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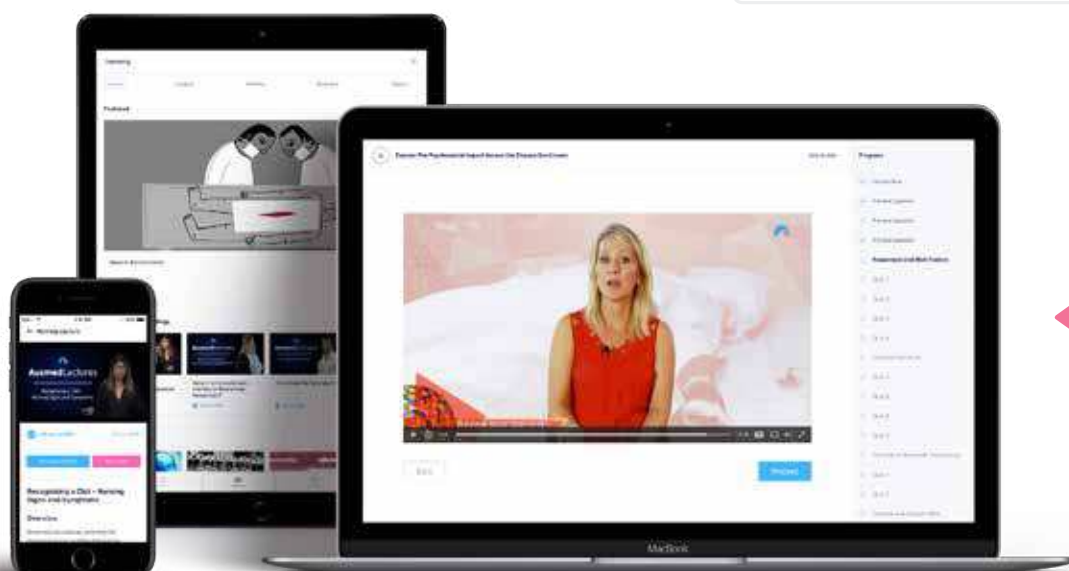
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NATIONAL CAMPAIGN
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RATIOS IN LAW

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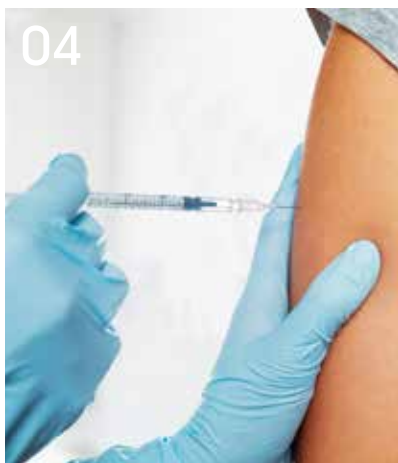
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If you are a financial member of the ANMF, QNMU or NSWNMA, you can transfer your membership by phoning your union branch. Don't take risks with your ANMF membership – transfer to the appropriate branch for total union cover. It is important for members to consider that nurses who do not transfer their membership are probably not covered by professional indemnity insurance.



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Editorial

Annie Butler ANMF A/Federal Secretary

This month we celebrate International Day of the Midwife, 5 May and International Nurses Day on 12 May. Both days are extremely important to the professions as they highlight the invaluable contributions midwives and nurses make in healthcare and the broader community.

International Nurses Day also marks the launch of the ANMF's national **Ratios for Aged Care Make them Law Now!** campaign. The theme of International Nurses Day, set by the International Council of Nurses, is **Nurses: A Voice to Lead- Health is a Human right.**

This theme aligns closely with the campaign's purpose, which is to point out the inequities that exist in aged care, such as a lack of staff and skill mix as well as the absence of transparency and accountability in aged care facilities.

Every ANMF state and territory branch will launch the campaign on International Nurses Day by rallying or holding events across the country.

For example, the ANMF (Victorian Branch) will be hosting a community rally in Moonee Ponds, where Bill Shorten resides. Speakers will include aged care reform advocate, Senator Derryn Hinch and former ANMF Federal Secretary and the new Member for Batman, Ged Kearney.

The New South Wales Nurses and Midwives' Association (NSWNMA, ANMF NSW Branch) will be organising barbecue lunches, entertainment and activities for the kids in Parramatta Park, Sydney, and at Twin Town Public Park, Tweed Heads.

The QNMU (ANMF Queensland Branch) will march the streets, before holding a family fun day, while South Australia will be rallying in Glenelg.

With this year's International Nurses Day theme in mind, I cannot think of a better way to mark the day than attending the launch of the campaign to support older Australians living in aged care facilities and those looking after them. I invite you and your families to attend an event near you so that together we can demonstrate that not only is good aged care essential but it is a human right.

For more information on what's happening in your state or territory go to your local ANMF website or facebook page. On these sites you will also find other ways to support the campaign.

To read more about the situation in aged care, this month's feature delves into the heartbreaking experiences of residents nurses and carers, working at these facilities.

This month's *ANMJ* also has an important spread on Hazards in the workplace. The feature is a timely reminder that while nurses and midwives have the right to work in a safe and healthy workplace environment and to perform their work without risks to their physical and psychological health, they must also be aware of potential hazards at all times and adhere to policies that keep them safe.

Before I sign off for another month, I just want to remind you that it's time to renew your annual general or non-practising registration by 31 May.

As you are aware, part of the process for registration is to ensure a minimum number of continuing professional development hours. Ways to build up your hours is to read the *ANMJ* or access ANMF's online professional training room, which has tutorials on a wide variety of topics. To access the tutorials and find out more, go to <http://anmf.org.au/cpe>

Annie



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ANMF NATIONAL AGED CARE CAMPAIGN



AGED CARE RESIDENTS UNWASHED AND UNFED

The ANMF is seeking to make ratios in aged care law.

The union's latest bid followed coverage of residents suffering due to understaffing in a Queensland aged care facility on the ABC's 7.30 Report last month.

Staff and relatives of residents of Pioneer Lodge and Gardens, owned by Bundaberg's Blue Care Aged Care Services, spoke about appalling conditions in which residents were left unfed and personal care unattended to because of time constraints on staff.

The home failed 15 of 44 standards including in provision of basic care such as adequate food and hydration and personal care in December.

The Aged Care Quality Agency (ACQA) found the facility did not have enough "appropriately skilled and qualified staff" and that "clinical incidents are not consistently identified, monitored, reassessed or actioned in a timely manner."

A December 2017 internal memo circulated to all staff at Pioneer Lodge showed residents reported they had been left on the toilet for 'prolonged periods of time', that there were not enough staff and the staff were too busy.

Tragically an 87-year old resident died of septicaemia two months after ACQA inspectors visited the facility.

Up to 11 enrolled nurses had been retrenched in the months leading up to the resident's death. The provider and the government was warned of the consequences last year, ANMF A/Federal Secretary Annie Butler said.

"In August last year when we learnt that Blue Care was sacking nurses across its aged care facilities in Queensland, ANMF members warned the provider and the government that residents would suffer.

"Tragically, that's what happened. And worse, we know that what's happened at Blue Care is happening around the country as providers continue to employ fewer and fewer nurses to care for an increasing number of vulnerable residents with increasingly complex medical needs."

The ANMF's national aged care campaign launching this month highlights how in the absence of mandated staffing ratios, dangerously low levels of nurse and carer staffing continue to put the lives of the elderly at risk.

From 2003 to 2016 there had been a 13% reduction in trained nursing staff working full time in aged care facilities, Ms Butler said. Residents received two hours and 50 minutes

of care per day from nurses and carers, well below the four hours and 18 minutes required.

The urgent problem that needs to be addressed is not funding but the declining quality of care due to chronic understaffing of aged care facilities, Ms Butler said.

"More funding may be necessary, but without adequate measures to ensure that government funds are used to increase care through higher staffing levels there is no point in increasing funding."

Federal Aged Care Minister Ken Wyatt said the Pioneer Lodge facility would be continued to be monitored. The Agency had conducted more than 1,500 unannounced visits on residential aged care facilities across Australia since October.

Ms Butler said the ANMF encouraged its members and families of nursing home residents to report any concerns to the Aged Care Complaints Commission. "However we are losing faith in the capacity of the current aged care regulatory system to protect elder Australians. It's clearly taking a toll on our elderly, their families and aged care nurses struggling to cope with dangerously high workloads, who are now starting to speak out. It is now time for action."

Minister Wyatt said a workforce taskforce was due to produce Australia's first aged care workforce strategy by July 2018.

To support ANMF's campaign go to:
www.morestaffforagedcare.com.au

PUSH TO OPEN UP DIALOGUE ON ADVANCE CARE PLANNING

Health sector leaders from across the country united last month to raise awareness about the importance of Australians discussing advance care planning and developing healthcare preferences for the future when they may be too sick to speak for themselves.

Australia's inaugural National Advance Care Planning Week, which ran from 16-22 April, focused on asking people of all ages to consider whom they would like to act on their behalf when they are no longer able to make healthcare decisions due to deteriorating health.

Advance care planning promotes care that is consistent with a person's goals, values, beliefs and preferences.

Statistics show a third of Australians will

die before the age of 75, with 85% of people dying due to a chronic illness, rather than a sudden event.

Yet around half of Australians are not able to make their own end-of-life medical decisions due to declining health.

An initiative of Advance Care Planning Australia (ACPA), a national program funded by the Commonwealth Department of Health, National Advance Care Planning Week saw more than 100 community groups and healthcare organisations sign up to host an event aimed at starting an important conversation regarding future healthcare preferences.

Ambassadors encompassed clinical experts, researchers and policy leaders including Dr Karen Detering, Medical Director of Advance Care Planning Australia, Liz Callaghan, CEO of Palliative Care Australia, and Dr Chris Moy, Chair of the Ethics and Medico-legal Committee of the Australian Medical Association.

Australia's public awareness effort linked with international initiatives held in the USA, Canada, and New Zealand.

Federal Health Minister Greg Hunt said advance care planning was a critical part of healthy ageing largely misunderstood by the public and that the National Advance Care Planning Week challenged all Australians to start conversation with loved ones about what living well means to them.

ADVANCE CARE PLANNING PROMOTES CARE THAT IS CONSISTENT WITH A PERSON'S GOALS, VALUES, BELIEFS AND PREFERENCES.

"Few people take the active steps required to enable control of their future healthcare," Mr Hunt said.

Dr Karen Detering, Medical Director of Advance Care Planning Australia, said evidence showed advance care planning can reduce anxiety, depression and stress experienced by families often asked to make medical decision for loved ones in need.

ACPA aims to increase advance care planning resources across health sectors and NGOs, improves workforce capability, produces resources for diverse consumers and communities, and builds evidence.

"Do it for yourself. Do it for your loved ones. And ideally do it when you're fit and well – don't leave it to chance on the day you present at the emergency room."



REGULATE AGED CARE TO RELIEVE ED PRESSURE

Aged care providers in Queensland have been accused of dumping residents in hospital emergency departments.

A Question on Notice by Member for Caloundra Mark McArdle on the numbers of aged care patients transported by ambulance to emergency departments reignited calls for better staffing in aged care.

Between 1 July 2015 and 8 March 2018, the Queensland Ambulance Service transported 6,765 acute patients from nursing homes to public hospital emergency departments within the Sunshine Coast Hospital and Health Service area.

Mr McArdle questioned how many of those residents were being sent to hospital for routine medical procedures.

Statewide data revealed an overall jump in transfers from 22,116 cases in 2014-15 to 25,833 in 2016-17.

Queensland Health and Ambulance Services Minister Steven Miles said the issue had come to his attention as he visited emergency departments around the state.

"What are the things putting them under the most pressure and one of them is the practice of sending nursing home patients to an emergency department because there isn't a nurse available to look after them."

Speaking at a Gold Coast hospital recently Dr Miles said the federal government needed to step up and regulate the aged care sector. The Turnbull government had intentionally dropped the

ball to save money, the Minister said.

"At the very least what we need is for these privately run for profit or community run aged care facilities...to have a system that looks at the needs of the residents and provides nursing care suitable to their needs. That's not what we have at the moment. At the moment they're relying on our hospitals to fill the gap."

Dr Miles reiterated his call for the federal government to introduce minimum safe staff to patient ratios in all residential aged care facilities across Australia and increase funding to the aged care sector.

Queensland Nurses and Midwives' Union Secretary Beth Mohle said the lack of laws and regulation in aged care meant older Australians were not getting the care they deserved or needed.

"Neither the Turnbull government or the Federal ALP have committed to introducing laws that would force aged care providers to safely staff their facilities. Right now, these facilities are not required to have even a single registered nurse on site."

Residential aged care facilities received more than \$16 million in taxpayer funds, Ms Mohle said. "These providers also reported more than \$1 billion in collective profits. Aged care providers can afford to pay for staff – they just need to be held to account."

www.morestaffforagedcare.com.au



DERRYN HINCH BACKS ANMF CAMPAIGN FOR AGED CARE RATIOS

Senator Derryn Hinch has pledged to support the Australian Nursing and Midwifery Federation (ANMF) throughout its national campaign pushing for mandated minimum staffing ratios in aged care.

ANMF A/Federal Secretary Annie Butler and ANMF Federal Vice President/Assistant to the Federal Secretary Lori-Anne Sharp met with Senator Hinch in Melbourne last month to outline the union's campaign and discuss joining forces to convince federal politicians to make aged care ratios law.

An aged care reform advocate, Senator Hinch introduced the Aged Care Amendment (Ratio of Skilled Staff to Care

Recipients) Bill into Federal Parliament last September seeking mandated ratios of skilled staff in nursing homes across the country.

In that bid he described elderly aged care residents as highly vulnerable members of society not currently guaranteed the standard of care they deserve, claiming that ambiguity surrounding minimum staffing standards in residential aged care facilities stipulated within the *Aged Care Act 1997* had allowed many aged care providers to keep profit margins up by cutting staff.

"Too many times in too many places, profit is the name of the game. Some companies running these places know that you can keep that profit margin up by cutting staff numbers and playing games with the numbers so that it looks like there are more staff physically dealing with the wants and needs of the residents than there actually are," Senator Hinch told Federal Parliament.

The positive talks with Senator Hinch included the ANMF illustrating the results of its landmark *National Aged Care Staffing and Skills Mix Project* published in 2016 that revealed aged care resident should receive about four hours and 18 minutes of care per day but almost half actually get just 2.84 hours of care.

The union also highlighted the complexity regarding mandated aged care ratios and

"SENATOR HINCH UNDERSTANDS FIRST-HAND THE CRISIS THAT IS FACING AUSTRALIA'S AGED CARE SYSTEM AND IS COMMITTED TO STANDING UP FOR THE VULNERABLE ELDERLY SO THEY RECEIVE THE LEVEL OF CARE THEY DESERVE."

offered its expert guidance to Senator Hinch's team moving forward to help determine the most appropriate skills mix.

A/Federal Secretary Annie Butler said Senator Hinch expressed full support for the ANMF's 'More Staff for Aged Care' campaign and will headline guest speakers addressing ANMF (Victorian Branch) members and community supporters in Queens Park in Moonee Ponds this month during the Victorian leg of the national campaign's launch on 12 May, International Nurses' Day.

"We commended Senator Hinch for having the courage and determination to fight for Australia's vulnerable elderly Australians living in aged care by introducing a Private Member's Bill seeking mandated ratios in Federal Parliament," Ms Butler said.

"Like the ANMF, he is well aware of the countless inquiries and reports that have examined the aged care sector. He concurs the system has been ignored by governments for too long and that it's now time for action to make ratios law."

Senator Hinch, who first became passionate about tackling the aged care crisis after listening to the despondent stories of two aged care workers, also pledged to encourage his fellow Senators to support the ANMF's aged care ratios campaign.

"Senator Hinch understands first-hand the crisis that is facing Australia's aged care system and is committed to standing up for the vulnerable elderly so they receive the level of care they deserve," Ms Butler said.

"We are pleased to have his support throughout our national aged care ratios campaign and believe he brings a crucial voice to the table as we call on federal politicians to support legislated staffing ratios in aged care.

"Senator Hinch is a well-known identity across Australia who holds significant reach in the broader community and has extensive experience in media circles that will prove invaluable. We know he genuinely cares about meaningful change and will not back down when it comes to fighting to protect the nation's elderly."

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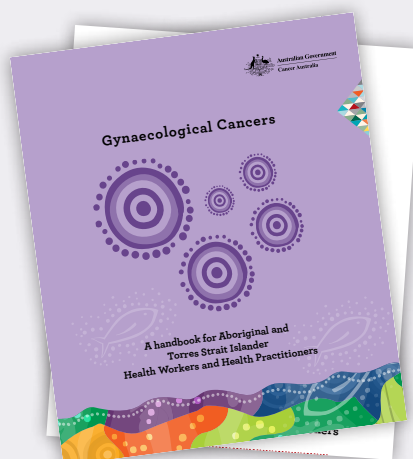


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NEW GYNAECOLOGICAL HANDBOOK FOR INDIGENOUS WOMEN



A new handbook is aiming to help Aboriginal and Torres Strait Islander Health Workers reduce the impact of gynaecological cancers in their communities.

The resource from Cancer Australia promotes risk reduction, cervical cancer screening, awareness of symptoms, early detection and appropriate and timely referral and treatment.

Aboriginal and Torres Strait Islander women are 2.5 times more likely to be diagnosed with and 3.8 times more likely to die from cervical cancer. They are 1.8 times more likely to be diagnosed with and 2.2 times more likely to die from endometrial cancer.

The guidebook guides health workers on how to address misconceptions, encourage uptake of cervical screening and HPV vaccination, and manage sensitive topics.

"It also emphasises the importance of ensuring women understand the medical advice they're given and explaining medical jargon, and how health workers can use diagrams, pictures and written information for the woman and her family to take away," Cancer Australia CEO Dr Helen Zorbas said.

The *Gynaecological Cancers: a handbook for Aboriginal and Torres Strait Islander Health Workers and Health Practitioners* is available under publications at: <https://canceraustralia.gov.au>

SKYROCKETING OUT OF POCKET COSTS FOR BREAST CANCER AND CHRONIC DISEASE SUFFERERS

Many Australians with breast cancer and certain chronic conditions are paying more than \$10,000 in out of pocket costs for treatment.

A national survey found more than one quarter of respondents treated for breast cancer and one third with chronic conditions like multiple sclerosis incurred the highest out of pocket costs – commonly more than \$10,000.

The Consumers Health Forum of Australia (CHF) *Out of Pocket* report released last month found despite having health insurance many patients racked up thousands of dollars for critical surgery, diagnostic scans and other treatment. One third of survey respondents reported the out of pocket costs were not explained to them.

"The expense is made the more difficult by the uncertainty and complexity of the relationship between treatment and costs with varying levels of cover, or no cover, provided by health funds and by Medicare," CHF CEO Leanne Wells said.

One in six reported that out of pocket costs had a significant impact on their lives.

A companion report *Hear Our Pain* also released last month highlighted pensioners and single mothers foregoing recommended care; patients faced with unexpected extra costs for junior surgeons, anaesthetists and MRI scans; and people using special access

to superannuation funds to cover bills.

The CHF's report which makes a number of near term and longer-term recommendations was launched in Parliament in Canberra. A key recommendation was for greater transparency on medical costs.

"Given the costs involved, consumers require clarity and certainty in ascertaining the fees they face, in total and in detail. This could be provided on an independent, authoritative website containing all doctors' fees," Ms Wells said.

One recommendation is for the provision of a single quote for overall treatment costs to patients.

CHOICE CEO Alan Kirkland said a more transparent private health system where average prices for common procedures such as knee replacement surgery, gall bladder and colonoscopy should be publicly available.

"It can be completely perplexing and sometimes impossible for patients in need of surgery to work out how much they will be out of pocket. What's worse, this often occurs when you are at your most vulnerable or least able to bargain over costs."

There was also no evidence of any link between the cost of a medical procedure and its quality or outcome, Mr Kirkland said. "In short, you could be thousands of dollars out of pocket and have a worse outcome than you would from a specialist who charges a lower fee that's fully covered by your private health insurance."

National Rural Health Alliance CEO Mark Diamond said those in rural and remote areas paid far more in out of pocket costs than urban Australia. "And costs really blow out when you add travel and accommodation to the out of pocket bill to access adequate medical care."

Ms Wells said the role private health insurance played in the cost and access to healthcare in Australia was in urgent need of scrutiny. Out of pocket medical costs are currently under review by the federal government's expert committee as part of a private health reform process.

YOUNGER ONSET DEMENTIA RESOURCES



Two new free online resources to help improve the support and care for people living with younger onset dementia are now available.

Understanding Younger Onset Dementia is a free online training module specifically for health professionals and support staff. Available on the Centre for Dementia Learning website at: www.dementialearning.org.au

Support Pathways for People with Younger Onset Dementia provides referral, service choices and options for families impacted by dementia. Available for download on the Dementia Australia website at www.dementia.org.au/resources



REMINDERS AND PROMPTS INCREASE VACCINATION UPTAKE

Health professionals should focus on changing people's behaviour to increase uptake of vaccination, a new review of the evidence shows.

Behavioural strategies were better than persuasion for promoting vaccination, according to a report by United States and Australian scholars.

One of the challenges of vaccination, they acknowledged, was that uptake varies across vaccines. Childhood vaccination generally has strong public support compared to the seasonal flu vaccine which many adults forego.

However, vaccination campaigns aimed to change perceptions and attitudes about vaccines were less effective than facilitating vaccination in more direct ways, according to the evidence.

The researchers found the most effective

"THE REPORT IS A REMINDER FOR ALL HEALTH SERVICES, WORKPLACES AND GOVERNMENTS TO MAKE IT AS EASY AS POSSIBLE FOR PEOPLE TO BE VACCINATED - REMINDERS, NUDGES AND REMOVING AS MANY BARRIERS AS POSSIBLE IS WHAT IS MOST EFFECTIVE."

behavioural strategies adopted were to:

- Facilitate action by providing patients with reminders and prompts.
- Reduce barriers by setting default orders and appointments.
- Shape behaviour by developing incentives, sanctions and requirements.

The best available evidence showed the percentage of people who actively refused all vaccines was incredibly small with neither vaccine refusal nor delay on the rise. In reality, most people received vaccines in line with their healthcare provider's recommendations. Many had favourable attitudes towards vaccination but did not always follow through to receive vaccines in full or on time.

"The report is a reminder for all health services, workplaces and governments to make it as easy as possible for people to be vaccinated - reminders, nudges and removing as many barriers as possible is what is most effective," University of Sydney Associate Professor Julie Leask said.

"Should we stop communicating about vaccination? No. It's not going to cause big jumps in vaccination rates. We need to help people practically too."

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WIDE VARIATION IN CLINICAL CARE FOR CHILDREN

A landmark study has found wide variation in health practitioners' adherence to recommended practice in common conditions for children.

Children received care in line with recommended clinical practice guidelines about 60% of the time for 17 clinical common medical conditions, according to the national CareTrack Kids study.

The Australian Institute of Health Innovation on the standard of healthcare for children in Australia evaluated care for 6,689 children under 16 years of age, in 2012 and 2013. It assessed how often care was given in accordance with clinical practice guideline recommendations.

The study found substantial variation in adherence to guidelines. Six conditions had estimated adherence to guidelines greater than 70% – four mental health conditions

(autism, ADHD, anxiety and depression), diabetes and head injury.

However compliance with recommended practice for other common conditions was lower: tonsillitis (43.5%), fever (53.5%) and upper respiratory tract infection (53.2%) and asthma (58.1%).

"The rate of high quality care for Australian children across these very common conditions varies considerably," lead author and Founding Director of the Australian Institute of Health Innovation at Macquarie University Professor Jeffrey Braithwaite said. "In practice, this could mean that rather than complying with guidelines for tonsillitis, fever or upper respiratory tract infection, a clinician may treat a child with antibiotics instead, contrary to recommendations."

However Professor Braithwaite said researchers recognised guidelines should not be followed slavishly all the time. "There are always exceptions, including that a family's preferences matter or that there are clinically relevant reasons for deviations."

The study was the largest of its kind ever conducted, involved 139 healthcare provider sites: 85 GP clinics, 20 specialist practices and 34 hospitals across NSW, QLD and SA.

The study highlighted which conditions needed most attention and would drive



concerted efforts to improve patient care, Professor Braithwaite said. "We need to reflect on how we can improve the healthcare system. Clinicians want to do their best for all their patients and we need to modify the system to help them achieve this goal."

The study suggested several improvements, including advanced electronic medical records to enable clinicians access to more real-time information, and more structured patient data collection to support better decision-making.



MINISTER FOR RURAL HEALTH SENATOR BRIDGET MCKENZIE, ANDREW LAMING MP, QUANDAMOOKA ELDER MERLE DIPPLE, AND TEAMS FROM AFTERCARE AND BRISBANE SOUTH PHN.

NEW MOBILE MENTAL HEALTH SERVICE FOR BRISBANE'S YOUTH

A new mobile mental health service that offers intensive treatment to children and young people in Brisbane's south will be piloted over the next year.

Federal Minister for Rural Health, Senator Bridget McKenzie, and Federal Member for Bowman, Dr Andrew Laming, launched the \$1.5 million program for the Redlands and

Bay Island areas of Brisbane last month.

The new service aims to improve access to intensive mental health treatment services for young people aged between eight and 25. It will specifically target 'hard to reach' young people with severe or complex mental health issues in the local community.

"Sometimes the mental health issues facing these young people are too complex or too severe to be effectively managed by existing services or a more flexible approach to assessment and treatment may be required," Minister McKenzie said.

Brisbane South Primary Health Network (PHN) identified a strong need for this type of service, Child and Youth Mental Health Program Coordinator Carissa Griffiths said.

"The process that was undertaken involved a literature review, data analysis and consultation with current services about what that gap was in child and youth mental health."

There was a service gap identified

between existing services for mild to moderate mental health issues and that of the tertiary system for more severe illness, Ms Griffiths said.

"We also identified the need for eight to 11 year olds who were not accessing services but for who there is a real risk of complex and severe mental health issues. We are hearing from headspace of a lot of young children that are requiring services that do not meet their age criteria."

Headspace provides services for children and young people aged 12-25.

This new pilot program runs from a community hub in Redlands. Aftercare, which provides mental health services to children and young people, will provide the mobile outreach service. Access to services and public transport was an issue in the Redlands and Bay Islands, Ms Griffiths said.

The program would provide help to vulnerable, hard to reach young people who often don't engage in traditional mental health services.

"We have children and youth on the Bay Islands, as well as Aboriginal and Torres Strait Islander children, who are hard to reach as well as those disengaged such as the homeless, those no longer in education and those linked to justice," Ms Griffiths said.

The pilot program would also identify and assist very vulnerable children and young people with complex family situations.

The \$1.5 million funding for the pilot program will run through to the end of June 2019.

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NURSES AND MIDWIVES RECOGNISED GLOBALLY

The critical role nurses and midwives play in delivering healthcare will take the spotlight this month during global celebrations marking International Day of the Midwife on 5 May and International Nurses Day (IND) on 12 May.

The annual events highlight the invaluable contribution nurses and midwives make to the health system and aim to strengthen and improve the professions so they remain at the forefront of healthcare.

International Nurses Day is celebrated each year on the birthday anniversary of nursing pioneer Florence Nightingale and the 2018 theme, set by the International Council of Nurses (ICN), is **Nurses A Voice to Lead – Health is a Human right**.

This year's theme for International Day of the Midwife, chosen by the International Confederation of Midwives (ICM), declares **Midwives leading the way with quality care**.

ANMF A/Federal Secretary Annie Butler said the events offered the opportunity to commend nurses and midwives for providing quality healthcare.

"Nurses and midwives represent the largest proportion of the nation's health workforce and continue to be voted the most trusted professionals by the community," Ms Butler said.

"This month's events allow us to applaud and reflect on their tireless work each and every day in providing healthcare across hospitals, communities and aged care facilities."

This year's IND explores the importance of health being a human right and advocating for access to affordable and quality healthcare.

"Fundamentally, no one should be denied access to their country's appropriate standard of healthcare because of their financial status, where the healthcare provided leads them deeper into poverty," ICN states.

A/Federal Secretary Annie Butler said this year's IND theme was particularly fitting because it aligns closely with the ANMF's current national aged care ratios campaign, officially launched on 12 May.

"International Nurses Day is the ideal opportunity to stand united and address the inequalities of health. Australia's elderly have a right to safe and quality healthcare at the end of their lives and it's just not happening."

Commonwealth Chief Nursing and Midwifery Officer, Adjunct Professor Debra Thoms, described International Nurses Day and International Day of the Midwife as



MIDWIFE LYNELLE MORAN

important vehicles for building awareness and influencing change.

"It's about talking about the critical role nurses and midwives play in the health of the Australian community every day in all sorts of settings and all sorts of different ways," she says.

Commenting on this year's themes, Professor Thoms said midwifery was poised to drive high quality care and good outcomes.

"Providing women with choice and access to midwifery models amongst all other parts of maternity is an important thing for services to think about but also for the profession to continue to promote."

Similarly, Professor Thoms said **Nurses A Voice to Lead – Health is a Human right** reflected global trends focusing on access to health and its wide-ranging impacts.

"It underlines the theme that is certainly coming out in the international organisations about the critical role that health plays for the community in not just your healthcare but in achieving improvements in your economic situation, in providing opportunities for work and education and the important role health plays in a sustainable world," she says.

"If we don't have good healthcare then we have trouble doing a whole lot of other really important pieces of work. It's an absolute baseline right and requirement for people in the community, in our world, everywhere."

Professor Thoms said nursing and midwifery still needed to work resolutely to promote the professions to ensure nurses and midwives can work to their full scope and maximise their contributions.

"It's nice to have a time of year where we

can focus in on all the great work that nurses and midwives do. It's a real opportunity to get together with colleagues and celebrate but also to make the wider world more aware of some of the work nurses and midwives do."

Midwives

Lynelle Moran has been a midwife for four years and currently works at the Sunshine Hospital in Victoria.

Pursuing midwifery later in life after having children, Lynelle describes midwifery as her dream job due to the connection reached with women and families.

"I just try to remember the experiences because it's so much about the continuum of childbearing – the pregnancy, the labour the post-natal period, helping to establish breastfeeding and helping young families start off on a positive foot."

Lynelle and her colleagues mark International Day of the Midwife annually by recognising each other's work and reflecting on special encounters.

"Midwifery is such a busy pace and I think days like this just make us come up for air and look around and acknowledge each other's work and reflect on what it is to be a midwife," she says.

"For me [Midwives leading the way with quality care] is about a continued commitment to grow my skills and knowledge. I feel like every day we learn in midwifery because it's just never-ending. I do that by keeping up with my skills but also drawing on the knowledge and expertise of those around me and more experienced midwives and midwives working in other settings."

FINAL CALL FOR NURSES AND MIDWIVES TO RENEW REGISTRATION



More than 380,000 nurses and midwives registered with the Nursing and Midwifery Board of Australia (NMBA) are being reminded to renew their general or non-practising registration by the end of May.

Online renewal opened in April and registered and enrolled nurses, midwives and nurse practitioners should already be receiving a series of registration reminder emails sent from the Australian Health Practitioner Regulation Agency (AHPRA) on behalf of the NMBA.

If nurses and midwives do not renew their registration by 31 May, or within the subsequent one-month late period, they face late payment fees, their registration lapses and they will have their name removed from the national Register of Nurses and Midwives as well as be unable to practice until lodging a new application.

As with previous years, nurses and midwives were sent a paper renewal certificate to fill out.

However, from 2019, renewal certificates will no longer be mailed and

the process will move exclusively online.

In 2016, more than 98% of nurses and midwives renewed their registration online.

"The renewal reminder emails are an easy way to access online renewal and resources explaining the renewal process," NMBA Chair, Associate Professor Lynette Cusack RN said.

"Online renewal is the simplest way to renew your registration."

Nurses and midwives wanting to renew their registration can visit <https://bit.ly/1kmfYjv> to find out more information.

Registration renewal dates

- **31 May**
Expiry of registration
- **1 June**
Late payment fee plus registration renewal fee
- **1 July**
Registration lapses and name removed from national register

NATIONAL GUIDE TO HELP CLOSE THE GAP



The third edition of a national guide for all health professionals aiming to deliver best practice healthcare to Aboriginal and Torres Strait Islander patients has been released.

The joint RACGP and National Aboriginal Community Controlled Health Organisation (NACCHO) guide is aimed at all healthcare providers, not just GPs, across Australia to improve prevention and early detection of disease and illness. The *National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people* is available at www.naccho.org.au

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QUEEN'S UNIVERSITY TEAM WITH
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BELFAST NURSES' INNOVATIVE APPROACH TO PRISONERS' SEXUAL HEALTH

Belfast nurses have introduced a novel approach to improve the sexual health of men in Northern Ireland's prisons.

The School of Nursing and Midwifery at Queen's University in Belfast worked with young male prisoners to develop a video animation promoting a positive attitude to sexual health testing. This coincided with the introduction of a nurse led initiative to provide asymptomatic sexual health check-ups for male prisoners.

Young men from Hydebank Wood College were co-producers in developing the animation. Young men were able to develop a video which was relevant and authentic to them, Queens' University Consultant Nurse in Sexual Health Dr Carmel Kelly said.

"Including their voices and experiences

during the creation of the intervention means that they are more likely to hear and act on those messages, which will not only improve their sexual health but also that of their partners and future partners."

The prison healthcare service was becoming increasingly primary care led with an emphasis on expansion of roles and responsibilities of nurses, said Tracey Heasley Clinical Nurse Lead for prison healthcare in the South Eastern Health and Social Care Trust.

It was the first time nurses had provided comprehensive check-ups. Previously medical consultants had mostly seen patients who exhibited symptoms.

"Introducing a nurse led sexual health service for patients without symptoms, will mean that patients with symptoms or testing positive will get to see our medical consultant much quicker."

Chief Medical Officer Dr Michael McBride said the health needs of the prison population were much greater than the community as a whole.

"As ever, early intervention and effective treatment, together with education to reduce future risk are key to success. Young male prisoners themselves have worked together to develop such an innovative approach to improving the sexual health of this frequently marginalised section of our society."

must remain a global public health and research priority. Lead author Dr Jahnavi Daru from Queen Mary University of London said anaemia in pregnancy was one of the most common medical problems pregnant women encountered both in low and high income countries.

"We've now shown that if a woman develops severe anaemia at any point in her pregnancy or in the seven days after delivery, she is at higher risk of dying, making urgent treatment even more important."

Anaemia was a readily treatable condition but existing approaches had not been able to tackle the problem, Dr Daru said.

"Clinicians, policymakers and healthcare professionals should now focus their attention on preventing anaemia, using a multifaceted approach, not just hoping that iron tablets will solve the problem."

TERTIARY-EDUCATED NURSES REDUCE RISK OF DEATH POST-SURGERY

Increasing the number of degree-educated nurses significantly reduces the risk of death in surgical patients with dementia, according to US research.

Surgical patients with coexisting Alzheimer's disease and related dementia (ADRD) were more likely to die within 30 days of admission and to die following a complication compared with patients without ADRD.

Having more nurses with a Bachelor of Science in Nursing (BSN) at the bedside improved the likelihood of good outcomes for all patients. However the effect was greatest for those with ADRD according to the *Journal of the American Geriatrics Society* study. The research showed a 10% increase in the number of BSN nurses was associated with 4% lower risk of death for those with ADRD.

The study was the first to examine the effects of clinician education on surgical outcomes for patients with ADRD. It included more than 350,000 patients who underwent general, orthopaedic or vascular surgery in one of 531 hospitals in California, Florida, New Jersey and Pennsylvania.

Patients with ADRD were older, had more comorbidities and longer stays, and experienced more complications, the study showed. Psychosis affected 1% of surgical patients without ADRD but nearly 18% of those with ADRD.

Patients with ADRD required close surveillance and diligent nursing care to prevent complications and quick intervention when complications arose, said lead author Elizabeth White at the University of Pennsylvania, School of Nursing.

"Patients with dementia are clinically complex and vulnerable, and nurses play a key role in monitoring and protecting these individuals from unwanted complications such as delirium and pneumonia after surgery.

"To do this, nurses must be able to think critically, problem solve and work well within interdisciplinary teams. These are all competencies emphasised in bachelor degree nursing programs."

The researchers recommended transition to a largely BSN workforce would contribute to improved surgical outcomes for patients with ADRD.

ANAEMIA IN PREGNANCY DOUBLES RISK OF DEATH

Pregnant women with anaemia are twice as likely to die during or shortly after pregnancy compared to those without the condition, according to research published in *The Lancet Global Health*.

The major international study of over 300,000 women across 29 countries suggested prevention and treatment of maternal anaemia

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Julianne Bryce



Elizabeth Foley



Julie Reeves

ANMF Federal Professional Officers

Co-author Faye Clarke, ANMF member and Aboriginal Nurse Adviser. She is a Gunditjmarra, Wotjaboluk and Ngarrindjeri woman and works as a Registered Nurse at the Ballarat and District Aboriginal Co-operative

THE IMPORTANCE OF CULTURAL SAFETY NOT A PRIVILEGE

Following two years of extensive consultation by the Nursing and Midwifery Board of Australia (NMBA) the new codes of conduct for nurses and midwives have been released. These revised codes have an important new inclusion: the principle of cultural safety.

The Australian Nursing and Midwifery Federation (ANMF), Australian College of Nursing, Australian College of Midwives and the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) all participated in each stage of the development and consultation on the new codes.

Responding to publicly aired misinformation these peak organisations for nurses and midwives have shown leadership by carefully and considerably explaining the benefits for all people when nurses and midwives provide culturally safe practice.

In their joint statement with the NMBA the four organisations expressed unequivocal support for the codes' guidance on respectful care to improve health outcomes for Australia's First Peoples.

NMBA's new codes of conduct feature cultural safety because 'racial discrimination is well documented as a contributing factor to poor health outcomes for Aboriginal and Torres Strait Islander Australians' (Australian Human Rights Commission, 2005).

The codes require that the care nurses and midwives provide eliminates racism and creates an environment in which Aboriginal and Torres Strait Islander people can feel safe to talk about their healthcare needs. In doing this, the codes are simply asking nurses and midwives to reflect, as they do in all areas of practice, about preconceived beliefs on which their practice is based, derived from 'what is normal for non-Indigenous Australians, particularly white Australians' (Mohamed 2018).

This means reflecting on inherent privileges associated with being part of the dominant culture in Australia and acknowledging the impact of white culture on this country's First Peoples.

In a previous column (ANMJ, 2014) we talked about nurses and midwives "acknowledging whiteness", and described what that meant for us after doing cultural safety training through CATSINaM:

We were confronted with the privilege that our 'whiteness' affords us in being part of the [white] dominant culture in Australian society; the fact that we will not be

discriminated against because of our skin colour; that we grow up with expectations of entitlements, often without thinking that others don't share that privilege....While we can't rewrite history or undo the wrongs of the past, we can commit to learning from the deep injustices of former generations and the perpetuation of discrimination by our generation [towards Aboriginal and Torres Strait Islander Australians].

THE CODES REQUIRE THAT THE CARE NURSES AND MIDWIVES PROVIDE ELIMINATES RACISM AND CREATES AN ENVIRONMENT IN WHICH ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE CAN FEEL SAFE TO TALK ABOUT THEIR HEALTHCARE NEEDS.

On 26 January 2018, Australia Day, the ANMF posted a question to Facebook to elicit members' views on changing the date of Australia Day, in view of sensitivities the current date has for Aboriginal and Torres Strait Islander peoples. Our colleague, Faye Clarke, a Gunditjmarra, Wotjaboluk and Ngarrindjeri woman, and ANMF member, provided commentary for the post expressing her difficulty in celebrating Australia Day on 26 January, in the same way as other Australians. As she said, "this date represents the beginning of very traumatic times for Aboriginal people, so why would we want to celebrate on that day? Commemorate yes, but not celebrate."

Responses from nurses and midwives to the ANMF post reflected those of the wider society, with both positive and negative comments. This has provided an opportunity to help our members join up the dots in making the connection between Aboriginal history, 26 January (first landing of white settlers, 1788) and the impact of this on Aboriginal health. Fellow nurse, Dr Ruth de Souza (2018), sums this up nicely

Australia is a white settler society like the United States, Canada and New Zealand. In such settler societies, colonisation and racism have had devastating effects on Indigenous health and wellbeing. These include: the theft of land and economic resources; the deliberate marginalisation and erasure of cultural beliefs, practices and language; and the forced imposition of British models of health over systems of healing that had been in Australia for millennia.

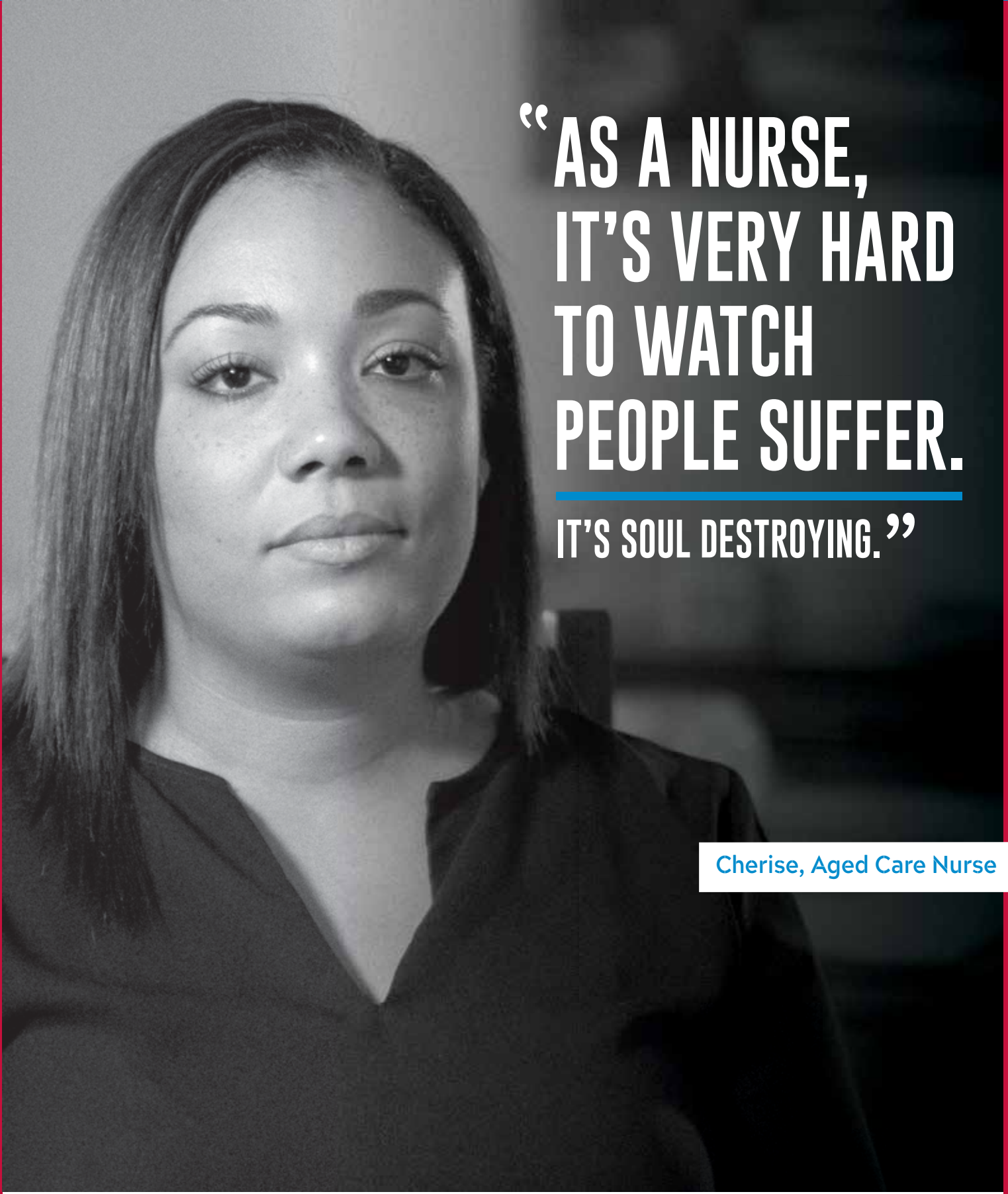
As forefront health and aged care professionals, the importance of nurses and midwives having an understanding of Australia's history through the lens of Aboriginal and Torres Strait Islander peoples, cannot be understated. The ANMF takes seriously our role in modelling and encouraging respect and reconciliation between Indigenous and non-Indigenous Australians (ANMF, 2016). Our business is to promote safe, competent nursing and midwifery care for all people in Australia - a culturally and linguistically diverse nation. The NMBA codes of conduct assist in the educative process needed to foster a culturally safe environment for all people receiving care, especially our First Peoples.

Joint position statement

Australian Nursing and Midwifery Federation, Australian College of Nursing, Australian College of Midwives, Congress of Aboriginal and Torres Strait Islander Nurses and Midwives, and NMBA joint statement: *Cultural safety: Nurses and midwives leading the way for safer healthcare*. Issued 23 March 2018. Available at: www.nursingmidwiferyboard.gov.au/News/2018-03-23-joint-statement.aspx

References

- Australian Human Rights Commission (2005) Social Justice Report 2005 cited in NMBA and CATSINaM joint statement on culturally safe care. Available at: www.nursingmidwiferyboard.gov.au/
- Cultural safety and respect, September 2014. ANMJ Vol 22(3), p23.
- Australian Nursing and Midwifery Federation. (2016). *Reconciliation Action Plan: December 2016-December 2018*. Available at: <http://anmf.org.au/pages/reconciliation-action-plan>
- de Souza, R. (26 March 2018) Busting five myths about cultural safety. Croakey. Available at: <https://croakey.org/busting-five-myths-about-cultural-safety-please-take-note-sky-news-et-al/>
- Mohamed, J. CEO CATSINaM. (24 March 2018) Cultural safety matters – the conversation we need to keep having. @Indigenous. Available at: <https://indigenoux.com.au/janine-mohamed-cultural-safety-matters/#.Wsqr4stPryd>



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

Cherise, Aged Care Nurse

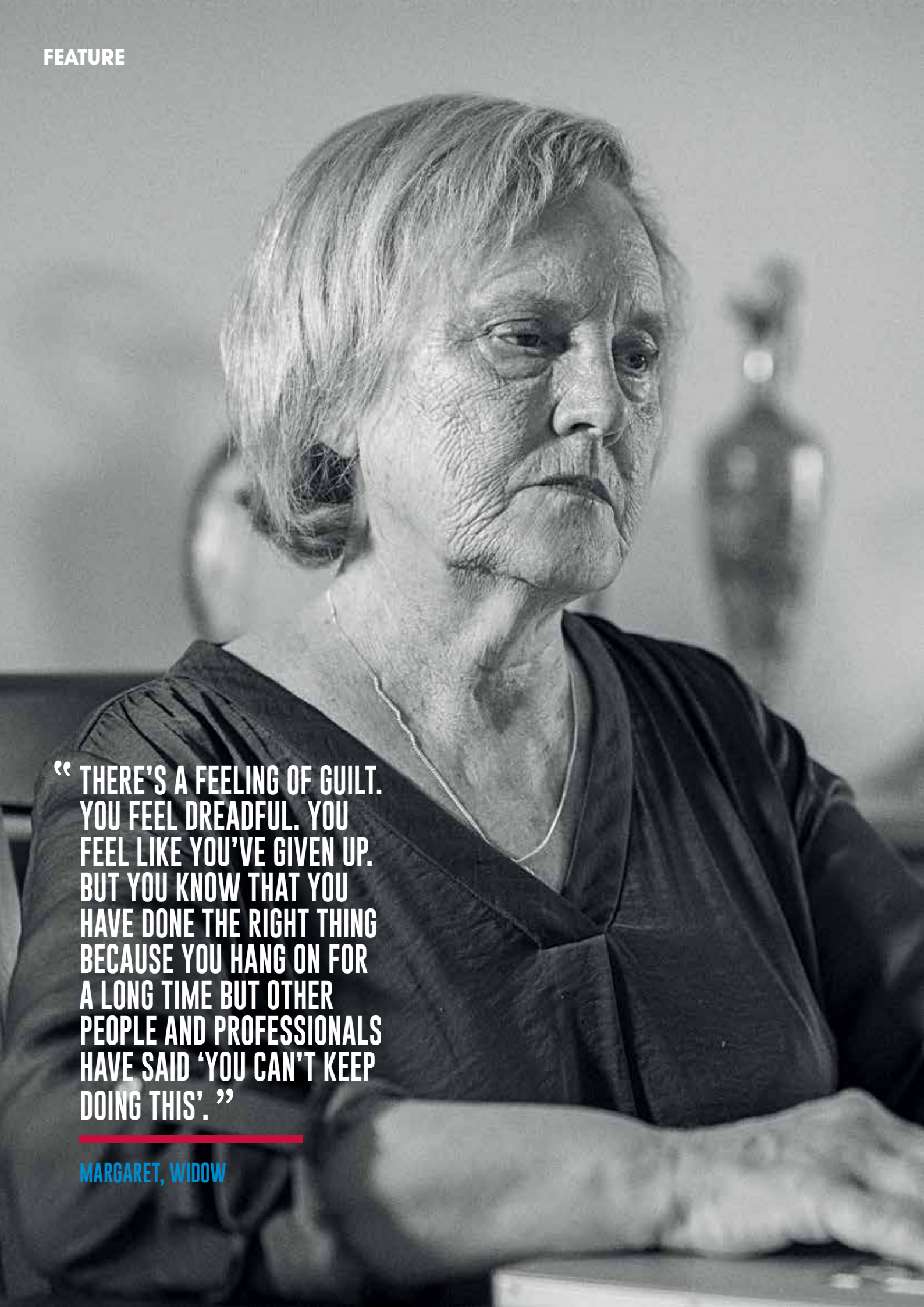
Chronic understaffing in Aged Care homes is leaving thousands of elderly Australians unfed, unwashed or even in soiled pads for hours because there’s simply not enough staff. The Federal Government must act now to make staff ratios law for Aged Care. Find out more at MoreStaffForAgedCare.com.au

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



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**RATIOS FOR AGED CARE
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“THERE’S A FEELING OF GUILT. YOU FEEL DREADFUL. YOU FEEL LIKE YOU’VE GIVEN UP. BUT YOU KNOW THAT YOU HAVE DONE THE RIGHT THING BECAUSE YOU HANG ON FOR A LONG TIME BUT OTHER PEOPLE AND PROFESSIONALS HAVE SAID ‘YOU CAN’T KEEP DOING THIS’.”

MARGARET, WIDOW

AGED CARE CRISIS

NATIONAL CAMPAIGN PUSHES FOR AGED CARE RATIOS IN LAW

The Australian Nursing and Midwifery Federation (ANMF) is launching a national campaign pushing for legislated staff ratios in aged care on 12 May, International Nurses' Day. The 'More Staff For Aged Care' campaign is calling on federal politicians to make aged care providers accountable for their use of taxpayers' money by mandating safe staffing ratios and ensuring elderly nursing home residents get the care they need and deserve. *Robert Fedele examines the aged care crisis.*

The ANMF's 'More Staff For Aged Care' campaign launch will involve state and territory branches across the country coming together with members and community supporters to draw attention to the impact of chronic understaffing in aged care.

Branches will hold activities on the ground, including rallies, aimed at convincing federal politicians to fix the crisis by supporting legislated staffing ratios in aged care prior to the next federal election.

Preparations for the campaign began back in March with a series of TV advertisements, billboards and social media posts featuring the stories of real people within the aged care system revealing how dangerous levels of understaffing is putting the lives of elderly nursing home residents at risk.

Voices include a registered nurse (RN), an assistant in nursing (AIN), a relative of a nursing home resident, a doctor working in the aged care system, a community supporter and a nursing home resident.

"I feel like sometimes I am on a production line, you don't get enough time to properly care for residents," says AIN Julie in one of the advertisements.

Almost 10,000 people across the country have already signed up to support the national campaign and its push for aged care ratios.

Branches will inform members about events taking place on the launch day closer to the date.

ANMF A/Federal Secretary Annie Butler says the campaign is not initially requesting more government funding for aged care but rather calling on federal politicians to exercise enough will to support mandated ratios across the sector so providers are accountable for the billions of dollars in funding they receive from taxpayers.

"Understaffing often means just one registered nurse has to manage the care of over 100 residents on a night shift or that a single carer has to feed, bathe, dress and mobilise 16 residents in under an hour," Ms Butler explains.

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

A HORRIBLE WAY TO GO

Margaret Zanghi's husband Ramiro passed away in a New South Wales aged care facility in 2007 after losing a battle with complex infections.

"He developed a very strong infection and he was taken to hospital but brought back [to the aged care facility] in the middle of the night yet



“IT WAS TIME TO GO BECAUSE ALL THE TIMES I REQUESTED EXTRA STAFFING OR EXTRA HOURS FOR OTHER PEOPLE TO HELP ME OUT THE RESPONSE WAS ‘SORRY WE DON’T HAVE ENOUGH FUNDING’.”

**REGISTERED NURSE
CHANMAKARA SUN**

had no hydrating drip or nothing and he was just left there and he drifted away,” Margaret recalls.

“I think it was a really awful experience. It’s not the fault of the nurses, although everything revolved around the nursing care.”

Margaret’s husband suffered from Lewy Body Dementia and she had been his full-time carer until frequent hospitalisations relating to urinary tract infections demanded he require 24-hour care.

“It’s very difficult,” she says of the decision to send a loved one into a nursing home.

“There’s a feeling of guilt. You feel dreadful. You feel like you’ve given up. But you know that you have done the right thing because you hang on for a long time but other people and professionals have said ‘you can’t keep doing this’.”

Margaret often visited the nursing home twice a day, quickly forming a friendship group with fellow “frequent visitors” who would look out for other people’s relatives when they popped in.

Margaret says the lack of nurses and sufficient care was prevalent.

“One thing [that stood out] was the absolute reliance on the RN but there were never enough RNs to go around,” she says.

“Going down the scale, I just saw there weren’t enough really qualified people.”

After her husband died, Margaret joined the Quality Aged Care Action Group (QACAG), supported by the New South Wales Nurses and Midwives’ Association (ANMF NSW Branch), to share her views as a consumer who had experienced the problematic aged care system.

A decade on, Margaret, a retired teacher, is the president of QACAG and still advocating for mandated ratios.

Over the years, she says countless government inquiries surrounding aged care have regrettably done little to trigger meaningful change.

One of the voices of the ANMF’s national ratios for aged care campaign, Margaret says she chose to speak out because of the awful conditions in the system that endure, underscored by a lack of resources, atrocious food, and what she considers widespread misery among residents that deserve better.

A CRISIS THAT SHAMES US

Fundamentally, the aged care crisis facing Australia traces back to the Aged Care Act 1997, which failed to set minimum staffing standards for government funded residential aged care facilities.

The Act does not specify what constitutes ‘appropriately skilled and qualified staff’ for the purposes of providing care and only states that the number of care staff should be ‘adequate’ to meet assessed care needs.

The grey area has evidently allowed aged care providers to make billions in profits at the expense of care.

A study released earlier this year showed some nursing homes were spending as little as \$6 per day to feed each resident three meals a day.

However, figures show Australia’s six largest for-profit aged care companies receive \$2.143 billion in government subsidies, which equates to 71% of revenue.

Governments have largely ignored the aged care crisis and seemingly failed in their duty to protect vulnerable elderly Australians.

Along with inaction on ratios, the Turnbull government slashed \$1.8 billion in funding from the Aged Care Funding Instrument

(ACFI) in 2016, placing further strain on small rural and remote facilities.

ANMF A/Federal Secretary Annie Butler puts the current aged care crisis down to governments’ lack of forward thinking.

She says Australians are living longer than ever before with chronic conditions and co-morbidities that require more complex care.

Increasingly opening up the aged care system to privatisation is another critical factor behind the sector’s decline, she adds.

“This is a sector of our society that has become increasingly invisible. They’ve become voiceless and disempowered because we lock them away and they’re not seen,” Ms Butler says. “The response of governments to the problem has focused on conducting review after review. I think we are aware of at least 15 different reviews. We know what the problems are and we know the solution lies in mandatory ratios for aged care. Now we just need to implement them.”

MOUNTING EVIDENCE

About 200,000 Australians live in residential aged care facilities.

Significantly, evidence commonly pinpoints chronic understaffing as the major reason behind the inability of nurses and carers to deliver quality care.

From 2003 to 2016, there has been a 13% reduction in trained nursing staff working full-time in aged care.

The state of play means the nation’s elderly are routinely left unfed, unwashed, in pain and at risk.

A study commissioned by the ANMF and undertaken by the ANMF (SA Branch) and researchers from Flinders University and the University of South Australia in 2016 investigated staffing levels in Australian

nursing homes, finding extensive episodes of missed care and failings in providing safe, quality aged care.

The report, National Aged Care Staffing and Skills Mix Project, found aged care residents should receive about four hours and 18 minutes of care per day - almost double the 2.84 hours of care they actually get.

It determined the minimum skills mix required to ensure safe residential care should comprise Registered Nurses (RNs) 30%, Enrolled Nurses (ENs) 20% and Personal Care Workers (PCWs) or Assistants in Nursing (AINs) 50%.

A subsequent online aged care survey run by the ANMF echoed the findings, with 92% of respondents reporting being asked to care for the same number of residents with fewer staff or less care hours, while 90% said current staff levels were simply not enough to carry out basic care such as bathing and bed changes.

Last year, a Senate Inquiry into the future of Australia's aged care workforce found inadequate staffing levels were leading to increased missed care, abuse and neglect of the elderly.

The Senate community affairs committee's final report recommended introducing minimum nursing requirements for all aged care facilities, including having a registered nurse present at all times.

Several months later, aged care advocate Senator Derryn Hinch introduced an Aged Care Amendment (Ratio of Skilled Staff to Care Recipients) Bill into Federal Parliament in a bid to push for legislated ratios in nursing homes.

He claimed the elderly were being neglected and highly vulnerable.

"Too many times in too many places, profit is the name of the game," Mr Hinch said.

"Some companies running these places know that you can keep that profit margin up by cutting costs, cutting staff numbers and playing games with the numbers so that it looks like there are more staff physically dealing with the wants and needs of the residents than there actually are."

In one of the more telling snapshots illustrating the grim state of aged care, a Monash University study last year uncovered a 400% spike in the number of premature and potentially preventable deaths in nursing homes over the 13 years between 2000 and 2013.

It found 3,289 nursing home residents died from potentially preventable causes including falls, choking and suicide.

LIVES PUT AT RISK

"I usually went home bawling my eyes out," says Registered Nurse Cherise about nursing home residents missing out on care due to understaffing.

"They were missing out on being able to be fed. The staff were so rushed trying to put meals out that half the time they would not know if people had eaten, especially if they were dementia residents.

"People wouldn't be toileted as often as

they were supposed to be so they'd sit in wet pads and could get infections."

Cherise pursued a career in aged care at 14, undertaking a school-based traineeship at a facility across the road.

By the end of year 12 she had finished her Certificate III in aged care.

She worked as a carer at the Blue Care facility in Queensland for five years before qualifying as an RN and taking charge at the 43-bed nursing home.

"It wasn't too bad for a while but probably the last two and half years I was there were horrendous," Cherise says.

"I was coming in early and going home sometimes at 1 o'clock in the morning when my shift was supposed to finish at 10pm because I didn't want to risk my registration by leaving things undone and at the same time you don't want to not provide care. You can't just leave."

Blue Care operates dozens of nursing homes in Queensland and came under fire in August last year after sacking nurses across several of its facilities and slashing nursing and care hours.

Months later, inspectors from the Aged Care Quality Agency (ACQA) paid an unannounced visit to Blue Care's Pioneer Lodge facility in Bundaberg, uncovering alarming patterns of sub-standard care.

The nursing home failed 15 of 44 aged care standards, with inspectors exposing insufficient staff levels, inadequate nutrition and hydration and a lack of personal and healthcare.

The ACQA concluded the facility did not have appropriately skilled and qualified staff and urgently needed to rectify its problems.

Cherise is not surprised by the findings given she had become increasingly frustrated by the organisation's inclination to hire carers with limited experience and knowledge over nurses.

She left Blue Care last year, partly to help look after her terminally ill grandfather and largely due to management ignoring her calls to address rising workload issues.

The tipping point occurred when Blue Care tried to force staff to be on-call overnight to fill in at facilities they did not work at.

"It was just dangerous and I refused to do it," she says.

Cherise was swiftly stood down after being painted a troublemaker but later cleared of wrongdoing following a disciplinary process.

She claims bullying by management throughout the ordeal left her shell-shocked and prompted her to leave the organisation and sector.

"It broke my heart to leave where I worked because I really loved it there," she says.

"I'm still in contact with [staff] because they're all my friends. The facility where I worked was actually a good facility and the staff that worked there were all long-time staff who cared about the residents and were good at their job but we lost so many good staff and Blue Care just didn't seem



"THIS IS A SECTOR OF OUR SOCIETY THAT HAS BECOME INCREASINGLY INVISIBLE. THEY'VE BECOME VOICELESS AND DISEMPOWERED BECAUSE WE LOCK THEM AWAY AND THEY'RE NOT SEEN."

**A/FEDERAL SECRETARY
ANNIE BUTLER**



“WHAT WE HAVE TO DO IS SHIFT THIS FROM AN INDIVIDUAL FEELING OF GUILT AND SHAME ON BEHALF OF FAMILIES AND WORKERS, TO CHANNELLING THE EMOTIONS ABOUT THAT INTO ANGER TOWARDS THE GOVERNMENT FOR THE SYSTEMIC FAILURE. THAT IS THE CHALLENGE.”

**QNMU (ANMF QLD
BRANCH) SECRETARY
BETH MOHLE**

to care.”

One of the voices of the ANMF’s ‘More Staff For Aged Care Campaign’, Cherise believes legislated staffing ratios are urgently needed to stop the declining quality of aged care.

“One reason I did this is I either had to find another sector of nursing or I had to do something about what I love and try and make a change.

“They [residents] don’t go into care by choice so I think at the end of their life they need people there who understand their illness, who can care for them properly and see them through to the end of their days.”

GUILT AND SHAME

The distressing failures unearthed at Blue Care’s Pioneer Lodge facility entered the mainstream spotlight last month through an investigation by the ABC’s 7.30 program.

The episode exposed information about staff giving up on feeding difficult residents, one of the ACQA’s inspectors observing a resident calling out for help with her head hanging over the side of the bed rail and call bell on the floor, and residents reporting being left on the toilet for prolonged periods.

The episode featured the account of Janice Williams, whose 87-year-old mother Joyce was a resident at Pioneer Lodge, arguing that her mother’s death in February this year could have been prevented if staff and management had listened to her concerns regarding a worrying infection.

Queensland Nurses and Midwives’ Union (QNMU, ANMF QLD Branch) Secretary Beth Mohle suggests the ABC’s raw depiction of the challenges facing aged care could provide a foundation for the ANMF’s ratios for aged care campaign as it strives to raise awareness.

“It’s a real life story about what’s going on, not only in Bundaberg but across the country,” Ms Mohle says.

“It was incredibly powerful and very important but that’s just the beginning of similar stories.”

The QNMU has been campaigning for action on aged care for several years and has employed dedicated staff to help steer the current campaign for ratios.

Some of its existing strategies tackling the crisis include resident safety advocates in aged care facilities and engaging with like-minded community groups to broaden and strengthen people power.

Ms Mohle concedes the aged care workforce is struggling but says the ANMF’s campaign is providing them hope.

“It is fundamentally a lack of nursing in aged care that we’re suffering from now and it is having devastating consequences for residents and their families,” she says.

“They [members] know this campaign is coming. They know we’ll have the might of 270,000 Australian nurses and midwives and community members who support this campaign. They are hopeful that we will achieve breakthrough with this campaign and then they will be able to deliver the care that they know they’re capable of.”

In an open Letter to the Editor, Ms Mohle

wrote that Australian politicians need to stop talking and act on aged care neglect.

“It is increasingly clear that despite numerous aged care reviews and media releases from the Turnbull government and opposition, aged care quality and safety does not come first in this country. Not even close.”

Ms Mohle believes unlocking the aged care crisis rests ultimately with people needing to confront two powerful emotions – guilt and shame.

Families must learn to deal with the guilt from putting their loved ones into aged care and the realisation that what they signed them up for doesn’t reflect the reality, she says.

Similarly, aged care workers need to overcome feelings of guilt and shame from not being able to deliver the care they know they can.

“It’s really confronting for them [staff] to actually realise. They are devastated by the fact they are doing the best they can in a system that is failing and it’s not their fault.

“What we have to do is shift this from an individual feeling of guilt and shame on behalf of families and workers, to channelling the emotions about that into anger towards the government for the systemic failure. That is the challenge.”

A STRUGGLING WORKFORCE

Registered nurse Chanmakara Sun grudgingly left aged care eight months ago after succumbing to the unrelenting stress and pressure of the job.

He suggests he is not alone, with many of his colleagues moving to different sectors or walking away from nursing altogether.

“It was time to go because all the times I requested extra staffing or extra hours for other people to help me out the response was ‘Sorry we don’t have enough funding’,” Mr Sun, who now works in a hospital, says.

“It was time to move along and perhaps if I can get some more experience from acute care and in the future we can help change the system, then I will go back.”

Mr Sun worked at a South Australian nursing home looking after 90 residents with multiple chronic illnesses and rising acuity.

He says insufficient staffing levels regularly compromised the ability of nurses and carers to deliver proper care.

“It could be anything simple from going to the bathroom on time or missing out on pain medications,” he explains.

“There’s a lot of pressure [on staff] from the time that you start your shift to the end and you never finish on time.”

Mr Sun believes the federal government needs to take responsibility for fixing the aged care crisis by implementing legislated ratios in aged care and making providers accountable for how they use funding meant for care.

“You can see from the news [headlines] that the food is not good enough, the meals are not good enough and the care is not good enough because they [providers] keep all the profits in their own pockets.”

Despite leaving aged care, Mr Sun remains connected to the sector and determined to help address wide-ranging

THE MINIMUM SKILLS MIX

REGISTERED NURSES (RN)

30%



ENROLLED NURSES (EN)

20%



PERSONAL CARE WORKER (PCW)

50%

WHAT CARE RESIDENTS SHOULD RECEIVE



4 HOURS & 18 MINUTES OF CARE PER DAY

WHAT CARE RESIDENTS ACTUALLY RECEIVE



2.84 HOURS OF CARE PER DAY

Source: National Aged Care Staffing and Skills Mix Project, ANMF, Flinders University Research Team and University of South Australia.



AGED CARE REFORM RALLY IN SOUTH AUSTRALIA, FEBRUARY 2018

and longstanding issues.

Earlier this year, he stood alongside colleagues at an Aged Care Reform Rally at South Australia's Parliament House, advocating for safer staffing and quality care.

"I do think the community is starting to realise more and more what they [residents] are missing out on," Mr Sun says.

"Once the general population understands what they [residents] are missing and what the government's not really telling them that will potentially give more power to change."

PEOPLE POWER

ANMF (SA Branch) Secretary/CEO Adjunct Associate Professor Elizabeth Dabars began her career working as a Personal Care Assistant (PCA) in aged care and progressed to a Registered Nurse in the sector.

For as long as she can remember aged care staff have faced growing challenges to provide safe and quality care to vulnerable elderly residents and the reluctance of policymakers to address the issues motivated her to join the union and actively push for change.

"The problem is that our elderly citizens need and deserve quality care and it's not fair on them to be given a sub-standard level of care and it's certainly not fair either on hardworking and dedicated staff trying to help them," Ms Dabars says.

"It's also terrible for people's family members to be constantly in a state of worry about whether their family member is getting treated appropriately, whether they're able to be toileted, whether they've had their dignity respected and whether they're able to just get their fundamental nutritional and other care needs met."

Ms Dabars says it's vitally important the country's nurses and midwives, irrespective of whether they work in aged care or not, support the ANMF's national aged care ratios campaign and help drive genuine change.

She says unless chronic understaffing is resolved frontline aged care nurses and carers will continue to struggle to provide proper care.

"The issues that people [staff] talk about are just as basic as the sadness they feel when they are not able to meet those basic needs," Ms Dabars says.

"The fact that people [staff] can't spend the time to make sure that residents feel comforted and cared for is just devastating."

Further, Ms Dabars points out that the aged care crisis is also affecting the public health system because a rising number of elderly people are unable to be appropriately looked after in residential aged care and instead admitted to hospital.

"They end up being shunted over into the public health system and that is unacceptable," she says.

"We should be making sure that people are getting the care they need and deserve in the facility they're in. The fact they end up getting shifted into a hospital setting can be very disorienting and make the situation far worse."

Ms Dabars says the aged care crisis has reached breaking point and that it is time aged care ratios are made law so providers are finally made accountable for taxpayers' funds.

"Unfortunately these types of things are about the bottom line and I don't think it's appropriate to be making profit out of people's fundamental healthcare needs when they're ageing."

MENTAL HEALTH TRIAGE AND ASSESSING RISK

Almost half of Australian adults will experience a *mental illness* at some point in their life. The tutorial, 'Mental Health Triage and Assessing Risk', available on the ANMF's Continuing Professional Education (CPE) website, is provided to enable nurses and midwives to appropriately assess risk and to assign appropriate mental health triage categories and patient management strategies.

Many nurses and midwives (particularly those working in Emergency Departments (ED)) are often required to assess patients presenting with mental health symptoms.

The complexities of mental illness along with the apprehension nurses and midwives can feel when confronted with mentally unwell patients can lead to poor management, including inappropriate referrals and use of resources. Additionally, despite the nurses' or midwives' best intentions, it may further agitate, frighten, or confuse the patient.

The Australasian Triage Scale (ATS), which provides consistency when applying Emergency Department Mental Health Triage, is used by all Australian EDs.

The mental health component of the ATS contains the protocols and guidelines for assigning the correct mental health triage category and the coinciding level of supervision and observation for each category.

The ATS mental health triage categories are assigned according to the patient's level of risk to themselves or others. All patients presenting to EDs are assigned a level of acuity using the (ATS), which comprises five tiers, or categories, of acuity. Each category determines the maximum time to treatment for the patient dependent on the urgency of the presenting medical problem and the threat of loss of life or limb.

Medical triage is based on three key assessment methods and is assigned five levels of acuity:

The three key assessment methods are:

1. Primary survey – a visual observation of the patient to detect any noticeable disability or alterations to airway, breathing, or circulation.
2. Clinical history taking – either from the patient or the person attending with the patient.
3. Collection of physical data.
4. When the three key assessments have been completed, the patient is allocated a triage category that determines the urgency of the treatment required, and the maximum time before the patient receives the treatment.

Category	Description	Maximum time to treatment
1	Life threatening	Immediate
2	Imminently life threatening	10 minutes
3	Potentially life threatening	30 minutes
4	Potentially serious	60 minutes
5	Less urgent	120 minutes

Illness, disease, and other physiological factors can cause alterations to mental states. Mentally unwell patients also suffer from injury, sickness and disease. Therefore, the first action is to assess for medical disorders using assessment protocols.

Nurses may find it difficult to communicate with patients who have altered mental states. Similarly the patient may not be able to tell the nurse what they are experiencing or provide a recent history.

This being the case, the nurse will have to rely on their own observation and assessment skills or information from family, friend, or other person who is familiar with the patient.

A MENTAL HEALTH TRIAGE ASSESSMENT IS NOT A TOOL TO MAKE A MENTAL HEALTH DIAGNOSIS; IT IS USED ONLY TO DETERMINE THE LEVEL OF URGENCY BASED ON RISK TO SELF OR OTHERS AND TO DETERMINE APPROPRIATE MANAGEMENT OF A PERSON PRESENTING WITH PSYCHIATRIC SYMPTOMS.

Nurses working in ED will likely be using the ATS method of assessment, while nurses working in other health environments will use tools and protocols normally applied for assessing physical health.

A patient with psychiatric symptoms needs to be managed appropriately while further assessments are taken to confirm or rule out medical conditions. The nurse needs to determine the level of risk they pose to self or others and assign the appropriate mental health triage category. The mental health triage category will then provide you with the required level of observation or supervision of the patient.

A mental health triage assessment is not a tool to make a mental health diagnosis; it is used only to determine the level of urgency based on risk to self or others and to determine appropriate management of a person presenting with psychiatric symptoms.

It is important to remember:

- not all violent or hostile behaviour is a result of mental illness;
- more than 90% of people with a mental

illness do not display violent or aggressive behaviour;

- medical disorders can also cause violent or hostile behaviour; and
- mentally unwell patients also suffer from sickness, injury, and disease and need medical attention.

If you feel threatened or are concerned about your safety for any reason:

- Stop the assessment.
- Remove yourself from the situation.
- Seek assistance from colleagues/security/police as per your workplace's protocols.

Mental health assessments at triage are based on the 'ABC' assessment of the patient and nurses will glean most of this information when you first come in contact with the patient and speak with them.

A = appearance, B = behaviour, C = conversation

Appearance

The overall appearance of a patient will give you an indication of their current state of mental health. What are you looking for?

Hygiene: Are they well dressed, well groomed, unkempt, is their hair clean, dirty, what about their finger nails or oral hygiene?

Clothing: Are their clothes appropriate for the weather or are they wearing a short sleeved shirt and bare foot in the middle of winter? Does their clothing match or do they look bizarre, do they have a shirt on backwards or upside down?

Body language: Do they look relaxed, maintain good eye contact, or do they have their arms folded, head down, stooped posture? Are they irritable or displaying angry gestures?

Behaviour can provide you with clues to their internal thought processes, their mood, attitude, and level of engagement. Are they:

- Agitated, pacing, restless or fidgeting, or displaying hostile or angry behaviour?
- Mute, statue like, rocking back and forth, or staring blankly and not responding?
- Displaying bizarre or inappropriate behaviour?
- Do they look like they are responding to hallucinations for example grabbing at things in the air, talking to someone who is not there, or seeing things that aren't real?
- Cooperative, uncooperative, withdrawn, standing too close, singing, running around, looking around as though they are frightened or paranoid?

Conversation

Their flow of conversation and how they respond to you will give you an indication of their thought content and thought processes:

Speech - how are they speaking?

Quantity - how much are they saying; are they talkative, mute, not saying much, or about normal?

Quality - how good is their speech; is it spontaneous, slurred, intelligible or unintelligible?

Rate - are they talking fast, slow, normal, do they stop and start as though something is interrupting them?

Volume - are they shouting, whispering, loud, softly spoken, low and menacing, or normal? Remember to take into account any noise in the environment, hearing problems, privacy issues, or other factors that may cause them to speak louder or softer than normal.

Thought is divided into thought content and thought form.

Thought content is a verbal expression of what they are thinking, are they expressing:

- Paranoid or conspiratorial themes?
- Depressed thoughts, thoughts of self-harm, suicide or wanting to die?
- Grandiose thoughts?
- Is what they are saying sexually explicit or inappropriate?
- Anger, threats or homicidal intent towards anyone?
- Normal, happy thoughts?

- Feelings of hopelessness or helplessness?

Thought form is how they string words or sentences together and can indicate (or not) alterations to cognitive processes:

- Do they make sense or is what they are saying illogical or nonsensical?
- Do they appear to have thought blocking by stopping mid-sentence or losing track of what they are saying?
- Are they jumping from one topic to another and are the topics related or all over the place?

Medical triage codes determine the maximum amount of time to treatment based on risk to life or limb, whereas **mental health triage codes** determine the maximum amount of time to treatment based on risk to self or others, but they have the same triage categories with coinciding response times as general triage.

The Australian Government Emergency Triage Education Kit Quick Reference Guide describes the mental health triage categories and appropriate patient management for each category.

The mental health triage categories and management are discussed in detail within the content of the tutorial. A real life case scenario is offered along with risk indicators, de-escalation techniques, and recognising signs of potential suicide are also discussed.

To access the complete tutorial go to:
anmf.cliniciansmatrix.com



30 MINUTES CPD

Reading and reflecting on this excerpt from the tutorial will provide you with 30 minutes towards your annual CPD.

Completing the tutorial, assessment and reflection will give you two hours of CPD towards your annual CPD registration requirements.

For further information you can contact the ANMF education team at **education@anmf.org.au** or phone **(02) 6232 6533**.

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HAZARDS IN THE WORKPLACE

Protecting yourself and your patients against workplace hazards is an essential part of the job for any nurse, midwife or carer. This month the ANMJ looks at aspects of physical hazards and emotional hazards to nurses, midwives and carers as well as hazards to the patient.



PSYCHOLOGICAL HAZARDS

Strategies to help deal with them

Work contributes to positive mental health and wellbeing. It provides structure, purpose, a sense of identity and self-worth. But what happens when the work is having an adverse effect on personal health and wellbeing? What strategies can be employed to stave off psychosocial stressors of the job?

"I think one of the biggest risks is that of the work and the sort of experiences confronted in the workplace: death and

trauma, aggression and conflict, loss and the unexpected," says Glenn Taylor CEO of the Nursing & Midwifery Health Program Victoria.

"We have that hyper-awareness that we all need when we work in the workplaces we do: to react to those situations that require us to be always primed, ready to go to respond. But long term it has a spiritual, emotional effect that can be quite destructive."

If you are switched on all the time, aware for crises to respond to, it is difficult to switch off, says Mr Taylor, which can lead to anxiety, depression, and psychological distress.

"You may have been a calm, insightful person and over the course of time, say 12 months or longer, your moods have changed and you may be more hyper-vigilant."

One thing that is common amongst

nurses and midwives experiencing symptoms of psychological distress is compassion fatigue, says Mr Taylor.

"The abnormal – death, trauma, horror – becomes normal. If you work in a trauma centre then death and dying is what happens but when you leave the most important thing is that you can leave it behind."

"What happens with compassion fatigue is the unrelenting demands of our working lives as nurses and midwives and the cumulative wear and tear comes at a cost to the individual. That cost has a physical and psychological response."

"It can be tiredness, lethargy, lack of motivation, lack of inspiration and hope – where you have just been sapped of your will. People often get on with their work but lack the vitality."

Reflection

"Some people walk out the door and work is gone. Other nurses, say junior nurses can take it home with them," says Mr Taylor.

For the latter, he suggests if possible using travel time home to reflect on the day.

"If you're in your car and it's too distracting no, but if you travel by tram or train then go through the day and think about the role you played. Go through your workday from 7am to 3pm and do an audit. What responsibilities did you have and check them off. Most nurses do medication rounds, did I finish those rounds? Was that a good conversation? Was that a good outcome?"

"You can then feel you completed your activities and did ok or if you forgot something you can call work if you need to. You can shred yourself away, now going to live a life outside of work."

Closing off your day

Have a way of closing off your day, Mr Taylor suggests. "Some people have a shower, others go for a walk. Some people do something meaningful. Download apps and do some mindfulness meditation. Compartmentalise your day, put work away and focus on your family and friends."

Do something for 'time out' for 10-15 minutes a day says Mr Taylor. "Where you are not responsible for anything or anyone - it's your own time to be selfish. Whether that's connecting with family or friends if it gives you joy and happiness, or hobbies, interests or pursuits."

Work satisfaction

This is the pleasure that you derive from being able to do your work, says Mr Taylor.

What's positive about your work, your colleagues, and the people you care for?

"In an ideal world, this should outweigh compassion fatigue. Some people come to us lacking hope. We get them to identify something they did that was commended by a colleague or management or a compliment from a patient or relative. Something reasonably special that reminds them why they got into what they do and for them to feel good at what they do."

Mr Taylor suggests nurses and midwives use a success inventory. "Write down in dot point and put in notes, on your phone and look at it when you are having a bad day or feeling down. It's about focusing on what you do have, not what you don't have."

Reflective practice

This is a more formal debriefing than a personal inventory of your day. Reflective practice is something that all nurses and midwives should do, says Mr Taylor.

"Most novice nurses have it built in to their training. It's basically to debrief - to reflect on the role we have played and the work that we have done."

Reflective practice can be done with another colleague, a mentor or supervisor that we can talk to about particular events, someone that can offer support from an experience.

"Usually this is someone you have lined



up to talk with in an unplanned adverse event, such as being assaulted. You need to have someone who can handle this sort of situation." It might be someone you went to uni with, or who is a ward unit manager, or a work colleague, or someone who works on a different ward in the same hospital environment.

Mr Taylor suggests having at least a couple of mentors/colleagues/supervisors so that you do not rely on one person.

"This is really important but also in an ideal world that you have people lined up. Someone you can say to "you have a lot of experience and we have some rapport, if I needed support or needed to talk with someone after a bad day, would you be available? So that you have already prepared someone if the situation arises later."

Mr Taylor acknowledges this is heavily reliant on trust and rapport and is well worth it.

Ask for help

Mostly we don't ask for help until something happens, Mr Taylor says.

"Some people recognise the signs at the first red flag. But for many of us, there's an event, incident, disciplinary process, fight, breakdown or break up."

"It's generally a slow burn. It's very important to check in with yourself, have family and trusted colleagues that will ask you 'Are you okay?' 'You seem out of character or out of sorts?'"

"If you can have those few trusted friends or colleagues that can tap you on your shoulder if your behaviour isn't consistent with how you are normally or you don't seem right. If you set it up now and do not wait until you are in a situation or place because you never know when you may need that support or help."

HAZARDS TO THE PATIENT

Infection control advances boost patient safety

As the Infection Control Coordinator at Calvary North Adelaide Hospital, Lisa Ryan's role is to ensure patients, staff and visitors have minimal exposure to infections.

The position includes a gamut of responsibilities to promote best practice infection control measures.

These include monitoring and auditing hand hygiene practices amongst staff, patients and visitors, invasive device surveillance, environmental safety, worker immunisation and both staff and patient education.

Lisa says hand hygiene is the most important aspect to ensuring patients do not contract hospital-acquired infections and is also critical in the prevention of infection across the broader community.

"That's something we spend a lot of time on, either auditing, teaching or just reporting on to our executive committees, both medical and nursing."

"Number two would be actual management of the patient while they're an inpatient. So the environmental state of the ward, the management of their invasive devices and their wounds while they're an inpatient."

"Number three is environmental management - hygiene, cleaning and the physical environment of the hospital."

Nurses, medical staff and allied health professionals are educated to follow correct policies and procedures regarding infection

MOVE SMART
COORDINATOR LESLEA
JOHNSON AT ST VINCENT'S
PUBLIC HOSPITAL IN
MELBOURNE



prevention.

Many Australian hospitals utilise Hand Hygiene Australia (HHA), as the peak national body, as a source of guidelines and online training.

Calvary North Adelaide participates in the HHA program, conducting regular audits of clinical, hospitality and administrative staff as well as Visiting Medical Officers, to identify hand hygiene compliance.

Across the organisation, Calvary North Adelaide sits above national benchmarks, with nurses consistently registering above 80% on auditing.

"The actual benchmark for hand hygiene is 80%. If you fall below 80% you are required to do something about it, usually education or taking it to the medical and nursing committees, etc.," says Lisa.

Lisa says understanding and awareness of the importance of infection prevention has grown over the past decade, aided in part by influenza and swine flu pandemics that lifted community awareness.

"If you stand out in front of hospitals now and watch the general public enter, probably more than half of them will use the hand rub on the way in. I think that's great."

Lisa says hazards related to infection that a patient could encounter in hospital settings are multifaceted.

"I train people about hand hygiene. I train them about invasive devices and antimicrobial stewardship and I also train them about health and wellbeing, being immunised and not coming into work sick."

Importantly, the hospital's regular audits help shape the direction of annual infection prevention training.

Lisa suggests infection control will develop further in coming years, citing antimicrobial stewardship and surgical antimicrobial prophylaxis compliance as areas for improvement.

"I think the education and profile raising has made a huge difference to infection control."

At Canberra Hospital, Wendy Beckingham works for ACT Health as its Assistant Director of Nursing (ADON) Infection Prevention and Control.

The role oversees Canberra Hospital and surrounding health centres, including mental health and prison units.

Canberra Hospital has a catchment area of about 700,000 people and Wendy says inroads have been made in infection prevention and control since she took on the role in 1998.

They extend to greater awareness of the need to reduce healthcare acquired infections and implementing strategies like surveillance, where data is collected on bloodstream infections, surgical site infections, multi-resistant organisms and how many flu cases develop during winter.

The hospital also investigates diarrhoea and gastro outbreaks.

Overall, however, Wendy believes infection prevention and control is still largely overlooked at health settings across the country.

"We've increased our size and how many staff we've got to do that work but I don't believe infection control anywhere is well resourced."

"People see that they need to have infection control but they can't identify

how many personnel they really need to do that job."

Wendy says the patient journey at Canberra Hospital has improved significantly, pointing to interventions that reduced bloodstream infections related to an IV line and saved the organisation close to \$2 million per year.

She says unless organisations maintain a 'healthy hospital' they can potentially expose patients, staff and visitors to numerous diseases.

"We need to make sure our air-conditioning specialists work to a program and test our air conditioning and check our filtered rooms. I would recommend that we have a very effective cleaning service because by cleaning microorganisms off surfaces you reduce hazards to patients."

"You may have heard about listeria recently in the news. It is making sure we have good services and they know what causes foodborne illnesses and reduce that risk to patients. It's making sure you've got clean linen because if you don't you can potentially give people surgical site infections."

Wendy says the list goes on and on, right down to cleaning the hospital's furnishing and fittings.

She says most nurses fully understand standard precautions and correct policies when it comes to infection prevention and control.

"I believe that comes from good education [from our end], building a good rapport with the clinical areas, making sure that you've got a good face out there, that you're really well known and respected and

have good knowledge.”

As for a patient stepping foot into Canberra Hospital, Wendy says they have never felt safer.

“I believe we’ve got good practices, good protocols. We have good processes. We’ve got the facilities for patients to report and not be scared to report to us if there’s a problem and I believe that the culture here at the hospital is that everybody’s happy to hear if we do have an issue and correct it.”

PHYSICAL HAZARDS

Leslea Johnson trained to become a registered nurse in the early ‘90s when unsafe manual handling techniques like top and tail lifts and cradle lifts were the norm.

After spending a decade away from the profession, Leslea completed a re-entry course at Melbourne’s St Vincent’s Public Hospital before working for several years across most wards.

For the past five years, Leslea has been working within the hospital’s Health Safety and Wellbeing Department as one of three Move Smart Coordinators tackling challenging patient manual handling risks by implementing safe solutions in a bid to prevent injuries.

“As a nurse on the wards I walked into this scenario where there were hoists everywhere and there were slide sheets and risk assessment and stuff we had never looked at as undergraduates,” Leslea recalls of the marked culture change she encountered upon returning to nursing.

Leslea says nurses, hardworking and stoic by nature, often place their own wellbeing below the care of their patients and therefore commonly expose themselves to physical hazards. “What we sometimes forget is just because you can do something doesn’t always mean that you should. I think we have this skewed idea where we don’t see the risk when it’s right in front of us.”

Leading hazards

As a Move Smart Coordinator, Leslea provides annual breakdowns to the hospital’s executive on patient manual handling incident reports, injuries and serious injuries.

Recent incident report trends at St Vincent’s show leading physical hazards involve occupational violence; both patient and non-patient manual handling injuries; slips, trips and falls; and staff running into something or having something run into them.

About six years ago, St Vincent’s undertook a critical review of its patient manual handling training program after barriers were identified.

The outcomes included a restructure involving engaging Move Smart Coordinators to provide patient manual handling training to all clinical staff as required.

Despite significant progress and greater awareness of risks among the hospital’s

staff, including almost 3,000 who carry out patient manual handling and are required to undertake Move Smart training annually, Leslea concedes incidents still occur.

“Unfortunately, with the environment that they work in, there’s a lot of conflicting priorities. I don’t think people do the wrong thing intentionally but the nature of the work and the type of environment they’re working in and pressures they’re working under competes with their own safety.”

Training

The patient manual handling training program at St Vincent’s starts with core basic training for new and existing staff so they absorb correct procedures and realise what ongoing support is available on the wards.

All staff exposed to the risks of patient manual handling are then required to undergo annual refresher courses.

The Move Smart team commonly delves into incident reports to uncover injury trends, and then tailors training packages around the problem area.

“I DON’T THINK PEOPLE DO THE WRONG THING INTENTIONALLY BUT THE NATURE OF THE WORK AND THE TYPE OF ENVIRONMENT THEY’RE WORKING IN AND PRESSURES THEY’RE WORKING UNDER COMPETES WITH THEIR OWN SAFETY.”

Data found repositioning dependent patients on a bed triggered the most incident reports and injuries at the hospital. The Move Smart team’s solution involved using inflatable HoverMatts, similar to lilos, with large weight carrying capacities. “Last year we taught all of our staff who attended the refresher how to roll patients, usually bariatric patients, using that HoverMatt. It was a really big step for us and a really successful technique,” Leslea says. In this vein, while Leslea believes general training is important, she suggests mitigating risk is usually underpinned by new equipment, such as the hospital installing ceiling hoists at a cost of \$1.5 million over 10 years, and putting appropriate controls in place. “We always look at whether we can eliminate risks or whether we can change a system or a process of work to make it safer or whether we can put in a piece of engineering or equipment to make things safer.”

Manual handling policy

St Vincent’s updated its Manual Handling Policy in 2017 to reflect regulations within Victoria’s latest *Occupational Health and Safety Act* and *Occupational Health and Safety Regulations*.

Its subsequent Manual Handling Policy now incorporates patient manual handling,

non-patient manual handling and care of the bariatric patient.

Generally, policies aim to eliminate the manual lifting of patients where reasonable.

The health and safety of nurses takes precedence over the patient’s requests, and methods and handling equipment to move or transfer patients must provide the highest level of protection for staff and patients.

“What our policy really aims to do is provide a framework for risk management of hazardous manual handling. It’s all to do with consultation, identification, assessment, controls, monitoring and review,” Leslea says.

Risk management

Leslea describes risk management as a methodology or framework that identifies and assesses hazards to determine their likelihood of occurring.

For example, the probability of a patient that has a code blue in a chair is very low to medium, but the consequences for staff that have to move that patient to treat them could be very high.

Leslea says other markers used to measure risk management include incident reports, workplace inspections and feedback from manufacturing companies that might flag a fault with a piece of equipment.

“Once we assess it and attribute high risk to it we would then look at how we control it and minimise it.”

The OHS Department at St Vincent’s includes an Injury Management Team and when incidents occur, early reporting is encouraged.

The process commonly involves the team liaising with the affected staff member, their manager and attending the worksite to ensure proper controls are in place, and further injuries can be prevented.

The staff member should expect to be supported to attend medical appointments and to work restricted duties if required.

The road ahead

Despite significant improvements, Leslea says St Vincent’s, like many other hospitals, has a long way to go in curbing patient manual handling injuries.

“We don’t live in a vacuum. There’s always change. Our incident reports show [manual handling] is still the number one cause of serious injury so that’s a bit of a cold reality.”

Leslea suggests rising numbers of overweight and obese people in Australia is reflected in the patient population and places further strain on the capabilities of nurses to care for the bariatric patient.

The Move Smart team currently visits wards and consults on complex manual handling issues, providing hands on assistance with bariatric patients, but Leslea believes this increasing cohort demands expert teams who can plan strategies, consult with staff and monitor care in order to improve safety.

“We have a population that is getting older, bigger and sicker. We’ve got a workforce that is working longer and ageing as well. That’s the complexity.”

UNDERTAKING RESEARCH ON THE ROLE OF ASSESSING HEALTH COMPLAINTS ABOUT PRACTITIONERS

By Annmaree Nicholls and Victoria Traynor

In 2010 Australia moved to a National Registration scheme for registered health professionals including nurses and midwives. This resulted in the establishment of the Nursing and Midwifery Board of Australia (NMBA) that sets National policy and professional standards and state and territory Boards that manage notifications/complaints about nurses, midwives and students. The *Health Practitioner Regulation National Law* sets out how the Boards and in NSW Councils are to be constituted and operate. The Australia Health Practitioner Regulation Agency (AHPRA) supports the Boards in their regulatory operation and maintains the National Register of nurses, midwives and students of the professions. However, in NSW the NSW Nurses and Midwives Council (NSW NMC) performs the role of managing complaints/notifications about nurses, midwives and students and the Health Practitioner Council Authority (HPCA) supports them in their regulatory function.

I work as a Professional Officer for the NMC and manage notifications about nurses, midwives and students' health. The majority of practitioners reported do not know who the NMC are, what they do and are confused as to why their health is being reviewed by someone who is not their treating team. In Australia,

like many countries the regulatory schemes are there to protect the public from health practitioners who are not suitably trained, competent and safe to practice, yet many health practitioners would be unaware of who the regulators are and what they do (Jones 2012).

This brief article outlines the process of panel review of reported health matters related to practitioners and the research being conducted to develop an understanding of the role of professional panel members.

To protect the public from substandard, unsafe and unethical practice the actions of the regulator are defined and guided by legislation known as administrative law. In Australia, this is the *Health Practitioner Regulation National Law*. The Nursing and Midwifery Board of Australia (NMBA) and in NSW the Nursing and Midwifery Council (NMC) are responsible for protecting the public with the intention not to be punitive but rather to work with the practitioner to improve competency and safety to practice their profession. The Boards and NMC are the administrators of the legislation and protectors of the public by presiding over hearings, committees or panels for the purpose of professional regulation (Staunton and Chiarella 2013).

In Australia, to be listed on the National Register, nurses and midwives must have completed an NMBA accredited nursing or midwifery course and declare that they meet registration standards to use the protected titles of the professions. Maintaining registration comes with the same obligations of complying to registration standards such as recency of practice, completing continuous professional development, having indemnity insurance and making declarations about criminal history and health (impairment) (Australian Nursing and Midwifery Board, 2016).

When the NMBA or the NMC is notified about nurses, midwives or students' health, the law prescribes how the notification will be managed.

'Impairment' is the legal term prescribed to health matters and the law states a practitioner is impaired if they have a physical or mental impairment, disability, condition or disorder that detrimentally affects, or is likely to detrimentally affect their capacity to practice their profession including substance abuse or dependence and the student's capacity to undertake clinical training (Staunton and Chiarella 2013).

Under the law, one option available to the regulator (NMC or NMBA) is to convene an Impaired Registrants Panel (IRP). The membership of the IRP as prescribed

in law (*Health Practitioner Regulation National Law*) consists of currently registered professionals, namely a medical officer and nurse or midwife of the same division, for example if the registrant is an enrolled nurse, than an enrolled nurse must be on the panel. The IRP panel meet to review the matter.

The nurse, midwife or student is provided with notice and background material about the IRP. The law prescribes that the IRP can go ahead in the absence of the practitioner if they chose not to attend. The IRP panel review the matter and make recommendations to the NMBA or NMC regarding any conditions to be imposed upon the registration of the practitioner, such as possible restrictions on their practice and ongoing health monitoring. Despite the commitment and challenges these professional members face, there is very little recognition or documentation in the literature of their role. This is true internationally with very little research being undertaken on the role of panel members reviewing health matters of healthcare practitioners.

The University of Wollongong and the NSW state regulator (NSW NMC) are combining to collaborate for the first time to explore how members who sit on IRP's operate. The NMC has made a commitment through innovative research to improve its recruitment processes and better prepare and support existing members to ensure the best possible outcome for the nurses, midwives and students. That is, allowing them to remain practicing safely thereby protecting the public as prescribed by the law. Annmaree Nicholls will be leading this research over the next 12 months with professional members from all geographical areas and professional roles invited to participate. The aim is to generate ideas about new ways of working in the area of the management of nurses, midwives and students with health concerns.





References

Australian Nursing and Midwifery Board 2016, viewed 17 October 2017, (www.nursingmidwiferyboard.gov.au/Registration-Standards.aspx).

Jones, M. L. 2012. A brief history of the registration of nurses. *British Journal of Healthcare Assistants* vol. 6(1) pp41-44.

Staunton, P. J. and Chiarella, M. 2013. *Law for nurses and midwives*. Chatswood, N.S.W, Churchill Livingstone.

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Linda Starr

AN UNSATISFACTORY FINDING

The introduction of electronic health records (EHR's) has created both hope and angst amongst healthcare professionals and the courts. On the one hand EHR's promise improved access to patient data on demand which in turn will improve the quality of healthcare.

On the other, the development and implementation of the technology has not been without difficulty and has led to issues around security, misuse of patient data and breaches of patient privacy.

However, findings in a recent coronial inquest of what the Coroner described as an entirely preventable death highlight that it is not only technological issues associated with EHR's that need addressing but also poor adherence to policy when using EHR's that can jeopardise the integrity of the notes and put the patient's health at risk.

Mr Herczeg was 72 years of age when admitted to hospital with a urinary tract infection, an indwelling catheter was in situ from an earlier hospital admission and he was placed on oxygen. These modes of treatment 'set the scene' for what was to follow. Whilst an uncomplicated admission and eventual discharge was anticipated, the patient died later that day from a traumatic injury leading to a coronial inquiry that found the cause of death to be: bilateral pneumothoraces and pneumoperitoneum due to insufflation of the bladder with rupture with contributing infective exacerbation of chronic obstructive pulmonary disease. The Coroner described Mr Herczeg's death as horrific and traumatic.

The inquiry focused on a number of issues the most pressing being-how could this event happen and why was the patient on oxygen?

A substantial amount of evidence confirmed that somehow at some time the patient's oxygen supply tube was fitted not to the nasal cannula but to the patient's catheter, filling his body with gas which led to his death. Despite considerable evidence being available from a detailed investigation on this point, the Coroner found that there was insufficient evidence to determine who was responsible for making this connection either accidentally or deliberately and declared that the tubing was interfered with by an unknown person.

It was during the consideration of why the patient was receiving oxygen at all that the issues regarding a failure to adhere to policy and a failure to adequately monitor the patient materialised. It was an

established fact that on admission around 04:30am the patient was on 4L of oxygen and that at 12:15pm prior to the patient being assessed by the respiratory team he was receiving 3L of oxygen. The respiratory team modified the patient's oxygen saturation levels to be between 85 and 92% but did not set the system to require a respiratory alarm to be triggered if the level rose above 92%. It is possible that had this been done the entry at 14:55 indicating that the patient's saturations were 96% on 2L of oxygen would have alerted the staff of the need to remove the oxygen. The next entry in the patient's notes at 12:58pm was:

THE INQUIRY FOCUSED ON A NUMBER OF ISSUES THE MOST PRESSING BEING-HOW COULD THIS EVENT HAPPEN AND WHY WAS THE PATIENT ON OXYGEN?

'SaO₂ currently 87% on room air. Home team have requested for nursing staff to not commence oxygen if possible.'

The Coroner was of the view that this cumulative information was significant and that it 'should have been significant to any competent staff reading the notes thereafter'. In other words, Mr Herczeg should not have been given oxygen unless his saturations fell below 85% and if commenced, the oxygen should cease when this returned to acceptable levels within that parameter. The Coroner held the view that if the patient had not been on oxygen in the first place the catastrophic outcome would not have eventuated.

How and why Mr Herczeg was on oxygen during his stay in the ward was a question the coroner could not answer with any certainty in part due to a dispute as to who was responsible for some entries in the patient's case notes.

A nursing entry at 14:26 hours stated that Mr Herczeg was on 3L of


oxygen per hour and oxygen levels were 91%. However, the nurse whose login details this entry was made under denied making such an entry claiming that at no time during her care was the patient on oxygen. It was this nurse's view that someone else made this entry under her login details, which is why her name was attributed to it. She remained adamant that as the patient was not receiving oxygen during the time she was caring for him, she would not have recorded that he did. To support her claim that another person must have made the entry, the nurse informed the inquest that it was a common practice of herself and other staff to not only login to the system and leave it open, but to key in their password in order to save data that has knowingly been recorded by another person. Additional evidence before the Coroner clearly demonstrated that this practice was prohibited under the rules and policies that regulated the use of the EHR.

This same nurse was also adamant that they informed the ward staff during handover that the patient was not to have oxygen, and whilst some present at the handover could not recall specific details regarding oxygen, one nurse was sure that the patient was on 2L of oxygen when they arrived on the ward, possibly delivered by a portable oxygen cylinder during transfer.

It appears that the ward staff, not looking at the EHR themselves, relied upon the verbal handover and assumed that as the patient had nasal cannula in situ he was to have oxygen and were therefore unaware of the modifications made by the respiratory team, leading the Coroner to conclude that the ward staff failed to provide an adequate level of care and supervision to this patient during his time on the ward.

This article explored two issues in this inquest: the risks associated with a practice of leaving an open log into a patient notes enabling others to make an entry under your login details and the harm that can result from relying on a verbal handover rather than reading the patient's notes when taking over their care.

Inquest into the Death of Stephen Herczeg SA Coroners Court 2017

 **An expert in the field of nursing and the law Associate Professor Linda Starr is in the School of Nursing and Midwifery at Flinders University in South Australia**

BETTER EDUCATION FOR HEALTHCARE PROFESSIONALS TO PREVENT STILLBIRTH

Midwives should open up conversations about foetal baby movements during pregnancy to help inform women and possibly prevent the tragedy of stillbirth.

University of South Australia (UniSA) research found more than 80% of bereaved parents and more than 60% of women who had a live birth were not told about the possibility of a stillborn child during their pregnancy.

The research found stigma around stillbirth was still entrenched and not helped by the lack of information from healthcare providers, including how to reduce the chances of it happening.

"We are not told about this in antenatal classes and neither are we told how to relate to a bereaved parent who has lost a child at birth," said project leader UniSA PhD candidate Danielle Pollock. Ms Pollock's PhD includes how midwives, obstetricians and GPs provide information about stillbirth and how best to educate a pregnant woman and her family.

Healthcare professionals were very comfortable talking about Down syndrome, spina bifida, listeriosis, even domestic violence, but stillbirth was a subject they avoided, Ms Pollock said.

"Healthcare professionals still report they do not want to talk about stillbirth due to inducing anxiety in pregnant women but there is no evidence to support that."

"My concern is the foetal movement

message is not happening – we are not talking through why it's important for the pregnant woman to check baby movements."

UniSA Associate Professor Jane Warland who is Ms Pollock's PhD supervisor said the research supported healthcare professionals to discuss stillbirth with women, which could be done from the 16-20 week antenatal appointment (or middle of pregnancy).

Evidence from Scotland where it was mandated for healthcare professionals to have the conversation [about the importance of the mother monitoring foetal movements] showed this increased information resulted in a decreased stillbirth rate, she said. The first thing was to open up the conversation during pregnancy, said Ms Pollock.

"Not just 'is the baby moving?' yes or no which is what is currently done in Australia. Instead, 'tell me about your baby's movements'. A woman might say, 'baby was very active last week but I haven't really felt baby this week or baby isn't as strong.'"

"Many ask the question in a blasé way when we really need to be talking about it as lifesaving information. It's a simple change to what we do but it can save babies' lives."



QUITTING FACEBOOK REDUCES STRESS BUT LOWERS WELLBEING

Deleting your Facebook account could reduce your stress levels, according to a University of Queensland (UQ) study.

Taking a Facebook break for just five days reduced a person's level of stress hormone cortisol. However study participants reported lower feelings of wellbeing.

Lead author Dr Eric Vanman of UQ's School of Psychology said people felt less content with their lives due to the social disconnection of being cut-off from their Facebook friends.

While Facebook provided many benefits, the amount of social information it conveyed was quite taxing, he said. "It seems that people take a break because they're too stressed, but return to Facebook whenever they feel unhappy because they have been cut off from their friends. It then becomes stressful again after a while, so they take another break. And so on." The study was published in the *Journal of Social Psychology*.

PREGNANCY RISKS FOR THOSE WITH ADHD NOT LINKED TO MEDICATION

Women being treated for attention deficit hyperactivity disorder (ADHD) should not stop taking stimulant medications without medical consultation, according to NSW researchers.

The University of Sydney study assessed the impacts of ADHD and its treatment on outcomes of 5,056 NSW women and their newborns. The researchers found adverse pregnancy and perinatal outcomes in both women with ADHD who took medication and those who were untreated.

Women diagnosed with ADHD at any stage were 20-30% more likely to have a caesarean delivery and their babies had an increased rate of needing support to start breathing or admission to a neonatal unit. These increases even affected women and babies who were not diagnosed or treated for ADHD until after giving birth.

This suggests that ADHD itself is a significant predictor of adverse pregnancy and perinatal outcomes, University of Sydney Senior Lecturer, paediatrician and study lead Alison Poulton said. "These adverse outcomes were seen even in women not yet treated for ADHD and in women who stopped taking stimulant medication several years before becoming pregnant, suggesting that the increased risk isn't caused by medication."

"Based on the evidence of this study, the potential benefit of ceasing treatment for ADHD during pregnancy may be limited."

STOPPING EXERCISE MAY INCREASE DEPRESSIVE MOOD

Stopping exercise in active adults may increase depressive symptoms, South Australian research shows.

The University of Adelaide study investigated the sudden cessation of exercise in 152 adults who had previously undertaken at least 30 minutes of exercise three times a week, for a minimum of three months.

Exercise cessation in some cases induced significant increases in depressive symptoms in just three days, University of Adelaide Head of Psychiatry Professor Bernhaud Baune said. "Other studies showed that people's depressive symptoms increased after the first one or two weeks, which is still quite soon after stopping their exercise."

Further research was needed to better understand how exercise cessation affected depressive symptoms, Professor Baune said. "For now, it is important that people understand the potential impact on their mental wellbeing when they suddenly cease regular exercise." The study was published in the *Journal of Affective Disorders*.



SELF-DETERMINATION AND THERAPEUTIC RECREATION: IMPLICATIONS FOR PERSONAL RECOVERY AMONG PEOPLE LIVING WITH MENTAL ILLNESS

By Ellie K Taylor, Lorna Moxham and Dana Perlman

Mental health professionals in Australia have a responsibility to provide recovery oriented care. The Australian Department of Health's (2013) *National Framework for Recovery-Oriented Mental Health Services: Guide for Practitioners and Providers* states this involves the maximisation of opportunities for self-determination.

Self-determination is an individual's disposition toward acting in a "self-directed, self-regulated, autonomous" manner (Field et al. 1998 p2). People with a mental illness (consumers) who report high levels of self-determination also report greater wellbeing (Chang 2011).

In last year's mental health edition of ANMJ, Taylor et al. (2017) underscored the importance of exploring the relationship between self-determination and personal recovery from mental illness.

While mental health policies and practices purport a relationship between the two concepts, little empirical evidence exists to support these claims. To address this gap in the literature, the relationship between self-determination and personal recovery was explored in the context of a therapeutic recreation (TR) initiative. Participants

were offered various opportunities to maximise self-determined behaviours, and a three-phase sequential mixed methods approach, including surveys, interviews, and a focus group, ensured a well-rounded exploration of this relationship.


The findings supported a relationship between the concepts of self-determination and personal recovery. Self-reported survey responses revealed that consumers who participated in the TR initiative were indeed more self-determined post-intervention. For aspects of self-determination such as awareness of self, perceived choice, and relatedness, this was maintained at three month follow up. While no significant change in competence (ie. a feeling of optimal challenge) was found, this could be ascribed to the difficult nature of transferring experiences of mastery in the TR


setting to one's larger construct of self and life (Lysaker and DiMaggio 2014).

Building on this, interviews focused specifically on how this rise in self-determination related to personal recovery. Van Kaam's (1969) psycho phenomenological method of analysis was utilised to explore the findings, given its previous use in exploring the lived experience of illness (Salmon 2012). An interplay between self-determination and personal recovery emerged. Many participants described how key tenets of self-determination – autonomy, competence, and relatedness – fostered their recovery journey and promoted confidence and a sense of purpose in life.

With regard to autonomy, participants described how making independent choices within the TR setting was a valuable principle they were able to transfer to their day-to-day lives. These participants found they regained control over their own wants and needs, thus improving their overall wellbeing. Similarly, many experienced a sense of competence, in that they were able to 'have a go' at activities and feel successful, despite physical limitations such as being overweight. The TR experience also promoted social connection and reminded participants of their capacity to help others. Most described how this encouraged them to relate to their peers within the broader community. Maximising these elements of self-determination meant the participants felt greater ownership over their recovery journey and had newfound hope for their future.

These findings have significant implications for the field of mental healthcare. The notion that TR activities can promote self-determination and subsequently support the recovery journey of consumers suggests that TR, and other similar interventions that promote self-determination, should be entwined with more 'traditional' approaches to mental healthcare. This has the potential to enhance consumer wellbeing and ensure a truly recovery-oriented approach.

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 **Lorna Moxham is Professor of Mental Health Nursing in the School of Nursing at the University of Wollongong**

 **Dana Perlman is Senior Lecturer in the School of Education at the University of Wollongong**



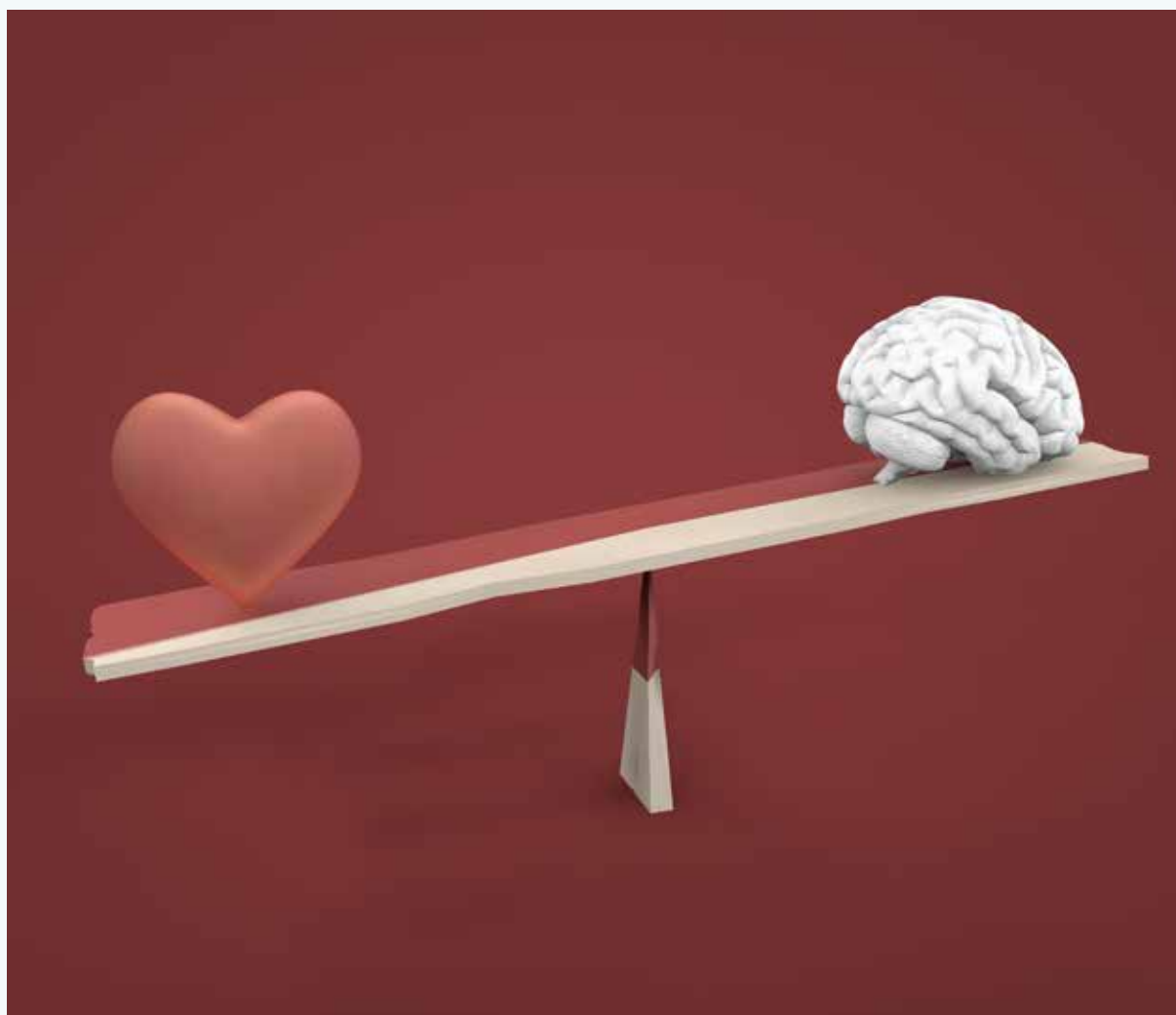
ELLIE TAYLOR

LEFT: RECOVERY CAMP



References

- Australian Department of Health. 2013. A national framework for recovery-oriented mental health services: Guide for practitioners and providers. Canberra, ACT: Australian Department of Health.
- Chang, L. 2011. An interaction effect of leisure self-determination and leisure competence of older adults' self-rated health. *Journal of Health Psychology*. 17(3): 324-332.
- Field, S., Martin, J., Miller, R., Ward, M. and Wehmeyer, M. 1998. *A practical guide for teaching self-determination*. Reston, VA: Council for Exceptional Children.
- Lysaker, P.H., and DiMaggio, G. 2014. Metacognitive capacities for reflection in schizophrenia: implications for developing treatments. *Schizophrenia Bulletin*. 40(3): 487-491.
- Salmon, J. 2012. The use of phenomenology in nursing research. *Nurse Researcher*. 19: 3-4.
- Taylor, E., Moxham, L., Perlman, D., Patterson, C., Brighton, R. and Sumsis, S. 2017. Self-determination in the context of mental health recovery. *Australian Journal of Nursing and Midwifery*. 23(10): 41.
- van Kaam, A. 1969. *Existential foundation of psychology*. New York, NY: Image Books.



EMOTIONAL INTELLIGENCE CAN HELP REGIONAL NURSES MAINTAIN THEIR MENTAL WELLBEING

By John Hurley, Marie Hutchinson and Desirée Kozlowski

One of the challenges to nurses' mental wellbeing is that the heavy workloads they experience can limit opportunities to deliver satisfying compassionate care (Bogossian et al. 2014).

Across rural, regional and metropolitan centres nurses

experience different workplace and lifestyle contexts. Rural and regional Australians have higher levels of social disadvantage, lower educational levels, and shorter lives than those in metropolitan areas (AIHW 2018). Consequent health choices and resultant poor health outcomes place additional burdens on nurses delivering services to this population.

Nurses in these centres also have limited access to supervision and professional mental health support services are sparse (Moran et al. 2014). Ongoing work dissatisfaction in these contexts challenges rural and regional nurses to maintain their mental wellbeing. Assuming some heightened self-responsibility towards their own mental wellbeing is therefore a necessity. Improving mental health requires the nurse to, in essence, shift some of the emotional labour they provide to others toward their own wellbeing.

One important behaviour change tool for nurses' mental wellbeing is to increase the frequency of their emotionally intelligent (EI) behaviours. EI involves demonstrating emotional self-awareness, emotional awareness of others, and meeting

one's needs better through combining emotional and technical knowledge. Importantly, EI training also incorporates managing one's emotional wellbeing (Palmer 2007).

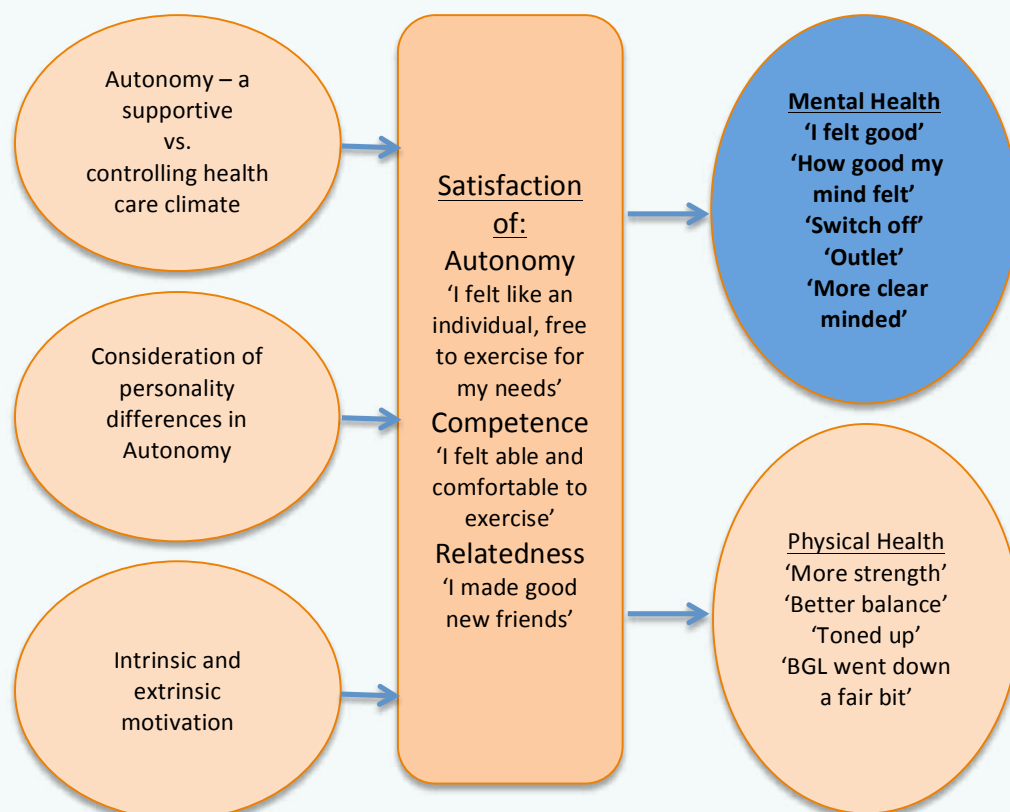
A recent study of 60 regional registered nurses by Southern Cross University found significant increases in EI scores following brief training and follow up coaching by health professionals, including nurses, who were accredited EI trainers (Hutchinson et al. in press). With EI being associated with better mental health and increased work satisfaction (Schutte and Loi, 2014) it offers an exciting option for nurses as a counterbalance to their demanding work environments (Hutchinson and Hurley 2013). Importantly EI is not fixed and can be increased with relatively little resource where accredited trainers are aware of nursing culture (Hutchinson et al. in press).

Dr John Hurley is Professor of Mental Health; Dr Marie Hutchinson is Associate Professor of mental health nursing and Dr Desirée Kozlowski is Lecturer in Psychology. All are at Southern Cross University



References

- Australia. Department of Health. 2018. Rural & remote health. Canberra: Australian Institute of Health and Welfare. v.5.
- Bogossian, F., Winters-Chang, P. and Tuckett, A. 2014. The pure hard slog that nursing is: A qualitative analysis of nursing work. *Journal of Nursing Scholarship*. 46: 377-388.
- Hutchinson, M. and Hurley, J. 2013. Exploring leadership capability and emotional intelligence as moderators of workplace bullying. *Journal of Nursing Management*. 21: 553-562.
- Hutchinson, M., Hurley, J., Kozlowski, D. and Whitehair, L. The utilisation of emotional intelligence capabilities in clinical reasoning and decision making: a qualitative, exploratory study. *Journal of Clinical Nursing*. <https://doi.org/10.1111/jocn.14106>
- Moran, A. M., Coyle, J., Pope, R., Boxall, D., Nancarrow, S. A. and Young, J. 2014. Supervision, support and mentoring interventions for health practitioners in rural and remote contexts: an integrative review and thematic synthesis of the literature to identify mechanisms for successful outcomes. *Human Resources for Health*. 12: 10.
- Palmer, B. 2007. Models and measures of emotional intelligence. *Organisations and People*. 14: 3.
- Schutte, N. S. and Loi, N. M. 2014. Connections between emotional intelligence and workplace flourishing. *Personality and Individual Differences*. 66: 134-139.



OLDER PEOPLE WHO EXERCISE HAVE BETTER MENTAL HEALTH

By Rebekkah Middleton, Lorna Moxham and Dominique Parrish

People with higher levels of physical activity report enhanced mental health (Law et al. 2014). In contrast, low levels of exercise can in turn lead to waning of physical and mental health, along with a decreased social network, as sedentary behaviours become the norm (Valencia, Stoutenberg & Florez, 2014). This is particularly so in older people.

From research, it is apparent how we engage older people with diabetes into exercise programs becomes even more of a challenge. But how do we encourage this engagement in exercise as health professionals, to enhance mental health in our older population, especially those with chronic illnesses?

When the older person's autonomy, competence and relatedness are supported and promoted within an exercise program, psychological needs in people are met. Autonomy encompasses having control and choice. Competence comprises the older person feeling capable about doing something. Relatedness embodies feeling connected to and supported by others. Once met, individuals are then more motivated

to initiate and maintain health behaviours. van Stralen et al. (2009) argues that realising one's potential for improved mental, and physical, outcomes enhances maintenance of exercise and commitment to a group within a program. Ryan et al. (2008) proposes that when these three aspects are met, subsequent improved mental health is supported. Participants in the lead authors' research supported this with comments around exercising in an exercise and health promotion program, such as, 'it got me out of the house, and that was a good thing' and 'I felt better about myself when I was exercising'.

How autonomy, competence and relatedness contribute to a more positive and enhanced mental health when older people are exercising is

summarised in Figure 1 Participant quotes from the lead authors research are included.

As health professionals we have a responsibility to promote and support motivation in older people to initiate and maintain health related behaviours. This is possible by engendering a sense of autonomy, and competence so that health related behaviours and actions are internalised, prompting self-regulation and sustainability of those behaviours (Ryan et al. 2008). These, along with relatedness, are core psychological needs that must be met. When met, it is purported that commitment to exercise occurs; thereby contributing to improved mental health.

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References

- Law, L., Barnett, F., Yau, M. & Gray, M. 2014. Effects of functional tasks on older adults with cognitive impairment at risk of Alzheimer's disease: a randomized controlled trial. *Age Ageing*, 43(6):813-20.
- Ryan, R., Patrick, H., Deci, E. & Williams, G. 2008. Facilitating health behavior change and its maintenance: Interventions based on Self-Determination Theory. *The European Health Psychologist*, 10(1):2-5.
- Valencia, W., Stoutenberg, M. & Florez, H. 2014. Weight Loss and Physical Activity for Disease Prevention in Obese Older Adults: an Important Role for Lifestyle Management. *Current Diabetes Reports*, 14, (10):1-10.
- van Stralen, M.M., De Vries, H., Mudde, A.N., Bolman, C. & Lechner, L. 2009. Determinants of initiation and maintenance of physical activity among older adults: a literature review. *Health Psychology Review*, 3(2):147-207.

FROM RESEARCHED TO RESEARCHERS: INVOLVING CONSUMERS AS COLLABORATORS IN MENTAL HEALTH RESEARCH

By Julia Bocking, Brett Scholz, and Brenda Happell

Australian mental health policy is very clear that consumers must be active participants in the design, implementation, development and evaluation of mental health services.

Given the importance of research to quality service delivery, it seems logical that the same expectation should apply to research. Embedding consumer perspectives ensures the ethics of mental health research, and improves the authenticity and relevance of research outcomes. Some advances in involving consumers as active participants or partners in research have emerged in recent times.

However, the path has been far from smooth and significant barriers have been identified. Organisational factors and the attitudes of researchers from traditional backgrounds are particularly notable. In the current state of play mental health research is primarily undertaken by researchers from health professional backgrounds. Understanding more about their views and experiences of collaborating with consumers in research is important to enable and facilitate improved consumer involvement.

With this in mind a research study was undertaken by SYNERGY: Nursing and Midwifery Research


Centre in collaboration with the Department of Psychological Medicine, University of Otago (for the first paper from this study, see Happell et al. 2018). In reflecting best practice, the research itself was co-produced with equal numbers of consumer and non-consumer researchers from Australia and New Zealand. Interviews were conducted with 11 mental health researchers from Australia and New Zealand who had worked collaboratively with consumers in research projects. The researchers represented the disciplines of nursing, psychology, psychiatry and social work, and included researchers from universities and health organisations.


The experiences of the researchers were overwhelmingly positive. The dynamic between different perspectives improved the quality of the research and enhanced its relevance, particularly for consumers. The unique perspective drawn from lived experience contributed to an environment of mutual learning. Promoting the many benefits of partnerships with


consumer researchers was seen as essential to improve clinical practice and the development of policy.

And of course there were barriers. These included the hierarchical nature of academia and the privileging of knowledge gained from science to knowledge gained from lived experience; significant power differentials between consumer and non-consumer researchers in terms of influence, credibility and access to resources; a paternalistic approach to consumers and lack of confidence in their capacity to contribute to research; lacking a clear understanding of meaningful consumer participation, and lack of funding and other resources to support this work.

Sadly, there are no easy solutions, and research participants described the need to keep 'chipping away', taking whatever opportunities they could to involve consumers in research and promoting the positive outcomes from this work. As our team and likeminded researchers continue to do what they can, promoting consumer research and its benefits is an important part of the process.

 **Julia Bocking, Consumer Academic, B. Social & Community Studies & B.Phil. (Hons)**

 **Dr Brett Scholz, BHLthSci (Hons), PhD, Post-doctoral Research Fellow**

 **Professor Brenda Happell, Professor of Nursing and Executive Director, RN, BA (Hons), PhD. All are located at SYNERGY: Nursing and Midwifery Research Centre at The Canberra Hospital**



Reference

Happell, B., Liggins, J., Gordon, S., Ellis, P., Bocking, J., Platania-Phung, C. and Scholz, B. (2018), "How did I not see that? Perspectives of non-consumer mental health researchers on the benefits of collaborative research with consumers", *International Journal of Mental Health Nursing*, doi:10.1111/inm.12453

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STUDENT NURSES
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NURSE EDUCATION AND THE MILITARY VETERAN

By Alan Finnegan, Jane Currie, Teresa Ryan and Mary Steen

No occupation is more dangerous than serving in a nation's armed forces, where service-personnel may face atrocious conditions and events. Some experience mental health problems including Post Traumatic Stress Disorder, depression and anxiety. The spouse and children are exposed to frequent moves, and endure long periods separated from a partner or parent.

Nurses are well placed to make a substantial difference in the care of veterans and their families, although many veterans believe healthcare professionals "cannot understand" their experiences (Finnegan et al. 2017).

To change this narrative, the UK has introduced a new under graduate educational initiative.

An initial single site pilot study was undertaken at the University of Chester, England in 2017. The

aim was to produce educational sessions that provided student nurses with an insight into the Armed Forces Community (AFC) of serving personnel, veterans and their families, and construct an understanding of the biopsychosocial needs aligned to their care, health and wellbeing. The intent was to stimulate critical thinking to focus on the individual and family needs by encouraging a problem solving approach.

The educational program includes a flipped approach where students prepared by examining if they had an AFC family connection such as a grandparent in World War II. They then were afforded an opportunity to present this relationship. There are quizzes, vignettes, classroom and blended learning. The sessions embrace technology and include online information resources, apps, Talking Heads, and video presentations (Finnegan et al. 2018). Students have access to a growing number of online lectures and will soon have an opportunity to join online discussions. Creating free online mediums presents a chance to share this information with the clinical workforce, welfare agencies and AFC beneficiaries.


The sessions are being evaluated to determine the students' views regarding relevance, and then using these recommendations to proactively develop the format. The pilot evaluation results strongly indicated that students' value and want this training. In addition, there is an ongoing qualitative study to identify the strengths and areas for development with students utilised as co-researchers. This insight will be triangulated with quantitative data to improve validity and reliability.


By creating a military focus across

higher education institutions, there is a chance to build a workforce that is empowered to provide the optimum care to the AFC. This also has the potential to promote research and community goodwill. The initiative is being extended to other UK universities, and there is scope to inform other multidisciplinary groups and global collaboration. The initiative working group includes international partnerships in the US and Australia in Sydney and Adelaide universities. It is envisaged that the sessions will positively enhance the wellbeing of military veterans and challenge long standing issues aligned to stigma.

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 **Ms Jane Currie MSc, BSc (Hons), RN(A), The University of Sydney**

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References

Finnegan, A.P., Brownsell, M., Steen, S., & Templeman, J. 2018. Evaluating the Needs of the Armed Forces Community. University of Chester. At: www.chester.ac.uk/health/crivw Accessed 21 March 2013

Finnegan, A.P., McGhee, S., & Leach, J. 2017. Educating Nurses to Provide Better Care for the Military Veteran & their Families. *Nurse Education Today*. 54, 62-63

FORENSIC MENTAL HEALTH: THE TRANSITION FOR REGISTERED NURSES

By Grant Kinghorn, Elizabeth Halcomb, Terry Froggatt and Stuart Thomas

Joining a new healthcare organisation is often a stressful experience due to the unfamiliarity of the new environment and work group. A recent literature review of registered nurses moving into new clinical environments suggested that nurses experience various challenges in adapting to new clinical areas (Kinghorn et al. 2017).

While formal and informal support

systems were regarded as valuable by transitioning nurses they were inconsistently available (Kinghorn et al. 2017).

Mental Health nursing has historically been seen as a challenging clinical area. Additionally, specific areas of the speciality, such as forensic mental health, have been seen to present further unique challenges for nurses.

Beyond the complexity of providing mental health nursing services, forensic mental health nurses often work within secure environments with complex patients with various risks. In this context, appropriate therapeutic engagement must be maintained to ensure a balance of risk management, security and containment with the client's need for care, treatment and intervention (Mason et al. 2008).

These unique challenges combined with the limited evidence around the transition of registered nurses into new areas of clinical practice highlights the need to understand the experience of transition for registered nurses entering forensic mental health environments. This knowledge will ensure that policy, education and practice appropriately support those transitioning to ensure that they are retained in the workforce.

PhD candidate Grant Kinghorn

from the School of Nursing, University of Wollongong, is currently undertaking a mixed methods study to understand the transition of registered nurses into employment within a forensic mental health setting. The first phase of the study is currently underway with an online survey being conducted to explore the workforce issues and identify elements which impact on the transition process of registered nurses moving into a forensic setting. This will be followed by interviews in the second phase to further explore these experiences and provide a deeper understanding of the survey findings. This project is being supervised by Professor Elizabeth Halcomb University of Wollongong, Professor Stuart Thomas (RMIT) and Dr Terry Froggatt (Nan Tien Institute).

Grant Kinghorn is a Lecturer at UoW and PhD Candidate

Professor Elizabeth Halcomb is Professor of Primary Healthcare Nursing at University of Wollongong

Doctor Terry Froggatt is Head of Programs at Nan Tien Institute

Professor Stuart Thomas is Professor of Forensic Mental Health at RMIT University



References

- Kinghorn, G. R., Halcomb, E. J., Froggatt, T. & Thomas, S. D. M. 2017. Transitioning into new clinical areas of practice: An integrative review of the literature. *Journal of Clinical Nursing*, 26, 4223-4233.
- Mason, T., Coyle, D. & Lovell, A. 2008. Forensic psychiatric nursing: skills and competencies: II clinical aspects. *Journal of Psychiatric and Mental Health Nursing*, 15, 131-139.



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MENTAL HEALTH IS A HUMAN RIGHT

By Kim Ryan

Although considerable progress has been made over recent years, human rights infringements against people experiencing mental illness still occur. This may be through involuntary treatment and containment; the politicisation of mental health; and discrimination borne from stigma (United Nations, 2017).

In 2017 the United Nations Special Rapporteur on the right to health identified "power imbalances in service provision, policy development, education and research; as well as the dominance of the biomedical model as major obstacles to recognising the human rights of people experiencing mental illness" (United Nations, 2017). We see examples of this politicisation of mental health in the way non-medical models of care, including many aspects of nursing and midwifery care, are often not given the same level of funding, political attention and consideration as medical models. Stigma can affect people's opportunity to participate socially and economically as well as their equity in access to employment and education, housing, healthcare, community and welfare services (Beyondblue, 2015).

In a country as prosperous as Australia, people with mental illness die up to 23 years younger than the general population. The impact of stigma behind this tragic statistic is not to be understated. People with

mental illness experience harmful delays in diagnosis and treatment of physical illness due to their physical health symptoms not being treated as equally as for someone without a mental illness (National Mental Health Commission, 2017).

All nurses and midwives have a role to play in promoting the human rights of people experiencing mental illness. The Australian College of Mental Health Nurses is undertaking a number of activities to support all nurses and midwives in line with this objective, including:

- developing a Mental Health Standards of Practice and training program to support General Practice Nurses to identify mental health risk factors, and to ensure assessment and follow up of physical health conditions;
- Conducting a review of the mental health content in undergraduate/pre-registration nursing courses with a view to informing the Registered Nurse Accreditation Standards Review and;
- 'Mental Health is a Human Right' - International Mental Health Nursing Conference 24-26 October 2018, Cairns.

Mental health nurse and 2017 Western Australian Nurse of Year Amy Wallace (pictured) successfully implemented a program to improve the physical health of mental health service users. Amy demonstrates to us all that despite the challenges, it sometimes only takes one person to implement changes and champion the vision of others and this can have a dramatic impact on the human rights of people experiencing mental illness.

 **Adj. Associate Prof Kim Ryan, RN, Credentialed Mental Health Nurse, CEO, Australian College of Mental Health Nurses**

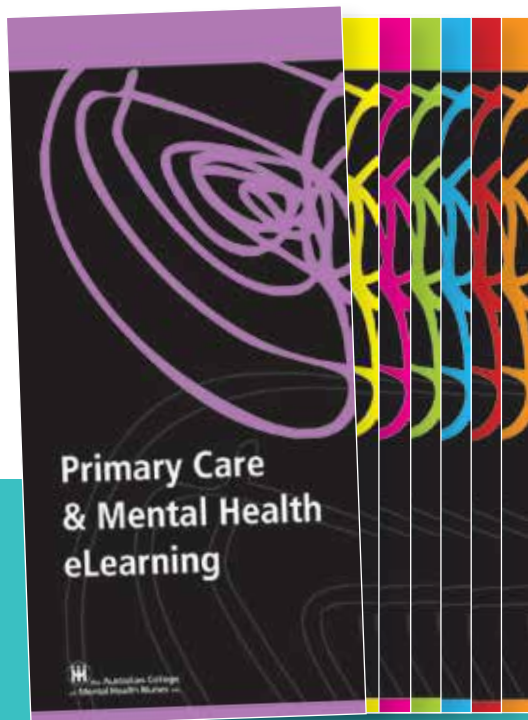


Reference

beyondblue Information Paper-Stigma and discrimination associated with depression and anxiety, (2015). beyondblue, Hawthorn, Victoria. www.beyondblue.org.au/docs/default-source/policy-submissions/stigma-and-discrimination-associated-with-depression-and-anxiety.pdf Accessed 24 March 2018.

National Mental Health Commission, (2017). *Equally Well Consensus Statement*, National Mental Health Commission, Sydney. <http://www.mentalhealthcommission.gov.au/our-work/equally-well.aspx> Accessed: 19 March 2018

Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, (2017). Office of the High Commissioner for Human Rights, Human Rights Council, session 35. www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=21689 Accessed 20 March 2018



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A NATIONAL PRIORITY: IMPROVING THE PHYSICAL HEALTH OF PEOPLE LIVING WITH MENTAL ILLNESS

By Russell Roberts, Kim Ryan, Oliver Burmeister and Chris Maylea

Many people who are diagnosed with a mental illness live healthy and long lives, but many more will suffer poor health and early death. People diagnosed with a mental illness will die on average 14-25 years earlier than the general population (Erlangsen et al. 2017). In 2018 this is an appalling statistic.

People living with mental illness have six times the rate of respiratory disease, four times the rate of cardiovascular disease, and two times the rate of diabetes (ABS 2017). Comprising only 15% of the population, people accessing mental health MBS/PBS services make up 55% of all cancer deaths (ABS 2017). For every Australian with a diagnosis of mental illness who dies early due to suicide, 13 die due to heart or respiratory disease (Roberts 2017).

The reasons for this are complex, and include the impact of psychotropic medication, stigma, discrimination, experiences of trauma, poor access to healthcare, substance use, smoking, lack of protective factors and the impact of illness on functioning and social interactions. A structured, collaborative, cross-sectoral and coproduced response is clearly required to address this glaring inequity.

We applaud the national Equally Well initiative, which makes improving the physical health of people living with mental illness a collective national priority.

The Equally Well Consensus Statement is endorsed by every Australian government and numerous national organisations, including the Australian Nursing and Midwifery Federation. Among its many actions, it seeks to improve mental health education in preregistration nursing programs (NMHC 2016).

Nurses will encounter people living with mental illness across mental, physical and primary

A STRUCTURED,
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healthcare systems, and are well positioned to lead change. Four out of five people living with a mental illness will also have a mortality-related physical illness (ABS 2015) and over half will have three or more comorbid conditions (AIHW 2017). Nurses can help change these statistics by undertaking comprehensive, ongoing physical health screening.

When people living with a mental illness do access health services, their physical health needs are often seen as a part of their mental health condition. This 'diagnostic overshadowing' leads to physical conditions being undiagnosed and untreated, which can prove fatal (Rethink 2013). Nurses can work to address stigma attached to mental health diagnosis, ensure that people are not discriminated against when accessing medical care and promote social inclusion and healthy lifestyles. The Equally Well website has a range of clinical and client self-help and advocacy resources to support care (<https://equallywell.org.au/>). The website also facilitates the sharing of best practice and initiatives to improve the physical health of people living with mental illness.

Nurses are well placed to show leadership by working respectfully and collaboratively with people living with mental illness and other health professionals to reduce these rates of poor health and premature death.

 **Russell Roberts is an Associate Professor at Charles Sturt University**

 **Adj. Associate Prof Kim Ryan is CEO at the Australian College of Mental Health Nurses**

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References

Australian Bureau of Statistics. 2015. *National Health Survey: Mental Health and co-existing physical health conditions*, Australia, 2014-15. Canberra: ABS.

Australian Bureau of Statistics. 2017. *Mortality of people using mental health services and prescription medications. Analysis of 2011 data*. Canberra: ABS.

Australian Institute of Health and Welfare. 2017. *Chronic Disease Comorbidity*. Canberra: AIHW.

Erlangsen A, et al. 2017. Cause-specific life-years lost in people with mental disorders: A nationwide, register-based cohort study. *The Lancet Psychiatry*. 2017;4(12):937-45.

National Mental Health Commission. 2016. *Equally Well Consensus Statement*. Sydney: NMHC.

Rethink. *Lethal Discrimination*. 2013. *Why people are dying needlessly and what needs to change*. London: Rethink Mental Illness.

Roberts R.J. Equally Well. 2017. Physical health and mental illness. *Australian Journal of Rural Health*. 25(6):324-5.

MENTAL HEALTH EMERGENCIES: ARE OUR REMOTE AND ISOLATED WORKFORCE PRACTICED AND PREPARED?

By Amanda North

Access to mental health services within rural and remote Australia is limited, with increasing remoteness the availability of mental health professionals decreases (AIHW 2015).



However, with increasing remoteness there is also increased rates of same day and overnight hospitalisation for mental health disorders (AIHW 2016), suicide (AIHW 2017), drug and alcohol use (AIHW 2017) and for Indigenous people significantly higher rates of psychological distress (Department of Prime Minister and Cabinet 2014). In these areas, generalist health practitioners are often the clinicians providing mental healthcare, particularly for urgent or acute presentations. Yet, how well equipped are generalist staff to manage people presenting with mental health concerns?

In Western Queensland 70% of

rural nurses reported low levels of competency in relation to mental healthcare, they consistently identified they did not have the skills or knowledge to identify, assess and treat mental health presentations. Not surprisingly over half indicated they had never undertaken mental health training or had only ever attended a half an hour in-service (Clark, Parker and Gould 2005 pp.210-211). These statistics align with anecdotal evidence from remote area nurses who often voice concerns that they have limited knowledge and confidence to assess and assist people presenting with mental health needs. In the

Northern Territory a small survey of remote area practitioners identified that over 80% believed educational resources in relation to aggression, psychosis, suicide risk assessment and management plans, child/adolescent mental health, psychotropic medication and assisting people with grief and loss would be moderately to extremely helpful. Respondents in this study also strongly valued face to face education and/or workshops over teleconference, web-based learning or supervision (Bulbrook et al. 2012).

CRANaplus as the core professional body representing remote and isolated health staff have listened to these concerns and have funded the development of a mental health emergencies training package. The exciting new course specifically targeting the needs of the remote and isolated workforce, will assist practitioners to develop skills and confidence to safely manage people presenting with mental health needs.

IN WESTERN QUEENSLAND 70% OF RURAL NURSES REPORTED LOW LEVELS OF COMPETENCY IN RELATION TO MENTAL HEALTHCARE, THEY CONSISTENTLY IDENTIFIED THEY DID NOT HAVE THE SKILLS OR KNOWLEDGE TO IDENTIFY, ASSESS AND TREAT MENTAL HEALTH PRESENTATIONS.

The course has been developed and will be facilitated by clinicians with qualifications and experience in mental health in the remote and isolated context. The Mental Health Emergencies Course combines pre-course theory via an online learning platform and a one day workshop. The workshop enables the practitioners the opportunity to apply the theory and to structure assessments in a simulated environment, using case studies, scenarios and vignettes. Like other courses offered by CRANaplus the workshop will focus on the practical hands on application of knowledge and skills.

For more information:

<https://www.youtube.com/watch?v=v4uLkg5UqKw&t=3s>

To enrol go to: <https://crana.org.au/education/courses/programs/mental-health-emergencies-course/>

Amanda North is Remote Clinical Educator – Mental Health at CRANaplus



References

- Australian Institute of Health and Welfare (AIHW). 2015. Mental Health Workforce. www.aihw.gov.au/getmedia/39ef59a4-4bb3-4f90-b117-29972245ca95/Mental-health-workforce-2015.pdf.aspx. Accessed March 2018.
- Australian Institute of Health and Welfare (AIHW). 2016. Healthy Communities: Hospitalisations for mental health conditions and intentional self-harm in 2013-14. www.myhealthycommunities.gov.au/our-reports/mental-health-and-intentional-self-harm/september-2016. Accessed March 2018.
- Australian Institute of Health and Welfare (AIHW). 2017. National Drug Strategy Household Survey 2016: detailed findings. Drug Statistics series no.31. www.aihw.gov.au/getmedia/15db8c15-7062-4cde-bfa4-3c2079f30af3/21028a.pdf.aspx?inline=true. Accessed March 2018.
- Australian Institute of Health and Welfare (AIHW). 2017. Mortality Over Regions and Time (MORT) books. www.aihw.gov.au/reports/life-expectancy-death/mort-books/contents/mort-books. Accessed March 2018.
- Bulbrook K.M., Carey, T.A., Lenthall, S., Byers, L. and Behan, K.P. 2012. Treating mental health in remote communities: what do remote practitioners need? *Rural and Remote Health*. 12: 2346.
- Clark, C., Parker, E. & Gould, T. 2005. Rural generalist nurses' perceptions of the effectiveness of their therapeutic interventions for patients with mental illness. *Australian Journal of Rural Health*. 13: 205-213.
- Department of the Prime Minister and Cabinet. 2014. Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice. Canberra: Commonwealth of Australia



INCREASING AWARENESS ABOUT POSTNATAL DEPRESSION IN MOTHERS OF NICU INFANTS

By Fiona Riches, Michael Hazelton and Jane Maguire

Postnatal depression affects 10-15% of new mothers, however in certain populations, heightened risk factors can elevate that rate by as much as 50%.

Known risk factors pertain to stressful life events such as history of marriage breakdown, death in the family, financial hardship, and premature birth or a traumatic delivery (Bicking and Moore 2012). Therefore, an increased risk of depressive symptomatology arising in women who have infants on the neonatal intensive care unit (NICU) is highly probable because these women have likely experienced a traumatic delivery or premature birth and it is unknown

if the other risk factors may also have occurred. Research has shown that the rate of postnatal depression in this population can be as high as 63% (Hall, Hynan et al. 2015).

Postnatal depression (PND) can have negative effects on the attachment between a mother and her child, and without effective treatment these consequences can be long lasting.

Early intervention is the best way to treat women with PND (Hall, Hynan et al. 2015), despite this as many as 50% of all cases of PND go unrecognised and untreated. Routine screening has been shown to be a successful way to assess and appropriately intervene in women displaying symptoms of PND, however no systematic framework is in place to screen women outside of their routine postpartum check-up. Routine assessment using screening tools such as the Edinburgh Postnatal Depression Scale has been shown to be both time-efficient and cost-effective (Vigod, Villegas et al. 2010).

The nurse-parent relationship is highlighted as one of great importance for mothers with an infant in the NICU (Parker 2011, Bicking and Moore 2012). Research shows that as the infant's health trajectory is constantly changing, the mother's ability to cope with the demands and emotions that accompany the ever-changing health status of their newborn can cause considerable strain and may result in negative mood alterations (Parker 2011). The nurse's role in helping guide and care for the mother during this phase is


paramount to not only the mother's wellbeing, but the mother-infant bond as well.

Despite research identifying the advantageous role of nurses and their optimum positioning for screening, clinical policies and procedures remain unchanged with one study stating that NICU nurses have a lack of knowledge (78% of NICU nurses declared that they had received no mental health training) or familiarity with diagnostic criteria to assess and intervene with (suspected) cases of PND (Sofronas, Feeley et al. 2011).

Integral to changing clinical practice and improving outcomes for mothers in the NICU is a better understanding of the knowledge levels of PND held by NICU staff however to date there is no literature examining this. This gap in understanding what the knowledge levels are is currently being addressed by a research project currently underway at the University of Newcastle. This study aims to capture and assess the knowledge of PND by NICU staff across Australia. For further information please contact Fiona Riches.

 **Fiona Riches is a PhD student at the University of Newcastle**

 **Michael Hazelton is Professor of Mental Health Nursing at the University of Newcastle, Newcastle**

 **Jane Maguire is Professor of Nursing at the University of Technology Sydney**



References

- Bicking, C. and G. A. Moore (2012). Maternal perinatal depression in the neonatal intensive care unit: the role of the neonatal nurse. *Neonatal Network* 31(5): 295-304 210p.
- Hall, S., M. Hynan, R. Phillips, J. Press, C. Kenner and D. J. Ryan (2015). Development of Program Standards for Psychosocial Support of Parents of Infants Admitted to a Neonatal Intensive Care Unit: A National Interdisciplinary Consensus Model. *Newborn and Infant Nursing Reviews* 15(1): 24-27.
- Parker, L. (2011). Mothers' experience of receiving counselling/ psychotherapy on a neonatal intensive care unit (NICU). *Journal of Neonatal Nursing* 17(5): 182-189.
- Sofronas, M., N. Feeley, P. Zelkowitz and M. Sabbagh (2011). Obstetric and Neonatology Nurses' Attitudes, Beliefs, and Practices Related to the Management of Symptoms of Maternal Depression. *Issues in Mental Health Nursing* 32(12): 735-744.
- Vigod, S. N., L. Villegas, C. L. Dennis and et al. (2010). Prevalence and risk factors for postpartum depression among women with preterm and low-birth-weight infants: a systematic review. *BJOG: An International Journal of Obstetrics and Gynaecology* 117(5): 540-550.

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GENERAL NURSE PROFESSIONAL PEER IN MENTAL HEALTH

By Michelle Cooling

My name is Michelle Cooling and I have been a registered nurse for 14 years. I work for Country Health SA at South Coast District Hospital (SCDH) in Victor Harbor.

In 2014, I was approached by my Nurse Unit Manager (NUM) to become part of a team of nurses for a pilot project in mental health at the SCDH, called the General Nurse Professional Peer (GNPP). I believe that I was approached partly due to my own adversity and lived experience, as well as my positive professional attitude towards people who have mental health issues.

The project was conceived and developed by my mentor Moira-Jane Conahan, who is the Mental Health Nurse Consultant (NC) in the Southern Fleurieu Mental Health Team. The project was a collaborative initiative between the SCDH and the local Community Mental Health Team.

The main aim of the project was to upskill a team of nurses in mental health issues. We were called the 'general nurse professional peers' and our role was to provide education and role modelling to our nursing colleagues to increase confidence and improve understanding of patients experiencing mental health issues, this would then improve the experience of patients presenting to the SCDH with a mental health issue, leading to an improved patient journey to recovery (MHCA et al. 2005; MHCA 2011; Link et al. 2002; Link et al 1991; Boyd 2003; Star Wards; ANMF guidelines 2013).

There was also the hope that this could lead to mental health being identified as an area that could belong to a portfolio and therefore provide the opportunity for a reclassification from RN1 to Clinical Nurse with a mental health portfolio, a nursing initiative not being undertaken anywhere else in South Australia.

Lack of knowledge and confidence as well as stereotyped views of people with mental illness



were identified as the most important issues impacting patient experience at the SCDH. These issues were identified through a survey of the whole of nursing staff as well as a patient feedback survey. Audits of patient notes showed inappropriate communication and poor key performance indicators.

We (GNPP nurse team) were given additional resources and education to increase our confidence when assessing and working with people and their families, using a 'train the trainer' framework. This enabled us to provide structured education at the SCDH, become positive role models for our peers as well as giving us the confidence to challenge stereotypical attitudes towards patients presenting to the SCDH with mental health issues. Part of our role also included auditing patient's files and seeking patient feedback on their hospital experience. Our focus was always to capacity build within our professional group (Nursing) hence the name General Nurse Professional Peer.

Since the beginning of the project, I have become aware of the huge disadvantages for people who have a mental health issue, living in a regional area. I have also been able to challenge peer attitudes and develop educational strategies that will assist my peers in assessment skills and documentation in mental health. Over the past four years my commitment and dedication to the mental health portfolio has improved my own professional and personal experience in effective communication with people around mental health.

In 2016 I decided to enhance my own professional knowledge and gain formal qualifications in mental health. I was successful in winning the Country Health SA, Margaret Tobin scholarship for a Post Graduate Diploma in Mental Health Nursing that I commenced in 2017.

This year I have been successful in being reclassified from an RN1 to a CN with the mental health portfolio at the SCDH. To my knowledge I am the only general clinical nurse within South Australia to have a Clinical Portfolio in Mental Health.

In Country Health SA, nursing portfolios have been established around the National Safety and Quality in Healthcare Standards (NSQHS). It was determined through the implementation of the project and the efforts to reclassify to CN with mental health as a portfolio, that mental health sits within standards 1, 2, 4, 5, 6 and 8 ACSQHC 2017).

I would like to see nurses from all hospitals develop their own mental health portfolios within the nursing professional structure. Having a focus on mental health will continue to enable and facilitate a positive recovery and journey for every consumer through the health system and we know that physical and mental health is inextricably linked. Providing holistic, general nursing care within this framework has the potential to improve the general wellbeing of all our patients.

Michelle Cooling is an RN at Country Health SA at South Coast District Hospital in Victor Harbor in SA

MICHELLE COOLING



References

- Australian Commission on Safety and Quality in healthcare. 2017. *National Safety and Quality Health Service Standards guide for multi-purpose services and small hospitals*. Sydney; ACSQHC.
- Australian Nursing and Midwifery Federation, 2013. *Management of Medicines in Aged Care*. Retrieved from: anmf.org.au/documents/reports/Management_of_Medicines_Guidelines_2013.pdf
- Boyd formerly Ritscher, J. E. 2003. Internalized stigma of mental illness: psychometric properties of a new measure. *Psychiatry Research*, 121, 31. UC San Francisco: Retrieved from: <http://escholarship.org/uc/item/3xp4748j>
- Link, B., Moroznik, J. & Cullan, F. 1991. The effectiveness of stigma coping orientations: Can negative consequences of mental illness labelling be avoided, *Journal of Health and Social Behaviour*, vol. 32, pp. 302-320.
- Link, B., Streuning, E., Neese-Todd, S., Asmussen, S. & Phelan, J. 2002. Stigma as a barrier to recovery: The consequences of stigma for the self-esteem of people with mental illness, *Psychiatric Services*, vol. 52, no. 12, pp. 1621-1626.
- Mental Health Council of Australia Report. 2011. *Consumer and carer experiences of stigma from mental health and other health professionals*.
- Mental Health Council of Australia, 2005. *Not for Service Experiences of Injustice and despair in Mental healthcare in Australia; A report of the consultations by the Mental Health Council of Australia and the Brain and Mind Research Institute in association with the Human Rights and Equal Opportunity Commission*
- Star Wards Practical ideas for improving the daily experiences and treatment outcomes of acute mental health inpatients. Retrieved from: www.starwards.org.uk/

MAY

17th National Nurse Education Conference

Changing worlds: Synergies in nursing, midwifery and health education
1-4 May, Crown Promenade
 Melbourne, Victoria.
www.dconferences.com.au/nnec2018

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

Enrolled Nurses' Conference

3-4 May, Melbourne.
www.ausmed.com.au/course/enrolled-nurses-conference

Star Wars Day

May the 4th

International Day of the Midwife

5 May.

7th World Congress on Breast Cancer

Pioneering spirit of enriching the lives and wellness of women
10-11 May, Frankfurt, Germany.
<http://breastcancer.conferenceseries.com/>

10th Australian Primary Health Care Nurses Association National Conference

Nurseforce for the future
10-12 May, Brisbane Convention and Exhibition Centre, Qld.
<https://www.apna.asn.au/>

7th World Congress on Midwifery and Women's Health

Caring women and newborns with skill and compassion
 11-12 May, Osaka, Japan.
<https://midwifery.nursingconference.com/>

International Nurses Day

Theme: Nurses A Voice to Lead – Health is a Human right
12 May. <http://www.icn.ch/publications/2018-nurses-a-voice-to-lead-health-is-a-human-right/>

4th World Congress on Midwifery and Women's Health

Caring women and newborns with skill and compassion
14-15 May, Singapore.
<http://midwifery.nursingconference.com/>

Global Experts Meeting on Neonatal Nursing and Maternal Healthcare

Novel advancement in neonatal nursing & maternal healthcare research
14-16 May, Singapore.
<http://neonatal-maternal.nursingconference.com/>

National Dementia Conference

15-16 May, Melbourne.
<https://www.informa.com.au/event/national-dementia-conference/>

3rd World Congress on Nursing Practice & Registered Nurses

Hand in hand creating tomorrow: nursing practice, education and research
16-17 May, Montreal, Canada. <https://nursepractitioner.nursingconference.com/>

3rd World Congress on Nursing Education & Research

Translate research outcomes into educational practice and policy
16-17 May, Montreal, Canada.
<https://nursingeducation.nursingmeetings.com/>

International Day against Homophobia, Transphobia and Biphobia

Theme: Alliances for solidarity
17 May.
<http://dayagainsthomophobia.org/>

Victorian Continence Resource Centre & Continence Foundation of Australia Victorian Branch 7th Annual State Conference

The Scope and Spectrum of Incontinence
17-18 May, RACV Goldfields Resort Creswick Victoria. This conference promises to lead the way in evidence based practice for nurses with diverse expertise and interest in a multidisciplinary approach. The Two day full program attracts a total of 11.5 CPD hours. Special package options available. Early Bird 13 April!
<http://continencevictoria.org.au/state-conference/>

Australian College of Dermatologists Scientific Meeting

19-22 May, The Gold Coast
 Convention and Exhibition Centre.
<http://www.adna.org.au/events/>

7th Palliative Care Nurses Australia Inc Biennial Conference

Fostering excellence in palliative care
20-21 May, Hilton Brisbane Qld.
www.pcna.org.au/

26th World Congress on Nursing Care

Advanced technologies and best practices in nursing & integrated care
21-23 May, Osaka, Japan.
<http://nursingcare.nursingconference.com/asia-pacific/>

Customer Experience in Aged Care Conference

Driving consumer acquisition and retention
22-23 May, SMC Conference & Function Centre, Sydney.
www.criterionconferences.com/event/cx-aged-care-conference/

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/>

3rd World Congress on Nursing Practice & Research

Hand in hand creating tomorrow: Nursing practice, education and research
23-24 May, Montreal, Canada.
<http://nursepractitioner.nursingconference.com/>

National Sorry Day

26 May

Anniversary of the 1967 Referendum

27 May

Reconciliation Week

27 May-3 June

Reconciliation Day

28 May

JUNE

Mabo Day

3 June

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Influencing Behaviour Change – a formula
 14-15 June
Influencing Behaviour Change – Theory & Practice
 14 June
Influencing Behaviour Change – Intensive Workshop/Case Studies
 15 June
Paediatric Respiratory Update
 21 June
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48th World Congress on Advanced Nursing Research

To promote excellence in nursing research
14-15 June, Dublin, Ireland. <http://nursingresearch.nursingmeetings.com/>

ANMF (Vic Branch Annual Delegates Conference

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

JULY

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AUGUST

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 13-14 August
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 16-17 August
Sleep: the how, why & the what – skills for your toolkit
 16 August
The Pressure to Breathe – the skills for success with NIV
 17 August
Respiratory Course (Modules A & B)
 20-23 August
Respiratory Course (Module A)
 20-21 August
Respiratory Course (Module B)
 22-23 August
 Ph: (03) 9076 2382
 Email: lunghealth@alfred.org.au

NETWORK

Royal Children's Hospital, Parkville, League of Former Trainees & Associates (including RCH graduate nurses) reunion, Luncheon, AGM, Guest Speaker
19 May, 10.30am for 11.00 am commencement, RACV Club, Melbourne. Contact Sally Mizrahi, Secretary E: sally0307@hotmail.com or Sue Scott E: sue.scott@rch.org.au or M: 0402 092 601 or <http://www.rch.org.au/loft/>

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

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

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



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

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



REFLECTIVE PRACTICE: UNDERSTANDING OURSELVES AND OUR WORK

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

Do you regularly engage in reflective practice? Is reflective practice encouraged at your workplace or amongst your peers? Does your workplace offer clinical supervision?

Reflective practice is the purposeful questioning and self-examination of an incident or experience, often under the guidance of a professional supervisor. It means we examine our own experiences, beliefs, attitudes and actions with the goals of improving the way we work and helping us gain a better understanding of ourselves and why we behave the way we do.

Research has shown incorporating reflective practice into our professional life encourages growth and can assist us to provide the best care to our patients. It can help us identify clinical and professional strengths and weaknesses, and is an invaluable tool for improving our clinical understanding and our own wellbeing.

Every day we care for the ill and vulnerable; giving, advocating, listening, educating, preventing illness and often averting crisis. It is more common for nurses and midwives to pursue reflective practice when there has been a critical incident, but we are less likely to reflect on ourselves and our work when things are going well.

Yet there is always room for improvement. Reflective thinking promotes analysis of what we did and why we did it, and further inquiry: were our actions effective? Could they have been more so? Reflection clarifies success or failure, and facilitates procedural insights and actions that can be considered for future practice (Nicole and Dosser 2016, p.36).

Clinical supervision provides a formal framework where nurses and midwives can achieve reflective practice. Employers who value reflective practice and provide clinical supervision should be commended. Many health professionals such as psychologists and social workers have long been encouraged to undertake clinical reflective practice.

When I was working in community health for the Royal District Nursing Service (RDNS) Homeless Persons Program, clinical supervision was offered monthly. This was accessed during working hours and paid for by my employer. Many staff found it invaluable in preventing vicarious trauma and compassion fatigue. I found attending regular supervision encouraged questioning, a commitment to learning and developed professional boundaries that enhanced my practice. Reflective practice is challenging, and so it should be. It may be easy to let it slide when things are going well, however it's important to keep up regular visits with your chosen supervisor. This assists in developing a relationship of trust and provides opportunity for your supervisor to help you develop reflective practice over time.

Victorian Maternal and Child Health (MCH) nurses have access to 1.5 hours of clinical group supervision each month. Experienced MCH nurses have commented that they always leave with new understandings and perspectives.

Unfortunately, clinical supervision, and therefore supported reflective practice, is not found in all clinical settings. It is encouraging to note though, that these

days, most nursing students are actively encouraged to reflect through journaling, and that this will hopefully cement the role of reflection in their professional life from an early stage.

In the absence of formal avenues of reflection, some nursing professionals have established informal ways to reflect. I was recently made aware of the Va Journal Club, a group of midwives across Melbourne who work in a variety of environments and use different models of care. They meet every six weeks in a pub in Melbourne's inner north to discuss and debate emerging midwifery research. Club member and midwife Lynelle Moran says that the Va Journal Club has become a forum for reflection, connection, rejuvenation and realignment. "I feel we share a collective motivation to address and improve issues that impact midwives and the profession as a whole."

EMPLOYERS WHO VALUE
REFLECTIVE PRACTICE
AND PROVIDE CLINICAL
SUPERVISION SHOULD BE
COMMENDED.

For reflection to facilitate learning and improve practice it is important to use it as an opportunity to consider alternative actions, as well as measure performance (Nicole and Dosser 2016, p.38).

One common and well-used model is Gibbs' reflective cycle, which has six stages:

- Description: what happened?
- Feelings: what were you thinking and feeling?
- Evaluation: what was good and bad about the situation?
- Analysis: what sense can you make of the situation?
- Conclusion: what else could you have done?
- Action plan: if it arose again what would you do?

Aside from increasing knowledge and awareness, providing guidance, challenging judgements and advancing our professional practice, the time spent on reflective practice can also contribute to the 20 hours of Continuing Professional Development required annually by the Nursing and Midwifery Board of Australia.

Engaging in reflective practice may be challenging, and initially, it may feel like you're stepping out of your comfort zone. You may feel vulnerable or exposed, or even that you have nothing to talk about, but I encourage you to persist. Find someone you are comfortable with, or take part in group supervision with your peers. The benefits will pay off for both your patients and yourself.



Reference

Nicole, J.S and Dosser I. 2016. Understanding Reflective Practice. *Nursing Standard* Vol 30 No. 36



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