

The background of the entire cover is a photograph of three women standing on a wooden deck. They are all wearing dark blue nursing scrubs with teal accents. The woman in the center is slightly taller and has her hands clasped in front of her. The woman on the left is smiling and has her hands clasped. The woman on the right is also smiling and has her hands clasped. They are standing in front of a large tree with pink cherry blossoms. The sky is visible through the branches.

ANMJ

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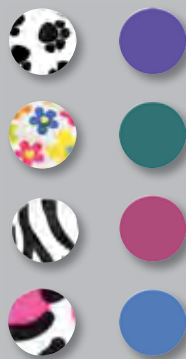


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If you are a financial member of the ANMF, QNMU or NSWNMA, you can transfer your membership by phoning your union branch. Don't take risks with your ANMF membership – transfer to the appropriate branch for total union cover. It is important for members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



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Editorial

Lee Thomas, ANMF Federal Secretary



With the ANMF's Biennial National Conference upon us final preparations have commenced.

As I wrote in last month's editorial, much of this conference is dedicated to discussing and debating resolutions on industrial, professional, political and social justice issues as put forward by members.

The Biennial is also an opportunity to review outcomes of past resolutions and to reflect on how much we have achieved.

Many of these achievements have helped positively shape what nursing and midwifery is today and if you read the back page of this month's journal, you'll realise just how far we have come.

The article, written by ANMF Assistant Federal Secretary Annie Butler, is about her mother's experiences working as a nurse in the 1950's and 60's.

When Mrs Butler commenced nursing in 1954 conditions were tough. But over time they improved significantly with the introduction of penalty rates, sick leave, carers leave, a 38-hour week and removal of non-nursing duties. Wages also increased considerably and access to education, information and support became a reality.

Mrs Butler attributes these outcomes to the union and according to Annie she gets fired up when people don't appreciate the achievements of the ANMF and its members.

Change is not always easy. It can be hard and uncomfortable but positive change can result in growth, and growth is necessary and is always worthwhile.

Making change also takes courage and leadership. To this end I commend our job representatives (however they are titled in each state and territory) for the magnificent job they do in standing up and advocating on behalf of members collectively and individually.

The ANMF views these delegates as its most valuable asset. Without them positive change to protect and grow the rights of nurses and midwives would be challenging and without a doubt the union would not be as strong as it is today.

CHANGE IS NOT ALWAYS EASY. IT CAN BE HARD AND UNCOMFORTABLE BUT POSITIVE CHANGE CAN RESULT IN GROWTH, AND GROWTH IS NECESSARY AND IS ALWAYS WORTHWHILE.

This month's feature looks at the role of the job representative, as well as showcasing some of our best.

Following the theme of change the ANMJ is looking at ways to transform communication to members. Given the highly digitalised age we live in we think the time is right to embrace this environment by developing more of an online presence and reducing the number of journals we produce.

To this end we are looking to develop a specialised ANMJ website giving readers timely access to information and reducing the production of the journal to either quarterly or bimonthly.

But before we make this decision we want to know how often you would like to see the ANMJ printed, either every second month or quarterly. Email us at: quarterlyorbimonthly@anmf.org.au We look forward to hearing your views.



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CHANGES AHEAD FOR THE ANMJ

After ANMF members were asked to complete an *ANMJ* communication survey last month, the results are finally in, and from what you have told us, it's time to change how we deliver nursing and midwifery news and information.

The survey, which attracted more than 6,000 responses, looked at what you like to read in the journal and how you prefer to receive your nursing and midwifery news.

The results showed 73% of people read all or most of the *ANMJ*. The content most read included clinical update, features, editorial, columns and news.

The top reasons for reading the journal were to keep informed about the latest nursing and professional issues. Advice, careers, tips and strategies in the workplace were the main topics you want to read more about.

Forty six percent said lack of time was the main barrier to reading the journal.

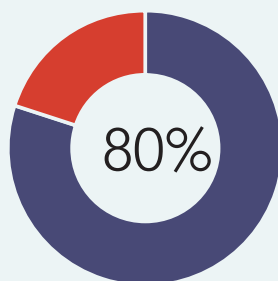
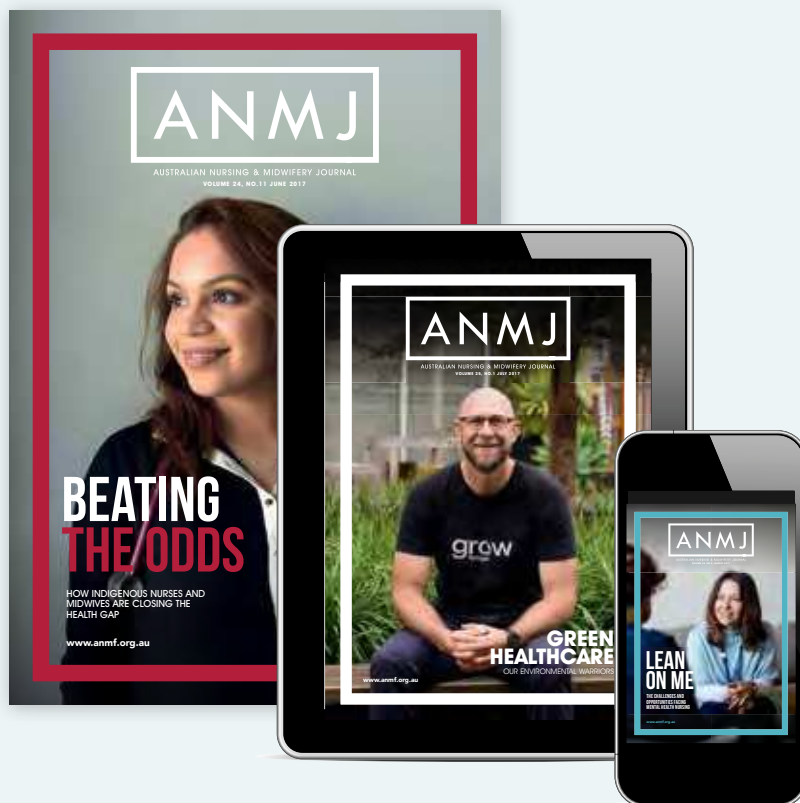
While 80% read the printed version of the journal, 40% said they didn't access the online version due to habit.

More than 77% of respondents said they would be interested in a specialised website to access the latest news information. Yet the leading reason for not wanting to access a specialised *ANMJ* website was that readers didn't want it to replace the printed journal.

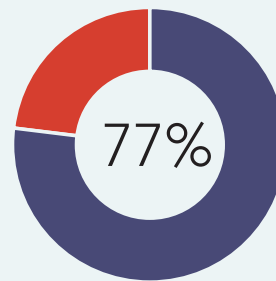
From what you have told us we need to change. Going forward the *ANMJ* will reduce its frequency and move to either a quarterly or bimonthly publication. The *ANMJ* will also develop a specialised website with more of the information that you want to read.

Not only will the website give readers timely access to the latest information, it will also help reduce the *ANMJ*'s impact on the environment.

ANMF Federal Secretary Lee Thomas said change to how the ANMF produces its communications was inevitable. "We are now living in a highly digitalised age that has changed how we access information. The time is now right for us to embrace it."



Read the printed version



Interested in a specialised website to access the latest news information



Do you have an opinion on how many times a year you would like to see the *ANMJ* printed? Let us know at quartelyorbimonthly@anmf.org.au

EMILY SHEPHERD



NURSES AND MIDWIVES BEAR BRUNT OF SPIKE IN OVERTIME

Money used to fund mounting overtime and double shifts being performed by Tasmanian nurses and midwives would be better directed at increasing minimum staffing levels and maintaining adequate casual pool staff numbers, according to ANMF (Tas Branch) Acting Secretary Emily Shepherd.

The stance followed the Branch's release of troubling hospital data last month, uncovered via the union's repeated requests to the state government via Right To Information (RTI) documents, which revealed the true extent of the increasing practice.

Documents showed Tasmanian nurses and midwives worked more than 16,000 hours of overtime from May to June this year, costing the Tasmanian Health Service (THS) almost \$1 million.

The Launceston General Hospital (LGH) recorded the highest number of overtime hours across the state during the period, undertaking 8,500 hours of overtime, equating to double the amount of their colleagues at the Royal Hobart Hospital (RHH) and over \$420,000 in extra expense.

The state's north-west, comprising the Mersey Community Hospital (MCH) and North West Regional Hospital (NWRH), also experienced higher demand, with staff at the NWRH working 981 hours of overtime in June and colleagues at the MCH taking on 402 hours.

Ms Shepherd said the findings backed up consistent feedback from members who disclosed being regularly asked to work overtime and double shifts.

She attributed part of the spike in demand to seasonal factors such as the flu and noted the need to properly address staffing issues and wellbeing.

"Certainly at the LGH we have seen a spike in double shifts and overtime both due to clinical acuity and the need for 1:1 care because of the ever increasing demand for service and flexing beds without an increase in permanent staffing levels," Ms Shepherd explained.

"Across the state (apart from the RHH where there is no flex capacity) flex beds always have an adverse impact on nursing and midwifery staff as they are routinely

staffed with nurses and midwives doing double shifts."

Ms Shepherd warned that recurring double shifts and overtime could be detrimental to the health of nurses and midwives.

"Overtime has a compounding effect and increases the risk of ill health among the nursing and midwifery profession," she said.

"The resulting effect is a vicious cycle of illness and the subsequent need for double shifts. Combined with flexing beds at short notice without adequate staff capacity, this will only perpetuate the increasing number of overtime hours and double shifts."

"ACROSS THE STATE (APART FROM THE RHH WHERE THERE IS NO FLEX CAPACITY) FLEX BEDS ALWAYS HAVE AN ADVERSE IMPACT ON NURSING AND MIDWIFERY STAFF AS THEY ARE ROUTINELY STAFFED WITH NURSES AND MIDWIVES DOING DOUBLE SHIFTS."

Ms Shepherd declared that the hefty cost to the state as a result of overtime and double shifts would be better utilised to implement minimum staffing levels and boosting casual pool capacity in order to meet demand. She vowed the ANMF (Tas Branch) would continue to lobby the government over the issue in a bid to prompt solutions.

STROKE TREATMENT AND CARE TRANSFORMED

Australian stroke sufferers will have access to the world's best treatment and care following the unveiling of new Clinical Guidelines for Stroke Management at Parliament House last month during National Stroke Week.

Federal Health Minister Greg Hunt said the updated guidelines would now make break-through clot retrieval stroke treatment standard for all Australian stroke patients.

The extensive process to develop the guidelines took two years and involved almost 100 health professionals and researchers from across 21 diverse healthcare disciplines.

The final guidelines include 250 recommendations for stroke treatment and care across the care continuum, beginning in the ambulance during critical stages and progressing through to hospital, rehabilitation and transition to home.

Key changes include training GP reception staff to recognise the signs of stroke; all acute stroke services implementing standard protocols to manage fever, glucose and trouble with swallowing in patients early; and the minimum amount of rehabilitation therapy for stroke survivors increased three-fold and boosted to three hours.

The guidelines mark the first of their kind in Australia to be developed and published on a digital platform accessible via smartphone, tablet or desktop, making them easier to access than traditional text-book like documents.

This year alone, Australians will experience around 56,000 strokes, or one stroke every nine minutes.

"Our researchers played a key role in the development of disability reducing endovascular clot retrieval – or thrombectomy – treatment, so it is fitting we adopt it as standard treatment for appropriate stroke patients," Mr Hunt said.

Similarly, Stroke Foundation CEO Sharon McGowan labelled the release of the updated guidelines an important step forward in improving treatment and care.

"Advancements in stroke treatment and care mean stroke is no longer a death sentence for many, however patient outcomes vary widely across the country depending on where people live," Ms McGowan said. "We now know what ideal stroke treatment and care looks like. We must focus on giving all patients access to it, in particular those living in regional Australia where stroke is having its greatest impact."

PROFESSOR JILL MABEN



HAVE HOSPITALS BECOME INEFFICIENT NURSING FACTORIES?

Despite digital technology playing a growing role in healthcare, patients still prefer human contact and meaningful face-to-face engagement that drives dignity, empathy and emotional support, according to Jill Maben Professor of Nursing Research at King's College, London.

Keynote speaker at the recent ANMF (SA Branch) Annual Professional Conference, Professor Maben put forth the contention while dissecting the future of nursing from a global and national perspective.

Identifying looming global healthcare challenges, headed by ageing populations and increasing chronic disease, Professor Maben said her extensive research continually underlined the importance of forging human connections when delivering healthcare.

"I think what patients tell us they want is they want to have contact. They want to have human contact. We interact with people and that's really important. They want to have visible eye contact, smiling, verbal greetings, etc. That's considerably important for patients."

In the face of a global nursing shortage, Professor Maben said the challenge to recruit and retain nurses was critical.

She posed whether a radical rethink was required to improve the delivery of healthcare in order to combat a reduction in creativity caused by a culture of simply

ticking off boxes that has subsequently led to a lack of meaningful interactions between nurse and patient.

She added that the state of affairs often made the job feel "a little bit like a production line".

Citing the work of medical historian Dr Roy Porter, who once claimed hospitals had become soulless factories, Professor Maben declared a similar viewpoint.

"I suggest to you that we have an inefficient nursing factory in hospitals, performing nursing not always as the patient needs it but as the system is currently organised around it."

Despite this Professor Maben said there were examples where quality healthcare was being achieved. She said Buurtzorg, a home-care organisation founded in The Netherlands that has expanded globally, was a prime example of how care could be better delivered to achieve improved outcomes across all health systems.

She said the nurse-led and nurse-run organisation involved self-managed teams that provided home care to patients in their neighbourhoods and is run with 70% RNs.

"It's championing humanity over bureaucracy. Autonomous teams work with primary care providers and support from the family and the community to bring patients to optimal functioning as quickly as possible," Professor Maben explained.

Professor Maben said Buurtzorg had proved successful because it deviated from the rigid standardisation of care, including de-humanising care, and instead focused on affording independent teams with greater autonomy, allowed to work to their full scope and truly focus on patients.

"Nurses act as a health coach for individuals and family, emphasising preventative health measures. The golden rule is nurses must spend 61% of their time in direct contact with the people they support."

She said she was unsure how to combat the evolution of soulless factories in hospitals, but suggested rediscovering primary care nursing could provide part of the solution.

TASMANIA FAREWELLS BRANCH SECRETARY

ANMF Tasmanian Branch Secretary Neroli Ellis is leaving the union after 15 years at the helm.

Ms Ellis has been appointed as the Deputy President of the Tasmanian Industrial Commission. Her commencement starts this month.

"Representing nurses, midwives and care staff has been an honour, privilege and pleasure over the past 15 years. As a nurse, I have always been passionate about improving the working lives of nurses, they are highly respected in the community."

Ms Ellis said there had been many achievements over the time. She highlighted the establishment of a Registered Training Organisation – the Health Education and Research Centre; training of care staff and enrolled nurses; and a comprehensive professional development service for members.

"Industrially, over this period, nurses' wages have increased around 60% and many improvements to conditions have been negotiated."

The ANMF Tasmanian Branch experienced a 140% increase in membership under Ms Ellis' leadership, which continues to grow.

"I leave the ANMF knowing that there is a strong voice for nursing and health in Tasmania and a growing union with over 8,000 members."

"There are still many challenges - but simply put - more nurses need to be employed."

ANMF Federal Secretary Lee Thomas paid tribute to Ms Ellis' contribution to nursing and the ANMF in Tasmania. "Neroli has done much to further the industrial and professional pay, conditions and services for the professions in the state. She has been invaluable to the success of the ANMF. On behalf of all our members, I wish her the best in her future endeavours."

A Branch election will be held in the near future with Emily Shepherd ANMF Tasmanian Acting Branch Secretary.



NEW RAH UNDER FIRE AMID PATIENT SAFETY CONCERNS

The fanfare surrounding last month's opening of the new Royal Adelaide Hospital (RAH) faded rapidly as widespread patient safety concerns pushed the Australian Nursing and Midwifery Federation (SA Branch) into threatening industrial action unless the problems were rectified immediately.

Just weeks after the much-hyped \$2.3 billion hospital's opening, the union raised its fears by exposing 13 serious patient safety concerns it believes are plaguing the new facility.

The host of concerns include a lack of skilled staffing, safety issues with duress alarms, a lack of communication in emergency situations, nurses "filling the gaps across all areas", and delays in receipt of blood products, drugs and equipment.

ANMF (SA Branch) Secretary/CEO,

Adjunct Associate Professor Elizabeth Dabars, declared nurses were deeply concerned that patients' lives would continue to be placed at risk unless the issues were urgently addressed.

Late last month, the union and its members delayed launching industrial action and shifted to monitoring SA Health's course of action in response to the situation, which will include managers holding off on increasing activity at the hospital as part of a planned ramp up.

The new hospital's underwhelming beginning followed further unexpected changes, with SA Health Minister Jack Snelling announcing his resignation from Cabinet not long after the hospital's grand unveiling.

Mr Snelling, who listed the new Royal Adelaide Hospital as one of his proudest achievements, will continue on as Member for Playford until the state election in March next year, but has swiftly been replaced by latest SA Health Minister Peter Malinauskas.

After taking on the challenging health portfolio, Mr Malinauskas hurriedly travelled to the new hospital to tour the facility and listen to the alarming concerns from nurses first-hand.

Opposition Health Minister Stephen Wade warned Mr Malinauskas must confront the overcrowding crisis currently gripping metropolitan hospitals and stall the imminent closure of the Repat Hospital.

He said scores of patients were flooding the Royal Adelaide Hospital's emergency department, with almost a dozen waiting for more than 12 hours for a bed, and that plans to close the Repat would only exacerbate the situation.

"It's unacceptable that patients are being forced to wait for hours in the back of ambulances and for more than a day in the RAH's ED to be admitted to the hospital," Mr Wade said. "Jack Snelling repeatedly stuck his head in the sand about the chronic problems plaguing South Australia's hospital system."

Troublingly, the state's issues extend beyond the RAH, with regional nurses last month commencing industrial action by stopping some hospital admissions in a bid to highlight inadequate staffing levels.

A recent review – jointly conducted by the ANMF (SA Branch) and Country Health SA – concluded Port Augusta, Whyalla, Port Pirie and Mount Gambier hospitals had insufficient nurses in order to cope with demand.

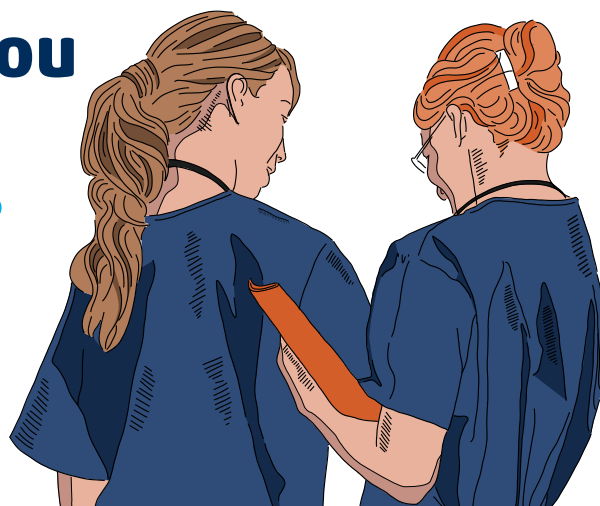
Adjunct Associate Professor Dabars said country nurses were essentially being forced to provide inadequate levels of care.

"Overworking our nurses is not a sustainable solution – it's a practice that is not only taking its toll on the health of nursing staff, it presents a ticking time bomb when it comes to patient safety."

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LYNNE LOMAX

HOPE FOR MOTOR NEURONE DISEASE: AUSTRALIA'S FIRST MND SPECIALIST NURSE

Australia's only dedicated motor neurone disease (MND) specialist nurse says continuity of care is key to the role.

RN Lynne Lomax shared her experience in a keynote speech at the annual Australasian Neuroscience Nurses Association conference held in Adelaide recently.

Ms Lomax is the dedicated nursing resource to support people living with MND in WA over the age of 65 years.

"It's predominantly about equity and access for people with MND aged over 65 to care in the community."

Funded by the Motor Neurone Disease Association of WA (MNDWA) Ms Lomax has been in the position for the past 12 months.

"It came about as MNDWA and the MND specialists identified a gap in services in MND in WA for people aged over 65 years; and that there was a real need for people with MND to be looked after in the community."

An acute RN with chronic disease management experience, Ms Lomax works alongside MND advisors and a multidisciplinary team who coordinate and liaise with specialists involved in the care of people living with MND.

The MND specialist nurse role was an integral part of the MND patient's journey, as well as their family, Ms Lomax said.

"My primary aim is to keep MND patients

at home for as long as possible, dealing with issues in the community that prevent admission, such as chest infections and respiratory problems."

Other complex nursing care includes PEG and issues with feeding and prevention of infection, coupled with lots of education. She is in the community three days a week and in clinic two days a week; with a third clinic once a month.

"Anecdotally the neurologists says they see less people with MND being admitted and they don't receive the calls they used to, patients come through me. If they get admitted it's often with co-morbidities such as diabetes or falls."

The MND specialist nurse position was developed in partnership with the MNDWA and Neurological Council of WA (NCWA) using a shared governance model approach. Ms Lomax presented the approach at the conference using a case study in a contemporary model of nursing to highlight how the principles and practice shape integrated health delivery.

"I really want to convey the message that we can improve the quality of life for people with MND and provide continuity of care. There is no cure but lots of hope – there is lots of research happening."

If neurology nurses want to get in contact with Lynne, email her at lynne.lomax@mndawa.asn.au

FACTS

- More than 2,000 Australians are affected by MND
- Two people are diagnosed and two people die each day from MND
- MND sufferers have a life expectancy of 27 months
- There is currently 140 people living with MND in WA

PARENTAL CONFIDENCE IN GPs DWINDLING

Parental confidence in GPs to care for their children is falling and could be contributing to over-crowded hospital departments, according to new research.

Australia's first national survey investigating parent confidence in GPs found less than half of parents had complete faith in their GP to handle most of their child's general health issues.

Lead researcher, University of Melbourne Professor Gary Freed, said parents' diminishing confidence in GPs could significantly affect the health system's organisation and structure due to more families attending emergency departments (EDs) for non-urgent ailments.

"We know from our previous research that most parents presenting to the ED with a child with a lower urgency condition did not try to go to their GP first and this was not due to lack of available GP appointments," Professor Freed explained.

The online national survey examined the responses of 2,100 parents of children aged from 0-17, finding that only 44% of parents were completely confident their GP could handle almost all general health issues experienced by their child.

About 56% of parents were totally confident in a GP to provide care for minor injuries for a child not requiring an X-ray.

Parents who were always bulk-billed showed the greatest confidence in GPs.

Professor Freed, who described GPs as the backbone of the healthcare system, said they needed better training and support to provide the best care possible for children.

ED presentations for children and an increase in speciality referrals have occurred across the nation, he added.

Professor Freed said it was unclear why parents reportedly lacked confidence in GPs, but suggested the fact GPs and trainees now see fewer children on average as possible factors in reduced confidence concerning their ability.

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emotional effects⁴

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associated staff
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The cost of staff absence is up to
\$4,032 per NSI⁶

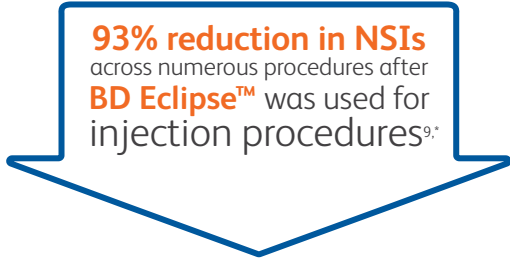


Counselling is often sought
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*Compared to when healthcare professionals were using conventional devices

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MANDATORY FLU SHOTS ON THE CARDS FOR AGED CARE WORKERS

The federal government is contemplating making it mandatory for all aged care workers to get flu vaccinations following a spate of deaths at nursing homes across the country, including eight residents who were struck down by the infection at a Victorian facility.

Federal Health Minister Greg Hunt announced the plans last month, stating he would work with medical authorities, healthcare workers and aged care providers to investigate ways to make vaccination compulsory for all aged care staff.

The unprecedented action was directly triggered by the recent deaths of eight elderly residents at St John's Retirement

Village in Wangaratta in Victoria and reports of several similar fatalities from flu at Strathdevon Aged Care in Tasmania.

Australia is experiencing one of its worst flu seasons on record, with 105,000 cases confirmed nationally so far.

"We cannot continue to have a situation where people, whose immunity is already low, are at risk from others who may be infected," Mr Hunt said. "Our job is to protect those who need our care."

Under current laws, there is no requirement for aged care workers to be vaccinated.

The ANMF's policy supports vaccination and immunisation for nurses and midwives so that the spread of disease in healthcare settings can be prevented.

The union strongly encourages all nurses and midwives to get routine vaccinations, unless the treatment is known to cause harm. It also states nurses and midwives have a professional responsibility to promote the benefits of immunisation and be informed around the myths and realities concerning the process.

ANMF Senior Federal Professional Officer Julianne Bryce backed the government's move, yet emphasised immunisation was a collective issue that demands wide-ranging support.

"We strongly encourage nurses and midwives and assistants in nursing (AINs) that work closely with the frail and vulnerable to be vaccinated," Ms Bryce said.

"But it's not just about aged care. Health workers in all sectors should be vaccinated. It really needs to be a consideration everywhere."

Ms Bryce suggested some health services were far more proactive than others in offering vaccinations that were free and easily accessible within the workplace.

If compulsory flu jabs are put in place, she said nurses and midwives should be afforded the appropriate assistance from employers to meet the requirements.

"Achieving 'herd immunity' takes a multi-faceted approach. It's not just health workers that need to be vaccinated but the entire community. People who are visiting their loved ones need to be vaccinated. Residents in aged care need to be vaccinated too. Again, some services are far more proactive in making sure that occurs regularly. They take preventative action."

Seniors' advocacy body COTA Australia welcomed the vaccination boost, revealing it had been concerned for some time over the rates of flu vaccination among aged care staff and inconsistencies between facilities.

URGENT CALL FOR VOLUNTEERS WITH CLINICAL DEPRESSION

Mental health advocates are appealing for Australians with clinical depression to participate in a global study.

The world's largest genetic investigation into clinical depression needs another 10,000 Australian study volunteers.

Interim data of the Australian Genetics of Depression Study found more than two-thirds of study participants have had to rely on multiple antidepressants to treat their clinical depression.

Co-Director for Health and Policy, Brain and Mind Centre at The University of Sydney Professor Ian Hickie said Australia had one of the highest antidepressant prescribing rates per head of all OECD countries.

"Given our lack of diagnostic methods to predict different responses to antidepressants, or forecast the potential for intolerable side-effects, we are exposing those battling clinical depression, to trial and error, which is often slower to deliver significant benefits."

Better targeting of existing treatments through individual genetic profiling before starting medication would be a major advance in clinical therapy, Professor

Hickie said.

The Australian Genetics of Depression Study is being conducted internationally, with 200,000 participants. Australia aims to contribute 10% of the total study population.

The initial findings involving 10,000 Australian volunteers was published in medical journal *MJA InSight* last month.

THE LINK BETWEEN GENETICS AND CLINICAL DEPRESSION WAS VERY CLEAR

Interim analysis found we've reached the limit of our current knowledge of treating clinical depression, Professor Hickie said. Another 10,000 volunteers were urgently needed to help crack the genetic code, he said.

The link between genetics and clinical depression was very clear, lead study investigator and Head of the Genetic Epidemiology Laboratory at QIMR Berghofer Medical Research Institute Professor Nick Martin said.

"Approximately 20,000 genes make up the human genome. Alternations in some genes cause clinical depression. But right now, we don't know what they are. What we do know, however, is how to find them. We just need a large enough study, performed the right way, to identify them."

The ground breaking study should enable researchers to identify between 50-100 genes that influenced a person's risk of developing clinical depression, Professor

Martin said.

"Only then, through cracking the genetic code of clinical depression, will we be able to develop new, and more effective, personalised treatments that target the problem directly."

High profile Australian mental health advocates have lent support to the study, including TV and radio personality and Director of SANE Australia Osher Gunsberg, Dan Hunt, Julie McDonald and Mitch Wallis.

Study participant and RN and midwife Megan was diagnosed with clinical depression just after she graduated with her Bachelor of Nursing degree. Megan has a strong family history of clinical depression and has trialled multiple antidepressant medications. "I personally believe depression is a combination of genetics, biochemistry and upbringing. It is a chemical and hormonal imbalance."

Megan hopes the study will shed light and improve outcomes for people with clinical depression. "Why people get depression and why some people suffer more than others. Why medication works for some people in the first instance and others like myself try and try again and get a lot worse rather than getting better."

"If like the statistics show, one in seven people experience clinical depression, that's one in seven nurses."

Study volunteers need to be aged 18 and over, who are undergoing, or have been treated for clinical depression.

To volunteer for the Australian Genetics of Depression Study:

www.geneticsofdepression.org.au



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HEALTH PROFESSIONALS CHALLENGE DRUG TESTING TRIAL

Hundreds of nurses have rallied with fellow health professionals in standing up against federal government plans to introduce a controversial mandatory drug testing trial for welfare recipients.

More than 200 registered nurses, together with 109 addiction specialists, 330 doctors and hundreds of allied health professionals, have signed an Open Letter opposing the proposal on the grounds it punishes Australians struggling with severe alcohol and drug problems and will push them further into poverty.

The suitability of a drug testing trial has been dissected over recent months through the Senate Community Affairs Legislation Committee's Inquiry into the Social Services Legislation Amendment (Welfare Reform) Bill 2017.

The plan involves drug testing 5,000 people receiving Newstart and Youth Allowance payments at three sites across the country – Logan in Queensland, Bankstown



REGISTERED NURSE LINDA KELLY IS OPPOSING MANDATORY DRUG TESTING FOR WELFARE RECIPIENTS.

in New South Wales, and Mandurah in Western Australia.

If the trial goes ahead, welfare recipients will be randomly tested for drugs including marijuana, ecstasy and amphetamines.

A positive drug test would result in that person being placed on income management, where 80% of their payments will be quarantined on a cashless debit card.

A second positive test will force people into mandatory drug treatment programs.

Victorian RN Linda Kelly, who is based in St Kilda and has worked for the RDNS Homeless Persons Program (HPP) for the past 18 years, put her signature to the letter for fear the crackdown on payments could have a detrimental impact on equal access to healthcare.

"I think it's really discriminatory," she said.

"It's focusing on marginalised groups and

Indigenous groups and they're the people that actually need the most support with their healthcare.

"I'm fearful that it might stop people from following up their health checks or advice or support and all those kinds of things because it might then negatively influence any Centrelink benefits that they have."

Ms Kelly said substance use was complex and often directly related to mental health issues. She claimed governments didn't fully understand the psychology behind substance use and that it was unfair for people on the fringes to be drug tested when those in mainstream society were not subject to the same scrutiny.

Ms Kelly, who works closely with the disadvantaged, believes the government's strategy will damage health outcomes.

"They [this cohort] are fearful of anything that's singling them out rather than the rest of the population. It makes them feel like they're the 'other' in society rather than full members of society and that's a huge problem in the homeless community."

Early last month, the Senate Community Affairs Legislation Committee recommended the Bill be passed, however, it still faces a stiff battle to become legislation, with both Labor and the Greens strongly against the plan.

Ms Kelly said she was hopeful the scheme could be thwarted and would continue to lobby with the medical community. "I think health professionals and particularly nurses always come from a social justice perspective. It makes sense to understand that health is going to be negatively impacted by these kinds of things."

NDIS IN FEDERATION SIGHTS

The National Disability Insurance Scheme (NDIS) commenced as a trial in July 2013, at four sites. On completion of the trial period in July 2016, rollout of the scheme began, across Australia.

An initiative of the Labor government, NDIS is intended to provide a range of support measures for people with disability, their families and carers. It is estimated that the NDIS will provide this support to about 460,000 Australians under the age of 65 with a permanent and significant disability. The aim is for them to be able to live as normal a life as possible, including participation in the community and employment. The NDIS is being implemented and administered by the National Disability Insurance Agency (NDIA), an independent statutory agency.

The ANMF has endorsed the

introduction of the NDIS from its conception, and strongly supports governments to fully and appropriately fund the scheme to ensure its viability and sustainability. Given our commitment to seeing the NDIS successfully implemented, we are concerned by feedback from members of their difficulties in working with the scheme. Specifically, we've been informed of funding discrepancies between nurses and allied professionals for their services provided under the NDIS. One such example is correspondence we've received from the Continence Nurses Society Australia (CNSA) detailing the specifics of these discrepancies. The funding remuneration is less than continence nurses previously received and is the same amount given to unqualified workers. This underfunding threatens not only the viability of the continence nurses' role but opens the client to receiving sub-optimal care from a worker who has no formal knowledge of the care requirements. It is apparent that the NDIA does not understand the role of the continence nurse nor are they recognised as an NDIA specialised care service.

On behalf of ANMF members, and with the interests of the NDIS care recipients in mind, Federal Secretary Lee Thomas and Assistant Federal Secretary Annie Butler

have raised these issues with bureaucrats and politicians. In addition, Professional Officers from the Federal Office and ANMF State and Territory Branch Offices have recently been attending open forums around the country, held by consultants McKinsey and Co, who are undertaking a review of the implementation of the NDIS. We have been able to raise our concerns about inaccurate pricing of services and inappropriate assessment of care needs leading to a mismatch of the provider of care. We've stressed that care is compromised in terms of quality, evidence-base, and outcomes, when price does not allow for a registered nurse who had previously provided care for health issues (especially those specialising in continence care, wound care, mental health or drug and alcohol issues) and instead unqualified/low qualified people are engaged in care of NDIS recipients. The flow on effect is a greatly increased risk of health issues deteriorating to the point of the person needing to enter the acute system, with a consequent negative impact on the ability of those services to meet care needs.

The ANMF will be providing further written feedback as we continue to highlight the issues that have been presented to us by our members who work in, or close to, the NDIS sector.

HINCH SHAMES STATE OF AGED CARE

Senator Derryn Hinch has introduced an Aged Care Amendment (Ratio of Skilled Staff to Care Recipients) Bill into federal Parliament in a bid to trigger mandated ratios of skilled staff in nursing homes across the country.

Mr Hinch tabled the Bill last month, stating its implementation would provide an important step in protecting the elderly instead of the financial interests of aged care facilities.

He described the elderly as important contributors to society who have helped make Australia great and deserved better levels of care.

"Unfortunately, many of these Australians who have given so much to society are highly vulnerable and are not currently guaranteed the standard of care they deserve within our aged care facilities," Mr Hinch told Parliament.

Mr Hinch said the ambiguity surrounding minimum staffing standards

in residential aged care facilities stipulated in the *Aged Care Act 1997* had resulted in many aged care providers dodging obligations. "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 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."

"UNFORTUNATELY, MANY OF THESE AUSTRALIANS WHO HAVE GIVEN SO MUCH TO SOCIETY ARE HIGHLY VULNERABLE AND ARE NOT CURRENTLY GUARANTEED THE STANDARD OF CARE THEY DESERVE WITHIN OUR AGED CARE FACILITIES,"

He backed his claims by drawing attention to an emerging aged care crisis, including one Victorian facility which met just 27 of 44 accreditation standards following an on-the-spot audit from the government regulator, the Australian Aged Care Quality Agency.

He further pointed to international research proving that having more RNs in aged care produces better quality care.

If the Bill passes through, Mr Hinch said the Department of Health, in consultation with the aged care sector, should take responsibility for calculating safe and specific ratios.

The ANMF commended Mr Hinch's stance and said it would soon meet with him, fellow Senators and MPs to support its passage through Parliament.

ANMF Federal Secretary Lee Thomas highlighted results from the union's ongoing national aged care survey which have revealed 92% of nurses and carers feel they are being asked to care for the same number of residents with less staff and hours, and that 90% believe current staffing levels aren't sufficient enough to provide proper daily care.

"Our members keep warning that inadequate levels of registered and enrolled nurses and appropriately trained care workers means that the basic care they can provide, including feeding and bathing, is being significantly compromised," Ms Thomas said.

"Without mandated staffing or care hours in nursing homes, the Federal Government is allowing aged care providers to decide on what an 'adequate' level of care is and as we've recently seen in Queensland, some providers aren't doing the right thing – sacking nurses and slashing hundreds of care hours."

NEXT CHAPTER BEGINS AT NEW ROYAL ADELAIDE HOSPITAL (RAH)

The new Royal Adelaide Hospital (RAH) opened its doors to the public last month and for hundreds of nurses it was back to business.

"We didn't really notice an opening," Clinical Nurse Specialist Jeffrey McMullen recalled. "It just kind of happened. We were there working and suddenly the first patient arrived from the old hospital."

Mr McMullen had worked at the old Royal Adelaide Hospital for the past eight years in its Infectious Diseases Unit.

For staff, part of the transition involved undertaking online learning courses in order to get up to speed with the new hospital's advanced computer systems and cutting-edge technology.

"We were very excited we were going to a new hospital because it's not every day you

move into a new hospital. A lot of us were nervous as well because at the end of the day it's a completely new way of working. How we worked and how we did things and all the systems that we used to do like paperwork and things like that will eventually be gone."

Mr McMullen revealed emotions ran high when it inevitably came time to make the shift.

The largest transfer of hospital patients ever undertaken in the state involved almost 300 patients being moved over two and a half days.

"People were emotional obviously because a lot of people had worked there for a long time and it was a system of nursing we were used to," Mr McMullen explained.

"I'll miss the staff most. We all worked in one unit and we all kind of knew each other and we knew the ward next door to us or we knew the ward around the corner from us."

Mr McMullen moved to the new RAH about a week before the hospital officially opened to ready the Infectious Diseases Unit. It's only early days and he admits the team is still finding its feet.

He lists new technologies, such as automatic drug dispensers, as among the most significant changes. "How we provide and facilitate care will have to change as we go along until we sort out a system that suits ourselves and the patients best."



JEFFREY MCMULLEN



GLOBAL

Health workers are not a target

The World Health Organization (WHO) has called for an end to attacks on healthcare workers caught up in armed conflict around the world.

WHO demanded safety from governments for healthcare workers in a global petition. Civilians are **#NotATarget**.

There were 302 reported attacks on healthcare workers worldwide in 2016 which killed 418 people.

WHO Director-General Dr Tedros Adhanom Ghebreyesus on World Humanitarian Day called for an end to attacks on healthcare facilities in conflict zones.

In Yemen alone, 2,000 people had died of cholera since April. Most would have survived if they had obtained treatment, Dr Adhanom Ghebreyesus said.

"These people are working around the clock. They struggle to find the medical supplies they need. Often there is no water or electricity. They work long days and nights. And many have not been paid in almost a year. On top of that, they run the risk of being targeted or attacked – simply because of the job they are doing."

"Every hospital destroyed and every medical worker killed wipes out years of investment and takes vital health services away from the people who need them most."

UNITED KINGDOM

Missing link is shortage of RNs to provide care

A failure to complete nursing care explains why hospitals with lower registered nursing staff levels have a higher risk of patient death, a UK study shows.

The University of Southampton study found that care left undone due to lack of time was the 'missing link' in the variation in mortality

rates in hospitals.

When RN staffing was lower, necessary care was more likely to be missed, University of Southampton principal research fellow Jane Ball said.

Each 10% increase in the amount of care left undone was associated with a 16% increase in the likelihood of a patient dying following common surgery, the study found.

"For years we have known that there is a relationship between nurse staffing levels and hospital variation in mortality rates but we have not had a good explanation as to how or why," Dr Ball said.

"IF THERE ARE NOT ENOUGH REGISTERED NURSES ON HOSPITAL WARDS, NECESSARY CARE IS LEFT UNDONE, AND PEOPLE'S LIVES ARE PUT AT RISK."

"These results give the clearest indication yet that RN staffing levels are not just associated with patient mortality, but that the relationship may be causal. If there are not enough registered nurses on hospital wards, necessary care is left undone, and people's lives are put at risk."

The findings come from further investigation of the major RN4CAST study of nurse staffing at hospitals in nine European countries, including 31 NHS trusts in England.

Missing nursing care was measured through a nurse survey and included activities such as patient surveillance, administration of medication on time, adequate documentation, comforting patients and pain management.

The analysis also looked at nurse qualification and confirmed that hospitals with higher numbers of RNs trained at degree level had lower risk of patient mortality.

"It is more evidence that shows that you cannot substitute fully qualified RNs with

less qualified staff, without taking a risk with patient safety. It is the number of RNs on duty that is key to ensuring complete care and minimising the risk of patients dying," Chair of Health Services Research at the University of Southampton Professor Peter Griffiths said.

The study was published in the *International Journal of Nursing Studies*.

ENGLAND

Aged care crisis in England to worsen

The current aged care crisis in England is set to worsen with latest research showing an extra 7,100 residential care places will be needed by 2025.

The research published in international medical journal *The Lancet* is the first to measure the extent of greater levels of dependency than simply greater numbers of older people.

The study found the length of time for women with substantial care needs is now on average three years and 2.4 years for men, aged over 65 years in England.

Lead researcher from Newcastle University Professor Carol Jagger said while the past 20 years had seen continued gains in life expectancy, not all of those had been healthy years.

"Though most of the extra years are spent with low dependency, including help with activities such as washing, shopping or doing household tasks, older men and women are spending around one year more requiring 24 hour care."

Life expectancy had increased for both men (77.9 to 82.6 years) and women (81.5 to 85.6 years) from 1991 to 2011. The number of years spent with substantial care needs (medium or high dependency) had nearly doubled over that time – increasing from 1.1 to 2.4 years for men; and from 1.6 to three years for women.

Correspondingly, the proportion of years that an adult aged 65 could expect to live independently dropped from 73.6% to 63.5% for men; and from 58% to 47.3% for women.

"This finding, along with the increasing number of older adults with higher rates of illness and disability is contributing to the current social care crisis," Professor Jagger said.

The researchers estimated that if rates of dependency remained constant, there would be an additional 190,000 older people with medium dependency, and 163,000 with high dependency by 2025 compared to 2015.

The authors highlighted the need for adequately trained professionals to care for older adults with complex needs.

"Expenditure on the care of older people will need to increase substantially and quickly," University of Oxford Professor Andrew Dilnot said. "Although the overall amount of care needed will increase substantially, this increase does not mean that every individual will need large amounts of care."

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UNION DELEGATE VANESSA HOBAN
WITH CANBERRA NURSES CLAUDIA
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PHOTO: JAY CRONAN



LEADERS OF THE PACK

OUR COMMITTED ANMF REPS



Depending in which state or territory you live in the chances are you have met job reps, union delegates, worksite representatives or job delegates. Despite varying titles, the role of an ANMF job rep (however titled) is clear cut – to represent nurses and midwives in the workplace and drive change to improve conditions. **Robert Fedele** takes a look at what is involved in the position and how it can empower volunteers both personally and professionally.

Australian Nursing & Midwifery Federation (ANMF) Federal Secretary Lee Thomas considers delegates as the union's most valuable asset.

"If we don't have job reps as a conduit between the members and the union office then we would be lost," she says. "If it wasn't for the hard work that job reps do every day, advocating on the ground and notifying the union when issues crop up, our union wouldn't be as strong as it is."

An active union member from the start of her career, Ms Thomas put her hand up to become a job rep while working as a midwife at the Queen Victoria Hospital in Adelaide in the late 80s.

Ms Thomas recalls a handful of industrial issues sparking her sense of duty, including management attempting to reduce workers' annual leave.

"The most important objectives for me were about maintaining people's rights, workers' rights, including my own at the time, and ensuring that people were treated fairly, whether it concerned working conditions or whether it was about individuals as members ensuring that they got treated with natural justice and procedural fairness if there was disciplinary action."

Today, the ANMF boasts thousands of committed job reps across the country.

Ms Thomas nominates the training and education all job reps undergo as a crucial step, suggesting the knowledge gained around organising, campaigning, legislation, workplace health and safety and advocacy proves invaluable.

"It's quite motivating because it gives you a real insight and some ability to be able to advocate on behalf of members collectively and individually," she says.

"It puts you in a mind-set that allows you to be confident about what you're doing with the back-up of the union behind you when you come across situations that perhaps you're not so familiar with."

Ms Thomas says nurses and midwives advocate on behalf of patients every day and choosing to become a job rep is an extension of that obligation.

"We say delegates are our most valuable asset. Of course, all our members are but it's our delegates that are crucial because it extends the union in a very visible way into the workplace on a day-to-day basis."

Ms Thomas, who rose to become the ANMF's Federal Secretary, says change ultimately requires action and members stepping up.

"If you're really determined to make everybody's working life different then you've got to be involved. You can't do it from the outside. You can't affect change. Collective action is always going to be the thing that achieves the best outcomes for all our members."

VISIBILITY

Registered Nurse Vanessa Hoban has been a fixture in the public sector for almost two decades.

She currently works in a General Medicine Unit, a ward which looks after a variety of complex patients including those suffering co-morbidities or psychiatric patients requiring medical care.

The 47-year-old became a union delegate five years ago.

"I don't think there was any one incident that led to it," she recalls. "There wasn't visible delegates at the hospital and I just felt we needed representation."

"Back then you only ever sort of called the union when there was a problem, not just to check in with people. I like to check in before things become a bushfire, before it escalates to this huge problem when it could have been de-escalated weeks ago."

Vanessa carries the "golden EBA" with her everywhere she goes.

"For me, the task is visibility," she explains.

"People need to know that the union is a professional body and that they are there to support you as a member, you as a nurse and you as a



"If it wasn't for the hard work that job reps do every day, advocating on the ground and notifying the union when issues crop up, our union wouldn't be as strong as it is."

LEE THOMAS

professional."

In leading her workplace, Vanessa aims to protect the rights of her colleagues and empower them to stand up for themselves.

A recent example involved attempts by her employer to change shift times which would push start and finish times back half-an-hour.

Vanessa says the seemingly small adjustment would likely have a big impact on nurses' schedules.

Through campaigning, members have been able to put the moves on hold, correctly highlighting such changes cannot be enforced in the middle of an EBA.

For Vanessa, the collective action helped her reinforce the power of a unified voice.

"It got people talking about 'well why am I in the union?'. It was great because they went 'Wow. Look what we can do when we band together and say No.'"

Still, Vanessa admits engaging members as a job rep has its ups and down.

"It's difficult as a delegate to try and explain to members that things take time to change and a lot of people don't see what you do behind the scenes. That you



"Some members want to be a member just for the money, as in you don't have to fight for a pay raise. They forget that actually it's not always about the dollar. It's about the working conditions that we have to fight for and the patients that we care for that we need to protect."

KYLA GLOVER

are firing off emails, getting petitions together, getting around to every ward.

"It's hard when time and time again we're short-staffed, time and time again we're not getting our annual leave, we're dealing with aggressive patients and it's hard to keep them engaged. You think to yourself just hang in there it's just not a battle that's going to be won overnight."

Vanessa says becoming a union delegate has improved her confidence, ability to communicate with members and courage to challenge management.

"Now I know how to spark up conversations to get people talking about what they're passionate about in our profession," she says. "It's a way that I can protect my colleagues. I get a great sense of satisfaction knowing I will do my utmost to protect them because when I was training and when I was a junior nurse I had a delegate on our ward who always had my back."

TAKING A STAND

An RN in the Emergency Department of the Flinders Medical Centre in South Australia, Kyla Glover opted to become



"For sites that don't have that union infrastructure, the job becomes more about walking in, finding people who are interested in the union, finding people who have their own workplace issues and then unionising around that and building a union from the ground up."

MICHAEL KIRBY

a worksite rep two years ago in a bid to safeguard working conditions.

"Some of the people who had been worksite reps at that time were sort of coming to the end. They didn't want to do it anymore and having such a large number of staff members in the ED, we need more than one rep."

At one of the busiest EDs in Australia, Kyla highlights safety and staff ratios as problematic issues.

"The working conditions at times can be extremely unsafe for patients and for us as nurses and the doctors as well. At the end of the day, that's what you're fighting for. It's the patient safety aspect of it."

"In emergency it's a one to three patient ratio, on the ward it's one to four. So we need to just keep that as one to three. There's no way we can manage a one to four ratio in our ED."

Kyla represents about 150 staff in the ED. She believes being a good worksite rep demands knowing the EBA back to front, being proactive about workplace issues and liaising with members and the union.

She credits the role with giving her a broader perspective on the union's



"I think you have to learn to be diplomatic. Like anyone else, I get a bee in my bonnet over a specific thing but you have to pick the fight that you can have and take the wins you can. You have to just keep nipping away at it."

AMANDA GILL



"To me, to provide a place where my colleagues can vent, get support and information is very satisfying. I feel it's a natural extension of caring for my residents – to care for their carers."

CLAIRE BATHGATE



PHOTO CREDIT: NATALIE PESTANA

"We were a ward of about 60 staff and only had one job rep and she was transitioning to retirement so left our ward to work somewhere a little bit quieter within the hospital and we were then kind of left with nobody. Members had no idea about what their rights were or anything like that so I put my hand up."

NICOLE BROWN

purpose.

"It doesn't matter what profession you're in you tend to work in your own bubble and you're actually only aware of your own department," Kyla suggests.

"But once you do a worksite rep course, with other worksite reps from other avenues, country, city, wards, departments, it enlightens you – wow there are far worse conditions than what we're fighting for."

Talking to staff, promoting the power of the collective and banding together for better working conditions and patient care typify Kyla's objectives as a job rep.

"Some members want to be a member just for the money, as in you don't have to fight for a pay raise. They forget that actually it's not always about the dollar. It's about the working conditions that we have to fight for and the patients that we care for that we need to protect."

After being a worksite rep for the past two years, Kyla says she keeps fronting up because there's a need.

"We say amongst ourselves [delegates] if we don't do it who's going to put their hand up to do it? I think new blood is always great but there's no one rushing to

put their hand up because they can see what we're all doing at times and it does put them off.

"The union has to have somebody in the department that they can actually come to. Both the union and the members have to have somebody to voice their concerns or issues to and be a liaison between the two."

BECOMING A JOB REP

Job reps assume countless duties – representing members in the workplace, recruiting new ANMF members, providing resources and advice, and referring members to the union to seek further information.

They also bring members together and build relationships with management and the union so they can help shape the industrial and professional framework in which nurses and midwives work.

Before becoming a job rep, candidates undergo comprehensive education and training to get themselves up to speed.

NSWNMA Branch Organiser Michael Kirby recruits and trains potential job reps.

For some settings, this means reaching out to members and building capability.

"For sites that don't have that union infrastructure, the job becomes more about walking in, finding people who are interested in the union, finding people who have their own workplace issues and then unionising around that and building a union from the ground up."

Michael says job reps are predominantly taught how to provide assistance and support to their colleagues.

One of the most important responsibilities is understanding what rights and responsibilities nurses and midwives retain under the EBA, he adds.

"When they're having conversations with people, rather than letting an issue float away they can identify 'Okay you've mentioned a problem about your workload there or about unpaid overtime...' and it's important just so they've got the education to know that a break in the Agreement's been made and then they can start teaching their colleagues about 'Ok well actually, that's not meant to happen and this is what we can do as a group to fix it'."

After three years covering the public sector, Michael is now tasked with supporting members working in aged care

"It's a way that I can protect my colleagues. I get a great sense of satisfaction knowing I will do my utmost to protect them because when I was training and when I was a junior nurse I had a delegate on our ward who always had my back."

VANESSA HOBAN



and attempting to “awaken that sense of class consciousness inside them” so that they rally to protect their rights.

When pitching to potential reps, he spruiks the power of the collective.

“If you want to win this right for yourself and want a better world then you need to become a rep,” he advises.

“If you’re a leader in the workplace and bring colleagues together it’s the only way that you’re going to get a better deal.”

Rather than having just one job rep at a workplace, Michael suggests it is wiser to encourage different personalities with diverse qualities to pool together.

“On bigger things, like trying to win better hours or more staff, you need someone who’s articulate, who’s prepared to be strong with management and not cower away at the idea they might get bad rosters.

“So you need someone who’s competent, articulate, I think they need to be a bit audacious as well. But within that you need a whole scope of people. Union work brings on all types of different problems and it takes all different types of personalities to resolve them.”

Michael says influential job reps are worth their weight in gold.

“It’s all good and well to have members on site but real union strength comes from activity and the activism participation of that membership. Job reps are absolutely crucial for not only getting people active but to keep maintaining that activism throughout a campaign and even when campaigns are over and there’s those little lulls, making sure those structures remain.”

LEADERSHIP

Northern Territory RN and job delegate Amanda Gill views her position as an opportunity to trigger change.

“I want to be able to be a voice for all nurses,” she says. “I want to be able to help educate and get staff to be aware of their roles, their responsibilities, their rights and entitlements.”

Amanda has been a job delegate twice, the first occasion when working as a remote area nurse (RAN), and now at her current post in the education team of the National Critical Care and Trauma Response Centre (NCCTRC) based at Royal Darwin Hospital.

Established in 2002 in the wake of the Bali Bombings, the NCCTRC is the Australian government’s disaster and health emergency response centre and tackles sudden health emergencies both onshore across Australia, and offshore throughout South East Asia.

The NCCTRC prepares Australian clinicians for deployment and local emergencies through unique education and training programs.

One of Amanda’s current challenges within the workplace surrounds balancing necessary work related travel against the Northern Territory Government’s Travel Policy and Time Off In Lieu (TOIL) entitlements.

The policy stipulates staff must travel within working hours, yet many courses

delivered by the NCCTRC require staff to travel outside of working hours, thus nurses can sometimes be disadvantaged.

Amanda says she is happy to step up and support staff not strong enough to voice their concerns.

“The trauma team work shift work. In our office, our courses run different times, days, nights, weekends, we travel a lot and I want to make sure that our staff and nurses are well cared for.”

Amanda lists listening, support, advice and the courage to raise issues as the most important parts of being a successful job delegate.

“I think you have to learn to be diplomatic. Like anyone else, I get a bee in my bonnet over a specific thing but you have to pick the fight that you can have and take the wins you can. You have to just keep nipping away at it.”

She adds that attending regular delegate meetings and finding out about other issues going on outside her workplace and how they’ve been tackled and resolved help her appreciate the union’s national footprint.

REWARDS

NSW RN Claire Bathgate works in residential aged care in Tweed Heads, caring for complex patients experiencing a range of health issues.

“It can be physically, mentally and emotionally demanding because of the number of residents that you are looking after, the complex needs that you are responsible for, the interplay between family members that we become involved in and the huge variety of things we are responsible for,” Claire says.

Claire was inspired to become a union delegate after witnessing tough working conditions.

“When I started nursing, I was really shocked at how constantly hard, good decent nurses were working. Everyone expects to work hard and fast to meet a deadline, but these nurses worked so incredibly hard all day, every day. The stories we all hear about missed breaks, staying back without pay to complete your notes or to finish something, and so on, they were played out every single day in the hospital I worked in. I just felt it was wrong.”

As a union delegate in aged care, Claire strives to protect her colleagues.

“I see my main roles as listening to members, offering support and information and at the moment, being involved in EA negotiations.

“To me, to provide a place where my colleagues can vent, get support and information is very satisfying. I feel it’s a natural extension of caring for my residents – to care for their carers.”

DEVELOPING A VOICE

Victorian Enrolled Nurse Nicole Brown was working at private hospital Epworth Richmond in surgical admissions when she felt compelled put her hand up to become a job rep.

The decision was triggered by the 2016

Private Sector EBA and widespread lack of knowledge around rights and entitlements.

“We were a ward of about 60 staff and only had one job rep and she was transitioning to retirement so left our ward to work somewhere a little bit quieter within the hospital and we were then kind of left with nobody. Members had no idea about what their rights were or anything like that so I put my hand up.”

Nicole attributes the lack of knowledge around industrial issues and the role of the ANMF to the ward’s relatively younger demographic. After investigating what it took to become a job rep, Nicole undertook training at the ANMF (Vic Branch).

Several months later she would boost her skills by commencing the Anna Stewart Memorial Project, a two-week development program run by the Victorian Trades Hall Council for women who want to get more involved in their union.

Nicole spent time at Trades Hall and the ANMF (Vic Branch) where she immersed herself in the union movement and increased her knowledge in areas such as recruitment and organising.

“There’s things that you learn that you didn’t know before about how to approach situations, how to communicate effectively with people, from recruiting to having grievance conversations and disciplinary conversations with people and being able to give people reassurance in times that aren’t so certain.

“The biggest thing was getting that holistic picture of where your money goes that you pay every fortnight and how hard everyone actually works.”

Nicole quickly put her new skills to use as a job rep.

“It opened doors for me to bond with colleagues. People who I maybe wouldn’t have spoken to the way I did if I wasn’t a job rep. Forming relationships with people which then kind of led onto working better as a team and better patient outcomes. You have a members’ meeting and everyone then kind of feels part of a unit and like they support each other.”

Nicole says becoming a job rep “completely changed my life”.

After taking on the role, she recently left to pursue a position as a Branch Organiser with the ANMF (Vic Branch).

“The job rep role, career wise, it made me a better communicator, it made me a more active learner and listener and just professionally, it’s completely changed my career direction.”

Asked to reveal what legacy she hopes she left on her former workplace, Nicole offers a culture of empowerment, questioning issues and knowing your rights.

“It comes back to a nursing thing and being able to help people. Leaving people after a conversation knowing that you’ve given them a little bit of education that they probably didn’t have before.”

A CHURCHILL FELLOWSHIP EXAMINING INTENSIVE HOME VISITING FOR VULNERABLE YOUNG MOTHERS

By Catina Adams

After my fourth baby was born, I said to my midwife – I can't think of a better job in the whole world, working with women, teaching them about pregnancy and birth, and then to be present, when a baby is born. She looked at me and smiled – if you feel that way, why don't you do it?

And that was it. Within three weeks, I had quit my job as a university registrar, enrolled to undertake nursing at La Trobe University as a 40-year old mature aged student. My friends at the time joked that I was moving from production into management.

Completing nursing studies I went on to study a Graduate Diploma in Midwifery, after which I worked in the Family Birth Centre at the Royal Women's Hospital. Three years later, I enrolled in a Master's degree in Child and Family Health nursing. At the time, I had a two-month old baby who came along to all our classes. He was our prototype, as we learnt how to check hips, do breastfeeding assessments, listen to hearts, and do infant developmental checks. My first job as a Maternal Child Health (MCH) nurse was with Hume City Council, supporting some of the most vulnerable families in Melbourne.

Maternal and Child Health nurses in Victoria work with families with children from birth to four years of age. The continuity of this relationship is a feature of the MCH service, and contributes to the satisfaction of clients and the MCH nurses doing the work.

In 2010, I worked on the MOVE project at La Trobe University. The MOVE project developed a clinical model to enable MCH nurses to more easily ask women about family violence (Taft et al. 2015). Women are most likely to experience family



CATINA ADAMS AND THE NURSE FAMILY PARTNERSHIP TEAM IN PENNSYLVANIA

violence during their first pregnancy or in the first year of their baby's life. MCH nurses see almost all women at birth, and up to 90% of families are still seen at 12 months. This privileged relationship enables difficult questions to be asked about family violence and other social issues.

After the MOVE project, I returned to Hume as MCH Team Leader, working with a great team of passionate and devoted nurses. We had many successes, creating specialist programs for different groups in our community, such as young mothers, Aboriginal and Torres Strait Islander families, and families from Culturally and Linguistically Diverse (CALD) backgrounds. We wrote a breastfeeding strategy, and developed ways of taking our MCH service out to where the clients were, with pop-up playgroups in shopping centres, and outreach into preschools and childcare centres.

In 2015, I applied for a Churchill Fellowship. Over 100 Australians each year receive Churchill Fellowships, with over 1,000 applicants nationwide. The Fellowship allows them to travel overseas to meet with industry and community leaders, to gain knowledge and experience for the benefit of Australia. The main criterion for selection is showing how the proposed Fellowship will be of benefit to the Australian people. I believe that nurses are particularly well placed to undertake projects which can demonstrate this social benefit.

I was awarded a Churchill Fellowship to study the Nurse-Family Partnership, a program where a family health nurse engages with the first-time mother early in her first pregnancy, and through a program of sustained home visiting, maintains contact until her child is two years of age. I visited Nurse Family Partnership teams in the US, Canada and the UK.

The Nurse Family Partnership program is powerful because it works through partnership, building on strengths, and working towards goals that the young woman has identified as important to her. The young mother is supported in her pregnancy and parenting journey to be the best mother she can be.

The program in New York has a wealth of experience and a sound evidence base, with the first babies in the program now in their thirties. They have demonstrated reductions in pre-term birth, drug and alcohol use, homelessness, crime, and repeat pregnancy. Proven benefits include higher employment and education rates for the mothers and children, and improved maternal and child health and wellbeing (Olds et al. 1988).

For the second half of my Fellowship, I travelled to the UK to observe the same program, but in its implementation phase. Comparing the experience of the mature, embedded program in the US with its younger sister program in the UK has enabled me to return to Australia with rich knowledge and insight.

I wrote a blog while I was away: <https://catinachurchillfellowship.wordpress.com/> and my final report can be found here: https://www.churchilltrust.com.au/media/fellows/Adams_Catina_2014_Strategies_for_engaging_young_parents.pdf

After the Churchill Fellowship I returned to Hume to work part-time as a MCH nurse, and started my full-time PhD, asking the question – How do enhanced maternal and child health nurses support families at risk of or experiencing family violence?

Catina Adams is a Midwife, Maternal and Child Health nurse and PhD student



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Julianne Bryce



Elizabeth Foley



Julie Reeves

ANMF Federal Professional Officers

CPD – WHAT'S THE POINT?

How hard is it for people to keep up with change? Sometimes it feels like there is so much happening it's impossible to keep track. At the same time, if you stay in the profession long enough you'll feel like there's nothing new under the sun.

Often it's difficult to believe so much time has passed when you're due to review documents again that surely were last reviewed only yesterday. Feels like Groundhog Day? Just today someone quoted to me that 'the days are long but the years are short'.

It's been seven years since the commencement of the National Registration and Accreditation Scheme (NRAS). Hard to believe isn't it?

Since 2010, we no longer use the term division 2 to refer to enrolled nurses, we no longer have endorsed enrolled nurses (EENs) and there's no point system for CPD.

Nobody understood what a so-called CPD point equated to anyway, so logic prevailed and now we refer to CPD hours rather than points. Makes sense doesn't it?

What a relief you say? Unfortunately old habits die hard. Reference to Div 2s, EENs and CPD points persist. Nevertheless, we can assure you these terms are all gone for good.

We all understand the importance of CPD as nurses and midwives. Our professions require us to keep up to date, maintain our knowledge and be inspired about how we can provide better care outcomes. Through CPD processes we can reflect on our own professional needs and undertake education to broaden our knowledge and expertise.

The Nursing and Midwifery Board of Australia (NMBA, the Board) *Registration Standard: Continuing Professional Development* sets out the minimum requirements for CPD for enrolled nurses, registered nurses and midwives. The Standard applies to all nurses and midwives who work either full-time or part-time, in paid or unpaid employment, even if they're on leave from work. They apply to a nurse manager, for example who is managing a burns unit or a director of nursing of a large health facility, a nurse working in the community in aged care or even the chief nursing and midwifery officer of the country. We are all required to meet the same standards outlined by the NMBA if you hold general registration as a



nurse or midwife.

To meet the Board's Standard, you must complete a minimum of 20 hours of CPD per 12 month registration period. If you are a nurse or midwife with an endorsement then you must also complete an additional 10 hours related to that endorsement. If you are a dual registrant, both a nurse and midwife, you must complete the required CPD for both nursing and midwifery. The good news is, if your CPD activities are relevant to both professions, the NMBA allows you to count those activities as evidence of both nursing and midwifery CPD hours.

WE ALL UNDERSTAND THE IMPORTANCE OF CPD AS NURSES AND MIDWIVES. OUR PROFESSIONS REQUIRE US TO KEEP UP TO DATE, MAINTAIN OUR KNOWLEDGE AND BE INSPIRED ABOUT HOW WE CAN PROVIDE BETTER CARE OUTCOMES.

Along with the requirement of a minimum number of CPD hours the Board also require nurses and midwives to keep records of your CPD activities for a period of five years. There is not a mandated tool that you need to use however there are key requirements that you need to document with each CPD activity. These include:

All evidence should be verified, and it must demonstrate that the nurse or midwife has:

- *identified and prioritised their learning needs, based on their self-reflection and evaluation of their practice against the relevant*

competency or professional practice standard;

- *developed a learning plan based on identified learning needs;*
- *participated in effective learning activities appropriate to their learning needs, and*
- *reflected on the value of the learning activities or the effect that participation will have on their practice. (NMBA, 2016)*

One of the difficulties our members sometimes struggle with when they are audited by the Board is the requirement for reflection and how it is documented. This section ensures that the regulator understands that you have reflected on the outcome of the CPD activity. They want you to document the extent to which the activity met your identified learning need. Therefore did it meet it or not? If the answer is YES then how did it change or impact your practice? If it only partially met your learning need or it did not meet your learning need at all, then what is your next step to achieve the identified learning need?

On the NMBA website the Board provide a sample template that you can use with examples of how each section can be documented. Each state and territory branch of the ANMF also provide various tools and resources, sometimes referred to as a portfolio that can assist you in keeping the required CPD cycle documentation.

So remember, time moves quickly and even though sometimes it feels like Groundhog Day we are all required by the regulator to formally document our CPD cycle of planning, completing CPD activities and reflecting upon the outcome of the activity completed.



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WORKING ABROAD

Ready to explore the world?

ONE OF THE BENEFITS OF BEING A NURSE OR A MIDWIFE IS THE ABILITY TO WORK ALMOST ANYWHERE IN THE WORLD. THE FLEXIBILITY THAT NURSING OR MIDWIFERY BRINGS ALSO ALLOWS THE OPPORTUNITY TO TRAVEL TO A MULTITUDE OF DESTINATIONS WHILE ALSO MAKING A LIVING.

THIS MONTH THE ANMJ FEATURES TWO OF THE MOST POPULAR DESTINATIONS FOR AUSTRALIAN NURSES AND MIDWIVES TO WORK AND LIVE IN.

THINKING OF WORKING OVERSEAS? FIND OUT WHAT IT'S LIKE WORKING AND LIVING IN THE MIDDLE EAST AND THE UK IN THIS MONTH'S SPECIAL.

Experience of a lifetime

BY NATALIE DRAGON

"Everyone is different and everyone will have a different experience. You cannot comprehend it until you're here," says Queensland emergency nurse Bambi Reichman who has been working in Saudi Arabia for the past ten months.



Bambi says she came to Saudi Arabia at a time in her life when she felt the need for a challenge professionally and also on a personal level. "I did a bit of research and looked into rural and remote areas of Australia and then started to think about international options as I have never really had the chance to travel.

"I started to look at recruitment agencies and came across CCM Recruitment. They have been amazing and have been in touch with me the whole time.

"The local culture, the people, the environment, the way of life, it's really unique and beautiful. Not many people can say they've been to this part of the world; you can't just book a flight and travel here as it is currently not open for tourism."

Bambi grew up in Derrinallum, in country Victoria and completed her Bachelor degree at Deakin University, Warrnambool. She worked at Barwon Health in Geelong, Victoria specialising in emergency for five years and also more recently at Noosa Private Hospital in Queensland in the ED.

Working in Saudi Arabia enables the opportunity to travel and go home with a little savings, she says.

"The benefits are amazing. It's tax free, you receive a relocation allowance, free housing, 54 days of annual leave and everything's so close you can travel on your days off. You can be on a six-hour flight to London.

"So far I have been to Dubai, Jordan and the Greek Islands. I have an upcoming trip booked to India and Sri Lanka with two friends I have met while being here."

Initially it was a culture shock, says Bambi. "There was a sort of awareness before I came here of what to expect but it was not until I arrived that I grasped the entirety of it, especially the dress code.

"Saudi Arabia is the only country in the world where women cannot drive. There is the option of Uber, regular taxis and the hospital also runs a limousine service.

"There is the call to prayer five times a day, and during this time businesses close their doors for up to 30 minutes so you have to be sure to work your daily routine around this.

"There is gender segregation in public, in coffee shops and in restaurants. The single section is for men only and the family section includes single women and families."

Bambi says there were also initial challenges at work - the environment, policies and procedures and equipment. Language and cultural barriers were the biggest challenge, despite the use of translators.

"Working within the emergency environment, effectiveness of communication is extremely important, especially as you are the first critical point of patient contact. My Arabic is slowly improving and I guess I have found ways of adapting my usual nursing practice to be able to engage with my patients."

"The ED is a really busy environment and the acuity of illness here is extremely high. The hospital I'm currently employed with are a national referral centre for organ transplantation, cardiovascular diseases, neuroscience and genetic disorders. People travel really long distances to come here - they may have travelled in their private family car for up to eight hours so by the time they get to us they can be quite unwell."

Another challenge was working with people from so many different countries and their various attitudes and nursing practice.

"You meet people from all over the

world, there is something like 64 nationalities working here in our hospital. I've made friends that will last a lifetime and have gained a newfound passion for cultural experience and travel which I never really had before."

Bambi says expats need to develop a support network at work and socially.

"Find strategies to help with the work to life balance. It's important to be social as it helps to keep your mind busy."

You need to give yourself time to settle in, says Bambi. "You need to be open-minded and have the potential to be able to step out of your comfort zone.

"Don't come with expectations. I think that way it's easier to adapt in and outside of work.

"Before I came here some of my family and friends were a little concerned in regards to my safety and I guess I was a little nervous also but the people here are lovely and I feel very safe. I think it's safer than any other place in the world right now.

"Due to their values and beliefs they are a very respectful culture. If you are mindful of their culture and way of life you will find respect is a two way street."

Bambi says she has grown both professionally and personally from the experience. "The opportunity for professional growth is huge. I've completed my adult and paediatric advanced life support and also my neonatal resuscitation just to name a few - there are so many courses available all of which are provided by the hospital with no out of pocket expenses.

"It may sound cliché but this really has been the experience of a lifetime and I don't regret a thing."

London Calling

BY ROBERT FEDELE

Australian nurse Ellen Carragher counts working as a nurse in the UK the best decision she ever made.



In 2011, Registered Nurse Ellen Carragher was flicking through the latest edition of the ANMJ when an ad by a travel nurse company promoting the value of working in the UK caught her eye.

Ellen maintained a burning itch to travel and the opportunity seemed too good to pass up. "I was busting to travel and London seemed like a pretty good base.

"It's still familiar enough, being English speaking and with the culture much the same and then a great location to go to Europe or Africa or America. It's so much closer than we are in Australia."

Ellen, 24 at the time, was a fledgling ED nurse with Western Health in Victoria before taking the plunge.

"I'd heard lots about nursing in the UK and how it was a bit daunting and busy and scary so I just wanted to prove to myself that I could do that too."

After signing on with Continental Travelnurse, the complex process of ticking all the boxes prior to being allowed to work in the UK took around nine months.

The hoops involved included the reasonably difficult IELTS English test, mounds of paperwork, providing references and demonstrating placements in some specialty areas of nursing and midwifery.

The final step involved flying to the UK to complete the month-long Overseas Nursing Program (ONP), a short course that brings travelling nurses up to speed on the National Health Service (NHS) and how it operates.

"So I had to move over there without a job lined up or anything and do that course and there was a fair bit of money involved in doing the English test, getting all the paperwork done and then doing the ONP.

"But I was so keen to travel that even

if I didn't get a nursing job, I would have found something else to do."

When Ellen's UK nursing registration was finally approved, she linked up with St Thomas' Hospital in central London and began a three-month stint working on its surgical ward in early 2012, followed by a further three months at the hospital's Clinical Decisions Unit, the equivalent of a short-stay unit back in Australia.

"Starting a new job anywhere is pretty nerve-racking but starting in a new country where you don't know anyone is really nerve-racking," she explains.

Ellen's first impressions working in a foreign environment hinted at noticeable differences between Australia and the UK.

For example nurses, referred to simply as staff, were still wearing tunics and pinafores and led by a matron and sister.

In terms of healthcare, Ellen says the difference in ratios immediately stood out.

"Here in Victoria, we're pretty spoilt with our ratios. Over there, the ratios just didn't seem to exist. I remember one shift, I was on the surgical ward and I had 14 patients. We did 12-hour shifts and you work with a buddy nurse but my buddy nurse had gone home sick at 11 early on the shift and then I had 14 post-op patients to myself."

Ellen says the eye-opener made her better appreciate Australia's health system and the way nurses are supported and given meaningful access to education.

Ellen suggests one of the more intriguing imprints left on her during her stay surrounded a greater sense of Florence Nightingale and the roots of the nursing profession's evolution.

"There just seemed to be a lot more evidence of that over there. You could relate it to all the historical developments in nursing and, how nursing had evolved.

You felt connected to the industry of nursing."

Asked to pinpoint what she learnt the most from her overseas adventure, Ellen says it was a combination of overcoming personal challenges and realising the opportunities afforded in Australia.

"It was the best thing I ever did for my career and for myself because it broadens your horizons and makes you see that there's way more than what we do here in Australia," she says.

"But apart from a few workplace and cultural differences, the main thing I took away is that nursing is the same the world over at the end of the day."

After finishing up at St Thomas', Ellen worked as a live in home carer to earn some extra money while continuing to travel for the next year before returning home to Australia.

She concedes one of the scheme's drawbacks was losing traction within the Australian health system and reveals finding it difficult to find employment upon her return.

Other downsides concerned losing the continuation of long-service entitlements and annual pay rises due to insufficient hours undertaken overseas.

Reflecting on her UK journey, Ellen says she wouldn't change a thing and would definitely encourage fellow nurses and midwives to give it a go.

"Even if you stay in your own country and work in a different setting and different services it definitely makes you a better nurse, just to see that there's more than one way to do something.

"But working in a different country and different health system altogether, I think just to see more, to experience more, definitely makes you a better nurse and a better professional."

Want to work overseas?

FIND THE ANSWER TO YOUR QUESTIONS HERE.

THE MIDDLE EAST:

Q Are there many job opportunities for RNs, ENs and Midwives in the Middle East?

A The Middle East being a large region of the world hires many international hospital staff, including registered nurses and midwives from Australia. There are many employment opportunities which are ongoing due to the sheer size of the facilities (hospitals ranging up to 1,500 beds). Unfortunately the Middle East does not employ enrolled nurses due to registration requirements.

Q Are all nurses and midwives eligible to work in the Middle East?

A Registered nurse and midwives with a minimum of two years' acute experience, in some cases three years, are eligible to work in the Middle East. Many countries in the Middle East also have age restrictions due to visa requirements. Discussing your experience and personal situation with a recruitment agency like CCM Recruitment will quickly determine if you are eligible for employment in the Middle East.

Q What kind of job opportunities are in demand?

A Like everywhere, nursing vacancies vary for each hospital. Generally speaking there are openings in all specialties which are ongoing, although, due to the population health needs in the Middle East, nurses with cardiac, intensive care, oncology and paediatric experience are always in high demand. You can check with your recruiter for vacancies with the particular hospital or country of interest.

Q How risky is it for females working in the Middle East?

A CCM Recruitment has been helping nurses travel to the Middle East for 30 years with very few issues. Most of the staff at CCM lived and nursed in the Middle East and have firsthand experience in the region. As with any hospital in Australia, the health and safety of all employees is of utmost concern and priority, with many hospitals dedicating departments responsible for nurses' welfare. On the rare occasion a problem may occur during your stay, assistance and support is available 24/7. Nurses who respect the local laws and traditions, and who come with an open mind will find the countries an enjoyable and rewarding experience.

Q What are the advantages for Australian nurses and midwives working in the Middle East over other countries?

A Living and working in the Middle East offers the chance to experience unique culture and traditions whilst gaining invaluable work experience in internationally renowned hospitals. Professional development is highly encouraged. Hospitals provide high standards of care in many specialties, with exposure to very different conditions and health needs to anywhere else in the world. You will have opportunities to grow both personally and professionally. Employment benefits are a great incentive for many Australian nurses, with many travelling to this region with a financial goal in mind. With some of the world's most exciting destinations just hours away, the Middle East is also the perfect base for global travel.

THE UK:

Q What kind of job opportunities are in demand in the UK?

A Nursing vacancies vary for each hospital so it's best to check in advance and see what is available. Generally speaking for specialty areas, nurses are always in demand which includes: cardiac, intensive care, theatre and oncology.

Q Are all nurses and midwives eligible to work in the UK?

A Registered Nurses that meet UK Nursing and Midwifery Council (UK NMC) registration requirements can apply for registration. These include holding current registration in Australia without restriction; having a minimum of 12 months experience; successfully completing at least 10 years of schooling prior to nursing/midwifery education and demonstrating a high standard of English language through an English exam. This process can be more complicated for Paediatric and Mental Health nurses and Midwives and is not generally available to Enrolled Nurses.

Q How does the pay in the UK compare to pay in Australia?

A A number of factors are looked at by the hospital to assess the rate of pay for each nurse such as years of experience and post graduate qualifications (recognised in the UK). The pay is relative to the cost of living. CCM have openings with private hospitals and the pay is higher compared with NHS hospitals.

Q What are the advantages for Australian nurses and midwives to work in the UK over other countries?

A Travel and lifestyle is most commonly the biggest reason for Australian nurses to work in the UK. Living on Europe's doorstep opens a world of travel at much lower costs than travelling from Australia and much shorter travel times. Like any new employment opportunity, nurses can learn so much from any new work environment and different health system.

Q Is there anything else nurses and midwives need to consider about working in the UK?

A Nursing in the UK is achievable for everyone who is eligible. The big plus is that you don't need years of experience to apply. Once you have 12 months experience you can get the ball rolling. Employment within the UK noted on your CV, is attractive to future employers. Commit to the registration application and take advantage of the support of a recruitment agency like CCM Recruitment and you are half way there!

Questions and answers supplied by CCM Recruitment



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- Suitable management experience and / or qualification
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- Flexible approach to work patterns

Informal enquiries to: **Mairead Carr, Director of Nursing at** Mccarr@Bonsecours.ie

THEATRE/CATH LAB/CARDIOLOGY STAFF NURSES

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- Be a Registered General Nurse with the NMBI (Nursing and Midwifery Board of Ireland)
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- Excellent interpersonal and communication skills
- Appropriate clinical skills with evidence of continuing professional development
- Must have flexible approach to work patterns in order to meet the demands of the service
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- Ability to work within a multidisciplinary team

TO APPLY:

Applications for these positions should be made in writing to include a letter of application with an up-to-date Curriculum Vitae to:

**Ms. Ann Dolan, Human Resources Manager,
Bon Secours Hospital, Renmore, Galway, IRELAND.**

Or e-mail: adolan@bonsecours.ie Tel: +353 (91) 381 958

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- Relevant experience in the theatre environment
- Proven ability to provide skilled clinical and technical assistance as a member of the Anaesthetics/PACU and Theatre nursing team
- Relevant course essential in Peri Anaesthesia and/or Peri Operative nursing or equivalent

CANDIDATE REQUIREMENTS:

- CNM 1 post requires a minimum of 3.5 years experience as a staff nurse in an acute general hospital
- A management qualification is desirable
- CNM 2 post requires a minimum of 5 years post registration experience in an acute general hospital
- A management qualification is essential
- Preceptorship/teaching and assessing of students is also desirable
- Registered in the General Division of the live register of nurses kept by the NMBI

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The successful applicant will be required to take responsibility on each shift for the nursing care of allocated patients. To work within the nursing team and assist colleagues as necessary in providing and maintaining the highest standards in patient care at all times and to work as part of the multidisciplinary team.

CANDIDATE REQUIREMENTS:

- Registered in the General Division of the live register of nurses kept by the NMBI
- A minimum 12 months experience or dual qualifications in Paediatric nursing is also desirable. (Paediatric Staff Nurses)
- A minimum 12 months experience working in an acute hospital

PERSON SPECIFICATION:

- Excellent interpersonal and team building skills
- Must possess strong communication skills and clinical skills
- Fluency in English, both written and spoken
- Must be computer literate
- Flexibility and excellent use of initiative

TO APPLY:

Application for the above positions is by way of letter and 1 copy of your Curriculum Vitae (unbound) to:

**Mandy O'Sullivan,
Recruitment Specialist,
Bon Secours Hospital,
College Road,
Cork, IRELAND.**

Or e-mail: ajosullivan@bonsecours.ie

Tel: +353 (21) 480 1657



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SBS CULTURAL ATLAS



The Federal ANMF office has worked closely with the Special Broadcasting Service (SBS) to give nurses and midwives free access to the SBS Cultural Atlas.

This is available to you on the CPE website under the research area.

The SBS Cultural Atlas is an educational resource providing comprehensive cultural information on the countries that Australia's biggest migrant populations have originated from. The aim is to improve social cohesion in Australia and promote inclusion in an increasingly culturally diverse society.

Developed in 2016, it aims to inform and educate the public in cross-cultural attitudes, practices, norms, behaviours, communication and business skills. It forms part of the SBS Cultural Competence Program, an online course of which the ANMF aims to include in its entirety on the CPE website in the near future.

By gathering such knowledge into one resource, the Cultural Atlas provides a unique opportunity for users to gain a broad understanding of the norms and behaviour that would generally be familiar to people from the culture of description. The cultural observations are contextualised with up-to-date statistics about Australia's migrant populations and stories of cultural differences experienced by those who were new to Australia. At a personal level, the

Cultural Atlas offers its users the chance to inform their judgements of cross-cultural experiences with a deeper understanding.

The Cultural Atlas itemises cultures by country. Using national cultures as the point of reference allows consistency and gives contextual history. However, it is important to acknowledge that cultures are not confined by national borders, nor are they homogenous within them. Every country contains a myriad of microcultures that differ from the dominant culture in identifying traits or characteristics. Therefore, the observations provided in the Cultural Atlas should not be strictly applied to all people of a country or misconstrued as stereotypes. Though many features of culture are persistent, culture continues to evolve.

The Cultural Atlas is a work in progress; its information is constantly being reviewed, updated and expanded. Presently, there are just over 30 countries published on the site. These cultures comprise of 20 largest migrant populations settled in Australia, or are among the biggest 50. Altogether, approximately 79% of Australia's migrants and 20% of Australia's permanent residents are born in one of the countries currently

published (ABS 2015 estimate). Subsequent countries will continue appearing on the site in order of the size of their migrant population in Australia.

Countries currently available on the Atlas include: Afghanistan, Australia, Bangladesh, Bosnia and Herzegovina, Brazil, Cambodia, Canada, China, Croatia, Egypt, Fiji, France, Germany, Greece, Hong Kong, Hungary, India, Indonesia, Iran, Iraq, Ireland, Italy, Japan, Republic of Korea, Lebanon, Macedonia, Malaysia, Malta, Nepal, The Netherlands, New Zealand, Pakistan, Papua New Guinea, Philippines, Poland, Russian Federation, Samoa, Serbia, Singapore, South Africa, Sri Lanka, Syrian Arab Republic, Taiwan, Thailand, Turkey, United Kingdom, United States of America, Vietnam and Zimbabwe.

Access to the detailed information provided on each culture is achieved by selecting the country you wish to explore on the world atlas.

Information provided includes core concepts, greetings, religion, family, naming, dates of significance, etiquette, do's and don'ts, communication, other considerations and business culture.



Population statistics, both in the country itself and within the migrant population of Australia are provided along with further information about arrival to Australia, English proficiency, ancestry, gender and average age.

Cultural awareness and understanding in healthcare provision is integral to providing culturally competent holistic care to individuals and communities originating from a country outside of Australia.

All cultures have systems of health beliefs to explain what causes illness, how it can be cured or treated, and who should be involved in the process. The extent to which patients perceive patient education as having cultural relevance for them can have a profound effect on their reception to the information provided and their willingness to use it.

Cultural differences affect patients' attitudes about medical care and their ability to understand, manage, and cope with the course of an illness, the meaning of a diagnosis, and the consequences of medical treatment.

Patients and their families bring culture specific ideas and values related to concepts

of health and illness, reporting of symptoms, expectations for how healthcare will be delivered, and beliefs concerning medication and treatments. In addition, culture specific values influence patient roles and expectations of how much information about illness and treatment is desired, how death and dying will be managed, bereavement patterns, gender and family roles, and processes for decision making.

People immigrate for a number of reasons, including seeking religious and political freedom, economic and educational opportunities, and for a better way of life for themselves and their children. They may have come from a country that is poor or a vulnerable population with a higher than average risk for developing health problems. They may come with very little literacy or English skills so communication can be difficult at times.

When caring for people in cross-cultural settings, learning about their cultural traditions can assist you in providing better care. This includes paying close attention to body language, lack of response or expressions of anxiety that may signal discomfort with the situation.



FOR INSTANCE, DID YOU KNOW?

EGYPTIAN CULTURE

Family is a very important part of life for Egyptian people and a significant component of Egyptian society.

The needs of one's family or community typically take precedence over one's personal needs or desires. Kinship plays an important role in social relations, and the general perception is that the individual is subordinate to the family.

Authority tends to lie with the eldest in the household, irrespective of gender.

It is relatively uncommon for women to approach and engage in conversation with men who are not a part of the family unless it is a boss, colleague or sales clerk. If the woman's husband or relative is present, a male sales clerk will talk to the man rather than the woman herself.

It is considered impolite to point the toe, heel or any part of the foot toward another person. Showing the sole of one's shoe is also impolite.

Modest dress and presentation is highly valued in Egyptian culture.

Greetings often occur before any form of social interaction. For example, a person joining a group is expected to greet all those present.

Touching all four fingers to the thumb with the palm facing inwards then shaking it up and down is used to tell someone to 'wait a moment'. To point, one usually uses their index finger.

To beckon someone, Egyptians tend to whistle, clap or say 'psst'.





MACEDONIAN CULTURE

A Macedonian may not always tell you when they have been insulted or what has upset them, but may instead become cold towards you or difficult to contact. If you notice this or realise you have offended them, be sure to make amends as soon as possible. Open apologies and sincere remorse are generally accepted and respected (depending on the circumstance). However, reluctance to do so can be interpreted as a sign of arrogance, and further jeopardise a relationship.

It is expected that people act more formal and respectful around their elders. For example, one would refrain from swearing or telling rude jokes.

Macedonians have quite a relaxed view of time. It is common to be late for meetings and other events to run over time.

Do not leave two windows open in a room. There is a cultural belief in Macedonia that when wind passes through a room, it will cause people to get sick.

Macedonians generally stay up quite late and may socialise into the later hours of the night.

People are expected to make regular direct eye contact throughout conversation.

People may point with their fingers. It is also common to indicate the location of something by making a gesture with one's head and eyes in the direction of the object.



NEPALESE CULTURE

There is a strong emphasis on cleanliness in Nepal, influenced by social and religious customs. Certain actions, objects and body parts are considered particularly pure or impure. For example, the head is understood to be the purest part of the body, whilst the feet are the dirtiest.

Elders are always shown a heightened amount of respect and are treated more formally.

Objects should be passed, offered and received with the right hand only or both hands together. The left hand is considered 'unclean' and is reserved for performing unhygienic activities, like cleaning. It is considered disrespectful to use your left hand when communicating with somebody; all gestures should also be made with the right hand primarily.

The best approach to communication is to be respectful and gracious. Be patient and prepare to listen.

If offering criticism or addressing a problem, do so directly to the person it concerns whilst keeping your approach soft and out of the view of others.

Do not complement a baby by saying it looks healthy or fat. There is a belief that this will bring sickness upon it.

Do not belittle a Nepalese person for having a strong accent. It is okay to ask someone to repeat themselves, but be sensitive to the isolation an accent barrier can create.



HUNGARIAN CULTURE

Hungarians tend to be quite individualistic, meaning that the interests of oneself and one's immediate family take priority. Hungarians rely on their close friends and family for support. For many Hungarians, close friends and family will be the first people they reach out to in a time of need, rather than the broader community or institutions.

Hungarians often pride themselves on using proper etiquette and expect others to do the same.

Calling someone by their first name before being invited to do so is considered rude.

Many Hungarians find whistling, humming or singing in public impolite.

Always cover your mouth when yawning.

Hungarians tend to be direct communicators. They will freely express their opinion or disagreement. It also is not uncommon for Hungarians to ask personal questions early on in the conversation. At times, this can come across as blunt, but it is not ill-intended.

Hungarians often express themselves with emotion and passion. They will usually use stories, anecdotes and jokes to prove their points in the conversation. They may also raise their voice when conversing with others since there is a tendency for people to talk all at once.



FILIPINO CULTURE

Filipinos often communicate indirectly in order to prevent a loss of face and evoking hiya (shame or embarrassment) on either side of an exchange. They tend to avoid interrupting others and are more attentive to posture, expression and tone of voice to draw meaning.



Speech is often ambiguous and Filipinos may speak in the passive voice rather than the active to avoid being perceived as speaking harshly. To find the underlying meaning, it is common to check for clarification several times.

Filipinos will try to express their opinions and ideas diplomatically and with humility to avoid appearing arrogant. The tone of voice varies widely by language, dialect and region.

Since many Filipinos try to save face and avoid hiya in their interactions, many will be overly polite and seldom give a flat 'no' or negative response. When conversing with your Filipino patient, try to focus on hints of hesitation. Listen to what they say and also pay close attention to what they don't say.

While Filipinos often laugh in conversations, the meaning of laughter tends to depend on the situation. At times, laughing may indicate happiness or pleasure, while other times it may be used to relieve tension. In some circumstances, laughter is used as an attempt to cover embarrassment.

Filipinos may point to objects by puckering their lips and moving their mouths in the direction they are pointing to.

Putting one's hands on their hips is a sign of anger.

Because they can be preoccupied with avoiding hiya, a Filipino is unlikely to directly refuse a proposal or reject something you say, even when they do not agree with it. Therefore, focus on hints of hesitation. Listen to what they say, but also pay close attention to what they don't say (and might implicitly mean) and double check your understanding.



HONG KONG CULTURE

Silence is an important and purposeful tool used in Asian communication.

Pausing before giving a response indicates that someone has applied appropriate thought and consideration to the question. This signifies politeness and respect.



Hong Kongers tend to laugh more softly than they speak.

Hong Kongese' preoccupation with saving face and politeness means that they will seldom give a flat 'no' or negative response, even when they do not agree with you. Therefore, focus on hints of hesitation. Listen closely to what they say, but also pay careful attention to what they don't say and implicitly mean.

The Hong Kongese communication pattern is less direct and verbose than what Australians are used to but is still bolder than other Asian communication styles. Speech is ambiguous with understatements often made. The purpose of this is to maintain harmony throughout the conversation and prevent a loss of face on either end of the exchange. The best way of navigating this rhetoric to find the underlying meaning is to check for clarification several times with open-ended questions.

Hong Kongers tend to speak very loudly on the phone. However, it is generally considered impolite to speak with raised voices.

Winking at someone is considered a very rude gesture in Hong Kong.

Hong Kongers avoid pointing at people and things with their index finger and use an open hand instead.

Hong Kongers express unhappiness/offence by sucking air through their teeth.

Sitting with crossed legs can offend some Hong Kongers. It is bad manners to touch someone's head.



Interestingly, when you compare some of the cultural aspects of the cultures presented here to those of the Australian culture, it is easy to see how conflicts and misunderstandings can arise. Particularly in a care environment where those receiving care can feel quite vulnerable.

We can see that some cultures perceive etiquette as an important part of communication and it shows respect. Australians rarely criticise if someone fails to observe formal etiquette, commenting on someone's manners can seem as pretentious or stuck up.

Moderate swearing is common among Australians where swearing can be offensive to some cultures.

Avoid asking Australians to do tasks you are capable of doing yourself; this is seen as lazy whereas in another culture it may be the norm to expect this eg. a woman should do the task for the man.

Australians can grow uncomfortable with long silences in conversations and may try to fill that silence, whilst in other cultures silence is seen as being respectful.

It is clear to see, once we start to delve into the intricacies of other cultures, that

taking the time to understand another's culture, whether it be your colleague or patient, can have a huge impact on the provision of quality healthcare.

You can access the Cultural Atlas on the CPE website anmf.cliniciansmatrix.com under research.

For further enquiries please contact the Federal ANMF Education team at: education@anmf.org.au or phone (02) 6232 6533.

PSYCHIATRIC DIAGNOSIS

By Mick Hawkins

There is clear evidence linking mental illness with physiological dysfunction (Konradi et al. 2004; Phelps 2017) and also with specific physiological markers. These can range from microbial imbalance in the gut (Baird and Santos 2003) to abnormal neuroimaging results (Rogers et al. 2016). However, specific causes remain unknown and physiological dysfunction or markers are seldom factors in diagnosis. For the most part, we diagnose mental illness by observing a cluster of symptoms (*Diagnostic and Statistical Manual of Mental Disorders* 2013). Is it reasonable to conclude that psychiatry is lagging other specialities in justifying diagnoses made?

For a long time it was known that excess sugar in the urine was a bad thing. However, it was only after endocrine research showed the connection between this and poor or no production of insulin from the pancreas that a precise diagnosis and properly targeted treatment became available to deal both with this symptom and its cause.

Despite a qualitative diagnosis with little or no reference to pathophysiology, our major first line treatment for mental illness is psychotropic medication (Thompson 2007); and this is acknowledged to have significant detrimental side effects in multiple areas from cardiologic dysfunction through to a comprehensive range of other diseases (Citrome 2009; Marano et al. 2011). Indeed, it could be argued that the line between curative and palliative care is being obscured when we justify medication that will both shorten life and lead to distressing side effects so as to make what life is left a little more tolerable for the patients and their families. And, as already observed, we do this with little or no physiological justification for the decision.

At the cellular level, it has been established that mitochondrial size and activity and mitochondrial apoptosis in the neuron are associated with bipolar disorder. Other mental illnesses including schizophrenia and depression are also related to mitochondrial characteristics (Lief 2008; Mattson et al. 2008).

Relying on symptoms alone to diagnose a mental illness puts us on dangerous ground because a range of physical illnesses including thyroid disorder and infection can lead to symptoms consistent with a mental illness (Diamond 2016; Hentz 2008).

The evidence now available allows us to agree with Prescott (2015) when she concludes that mental illness is part of a non-communicable disease epidemic inflicting the world; and it is no more a sign of weak character or inability to cope than are cancer or diabetes. Is the stigma that remains attached to mental illness related significantly to the way in which it is diagnosed?

So is there a way ahead and what is it? Can the psychiatrist be replaced with physicians

and biochemists? Additionally, can we use the research that has already established a link between mental illness and genetic inheritance, epigenetics, and environmental factors (Szyf 2008)? How far away are we from the affordable pathophysiological tests that will define the cause of a specific mental illness and lead us towards discrete therapy? Is there a place for behavioural therapies in the brave new world?

It would be foolish to try to make the argument that psychiatrists are less necessary than any other speciality, but as argued by Prescott (2015), all specialist disciplines would benefit if the barriers between them were less rigid.

Perhaps, the psychiatrist could share the diagnostic burden with other disciplines and concentrate on optimum management therapies: cognitive, complementary, pharmacological, and electroconvulsive (but note that electroconvulsive therapy shares the uncertainty of how it acts and what it acts upon as much as pharmacological interventions) (Wahlund and von Rosen 2003).

As well as needing to understand the specific pathophysiological root of mental illness we need to continue to understand those elements that make us more prone to mental illness, and it is here that the study of genetics and epigenetics will remain an essential complement (Virtual Genetics Education).

Our distance from the affordable laboratory tests to determine specific mental illness is proportional to the level of motivation by the psychiatric community to join in the search for them.

AS WELL AS NEEDING TO UNDERSTAND THE SPECIFIC PATHOPHYSIOLOGICAL ROOT OF MENTAL ILLNESS WE NEED TO CONTINUE TO UNDERSTAND THOSE ELEMENTS THAT MAKE US MORE PRONE TO MENTAL ILLNESS

The DSM 4 (Psychiatric Diagnoses are categorised by the Diagnostic and Statistical Manual of Mental Disorders) has been replaced by the DSM 5 after onerous and time consuming consultation, and it is likely that work is already underway on the DSM 6. None of this effort will help to determine the bodily bits that will yield up the cause of mental illness nor identify discrete therapies.

Until this happens, the development of more effective diagnoses and therapies will depend on the qualitative best guess of the assembled experts. Only when the psychiatric community becomes a major player in the research efforts to determine cause of and primary health measures for the control of mental illness will the practical progress be made that will open the field to tailored interventions with minimal adverse side effects.

Mick Hawkins is recently retired after around twenty years as a mental health nurse. He has a special interest in the physiological variations found between those without a diagnosed mental illness and those with one.

This article has not been peer reviewed and is the opinion of the author



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Linda Starr

FRIENDSHIP OR THERAPEUTIC RELATIONSHIPS?

Browsing through a list of recent decisions by the Courts and Tribunals serves to remind us of the need for the regulation of health practitioners and the establishment of registration standards, codes and policies to guide professional conduct.

Cases of holding out to be a registered midwife to emergency personnel assisting a woman following a homebirth (AHPRA v Name not Disclosed 19/6/17). Providing services as a registered psychologist when never having been registered as one (AHPRA v Name not Disclosed 30/5/17) or a registered medical practitioner prescribing medication who had not been registered since 2004 (AHPRA v Name not Disclosed 6/2/17) to cases of professional misconduct following convictions of multiple counts of criminal misconduct (NMBA v Brewer (Review and Regulation) [2017] VCAT 384) or the failure to properly administer medications (Nursing and Midwifery Board v Camille Els WA SAT 2017) can be found.

However, one of the many cases concerning breaches of professional boundaries is presented in this article as it serves to remind us of the need for health practitioners to maintain a therapeutic relationship with their clients and how easily this can become blurred particularly during long term professional relationships and impair our judgement.

In this case the SA Health Practitioners Tribunal found that a medical practitioner had engaged in professional misconduct when he continued to treat an elderly patient in the community despite being aware that she had made him a beneficiary in her will. The practitioner had been treating the patient from 1996 until 2010 when the Medical Board received a notification from a former beneficiary that the MO was now the dominant beneficiary of the estate.

He was ordered to cease treating the patient and to enable another GP to take over her care. The patient died in 2015 aged 96.

The practitioner admitted the conduct and that he had become over involved in the patient's personal affairs (doing her banking, some shopping and some home maintenance) over time and had not attempted to dissuade the patient from making him a beneficiary. The MO had also given several gifts to his patient (two ornaments and a subscription to a magazine) and invited her to his house on at least two occasions.

It also became apparent that during this time the patient had gifted money and gifts to the practitioner (\$1200 to buy artificial lawn for his

house, a gold watch and a gold bracelet) and to his son including a sum of \$5,000 and a further sum towards the purchase of a car. The Medical Board submitted that the MO had a choice to either remain friends (and possibility a beneficiary) and cease being her treating practitioner or just be her treating practitioner and not a beneficiary. The Medical Board sought an opinion regarding this conduct from another respected GP who concluded that :

'...[MO] was required to choose between his role as a medical practitioner and that of a friend... He should have engaged with Mrs Murray to arrange for an independent general practitioner to take over her medical care ...it is apparent that [he] was aware of his beneficial status of her various wills and he should have reported his dilemma to the Medical Board of SA and later to AHPRA, and declined to continue as Mrs Murray's doctor ...[but]... chose to continue in his role as the medical practitioner for Mrs Murray while informed that she made wills in which he was the dominant beneficiary of a significant financial estate. Mrs Murray was reportedly frail with multiple medical problems and very dependent on Dr Grogan to treat her medically and assist with her domestic needs, placing her in a vulnerable position and at risk of manipulation...[he has] not conformed to the codes of professional conduct, [and as such his] standard of conduct has fallen seriously below that expected of his peers...' (para 29 & 30).

The Tribunal agreed stating that it was the MO's responsibility to establish the doctor-patient boundaries and set down the ground rules.

There was some concern that this patient who was frail with a number of medical ailments was at risk of developing a dependency and vulnerability on the practitioner and as such was at risk of being manipulated.

However, notes from a Public Trustee officer interviewing the patient when making alterations to her will revealed that they:

'...could not detect any undue influence by this doctor towards [testatrix].. [who] was adamant that the doctor was a very good friend and should receive the estate...[she] presented well...displayed memory recall and understanding...[and] knew the contents of her last will, knows

PROFESSIONAL CODES OF CONDUCT AND ETHICS HAVE BEEN DEVELOPED TO DEFINE PRACTICE AND BEHAVIOUR AND ESTABLISH PROPER STANDARDS. REVIEWING THESE FROM TIME TO TIME MAY ENABLE US INDIVIDUALLY TO REFLECT ON OUR OWN CONDUCT AND REDUCE THE RISK OF SUCH NOTIFICATIONS BEING MADE.

what a will is about and what it does and knew her assets and approximate value...I believe she has testamentary capacity (para43).

As such it was concluded that the patient had not been manipulated at all in her decision making.

The tribunal noted that the purpose of disciplinary proceedings was not to punish practitioners but to provide public protection and to maintain and assure the public that professional standards are maintained in order to uphold the public's trust and confidence in the professions. As such the Tribunal noting the remorse and insight of the practitioner found him guilty of professional misconduct, issued a reprimand, a fine of \$25,000 and imposed conditions on his license to practice including legal and ethical responsibilities for MO's and professional boundaries.

Professional codes of conduct and ethics have been developed to define practice and behaviour and establish proper standards. Reviewing these from time to time may enable us individually to reflect on our own conduct and reduce the risk of such notifications being made.



Reference:

Medical Board of Australia v Grogan [2017] SAHPT 8 (30 June 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



THE IMPORTANCE OF COMMUNITY SERVICE DELIVERY FOR MOTHERS WITH POSTNATAL DEPRESSION

By Yvonne Parry, Pauline Hall, Janine Kalisch and Shelly Abbott

The importance of 'setting' cannot be underestimated when delivering services to mothers with postnatal depression. Postnatal depression effects the interaction between the infant, mother and family both physically and psychologically (Bergink et al. 2011; Bowen et al. 2013).

Attending to the needs of the infant is impacted by postnatal depression and has longitudinal consequences if left untreated (Bergink et al. 2011; Ji et al. 2011; Bowen et al. 2013; Bowen et al. 2014). Additionally, postnatal depression and its impacts compound accumulatively and exponentially for the mothers, infants, children, and families (Bergink et al. 2011; Ji et al. 2011; Bowen et al. 2013; Bowen et al. 2014). Programs that do not directly address perinatal depression have been shown to be ineffectual and detrimental to the families dealing with postnatal depression (Bowen et al. 2014). Given the accumulative detrimental impact of postnatal depression on mothers, infants, children and the family, programs that address postnatal depression have the ability to significantly change deleterious physical, psychological, behavioural and social outcomes for mothers, infants, and families.

The screening of all pregnant

women accessing local medical and hospital services is now often routine and uses the Edinburgh Postnatal Depression Scale (EPDS). The EPDS is an internally recognised postnatal depression assessment tool (Cox et al. 1996; Bergink et al. 2011; Ji et al. 2011; Bowen et al. 2012; Matthey and Ross-Hamid 2012). The score provided by the EPDS can indicate levels and impacts of postnatal depression.

This community based program is delivery by speciality perinatal/postnatal mental health professionals (psychologist and maternal/mental health nurses) and child development specialists (for the supporting play group and crèche). The mothers and infants/children attend a nine week program. This program provides the mothers with skills to address their depression and promote optimal care for their infant/child. This program was evaluated in 2014 using a mixed methods framework.

The qualitative findings from interviews and focus groups (30 participants, five staff and 25 mothers) found all participants stated that the mothers would not have attended if the intervention had been delivered in hospital settings and these are captured below:

I was so glad I could come here and not the hospital for help. This community hub is great. The hospital puts us [mothers] off going to get help...it feels more natural here, more friendly, more supportive, like a home away from home (P2).

You are not judged coming here. This community setting is better for baby too...it's more child friendly. I wouldn't go if it was at the hospital (P8).

We know the mothers won't attend if we had the group sessions at the hospital. They have told us, they won't turn up (S2).

One of the standout results from this research project was that of 'setting' (Parry et al. 2016). The setting was vitally important for all participants. The use of community settings enhances the delivery of programs to vulnerable population groups and, in this case, has aided the uptake of important intervention programs.

Dr Yvonne Parry is Senior Lecturer and Ms Shelly Abbott is a Research Associate. Both are at Flinders University, College of Nursing & Health Sciences

Dr Pauline Hall is a Perinatal Clinical Psychologist and Ms Janine Kalisch is a Project Nurse. Both are at Queen Elizabeth Hospital, Western Perinatal Support Service, Western Perinatal Support Team



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WOMEN'S HEALTH IN INDIA

By Vanessa Haines, Judith Anderson and Brian Burke

Upon accepting an offer to travel abroad to rural India with 15 other students as part of my undergraduate nursing studies through the Beyond Borders learning program in Malavli, two hours south of Mumbai, I braced myself for two weeks of adventure, learning and culture shock (Maginnis et al. 2015).

These expectations were exceeded as I certainly did not anticipate the global health exposure that I consequently gained and the raw insight into women's health that is present in India today especially given the maternal mortality rate to be 438/100,000 (Patil et al. 2002).

This program was well organised with every day planned to allow for the exposure to the dynamic healthcare system in rural India. We were taken to Kalpataru hospital, a leading maternity hospital in Lonavala specialising in treatment and surgeries related to gynaecology and obstetrics. The hospital appeared clean and full of patients waiting to be seen in the foyer. There was no booking system so patients were seen on a first come basis. Shoes were to be removed upon entering, a custom practiced widely throughout Indian homes, shops and medical facilities (Singh 2015).

Here we met an obstetrician who invited a small group to sit in on his consultations with women having antenatal check-ups. Although we were invited by the doctor to observe his consults there was minimal permission obtained from the patients as our presence was usually accepted without explanation (RACGP 2017). This concept was foreign to me as seeking permission especially as a student is a must prior to any consultation in Australia.

The interactions between the pregnant women and the obstetrician perplexed me on my first encounter. A heavily pregnant woman and her husband entered the office and the husband comfortably took a seat while his wife stood. The doctor spoke explicitly to the husband and any questions were asked via the husband. Given our fundamental principles of nursing in Australia being a patient-centred approach (NMBA 2010; Overgaard et al.



2012), I felt uncomfortable with this interaction and immediately felt empathy towards this woman.

Having the opportunity to observe the healthcare system in rural India, particularly focusing on women's health, was an eye opening experience. Observing the clinical practice is familiar when compared to practices in Australia. When having the opportunity to observe a caesarean section I noted the absence of nursing intervention, communication with the patient (Basu & Dutta 2007) and basic hand hygiene (WHO 2009).

Nurses and midwives were not present in the numbers I was accustomed to and thereby not much nursing or midwifery care was provided (Department of Health 2015). Communication with the patient was very limited. Although the obstetrician performed the necessary APGAR assessment and gave the mother physical care, there was an overwhelming lack of a patient centred approach (Basu & Dutta 2007). This theme was also observed with many interactions I saw while rotating through different aspects of the healthcare system in India.

Given the emphasis on patient centred care and building rapport in an effective therapeutic relationship running concurrently in every unit of study ingrained in my undergraduate degree of nursing (NMBA 2010), I couldn't fathom how the comfort of patients and basic communication was not a priority. I asked many questions in this regard of the doctors and it was explained that India has over one billion people and over

20 million in Mumbai alone. The healthcare system is pushed passed capacity (Hazarika 2013) and patients aren't given the time that we as nurses in Australia pride ourselves on. Instead patients are seen by doctors. Many people are only ever seen once in their lives due to the enormity of the population (Hazarika 2013). The biomedical model is predominantly used with doctors making the decisions and nurses executing medication orders (Patil et al. 2002).

The entire experience was enlightening especially the opportunity to immerse myself in the culture and developing an understanding of the healthcare system. I have returned home with a new appreciation for the Australian healthcare system and the emphasis on holistic patient care. I have new appreciation for the cultural differences, particularly those related to women in other countries and how this can impact on their expectations when they are experiencing healthcare in Australia.

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Judith Anderson and Brian Burke are Clinical Facilitators at Charles Sturt University

VANESSA WITH A WOMAN AND HER CHILDREN FROM A SMALL VILLAGE JUST OUTSIDE OF MALAVLI



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CALLING FOR A RENEWED FOCUS ON THE SOCIAL MODEL OF HEALTH WHEN EDUCATING HEALTHCARE PROFESSIONALS ABOUT WOMEN'S HEALTH

By Sue Dean and Tracy Levett-Jones

It is thirty years since a new scholarship for women was introduced into universities across the world and along with this came a new consciousness of women's health.

The women's movement of the 1970s saw women's health emerge as a new academic discipline and as a discrete and interdisciplinary area of clinical practice, teaching and research scholarship. Prior to the 1970s medicine maintained control of and pathologised most aspects of women's health (Robbins et al. 2008). However, a backlash against patriarchal institutions and attitudes resulted in women beginning to examine critique and often reject the dominant power structures in society. Along with recognition of the lack of women's voices in decision making concerning their own healthcare, came a need to reshape the way in which women's health was understood and healthcare was delivered. The women's movement also resulted in an awareness of the need for improved education of healthcare professionals and increased attention to the social construction of gender and the effect that social, cultural, political and economic factors have on the health of women in particular.

As a discrete practice area, women's health must look beyond

the dominant biomedical model, accepting that social, environmental, and economic and gender factors all influence a woman's health outcomes and quality of life. There needs to be a focus on health promotion, disease prevention, equity of access to appropriate and affordable services, and strengthening of the primary healthcare system. Fundamental to these broad concepts is the healthcare worker's role in ensuring that accessible information is provided, along with consultation, advocacy and community development.

If nurses are to be effective in applying a social model of health to the care of women, there are fundamental things that must be included in education programs. These include:

- an understanding of feminist principles;
- an understanding of the relationship between gender and health, an ability to interpret research in relation to gender and health;
- an appreciation of the social

and economic determinants on women's health;

- recognition of the medical model and its dominance in Western health systems, and
- an appreciation of the context in which the majority of nursing programs are delivered.

Further, to be effective, education about women's health needs to move away from the emphasis on biological and reproductive functions and students need to be guided to place women's health in the context of the broader social and psychological factors that impact on health.

Indeed, the International Council of Nurses advocates that nurses "require formal education and training in gender sensitivity and rights and the skills to appraise, monitor and evaluate policies and programs from a gender perspective" (Allen et al. 2013).

There is evidence that nurses tend to be drawn to the clinical psychomotor skills and technical aspects of their work over contextual concerns (Dean et al. 2015; van Iersel et al. 2016). Many students are drawn to nursing as a profession by the media portrayal of nursing and the general perceptions of nursing. Nursing students prefer working in acute care settings as the acute nature of the work and the technologically driven settings appeal (van Iersel et al. 2016). Nursing interventions however, are wider than a clinical or technical skill and a nurse's role must include assisting patients to become empowered to make decisions concerning their own health and the delivery of healthcare generally. Traditional models of patient care will not be able to meet the demands of the future and it is imperative that new approaches are needed.

It is time to renew the focus of nurse education and in particular the way we address women's health.




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OLDER WOMEN WITH DIABETES AND EXERCISE ENGAGEMENT IN A 'SAFE' ENVIRONMENT

By Rebekkah Middleton, Lorna Moxham and Dominique Parrish

Older people with diabetes have increased risk for loss of muscle mass, which results in decreasing strength. This is more pronounced in women (Ferriolli et al. 2014).





There is strong evidence to suggest that physical activity improves diabetes outcomes by assisting glucose control, promoting weight management and preventing related complications (Hu et al. 2014), as well as improving an individual's overall health and wellness (Law et al. 2013). Despite the evidence, there is reportedly still a lack of engagement in exercise by older women with diabetes (Jennings et al. 2013).

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

Older women with diabetes identified they were influenced to engage in a program involving exercise by being able to exercise in a 'safe environment'. Women outlined this as a motivator to join and continue in the program. Reasons for this ranged from physical esteem to confidence. For example, one woman said 'Going into the class was a safe environment. It got me back in - basically got me back into the gym and gave me the confidence to be able to go back into classes and not have people staring'. Another woman reported feeling 'safe' in the program. She spoke about how this occurred because she was in a group with other women experiencing a similar condition. The women participants shared that they found the environment they exercised in to be their 'security blanket' where they 'felt included' – it was 'our group'.

As RN/RMs, our delivery of care to older women with diabetes and referral to programs needs to be mindful of ensuring the woman feels safe. Whether someone will engage in recovery or in additional services is determined by how the woman perceives herself and her environment. Results from this research, can lead to better understanding of how engagement, particularly of older women, in health promotion and exercise programs can be enhanced.

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

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

PATRICIA HUSSEY
ENGAGING 'SAFELY'
IN EXERCISE



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NEW COLLABORATIVE INITIATIVE TO IMPROVE ACCESS TO HEALTHCARE FOR MIGRANT AND REFUGEE WOMEN

By Gulnara Abbasova

The Migrant and Refugee Women's Health Partnership - launched in November 2016 - is a national initiative bringing together health practitioners and community to address systemic barriers to access experienced by migrant and refugee women.

The Partnership applies a holistic approach, focusing on both clinicians - embedding cultural competency in clinical education, training and practice, and healthcare consumers - enhancing systemic health and wellbeing literacy strategies for migrant and refugee women.

Nursing and midwifery representation and leadership in the Partnership is critically important and contributes to achieving systemic-level change in access to healthcare for migrant and refugee women. Delivering care that meets the needs of women in a culturally diverse Australia cannot take place without nurses and midwives who understand the impact of cultural determinants on women's health and can provide culturally competent care.

With Australia's growing population diversity, nurses and midwives increasingly find themselves caring for women whose culture, linguistic background or health perspectives they may not understand or be familiar with. Strategies should be in place to empower both health practitioners and migrant and refugee women in this regard.

Existing research demonstrates

CULTURE INFLUENCES WOMEN'S EXPECTATIONS FOR CARE, HEALTH BELIEFS AND BEHAVIOURS, AND SHOULD BE CONSIDERED IN THE CONTEXT OF HEALTH LITERACY AND PROVISION OF CARE, PARTICULARLY WHEN ADDRESSING SENSITIVE HEALTH TOPICS SUCH AS SEXUAL AND REPRODUCTIVE HEALTH.

that migrant and refugee women face greater challenges in accessing healthcare. Their healthcare needs are frequently complicated by premigration experiences. They underutilise preventative health services and are overrepresented in the use of acute and crisis services. Settlement is an overwhelming process, and women often overlook their own health issues. Further, health promotion and prevention strategies may not be as effective in reaching women from migrant and refugee backgrounds as they could be.

There are a number of key factors that should be taken into consideration when caring for women from migrant and refugee backgrounds. Culture influences women's expectations for care, health beliefs and behaviours, and should be considered in the context of health literacy and provision of care, particularly when addressing sensitive health topics such as sexual and reproductive health.


Individual context and experiences, including pre-migration experiences, also impact greatly on women's health literacy and systems knowledge, with vastly different levels of knowledge and capacity to navigate the healthcare system across the great diversity of migrant and refugee women.

Significant focus should be placed on the capacity of nurses and midwives to communicate and engage effectively with migrant and refugee women. They often lack the English proficiency or health literacy to provide the practitioner with relevant information and the confidence necessary to be active participants in the process.

Equally important is developing trust and collaboration-based relationships between nurses and midwives and migrant and refugee women in order to create an enabling and empowering environment where women feel comfortable and encouraged to ask questions to improve their health literacy.

Bringing together a range of stakeholders, the Partnership's goal is to work collaboratively to enable the implementation of niche good practice models in culturally appropriate care across all healthcare settings.

For more information about the work of the Partnership, please visit www.culturaldiversityhealth.org.au

 **Gulnara Abbasova** is Executive Officer at the Migrant and Refugee Women's Health Partnership

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TRICIA AND DIRK MULDER WITH BABY PIERCE AND FIONA STANLEY HOSPITAL REGISTERED MIDWIFE VANESSA DE GRAFF

NEW FETAL SURVEILLANCE CLINIC LEADS TO MORE EFFICIENT CARE

By Anni Fordham

A new fetal surveillance clinic at Fiona Stanley Hospital (FSH) is cutting wait times and freeing up urgent care beds for expectant mothers.

Previously, pregnant women requiring regular cardiotocography (CTG) monitoring due to medical disorders like gestational diabetes would present to the Maternal Fetal Assessment Unit (MFAU).

MFAU also provides urgent assessment for women with unexpected complications so those needing routine CTGs once or twice a week could be waiting some time, depending on other cases presenting on the day.

FSH Midwifery Manager Ambulatory Services Peta Skuthorp said the new clinic meant women had more certainty around appointment times.

"Time is precious and not everyone can afford to be waiting for long periods, so we've listened to patient feedback and changed the way we do things," Peta said.

"Because these women are no longer waiting alongside urgent cases, their wait time has effectively

been reduced to zero.

"The knock-on effect is that the MFAU now has more capacity to efficiently deal with those urgent cases."

Tricia and Dirk Mulder had their second child, Pierce, two weeks ago and attended the new clinic for monitoring twice a week during the later stages of their pregnancy.

Dirk said the best thing about the new clinic was being seen at the scheduled appointment time, and having the same midwife each time.

DUE TO THE SPECIALIST SKILLS REQUIRED TO OPERATE THE SERVICE, IT'S ALSO PROVIDING A PROFESSIONAL DEVELOPMENT PATHWAY FOR MIDWIVES.

"Sometimes in the public health system you can start to feel like a number, but we felt the midwifery staff within the clinic really took the time to get to know us," he said.

"It was really good to see the same familiar face each time we came in and to be able to get the CTG done without waiting around.

"The birth went very smoothly too, thanks partly to our wonderful obstetrician Dr Sunanda."

The clinic, which runs two days a week, is staffed by a dedicated team of specialist midwives working alongside the medical team to provide prompt assessment and continuity of care.

"Our highly trained midwives consult regularly with medical staff to ensure we're providing exceptional care in a familiar and friendly environment," Peta said.

Due to the specialist skills required to operate the service, it's also providing a professional development pathway for midwives.

"The midwives conducting the surveillance clinic are required to have a number of advanced level qualifications in fetal surveillance so it's a great incentive for those who want to advance their skills and gain more specialised experience."

Peta said feedback from patients had been overwhelmingly positive since the service began in May. "The women who come to see us have competing demands on their time, like we all do – so being able to pop in at their allotted time and then get on with the rest of their day makes a big difference."

Anni Fordham is A/Media Coordinator, Corporate Communications at South Metropolitan Health Service in Western Australia

PHYSICAL AND MENTAL ISSUES LINKED TO BULLYING

Almost one in five 18-23 year old women have been bullied resulting in serious physical and mental health issues, according to research from the University of Newcastle.

Lead author Natalie Townsend from the Research Centre for Generational Health and Ageing and Hunter Medical Research Institute Public Health Program, said it was very concerning that more than half of women who were bullied recently had suicidal thoughts, and a third had self-harmed. "Women who experienced bullying reported worse general health, higher levels of psychological distress and were more likely to smoke, take illicit drugs and be overweight or obese."

The researchers found that compared to women who had never experienced bullying, those recently bullied were:

- 2.9 times more likely to have psychological distress
- 2.7 times more likely to have felt that life was not worth living
- 4 times more likely to self harm

Twenty-seven percent of the recently bullied women reported their general health as 'fair' to 'poor' compared with 10% of women never bullied. The physical impact was long lasting with 17% of women bullied in the past reporting their health as 'fair' or 'poor'.

"It's important to understand that even when bullying isn't physical, the experience still has long lasting effects on physical health, not just mental health," Ms Townsend said. "Our body's physical and hormonal response to stress can increase the risk of chronic disease and trigger the onset of predisposed conditions."

Co-author Professor Deborah Loxton said policymakers and healthcare professionals urgently needed to recognise the scale of the problem and take action. "We need to provide interventions and ongoing support and treatment for adults."



EMPOWERING WOMEN TO EXERCISE

Health Promotion Foundation VicHealth is launching a campaign to improve the health of women across Victoria.

The, *This Girl Can* campaign, based on the highly successful UK campaign *Sports England* campaign, will showcase real local women giving it a go and getting active regardless of fitness level, ability or how they look.

The aim of the campaign is to help Victorian women overcome feelings of judgement when exercising.

Unpublished VicHealth research identified fear of judgement and intimidation as key factors holding women back from getting active. More than 41% of women surveyed identified as feeling too embarrassed to exercise in public.

VicHealth CEO Jerril Rechter said VicHealth was calling on women to share their story and be part of the global *This Girl Can* movement to help others overcome fear of judgement they experience that stops them from participating in physical activity. "In Australia and Victoria, women are less active than men throughout their life- this is particularly evident in women with children," she said. "*This Girl Can* is a celebration of active women who are doing their thing no matter how they look, how well they do it, or how sweaty they get."

Women can submit their stories at www.thisgirlcan.com.au

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to practice that include; prescribing medications, referring to specialists, writing certificates, admission and discharge of patients, and ordering and interpreting of diagnostics.

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MORE PREGNANT WOMEN ARE BEING TREATED FOR GESTATIONAL DIABETES

Victoria has experienced a 75% increase in the number of pregnant women being treated for gestational diabetes as doctors reduce the threshold for diagnosis.

The introduction of universal screening in 2015 and a reduction in the blood glucose levels for diagnosis has resulted in more women being diagnosed and receiving treatment for gestational diabetes.

The change in the diagnosis was needed so as to reduce the risk of pregnancy complications and low blood sugar levels in newborn babies, according to the head of the Women's Diabetes Clinic, Dr Tom Cade. "We had the potential to be missing women with gestational diabetes who may have had large babies and delivery complications.

By lowering the threshold for diagnosis of gestational diabetes it means more women can access our service, receive the monitoring they need and treatments if their blood glucose becomes too high."

Dr Cade said that gestational diabetes can often be treated through diet and exercise or failing those interventions, insulin medication.

While many women only experience diabetes during their pregnancy, there are a growing number of women who fall pregnant with pre-existing Type 2 diabetes.

"Type 2 diabetes used to be rare in pregnant women, but as we see the growing rate of obesity and women choosing to have children later in life, we are seeing an increase in the number of pregnant women with Type 2 diabetes," Dr Cade said.

MATTERS OF THE HEART

By Lisa Kuhn

It is a scenario that is played out in emergency departments across Australia every day - a woman comes in with symptoms that don't fit with the archetypal heart attack.

She is not complaining of severe chest pain or clutching her chest. Her symptoms of extreme fatigue and shortness of breath have been happening on and off for weeks and may mimic something else, so she slips down the queue.

Heart disease is the number one killer of women in Australia and across the world, but is not often given the attention it deserves. If a woman is having a heart attack ('acute myocardial infarction') she is more likely to have delayed treatment than men, increasing her risk of death.

This inequitable situation has been my major research focus for the past decade.

Back in 2007, I had a chance conversation with a colleague while working as an emergency nursing lecturer. She told me about research from the US highlighting the disparity between women and men who had heart attacks and I wondered if there were similar challenges in Australia.

I decided to do a PhD to look at the issue and found that in Australia, women were treated differently too.

Compared to men, women received delayed treatment, fewer



HEART DISEASE IS THE NUMBER ONE KILLER OF WOMEN IN AUSTRALIA AND ACROSS THE WORLD, BUT IS NOT OFTEN GIVEN THE ATTENTION IT DESERVES.

tests, and less cardiac unit admissions. Women with some types of heart attacks were twice as likely to die in hospital than men.

This work shows a need to reappraise decision making by clinicians when assessing women for heart attacks and the processes

involved in getting patients access to evidence-based care as quickly as possible. It demonstrates the need to raise awareness of possible gender differences in heart attack management.

My current work involves developing a predictive model to see which women do not receive evidence-based care so that this can be avoided. To do this, I'm looking at the role of numerous factors including symptoms, age, co-morbid illness, preferred language and socio-economic status.

We have assumed for too long that heart disease in women and men are the same, but now we are starting to think that the conditions may differ between genders. One of the problems is that most of the research on heart attacks has been done on men. Even the diagnostic tools we use such as stress tests are based on research done mostly on men. The truth is that women are not simply smaller versions of men. Their blood vessels can react differently during a heart attack and the role of hormones and many other factors come into play. Diabetes and high blood pressure, including during pregnancy are important risk factors to consider when a woman presents for treatment.

There is still a long way to go, and much we don't yet understand, but it is imperative that we don't consign women to preventable early deaths or heart failure by not acting quickly enough to limit the damage done to their hearts.

Morbidity and mortality are avoidable, if clinicians apply the evidence to their practice.

 **Dr Lisa Kuhn** is an emergency nurse and member of the Centre for Quality and Patient Safety Research (QPS) in Deakin's School of Nursing and Midwifery.



MENTAL HEALTH NURSES AS MOTHERS

By Debra Klages

Debra Klages is a mental health nurse and a PhD student from the University of New England. Her research interests focus on the experiences of mental health nurses who are mothers of adult children diagnosed with schizophrenia.

According to the World Health Organization (2016) there are 21 million people diagnosed with schizophrenia. Parents play a vital role in the support of their loved ones who have this lifelong condition and studies indicate that mothers are their primary carers (Klages et al. 2017).

Mental health nurses have children too, and if their adult son or daughter is diagnosed with schizophrenia, their parental responsibility changes. The dual role of a mental health nurse and mother may be incredibly difficult to navigate for emotional, ethical, practical and institutional reasons.

Debra's research project, which is currently under way, aims to gain a deep insight and understanding into the stories and experiences of mental health nurses who are mothers of a son or daughter with schizophrenia.

The project has the potential to inform and guide mental health nurses and other healthcare professionals who will be able to use the findings to improve services for people with schizophrenia as well as their family members.

If you are interested in this project, please contact Debra Klages: dklages@myune.edu.au



References

Klages, D., Usher, K. and Jackson, D. 2016. 'Canaries in the mine'. Parents of adult children with schizophrenia: An integrative review of the literature. *International Journal of Mental Health Nursing*.

World Health Organization 2016. *Schizophrenia fact sheet*. www.who.int/mental_health/management/schizophrenia/en/. Accessed 24 August 2017.

Debra Klages is a PhD candidate at the School of Health, University of New England. She is an RN, and holds a BScN, Master in Advanced Nursing Practice (Mental Health)

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OCTOBER

Global Alcohol Policy Conference

Mobilising for change – Alcohol policy and the evidence for action
4-6 October, Melbourne.
www.gapc2017.org.au/

National Mental Health Week

8-14 October. www.mentalhealthvic.org.au/

World Mental Health Day

10 October. www.1010.org.au/

Congress of Aboriginal & Torres Strait Islander Nurses & Midwives (CATSINaM) Professional Development Conference

Claiming our Future
10-12 October, Sofitel Broadbeach, Gold Coast Qld. <http://catsinam.org.au/>

13th Biennial National Enrolled Nurse Association of Australia (ANMF SIG) Conference

Empowering Enrolled Nurses in our scope of practice
11 October, Wrest Point, Tasmania.
www.nena.org.au

Lung Health Promotion Centre at The Alfred Managing COPD

12-13 October
Spirometry Principles & Practice
23-24 October
P: (03) 9076 2382
E: lunghealth@alfred.org.au

Australasian Rehabilitation Nurses' Association 27th Annual Conference

The changing landscape for rehabilitation nursing: Transitions, transformation, future visions
12-13 October, Adelaide, SA.
www.arna.com.au/

Australian College of Neonatal Nurses Conference

12-14 October, Daydream Island, Qld.
www.acnn.org.au/events/acnn-national-conference/

21st Australasian Menopause Society Congress

Menopause: Exploring the evidence
13-15 October, Sofitel Sydney Wentworth, NSW. www.ams2017.org/

Medical Imaging Nurses Association National Conference

14-15 October, Grand Hyatt Melbourne. Contact Deb Shears E: Deborah.Shears@i-med.com.au or <https://www.anmfvic.asn.au/events-and-conferences>

National Anti Poverty Week

15-21 October. <http://www.antipovertyweek.org.au/>

27th Surgical Nursing & Nurse Education Conference

Innovations and Advanced practices in Surgical Nursing
16-17 October, Dubai, UAE.
<http://surgical.nursingconference.com/>

World Self Medication Industry (WSMI) General Assembly

The Health Economic Value of Self Care
18-19 October, International Convention Centre Darling Harbour, NSW. <http://wsmiga2017.com/>

Australian College of Neonatal Nurses 25th National Conference

Shaping neonatal care: From past to future
18-20 October, King Fisher Bay Resort, Fraser Island, Qld. www.acnn.org.au/events/acnn-national-conference/

35th Annual CRANaplus Conference

The future of remote health and the influence of technology
18-20 October, Cable Beach Club Resort and Spa, Broome WA.
www.cranaplusconference.com/

Bendigo Nurses' Conference

23-24 October, Lakeview Resort Bendigo Victoria. www.ausmed.com.au/course/bendigo-nurses-conference

5th Annual National Acquired Brain Injury Conference

24-25 October, Rendezvous Hotel, Melbourne. www.informa.com.au/event/national-acquired-brain-injury-conference/

Rural and Remote Mental Health Conference

We're in it together
25-27 October, Broome, WA. E: event@peppermint.com.au

35th Audiometry Nurses Association of Australia Annual Conference & AGM

25-27 October, Novotel Wollongong Northbeach, NSW. www.anaa.asn.au/

Australian & New Zealand Orthopaedic Nurses Association (ANZONA) Conference

Let's us articulate, align and unite
25-27 October, Pan Pacific Hotel, Perth WA. www.anzonaconference.net/

43rd Annual International Mental Health Nursing Conference

25-27 October, Tasmania. www.acmhn.org/news-events/conference-news/acmhn2017

Australasian Marcé Society for Perinatal Mental Health Conference

When the bough bends: Resilience in the perinatal period
26-28 October, Brisbane Convention and Exhibition Centre.
<http://marceconference.com.au/>

ANMF Occupational Health & Safety Conference

27 October, ANMF Carson Conference Centre, 535 Elizabeth Street, Melbourne. The ANMF OH&S conference attracts up to six hours of CPD required by the NMBA for registration renewal. www.anmfvic.asn.au/events-and-conferences

Nursing and Legal Concepts - South Pacific

Keeping you and your patients safe
28 October-5 November 2017. Join us as we sail the South Pacific and participate in this master class nursing and legal concepts conference. Cruising aboard Carnival Spirit will elevate this travel CPD event, to that unforgettable trip you will be longing to relive. <https://www.nursesfornurses.com.au/events>

Australian College of Midwives 20th National Conference

Calling all midwives: The truth is out there!
30 October- 2 November, Adelaide, SA. www.acm2017.org/

NOVEMBER

November Month

Is an annual, month-long celebration of the moustache, highlighting men's health issues, specifically prostate cancer and depression in men (au.movember.com/)

Lung Health Promotion Centre at The Alfred

Asthma Educator's Course
1-3 November
Smoking Cessation Facilitator's Course
16-17 November
P: (03) 9076 2382
E: lunghealth@alfred.org.au

4th International Conference for PeriAnaesthesia Nurses

Tides of change, with advocacy, education & research
1-4 November, Luna Park Sydney, NSW. <http://icpan2017.com.au/>

3rd Annual Falls, Fractures & Pressure Injuries Conference

2-3 November, Rendezvous Hotel, Melbourne. www.informa.com.au/event/falls-fractures-pressure-injuries-management-conference/

Australasian HIV & AIDS Conference

6-8 November, National Convention Centre Canberra. www.ashm.org.au

Marriage Equality Postal Survey

Final deadline to return forms
6pm Tuesday 7 November.

Australasian Sexual Health Conference

7-9 November, National Convention Centre Canberra. www.ashm.org.au

34th International Nurse Education & Nurse Specialist Conference

The role of nursing in advancing global health
8-9 November, New Orleans, Louisiana, USA. <http://nursespecialist.nursingconference.com/>

Eureka Climb

12 November. The race to the top of Melbourne's tallest building. At 88 levels and 1,642 steps, it's Australia's biggest vertical race!
www.eurekaclimb.com.au

3rd Annual National Family and Domestic Violence Summit

13-14 November, Radisson Blu Plaza Sydney. www.informa.com.au/event/national-family-domestic-violence-summit/

3rd World Congress on Midwifery and Women's Health

Excelling innovations in midwifery and nursing for women's health
13-14 November, London, UK.
<https://midwifery.conferenceseries.com/europe/>

World Diabetes Day

14 November. www.idf.org/worlddiabetesday

26th Transplant Nurses' Association National Conference

Success. Solidarity. Sustainability
15-17 November, Rydges Melbourne. www.tnaconference.com.au

International Men's Day

19 November. www.internationalmensday.com/

DECEMBER

World AIDS Day

1 December. www.worldaidsday.org.au

NETWORK

Alfred Hospital Nurses League Inc.
98th Annual General Meeting and Lunch

21 October at 1200, Emerald Hotel, South Melbourne. Contact Elizabeth Angell E: angell@bigpond.net.au

Sturt College, First Year Nurses, 40-year reunion

4 November. See event on Facebook. Contact Elizabeth Jarman M: 0422 702 917 or E: elizabethjanejarman@gmail.com

Prince Henry's Hospital, 1/73, 45-year reunion
27 January 2018. Contact Jeanne O'Neill (nee Pinder) E: ej_oneill@yahoo.com

PHH, POW and Eastern Suburbs Hospitals, NSW reunion for PTS intake of Feb 1973

17 February 2018. Contact Roslyn Kerr E: gert2@optusnet.com.au or Patricia Marshall (nee Purdy) E: tpatric135@bigpond.com

Alfred Hospital, Group 3/68, 50-year reunion

June 2018. Contact Isabelle E: isabellehenry360@gmail.com

NDSN Bendigo School 71, 50-year reunion

2018. Seeking students from Bendigo, Castlemaine, Echuca, Swan Hill and Mildura. Contact E: margie_coad@hotmail.com or M: 0427 567 511



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

BUILDING RESILIENCE

Your lead feature article on mental health nursing in the August 2017 *ANMJ* rightly stresses the need for nurses to work on their own development of resilience and professional skills.

Especially in mental health practice, we emphasise to our clients a set of basic living skills, but then succumb to the pressure of our environment and fail to utilise them ourselves. Just as our clients are tempted to take the quick fix of avoidance and helplessness, the pressure of our environment presents us with the same temptation.

As one of the prime deliverers of health services, we are not responsible for the poor governance that so often makes that delivery more difficult.

However, we are responsible to be true to ourselves and to arm ourselves with those skills and mental attitudes enabling us to challenge our work environment and gradually prove to the policy decision makers that anything they do that does not enhance the ability of the care deliverer to deliver is a waste of time and resources.

Mick Hawkins MHN, SA

CAMPAIGN AN INSULT TO NURSES AND MEDICAL STAFF

The article Campaign calls on nurses to help improve patient care, published in the *ANMJ*, Vol 25, No.3, pg 6, is an insult to nurses employed within the public sector of the Victorian healthcare industry.

Victorian nurses 'are being implored to pay more attention to the needs of patients and families' to 'help slash problematic medical indemnity claims'.

Perhaps if the Victorian government alongside the VHIA, the ANMF - (Victorian Branch) and the AMA Victoria worked to legislate adequate fatigue risk management strategies within the healthcare industry, the number of 'problematic medical indemnity claims' would be reduced.

The healthcare industry lags behind other industries such as mining and construction, aviation and transport in the management of workplace fatigue.

Currently there is no limit to the amount of overtime a nurse can work, nor the number of hours they can work across multiple employment sites.

Recall, is not limited and the 14 hour excessive hours clause in the current 2016-2020 EBA and is at best laughable with the determining factors required for this clause to apply.

The medical profession still works under the same framework of unpaid overtime, excessive on call periods that were in place when I commenced employment as a Nurse 25 years ago.

In the chronically under staffed theatre department of a major metropolitan tertiary hospital in which I am employed, the Nursing colleagues I work with do not need to be insulted by an advertising campaign 'imploping' us to 'pay more attention to the needs of our patients and their families'.

Perhaps members of the VMIA would like to come and spend some time within my department, the Health Minister would also be very welcome, and witness themselves the standard of care delivered by nursing staff, advocating for the patient and ensuring that medical and allied health staff are accountable for their delivery of care.

Caryn Auld RN, Vic

NEWS

NURSES LEAD WAY IN CARING FOR HOMELESS

Community Health Nurse Claire Dowling was drawn to working with the disadvantaged after witnessing first-hand the impact of poverty and health disparities in her hometown of Glasgow in Scotland.

"I have this strong belief in social justice and equity and the fact that some people in society do not have the assistance of someone with health knowledge to help their capacity to be able to change in order for them to have self-determination and work on their own goals," Ms Dowling said.

Ms Dowling moved to Australia in 2005 and soon began working for the Royal District Nursing Service (RDNS) Homeless Persons' Program (HPP), an outreach service involving a team of community health nurses who offer holistic primary healthcare to people experiencing homelessness.

Most clients have fallen through the cracks, either unable to navigate the health system due to not having a roof over their head or assessed as too difficult by services. "Within our program we talk about homelessness making people sick," Ms Dowling said. "Clients actually have quite complex morbidities like liver cirrhosis, respiratory disease, diabetes, Hepatitis C, mental illness and substance use disorders, all of which are potentially not managed in any way."

MOST CLIENTS HAVE FALLEN THROUGH THE CRACKS, EITHER UNABLE TO NAVIGATE THE HEALTH SYSTEM DUE TO NOT HAVING A ROOF OVER THEIR HEAD OR ASSESSED AS TOO DIFFICULT BY SERVICES.

Ms Dowling is based at SalvoCare Eastern Homelessness and Support Services and covers Victoria's entire Mornington Peninsula in delivering healthcare to the homeless.

According to Homelessness Australia, on any given night over 200 people are homeless across the country.

In 2014-15, 255,657 people received support and almost seven million nights of accommodation were provided by specialist homelessness services.

Ms Dowling is shedding light on the problematic issue as part of Homelessness Week 2017, which runs from 7-13 August.



COMMUNITY HEALTH NURSE CLAIRE DOWLING

an annual event used to raise awareness of people experiencing homelessness and the issues they face.

"Nurses in particular are at the forefront because we are the ones who are seeing the clients who are most at risk of presenting to emergency departments and at most risk of death from their illness."

"Nurses are pivotal in being able to assess what their immediate needs are and what the short-term to long-term goals for the person are and then linking them into the most appropriate services because quite often we find that the navigation within the service isn't there."

Illustrating the impact nurses can make, Ms Dowling revealed recently working with a 51-year-old client named Alan (not his real name) who she encountered while conducting outreach across Rosebud's private rooming houses.

Through engagement, Ms Dowling uncovered that Alan had been homeless for 20 years and had returned to Rosebud in a bid to reconnect with family.

Diagnosed with schizophrenia at 18, Alan worked as a mechanic until his condition became unmanageable.

He lost his job, then his private rental accommodation, and spiralled into decades of transient homelessness after losing the social supports most people take for granted.

Ms Dowling recounts assessing Alan as both mentally and physically unwell, triggered in part by numerous hospital admissions that didn't deliver follow-up

healthcare. Alan was suffering cirrhosis of the liver, a bladder tumour, an acquired brain injury due to alcohol dependence and exacerbation of his mental illness.

Through the support of Ms Dowling's nursing care and collaboration with other services, Alan was able to get back on track by accessing crisis services and then being allocated a home care package via an aged care assessment service which led to independent living.

His bladder tumour has now been treated, his liver cirrhosis is stable and he is taking steps to minimise his drinking.

"He's achieved his goals and his goal was to achieve housing and be independent but I don't think that would have happened had we not worked with him," Ms Dowling said.

"It gives you motivation to continue to assist the clients to achieve their personal goals and to try and build capacity for their own personal change because quite often the clients don't believe. They have no sense of self-esteem and don't believe in themselves. But by informing them and empowering them you can assist them to have that capacity."



Homelessness Week 2017 runs from 7-13 August. For more information visit www.homelessnessaustralia.org.au

LETTER OF THE MONTH

SUPPORTING THE HOMELESS

Thank you for the article in the August issue of the *ANMJ* about homeless Australians, and the wonderful nurses who work in this area.

The care and support they provide to Australians who have no place to call home, is heart-warming.

The number of Australians who are living on the streets is alarming, to say the least. These are men, women, teenagers, and children and babies with their homeless parents.

It seems to be a less trendy area to support with political/social groups such as *GetUp* showing little to no support in this area.

I hope the Homelessness Week in August brought the attention homeless Australians deserve and that permanent measures are put in place to prevent homelessness in Australia.

This is an issue that cannot be ignored. I tip my hat to the community health nurses who are not ignoring the homeless issue, but rather are doing great work in this area.

Gabrielle Brandt RN, SA

The winner of the *ANMJ* best letter competition receives a \$50 Coles Myer voucher.

If you would like to submit a letter to the *ANMJ* email anmj@anmf.org.au Letters may be edited for clarity and space.



MY INSPIRATION

Assistant Federal Secretary, Annie Butler



Why we enter into a profession of our choosing differs for everyone. My motivation to become a nurse was because of my mum. Not only was she my inspiration, she also helped me to understand why the union is so important for our professions.

My mother, Pamela Butler, has been a nurse for more than sixty years and a member of this union for almost most of them (she'll skin me alive if I say her actual age but I'm including important dates).

Pamela started her nursing career in 1954 at the Royal Alexandra Hospital for Children in Sydney, now Westmead Children's Hospital, when you had to pay a 'guinea' a week to stay in the nurses' home, and for the nine weeks of 'PTS', spend three days in the classroom, one day on the wards and one day at East Sydney Tech to learn 'invalid cookery'. All in full uniform of course.

On her first ward as a 'junior junior', she had to "clean sister's desk, wash all the tiles down one side of the ward and clean the pan room all before sister arrived", and go outside to the freezer to chip buckets of ice for the oxygen tents. Mid-winter or not, no 'germ carrying cardigans' were allowed as ordered by sister.

As a 'senior junior' she got to clean the thermometer trolley, wash the tiles on the other side of the ward and then take care of the children! Clean them, feed them, change them, give their medications, in those days mostly SC and IM injections, catheterise them and insert nasogastric tubes as needed. This was also in the time before the polio vaccine, so she cared for the post-polio children living in iron lungs, some of whom had been in hospital for eight years or more.

Conditions were tough: she had only one and half days off per week; worked day,

evening and, after the first year, night shifts with no penalties; had to fit lectures around night duty; had no sick leave and the possibility of paid overtime was still a distant dream. It was also the time when the children were only allowed visitors once a fortnight from two to four pm on a Sunday afternoon.

Graduating in 1958, she became a junior sister, and donned a very fetching uniform, "frequently catching the eye of the doctors" she tells me. At a time when there weren't many senior sisters around, the junior sisters took much of the responsibility for running the hospital. For 500 beds, there was one junior sister for the medical block, one for the surgical, one for the private wing and one senior sister for the entire hospital.

After graduating as a junior sister she cleared two pounds a fortnight and was allowed two full days off a week.

In 1960 my mother went to Sydney's Crown St Hospital to do her midwifery training, a very progressive hospital for the time she says. They put the baby on the breast as soon as the baby was delivered, had 'rooming in' and taught the mothers to hand express, for their own babies and the NSW milk bank!

The autoclave was used to sterilise breast milk and the nurses also used it to caramelise their own sweetened condensed milk treats.

My mother joined the union in 1961 working for the department of public health on a scholarship for her mothercraft training. With six months training then bonded to service for 18 months, she cared for 7-day olds to 5-year olds. She worked in Karitane's 'step down' unit, where mothers and babies stayed for a week to learn parenting. After discharge, the cots' tea tree mattresses had to be unstitched, the tea leaves taken out, placed in clay pots, baked until sterile, replaced and resewn.



Then came her own babies, yours truly and my sister. My father was a school teacher, so my mother worked night shifts, still for no penalties. Struggling with living costs she left the union until 1969.

When, taking a job as matron of a nursing home and back to fulltime work, she re-joined for 'safety and protection' and the recently introduced penalty rates at that time.

She's been a member ever since and has seen so much improvement in her working life- penalty rates, sick leave, carer's leave, a 38-hour week, removal of non-nursing duties, much better wages than she could have ever imagined, access to education, information and support.

After all she has seen she gets very fired up when people don't appreciate the achievements of the union and its members.

I don't have the space here to describe everything my mother's done over the course of her career, she's worked just about everywhere, clinically and geographically, and, amazingly, continues to work helping parents with their babies and participate in the ANMF as a member of the Victorian Branch.

She's given so much to the community for so long, and for my whole life shown me such pride in her profession and trust and belief in her union.

It's little wonder I've ended up where I am.

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