A number of other themes associated with awareness of nurse clinic models and barriers impacting

on their establishment included:

- A lack of resources which provide an easy to understand, end-to-end view of clinic set up;
- A lack of awareness of the diversity of potential clinic types;
- Unrealistic expectations of nurses to be solely responsible for the majority of tasks required in the setting up and operation of nurse clinics;
- Difficulties accessing training.

Throughout the consultation, themes also emerged which highlighted a number of challenges associated with the operation of nurse clinics – concern that nurse clinics take time to prove their effectiveness; a lack of awareness of different funding models and external funding opportunities.

Following completion of the consultation, the suggested content was ordered into a series of eight building blocks, each containing the key components for establishing a nurse clinic. The building blocks provide a modular and replicable approach, and supports the


PRIMARY HEALTH CARE PROGRAM – HAS DEVELOPED A SUITE OF RESOURCES, WITH THE PRIMARY FOCUS ON INCREASING THE LEVEL OF KNOWLEDGE AND UNDERSTANDING OF NURSE CLINIC MODELS, TO SUPPORT NURSES AND EMPLOYERS IN THEIR ESTABLISHMENT.

development of models that suit the local context, accounting for factors such as community need, staff availability, expertise and organisational capacity, whilst reinforcing the concept that there is no single approach to setting up a nurse clinic.

All you wanted to know about setting up a nurse clinic is available at [www.apna.asn.au/nurseclinics](http://www.apna.asn.au/nurseclinics)

## Nurse Clinic Building Blocks

Building block	Content
A clear plan	Identifying opportunities Creating the plan <b>Aims and goals</b> <b>Clinic models</b>
Funding	Types of funding and how they apply to clinics Sustainability
Location and facilities	Physical space Clinic operating times <b>Equipment</b>
Staffing and HR	Roles and responsibilities Human resource policies and planning <b>Professional development</b> <b>Working as a team</b> <b>Formulating relationships</b>
Best-practice care	Evidence-based care Clinical guidelines <b>Quality Improvement approach</b>
Patient engagement	Patient pathways Creating appointments <b>Reminders and recalls</b> <b>Promoting the clinic</b>
Supporting systems and processes	Appointment systems Referrals <b>Patient registers</b> <b>Forms, templates and policies</b> <b>Data management</b>
Evaluation and improvement	Health outcomes Clinic efficiency <b>Evaluating the patient experience</b>

 **Linda Govan**  
is Project Manager, Enhanced Nurse Clinics at the Australian Primary Health Care Nurses Association (APNA)

## NEW ZEALAND

## NEW LAWS EMPOWER NURSES TO UTILISE FULL SCOPE

New Zealand's clinical nurse specialists can finally work to their full scope of practice after the removal of longstanding restrictions as part of new laws within the Health Practitioners (Statutory References to Medical Practitioners) Amendment Act.

New Zealand Nurses Organisation (NZNO) chief executive Memo Musa said clinical nurse specialists are qualified to carry out many tasks that have been unnecessarily restricted to doctors, listing the signing of death certificates, prescribing controlled drugs and signing sick leave certificates as examples.

"In a modern health system, nurses should not operate as a doctor's second in charge but be enabled by the removal of longstanding and draconian red tape," Mr Musa said. "These amendments mean more nurses can readily improve public access to some medicines, and are enabled to work to their full breadth and scope of practice."

Mr Musa said it is often easier and quicker to see a nurse than a doctor so the changes mean more people in the community can access healthcare sooner.

"In addition, it is encouraging to see the Minister of Health has his sights set on addressing bottlenecks and problems in primary healthcare as he clearly realises this will ease up hospital loads and improve

## UK

## CALLS FOR ACTION AS NURSE NUMBERS PLUNGE

The Royal College of Nursing (RCN) has called on the government to address the current "dangerous and downward" spiral facing the National Health Service (NHS) that is causing an alarming drop in nurse numbers.

The RCN's calls for action emerged after the recent release of NHS Digital figures that show one in 10 nurses are leaving the NHS in England each year, including more than 33,000 in 2017, meaning there are more nurses leaving the profession than entering it.

RCN said the disappointing figures illustrated how short-sighted cuts to nurse training places had put off the next generation of British nurses from pursuing careers in the profession when they are most needed as more experienced nurses increasingly becoming demoralised and move on.

RCN chief executive Janet Davies said nurses deliver the most patient care, and that the workforce withstands the worst due to insufficient resources.

"We already know there are 40,000 unfilled nurse jobs in England and things continue to head in the wrong direction. There cannot be safe care for patients while the government continues to allow nursing on the cheap."



The RCN has called on ministers to make urgent investment in services and those who provide them; including giving nurses a meaningful pay rise above inflation, increasing the number of training places and supporting career development.

Importantly, RCN's calls mirror wider growing unrest in England regarding the NHS crisis.

In London last month, thousands of demonstrators bearing placards with slogans including 'more staff, more beds, more funds', rallied to fight budget cuts.



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## PALLIATIVE CARE RESEARCH DOES GENERALIST NURSE A DISSERVICE

I read with interest the Focus: Palliative Care suite of articles in the *ANMJ* 25:6, Dec 2017-Jan 2018.

While I found the articles informative and have enhanced my knowledge regarding the provision of palliative care, I would like to comment in particular on the prospective research mentioned in *The importance of the specialist palliative care nurse* (p. 41) as I believe it does generalist nurses a disservice.

As a past nurse manager of a small northern NSW public hospital, and a present casual registered nurse in the same area, I would like to comment that, in a rural area, while the specialist palliative care nurse is a vital component of palliative care services, providing support in regional specialist units, community care, and expertise to outlying small hospitals regarding best practice palliative care, it is the generalist rural nurse that provides care in the small rural hospitals 24/7.

This can be because there are not sufficient available beds in the regional specialist unit, but importantly and more often because the patient wants to be closer to home, family and the familiarity of the local hospital staff.

The assumption that non specialist palliative care nurses find the provision of palliative care more confronting, challenging and stressful is at best a generalisation and at worst demeaning.

The observation of the vast majority of rural nurses I have had the honour to lead over the years tells a story of empathy, kindness and the provision of effective evidence based palliative care culminating in an environment of love, compassion and advocacy for patients and families and ultimately the best death possible if the patient chooses to die in the hospital setting.

I therefore respectfully argue that the researchers would have difficulty generalising any research results outside of metropolitan areas.

Elizabeth McCall RN, NSW

## UNDERVALUING EXERCISE FOR AGED CARE RESIDENTS



I read the February edition of the *ANMJ* with great interest, and was most struck by the comments made by Brett and Traynor (2018, p. 38) in their article about dementia and exercise, and the failure of the funding tool ACFI to promote enablement of aged care residents.

Having spent time working in aged care trying to marry the aspirations of residents with the tool that rewards dependence with more funds I was left feeling completely disillusioned.

It seems odd to think that a person with Tubigrip applied to both their legs, swallowing antidepressants and wearing a continence aid attracts more money than a person being supported to maximise their continence and promoting their health and wellbeing by exercising.

Brett and Traynor (2018) have rightly pointed out that there is a large body of evidence supporting the value of exercise for both physical and mental health. This is supported in your journal by Middleton, Moxham and Parrish (2018, p 30) who report participants feeling clearer of mind, happier and more positive after exercise.

People with dementia may not have the means to verbally express their need for fulfilment and positivity, but they do not differ from the group of older people alluded to by Middleton et al. (2018) and deserve the opportunity to reap the same benefits.

Surely it is time for the ACFI tool to be revised to provide reward for gains to health and wellbeing.

Amanda Crombie, Dementia Clinical Nurse Consultant, Vic

## REFLECTING ON THE THERAPEUTIC LIE

As a nurse of some forty-years, I remain fascinated with research in any area that improves patient outcomes.

Which is why I search out journals that publish this in not only academic journals but also online forums like *The Conversation*.

Hearing the reflection on the potential benefit of the use of the therapeutic lie in *ANMJ*, February 2018, was very relevant and well written.

In both my personal and professional life I have encountered situations where a person with dementia is confused and in distress.

I remember doing my rounds as an evening district nurse to find an elderly agitated woman worried that her husband had not come home.

When in fact he had been dead for many years.

In this situation it would have been beneficial to have a care plan with an agreed plan, but it seems there are no guidelines on this issue.

In this case I used my own clinical judgement and used what is now called a therapeutic lie.

The therapeutic lie sounds like a contradiction in terms, when in fact it may lead to good outcomes if agreed on by family and professionals.

Hoping this opens the door to more engagement with people with dementia, further research and practical guidelines for health professionals.

Jenny Esots RN, SA

LETTER  
OF THE  
MONTH

**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](mailto:anmj@anmf.org.au) Letters may be edited for clarity and space.**





# MARCH

**Lung Health Promotion Centre at The Alfred**  
**Spirometry Principles & Practice**  
 1-2 March  
**COPD – From Diagnosis to Management**  
 8-9 March  
**Asthma Educator's Course**  
 14-16 March  
 Ph: (03) 9076 2382  
 Email: lunghealth@alfred.org.au

**47th Global Nursing & Healthcare Conference**  
 Exploring latest innovations in nursing and healthcare  
**1-3 March**, London, UK. <http://global.nursingconference.com/europe/>

**We Can Walk and Run It Out! Supporting gynaecological cancer research**  
**4 March**. The 13th annual fundraising walk and run around the iconic Tan Track in Melbourne! Your support as a participant, volunteer or fundraiser will allow us to generate funds for research and clinical trials, lessening the impact of gynaecological cancer on our mothers, sisters, daughters, aunts, wives and friends. <http://wecanwalkitout2018.gofundraise.com.au/>

**Clean Up Australia Day**  
**4 March**.  
[www.cleanupaustraliaday.org.au](http://www.cleanupaustraliaday.org.au)

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

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

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

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

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

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

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

**National Close the Gap Day**  
**15 March**

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

**St Patrick's Day**  
**17 March**

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

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

**March Equinox – Equal day and night, nearly**  
**20 March**

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

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

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

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

# APRIL

**Lung Health Promotion Centre at The Alfred**  
**Smoking Cessation Course**  
 19-20 April  
**Respiratory Course (Modules A & B)**  
 30 April-3 May  
**Respiratory Course (Module A)**  
 30 April-1 May  
 Ph: (03) 9076 2382  
 Email: lunghealth@alfred.org.au

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

# MAY

**17th National Nurse Education Conference**  
 Changing worlds: Synergies in nursing, midwifery and health education  
**1-4 May**, Crown Promenade Melbourne, Victoria. [www.dccconferences.com.au/nnec2018](http://www.dccconferences.com.au/nnec2018)

**Lung Health Promotion Centre at The Alfred**  
**Respiratory Course (Module B)**  
 2-3 May  
**Spirometry Principles & Practice**  
 7-8 May  
**Asthma & Allergy Management Seminar**  
 14 May  
 Ph: (03) 9076 2382  
 Email: lunghealth@alfred.org.au

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

**National Sorry Day**  
**26 May**

**Anniversary of the 1967 Referendum**  
**27 May**

**Reconciliation Week**  
**27 May-3 June**

**Reconciliation Day**  
**28 May**

**10th National Medicines Symposium**  
 Population to personal healthcare: The future is now  
 Evolving systems | Reimagining policies | Clinical innovations  
**30 May-1 June**, National Convention Centre, Canberra.  
<https://www.nps.org.au/nms2018>

# JUNE

**Mabo Day**  
 3 June

**Lung Health Promotion Centre at The Alfred**  
**Respiratory Update Seminar**  
 4 June  
**Influencing Behaviour Change – a formula**  
 14-15 June  
**Influencing Behaviour Change – Theory & Practice**  
 14 June  
**Influencing Behaviour Change – Intensive Workshop/Case Studies**  
 15 June  
**Paediatric Respiratory Update**  
 21 June  
 Ph: (03) 9076 2382  
 Email: lunghealth@alfred.org.au

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

# NETWORK

**Geelong Hospital Nurses League 84th annual reunion and AGM**  
**17 March**. If you have a connection to the Geelong Hospital (University Hospital), are a past trainee or current employee and are interested in attending this reunion, contact Bev Lodge P: (03) 5243 7794 or E: [terrylodge@bigpond.com](mailto:terrylodge@bigpond.com)

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

**Alfred Hospital, Group AP87 31-year reunion**  
**29 April**, 12.00pm, Biricchino Café, 100 Scotchmer Street, Nth Fitzroy Vic. Contact Liz Crock E: [lizcrock60@gmail.com](mailto:lizcrock60@gmail.com) or M: 0400 833 196

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

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

**Alfred Hospital, Group 3/68, 50-year reunion**  
**June**. Contact Isabelle E: [isabellehenry360@gmail.com](mailto:isabellehenry360@gmail.com)

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

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



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



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LIESL AND KATHRYN

## A PASSION FOR MATERNAL AND CHILD HEALTH

Natalie Dragon

Three months at her daughter's bed side in the burns unit at Western Australia's Princess Margaret Hospital inspired Liesl Baxter to make the life-changing decision to go into nursing.

"I was surrounded by really strong women who were good at decision making."

A paternalistic upbringing and dominant males in her life, the exposure to strong women was incredibly powerful, says Liesl. "These were nurses and I admired them and wanted to be like them. I was at a crossroads in my life and needed to make some changes. I went home and started to take responsibility for the decisions in my life."

With a passion for maternal and child health, Liesl undertook her midwifery education on completing her RN degree. She worked for Ramsay Health Care, the King Edward Hospital and Bentleigh Hospital. Liesl says she took up every

opportunity on offer. "They say nursing can take you anywhere. I had the opportunity to work in a breastfeeding centre and I did it. I had the opportunity to work in perinatal loss and deliver still birth babies and I did it. I gave immunisations to kids. I went up north to do some remote work."

It was at university where Liesl 'fell in love with Aboriginal health'. "I had little insight into the effects of racism and transgenerational trauma and health outcomes." It was there that she met friend and mentor Gayle Yarren, a Noongar Aboriginal woman from Quairading with Whadjuk and Ballardong heritage.

"Through her friendship and sisterhood I got to learn about her culture within my own context. I walked that journey. I saw how much harder it was for her than me [at university]. I became aware of the health disparities in health outcomes between Indigenous and other Australians. I became concerned what my contribution as a nurse was going to be."

A lightbulb moment for Liesl came as a graduate midwife in an antenatal clinic. A woman from far north WA was down for antenatal care in Perth, off country. "She told me she was upset because she was birthing off country. Australia to us is one country, to Aboriginal people it is over 300 countries. She had traversed across several

countries. To birth in Perth meant her first born son would lose his birth right. This was a significant life changing course in her life in that her first born son would not birth on country and the loss of that."

"I asked myself: 'Is there any way we can make this different? Is there a modern day acceptable way?' I asked her: 'Is there someone in your community who could sanction that say the first thing your child touches could be the sand from your country.'"

The Aboriginal woman went back and floated the idea which was accepted by the community, says Liesl. "So she brought back a jar of red dirt from her country for the birth and there was a modern day facilitation of an ancient tradition. That day I realised if I hadn't fought and advocated for this woman she would have been worse off than when she came in."

Liesl says she ensures a person's spiritual, emotional and mental needs are protected. Cultural safety is all about effective communication. There are a lot of fears, particularly with the Stolen Generation and transgenerational trauma, she says. "So many children were taken. We expected these children to be good parents without being parented themselves and then they faced criticism. Many turned to alcohol and drugs because they don't have the knowledge and education to make different choices."

"The tentacles [of trauma] are far-reaching. When you deal with the fear and trauma then you get good results and outcomes with engagement and uptake."

An endorsed midwife, Liesl has been Manager of Maternal and Child Health since it opened more than two years ago at Derbarl Yerrigan Health Services which has been in operation for 40 years. The service prides itself on providing high quality maternity services that are welcoming, culturally safe, responsive and respectful.

"The more immersed in the work at Derbarl I became, the more I could see the ramifications for that population," says Liesl.

It's about development of therapeutic relationships and the development of trust, she says. "We provide longer appointments and we really focus on continuity of care to keep that engagement strong."

Liesl's partner is a nurse in chronic disease in Aboriginal health and both have a vision and long term goal to make a difference in Aboriginal health. This includes to do more remote work and research, including on the barriers to access.

Liesl has already been involved in several research projects: safe sleeping; improving the uptake of immunisation; birthing on country; and a new screening tool for postnatal depression instead of the EPDS tool through Murdoch University.

Liesl strongly believes in mentorship. "All my mentors are really strong women who are consumer advocates, women's advocates, and who fight for justice and humanitarianism. I mentor students because I was mentored by strong women. Giving back is a part of the job."



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