

ANMJ

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November 2017

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Clinical Deterioration – Identify, Assess, Prevent	Melbourne	30 Nov – 1 Dec
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December 2017

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Everyday Ethics for Nurses Conference	Adelaide	4 – 5 Dec
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Mildura Nurses' Conference	Mildura	11 – 12 Dec
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Clinical Deterioration – Identify, Assess, Prevent	Adelaide	14 – 15 Dec
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Transfer your ANMF membership

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



It's been a busy couple of months attending ANMF annual delegate conferences across the country.

While joining in on these events it's been wonderful meeting or reconnecting with many of you in every state and territory I have visited. I must say it really is one of my favourite things to do.

The conference is also a great opportunity for nurses and midwives to network with each other to discuss issues most important to them.

A substantial part of state and territory delegate conferences is dedicated to discussing and debating resolutions on industrial, professional, political and social justice issues which are put forward by members. If those

resolutions are passed they help shape policy and direction for each of the branches.

The enthusiasm this evokes amongst delegates is awe inspiring and always creates a swell of pride within me. Because of this passion I am assured that our professions are in good hands and will continue to grow and evolve in the years to come.

Every two years the ANMF Federal Office holds its own national conference. The next one is set to occur in Tasmania in October this year. Nominated delegates from each of the branches attend this conference to debate matters of national policy. While it is not a policy making body as such it helps provide a national vision and a direction for the ANMF Federal Executive on issues that matter most to members.

To help understand what ANMF's national biennial conferences are about ANMF's feature this month looks into their importance and how they influence the nursing and midwifery professions as a whole.

THE ENTHUSIASM THIS EVOKES
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A SWELL OF PRIDE WITHIN ME.

At the state and territory branch delegate conferences, Assistant Federal Secretary Annie Butler and I have been speaking about aged care and the plight of the sector. We will be talking about this again at the National Biennial Conference.

If you have been reading my editorials over the past few months you would know how concerned the ANMF is about aged care, particularly around the reduction of qualified staff at many aged care facilities - the consequences being substandard care and dangerous conditions for residents. Without doubt it's a dire situation as aged care descends more deeply into trouble. Just recently, aged care providers Southern Cross Care and Blue Care both announced plans to slash nursing hours and cut staff.

As a matter of urgency Annie Butler and I held talks on the matter with Aged Care Minister Ken Wyatt in Canberra late last month. At this stage I can say the minister was listening which is hopefully a positive step towards improvements in the sector.



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AGED CARE CRISIS PROMPTS NATIONAL CAMPAIGN

The Australian Nursing and Midwifery Federation (ANMF) is calling for first-hand evidence regarding staffing cuts, reductions in hours, and roster changes as it ramps up its fight to safeguard aged care in the face of an intensifying national crisis.

The union's ongoing national aged care survey includes examining whether staff are being asked to look after the same amount of residents with less numbers or hours and what impact the workplace environment has on the care residents receive.

The survey also considers the potential impacts on staff themselves by attempting to gauge the effect of increased workloads and if nurses have contemplated leaving the organisation of profession.

The timely survey emerges as longstanding problems plaguing the aged care sector arguably reach breaking point.

In recent months, prominent aged care providers Southern Cross Care and Blue Care have both announced plans to slash nursing hours and cut staff, triggering fears for the quantity and quality of care being provided to elderly nursing home residents.

In July, Southern Cross Care revealed it would cut staff and carer hours across several of its sites in Queensland, Tasmania and South Australia.

In Queensland, SCC plans to slash more than 2,800 hours of care per fortnight from at least eight of its nursing homes.

Similar cuts across Tasmania led to staff voting to commence industrial action last month in order to protect fair conditions and reasonable wage increases above the award minimum as part of EBA negotiations.

ANMF members wore campaign badges and handed out information flyers to residents and families in a bid to raise community awareness about the troubling issues nurses and carers are facing.

A rally was also held outside Southern Cross Care Tasmania's Rosary Gardens facility.

Worryingly, the grim state facing aged care was compounded when fellow provider Blue Care announced its own cuts last month, sacking 11 qualified enrolled nurses across its three Bundaberg facilities.

"This is nothing short of a disgrace," ANMF Federal Secretary Lee Thomas said.

"Sadly, it proves that providers like Blue Care cannot be trusted in providing proper, safe levels of staff to deliver care to their nursing home residents."

The decision will result in a loss of more than 1,500 nursing and care hours yet Blue Care, Queensland's largest aged care provider, blamed the cuts squarely on a \$1.2 billion reduction in federal funding.

Ms Thomas predicted the cuts would only exacerbate the already stretched aged care system.

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ANMF Federal Secretary
Lee Thomas

Her views stem from findings of a recent Senate Inquiry which indicated inadequate staffing levels were leading to increasing missed-care episodes, abuse and neglect of the elderly.

"It's incongruous that Blue Care's own mission statement declares it is "committed to assisting people who require care" yet it is drastically slashing hundreds of nursing hours and allowing less qualified personal care workers to administer medication in lieu of high-trained nurses," Ms Thomas said.

"That's hardly a commitment to care is it? If anything it's only going to compromise the care they can provide to their residents."

The ANMF's ongoing national, online aged care survey has already identified widespread cuts to nursing and care hours across the country.

At last count, more than 500 ANMF members had undertaken the survey, with 94% reporting being asked to care for the same number of residents with fewer staff or less care hours, while over 89% said current staffing levels simply weren't enough to carry out basic care such as bathing and bed changes.

In a somewhat positive step, Ms Thomas and ANMF Assistant Federal Secretary Annie Butler held urgent talks with Aged Care Minister Ken Wyatt in Canberra last month.

Ms Thomas said the latest events have sparked long-held fears that other aged care providers will follow suit and also attempt to cut nursing and care.

To participate in the survey go to: <https://www.surveymonkey.com/r/D95M562>

VICTORIA PAVES THE WAY FOR VOLUNTARY ASSISTED DYING MODEL

The Victorian government will press ahead with legislation on voluntary assisted dying to be introduced into state Parliament in coming months.

The state government has incorporated all 66 recommendations of a final report by the Ministerial Advisory Panel which drafted the legislative framework for assisted dying in Victoria.

The Panel recommended a pre-dominantly self-administered scheme for Victorian adults with decision-making capacity, with a terminal illness, who are suffering with a prognosis of 12 months or less to live. It includes 68 safeguards aimed to protect against exploitation and coercion.

Under the proposed model, a Voluntary Assisted Dying Review Board will be established to review every case of assisted dying in Victoria. New criminal offences will include health professionals who act outside scope of the scheme.

"The Victorian government now has the opportunity to pass a Voluntary Assisted Dying Law that provides for choice and control to those suffering at the end of their life," Dying with Dignity Victoria President

AS NURSING AND MIDWIFERY PROFESSIONALS WE ARE OFTEN CAUGHT IN THE CROSSHAIRS OF THIS DEBATE, EITHER DIRECTLY DURING OUR DAILY WORKING ROLES OR WHEN DISCUSSIONS ARISE WITHIN OUR COMMUNITY OR FAMILY CIRCLES.

Lesley Vick said.

All Victorian MPs will be granted a conscience vote on the legislation, with Parliament expected to vote on the issue before the end of the year.

Hundreds of nurses and midwives voted in support of the need for legislative change for assisted dying in NSW. More than 500 delegates at the recent NSW Nurses and Midwives' Association (NSWNMA, ANMF NSW Branch) annual conference endorsed an updated position on behalf of their 64,000 nursing and midwifery colleagues.

NSWNMA President Coral Levett acknowledged the diverse membership of nurses, midwives and assistants in nursing. "As nursing and midwifery professionals we are often caught in the crosshairs of this debate, either directly during our daily working roles or when discussions arise within our community or family circles."

It was imperative nurses and midwives had a well-informed position on the topic, Ms Levett said. "This is a very important issue for the nursing profession. Given our compassion for those who suffer and our concern for quality of life being afforded to every individual, this is an issue worth fighting for to ensure the right balance is achieved and all sides of the debate are well considered."

OVERWHELMING RESPONSE TO ANMJ'S SURVEY



The ANMJ was swamped with responses to its member communication survey last month.

Over 6,000 nurses, midwives and assistants in nursing from around the country completed the survey online or on paper.

The purpose of the survey was to find out what nurses and midwives would like to read in their journal as well as help shape the future direction on how the ANMJ will be published in the future.

Responses from members are currently being analysed and we will keep you posted on the results.

Everyone that completed the survey went into the draw for an Apple Watch Series 2. The lucky winner of the draw was Melinda Dickinson from South Australia. Congratulations Melinda!

The ANMJ team would like to thank all participants who completed the survey.

SUPERBUG SURVEY OF AUSTRALIA'S HOSPITALS

Australian hospitals will be put under the microscope in the first infection survey in more than 30 years.

The National Healthcare Associated Infection Point Prevalence Survey will count how many patients in a sample of Australian hospitals have an infection on one day.

Researchers from Deakin University, Avondale College of Higher Education and Monash University will begin recruiting hospitals nationwide from this month in the three-year project.

"There's a current lack of data on what's happening nationally and we need to understand the national burden of healthcare associated infections, then use this information to develop national infection prevention initiatives," said

lead researcher Dr Philip Russo of the Centre for Quality and Patient Safety at Deakin University's School of Nursing and Midwifery.

Professor Brett Mitchell from Avondale College of Higher Education said Australia was one of the only OECD countries not to undertake such surveys. The last time a similar survey was carried out in Australia was in 1984. In many comparable countries, surveys were carried out every few years. Professor Mitchell said current European studies showed infection rates of 3-8%. Surveys were critical in setting national agendas and priorities, he said.

"We will also be gathering data on the prevalence and type of bugs in hospitals, as well as how many patients have resistant strains.

"There's a lot of media attention on the use of antibiotics and the burden of multi-resistant organisms in Australia, but we don't actually know how prevalent these superbugs are in our hospital system as a whole."

For more information, visit www.ipcca.com.au/pps

SEXUAL ASSAULT AND HARASSMENT RIFE AT UNIVERSITIES

A landmark report shows unacceptable rates of sexual assault and sexual harassment across Australia's universities.

The Australian Human Rights Commission report found sexual assault and sexual harassment were occurring in varying degrees across most areas of university life, mostly affecting women.

Almost one third of sexual harassment reported occurred on university grounds or in teaching spaces.

One in five of those who reported being sexually assaulted said it occurred at a university or residence social event.

"We found that colleges are a particular area of concern, particularly for women who were four times as likely as men to have been sexually assaulted in this setting," Sex Discrimination Commissioner Kate Jenkins said.

A national survey was completed by more than 30,000 university students across all 39 Australian universities. More than 1,800 people made submissions to the Commission.

Across all university settings the Commission found that women were three times as likely as men to be sexually assaulted in 2015 or 2016; and almost twice as likely to have been sexually harassed in a university setting in 2016.

"While anybody can experience sexual assault or sexual harassment, it is clear from the data that women at university experience these behaviours at disproportionately

higher rates than men," Commissioner Jenkins said.

Disturbingly the research found that most students who were sexually assaulted or sexually harassed at university in 2015 and 2016 did not make a formal report of complaint to their university.

"Only 6% of students surveyed thought their university was currently doing enough to provide clear direction on procedures and support services. Only 4% thought this was the case in relation to sexual assault," Commissioner Jenkins said.

1.6%

of respondents experienced sexual assault in a university setting (including public transport to and from university) in 2015 or 2016.

21%

of respondents reported that they experienced some form of sexual harassment in a university setting in 2016.

The report includes nine recommendations on areas for action and reform – eight of which are directed at universities and one at university colleges.

"The evidence is clear that universities need to do more to prevent such abuse from occurring and to build a culture that responds appropriately to these incidents by supporting victims and sanctioning perpetrators," Commissioner Jenkins said. University of Sydney Vice-Chancellor and

"THE EVIDENCE IS CLEAR THAT UNIVERSITIES NEED TO DO MORE TO PREVENT SUCH ABUSE FROM OCCURRING AND TO BUILD A CULTURE THAT RESPONDS APPROPRIATELY TO THESE INCIDENTS BY SUPPORTING VICTIMS AND SANCTIONING PERPETRATORS."

Principal Dr Michael Spence said the report confirmed the seriousness of the problem. "While work has begun, there is more we can do. All members of the university community can help ensure each other's safety and wellbeing."

Universities Australia, the peak body representing Australia's 39 universities, released a 10-point action plan in immediate response to the Commission's report.

Australian universities would take strong and swift action to prevent sexual assault and sexual harassment, Universities Australia Chair Professor Margaret Gardner said. "We send a strong and clear message today that these behaviours are not acceptable. Not on our campuses – and not in Australia society."

Initiatives in the 10-point action plan include: development of an evidence-based respectful relationships program for university students; new specialist training counsellors; a 24/7 national interim support line operated by Rape and Domestic Violence Services Australia; new training for university staff including first responder training; and development of best practice guidelines to respond to reports of sexual assault and sexual harassment. Universities Australia remained committed to the *Respect. Now. Always.* initiative launched in February 2016, Professor Gardner said. "We have listened – and we will act."

The Australian Human Rights Commission report can be found at:

www.humanrights.gov.au

CAMPAIGN CALLS ON NURSES TO HELP IMPROVE PATIENT CARE

Victorian nurses and fellow healthcare professionals are being implored to pay more attention to the needs of patients and families so that they can deliver better patient care and help slash problematic medical indemnity claims.

Developed by the Victorian Managed Insurance Authority (VMIA) in partnership with Monash Health, the *In Their Shoes* campaign features a series of videos depicting healthcare staff being asked to put patients first by considering the situation from their point of view.

Specifically, the campaign aims to remind healthcare staff and clinicians that every patient is someone's son, daughter, friend or colleague in the hope of encouraging healthcare workers to listen to their patients more attentively and consider their work from the patient perspective.

Medical indemnity claims account for two out of three of the state's total claims liabilities and the campaign will attempt to combat the problem by building care around the needs of the patient and improving their experience.

Launched by Safer Care Victoria, the initiative's three videos are being circulated

across Victoria's public hospitals.

It Could Be Me follows a typical patient journey through the health system from consultation to surgery and rehabilitation.

In another account, experienced GP Dr Philip Worboys shares his experience as a patient in **It Was Me**, detailing an incident where he was hit by a car at high-speed while riding a bicycle and left in a critical condition.

Lastly, Dr Rachel Rosler shares her story in **It Was My Daughter**, recounting when her daughter was born prematurely at 26 weeks and needed neo-natal intensive care.

VMIA CEO Colin Radford said it was pleasing to be investing in initiatives that improve outcomes for patients and their families. "Improving the patient experience, through increased empathy – by walking in their shoes – is key to improving outcomes for both patients and staff."

NURSE JOINS STROKE FOUNDATION CLINICAL COUNCIL

Australia's first stroke ambulance nurse, Skye Coote, has been appointed to the Stroke Foundation's Clinical Council to help bolster its work in shaping policy development, service delivery and improving access to information on stroke.

A pivotal part of the Stroke Foundation, the Clinical Council brings together Australia's leading clinicians, academics and researchers in a bid to ensure stroke sufferers have access to the latest advancements in treatment and care.

"I am proud to join the Stroke Foundation Clinical Council with some of Australia's leading minds on stroke," Skye said. "The Clinical Council is a link between the Stroke Foundation and the health system. I'm hoping that my

widespread and varied practical clinical experience and expertise in stroke, intensive care and emergency nursing will allow me to offer unique insights and provide a direct influence on the council."

Skye is currently spearheading Australia's first Mobile Stroke Unit at the Royal Melbourne Hospital.

Set to launch later this year, the ground-breaking project will involve an ambulance being fitted with a CT scanner and armed with specialised stroke personnel to allow the assessment and treatment of stroke to begin immediately rather than having to wait to arrive at a hospital.

Several years in the making, the hope is that the Mobile Stroke Unit can help close one of the major gaps in care by improving the system's response to stroke.

Treating stroke is time critical and compounded by the fact many people in the community fail to notice or understand the signs of stroke such as blurred speech or facial changes.

"I'm particularly passionate about reducing the gaps in stroke care and the burden that this devastating condition can cause," Skye said.

"Stroke kills more women than breast cancer, more men than prostate cancer and leaves thousands with an ongoing disability. Yet it can be treated. Time

STROKE AMBULANCE NURSE SKYE COOTE.



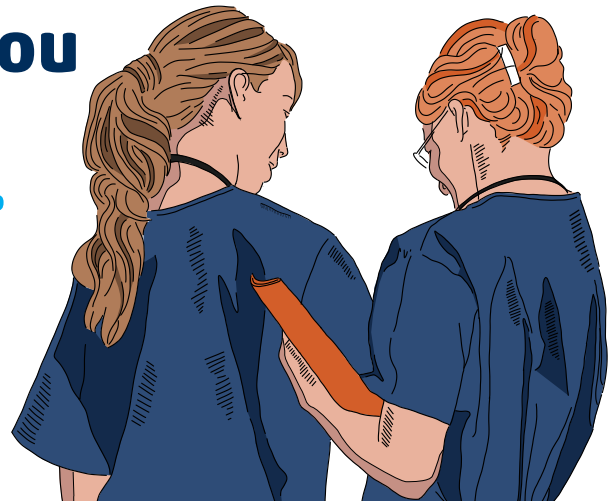
critical treatments can save lives and reduce disability.

"To improve stroke care, it is vital that we continue to educate health professionals and also the public on recognising stroke, reducing their risk factors and seeking treatment."

"Nurse's Back" - are you suffering in silence?

Nurses are 60% more likely than all other occupations to report chronic soreness and pain, with the majority of injuries caused by overexertion.

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ROYAL WOMEN'S HOSPITAL NURSE CARMEN BARRY IS TAKING PART IN THE PROGRAM.

PILOT PROGRAM TARGETS MENTAL HEALTH OF NURSES AND MIDWIVES

A proactive pilot program to be trialled by 2,500 Victorian nurses and midwives will focus on equipping the workforce with the skills to improve their mental, emotional and physical health.

Led by the Royal Women's Hospital in partnership with ABC Commercial, the Happy People pilot program is being rolled out across diverse health settings including the Peter MacCallum Cancer Centre, Melbourne Health and throughout parts of the Grampians Health Region.

The project involves tracking the behaviour of nurses and midwives and providing them with strategies to better manage their daily demands and job stress.

It was largely sparked from hospitals expressing a keen desire to identify new ways in which to assist nurses and midwives to manage their sleep, improve their moods and maintain energy levels.

"Their ever changing sleep patterns due to shift work can impact on their energy levels and

overall health," leader of the project, Professor Tanya Farrell explained.

"Nurses and midwives are so good at caring for others we need to give them back some time and tools that will assist them in caring for themselves."

Funded by the Victorian Department of Health and Human Services, the Happy People program will aim to foster a healthy and energised workforce in order to retain quality staff and improve patient outcomes.

Carmen Barry, a nurse who works in the Royal Women's Hospital's theatre team is taking part in the program.

"Working shifts has a huge impact, not only on my work, but my personal life.

"It is hard to sleep during the day when I've done a night shift, and it is difficult to maintain a routine for exercise and catching up with friends and family when your work schedule changes from week to week.

"I hope this program will give me some great tools for boosting energy and improving sleep and mood, and act as a reminder to take care of myself."

ABC Commercial CEO Robert Patterson suggested organisations were beginning to realise that maintaining a happy, resilient and energised workforce was crucial to a successful workplace.

"In today's landscape it's not enough to engage employees in wellbeing programs, you have to be able to justify the investment," he said.

"This has led to a growing appetite for evidence-based programs that provide positive results for participants and tangible outcomes for business, backed up with data and analytics."

VERBAL ABUSE LINKED WITH HIGHER LEVEL OF ANGER IN MENTAL HEALTH NURSES

Nurses who are subject to humiliating personal remarks experience higher levels of distressing emotions, including anger according to UK research.

The particular type of insidious and seemingly less severe form of verbal aggression played a larger role in mental health nurses' endorsement of practices such as restraint or seclusion, the latest research found.

"Nurses who reported being the target of derogatory remarks reported higher levels of anger than their colleagues. This was not true for those who had witnessed greater levels of physical aggression or self-harm," Birmingham City University Lecturer in Forensic Psychology Dr Rahul Jalil said.

The research involved rigorous assessment of mental health nurses working in three UK secure mental health units.

Exposure to physical aggression and self-harm were already known to have detrimental consequences for nurses working in mental health in terms of staff sickness and trauma, the researchers noted.

Targeted, personal and verbal aggression by patients could adversely affect mental health nurses' decision-making regarding physical restraint, the research found.

"The same nurses who experienced humiliating remarks were more likely to endorse coercive management techniques, such as restraint or seclusion," Dr Jalil said.

However, this did not translate into increased use of restraint or seclusion, he said.

Abertay University Professor in Mental Health Nursing and study supervisor Geoff Dickens said the results had real implications for education and training for staff in the prevention of violence and aggression. "Training provision largely focuses on managing physical aggression through techniques such as de-escalation. While this is great, more attention should be paid to how nurses regulate their own responses to this behaviour.

"Anger seems to be a mechanism that plays a unique role. While it is common to hear that nurses should 'just deal with it', it is unreasonable to believe that nurses are immune and can do this without help or support."

The role of anger in patient aggression, as well as in the nurse-patient therapeutic relationship should be considered, Dr Jalil said.

"It seems that existing checks and balances, perhaps including team support or nurses' own self-awareness, act to prevent a spiral in which behaviour is dealt with coercively, which in turn might make patients more likely to insult the nursing staff."

'Mental health nurses' emotions, exposure to patient aggression, attitudes to and use of coercive measures: cross sectional questionnaire survey' was published in the *International Journal of Nursing Studies*.

AMH Children's Dosing Companion 2017 Release Available Now



The AMH Children's Dosing Companion is Australia's national independent dosing guide for prescribing and administering medicines to children from birth to 18 years with evidence-based, peer-reviewed and up-to-date information. The July 2017 release extends the number of monographs included to almost 400 drugs. Available now in print or online. Go to www.amh.net.au



VICTORIAN WOMEN ARE ENCOURAGED TO GET SWEATY IN A GLOBAL CAMPAIGN AIMED TO GET WOMEN MORE ACTIVE.



VICTORIAN WOMEN SIGN UP TO THIS GIRL CAN CAMPAIGN

It is the first time the Sport England campaign will be delivered outside of the UK which has seen 2.8 million more women get active over the past two years.

The Australian version of the **This Girl Can** campaign will showcase real local women giving it a go and getting active regardless of their fitness level, ability or how they look.

Health promotion foundation VicHealth which launched the campaign last month has called for Victorian women to share their story and be part of the global **This Girl Can** movement to help others overcome the fear of judgement they experience that stops them from participating in physical activity.

VicHealth CEO Jerril Rechter said unpublished VicHealth data found fear of judgement and intimidation were key factors holding women back from getting active. More than 41% of women surveyed identified as feeling too embarrassed to exercise in public.

"Concerns about how they look when they exercise, that they aren't skilled enough to exercise or that they should be prioritising their family or work over activities, are real obstacles many women face when starting a sport or exercise program."

In Australia and Victoria, women were less active than men throughout their life, which was particularly evident in women with children, Ms Rechter 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."

Whether it's in the gym, a team sport or a solo run, the campaign wants to hear from local women.

"We're calling for Victorian women to share their story and be part of this ground-breaking campaign which is all about women inspiring other women to get active," Ms Rechter said.



Women can submit their stories at www.thisgirlcan.com.au or by visiting the mobile story pod which will be touring Victoria for the rest of 2017.

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NEW ROYAL ADELAIDE HOSPITAL (RAH) OPENS DOORS

South Australia's much-anticipated new \$2.3 billion Royal Adelaide Hospital (RAH) kicked off by treating a kidney transplant recipient in August in the lead-up to officially opening its doors to the general public earlier this month. The state-of-the-art 800-bed hospital is poised to provide a comprehensive range of complex clinical care to an estimated 85,000 inpatients and 400,000 outpatients every year.

Transformed into one of Australia's most advanced healthcare facilities over the past decade, the state's flagship hospital spans the equivalent of three city blocks and boasts innovative design and cutting-edge technology that will help bolster aims to improve health outcomes.

Some of the contemporary hospital's key features include 700 overnight beds, a 40-bed mental health unit, 40 technical suites and a 25% increase in the capacity to treat emergencies.

History was made last month when 51-year-old Paul Panos became the first patient to be treated at the hospital.

Mr Panos, who received a donor kidney from his mother six years ago, headed into



the hospital for a regular check-up.

He was swiftly followed by over 150 patients throughout last month as the new RAH attempted to find its feet.

The hospital chose to launch gradually last month by opening a small number of renal outpatient and radiation oncology services in a bid to allow some staff to settle into their new working environment alongside smaller levels of activity and low-risk patients.

SA Health Minister Jack Snelling said seeing the hospital finally come to fruition was a major step forward for the state's healthcare services. "As of today South Australians like Paul are able to start having their appointments and treatment in this magnificent facility which will service the

South Australian community for decades to come."

About 2,000 nursing staff have been preparing to make the transition to the new RAH for several years.

As the hospital's opening date has loomed closer, the ANMF (SA Branch) has continued to collaborate with SA Health and the Central Adelaide Local Health Network to iron out issues relating to models of care and staffing arrangements.

"Ensuring appropriate care for patients and safe working conditions for members remains at the forefront of our role and it is what we will continue to do up to and beyond September," ANMF (SA Branch) Secretary, Adj Associate Professor Elizabeth Dabars said.

NATIONAL REAL-TIME PRESCRIPTION MONITORING TO PREVENT MISUSE AND DEATHS

Health and consumer groups have welcomed the federal government's announcement for national rollout of real-time monitoring of prescription medication.

The federal government will invest more than \$16 million on The Real Time Prescription Monitoring system.

The System will alert prescribers and pharmacists if patients receive multiple supplies of prescription-only medications. The aim is to target misuse and harm by

doctor shopping and script forgery.

"With this injection of funding – and close collaboration with states and territories – we have the means to provide a nationally consistent, mandated system for real time monitoring of controlled drugs," Federal Health Minister Greg Hunt said.

Tasmania has already introduced real-time monitoring of prescribed drugs while NSW is in the process of implementation.

Legislation was introduced to the Victorian Parliament last month to enable the system to be rolled out from next year. The Victorian Bill provides doctors, nurse practitioners and pharmacists, access to a system that will review prescription histories of patients in their care.

The Bill makes it mandatory for prescribers and pharmacists to check the system before writing or dispensing a prescription for a high-risk medicine.

"Our legislation will allow Victoria to implement the most comprehensive real-time prescription monitoring system

in Australia," Victorian Health Minister Jill Hennessy said.

The system will monitor all Schedule 8 medicines such as morphine and oxycodone, with the highest risk of misuse; and monitor other high-risk medicines, including benzodiazepines.

There were 372 overdose deaths involving prescription drugs in Victoria in 2016 – higher than the number of deaths on Victorian roads.

The AMA and Pharmacy Guild of Australia have repeatedly called for real-time prescription monitoring.

Pharmacy Guild of Australia Victorian Branch President Anthony Tassone said recommendations for a real-time prescription monitoring system had been the subject of 21 coronial findings since 2012.

"Whilst a real time prescription monitoring [system] will go a long way to identify patients who may unfortunately have a drug dependency or drug misuse concern, it's vital that there are appropriately funded drug addiction and counselling services to refer patients."

NEWLY ENDORSED NURSE PRACTITIONER BOOSTS EXPERT IMMUNISATION SERVICE

A Victorian nurse has become just the third nurse in Australia to attain endorsement as a nurse practitioner (NP) in the field of immunisation.

Recently endorsed NP Sonja Elia has worked at the Royal Children's Hospital in Melbourne for more than two decades, spending much of her time as part of its dedicated immunisation team.

"Essentially it's a drop-in centre," Sonja explained.

"So families attend the immunisation clinic and are opportunistically immunised while they're either in hospital for an appointment or they're a sibling of a patient or anyone who just visits the hospital."

Sonja leads a team of around eight staff at the service, which also offers a telephone advice line to GPs, parents and the community seeking information on immunisation or the latest vaccines.

A few years ago, Sonja decided to extend her scope of practice by pursuing a master's degree in advanced practice nursing in order to qualify as an NP and be able to prescribe vaccines without the

reliance on doctors.

One recent example involved Meningococcal B, a highly sought after vaccine, where nurses at the unit were forced to refer families back to their GPs in order to obtain a script. "I could really see a deficit in what we were doing in our day-to-day work," Sonja recalled.

"It just seemed like I could take them [patients] so far and then have to hand them over to my medical colleagues."

With her new autonomy, Sonja can now offer special risk vaccines to patients including Meningococcal ACYW, Hepatitis A and Meningococcal B.

She claims to have already seen a significant uptake in immunisation rates for Meningococcal B since her commencement as an NP and believes the streamlining will progressively lead to better outcomes and care.

"We are the experts. We are the immunisation service at the Royal Children's Hospital. GPs call on us for advice and expertise and now we can really close the loop and make sure that kids will get the vaccine and get protected against the disease more timely."

As a nurse working in immunisation, Sonja said the constantly changing vaccine schedule creates continual challenges yet also offers nurses the chance to utilise their gamut of skills in educating families, sharing knowledge and making accurate clinical decisions.

Sonja suggested the rise in new diseases, for example, Meningococcal W, illustrated why a specialist immunisation service is crucial. "Immunisation concerns have always been the same, they haven't really changed, and the rate of non-immunisers has always stayed the same, around 3%. But what we are seeing is the schedule's become a little bit more complicated. We've introduced more new vaccines that have all these different rules and regulations around how we give them."



"WE ARE THE EXPERTS. WE ARE THE IMMUNISATION SERVICE AT THE ROYAL CHILDREN'S HOSPITAL. GPs CALL ON US FOR ADVICE AND EXPERTISE AND NOW WE CAN REALLY CLOSE THE LOOP AND MAKE SURE THAT KIDS WILL GET THE VACCINE AND GET PROTECTED AGAINST THE DISEASE MORE TIMELY."



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MENTAL HEALTH NURSING NEEDS TIMELY REBOOT

Mental health nursing must look itself in the mirror and rediscover the importance of compassion and person-centred care or risk further disenfranchising people experiencing mental illness trying to access help, according to UniSA's Professor in mental health Nicholas Procter.

Speaking at last month's ANMF (SA Branch) Annual Professional Conference, Professor Procter argued mental health nursing was in danger of becoming oversimplified and required a "refresh" in order to encourage better therapeutic engagement and defined personal recovery plans. "I think there's a great danger of an over-simplification of mental health care.

"People with complex mental illness, together with their families, experience remarkable and debilitating stigma, marginalisation, and disenfranchisement."

Professor Procter said recent high-profile national incidents framed around mental healthcare had thrust the speciality into the spotlight.

Drawing on South Australia's Oakden scandal, which involved the systemic mistreatment of elderly residents at an aged care facility, as well as the equally confronting death of a woman at Lismore Base Hospital after she was placed in seclusion, then hit her head on walls and fell at least 20 times, Professor Procter said both stories demonstrated a breakdown in quality care and how, in some pockets, mental health nursing must change.

"Human connections have been lost. Staff, consumers and families have been traumatised. And there's a distinct failure of personal recovery."

Professor Procter suggested an undue focus on beds and metrics had deviated the focus away from person-centred care.

Similarly, he claimed the National Disability Insurance Scheme (NDIS) was inherently flawed and does not foster therapeutic relationships but simply transactions and therefore contributes to the growing uberfication of healthcare and potential for greater alienation.

For example, Professor Procter said mental illness was on the rise but a large cohort, whom he dubs "the missing middle", is falling through the cracks.

"Mental health nursing provides a platform for people with mental illness,

PROFESSOR NICHOLAS PROCTER



with their families, to experience person-centred care. This missing middle are people who exist in our society who are not quite acutely unwell to be in hospital in traditional inpatient settings, and are too complex for primary care."

"PEOPLE WITH COMPLEX MENTAL ILLNESS, TOGETHER WITH THEIR FAMILIES, EXPERIENCE REMARKABLE AND DEBILITATING STIGMA, MARGINALISATION, AND DISENFRANCHISEMENT."

Professor Procter flagged trauma informed practice, which acknowledges how adverse childhood experiences and events have increased the likelihood of adult mental health outcomes, as an important strategy that should be more widely utilised. "Trauma informed practice really says the events and experiences that you've had and the way that you respond now in your adult life are really coping mechanisms.

"So the question changes in trauma informed practice from one of what is wrong with you to what has happened to you?"

Professor Procter said mental health

nursing needs to rediscover its ideals around compassion and invest in collaborative partnerships in order to evolve. He pointed to positive innovations in South Australia that have facilitated critical shared learning opportunities as an example of what can be achieved.

Established almost a decade ago, Shared Learning in Clinical Practice holds regular symposiums that dissect mental healthcare across the state with a focus on frontline practitioners and the consumer experience.

"This is about information exchange. This is about building capacity. This is about having discussions and debates and sometimes those debates don't ask questions they punch questions at each other."

Professor Procter said the incidents that occurred at Oakden and Lismore Base Hospital do not define mental health nursing and don't reflect the sector's attitude to how care should be delivered.

He believes powerful change can occur through inward critical assessment of the specialty and its delivery of care. "If we join together it's because we want things to be different. If we want things to be different we need to let go of old governance structures. We need to let go of the use of seclusion and restraint practices. We need to let go of how we might perceive ourselves."

WOMEN'S HEALTH WEEK: YOUR HEALTH A PRIORITY



Women's Health Week (WHW) 2017 is about women making their health a priority.

More than 40,000 women are signed up to take part in over 1,000 events nationwide during 4-8 September.

Results of a nationwide survey of more than 10,000 women on mental health and anxiety, physical activity, and sleep and fatigue will be released just prior to WHW.

Last year's Jean Hailes national survey found the two biggest barriers for women not maintaining a healthy lifestyle were lack of time and health not being a priority.

"If we think of the safety instructions on an aircraft – to put your own oxygen mask on before helping others. If you're not looking after yourself, eventually those around you will also be impacted," Jean Hailes Executive Director Janet Michelmores said.

"Women's Health Week is about setting aside some time in our busy lives to think or talk about health issues, and possibly think about ways you can make a few positive changes."

It is the fifth Jean Hailes for Women's Health annual WHW which started in 2013. In 2016, a record 23,000 participants took part – more than double the previous year's number – in 620 events held around the country.

WHW events include from health and wellness checks to afternoon teas, bike rides and movie screenings.

"They can get together with friends and share a cooking class or join a bike ride – it's whatever they want to make of it," Ms Michelmores said. "By investing more time in ourselves, we're better able to look after the ones we love and care about."

Women can sign up to receive a daily email or host or attend an event in their area. For more information, visit www.womenshealthweek.com.au

MENTAL HEALTH DASHBOARD INDICATES ENGINE PROBLEMS



A digital public health initiative to assess Australians' mental health found significantly higher rates of depression and anxiety than current Australian Bureau of Statistics data.

Survey participants of *Australia's Biggest Mental Health Check-in* were significantly more likely to experience depression if they reported high levels of perfectionism, poor sleep, low trust and social withdrawal as a coping mechanism.

The digital public health initiative involved more than 3,100 Australian and New Zealand participants aged 18-89, over two four week-long campaigns.

A digital wearing device worn by survey participants to assess for mental health issues found 39% had depression while another 37% met the criteria for anxiety disorders.

Nine in 10 study participants who showed symptoms of a severe mental health illness had either not undergone, or were not receiving any, treatment.

Psychologist and inventor of the **Check-in** Peta Slocombe (pictured) said about 30% of study participants assessed with mental health issues with the technology were unaware.

"Most people are like a frog in warm water. They have a tough shift or difficult day which rolls into a week, then a month and becomes the normal state of play. People with mental health symptoms do not wake up with a swollen eye or rash that alerts them that there's an issue – it's slow warming."

People did not perceive mental health in the same way as they did a physical illness and most commonly only addressed issues when they became unavoidable, Ms Slocombe said. This included poor sleep, decreased resilience, higher expectations and perfectionism coupled with lower self-awareness.

Generation Z (18-24 years) recorded the highest incidence of depression, anxiety and

sleep disturbance, and shared the lowest scores of all age categories on trust.

Generation Y (25-35 years) were the next most likely to have a mental health illness; while Generation X (45-54 years) were the least likely.

The **Check-in** technology was designed to make it cheaper, faster and more efficient for people to undertake a mental health check, Ms Slocombe said.

Participants completed an online, subjective measurement of their mental health, and used the wearable technology to assess a dashboard score of their mental wellness.



"By arming people with accurate information and appropriate treatment and support, they can effectively and efficiently get their lives back on track," Ms Slocombe said.

The **Check-in** reinforced the need for earlier intervention in mental health, earlier markers in diagnosis, and more accessible screening programs to help reduce the incidence of mental illness, she said.

"Our results reveal high variability in the traditional identification and management of people living with mental illnesses and mount a strong argument for change, if we are to turn the tide on what has become the planet's single biggest disease."

LOOMING SA ELECTION SPARKS HEALTH PROMISES

The South Australian government will form a joint working party with the ANMF (SA Branch) to evaluate the potential to establish nurse-led primary and urgent care services within the state.

SOUTH AUSTRALIAN HEALTH MINISTER JACK SNELLING.
PHOTO: GREG ADAMS



SA Health Minister Jack Snelling delivered the announcement at last month's ANMF (SA Branch) Annual Professional Conference as several state politicians were placed under the microscope and asked to unveil their vision for health ahead of next year's March state election.

During his address, Mr Snelling guaranteed the Labor Party would protect penalty rates and ensure public hospitals dodge privatisation.

He trumpeted Labor's track record of investing in health infrastructure, citing the recently opened new Royal Adelaide Hospital and ongoing redevelopments to the Queen Elizabeth Hospital, while lauding nurses for their dedication and commitment.

"When it comes to creating an efficient health system, buildings and beds and budgets are vital considerations," Mr Snelling said. "But we should never forget that ultimately this is a human service we're providing and the quality of health professionals is crucial."

Significantly, Mr Snelling insisted nurses and midwives deserve the opportunity to broaden their skills and work to higher levels, pledging his support for the professions working to their full scope of practice and pursuing advanced practice roles.

Labelling health a complex area, Mr Snelling forewarned the system was likely to face increasing pressures in coming years and that it is imperative to plan for the future.

"We must understand that our health system is by no means unimprovable. We must accept that current pressures on budgets and pressures created by an increase in patient demand are likely to become only more acute."

The ANMF (SA Branch) recently released its own Health Policy Position

Statement outlining chief issues concerning nursing and midwifery that it hopes political parties will rally behind and commit to in the forthcoming election.

The union's leading issues surround safeguarding funding for the state's health system, enabling nurses and midwives to work to their full scope, rebuilding nursing and midwifery leadership of clinical practice and clinical governance, and ensuring meaningful workforce planning takes place in order to cater for future demand in services.

"WE MUST UNDERSTAND THAT OUR HEALTH SYSTEM IS BY NO MEANS UNIMPROVABLE. WE MUST ACCEPT THAT CURRENT PRESSURES ON BUDGETS AND PRESSURES CREATED BY AN INCREASE IN PATIENT DEMAND ARE LIKELY TO BECOME ONLY MORE ACUTE."

Other notable appeals involve better supporting public hospitals and emergency care, establishing nurse-led primary care and urgent care services, backing voluntary euthanasia laws, and acting on climate change.

In his statement to delegates, opposition health spokesman Stephen Wade drew attention to clinical governance, suggesting recent bumbles including South Australian cancer patients at the Royal Adelaide Hospital and Flinders Medical Centre being given the incorrect frequency in doses of a chemotherapy drug, illustrated shortcomings in clinical governance.

Echoing the ANMF (SA Branch) Health

Policy Position Statement, Mr Wade said strengthening clinical governance was crucial.

"Fundamentally, clinical governance will be delivered by clinicians. But it must be supported. Clearly, management and politicians need to ensure hospitals and health services have sufficient resources. They need the right number and the right mix of staff to deliver quality and safe care."

Mr Wade conceded workforce planning had fallen off the radar in recent years and needed urgent addressing to ensure the future of the next generation of nurses and midwives.

Admitting the Liberal Party had historically lacked substantial health policies, Mr Wade claimed the state's health system was "at a crossroads" and that his team would trigger reform by fleshing out a system-wide health reform agenda in coming months fundamentally different than Labor's problematic Transforming Health.

Lastly, Greens MP Tammy Franks shone the spotlight on Indigenous health, declaring the party would continue to attempt to repair a history of inadequate healthcare.

Ms Franks said the Greens' health policy was typified by access to quality healthcare being a basic human right and acknowledging the importance of how social determinants shape health outcomes.

She said primary healthcare initiatives were crucial and that consumers should hold the right to help determine the delivery of services.

Ms Franks raised several of the Greens' key platforms, calling the resistance to medical cannabis in Australia "an offence" and backing voluntary euthanasia so terminally ill people can die with dignity.

She also declared the Greens would protect penalty rates and stand up for workers' compensation rights.

HELPING PEOPLE WITH MENTAL HEALTH ISSUES ON THE CANARY ISLANDS

By Rasa Kabaila

On a recent trip to the Canary Islands I volunteered at a centre that runs programs for people with mental health issues.

The centre, known as 'El Cribó', is based on one of the islands called Lanzarote.

El Cribó's ethos is to provide different occupational workshops that allow clients to develop skills which give them the highest degree of autonomy possible. This also includes normalisation and integration within their social and family context. Based on this ethos these programs have had highly successful therapeutic outcomes.

At El Cribó the aim is to reduce the stigma of mental health issues in the community and promote awareness. El Cribó does this by giving the clients at the centre every opportunity to participate within their local community including many community events, such as the El Cribó band participating in Carnival each year.

El Cribó provides many activities for clients to pick from which are run co-currently every day. A few of the activities that are run include: gardening, floristry, graphic design, conversation group about sexuality and relationships, meal planning and healthy eating group, music group, sports' group, debating group, conversation group about budgeting and cleaning. Numerous excursions include cycling, trips to the beach, fundraiser nights and karaoke and psycho education groups.

Many of the staff have worked at El Cribó for over 10 years and still maintain the same enthusiasm as when they first started. All of the clients who attend the groups have a good rapport with staff and continuously state how helpful El Cribó has

been for them by giving meaning in their life, learning new skills, having routine, motivation, receiving support and feeling like a part of a family.

The people of El Cribó believe it is the day program activities that really help them to stay well and happy, more so than medication and seeing the doctor. While not dismissing the value of health professionals or medicine, it is evident that these kinds of activities are equally as important in

greenhouse group. El Cribó owns a greenhouse where all of the plants and produce are grown by the clients. I helped harvest and prepare organic tea. The tea is offered to the community in return for donations, which creates ongoing and long term rewards for the people of El Cribó.

There are many benefits of gardening for the clients such as giving a sense of responsibility that allows them to be nurturers. Gardening also keeps clients connected to other living things; it is a mindful activity, and it is a form of exercise that releases 'happy hormones'.

Additionally, gardening gives clients a chance to be outdoors and amongst nature and take in some vitamin D from the sun.

Through all the activities that are provided the clients have become proficient in so many ways that have helped them grow, practically and creatively.


But without a doubt El Cribó would benefit from more funding as public resources are scarce and many expenses are not included in the subsidies.

More money is needed to help clients with greater needs, to improve program functionality and improve the decor, such as furniture – the chairs are very deteriorated. El Cribó could also be better equipped with a small kitchen and some of the computers also need updating.

I've felt so honoured to be

part of El Cribó; it's such a wonderful place. If you would like to donate to El Cribó or volunteer, please contact the ANMJ for my details to discuss opportunities.

For more information about El Cribó go to: <http://elcribo.org/>

 Rasa Kabaila is a Mental Health Nurse from the ACT

Artwork at El Cribó



mental health recovery.

One of the activities I sat in on was a graphic design class where the clients were learning detailed orientation and map making. Previous students' work in the class included computer designed Christmas cards and self-portraits.

While I was there to help facilitate the group, the clients were helping me by teaching graphic design skills.

My favourite group was the garden/

FACING LIFE HEAD ON

By Natalie Dragon

"I am an ordinary person who has had some extraordinary experiences," says humanitarian, emergency nurse and paramedic Helen Zahos.

In 17 years of nursing, Helen has nursed post events such as the Bali Bombing, floods, cyclones, and typhoons. She has joined numerous international responses from the Philippines and Nepal to Syria and Iraq.

Helen grew up on Groote Eylandt in the Gulf of Carpentaria. "Going back to a little girl, I was always bandaging stuff up and I was a girl guide. So I knew from a young age I would be helping people in some way – I just didn't know it would be in nursing and as a paramedic."

Helen says she has always faced challenges head on, including getting a pet children's python called Demetri because she was petrified of snakes. "I thought: 'How can I get over this? Perhaps by watching how they behave.'"

Similarly, she took up scuba diving to tackle a fear of crocodiles and sharks instilled from living on Groote Eylandt. "I thought maybe if I can just see what's happening under the water."

Fear holds people back and gets them stuck, Helen says. "You need to go out and give it a go or you'll never know."

"I SPEAK GREEK AND SO I WAS WITH MUMS IDENTIFYING THEIR BABIES WHO HAD DROWNED IN THE MORGUE"

Helen Zahos

As a student nurse, Helen took on a first aid course and ended up doing studies in paramedicine on the weekend. "It was another side to emergency healthcare and it was hands on." It was this that landed her the first graduate position in the ED at Royal Darwin Hospital. "I was in the elevator as a paramedic with a patient, with the coordinator for student nurses. On my way up she said to me 'you are one of our students. You can obviously handle blood and guts and cope with stressful situations'. It was literally an elevator ride that got me on my way. My whole career I have been absolutely lucky at the time."

Helen worked remote area nursing, including a stint in the APY Lands where Gayle Woodward was murdered. She herself was attacked in an incident with an axe.

"I took time off I was pretty traumatised. I felt disappointed that I didn't jump up and down a bit more for change. But at the time I was too traumatised. It shouldn't have come to the point where a nurse gets murdered to address nurse safety."

It's Helen's humanitarian and nursing work which has left indelible marks on her professionally and personally. She volunteered in Northern Greece, in a Syrian refugee camp last year. "Three months was very intensive with mass casualties. In Lesbos, I was there for a couple of weeks – there were 5,000 people a day. It was so hectic that UNHCR couldn't count them all."

A tragic boat tragedy ensued while Helen was there, in which 11 people died.

"I speak Greek and so I was with mums identifying their babies who had drowned in the morgue. It was so big yet the world didn't hear about it. We were crying out 'this is happening now. We do not have the resources.'"

"The difference between a cyclone or a typhoon is the whole world turns up to help. When there is a crisis due to war or conflict no one wants to be involved."

Helen says such was the desperation of people fleeing for their lives that even NATO warships sitting in the water did not deter people coming. "Those life jackets cost 700 euros. People had been out for weeks on end exposed to the elements. You see a lot of traumatised people in the camps."

Helen worked on Christmas Island at the Asylum Seeker Detention Centre in 2013.

"I had the pleasure of meeting the most beautiful people – women and children."

She describes the experience as deeply disturbing. "There were kids waiting at the fence, calling you 'officer'. It was really hard to see the little ones drawing pictures for you. We would ask them to write their names on their pictures to put them up on the wall and they would write their boat numbers. These children were in our care – this is their



welcome to Australia."

Helen is often contacted by other nurses seeking similar experiences. "This did not happen overnight. But still I say 'wow' I've ticked all my boxes."

"I say to the girls who have got their skills up and are comfortable to travel, I highly recommend it, particularly the smaller hospitals around Australia where there is amazing teamwork where people really pull together and you are very much part of the community."

Helen says nurses don't have to volunteer overseas for months on end, they can take time out while on holiday.

"There are smaller groups that will take you on. It's about putting it out there. Let people know, let organisations know that you want to help. Register online. If an event happens you are already processed, it's too late when an event happens."

Helen says she is passionate and proud to be a nurse. "Nursing is not just a career, it's a way of life. It's who you are."

Her advice to others is to be the 'best you can be'. "Challenge yourself. Take opportunities when you get them, do not let them go by. You may surprise yourself. Don't be scared to ask for help and equally admit when you don't know."

While skills such as quick thinking and compassion are handy, Helen says at the end of the day it's about the patients. "I'm not saying you have to be an activist, but you do have to be an advocate."

Helen currently works at the Gold Coast University Hospital in Emergency.



Megan-Jane Johnstone

IS NURSING ETHICS GOOD ENOUGH?

The field of nursing ethics has developed exponentially since the first article on the subject was published in 1889.

For well over a century nursing scholars have devoted considerable attention to developing and articulating: the ethical concepts, values and theories that are particular to the profession and practice of nursing; the relationship between nursing ethics and the various fundamental traditions in philosophical ethics; the integration of nursing ethics with nursing theory; and 'the extent to which the theoretical roots of nursing ethics inform the scope, implications, relative significance and authority of the nursing profession's moral values and standards in healthcare and society' (Johnstone 2015, p. xxiii). Whether this effort has resulted in 'good' nursing ethics, however, remains debatable.

A question of nursing ethics

As has been discussed previously in this column, there is a growing body of literature on the problem of nurses falling short of meeting the ethical conduct standards expected of them. In addition, research has shown that nurses tend to make moral decisions based on their own personal values, convictions and experiences rather than the profession's codified guidelines and standards of ethical conduct (Goethals et al. 2010). Given this, there is scope to question whether nursing ethics, as it stands today, is 'good'? And, if it is good, whether it is *good enough*? The short answer is: *not quite*.

The goal of nursing ethics

The ultimate goal of nursing ethics is to promote the wellbeing of patients through the delivery of *good nursing care*. Up until the early 1970s, nursing ethics was fundamentally concerned with the cultivation of moral character ('the virtues') in nurses. It was also concerned with cultivating in nurses a humane disposition ('promoting the good of humanity') coupled with a sense of civic duty and the expectation this duty would be fulfilled. The rise and development of contemporary bioethics in the 1970s, however, saw a radical shift away from this orientation and the adoption of a 'quandary-style' of ethics which was concerned primarily with exotic ethical problems and perplexities

that needed resolution (eg. abortion, euthanasia, genetics and reproductive technology) (Johnstone 2015b). As has been suggested elsewhere, this shift in moral orientation was not necessarily progressive and, in several respects, has been 'at the expense of a more holistic approach to the goals and purpose of nursing ethics and its capacity to guide the ethical practice of nursing care' (Johnstone 2015a, p. vii).

THE ULTIMATE GOAL OF NURSING ETHICS IS TO PROMOTE THE WELLBEING OF PATIENTS THROUGH THE DELIVERY OF GOOD NURSING CARE.

Good nursing ethics

Whether a given ethical system is 'good' or otherwise is ultimately determined by its outcomes ie. whether it has fulfilled the task(s) it was set and achieved its desired moral ends.

The task of contemporary nursing ethics has primarily been to: cultivate the moral character of nurses; provide nurses with a moral compass to help them successfully navigate the moral terrains of their everyday practice; and to develop in nurses the capacity to articulate clearly the ethical issues they encounter in health care contexts *as well as* to provide robust reasons and sound justifications for their decisions and actions. Nursing ethics has also sought to emphasise the importance of moral leadership in nursing apropos identifying, confronting and remedying behaviours in nursing and healthcare contexts that are morally unacceptable.

Despite the tremendous work and progress in moral thinking that has occurred over the past century, there are indications that nursing ethics has perhaps failed at its most basic tasks: the moral character of nurses is being increasingly called into question (eg. see literature on bullying, academic dishonesty, uncaring attitudes, and other questionable behaviours in the workplace); nurses are either unaware of or ignore the codes of ethics that have been ratified by their respective national nursing organisations; and nurses are far too easily swayed by public opinion, dogmatic moralising, and high-sounding rhetoric rather than reasoned argument when it comes to taking a stand on controversial ethical issues.

Equally worrying is the propensity

by nurses writing on the subject of nursing ethics to take a 'tick box principlism' approach to their work. On account of being theoretically deficient, this approach is not only misguided but seriously risks misleading nurses down the path of moral error.

The future

Nurses are living in a time when old certainties are shifting and where identifying the 'right' position to take on given moral issues has become increasingly difficult. Deciding a right course of action can be especially difficult in contexts where a clear-eyed view of the world is muddled by populist opinion and personal dogma masquerading as 'fact'. In this new era of shameless populism, 'fake news', and post-truth politics, it is perhaps time for the nursing profession to bring a new scrutiny to its system of ethics and its ability to equip nurses with the capacities they need to achieve the moral ends of nursing – particularly in contexts where the health security of people is being threatened by ideologically driven public policy.

Nursing ethics, as originally conceptualised, was not concerned with preventing or resolving moral dilemmas or distress. Neither was it concerned with trying to settle negative emotions or unresolved moral regret. Rather it was about cultivating the moral character of nurses and, with it, their capacity to uphold the values of virtuous conduct and, equally important, to *judge* which values to uphold and how to apply them effectively in practice. All things considered, it is perhaps here—the basics of what constitutes 'good' moral character—that the scrutiny of contemporary nursing ethics ought to begin. What is also required is a renewed moral discussion on the future content and direction of nursing ethics and what is really needed to enable nurses to meet the challenges and opportunities of the future.

Megan-Jane Johnstone is a retired Professor of Nursing who now writes as an independent scholar. Internationally renowned for her work, she has published extensively on the subject of nursing ethics and is the author of the widely acclaimed book *Bioethics: A Nursing Perspective*.



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THE ANMF BIENNIAL NATIONAL CONFERENCE

BE INSPIRED

The Australian Nursing and Midwifery Federation will be holding its 13th Biennial National Conference in Hobart next month. What does the conference entail and why is it important to nurses and midwives across the country? **Natalie Dragon** investigates.

Angela Manion says she was awestruck at her first ANMF Biennial National Conference in Adelaide in 2001.

"I had just been employed as an organiser and went as an observer to get more of an idea of the running of biennials and what they entail.

"It was a real eye-opener. There were these really strong-minded informative people who were very passionate. I was a clinical hands-on nurse who had no prior exposure to these nurse leaders who were so impressive. I really enjoyed the whole experience."

The national forum is a great opportunity to network with others and discuss the issues, says Ms Manion, an ANMF Tasmanian Branch workplace representative and former Branch Councillor. "Considering every state and territory is different in the workplace there are often the same issues and it's encouraging and informative to discuss these with like-minded people."

"I have seen resolutions put forward and debated – some contentious with people getting their views across in discussions and amendments taken very seriously – which then guide the federal activities for a while."

Delegates are encouraged to go to gain information but also to have a voice, she says. "Some of the issues do not necessarily affect us but they may in the future. Our Branch Secretary says 'We don't go with no opinion'. Even if we know nothing or relatively little about an issue we are encouraged to find out.

"At the national dels' conference in Brisbane there was a resolution on immunisation. Whether three vaccines should be given together or separated out – I don't work in that area and didn't know. There are environmental issues that I'm not all over, such as fracking. You really have to find out and go with your opinion – not to abstain."

Ms Manion is passionate about

workloads and safe staffing. "In my 18 years of nursing it has improved 100% but it still needs to be addressed. People are thrown into the deep end. People are still put into situations which are not particularly safe for anybody. In our hospital we have had grievances about workloads.

"Other professions do not have to miss their breaks or go home half an hour later than they should. Yes, it happens on shifts but it shouldn't be the standard.

"CONSIDERING EVERY STATE AND TERRITORY IS DIFFERENT IN THE WORKPLACE THERE ARE OFTEN THE SAME ISSUES AND IT'S ENCOURAGING AND INFORMATIVE TO DISCUSS THESE WITH LIKE-MINDED PEOPLE."

"It's something I am passionate about – making sure people get what they are entitled to, what their rights are and to have a good experience as a nurse. I had a really great experience early on in my career, it was busy but I was around positive, inspiring nurses. I want everyone to have that experience."

Unity

The Australian Nursing and Midwifery Federation (ANMF) is Australia's largest union with over 259,000 nurses who are members of the union in one of the eight Branches established in each state and territory.

The ANMF Biennial National Conference brings together nominated delegates from each Branch in a forum for consideration and debate on matters of national policy, ANMF Federal Secretary Lee Thomas says.

"It helps to inspire and create enthusiasm amongst members. Whilst it's not a policy making body as such, it does help set the future direction for the ANMF Federal Executive on the issues that matter to members the most."

Similar to state and territory ANMF Branch conferences, delegates present, discuss and debate resolutions on industrial, professional, political and social justice issues. The motions usually relate to national matters but can be state based, particularly if a Branch is seeking national support on an issue.

"We are generally all on the same page at the biennial national," says ANMF Federal President and QNMF President Sally-Anne Jones. "The biennial national feels different than the state dels'. It's more of the vision of the ANMF as a whole – uniting branches and the whole country on federal issues.

"It's not so much about pay entitlements but the plight of workers in aged care and the community care sectors. Not so much about our night shift penalty rates but getting nurses to the bedside in aged care."

It's a "magical opportunity" every two years, says Ms Jones. "Nurses and midwives need to be inspired, away from the day to day drudgery and the challenges of doing union work which are not clear when you are having a bad day on the ward. Nurses and midwives need those messages that give them goosebumps – something that inspires.

"I think it gives Branch officials the opportunity to get together – the true rank and file nurses who are councillors, frontline nurses and midwives who get a chance to get together in their elected positions."

It's the only opportunity where workplace delegates get together nationally to discuss things of importance to them and to represent their state and territory branches, ANMF Senior Federal Industrial Officer Nick Blake says.

"Industrially I think the bulk of the delegates work in hospitals but the issues

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The Federal Office coordinates the activities of the Branches in response to national issues of importance to nurses. The Branches respond to issues at a State and Territory level and actively represent the industrial and professional interests of members at the local level. Motions presented at the biennial usually relate to national matters but can be state based, particularly if a Branch is seeking national support on an issue.

The ANMF's successful campaigns fought by the ANMF's Federal Office and State and Territory Branches include:

- Defeating the proposed GP co-payment
- Scrapping plans to triple university HECS fees
- Allowing Australian nurses to help in the Ebola crisis in West Africa
- Gaining commitments for mandated nurse to patient ratios in Victoria and Queensland
- Protecting penalty rates for nurses and midwives and AINs

are consistent across the whole of the profession – staffing levels, workloads, precarious employment and issues that arise from gender. It's a good opportunity to get together and debate and discuss those type of issues.

"While the delegates' conference is not a policy-binding forum it provides clear direction to the Branches and the federation about what the priorities the delegates see for the next two years.

"I don't think there has been a resolution passed that has been knocked back from Federal Executive. If there are contentious issues, they are usually sorted out on the floor."

Resolutions

Acting ANMF Tasmanian Branch President James Lloyd considers the resolutions the highlight at the Biennial National Conference.

"It really inspires me – the level of passion and debate. It is quite refreshing; it's really democratic. People agreeing and disagreeing and reaching common ground.

I found it really empowering. It made me see there is a united movement in nursing around Australia."

Mr Lloyd says he gets inspiration from other states. "How they are doing it, how things are worse or how things are better - even how they have done their campaigning, such as how they have done their posters. I am always inspired by posters.

"Queensland had a poster of a nurse in a traditional white uniform with her back turned saying: 'nurses are worth it'."

Mr Lloyd says his passion locally is safe staffing and graduate nurses – making sure hospitals are correctly and adequately staffed.

"We are trying to get nurse to patient ratios in Tasmania. In our last EBA we got the government to agree to nurse patient ratios and we are still working through final details. But in principle government has agreed."

He says the Biennial National Conference enables nurses and midwives to have a voice and to influence the direction of nursing. "I found it could really give me a voice, a lift up and really inspired me.

It's good to go and have your voice heard and hear the other voices and see that we are a lot of people having the same problems."

Mr Lloyd has been on the ANMF Tasmanian Branch Council for the past six years.

"I was at the stage in my life where I wanted to have a voice and wanted to start to affect change in my profession. Someone on Branch Council tapped me on the shoulder and said 'Branch Council will give you the voice that you want'.

"I think Branch Council does give me a voice and allows me to affect change in nursing in Tasmania. I cannot do that individually. I want to advocate for change for those at the coalface - what the reality is like for nurses at the bedside."

Networking

ANMF Federal Vice President Lori-anne

ANMF ASSISTANT FEDERAL
SECRETARY ANNIE BUTLER
PHOTO: GREG ADAMS



PHOTO: GREG ADAMS



PHOTO: ROB J WILLIAMS



PHOTO: ROB J WILLIAMS

Sharp says the Biennial National Conference is an opportunity to vet with interstate colleagues. "It's fantastic to learn about other issues and challenges for our state and territory comrades – from remote Australia to Tasmania. We get to share our experiences and knowledge – we get to reflect on our practices and problem-solving."

"As a Victorian nurse and member of the ANMF Victorian Branch Executive with a high density membership, it's important to be mindful of the issues of smaller Branches and the struggles they have in their workplaces."

As a team coordinator at the RDNS Homeless Program, Ms Sharp is passionate about social justice. "Equity in healthcare and that everyone has access to universal healthcare regardless of their circumstances – that everyone has the same lot."

Victoria's proposed Choices in Assisted Dying legislation will be topical at the national biennial with debate scheduled in state Parliament, says Ms Sharp. Open and supportive, she considers there are clear and concise guidelines to the legislation.

"I think it is a well-considered report with plenty of safeguards and targets those in extreme suffering with less than 12 months prognosis. I think when people are given a choice it empowers them and gives them the right to self-determination."

"It allows for nurses and doctors to have a conscientious objection if they do not want to partake. I think as nurses potentially we could be the leaders in this area."

"IT'S FANTASTIC TO LEARN ABOUT OTHER ISSUES AND CHALLENGES FOR OUR STATE AND TERRITORY COMRADES – FROM REMOTE AUSTRALIA TO TASMANIA. WE GET TO SHARE OUR EXPERIENCES AND KNOWLEDGE – WE GET TO REFLECT ON OUR PRACTICES AND PROBLEM-SOLVING."

Speakers

Member of the ANMF SA Branch Executive Lynn Croft says there are always top quality speakers at the Biennial National Conference.

"Really interesting speakers. You leave feeling re-energised and go back to work inspired talking to colleagues about local and national issues."

"There are often international speakers where we get to benchmark against where we are nationally. At the Biennial National

Conference it's a national agenda and it's always nice to throw a politician in there and get them on the spot – to talk about what their beliefs are and their political platform – all in good humour."

Campaigns

ANMF SA Branch Councillor and Executive Member Janice Clifford says the Biennial National Conference is a forum that inspires nurses and midwives to action in various campaigns.

"My passion is about nurse safety in the workplace together with safe staffing and skills mix on all shifts and we continue to fight for these goals."

"We all wanted to get on board the 'Strike Train' when Brett Holmes told us of their EB campaign – such a powerful and well organised event."

Members had enthusiastically participated in events at Biennial National Conference, says Ms Clifford. "Such as the rally in Brisbane to protest about unheralded staff cuts, the 'Because We Care' campaign in Sydney in our t-shirts we greeted the Minister for Ageing, and Adelaide last biennial where we stood behind a banner about asylum seekers saying we shall not be silenced."

Power of the movement

Vice-President of the ANMF ACT Branch and former workplace delegate Shane



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Carter says the last national biennial in 2015 was particularly memorable with the plight of refugees and asylum seekers exposed. The gag orders on healthcare workers who cared for those on Christmas and Manus Islands were highlighted by international human rights lawyers.

"The gag orders just went against everything I stand for as a nurse. There are mandatory reporting requirements for neglect that we are required to report yet the federal government's gag orders on reporting abuses on Manus Island flew in the face of that.

"It really highlighted for me what nursing is all about. Not too many nurses were not prepared to go to jail for it. It shows a movement can overturn government policy."

Mr Carter says he believes strongly in the union movement and workplace safety.

"I am a mental health nurse and unfortunately it is part of the job and it shouldn't be. There is exposure to occupational violence and aggression on a daily basis. Unfortunately it's across the board in nursing and nationwide the levels of assault on nurses is very high.

"I have been off work three times injured and seen some of my co-workers never come back. The bottom line is I don't like seeing my friends getting hurt – that upsets me."

Zero tolerance to violence, staffing ratios,

and insecure work are all key issues for the profession, he says.

"The nurse to patient ratios campaign 'ratios save lives' is important. We know the statistics – the more patients we look after going over a certain ratio, the greater the chances of increased adverse events and it costs more than to put on an extra nurse."

Aged care

This year's hot issue will be what's happening in the aged care space, says ANMF Federal President Sally-Anne Jones.

"For me it's getting that third level of worker registered. In light of what's happening in the community and home care front, and sub-contracting of services to the lowest bidder. It does not guarantee quality; it's selling off who can provide services at the cheapest price."

It affects the profession as a whole, argues Ms Jones. "Not registering that third level worker undermines what they do which is nurse people. That's what they do – they feed people, dress them and care for them with the particular skill set of nursing."

The consequences of successive federal Budgets had been inadequate funding for aged care, she says.

"The ANMF is launching a massive campaign in the lead up to the federal election. I think many of the resolutions at

this year's biennial national will support the ANMF in lobbying government. It will give power to the ANMF – 'look at what our members are saying'."

ANMF Assistant Federal Secretary Annie Butler anticipates Federal Executive will get clear direction this year from members on aged care.

"One of the key issues is safe staffing which means safe staffing for everyone – nurses and midwives, AINs, carers, patients and residents in aged care facilities."

A key priority is that every vulnerable older person in Australia has access to safe quality care, says Ms Butler.

"We are getting more and more concerned with the lack of safe quality care in residential aged care particularly. We have been talking to delegates going around conferences, building a body of research looking at all aspects of what's needed to provide proper safe staffing to get quality care."

This year's biennial national includes a guest speaker, a demographer. "We are going to be looking at the Census last June 2016. We know the ageing population is an issue. The mantra is that we are getting older, living longer but longer with more disability. We want to know how we sit in Australia compared with other countries," says Ms Butler.

"We are going to put to a panel of



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federal politicians and ask them what they think is the answer to ensure safe and quality care in aged care."

ANMF Federal Vice President Lori-anne Sharp says nurses and midwives need to ensure aged care stays on the forefront of people's minds.

"We have heard some horrific stories in aged care. It often gets lost when people feel powerless. Give people roles – if they have a relative in aged care ask them to speak or write to their local MP, or ring up the radio station – get them to expose it and get it out there."

"If it's not in your micro-world you won't think about it. If one in 10 people get active that will have an impact. Talk about it in incidental conversations with people in the supermarket."

Leadership

Bringing about change requires leadership and action, says Ms Sharp. "I think as nurses we are natural leaders, well respected in the community, compassionate and hard-working."

"It's around finding that confidence to step up into those leadership roles. It's going to these forums where everyone is a nurse or midwife and where there are those leaders, and pushing yourself a little bit further each time."

It's about engaging with others and

stepping up to put their resolutions forward, Ms Sharp says.

"Everyone's voice is encouraged and supported. The national delegates' fosters an environment for new nurses and gives them an opportunity to see 'I can do this' and potentially be mentored by people who have been in the movement a bit longer to then move up and into those roles."

Getting involved

Victorian ANMF workplace representative Natalie Davis has been a job rep for just over 15 months. She signed up at an ANMF Victorian EBA statewide members meeting at Moonee Valley.

"In my hospital the ballot [to take protected action] was unsuccessful. I really thought that as a collective we could have done more. The person sitting next to me said 'you should be a job rep'. So I signed up not knowing what to expect."

"The last 15 months I have had training, been to the state dels' conference and now I am going to the national dels'."

"I am eager to see how people put forward resolutions and learn what the process is and how to do it. I am going to embrace this opportunity to become the best job rep I can be."

"I have always been one to stand up and have my say. I am very passionate if

something's not right and in supporting others in my workplace."

Together with a co-job rep and the ANMF, Natalie has dealt with OHS issues, and signed up people as members.

"Together with my co-job rep we recruited another two job reps and we have worked together to resolve eight of nine OHS issues in our workplace. Our ANMF membership is not 100%. Already myself and another job rep are looking at areas [in the workplace] where there are no job reps and looking at where we might recruit in those areas. We need to have more job reps to be really proactive in our workplace."

ANMF Tasmanian workplace rep Angela Manion says nurses and midwives should definitely get involved with their union.

"You get information that you do not know you need, until you need it. And the more you understand what your rights are. I get asked something every day about what we are entitled to and how to go about it. I know about the award, the State Services Act, meetings and procedures."

"Actively we are like a drop in the ocean by ourselves," says ANMF ACT Branch Vice President Shane Carter.

"To have a voice and be able to use it is so important. It's really important to join the union, for us to grow in strength and I think that's happening."

IMPROVING HIV RELATED BIOMARKERS IN COMPLEX INDIVIDUALS

By Kurt Andersson-Noorgard and Denise Cummins

Introduction/background

Adherence to treatment plans to manage disease can be difficult for many patients. This can result in inadequate treatment, treatment failure, increased costs and ongoing care issues.



THE RESULT OF POOR ADHERENCE IN HIV INFECTION CAN INCLUDE PROGRESSION OF THE DISEASE LEADING TO MULTIPLE HEALTH DISPARITIES INCLUDING COGNITIVE DECLINE, OTHER CHRONIC HEALTH PROBLEMS, PSYCHOSIS, DISABILITY AND EARLY DEATH (HERBERT ET AL. 2014).



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While this issue crosses disease processes and patient groups, adherence is particularly important when treating HIV infection. Poor adherence to medications in PLHIV (People living with HIV) can lead to resistance HIV developing, early death, and significant disability. This is particularly true for treatment for HIV where adherence to antiretrovirals is essential.

This article focuses on adherence to these medications but can be applied to all illnesses where adherence to medications or directions is crucial.

Overview of problem/issue

Adherence, the level at which a patient follows the recommendations of health professionals, is essential for improvement of many health conditions. Across many conditions poor adherence to medications, and attendance at review appointments averages 25% and can be as high as 50% (DiMatteo 2004).

Therefore regardless of the area of health we work in, adherence plays a major part in the outcomes of care provided.

Treatment adherence in HIV infection is particularly important.

While many HIV positive individuals do take medications at the required level for the infection to be managed as a chronic condition, there are smaller groups, many marginalised, who have difficulty with maintaining this level of adherence, including people living with mental illness (PLWMI) (Bogart et al. 2006), cognitive issues (Becker et al. 2011), substance abuse (Nicholas et al. 2014) or a combination of these. Working with these groups of marginalised individuals requires the development of ad hoc highly individualised practices (HIP) and 'not in the book' interventions to build trust and therapeutic relationship.

Risks to health in target group

The introduction of combination antiretroviral therapy (cART) has transformed the treatment of HIV from a life-threatening illness to a long-term condition (Crum et al. 2006). The benefits of cART though are determined by the person's ability to maintain high levels of adherence over a lifetime to achieve suppression viral load of HIV-1 RNA and to increase CD4 T cell lymphocytes (Bae et al. 2011). These biomarkers prevent further immune damage from the virus and reduce morbidity and mortality from HIV infection.

The result of poor adherence in HIV infection can include progression of the disease leading to multiple health disparities including cognitive

decline, other chronic health problems, psychosis, disability and early death (Herbert et al. 2014). Poor adherence also has the potential for disease progression (Johnson 2009) leading to multiple opportunistic infections such as cytomegalovirus and pneumonia which require intervention and inpatient admissions. The development of antiviral drug resistance (Maggiolo et al. 2007) from poor adherence, like antibiotic resistance, creates a risk for a resistant HIV to be transmitted, make treating the virus more difficult and eventual early death (Boussari et al. 2015).

WHILE MANY HIV POSITIVE INDIVIDUALS DO TAKE MEDICATIONS AT THE REQUIRED LEVEL FOR THE INFECTION TO BE MANAGED AS A CHRONIC CONDITION, THERE ARE SMALLER GROUPS, MANY MARGINALISED, WHO HAVE DIFFICULTY WITH MAINTAINING THIS LEVEL OF ADHERENCE, INCLUDING PEOPLE LIVING WITH MENTAL ILLNESS (PLWMI) (BOGART ET AL. 2006).

Taking any treatment at least daily for a lifetime is a challenge for even the most well organised and motivated patient with poorer long term adherence problems seen in those with a substance dependence including alcohol (Glass et al. 2010), mental illness (Joska et al. 2014) and neurocognitive disorders (Ettenhofer et al. 2009). The group targeted by and referred to this project had traditionally been poorly engaged with HIV services, missing multiple review appointments with various providers, had unstable housing, cognitive decline related to poor adherence to cART, and significant substance abuse issues.

Opportunities to address

By targeting these individuals with highly individualised care health gains can be achieved. These HIP are difficult to be systematised in any way but all had a basis of starting with the person's immediate needs and building trust. We do not believe that we are the only group who has had success in reaching, and improving adherence amongst this group of complex and marginalised individuals but when reviewing the literature it became apparent that the HIP are not often written of but are of value to

nurses to be aware of.

Project outline – aims/nursing interventions

The aim of the project was to find out whether care provided had an impact on health outcomes, in particular the CD4 and viral load levels of people with PLWHIV and cognitive issues, mental illness and/or a substance abuse issue. The project also wanted to explore the 'not in the book' activities undertaken to improve these markers.

An application to the SLHD Ethics Committee to access patient data, namely HIV viral load and CD4 cell counts, was approved for the period of 2014-2016 and a database without identifying information was created in the RedCap® program.

The HIV Nursing Specialist Services is situated within Sydney District Nursing Service which is part of Sydney Local Health District and is staffed by two clinical nurse consultants. One of these is a specialist in HIV and the other in HIV mental health, forming a dualist 'micro-team', able to redirect efforts quickly and on an individualised ad hoc basis; each also provides a different point of view.

Patients referred to the service are typically more complex, including those with multifaceted health problems related to HIV and with a serious mental illness (SMI), substance use or cognitive symptoms challenging medication adherence. While patients during the period were referred for other issues such as follow up after discharge from hospital, the participants in this project were all referred with the primary need being assistance with adherence of which the majority had not had an undetectable viral load nor a CD4 count in the normal range in the year prior to the interventions.

Along the way we realised that the interventions and practices we were doing were all very different but very similar in process. Mental illness, substance abuse and/or cognitive decline impact upon people's abilities to organise, plan and adhere to treatments. With this in mind traditional interventions for adherence were initiated. These included assistance with obtaining scripts 74% (14), having Webster packs made 58% (11), and attending medical reviews 84% (16). The more HIP interventions concentrated on engagement with our service and by extension of other services the person required.

Results

From the group of 24 we initially followed, three died in the period after showing marked improvement in their biomarkers at the first reviews



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Glass, Tracy R., Manuel Battegay, Matthias Cavassini, Sabina De Geest, Hansjakob Furrer, Pietro L. Vernazza, Bernard Hirschel, Enos Bernasconi, Martin Rickenbach, Huldrych F. Günthard, Heiner C. Bucher, and H. I. V. Cohort Study Swiss. 2010. Longitudinal analysis of patterns and predictors of changes in self-reported adherence to antiretroviral therapy: Swiss HIV Cohort Study. *Journal of acquired immune deficiency syndromes (1999)* 54 (2):197. doi: 10.1097/QAI.0b013e3181ca48bf.

Herbert, Sophie, Emily Chung, and Laura Waters. 2014. HIV Treatment. *Current Treatment Options in Infectious Diseases* 6 (3):271-293. doi: 10.1007/s40506-014-0023-3.

with other illnesses attributed to their deaths. A further two individuals were lost to follow up, leaving 19 people. Of the 19, 11% (2/19) were Aboriginal or Torres Strait Islander; 89% (17) were male, 5% (1) were female and 5% (1) were transgender. The average age was 47 years with a range of 21 years to 82 years with an average of 14 years infection with HIV.

The primary mental illness or cognitive disorder in the group were:

- depression 37% (7);
- schizophrenia 32% (6);
- anxiety 18% (3) and
- HIV Associated Neurocognitive Disorder 18% (3).

There was no substance abuse in 37% (7) though alcohol dependence was seen in 32% (6) and methylamphetamine (Ice) dependence in 32% (6).

Concerning physical health, all individuals had at least one comorbid condition including hepatitis C 32% (6) and cardiac disease 32% (6), with an average of 2.3 comorbid diagnosis and a range of one to nine diagnoses.

Seventy four per cent (14) had a detectable viral load with five (26%) having achieved an undetectable viral load in the last year prior to referral, this group were referred due to reporting difficulties with adherence.

After the varied interventions by the two clinical nurse consultants 84% (16) achieved a non-detectable viral load with the remaining three (16%) improving their viral load. An improvement in CD4 levels was seen in 84% (16) with a mean improvement of 81 CD4 cells per mml, no improvement was seen in 16% (3). An improvement in these two markers increase the ability of the immune system to protect the person from opportunistic infections.

To give an idea of the HIPs undertaken the following vignettes show the person centred care which is essential to develop a therapeutic relationship which can lead to improved medication adherence.

'TOM'

A 50 year old male living with schizophrenia was attending his treating clinic in a highly distressed state in an erratic manner making ongoing care difficult. He was not managed by any mental health service due to difficulty in locating him at any given time.

He was functionally homeless, resorting to living in a sex on premises sauna in central Sydney which greatly increased his risks of opportunistic infections.

After referral it was difficult to locate Tom and develop an ongoing relationship with him. Several weeks after referral sources reported he

would always be at a specific venue on a Friday afternoon or would be at a local fast food shop nearby. After a phone conversation he agreed to meet outside the venue or on the street outside the fast food shop. Meetings with Tom continued to occur at these locations for several weeks. Often he refused to go anywhere else but was happy to sit on the street and talk. The planned weekly meetings were achieved with Tom on nine out of 12 attempts. Over time a trusting relationship was built allowing for assistance with housing, linkage with a pharmacy to provide Webster packs and linkage to mental health services with a case manager allocated.

APPROACHES TO
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'JACK'

Jack is a young man who stayed up all night playing video games. He often failed to turn up for medical appointments and was inconsistent taking his medications. HIP interventions made included the playing of video games (even though the nurse was terrible at it). As the youngest member of the cohort Jack had over 10 years of detectable viral load and low CD4. Using the 'health packs' within the games helped him to compare it with his own use of antiretroviral medication. This was something he could relate to personally and Jack has now had an undetectable viral load and normal range CD4 cells for over two years.

'SUE'

Sue is a 56 year old woman who had many symptoms of cognitive decline. Her memory had deteriorated; she missed appointments, was unable to organise her finances, had a poor diet with weight loss and was not taking any medications. She loved to shop at charity shops, where she would frequently lose track of time. Consequently she was often not at home when visited for support.


Her CD4 count was less than 50 so she was susceptible to opportunistic infections. On one visit the nurse saw Sue at the bus stop. Sue had forgotten the nurse was coming and


did not want to go home for her consultation. Subsequently, the nurse took her to the shops so as to be able to talk to her along the way. The nurse then scheduled the next few appointments escorting her to the local charity shop to provide a nursing consultation on the run. Over time Sue was referred to several support services to improve her nutrition and she eventually agreed to go with the nurse to the doctor and recommence on her medications. She agreed to allow home visits to monitor and support adherence, with every few visits a drop off to the shops. Many notes were placed around her house and frequent reminder telephone calls were provided until she had an established routine. Eventually only home visits were provided as her cognitive symptoms improved due to medication adherence and improvements in CD4 counts.

Conclusion

Medication adherence is often challenging for all patients and for PLHIV it is essential to maintain health and wellbeing. Approaches to maintaining adherence need to be person centred, particularly for individuals from marginalised populations who may have alternative lifestyles and interests. Acknowledgement and acceptance of the person's circumstances can lead to non-judgemental, highly individualised practices to help maintain adherence.

We would like to stress that everything done with and for the individuals was ethically sound and within guidelines with maybe just a slight stretch on occasion but all defensible. If we were to have a guiding principle it would be to 'find out the context before you try to change it'.

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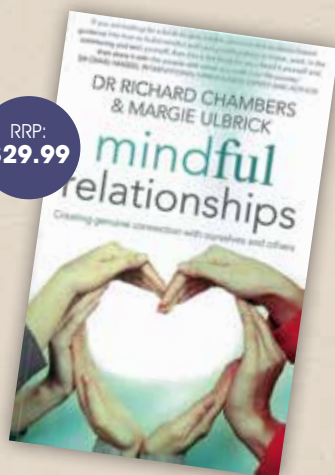
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RRP:
\$34.99**THE LONGEVITY LIST**

BY PROFESSOR MERLIN THOMAS
PUBLISHER: EXISLE PUBLISHING

ISBN: 978-1-921966-73-6

Modern life is ruining our chances of living to a 100, according to author and Professor of Medicine at Monash University Merlin Thomas. *The Longevity List* takes a lighthearted and entertaining approach looking at the evidence of the wealth of health information we are bombarded with. A physician and research scientist, Thomas aims to sort the medical fact from health industry myths - and provides his scientifically backed verdict. He covers everything from why taking statins to lower LDL cholesterol might not be a good idea for everyone with higher levels, to whether there's a connection between donating blood regularly and living a longer life. Chapters include: Do I really have to: Get off the couch? Find love? Lose the waist? Get more sunshine? Cut down the booze? Cut down caffeine? Give up sugar? This book is a funny, informative guide to living a longer, healthy life and guaranteed to give a laugh while also dispelling some age-old myths with a bit of trivia thrown in for good measure.

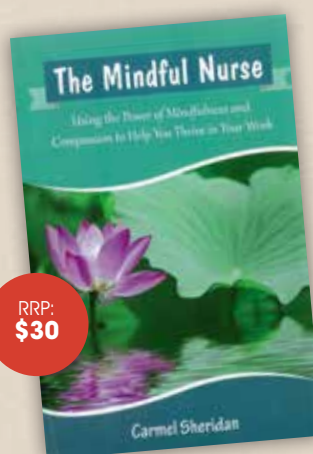
RRP:
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CREATING GENUINE CONNECTIONS WITH OURSELVES AND OTHERS

BY DR RICHARD CHAMBERS & MARGIE ULBRICK
PUBLISHER: EXISLE PUBLISHING

ISBN: 978-1-921966-78-1

Mindful Relationships provides a step-by-step guide to using mindfulness to enrich relationships and more effectively manage the stresses associated with resolution and conflict. Real-life case studies are used to highlight key principles, as well as practical exercises to enable the reader to develop their mindfulness skills to improve their relationships with themselves and others. Chapters include: the mindful self; the mindful couple; the mindful family; the mindful workplace; and creating a mindful society. Key aims of the book include how to: increase awareness of own and others' relational patterns; calm and soothe emotions; communicate more effectively; enhance connection and empathy; reduce defensive patterns; and work effectively within families and workplaces. A topical read aimed to enhance relationships with mindfulness in all areas of life.

RRP:
\$30

THE MINDFUL NURSE:
USING THE POWER OF MINDFULNESS AND COMPASSION TO HELP YOU THRIVE IN YOUR WORK

BY CARMEL SHERIDAN
PUBLISHER: RIVERTIME PRESS

ISBN: 978-0-9933245-2-9

There's no doubt nurses work in challenging environments across the healthcare spectrum. While also true that the ideals of providing compassionate care remain at the core of the profession, the experience of many nurses illustrates how physically draining and emotionally gruelling the career choice can prove. *The Mindful Nurse* outlines how the practices of mindfulness and compassion can help nurses build resilience and therapeutic presence in order to cope with daily challenges and revitalise their practice. A handy guide for both novice and experienced nurses, as well as educators, the book teaches mindfulness and compassionate practices that can easily be applied to improve nurse self-care and patient wellbeing. Key strategies include nurturing others without depleting yourself, overcoming compassion fatigue and burnout, reducing mistakes through managing attention, and reviving love for the profession. Written by psychotherapist Carmel Sheridan, *The Mindful Nurse* provides a valuable tool for all nurses looking to boost their health and thrive in their work.

RRP:
\$30

NURSING – CHALLENGES, LAUGHTER AND TEARS

BY ONDRIA CHEESEMAN
PUBLISHER: EUREKA HOUSE

ISBN: 978-0-9871185-4-7

Ondria Cheeseman's nursing memoir *Nursing: Challenges, Laughter and Tears* is a labour of love that delves into her career as a nurse and the challenges and opportunities it brought along the way. The book charts Ondria's entry into nursing and landing her first job, working across a variety of unique healthcare settings, becoming a mother and juggling work, and reflections on the profession. Notably, when working in Australia and countries across the Pacific, Ondria often faced difficult environments in supporting local people and delivering timely and appropriate healthcare. The profound experience, however, undoubtedly helped shape her nursing career and allowed her to recognise that even in the most basic circumstances, people can still find the courage and willpower to laugh and enjoy their lives. It's a life lesson Ondria believes everyone living in privileged worlds can learn from and one which certainly still resonates with her today.

IMPORTANCE OF ELDERS IN INDIGENOUS CULTURES

A study exploring the contemporary role of Elders in Aboriginal and Torres Strait Islander communities has found greater support is needed to strengthen the role.

This was found especially in relation to the Stolen Generation, the loss of traditional knowledge and low Indigenous life expectancy.

The research, which was the first of its kind to explore the wellbeing and contemporary role of Indigenous Elders, showed that Elders played a vital role in addressing an array of issues affecting Indigenous Australians.

"Our study reveals Elders not only play an integral part in preserving traditional knowledge, they are also pivotal in helping tackle broader community issues such as health, education, unemployment, racism and oppression. By empowering Elders with the support necessary to address issues in their communities, we can make a positive step in helping close the gap and transferring sacred spiritual knowledge," Research Lead Dr Lucy Busija from ACU Institute for Health and Ageing said.

Indigenous community leader Dr Maree Toombs, Director of Indigenous Health at the University of Queensland said insights from the research would be used to enhance the role of Elders within the local community. "The research paints a more detailed picture of the perceptions of Elders within the community and how we can increase the transfer of knowledge, culture and language."



AUSTRALIANS NEED TO BE MORE ACTIVE

Australians' inactivity has not improved over the past 22 years, a report has found.

Despite campaigns to promote physical activity, Australians' activity levels have changed little from 1989 to 2011.

According to Lead Researcher Sydney University's Dr Josephine Chau a wider ranging approach is needed to address the stagnant levels of physical activity. "The research suggests we need to be more motivated to explore other ways of promoting an active lifestyle. We need a national approach to physical activity that incorporates everyone's needs.

"We need the political will for a national, cohesive and comprehensive strategy, which means federal government backing.

"In saying that, we can't just have a one-size-fits-all approach. People of different genders, backgrounds and socioeconomic situations all have varying resources and needs. The approach will need to be well coordinated and take into account all the different sectors of society, including the communities and environments in which they live."

The study found only 39.2% of adults in 1989 were sufficiently active, with that rate only rising to 40.7% in 2011.

Overall the study showed a decrease in the levels of physical activity in Australia while inactivity levels have remained steady. Only two-fifths of the population achieved sufficient levels of activity over the 22 year period, with a little over one third being inactive.

Sufficient activity was considered greater than or equal to 150 minutes per week of moderate to vigorous activity and of inactive less than or equal to 30 minutes per week of moderate to vigorous physical activity.

The research was published in the *Australian and New Zealand Journal of Public Health*.

RESEARCH AIMS TO REDUCE THE BRAIN'S SENSITIVITY TO PAIN

Psychologists are exploring ways in which to reduce the brain's sensitivity to lower back pain so that improved management techniques can be employed.

Dr Melissa Day, from the University of Queensland's School of Psychology is currently comparing three different non-drug treatments in a bid to examine how to change the way the brain processes low back pain.

The research is aiming to achieve optimal function and increase the quality of life of sufferers.

"Living with chronic low back pain leads to the brain being re-wired over time, which gradually sensitises the individual to the pain and results in worsening long-term outcomes," Dr Day said.

Psychological treatments have been shown to reverse these neurological changes, increase brain volume and improve pain intensity, disability, mood, sleep and other functions, Dr Day added.

Dr Day, who said traditional treatments such as opioids cause unpleasant side-effects for many people, is now investigating changes in pain state by promoting non-pharmacological pain-management skills for chronic low back pain sufferers in a bid to re-wire the brain in how it reacts to pain. "We aim to harness the mechanisms underlying the neural plasticity of the brain to make it work for patients and improve their pain, rather than work against them and cause increased suffering."



CUP OF TEA COULD HELP PREVENT DISEASES INCLUDING ALZHEIMER'S

The humble cup of tea could help prevent a number of diseases, including Alzheimer's disease and diabetes, according to new research.

Researchers from Edith Cowan University's (ECU) School of Medical and Health Sciences examined over 100 studies from around the world that have investigated tea consumption.

They found black, white and green tea could reduce the risk factors associated with Alzheimer's disease and diabetes.

The findings offer hope to more than 65 million people expected to be living with Alzheimer's disease by 2030 and curbing the 5.1 million deaths attributed to diabetes in 2013.

ECU Centre for Excellence for Alzheimer's Research and Care Research Fellow Dr Binoshia Fernando said the review offered new lines of enquiry for scientists. "There is strong evidence that tea consumption can lower the levels of beta amyloid b in the brain, the build-up of which can cause Alzheimer's disease.

"In particular, a number of studies have found that the flavonoid Epigallocatechin gallate (EGCG), which is found in tea, can reduce the levels of beta amyloid b in the brain, which could delay the onset of Alzheimer's disease."

The research also found that drinking tea could be protective against diabetes, with one study reporting a significant reduction in symptoms, including a 15-fold increase in insulin activity.

Dr Fernando concluded that tea was a safe and acceptable approach toward lowering risk factors associated with diabetes and Alzheimer's and suggested more randomised clinical trials are now needed to determine what types and amounts of tea are required to achieve optimum results.

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Debbie Richards,
Federal
Industrial
Research
Officer



STATE OF AGED CARE

Horrific stories from the families of residents in aged care have surfaced in the media again and once more we are deeply shocked, angry and distressed that our elderly nursing home residents can be treated so appallingly.

Even more disturbing is that we know the situations highlighted by the media are not uncommon. We know, over many years of contact and feedback from concerned ANMF members who work in the hundreds of residential aged care facilities across the country that residents do not receive the level of personal and nursing care they require. And we know this is inexcusable.

All the reports, reviews and inquiries into the aged care system over the past 20 years, (and there are literally hundreds), have done nothing to address the quality of care and improve the life of residents. Our members tell us the situation just gets worse and worse as the budget bottom line takes priority over anything else. Cost cutting by aged care providers directly impacts on resident care. In particular the number and mix of nursing and care staff on each shift is central to the provision of care and is generally the first area to be targeted. Cost cutting in other areas such as food, laundry and cleaning also impacts on the quality of life for residents.

Understanding the various components of government funding for residential aged care services is beyond the comprehension of most of us. And even more challenging is the question of whether we can ever know if the funding is ending up in the right place. Can we be confident that aged care providers are delivering the standard of care and service to the residents they are funded for?

Funding residential aged care is a big ticket item in the Federal government's budget. It is the principal funder of residential care providing \$11.5 billion in the 2015-16 financial year. The main source of funding for providers is the Aged Care Funding Instrument (ACFI) which provides funding for the personal and nursing care of each resident based on an assessment of their relative needs.

Federal government concerns about an unexpected blow out in ACFI funding claims triggered the latest round of budget cuts of \$1.2 billion. This included making changes to ACFI via the scoring requirements in the complex healthcare domain together with a series of indexation pauses and partial indexation pauses up to the 2018-19 financial year.

Aged care residents, nursing and personal care staff are already bearing the brunt of these cuts with two major aged care providers in Queensland sacking staff and reducing nursing hours across all shifts. Blue Care has sacked 11 enrolled nurses across its Bundaberg facilities and slashed 1,540 nursing and care hours. While Southern Cross Care is cutting over 2,000 nursing hours across its facilities.

At the time of writing, of the 300 aged care members who completed an online survey on staffing and other changes in their facility, 94% reported reduced staffing levels and less care hours per resident. 89% stated that their current staffing levels were not adequate to provide even basic care, including bathing and bed changes.

Our aged care residents deserve

much more than this. They are entitled to decent safe care and a reasonable quality of life in the latter part of their years. The ANMF is campaigning for mandatory minimum staffing and skill mix requirements as part of the solution to provide some certainty and safety for residents and staff.

Changes to funding and budget cuts are a constant in the aged care sector. Understanding the implications of any change in this area is extremely difficult. Government funding makes up the highest proportion of revenue for aged care providers with ACFI subsidies accounting for roughly 90% of that revenue.

Determining the impact of any change or cut on facilities is also complicated as the sector is made up of different types of providers, for example, for-profit operators and not for profit providers including religious and charitable. The size of the facilities, the care needs of the residents and location of the facility are also factors to take into account. All these factors contribute to the wide range of financial performance across the sector.

ANMF's commissioned research* into the financial viability of providers following the latest budget measures shows, on average, an overall drop in revenue in 2017-18 through to mid-2019 but the impact varies enormously across the sector.

Operators sitting in the top 25% of financial performers will continue, on average, to maintain net earnings per resident at between \$16,500 to \$18,870 per year. In contrast, those sitting in the bottom 25% of financial results who are already operating in negative territory are projected to be in a far worse situation by 2020.

Our research also shows that for-profit providers are impacted more by the budget cuts because, on average, they have a greater proportion of residents with higher care needs.

Government revenue per resident per year will decrease slightly in 2017-18 but increase again in each year between 2018-19 and 2020-21. The modelling shows the impact of the cuts on the for-profit providers taking effect in the 2017/18 and 2018-19 financial years. However the impact is relatively minor and net earnings per resident per year continue at a healthy \$6,206 in 2017-18, bottoming to \$4,961 in 2018/19 then rising again over the next two years to \$6,404 by 2020-21.

Bottom lines and financial performance are one part of the picture, but it's the residents and staff who tell the real story about what is happening in aged care and they are the ones that should be listened to.

*Report on the financial impact of the 2016-17 Federal Budget on residential aged care providers, UCoDA July 2017



THE NURSE ROLE IN MEDICATION ABORTION PROVISION, A SOUTH AUSTRALIAN EXPERIENCE

By Nola Savage and
Helen Gibbons

Medication abortion has been available to Australian women since 2009. Despite the constraints of the current South Australian abortion law, requiring two medical officers to consult with the woman, medication abortion is predominantly a nurse run service which provides significant economic savings for the health budget.

The World Health Organization states medication abortion can be provided by primary level health workers which includes nurses and midwives. Little information has been published about the Australian nurse's experience of medication abortion provision. This brief article summarises the role nurses play in providing evidence based medication abortion care for women in South Australia.

Nurses provide initial consultation using a woman centred approach, with a focus on her choice, safety both physically and emotionally, pain management and symptom control. Nurses provide detailed information about the process to enable informed consent. Exploration of local resources the woman can access in the event she requires

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additional support. Contraception counselling enables women to make an informed choice about their fertility management. Nurses administer and insert long acting reversible contraception if requested once consent is obtained. Collection of vital signs and laboratory tests ensure her physical safety and future fertility is not compromised. Follow up counselling provides a safety net for the woman in the event of her experience differing from her expectations, as well as providing a successful outcome not only for the woman but also the healthcare team.

From initial consultation to follow up, the nurse is the most prominent health worker in the woman's medication abortion journey.

 **Nola Savage
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Coordinators in
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Advisory Centre
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Adelaide Local
Health Network
in South
Australia**



THE 'HOLDER OF SECRETS': A DAY IN THE LIFE OF A SEXUAL HEALTH NURSE

By Anne Baynes

It's 8.45am Monday morning and already there are five patients waiting for the sexual health walk-in-clinic. Doors open at 9am and patients self-triage to see a doctor or nurse practitioner (NP) if they have symptoms, or a nurse for screening.

My first patient is a male requesting a sexually transmissible infection (STI) and blood borne virus (BBV) screen.

This man has sex with other men (MSM) so we swab his throat for gonorrhoea, his rectum for chlamydia and gonorrhoea (he is told how to do this himself), and collect a urine specimen for chlamydia. We also take blood for HIV, syphilis and hepatitis A and B.

Next up, is a young woman wanting to access emergency contraception, then a middle aged man wanting cryotherapy for his previously diagnosed genital warts. A young woman presents for her second hepatitis B vaccination. Everything is straightforward so far. However a distressed male presents saying he has a long-term female partner of many years, but after too much alcohol at the weekend he has had anal sex without a condom with an unknown male. He says he feels very guilty and is worried about how to tell his long-term partner. There is no judgement as we try to work through the best possible outcome for him. This consultation requires time and empathy. Baseline STI, and BBV screening is attended as well as kidney and liver function tests. He meets the criteria for accessing HIV post exposure prophylaxis, which is a month's supply of HIV antiretroviral medication and must be started within 72 hours of possible exposure

to reduce his risk of contracting HIV. This is outside my scope of practice as an RN so I will refer him to the NP for management. We will also need to discuss protecting his female partner with condoms and repeat testing in three months to cover the HIV window period. Next up, a low risk heterosexual young male presents for the third screen in two months. This requires education and counselling around appropriate timing of screening, in line with current STI guidelines.

As well as my clinical role I work as a Public Health Nurse to assist with partner notification (contact tracing) for notifiable STIs diagnosed in ACT community settings. This includes assisting patients recently diagnosed with chlamydia to contact trace their sexual partners from the past six months. Most patients I phone have attended their contact tracing already, however one young person I contact has not yet been notified that she has chlamydia so I refer her to her GP for treatment and discuss how we can help with contact tracing. Our clinic also offers outreach testing for marginalised groups and tonight I am going to two brothels to offer screening to sex workers via our Sex Workers' Outreach Program.

All of our nursing team working on the walk-in clinic provide asymptomatic screens, physical assessments, vaccinations, STI

management (for example we have standing-orders for chlamydia), contact tracing, result management and advice. Anything outside our scope of practice we refer to our NP or doctors. Most days we are involved in teaching medical students. We also provide sexual health promotion and education, liaise with other community organisations and health professionals and contribute to research projects and quality improvement activities. This week clinic nurses are involved in the Specialist HIV Clinic, an outreach school program where education and screening is provided for year 11 and 12 students and a fast track after-hours M Clinic for men who have sex with men (MSM) wanting an asymptomatic screen. Nurses working at the clinic have post graduate sexual health qualifications and have come from varying backgrounds including theatre nursing, midwifery, women's health, emergency department and forensics.


What are the attributes of a sexual health nurse? The same for most nursing jobs: kindness, empathy, good communication skills, compassion, respect for confidentiality and a sense of humour.

ANNE
DEMONSTRATING
TO A PATIENT
HOW A SPECULUM
EXAMINATION IS
DONE

WHAT ARE THE ATTRIBUTES OF A SEXUAL
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SENSE OF HUMOUR.

We work autonomously as well as being part of an interdisciplinary team where we can bounce ideas off each other, receive support and have a good laugh. A sexual health nurse also requires a selective memory as he/she is a holder of many secrets. For example a colleague was at a dinner party sitting next to a middle-aged man and his wife. The man kept turning to my colleague and saying 'I'm sure I know you from somewhere'. Her response was that no she was sure they hadn't met, knowing too well that this was a patient who had presented to the clinic for a STI screen a month prior, after unprotected sex with a casual female partner.

Being a sexual health nurse is a great job. We are very privileged; within a few minutes of meeting someone, we are privy to intimate information and have the satisfaction of making a little difference to their life.

 **Anne Baynes is an RN at the
Canberra Sexual Health Centre at
the Canberra Hospital in the ACT**

A WOMEN'S HEALTH ISSUE: FEMALE GENITAL MUTILATION (FGM) IN AUSTRALIA

By Monica Diaz and Mary Steen

While developing an online module for perineal wound care, funded by The Wound Management Innovation Cooperative Research Centre (WMI CRC), the authors of this paper found a lack of information and resources for health professionals to support women with female genital mutilation (FGM) during pregnancy, childbirth and following birth in Australia.

Most of the information available aims at eradicating the practice of FGM and the protection of children. However, there is very little information on how to care and support child bearing women with FGM during pregnancy, childbirth and following birth.

The incidence of FGM in Australia

In Australia, it is estimated that 83,000 women and girls live with FGM but it is likely that this number may be under-estimated as there are no reporting systems in place to record this data accurately. See link, <http://www.nofgmoz.com/2014/03/25/new-statistics-of-girls-at-risk-of-fgm-in-australia/>

FGM and negative maternal health consequences

FGM is an independent risk factor for adverse maternal and fetal outcomes in pregnancy and childbirth (WHO 2010; Chibber et al. 2011; Kaplan et al. 2013). FGM has numerous short and long term negative health consequences for the woman. Women who have had FGM are at an increased risk of miscarriage in the first trimester, threatened preterm labour, urinary tract infections, obstructed labour, catheterisation, caesarean sections, fetal distress, episiotomies, perineal tears, post-partum haemorrhage, longer hospital stays and postnatal depression (WHO 2010, Kaplan et al. 2013; Gayle and Rymer 2016). Procedures

such as: vaginal examinations, speculum examinations, amniotomy, induction, fetal scalp electrodes and catheterisation are difficult to perform in pregnancy and childbirth on women who have had infibulation due to the narrowing of the introitus (Kaplan et al. 2013; Momoh et al. 2016). Infibulation causes significant scarring of the perineum and surrounding tissues. The formation of keloids, cysts and vulvar abscesses as a result of infibulation add to the scarring and toughening of perineal tissue (Kaplan et al. 2013). The perineum loses elasticity and therefore, its ability to stretch during a vaginal birth. Women with type I, and type II FGM are three and five times, respectively, more likely to sustain severe perineal trauma (3rd and 4th degree tears) than women who have not had the procedure (Kaplan et al. 2013).

Guidelines and education

Thus, it is vitally important that health professionals are supported to give best practice and guided by clinical guidelines to enable them to care for pregnant women and new mothers with FGM.

As members of the mothers, babies and families research health group, within the School of Nursing and Midwifery at UniSA in South Australia we have established a collaborative partnership with ShineSA to increase awareness of the issue of FGM in Australia. ShineSA focuses on legislation, child protection and the experiences of

women with healthcare services but there is no specific information or guidance available for the support and care of women during pregnancy, childbirth and following birth.

Therefore, there is an urgent need to address the lack of resources available to assist health professionals, especially midwives and to develop best practice guidelines and provide continual professional education and training of midwives. Guidelines and an education workshop for midwives are now being developed and will be available at the end of 2017.

Mary Steen is a Professor of Midwifery at the School of Nursing and Midwifery, Division of Health Sciences at UniSA and Honorary Professor at Women and Children's Hospital. She is the Chair of the Mothers, Babies and Families (MBF) Research Group and facilitates the promotion of research and scholarly activities both nationally and internationally.

Monica Diaz is a Research Midwife, Post Graduate Student and a member of the MBF research group at the School of Nursing and Midwifery at UniSA. She is also a clinically based midwife working in the Women's Assessment Department at the Women and Children's Hospital. She is a member of the mother, babies and families research group.



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PATIENT VOICE: ENCOURAGING CONVERSATIONS ABOUT HIV ASSOCIATED NEUROCOGNITIVE DISORDER

By Denise Cummins, Donna Waters, Christina Aggar, David Crawford and Catherine C O'Connor

HIV associated neurocognitive disorder (HAND) affects many people living with HIV (PLHIV) and can be challenging for people partnering in their care. Early recognition and treatment of HAND may improve health outcomes and quality of life but initiating a conversation about it can be difficult for PLHIV and their caregivers.

A workshop at the International AIDS Society Annual Conference held in Melbourne, Australia in 2014 explored the topic *Recognising signs and symptoms of HIV associated cognitive impairment (HAND) and practical strategies for resource poor settings*. The workshop program was developed in collaboration with experienced HIV clinical nurses and health staff from a sexual health promotion unit in Sydney, Australia. The target audience was support workers and healthcare professionals working with PLHIV from resource poor settings. Workshop presentations included: risk factors and signs and symptoms of HAND; screening tools, diagnosis and treatment options; and considerations for annual monitoring of PLHIV.


Aiming for a target of 50 delegates, 70 national and international delegates attended, with many Australians identifying as PLHIV who were concerned about HAND. Therefore, aside from the original intent of the workshop, it was evident that


delegates with HIV had attended the workshop to seek further information about cognitive impairment and were concerned about HAND.

Following the conference, a HAND Think Tank was held to address this identified gap in information and service to PLHIV. The HAND Think Tank was a nurse-led initiative inclusive of expert medical and nursing specialists in partnership with Positive Life NSW. Positive Life NSW is a non-profit community-based organisation that aims to empower people living with HIV in NSW with access to information, referral and advice on all relevant issues.

A short online survey was developed and distributed to PLHIV via the Positive Life NSW website, Facebook and Twitter accounts. The survey aimed to ascertain the knowledge and concerns of PLHIV regarding HAND. The survey was open online for one month, receiving 163 responses. The results confirmed that 68% of respondents were concerned about HAND. Half (56%) of


the respondents had already spoken to someone about their concerns and although most had encountered a positive experience, others had not, with 21% stating that they would not talk to anyone about HAND again. Thirty-nine percent wanted advice on how to begin the conversation about HAND with either their doctor or their loved ones, as did those respondents who were carers (6%) of PLHIV. The survey has facilitated an ongoing partnership between clinical nurses and Positive Life NSW, to develop resources to assist PLHIV and their carers to have a conversation about HAND. The content and language of the resources have been reviewed by clinical experts and Multicultural HIV and Hepatitis Services NSW. The resources will also be focus tested by PLHIV. Community and primary healthcare nurses can use these resources to initiate a discussion with their patient and to support and encourage PLHIV to discuss their concerns with either their doctor or significant others.

 **Denise Cummins is a Clinical Nurse Consultant HIV Disease, Sydney District Nursing, Community Health, Sydney Local Health District**

 **Professor Donna Waters is Dean, Sydney Nursing School, University of Sydney**

 **Dr Christina Aggar is Senior Lecturer, School of Health and Human Sciences, Southern Cross University**

 **David Crawford is Treatment Officer, Positive Life NSW**

 **A/Prof Catherine C O'Connor is Director of Sexual Health Service, Community Health, Sydney Local Health District**



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www.positivelife.org
(Accessed June 2017)

THE 2017 AUSTRALASIAN SEXUAL HEALTH CONFERENCE

7 – 9 November, Canberra

By Amy Sargent

The conference will once again be held back-to-back with the Australasian HIV&AIDS Conference, however this year there will be two days of crossover programming allowing access to even more sessions.

Taking forward the agenda for re-thinking sexual health established by the 2016 Australasian Sexual Health Conference in Adelaide, this year's interdisciplinary conference addresses

how sexual health can be re-formed: firstly towards more integrated and personalised provision attuned to people's needs; and secondly, to make more streamlined and cost-effective use of available resources.

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- Simon Blake, Chief Executive Officer, National Union of Students, UK
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- Ayden Scheim, Epidemiology & Biostatistics, Western University, Canada
- Professor Danielle Mazza, General Practice, Monash University, Australia

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 **Amy Sargent is the Project Officer, Conference, Sponsorship and Events at the Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM)**



Daniel Cordner



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PrEP AND TREATMENT AS PREVENTION: WHAT DOES THIS MEAN FOR HIV IN AUSTRALIA?

By Daniel Cordner

As a HIV positive gay male I never thought this day would come, that by taking daily medication, I cannot transmit HIV. There is also now a new way to end all new HIV transmissions. PrEP, (pre-exposure prophylaxis), is making that a reality.

What is PrEP?

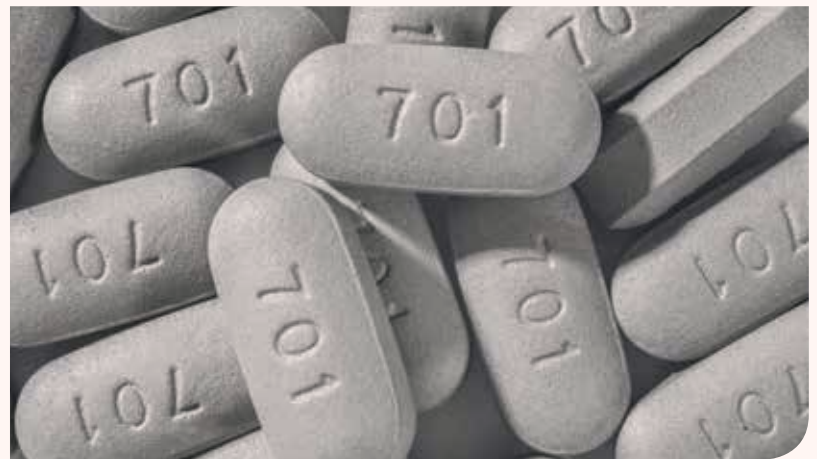
PrEP is the use of HIV antiretroviral drugs, taken by HIV negative people to prevent HIV transmission. PrEP when taken daily provides proven protection against HIV.

Men who have sex with men (MSM), partners in sero-different relationships (including heterosexuals) on PrEP receive regular three monthly check-ups including sexual health screening. This means MSM are having more regular sexual health checks, in-turn picking up and treating STI's earlier. The idea that STI's are on the increase due to some MSM taking condoms out of the equation is not true. MSM are having a conversation around sex and STI's more openly than ever before. People are making more informed decisions about risk factors and choices they make.

By taking PrEP, as directed, you are always prepared. Condoms must be used correctly every time, to provide protection. Condoms do not provide full protection against all STI's, like chlamydia, syphilis and gonorrhea. Condoms are no longer the only solution to preventing HIV transmissions.

The NAM Aidsmap website points out that condom usage began to fall long before PrEP became available.

Globally there have only been four cases of HIV transmissions, one of those in Australia for people using PrEP (SBS 2017). Two of those involved rare drug-resistant strains, one being thought to be via very high risk sexual activity (Poz.com 2017) and the fourth is under investigation. Let's not focus on these four cases and forget about thousands of people



that have not acquired HIV while taking PrEP.

Prevention is better than cure

By understanding that PrEP is part of the equation, not the whole solution, we can see how it can be used to engage in new conversations around sexual practice. By accepting that condoms are only part of that solution, not the whole solution, it allows for alternatives. In places like San Francisco (WHO 2017) and Denmark (Aidsmap 2017), HIV transmissions are reducing for the first time since the epidemic began. It's been proven as an effective tool in the kit for HIV prevention.

Treatment as prevention (TasP)

Part of this equation is that now someone living with HIV who takes their HIV antiretroviral medicine can reach an undetectable viral load (UVL is someone with a viral load under 50 copies/ml) (Aidsmap 2017). People living with HIV on (antiretroviral treatment) with a sustained undetectable viral load in their blood have a zero risk of sexual transmission of HIV.

Numerous studies have confirmed this. The most recent study, Opposites Attract, has shown zero HIV transmissions for couples with different HIV statuses (Star Observer 2017).

The study, which is the largest to date, looked at HIV transmission risk among gay male couples where one partner in the couple is HIV positive and the other partner is negative. The research followed 358 couples from Thailand, Brazil and Australia from 2012–2016, with almost half of the participants from Australia.

The couples in the study engaged in over 12,000 acts of condomless sex where the positive partner had UVL through antiretroviral therapy, and the negative partner was not taking pre exposure prophylaxis (PrEP), resulting in zero cases of HIV transmission.

Conclusions from the study were: "In terms of HIV prevention, if condom use is safer sex, then sex with

someone who has maintained an UVL is even safer sex."

The results of this study were presented at the International AIDS Society Conference in Paris.

Taking the shame and fear out of HIV

In the 1960's birth control was provided to prevent unwanted pregnancies. It was another tool to prevent conception, along with condoms. Until now, there has only been one way to prevent HIV. At the time the pill was blamed for promiscuity, hideous side effects and even destroying marriage. Now, the pill is widely prescribed and has helped liberate millions of women (The Guardian 2010).

If you were to take a daily preventative pill for heart disease or diabetes, there is no judgement. It's time we move past the shame and the fear around blood borne viruses and sexually transmitted infections. Let's stop denying access to preventative medicine that can change the landscape of HIV forever. Let's stop placing judgement on how the virus can be transmitted and provide healthcare that is fair to all.

PrEP and Undetectable are both bio-medical evidence based methods for reducing new HIV transmissions. It's time to start believing in the research and put our personal opinions aside on what is seen as 'safer sex'.

There is still a long way to go with the fight against HIV. But with the help of PrEP and Treatment as Prevention it is opening up new conversations, helping reduce new transmissions and is even bringing some hope to end all new HIV transmissions.

Further information:

<http://endinghiv.org.au/au/>

Daniel Cordner is a graphic designer who has been living with HIV for 11 years. Daniel is involved with the Living Positive Victoria Postive Speakers Bureau.

EDUCATION THE KEY FOR DONNA

By Anni Fordham

As the only nurse practitioner working exclusively in sexual health in a metropolitan public hospital in WA, Donna Keeley has a high level of autonomy and responsibility.

She can diagnose and treat sexually transmitted infections (STIs), prescribe medications, order pathology tests, take biopsies and administer contraceptive implants.

But if you ask her what her most important responsibility is, she'll give you one word: education.

Donna completed her studies to be a nurse practitioner in 2008 through Curtin University and further education continues to be an important part of her role.

"Completing my nurse practitioner qualification and then being appointed has been both the biggest challenge and the greatest achievement of my career," Donna said. "Although I've been working as a nurse practitioner for five years, regular study and research is still essential to keep up to date with the latest developments in sexual health."

"It takes a lot of time on top of my busy workload, but it's worth it to know that I'm providing the best possible care to my patients."

Donna is part of a small team based at Fremantle Hospital, providing sexual health education, screening and treatment to people in south metropolitan Perth.

The team provides outreach services at a range of locations, providing holistic care for people experiencing or at risk of sexually transmitted infections or other sexual health conditions.

"We have an experienced team of nurses, doctors, and a clinical psychologist who collaborate to provide tailored care in a holistic and sensitive way."

Donna said becoming a nurse practitioner had allowed her to grow professionally and take on more responsibility.

"I really enjoy being able to manage each case from start to finish, and I think patients like the fact that they have one point of contact throughout. I still need to bounce ideas off my colleagues from time to time, but we have a close-knit team that really supports each other so it works well."



WESTERN
AUSTRALIAN NURSE
PRACTITIONER
DONNA KEELEY

After 20 years in sexual health, Donna said screening tools and treatments had advanced significantly but it was important not to get complacent.

"Treatments are now easy and often one-off, but the message to young people is not to become complacent. The more you are infected, the higher chance you have of fertility problems."

The community's understanding of STIs has also come a long way, but there are still barriers to people seeking treatment, such as embarrassment, fear and stigma.

I REALLY ENJOY BEING
ABLE TO MANAGE EACH
CASE FROM START TO
FINISH, AND I THINK
PATIENTS LIKE THE FACT
THAT THEY HAVE ONE
POINT OF CONTACT
THROUGHOUT.

They may not want to go to their regular GP or may not have a GP at all.

"With young people, sometimes they might be having sex at a young age and are worried about confidentiality," Donna said.

"People may be fearful of what the testing and treatment process might entail, or others might just feel embarrassed to talk about their problem."

Donna's team provides outreach clinics outside of the hospital to help meet this need and have formed

partnerships with Headspace and other agencies to deliver these services in some areas of Perth.

"Through Headspace we provide free sexual health screening, information and reproductive health information to under-25s," she said. "We also collaborate with other local community centres to target various at-risk groups."

Donna said young people aged 15-24 continued to be one of the hardest groups to reach, with rates of sexually transmitted infections, particularly chlamydia, on the rise in this age bracket.

"The problem is most people who contract these infections don't have symptoms but there can be a risk to the person's reproductive health."

"Frequent screening is vital for people who are at high risk."


Syphilis is also a significant issue with rates increasing rapidly over the past four or five years.

"We thought syphilis was under control in Australia a few years ago but it has risen sharply," said Donna.

"There could be various reasons for this, including complacency around the use of condoms, people having sex at a younger age and more diverse sexual behaviours."

"Although syphilis is easily treatable, the health consequences if left untreated can be serious so it's important we keep talking about it and keep educating people about the importance of safe sex."

"Every patient I see is an opportunity to have those conversations and equip people with the knowledge to keep themselves and their partners safe."

 **Anni
Fordham
is Media
Coordinator
at South
Metropolitan
Health Service
in WA**



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SEXUAL HEALTH NURSES FROM CANBERRA SEXUAL HEALTH CENTRE

HOW CAN I GET A JOB IN SEXUAL HEALTH NURSING?

By Shannon Woodward

A great place to start would be to call the nursing manager of a service near you to ask what sort of experience or educational background they prefer when recruiting.


Some services may be looking for an experienced nurse or some may be happy to recruit a nurse with no experience. You can also talk to the nurse manager about the possibility of a short work placement to see if

you would like to work in this specialty area. Some nurses are able to use professional development leave to do this.

The entry point into sexual health nursing is usually a Certificate in Sexual and Reproductive Health. These courses are offered by numerous providers across Australia. The minimum post graduate nursing or midwifery experience before you can enrol into these courses is usually 1-2 years. Most of the courses include a self-directed learning package, a clinical component, and some face to face learning and can be completed part time or via distance education. Completion of a Certificate in Sexual and Reproductive Health not only enables you to work in sexual health, it also may help you to get a job in other areas including Family Planning and Reproductive Health, HIV Nursing, Women's Health, Adolescent Health and Men's Health.

The Australian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM) also provide numerous short courses and workshops focusing on sexual health, sexually transmissible infections and blood borne viruses throughout Australia for nurses. There are several free learning opportunities relating to Sexual Health, Reproductive Health and HIV listed on the Australasian Sexual Health and HIV Nurses Association (ASHHNA) website at <http://ashhna.org.au/resources/>

Additionally please feel welcome to contact ASHHNA at ashhnanurses@gmail.com if you have any questions about a career in sexual health nursing.

 **Shannon Woodward is a Nurse Practitioner and President of the Australasian Sexual Health and HIV Nurses Association (ASHHNA)**

WHAT IS ASHHNA ALL ABOUT?

By Shannon Woodward

The Australasian Sexual Health and HIV Nurses Association (ASHHNA) is the peak Australasian Sexual and Reproductive Health and HIV Nurses' professional organisation.

ASHHNA members support each other to share and develop knowledge and skills to improve the sexual and reproductive health of individuals and communities and support people living with HIV. Our aims are to:

- promote Sexual and Reproductive Health and HIV nursing as a


- professional specialty;
- advance the standards and scope of Sexual and Reproductive Health and HIV nursing practice;
- facilitate the exchange of professional information to ensure effective communication and networking;
- represent Sexual and Reproductive Health and HIV nurses in discussions with government and non government bodies at the state, territory and federal level;
- support the standard and scope of evidence based professional development of nurses in the specialty;
- promote collaborative research in Sexual and Reproductive Health and HIV nursing.

We do this by:

- developing competency standards for Sexual and Reproductive Health and HIV nurses;

- representing ASHHNA and promoting nursing and the specialty on the following committees:
- Coalition of National Nursing & Midwifery Organisations (CoNNMO)
- Australasian Sexual Health Alliance (ASHA)
- Australasian Society of HIV, viral hepatitis and sexual health medicine (ASHM) HIV Treatment Guidelines Committee
- ASHM National HIV Standards, Training and Accreditation Committee (NHSTAC)
- ASHM HIV Conference Organising Committee
- keeping nurses up to date with current information via social media, email list and newsletters;
- providing an annual professional development scholarship.

More information on ASHHNA can be viewed at <http://ashhna.org.au>

 **Shannon Woodward is a Nurse Practitioner and President of the Australasian Sexual Health and HIV Nurses Association (ASHHNA)**



Suzanne Wallis

ENGAGING WITH HIDDEN AND MARGINALISED GROUPS IN THE RURAL SETTING – SEX WORKERS, WHERE DO WE BEGIN?

By Suzanne Wallis

In Victoria there is at present a two tiered sex industry. Where it operates legally it is regulated and the relevant legislation is the Sex Work Act 1994, Sex Work Regulations 2006, Sex Work (Fees) Regulations 2004 and the Public Health and Wellbeing Act 2008.

It is proscribed that sex workers working in the legal industry in Victoria must demonstrate evidence of regular testing for sexually transmissible infections (STIs) and blood borne viruses (BBVs), with the interval of testing currently being set as three monthly.

Sex work is still held by many community members as a stigmatised occupation and as such it is a hidden profession where anonymity and confidentiality are prized with inadvertent disclosure in small communities a constant concern.

An article by Thomas et al. (2014) discusses which primary healthcare services should be made available to Australians living in rural and remote communities, with sexual and reproductive health being identified as a core service.

In 2011 a partnership between Melbourne University – Centre for Excellence in Rural Sexual Health (CERSH) and Goulburn Valley Health (GVH), enabled the development of a Nurse Practitioner led, Meryula Clinic, to deliver an accessible sexual health clinical service in the Goulburn Valley.

Within this community is located a legal brothel and escort service. So how do we engage with and provide an appropriate service that will enable

workers in the legal sex industry to meet their testing obligations within this rural setting?

Engagement

This was achieved by visiting the brothel and meeting the owner and managers.

Visits/tours of the brothel were provided for relevant GVH staff (reception, nursing, allied health).

Non-judgmental approach and flexibility

Appointments are made using whatever name is offered and identity is clarified at attendance.

Timely and responsive service

A direct phone contact is available for appointments and advice – health, legal, supportive care – which is utilised by both workers and brothel management.

Following testing, results and further management advice are provided via SMS.

Client feedback

This has been overwhelmingly supportive of the service provided and the relationship developed.

Clients who have retired from

SEX WORK IS STILL HELD BY MANY COMMUNITY MEMBERS AS A STIGMATISED OCCUPATION AND AS SUCH IT IS A HIDDEN PROFESSION WHERE ANONYMITY AND CONFIDENTIALITY ARE PRIZED WITH INADVERTENT DISCLOSURE IN SMALL COMMUNITIES A CONSTANT CONCERN.

working in the sex industry continue to utilise the service for routine sexual and reproductive healthcare.

Suzanne Wallis is a Rural Sexual Health Nurse Practitioner at Community Health @GV Health and Honorary Fellow Rural Health Academic Centre at the University of Melbourne



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SOCIAL SUPPORT NETWORKS OF PEOPLE RECENTLY DIAGNOSED WITH HIV IN QLD

By Olivia Hollingdrake, Judith Dean, Chi-Wai Lui, Allyson Mutch and Lisa Fitzgerald

Advances in treatment have resulted in longer life expectancy for people living with HIV (PLHIV), but ensuring people are living well remains a challenge for nursing practice (Bradley-Springer et al. 2010).

The quality of life (QOL) of PLHIV is affected by comorbidities, social isolation and persisting societal stigma and discrimination (Lazarus et al. 2016). Nurses are uniquely positioned at the interface between the clinical and social aspects that influence QOL for PLHIV. With the evolution of HIV nursing roles from acute to primary care models, nurses are increasingly involved with supporting individuals to 'self-manage' (Dean et al. 2014).

Although social support is important to self-management (Vassilev et al. 2014), current literature focusing on self-management of HIV predominantly targets individual health behaviours (Bolsiewicz et al. 2015). There is little evidence of the role and function of social support networks and their interface with models of nursing care and self-management.

Method

Using qualitative social network mapping, this study examines the informal and formal social support networks of Queenslanders recently diagnosed with HIV (<5 years). Phase one, indepth interviews with 15 recently diagnosed PLHIV, will map

and describe supportive networks and provide insight into their experiences of mobilising network support following diagnosis. Phase two will involve interviews with a selection of the key support providers identified through the mapping as being pivotal in meeting the support needs of PLHIV.

Preliminary results

The social support networks of participants are diverse, ranging from sparse connections through to tight networks of family, friends and a range of formal providers. Disruption of social networks following diagnosis creates challenges for sourcing and maintaining support. Several participants revealed that nurses had been pivotal in helping address their fear of disclosing their status to their networks and assisting them to access support and services. A comprehensive network of services (including peers) is important to support self-management, particularly for those with limited informal networks. The broader social challenges of living with HIV remain central areas of concern, particularly in relation to health service access, stigma and social isolation.

Implications for nursing practice

This research will provide insight into network support beyond the clinical environment, contributing to a broader picture of HIV self-management. Supportive care networks, often shaped following diagnosis, may play a role in determining PLHIVs ability to self-manage in the longer term. The nursing role remains vital, especially for those with sparse social networks and fractured family connections. Nurses are in a unique position to provide care and education not only to recently diagnosed PLHIV, but also their broader support networks. Supporting these wider networks will assist PLHIV to live well in the long-term, a key priority of contemporary HIV nursing care.

Olivia Hollingdrake is an RN and PhD Candidate; Dr Judith Dean is an RN and Post Doctoral Research Fellow; Dr Chi-Wai Lui is a Lecturer; Dr Allyson Mutch is Senior Lecturer and Dr Lisa Fitzgerald is a Lecturer. All are in the School of Public Health at the University of Queensland, Brisbane



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BREAKING THE CHAIN OF TRANSMISSION: NURSES' ROLE IN PREVENTING STIs

By Christopher Patterson, Lorraine Fields and Lorna Moxham

Sexually transmitted infections (STIs) affect people of all ages, socioeconomic levels and cultures and are now a serious public health issue that has reached epidemic proportions in many nations.



More than 30 different bacteria, viruses and parasites are known to be transmitted through sexual contact with eight pathogens being linked to the greatest incidence of disease. Although often preventable, STIs are on the increase worldwide with the World Health Organization (WHO 2016) estimating that more than 500 million new infections of curable STIs like gonorrhoea, trichomoniasis, syphilis and chlamydia occur globally each year.

STIs have a profound impact on sexual and reproductive health but can largely be prevented with behaviour change and this is where nurses play a vital role. Some behaviours are more likely to result in a person acquiring an STI than others and risky behaviour includes having sex with multiple and new partners, misusing drugs, engaging in unprotected sex, having sex while intoxicated and having sex in exchange for money. Behaviour change though, remains a complex challenge but nurses are well positioned to enable behaviour change given their theoretical understanding and their knowledge translation skills.

Sexually transmitted infections include those caused by bacteria, viruses, fungi, protozoa and parasites. Portals of entry for these agents of transmission include the mouth, genitalia, urinary meatus, anus, rectum and skin. STIs have many consequences and nurses who understand disease processes have the responsibility to provide health education to all people regardless of their gender, age or sexual orientation on how to prevent


STIs. Nurses have a critical role in the prevention of STIs by providing accurate information about these diseases, their prevention, treatment and potential complications. Nurses should be aware of policies, protocols and strategies and be aware that Australia has guidelines within the *Third National Sexually Transmissible Infections Strategy 2014–2017* and that the World Health Organization (WHO 2007) has a publication called *Global strategy for the prevention and control of sexually transmitted infections: 2006–2015*.

Some sobering statistics to compel nurses to be part of the solution.

- A person may have an STI but have no symptoms.
- Two or more STIs frequently coexist in the same person.
- More than one million people acquire an STI every day.
- More than 530 million people have the virus that causes genital herpes (HSV2).
- More than 290 million women have a human papillomavirus (HPV) infection. HPV causes 530,000 cases of cervical cancer and 275,000 cervical cancer deaths each year.
- Some STIs can increase the risk of HIV acquisition three-fold or more.
- STIs can have serious consequences beyond the immediate impact of the infection itself, through mother-to-child transmission of infections and chronic diseases.
- Drug resistance, especially for gonorrhoea, is a major threat to reducing the impact of STIs worldwide.
- In developing countries, STIs and

their complications rank in the top five disease categories for which adults seek healthcare.

- In women of childbearing age, STIs, excluding HIV, are second only to maternal factors as causes of disease, death and healthy life lost. According to estimates from the WHO (2015), around 36.9 million people were living with HIV in 2014. The number of people newly infected with HIV in 2014 was two million.
 - AIDS deaths globally in 2013 accounted for 1.5 million people.
 - AIDS incidence in Australia (0.9 per 100,000 population) is similar to that in the UK and Canada (1.4 and 0.8, respectively) but much lower than in the US (12.8).
 - New South Wales had the highest incidence of AIDS diagnosis followed by Victoria, Queensland, Western Australia, South Australia, the Australian Capital Territory, Tasmania and the Northern Territory.
 - Chlamydia was the most common STI notification in Australia.
 - Indigenous Australians are over-represented in STI notification data.
 - One in two sexually active people will contract an STI by age 25.
- It's time to break the chain and nurses must be part of the solution.

 **Christopher Patterson and Lorraine Fields are Lecturers and Lorna Moxham (PhD) is Professor of Mental Health Nursing. All are in the School of Nursing, Faculty of Science, Medicine and Health at the University of Wollongong in NSW**



Reference
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KINDNESS AND CARING

By Julie Green

Caring with kindness - a fundamental principle of the women centred care I am privileged to provide during my work at The Pregnancy Advisory Centre in Adelaide.

I work in a stand alone publicly funded abortion clinic. My workplace is made up of registered nurses, midwives, enrolled nurses, doctors and social workers. We are a supportive bunch, more like a family and we enjoy the normal ebbs and flow of a family network. We have far more in common than not, and we are joined with our mutual commitment to supporting women.

It is estimated, an unplanned pregnancy is experienced by half of all women, and that one in three women will have an abortion (Children by choice 2017). This results in many different reactions from a woman. The choice of when to parent is a fundamental right of women in Australia, and has been hard fought for by many in our community.

However, many women feel the societal stigma of the choice not to continue a pregnancy.

I have currently worked for eight years in this abortion clinic. It has been one of the most rewarding, job satisfying career options I have undertaken as a registered nurse. My day to day caring encompasses supporting all women ie. from 14 year olds with a world of potential, to busy mums of three in their 40s, the opportunity to support these women to take control of their lives and reproductive rights, means abortion providers can experience a professional satisfaction missing in many health services.

People often say when they enquire where I work, "that must be difficult or sad". Of course, caring for any person when they are not in optimal health can be all of these things. I say optimal health because the complex stress that women find themselves with when faced with an unwanted pregnancy is not optimal psychological or physical health. Difficult and sad situations are why so many of us become nurses, midwives and doctors. Being able to take 'difficult and sad' and turn it into relief and empowerment is the reason we stay nurses, midwives and doctors.

It is a privilege to support and unburden women, who often come

WORKING WITH WOMEN
IN ABORTION CARE IS A
THOROUGHLY REWARDING
CAREER CHOICE FOR
NURSES AND MIDWIVES. I
CAN HIGHLY RECOMMEND
THIS CAREER PATHWAY.

having already used their complex problem solving skills to work through what is best for them and their family. I work in a non-judgemental service that allows me the time and resources to support women. It's a pleasure to see the relief a woman experiences within a short time of visiting our centre. They realise that unplanned pregnancy and abortion is very common and that there will be no judgement, only caring with kindness that is offered to them during an often difficult time.

Working with women in abortion care is a thoroughly rewarding career choice for nurses and midwives. I can highly recommend this career pathway.

Julie Green is a Clinical Nurse in the Pregnancy Advisory Centre at Central Adelaide Local Health Network in South Australia



Reference

Children by Choice – Unplanned Pregnancy in Australia. 2016. <https://www.childrenbychoice.org.au/factsandfigures/unplannedpregnancy> Accessed June 2017.

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STUDENTS PARTICIPATING IN FEMALE ANATOMY SESSION, BRAD WILSON, NICHOLAS FISHER, NICHOLAS YACCOB (WITH SPECULUM), CHLOE DELACY, SARAH BUCHMAYER AND DEBBIE MORGAN RN

SEXUAL AND REPRODUCTIVE HEALTH EDUCATION PROJECT FOR ABORIGINAL AND TORRES STRAIT ISLANDER YOUNG PEOPLE IN THE AUSTRALIAN CAPITAL TERRITORY (ACT)

By Debbie Morgan

Sexually transmitted infection (STI) rates in Aboriginal people are the highest of any specific population group in Australia, disproportionately affecting young people under the age of 30 throughout all community groups (Ward et al. 2014 p1).

In response to the poorer health and life expectancy outcomes for Aboriginal and Torres Strait Islander people, the Australian government initiated the Closing the Gap Campaign in 2006.

As part of a Closing the Gap initiative, Canberra Sexual Health Centre (CSHC) joined the Antenatal care, Pre-pregnancy and Teenage Sexual and Reproductive Health project in 2012. This project includes a midwife who runs Core of Life pre-pregnancy education and the CSHC providing education and promotion of sexual health testing with the aim of reducing the prevalence of STIs in Aboriginal and Torres Strait Islander young people in the ACT.

A sexual health nurse is employed to provide flexible education activities to schools, community organisations and other youth facilities with a high proportion of Aboriginal and Torres Strait Islander participants. Education content is tailored to each group with potential topics

including anatomy, sexuality, consent, contraception, blood borne viruses (BBV), STIs, sexual healthcare and services, safer sex and safer injection practices. Where possible education is provided over multiple sessions, via different modes of delivery and includes opportunistic STI testing. The sexual health nurse consults with organisations and schools in deciding the number of sessions and what style of presentation and topics are most relevant for the group.

"Health service access and appropriate testing and treatment are recognised as an important factor in reducing STI and BBV incidence prevalence in Aboriginal and Torres Strait Islander communities" (Ward et al. 2014 p41).

Some community organisations have initiated clinic visits so young people can become familiar with the location and services offered at CSHC, with the aim to demystify and normalise a visit to a sexual health service. The visit to the clinic

includes a brief education session which demonstrates what is involved in registering as a client, having an STI and BBV screen, and genital examination using pelvic models in the clinic setting. All the young people who have participated in these clinic visits have provided positive feedback. As part of the visit STI and BBV screening is offered and most students participate in testing. This clinic visit is usually the first time young people have attended a sexual health service and the first time they have had STI and BBV testing.

Project outcomes include the development of knowledge and skills to encourage confidence in Aboriginal and Torres Strait Islander young people to seek sexual healthcare at a range of services across the ACT.

Debbie Morgan is a Sexual Health Nurse at the Canberra Sexual Health Centre at the Canberra Hospital in the ACT



Reference

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SEPTEMBER

National Blue September Month (Fighting Cancer in Men)
www.blueseptember.org.au

National Prostate Cancer Awareness Month
www.prostate.org.au/articleLive/

National Gold Bow Day (The Australian Thyroid Foundation)
1 September.
www.thyroidfoundation.com.au/atf-awareness-events/gold-bow-day.html

National Footy Colours Day – Fight Cancer Foundation
2 September.
www.footycoloursday.com.au

Lung Health Promotion Centre at The Alfred
Asthma & Allergy Seminar
4 September
Respiratory Course (Modules A & B)
18–21 September
Respiratory Course (Module A)
18–19 September
Respiratory Course (Module B)
20–21 September
P: (03) 9076 2382
E: lunghealth@alfred.org.au

12th Conference of the Australian College of Nurse Practitioners
Innovate, integrate, motivate: Leading advanced practice
4–7 September, Sofitel Brisbane Central, Qld.
www.acnncpconference.com.au/

Women's Health Week
4–8 September.
www.womenshealthweek.com.au/
E: whw@jeanhailes.org.au or
P: 1800 JEAN HAILES

International Wound Practice and Research Conference
6–7 September, Brisbane Convention & Exhibition Centre.
http://iwprc2017.com.au

Wound Care and the Latest Best Practice
A practical approach to wound management
7–8 September, Hobart.
https://goo.gl/yzh6nQ

National R U OK? Day
8 September. www.ruokday.com/

Victorian School Nurse Conference
9 September, Lauriston Girls School Armadale. Contact Lindsey Booth
E: lbooth@whitefriars.vic.edu.au
M: 0407 509 622. Book at
www.trybooking.com/OPRX

World Suicide Prevention Day
10 September. http://wspd.org.au/

3rd Australian Nursing and Midwifery Conference
14–15 September, Newcastle Exhibition and Convention Centre, Newcastle, NSW. www.nursingandmidwiferyconference.com.au

Enrolled Nurse Professional Association (ENPA NSW) Conference
21–22 September, Mercure Hotel, Sydney. http://www.enpansw.org/

ANMF Australian Nurses and Midwives Conference
21–22 September, Melbourne Convention and Exhibition Centre. Register now to attend Australia's most extensive nursing and midwifery conference. Attending both days earns you 15 hours of CPD. http://bit.ly/ANMFEvents

23rd World Nurse Practitioner Conference
Bridging Excellence in Nursing and Nursing Practice
28–29 September, Dubai, UAE.
http://nursepractitioner.nursingconference.com/middleeast/

18th Australasian Nurse Educators Conference
Transition, Technology, Transformation
28–30 September, St Margaret's College, Christchurch, New Zealand.
http://anec.ac.nz/

World Heart Day
29 September.
www.world-heart-federation.org/what-we-do/world-heart-day/

International Police Remembrance Day
29 September. www.afp.gov.au/about-us/our-organisation/ceremonial-events-and-functions/ceremonial-events/national-police

OCTOBER

Lactation Consultants of Australia & New Zealand (LCANZ) Seminars 2017
Please join us in October for our walking tour in Sydney and Wellington. Speakers, topics, and more info can be found on our website: www.lcanz.org

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.
http://www.acnn.org.au/events/acnn-national-conference/

21st Australasian Menopause Society Congress
Menopause: Exploring the evidence
13–15 October, Sofitel Sydney Wentworth, NSW.
http://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/

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

Australasian Sexual Health Conference
7–9 November, National Convention Centre Canberra. www.ashm.org.au

Eureka Climb
12 November. The race to the top of Melbourne's tallest building. At 88 levels, 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/

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

NETWORK

Prince Henry's Hospital Melbourne, October Group, 50-year reunion
7 October. Contact Terri Flanagan (nee O'Loughlin) E: t.flanagan@bigpond.com or M: 0417 900 509

Alfred Hospital Nurses League Inc. 98th Annual General Meeting and Lunch
21 October at 12.00, Emerald Hotel, South Melbourne. Contact Elizabeth Angell E: angell@bigpond.net.au

Sturt College, First Year Nurses, 50-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: tapric135@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

NOTICE TO MEMBERS ANMF FEDERAL OFFICE FINANCIAL REPORT

The ANMF Federal Office Financial Report for the year ended 30 June 2017 is now available at www.anmf.org.au. Members without internet access may obtain a hard copy of the report by applying in writing to:

Federal Finance Officer ANMF
Level 1, 365 Queen Street
Melbourne Vic 3000

GREEN HEALTHCARE NEEDED

Thank you for your article 'Green healthcare' (July issue of the *ANMJ*). I am encouraged by the recycling efforts of workplaces such as Epworth Healthcare in Melbourne.

I am a nurse working in a private healthcare clinic and despair at the amount of waste we produce. This includes plastic medicine cups that we throw out in the hundreds each and every week; new plastic cups that arrive individually wrapped in plastic and an incredible amount of perfectly edible food thrown out every day. In our garden we grow a small amount of herbs and vegetables but this produce cannot be used for patient meals.

I feel powerless to do anything about this waste. Even if staff wanted to we cannot take this food home to feed our dogs or chickens due to OH&S legislation. We have minimal recycling options and even those are then wrapped in plastic garbage bags.

As someone who cares deeply for the environment and takes steps in my personal life to reduce waste and environmental pollution, the waste I witness daily in my workplace is distressing.

Where is our duty of care to the environment? How can we contribute to the UN's Sustainable Development Goals? When will things change? Yours in despair.

RN, Tasmania

LETTER
OF THE
MONTH

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

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



EUTHANASIA

As the ANMF continues its support and push for voluntary euthanasia in Australia, I wonder if it has been keeping an eye on what has been happening in The Netherlands in this regard.

For example, in June this year, it was reported that the Dutch political party D66 was preparing to introduce the '*Completed Life Bill*' which would allow any person aged 75 or over, even if they are perfectly well, to receive euthanasia.

This same party openly admits that they would like to legalise euthanasia for any adult who wishes to die.

Who would have thought that when euthanasia was introduced in The Netherlands in 2002 that 15 years later, it would 'progress' to this stage. And this comes at a time when data from The Netherlands shows that in 2015, 400 patients were put to death by their doctor without having given explicit consent. In Melbourne's *Herald Sun* on 5 July, Notre Dame University Bioethics Professor Margaret Somerville expressed that "once euthanasia is normalised, slippery slopes are unavoidable".

I continue to ask how the ANMF has arrived at its view to push for euthanasia. How has it consulted its members in reaching this decision? Why hasn't the ANMF presented both sides of this debate?

Neil Mills, SA

THE HORRIFYING HANDOVER

I work steadily all shift taking care of the patients allocated to me, meeting their ADL and clinical needs, recording data, cleaning up mess, providing pain relief, providing comfort and care. When it is time to handover I review the patients who have placed their trust in me, to be their body when their own body is unable to function effectively.

My patients are clean and comfortable, I feel all is right with the world. The incoming, fresh nurse arrives. The patient folder is scrutinised with critical eyes. Tiny errors are pointed out- the nurse gives a hard stare. Minute imperfections and omissions are questioned, more hard staring.

My heart pounds, I feel my stomach churn. A fog descends over the mind; I am unable to answer a direct question. All information has suddenly disappeared from my brain. Things I was certain of now seem very doubtful. The oncoming nurse shows no mercy. It appears I have been doing nothing at all for the entire shift. What have I been doing, to fail so badly? Where, I wonder, did the time go?

The fact that the patients are content counts for nothing at these handovers.

This is what handover has become. Not a sharing of information but an inquisition- a time to put down the efforts of another.

If we can be kind to the people in our charge why not be kind to our colleagues, those who are tired from the day long hard slog, probably dehydrated or traumatised by the experiences and events of the shift, who are depleted from having too little time in which to do too much for too many people.

Kindness and compassion can be offered to all whom cross your path, in any situation. It doesn't have to be reserved for those with a pathology.

Love and kindness grow exponentially. The more you offer the more there is. Save some for your colleagues, make the world a better place.

Sally Niemann RN, SA

Retraction

The article 'Dying in subacute care' published in *ANMJ* February 2017 is retracted at the request of the speaker who featured in the text.

SPOTLIGHT ON MENTAL HEALTH

Many thanks for the spotlight on mental health nursing, 'Lean on me', in the August issue of the *ANMJ*.

I recently had the opportunity to network with nursing colleagues from all over Adelaide at the annual ANMF (SA Branch) nurses' conference at the Adelaide Convention Centre.

I met many nurses and had to search my brain for when and where I knew people. I am a long timer in the nursing profession, coming up to forty years. There have been many advances but what hasn't changed is a nurse's ability to focus on optimum patient care.

Sometimes the toll of trying to 'help' people can become overwhelming. This is a most particular occupational hazard in mental health nursing. There are policies, procedures and methodology to assist with this. But the human element of seeing people in acute distress can reach saturation point.

Robert Fedeale reports on the need to value this profession, who unfortunately often see people only at their lowest point.

I would add my voice to person centred care that recognises both the consumer and health professional.

Just as the lyrics sung by Ben Lee - 'we are all in this together'.

Jenny Esots RN SA

BIG DATA AND HEALTHCARE

I recently watched a movie called *Hidden Figures* – a film that followed three incredible women's contribution to the United States' pursuit for a man to enter space during the late 1950s and 1960s.



Sally-Anne Jones, ANMF Federal President

I was moved and empowered by the story as the themes of race and gender inequality were explored in a number of ways, but I was equally drawn to reflect on the use of data and technology – both then and today.

In 1960, data was gathered, stored and reported firstly by hand and then through massive computers that filled whole rooms. Complicated algebraic calculations were completed using slide rules and longhand, where reams of paper were consumed to provide a single piece of information to be used for one tiny part of the journey of a spacecraft and then never used again.

The astronaut, strapped in and waiting for ignition, waits as the results of all that data come to fruition and upon which his life depends.

Healthcare in any setting today is saturated in data, and as the tsunami of data continues to grow we may be asking how this is used to

create meaning for the people in our care.

Data now streams from daily life: from phones and credit cards and televisions and computers; from the infrastructure of cities; from sensor-equipped buildings, trains, buses, planes, bridges, and yes, even hospitals.

The data flows so fast that the total accumulation of the past two years dwarfs the prior record of human civilisation. But it is not the quantity of data that is world-shattering. What is world shattering is that now we can do something with the data.

The term 'Big Data' refers to extremely large data sets that may be analysed computationally to reveal patterns, trends, and associations, especially relating to human behaviour and interactions. Big Data in healthcare is being used to predict epidemics, cure disease, improve quality of life and avoid preventable deaths. With the world's population increasing and everyone living longer, models of treatment delivery are rapidly changing, and many of the decisions behind those changes are being driven by data. The incentive now is to understand as much about a patient as possible, as early in their life as possible – potentially identifying early signs of serious illness at a stage that treatment is far more simple, effective and inexpensive than if it had not been found until later.

"Every revolution in science – from the Copernican heliocentric model to the rise of statistical and quantum mechanics, from Darwin's theory of evolution and natural selection to the theory of the gene – has been driven by one and only one thing: access to data" (John Quackenbush, a professor of biostatistics and computational biology 2017).

Given the sheer size of the human population and the incredible complexity of healthcare delivery, with thousands of diseases, thousands of medications and interventions, the reconciliation of data-driven improvements in clinical medicine with good population health is complex. However, the recent development of new methods to collect, analyse and apply data on an unprecedented scale may allow the gap between healthcare delivery and population health to be bridged and many health outcomes to be improved.

The convergence of increasing data availability, analytical capabilities, and the pressing need to improve healthcare quality and patient outcomes have created the 'big data analytics' (BDA) era in healthcare. I can recommend the article, Rumsfeld, Joynt and Maddox 2016, Big data analytics to improve cardiovascular care: promise and challenges, *Nature Reviews Cardiology*, 13(6), (pp.350-359) which presents the opportunities of big data use in one specific disease, in simple terms exploring the benefits, risks and

expectations of the big data revolution in health.

In a World Health Organization bulletin in 2015, Rosemary Wyber et al. stated that the collection of information from individuals, which is a prerequisite for any big data approach, is "fraught with ethical, regulatory and technological issues. Given the increasing complexity of the field, the protection of individuals and populations must move from purpose-specific consent to emphasise appropriate use, risk assessment and risk minimisation. The anonymisation of data must be robust, monitored and enforced. Appropriate use must remain coherent with evolving societal values. Furthermore, the big data approach can amplify the existing difficulties associated with healthcare delivery in settings with scarce resources."

Any electronic database can be hacked. In May and June 2017, companies in nearly 100 countries were made vulnerable to a global 'ransomware' attack, including Britain's health service. Fortunately, it seems no patient level data was lost during that time. But increasing volumes of storage and use of health data increases vulnerability to mishap – malicious or otherwise.

Even in advanced IT developed countries, purpose-specific informed consent is increasingly being rendered meaningless by high levels of complexity in the ways that collected data are or might be used. Privacy protection is a right and preservation of public trust is a necessity. However, as the full potential of the big data approach to improve health becomes clearer, perhaps there is also a right for populations to reap all of the potential benefits of such an approach.

The development and use of big data in health is necessarily moderated by patient privacy, consent, data security, and many other legal considerations, and must remain so.

It feels as though technological capability is currently outstripping our moral, ethical and legal frameworks that ensure safety and personal identity security.

And so back to the movie and its references to data...it strikes me that, while different to NASA, things are not that much different in healthcare.

The reams of data that we begrudgingly enter, collect, report and respond to feel meaningless and endless – somehow very disconnected from actual patient care. And yet a patient, waiting for our care, whether at home, in a residential facility, in an acute setting, family or community, awaits the results of a bunch of data to come to fruition and upon which his or her life may depend. Those seemingly wasted minutes you dedicate to entering *any* data about your patient may have a bigger impact in healthcare and health outcomes than you can imagine.

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