



# ANMJ

AUSTRALIAN NURSING & MIDWIFERY JOURNAL  
VOLUME 25, NO.2, AUGUST 2017

## LEAN ON ME

THE CHALLENGES AND  
OPPORTUNITIES FACING  
MENTAL HEALTH NURSING

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14

# LEAN ON ME

THE CHALLENGES AND OPPORTUNITIES FACING MENTAL HEALTH NURSING

## REGULARS

### 02 DIRECTORY

### 03 EDITORIAL

### 04 NEWS

### 10 WORLD

### 12 OH&S

WHAT LEVEL OF RESPONSIBILITY MUST NURSES AND MIDWIVES TAKE AGAINST WORKPLACE INJURY?

### 14 FEATURE

LEAN ON ME: THE CHALLENGES AND OPPORTUNITIES FACING MENTAL HEALTH NURSING

### 20 ISSUES

NURSE MANAGERS: WHY EMOTIONALLY-INTELLIGENT LEADERSHIP MATTERS

### 21 PROFESSIONAL

ONE FOR ALL AND ALL FOR ONE

### 22 EDUCATION

PRE AND POST-OPERATIVE CARE

### 24 ISSUES

PERIPHERAL INTRAVENOUS CANNULA IN THE EMERGENCY DEPARTMENT

### 25 LEGAL

DISCIPLINARY ACTION FOR FAILING TO REPORT AN ERROR

### 26 CLINICAL UPDATE

VOODOO HEALTH POLICY – THE PERSECUTION OF HIV+ PERSONS WHO ARE APPLYING TO IMMIGRATE TO AUSTRALIA

### 30 RESEARCH

### 31 VIEWPOINT

TOWARDS A NEW MODEL OF CARE

### 32 FOCUS

EDUCATION: PART 2

### 47 CALENDAR

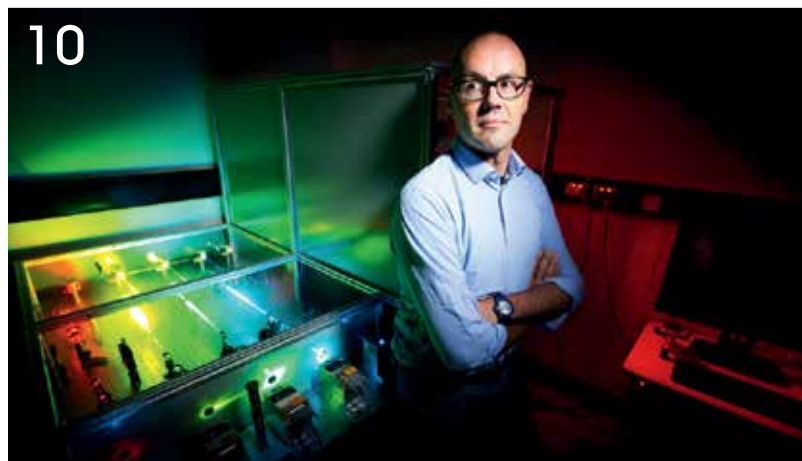
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24

10



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Senior Design: Daniel Cordner

Printing: Franklin Printing

Distribution: D&D Mailing Services

The Australian Nursing & Midwifery Journal is delivered free monthly to members of ANMF Branches other than New South Wales, Queensland and Western Australia. Subscription rates are available on (03) 9602 8500. Nurses who wish to join the ANMF should contact their state branch. The statements or opinions expressed in the journal reflect the view of the authors and do not represent the official policy of the Australian Nursing & Midwifery Federation unless this is so stated. Although all accepted advertising material is expected to conform to the ANMF's ethical standards, such acceptance does not imply endorsement. All rights reserved. Material in the Australian Nursing & Midwifery Journal is copyright and may be reprinted only by arrangement with the Australian Nursing & Midwifery Journal

Note: ANMJ is indexed in the cumulative index to nursing and allied health literature and the international nursing index ISSN 2202-7114

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ON A2 GLOSS FINESSE,  
PEFC ACCREDITED  
PAPER. THE JOURNAL  
IS ALSO WRAPPED  
IN BLOWRAP, A  
DEGRADABLE WRAP.

# 131,889

## TOTAL READERSHIP

Based on ANMJ 2014 member survey pass on rate

Circulation: 90, 174

BCA audit, March 2017



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## Editorial

Lee Thomas, ANMF Federal Secretary



Aged care and the treatment of older Australians have been in the media spotlight of late, but not in a good way.

You may have heard or read reports about an aged care resident near Newcastle found with maggots in her mouth. Other aspects about the standard of her care are also being questioned.

In South Australia, the Oakden nursing home for older people with complex mental health needs came under scrutiny earlier this year for many disturbing incidents including gross inappropriate treatment of their residents – not to mention the unhygienic conditions they were forced to live in.

Sadly these are just two examples of many horrific incidents that are occurring in aged care facilities across the country – a clear indicator that aged care has hurtled into severe crisis.

Much of this problem is systemically linked to a lack of minimum staffing and appropriate staffing mixes in aged care facilities.

This was indicated in the Australian Law Reform Commission's recent damning report, *Elder Abuse – a National Legal Response*. It acknowledged a direct association with the lack of minimum staffing regulations and appropriate skill mix and the administration of inappropriate care as one of the greatest abuses of vulnerable nursing home residents.

A recent Senate Inquiry into Australia's under-resourced aged care workforce also found nurse to resident ratios were too low and risked compromising the quality of care delivered. The Inquiry received over 323 submissions and members working on the ground in aged care recounted shocking stories of how the elderly were being neglected due to staffing shortages.

What more evidence does the government need to acknowledge this sector is in crisis and needs fixing immediately? Why as Australians are we allowing our vulnerable elderly to be treated this way?

It's time for the government to act now and accept the recommendations made in the Inquiry and address the urgent and undeniable need for minimum staffing levels in aged care. This is critical to the survival of people living in nursing homes everywhere.

In the journal this month the feature looks at another group of vulnerable Australians – those living with mental illness. The feature delves into how the sector has been reformed over the years and why allowing mental health nurses to work to their full scope is crucial to the care of their consumers under the current model.

In news, a petition presented to the House of Representatives has called for urgent consideration to award Gold Cards to all surviving Australian nurses, doctors, physiotherapists, radiographers and laboratory technicians who volunteered in Vietnam during the war. The ANMF and the Southeast Asia Treaty Organization (SEATO) nurses have campaigned for about 15 years for civilian nurses who served in the Vietnam war to receive access to entitlements under the *Veterans' Entitlement Act*. We urge Parliament to act on this petition and give these nurses and other healthcare workers the entitlements they truly deserve.

I also urge you to read the back page this month where ANMF Federal Vice President Lori-anne Sharp debuts her first column for the *ANMJ*. In her article she talks about her journey as a job rep for the ANMF Vic Branch (also known as work site reps or delegates in some states) and how this has given her the confidence to take on other roles in her life.

lee

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PAGE 14 TO  
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ON MENTAL  
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## CIVILIAN NURSES LEAD THE MARCH ON NATIONAL VIETNAM VETERANS' DAY

The fight for civilian nurses who served in the Vietnam War to have proper recognition and receive access to veterans' entitlements has been re-ignited with a petition tabled in Parliament.

It comes as the civilian surgical teams will lead the march to the Shrine of Remembrance in Melbourne for the first time on National Vietnam Veterans' Day on 18 August.

A petition presented to the House of Representatives late last month called for urgent consideration to be given to the awarding of Gold Cards to all surviving Australian nurses, doctors, physiotherapists, radiographers and laboratory technicians who volunteered and essentially worked as a civilian in the army in Vietnam from October 1964 to December 1972 during the Vietnam War.

It is estimated about 450 of these health professionals are still alive. Many have serious health conditions such

as cancers, non-Hodgkin's lymphoma, autoimmune disease, multiple sclerosis, post-traumatic stress disorders and other anxiety disorders. Some were entitled to ComCare up to the age of 65 but, due to age, none are now eligible.

The Southeast Asia Treaty Organization (SEATO) nurses and the ANMF have campaigned for about 15 years for civilian nurses who served in the Vietnam War to receive access to entitlements under the *Veterans' Entitlements Act 1986*.

"Despite active service in Vietnam they have been considered as civilians and therefore not entitled to benefits under the *Veterans' Entitlements Act 1986*," ANMF Federal Secretary Lee Thomas said.

A morbidity study of female Vietnam veterans released by the federal government in 1998 identified 16 conditions with a higher incidence than normal for Australian women. Congenital defects were found amongst some children of women who had served in Vietnam.

Former ANF Federal President and RN Jennifer Gibbs set up the petition after viewing The Alfred's 'Nineteen Nurses', a DVD on the civilian nurses who served in Vietnam.

"I've worked with nurses who came back from Vietnam and I did not properly understand until now."

Once tabled, the relevant government department has three months to respond to the House of Representatives. Ms Gibbs said she planned to take the case direct to Canberra.

Former Vietnam veteran civilian nurse and avid campaigner Dot Angell (pictured) welcomed the petition. "I think it's great because it's been put up by a group other than the civilian surgical teams – it means we have the public backing us."

Ms Angell will provide the keynote address at this year's National Vietnam Veterans' Day at The Shrine in Melbourne. "I consider it a great honour; it means that the military veterans totally accept us as veterans."

Ms Angell has two autoimmune conditions and post-traumatic stress disorder. She said the civilian surgical teams would continue their fight to help future generations.

"Never again should a civilian force be sent into a war zone without appropriate war coverage. I think that's the most important point now - it's not just for us but for future generations."

"We are trying to get the government to give every ex-service person a Gold Card on their discharge so they can access proper health treatment and not just for mental health access," Vietnam veteran George Dragon said.



## CATCH-UP VACCINES TO INCLUDE REFUGEES

Health organisations have welcomed the federal government's announcement last month for 'catch-up' vaccines under the National Immunisation Program to include refugees.

The 'catch-up' program for young people under 19 years of age who have missed out on vaccinations will be expanded to include refugees and humanitarian entrants into Australia of all ages.

Government statistics show there are currently 467,000 Australian children and young people aged 10-19 years who are not fully immunised.

The lack of full immunisation in the community which threatens herd immunity to prevent infectious diseases outbreaks was highlighted at the Communicable Diseases Control Conference held in Melbourne last month.

Vaccine-preventable diseases such as measles, meningococcal and whooping cough posed a significant threat to health security in Australia, leading epidemiologists and public health experts warned.

Public Health Association of Australia (PHAA) CEO Michael Moore said it was critical Australia did not become complacent about immunisation.

"Many dangerous diseases are no longer commonplace, and we don't want to see the return of these diseases in Australia as a result of people not receiving the proper vaccinations."

Mr Moore said it was a practical decision to include refugees and humanitarian entrants to Australia in the national immunisation program. More than 11,000 refugee and humanitarian entrants will be eligible to receive the catch-up vaccines.

"They may not have been available to them during childhood, and this will provide them with protection from disease as well as further safeguarding the rest of the population from outbreaks."

Australian College of Nursing CEO Adjunct Professor Kylie Ward said immunisation was particularly vital at times like now. "We are seeing a 50% spike in the number of cases of whooping cough in South Australia compared to the same time last year."



## PRIVATISATION OF NSW HOSPITALS SCRAPPED

Several public hospitals in New South Wales have escaped privatisation after almost a year of determined campaigning by the NSW Nurses and Midwives' Association (NSWNMA ANMF NSW Branch) helped trigger a backflip from the state government

Five public hospitals – Maitland, Wyong, Goulbourn, Shellharbour and Bowral – were flagged for privatisation last year in shock developments that sparked concerns over the potential for poorer quality patient care and left hundreds of nurses and midwives facing uncertain futures.

In recent months, the state government, likely responding to widespread community backlash, shelved many of its plans when confirming three of the hospitals, Wyong, Bowral and Goulbourn, would no longer be moving into private hands.

However, concerns still linger for the remaining two hospitals.

While a new model was announced for Maitland Hospital by the state's Health Minister, NSWNMA claims it will not meet the needs of the community, nor staff, and nevertheless represents privatisation of a public service.

For example, NSWNMA General Secretary Brett Holmes (pictured) pointed

to staff losing their Public Health Conditions of employment after two years and raised similar fears that there will be no guarantee on staff to patient ratios in two years' time when staff are forced to migrate to a new employment agreement.

Elsewhere, Shellharbour Hospital remains in limbo.

Positively, the government's decision to back away from several of its strategies marks a major win for the union and bolsters future campaigns against private involvement.

**"HANDING OVER PUBLIC HOSPITALS TO BE BUILT AND RUN BY PRIVATE OPERATORS RESULTS IN A LOSS OF ACCOUNTABILITY, A LACK OF SAFE PATIENT CARE AND MORE TAXPAYERS' DOLLARS BEING GIFTED TO PRIVATE SHAREHOLDERS."**

Mr Holmes said the outcome illustrated that common-sense had prevailed.

"There is overwhelming evidence showing public-private run partnerships are an expensive, ill-fitting model when it comes to the health sector.

"Handing over public hospitals to be built and run by private operators results in a loss of accountability, a lack of safe patient care and more taxpayers' dollars being gifted to private shareholders."



Mr Holmes said the NSWNMA's unwavering stance against privatising public hospitals would continue.

He added it was now imperative that the government fast track funding to ensure upgrades at several of the hospitals in question are carried out and delivered on time in order to cater to growing community demand.

The government's privatisation plans had forced hundreds of professional nursing and midwifery staff to wait on the sidelines as their futures were considered, with Mr Holmes paying special mention to their resolve and continued hard work and dedication.

## DRAFT NATIONAL MIDWIFERY FRAMEWORK SCRAPPED

Midwives' and medical groups have applauded the recent decision to scrap a draft framework to inform national maternity services.

The proposed draft National Maternity Services Framework (NMSF) lacked support across the sector and has been highly criticised by midwives, doctors and consumers.

The decision to start afresh by the Australian Health Ministers' Advisory Council (AHMAC) came at a national workshop. There was overwhelming support from stakeholders including midwives, nurses, doctors and health

consumers to scrap the document with concerns over lack of consultation and that the NMSF did not meet the needs of women and services.

Australian College of Midwives (ACM) past President Professor Sue Kruske said the best thing for all concerned was to start again. "The consultation process for the draft Framework was inadequate and the timeframes unrealistic to ensure meaningful contributions and buy-in from the stakeholder groups, especially consumers."

ACM concerns included a focus on antenatal health risk factors and clinical conditions in the antenatal period rather than a broader discussion about what was the appropriate approach across the whole childbirth continuum, Professor Kruske said.

"Despite the very strong message at the forums that continuity of midwifery was an effective model for maternity care, this was completely ignored, as were the role of midwives within the Framework."

Professor Kruske said the ACM was committed to working with the government and an adequately represented reference/working group to ensure outcomes that met the needs of Australian women.

Australian Medical Association (AMA) representative and obstetrician Dr Gino Pecoraro said the decision to scrap the flawed NMSF was a win for the women and children of Australia.

"What has happened has been a monumental missed opportunity to achieve the best possible maternity care for mothers and babies".

The AMA remained committed to working with government and all stakeholders to see a strong and safe framework, Dr Pecoraro said.

Rural Doctors Association of Australia (RDAA) Vice President Dr John Hall said there had been no specific consultation with rural clinicians.

"It is great to see AHMAC responding to the concerns not only of doctors – but also of nurses, midwives and health consumers – by agreeing to a new process that will better reflect the views of all stakeholders."

Dr Hall said the views of rural women, along with health professionals who provided much-needed maternity and obstetric care in the bush needed to be reflected in the new draft framework.

## NURSES LEAD WAY IN CARING FOR HOMELESS

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

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

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

Most clients have fallen through the cracks, either unable to navigate the health system due to not having a roof over their head or assessed as too difficult by services.

"Within our program we talk about homelessness making people sick," Ms Dowling said. "Clients actually have quite complex morbidities like liver cirrhosis, respiratory disease, diabetes, Hepatitis C, mental illness and substance use disorders, all of which are potentially not managed in any way."

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

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

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

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

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



COMMUNITY HEALTH NURSE CLAIRE DOWLING

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

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

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

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

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

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

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

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

healthcare.

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

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

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

"He's achieved his goals and his goal was to achieve housing and be independent but I don't think that would have happened had we not worked with him," Ms Dowling said. "It gives you motivation to continue to assist the clients to achieve their personal goals and to try and build capacity for their own personal change because quite often the clients don't believe. They have no sense of self-esteem and don't believe in themselves. But by informing them and empowering them you can assist them to have that capacity."



Homelessness Week 2017 runs from 7-13 August. For more information visit [www.homelessnessaustralia.org.au](http://www.homelessnessaustralia.org.au)



## MIDWIFERY STANDARDS OPEN FOR FEEDBACK

Draft standards for midwifery practice are open for public consultation until later this month.

The Nursing and Midwifery Board of Australia's (NMBA) current *National competency standards for the midwife* were published in 2006. They are the core competency standards by which a midwife is assessed to obtain and retain registration to practise in Australia. The standards include the role and scope of a midwife; model of education and training; and the regulatory framework within which midwives operate.

Deakin University was appointed to develop the *Midwife standards for practice* which included a review of the existing *National competency standards for the midwife (2006)*.

"The draft *Midwife standards for practice* have been thoroughly researched so that they're suitable for midwives in all contexts of practice. These standards will provide a framework for assessing a midwife's competence to practice in Australia and are important for public safety," NMBA Chair Associate Professor Lynette Cusack said.

"We are now asking the profession and other stakeholders to review these standards and complete the survey to give us their feedback." Those interested are encouraged to provide feedback through an online survey, which is open until **Friday 25 August 2017**. The *Midwife standards for practice* consultation documents and survey can be accessed at [www.nursingmidwiferyboard.gov.au](http://www.nursingmidwiferyboard.gov.au)

## AGED CARE ADVOCACY PROGRAM

The federal government announced \$25.7 million in funding for a new national aged care advocacy program last month.

The new program will be delivered by the Older Persons Advocacy Network. OPAN will deliver the advocacy program through its network of nine service delivery organisations across Australia.

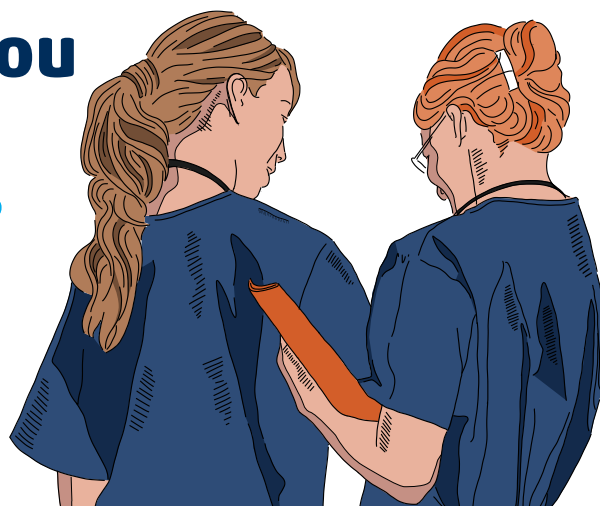
Federal Aged Care Minister Ken Wyatt said the move to a single provider would drive a more consistent, national approach to the delivery of advocacy services. Leading seniors' advocacy group COTA Australia Chief Executive Ian Yates said advocacy groups had a crucial role to play in the rapidly changing aged care environment to ensure consumers were able to exercise their rights and get the best out of the aged care system. "This is now a genuinely national program that should in the near future see better outcomes for aged care consumers everywhere across Australia."

The federal government also announced \$34million in funding grants to support innovation in dementia care and other aged care services. A total of 42 projects will receive grants with the focus on six priority areas. For more information visit tenders and grants at [www.health.gov.au](http://www.health.gov.au)

## "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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## POWER OF POSITIVE THINKING TO FACE ILLNESS AND TRAUMA

Positive thinking may have the power to hasten the recovery of seriously ill patients and help disaster victims to overcome the psychological impact of a traumatic experience.

The research from the University of Sydney Business School is to be published in the *Journal of Consumer Research*.

"People who are more optimistic about their recovery when they are ill are more likely to recover. They're more likely to have positive mental health, and they're more likely to have a range of positive physiological outcomes," University of Sydney's Professor Donnel Briley said.

The research team included

experts from Stanford University and the University of Houston in the United States. The researchers monitored levels of optimism in ill and traumatised people through a series of experiments and 'different variables'. They also looked at physiological outcomes.

"For example, we included in one study a hand grip task and we found that people squeezed it longer and more vigorously the more optimistic they were about their futures," Professor Briley said.

The most effective thoughts were those that focused on future activities or behaviours.

"Mentally stimulating your future is incredibly important to optimism. If I'm ill, I might want to exercise more and by imagining myself exercising more actually makes it more likely that I will exercise more in the future," Professor Briley said.

Culture also played a major role in determining the type of thoughts that produced a positive or optimistic state of mind, the researchers found.

In one study that involved cancer patients, those of an East-Asian background were much more optimistic when thinking about the particular situations they might face in the future while this bogged Anglo-Saxons down, Professor Briley said. "Anglos were much more optimistic when they were thinking in the abstract, and not about specific situations."

## NEW AWARD CELEBRATES HIGH-PERFORMING HEALTHCARE SYSTEMS

The Australian Council on Healthcare Standards (ACHS) has launched a new program designed to showcase high-performing systems or services within healthcare organisations.

Dubbed The Exemplar Award, the program was triggered by a perceived lack of recognition among consistently high-performing healthcare organisations.

ACHS President, Professor Len Notaras, said the Council had been

working towards delivering such a program for several years.

"We have had numerous requests from our high performing member organisations who have been keen to seek recognition beyond the meeting of accreditation standards," Professor Notaras said. "We understand the need for recognition can be a driving force in attaining high-performance results that translate to high quality consumer/patient outcomes."

Importantly, the introduction of The Exemplar Award is likely to set new benchmarks when it comes to the establishment of future projects.

The program involves four distinct application phases beginning with an expression of interest, documented application and submission, before being assessed.

All submissions will be required to qualitatively and quantitatively demonstrate their achievements.

"The early feedback we have received from some of our members has been a strong sense of excitement that there is now an award that recognises exemplary innovation, appropriately judged against seven key factors of high performance," Professor Notaras said.

## SYMPTOMS OF TYPE 1 DIABETES OFTEN OVERLOOKED

Hundreds of Australians are hospitalised each year with serious life-threatening situations before being diagnosed with type 1 diabetes, a call for action from Diabetes Australia has warned.

Launching their new campaign *It's About Time* last month, Diabetes Australia urged the community, families, schools and health professionals to better recognise the early signs of type 1 diabetes in order to avoid costly and unnecessary hospitalisations.

It revealed about 640 Australians are hospitalised each year before discovering they have type 1 diabetes.

The admissions stem from failure to detect early symptoms of the chronic condition such as thirst, increased visits to the toilet and weight loss that can lead to a dangerous condition called diabetes ketoacidosis.

"This can be life-threatening," Diabetes Australia CEO Professor Greg Johnson warned. "But most of these hospitalisations could be avoided if the early signs were identified and the type 1 diabetes treated before progressing to ketoacidosis."

The awareness campaign encourages all Australians to learn the early signs of type 1 diabetes and specifically asks people to look out for the 4T's – thirst, toilet, tired, and thinner.

Type 1 diabetes is more common than most people think, with more than 3,000 Australians, including 50% of children and adolescents, diagnosed each year.

If early signs are uncovered, people are urged to see a doctor straight away.

Professor Jerry Wales, from the Lady Cilento Children's Hospital in Brisbane, said his workplace has increasingly seen patients presenting to hospital with diabetes ketoacidosis.

"Too many children arrive at hospital seriously ill from type 1 diabetes and it is only when they get to hospital that they are diagnosed," Professor Wales explained.

"Diabetes ketoacidosis is a serious condition associated with high blood glucose levels. It is a sign of insufficient insulin. People who are showing signs of diabetes ketoacidosis need urgent medical assistance."

As part of the awareness campaign, Brisbane mother Jessica Browning recounted the experience of her son, Reuben, being diagnosed after feeling extra thirsty and losing weight.

Doctors initially believed his symptoms stemmed from a viral infection but after deteriorating further, Reuben was formally diagnosed with type 1 diabetes after being taken to hospital.

"We were lucky a nurse knew it was type 1 diabetes almost as soon as we arrived. She said if we hadn't arrived sooner he wouldn't have woken up the next morning."

## INQUIRY SET TO EXAMINE TASMANIA'S STRUGGLING HEALTH SYSTEM

The ongoing struggles plaguing Tasmania's acute health system have reached breaking point, with overcrowded hospital emergency departments becoming the norm and more and more people forced to wait for beds, according to ANMF (Tas Branch) Secretary Neroli Ellis.

Ms Ellis' sobering depiction follows the launch of a new Parliamentary Inquiry set to investigate the rising pressures compromising the state's delivery of acute health services.

The Upper House Inquiry will seek to investigate the capacity of Tasmania's main hospitals, including mental health services, to improve patient outcomes.

Key areas of focus will surround the current and projected state demand for acute health services, factors compromising the capacity of each hospital to meet demand, whether funding is sufficient and the impact and extent of triggers to adverse patient outcomes.

Chair of the Inquiry, Rob Valentine, said the examination had resulted from increasing concerns voiced by nursing bodies, other key stakeholders and the



community.

"It will provide an opportunity for those people at the coalface or as patients negotiating the system, to share their stories and experiences to a non-partisan Inquiry, in confidence if necessary, so the reality of acute care access is better understood," Mr Valentine said.

The Inquiry will accept submissions up until 18 August.

Ms Ellis said the ANMF Tas Branch would highlight the urgent need to restore problematic bed shortages at the Royal Hobart Hospital, caused by current redevelopments, which have been shown to lead to adverse outcomes.

According to an Australian Institute of Health and Welfare (AIHW) report from 2014-2015, Tasmania needs an extra 200 acute public hospital beds in order to meet its population's growing demands.

Elsewhere, the union's submission will advocate for funding of Hospital Avoidance

MS ELLIS SAID THE ANMF TAS BRANCH WOULD HIGHLIGHT THE URGENT NEED TO RESTORE PROBLEMATIC BED SHORTAGES AT THE ROYAL HOBART HOSPITAL, CAUSED BY CURRENT REDEVELOPMENTS, WHICH HAVE BEEN SHOWN TO LEAD TO ADVERSE OUTCOMES.

programs such as hospice@HOME, which could empower consumers with the option of dying at home and not being forced to die in hospital.

Ms Ellis conceded problems at the state's hospitals had caused great angst among nurses and other health professionals unable to cope with demand.

The ANMF Tas Branch recently sent a solutions paper to Royal Hobart Hospital's management team where it canvassed staffing the hospital as a seven day, 24-hour service.

Positively, the Branch has been handed a spot on the government's New Beds Implementation Team Reference Group, which will track towards ensuring future bed announcements are rolled out in a timely manner.

Ms Ellis said a looming state election next year had put health on the priority list of all parties.

"Nurses are best positioned working twenty four hours a day to identify any system issues and must be heard," Ms Ellis said. "There is a culture of lack of transparency and the Inquiry will enable data and true accounts to be forthcoming and, finally, real problem solving rather than avoidance to be addressed."

## FIJI'S FLOATING HEALTH CLINIC SEEKS VOLUNTEER NURSES

Ever wondered what it might be like to test your nursing skills abroad by helping to deliver healthcare to those less fortunate?

If you answered with a resounding yes then the Sea Mercy program, a floating health check clinic that provides vital healthcare services to the remote islands in the South Pacific, might prove just the ticket.

The inspiring not-for-profit charity was developed in a bid to respond to the disaster and critical care needs of remote islanders.

Its vision revolves around a mission to deliver much-needed healthcare to remote islands that face significant challenges in creating their own healthcare structures.

With more than 20,000 islands spread across 11,000,000 square miles of the Pacific Ocean, there are no roads, power lines or phone systems to connect remote islands with the same healthcare services afforded to larger islands.

The gap leaves many remote islanders without access to basic healthcare services and directly contributes to widespread health disparities.

A single vessel can make a big difference and Sea Mercy and its fleet of over 50 floating healthcare clinic vessels steps in to fill the void by sailing the high seas to meet healthcare needs and assist in emergencies during natural disasters.

Since 2012, Sea Mercy's fleet has visited more than 150 remote islands, provided access to over 350 volunteer nurses, doctors, and dentists, and treated more than 15,000 patients.

Of course, Sea Mercy's work in

connecting remote islanders to healthcare wouldn't be possible without the ongoing support of volunteer health professionals, including nurses, to help deliver care.

One of Sea Mercy's successful ventures, in Fiji, is currently seeking nurses to step up and volunteer on a two-week rotation that will involve working alongside at least one doctor on a small catamaran.

The healthcare clinic sails between islands, with treating diabetes a major focus.

While venturing abroad and volunteering in the South Pacific will no doubt provide nurses with an eye-opening and rewarding experience, it can also offer the chance to test clinical skills under different conditions and boost professional development.



To find out more about volunteering with Sea Mercy visit [www.seamercy.org](http://www.seamercy.org)





## GLOBAL

## Infectious diseases and antimicrobial resistance under the spotlight

**Two key conferences on tackling the global threat of infectious disease and antimicrobial resistance were held in Australia last month.**

The University of Wollongong's (UOW) Global Challenges summit included experts from medicine, nursing and biological sciences looking at ways to address antimicrobial resistance.

A UK government report projected that antimicrobial-resistant infections could lead to at least 10 million additional deaths per year and cost the global economy up to US\$100 trillion by 2050.

Professor Antoine van Oijen (pictured), an Australian Research Council Laureate Fellow said antimicrobial resistance was an urgent and truly global challenge.

"Advances will need to be made by researchers not just in developing new drugs and point-of-care diagnostics, but also involving media and communication experts thinking of new ways to better educate people about antibiotics, economists studying cooperative mechanisms between government and big pharma, nursing researchers developing best practices, environmental researchers finding ways to remove antibiotics from wastewater and more."

The Communicable Diseases Conference held in Melbourne drew 370 delegates working in health agencies, research and non-government organisations.

The 2017 conference theme 'Infectious Diseases: a global challenge' highlighted the urgent need for the world's nations to form a united front against the threat of communicable diseases.

"As globalisation worsens the spread between countries and antibiotic resistance lurks as a major public health danger," Australian Department of Health Chief

Medical Officer Dr Brendan Murphy said.

International and local challenges included the risks of pandemic influenza, antimicrobial resistance and new emerging zoonotic disease, Dr Murphy said.

Important conference themes included global outbreak threats, new means of detecting and tracking infections and surveillance.

Great progress had been made in the past century in the elimination and control of infectious disease such as the eradication of smallpox and progressive eradication of polio and malaria, World Federation of Public Health Associations President Michael Moore said. "We must continue to use all available resources and technologies to reduce the threat of communicable disease."

## UNITED KINGDOM

## Antimicrobial products resistant to bacteria

**UK scientists have discovered a link between a major mechanism of antibiotic resistance and resistance to the disinfectant triclosan which is commonly found in domestic products, including soap.**

Researchers made the unexpected finding that bacteria which mutated to become resistant to quinolone antibiotics also became more resistant to triclosan.

"The worry is that ...triclosan exposure might encourage growth of antibiotic strains," the researchers reported.

There had been an explosion in the marketing of products aimed at the home market labelled as 'antimicrobial'.

"Given the prevalence of triclosan and other antimicrobials in the environment, a greater understanding of the impact they can have on bacteria and how exposure to these antimicrobials may impact the selection and spread of clinically relevant antibiotic resistance is needed," Co-author University of Birmingham Professor Laura Piddock said.

## KENYA

## Kenyan: national elections follow nurses' strike

**Kenyans are set to vote in their national elections this month. It followed strike action in Kenya by government nurses which brought health services to a recent halt.**

Kenyan National Union of Nurses Acting General Secretary Maurice Opetu told *Reuters* a collective bargaining agreement for the nurses had been negotiated and agreed on but the government had not been ready to sign it.

International medical journal *The Lancet* reported 12 patients unable to access vital

services and care had died during the strike action in June. More than 27,000 nurses were reported to have stayed at home, according to *The Lancet*.

While essential services were delivered, maternity services were effectively grounded and those with mental illness or substance addiction were turned away.

A 100-day doctors' strike in December 2016 over pay and conditions also led to patient deaths and crippled services. Nurses had gone on strike alongside doctors but stopped when the government agreed to a collective bargaining agreement.

## YEMEN

## UNICEF: Pay health workers in Yemen

**UNICEF and the World Health Organization (WHO) called on authorities in Yemen recently to pay local health workers while the country tackles the world's worst cholera outbreak.**

In two months, the cholera outbreak in Yemen exceeded 200,000 suspected cases – at an increasing average of 5,000 cases a day. More than 1,300 people had died, one quarter of those children.

An estimated 30,000 local health workers who played the largest role in ending the outbreak had not been paid their salaries for nearly 10 months, according to UNICEF.

"We urge all authorities inside the country to pay these salaries and, above all, we call on all parties to end this devastating conflict," read a joint statement from UNICEF Executive Director Anthony Lake and WHO Director-General Margaret Chan.

The deadly cholera outbreak was the direct consequence of two years of heavy conflict, according to UNICEF and WHO.

Collapsing health, water and sanitation systems had cut off 14.5 million people from regular access to clean water and sanitation.

UNICEF, WHO and other agencies had worked around the clock to detect and track the spread of disease and to reach people with clean water, adequate sanitation and medical treatment. Rapid response teams went from house to house to educate on clean and storing drinking water.

## BRITAIN

## Britain: 1.9 million fewer light up

**Latest figures show 1.9 million fewer smokers in Britain since the introduction of cigarette bans in all UK pubs, clubs, bars and restaurants 10 years ago.**

Cancer Research UK data showed the lowest smoking rates ever recorded with around 8,300,000 adult smokers in Britain. The proportion of 16-24 year olds had fallen to 17% compared with 26% in 2007.

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# WHAT LEVEL OF RESPONSIBILITY MUST NURSES AND MIDWIVES TAKE AGAINST WORKPLACE INJURY?

In 2012, *Safe Work Australia*, the nation's peak body charged with developing national policies relating to work health and safety (WHS) and workers' compensation, launched the *Australian Work Health and Safety Strategy 2012-2022*.

The strategy is underpinned by the notion that all employees, regardless of occupation, have the right to a healthy and safe working environment.

Significantly, it set three national targets to be achieved by 2022, including cutting worker fatalities from injury by at least 20%, reducing the number of compensation claims resulting in one or more week's time off work by at least 30%, and similarly slashing the number of claims made for one or more musculoskeletal disorders resulting in one or more week's off work by 30%.

The long-term strategy also outlined national action areas and priority industries, including healthcare and social assistance both of which are consistently ranked among the top few industries with the highest number of serious claims among all Australian industries since 2009-10.

Nursing and midwifery form part of the healthcare industry and remain a high risk group due to the nature of the work they carry out on a daily basis.

The professions are exposed to a range of hazards that can potentially cause injury such as handling sharp devices, performing physically demanding tasks such as lifting patients, and widespread occupational violence.

Between 2000-01 and 2014-15 body stress accounted for over half (51%) of workers' compensation claims, with the majority caused by lifting people or moving beds, trolleys and other medical equipment.

The findings showed slips, trips and falls made up 19% of claims, with most involving stairs or falling over objects in high traffic areas.

Unsurprisingly, the impact of injuries on individuals can be substantial and lead to physical and emotional stress, financial strain and job restrictions.

A Safe Work Australia spokesperson said evidence shows the potential risks in healthcare can be triggered by failures in design and flawed systems that create excessive work demands and poor support and job environments.



"To manage healthcare hazards there needs to be a focus on the role of management in general, consultation with healthcare workers on safe design of work, and an understanding of the intersecting pathways of leadership and culture."

It raises the question about work health and safety compliance and how much responsibility nurses and midwives share in protecting themselves against injury on the job.

WorkSafe Victoria's Executive Director Health and Safety Marnie Williams said employers were essentially responsible for providing safe working environments for their staff.

Workers' compensation laws and entitlements vary between states but fundamentally operate under a no-fault system without regard to personal negligence or non-compliance with policies.

Claims for compensation can even relate to pre-existing injuries, illnesses or diseases that have been worsened by the workplace.

"Healthcare workers deal with an incredible array of issues every day. Whether it's a nurse in an emergency department dealing with a drug-affected patient, a midwife moving a pregnant mum, or an aged care worker managing a dementia patient, everyone has the right to get home safely at the end of the day," Ms Williams said.

"This means creating safe systems of work so workers understand the risks associated with different tasks and how to follow correct procedure. It is also vital that workers are given appropriate induction, training and supervision so they know what to do to ensure they stay safe at work."

Ms Williams said workers hold a duty to follow the correct procedures stipulated by their employer and must take reasonable care for their own health and safety and that of their colleagues.

She added that many of the safest and most progressive workplaces emerge when workers feel comfortable reporting health and safety matters to their employer and a truly collaborative approach is forged.

Despite workers' compensation operating under a no-fault system, claims are seldom clear-cut and often rejected.

For example, some insurers might argue a nurse's condition is simply related to age and natural wear and tear rather than a specific incident or work-related task.

A nurse or midwife who sustains an injury on the job must report it to their employer within 30 days of becoming aware of the condition before lodging a claim and involves obtaining medical certificates and supporting information.

It's a complicated process and many nurses and midwives engage law firms to help facilitate claims and deal with insurance companies. The ANMF can help members with this process and organise legal support if required.

Specialist personal injury and compensation firm Law Partners regularly deals with claims involving the health sector.

Many relate to manual lifting and not having adequate equipment.

"It's usually because there was no equipment or the equipment was too far away to quickly grab while they were moving a patient – and had they left the patient would have fallen," Law Partners' Principal Lawyer Chantille Khoury explained.

Ms Khoury said law firms such as Law Partners don't normally set out to establish fault and instead aim to get involved in the process from the beginning to ensure full entitlements are paid.

It's not uncommon for insurers, for instance, to deliver compensation at the wrong pay rates or not take shift allowances and penalties into account.

"We really like to just work with the nurse or midwife to see what his or her objective is. So if the objective is to get what they're entitled to and return to work, then we work with them to do that. If someone is too injured to return to work, we want to make sure their future is looked after."

Ms Khoury said most nurses aren't fully aware of what sorts of injuries they can make claims for and some believe their employment could be threatened if they raise problems, which is not the case.

She said having the backing of a lawyer was sensible given the complexity of claim forms. "If you don't have a solicitor, or know how to tone the language or answer various questions on claim forms, it's very easy for your claim to get rejected. Whilst a lawyer will be able to pick up the pieces and get it approved, it does take about three to six months for that to happen. During that time entitlements will be affected, and you'll be losing money or missing out on treatment, so you're better off using a lawyer from the start."



# SHOES IN REVIEW

All nurses and midwives need the right type of footwear to survive busy shifts on the go. Not only do they need to be protective and sturdy enough to endure throughout the day but give comfort and support to ensure backs and feet are free from fatigue. Here are six of the best.



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## HOKA

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INGRID COTHER,  
PHOTO: JAMES ELSBY



# LEAN ON ME

## THE CHALLENGES AND OPPORTUNITIES FACING MENTAL HEALTH NURSING

As reform continues to shape Australia's mental health system, greater access to mental health nurses across all levels of healthcare is crucial. When allowed to work to their full scope, mental health nurses possess the ability to engage and connect with people while helping them drive their own recovery journeys. **Robert Fede** reports.

Several decades ago it was considered normal for a person experiencing mental illness to be shipped off to an asylum to live out their days. Such was the thinking that the concept of recovery was off the radar and largely regarded as unattainable.

Ideas started to change when Australia's asylums were shut down in the 90s and mental health services shifted into general hospitals, GP clinics and the community.

The move into mainstream settings occurred alongside the growing philosophy that people experiencing mental illness had the capacity to shape their own recovery journeys.

Ingrid Cother, a mental health nurse at Eastern Community Mental Health Services in Adelaide, engages with clients across the care continuum as part of an integrated community team.

The role includes assessments, building care and treatment plans and linking clients with other programs and services. Clients range in age from 16-64 and experience everything from anxiety and affective disorders to psychotic disorders.

"My focus is across the whole care continuum," Ingrid says. "It could start with assessment and crisis intervention and treating people when they're acutely unwell, but also moving through to providing longer term care co-ordination, which tends to be goal focused. You're looking at what people want to achieve with their treatment and trying to link them in with services that can help."

Ingrid's objective reflects the sector's gradual shift from the hospital into the community and recovery oriented services. In that time, important programs such as Better Access were introduced, the federally funded initiative increasing community access to mental health professionals such as psychiatrists and psychologists.

"It's a fundamental shift because it's actually about people with mental illness being able to live in the community just like anyone else and there's a fundamental principle underlying that which is essentially human rights – the right for people to choose how they live their life and supporting people with their personal recovery to live the best life possible with or without their symptoms."

Despite inroads, Ingrid says mental health nursing remains underutilised.

She maintains there's greater scope for advanced practice roles that enable earlier initiation of pharmacological treatment, which may prevent hospitalisations and improve health outcomes.

Currently, Ingrid could assess a client and identify their mental health diagnosis, yet the person would likely need to wait to see a doctor to receive pharmacological treatment.

It leaves her having to weigh up whether to take a person to hospital so they can access care promptly or hold off. It's merely one example of how mental health nurses could be better utilised to benefit consumers, Ingrid says.





DONNA HANSEN-VELLA

**"I'm not the decision maker; the people I care for are. It's their life. It's their experience of mental illness. It's their journey of recovery. In some aspects I feel like mental health nurses are being allowed, through changes in the legislation, to actually practise nursing how we should practise nursing and how we were trained to practise nursing."**



AMY BOON

**"It's not about needing in-patient beds because we think that's where people should be. We want people in the community. But we know that there needs to be something there in the acute stage so that people are safe and able to be cared for."**

Ultimately, while Ingrid trusts modern mental healthcare is heading in the right direction, she stresses true change can only occur through a combined effort involving governments investing in services, the community viewing mental health as a shared issue and a reduction in stigma achieved by normalising the experience of living with mental illness.

## THE STATE OF PLAY

According to the 2007 National Survey of Mental Health and Wellbeing, around 7.3 million people or 45% of Australians aged 16-85 will experience a mental health-related condition such as depression, anxiety or psychotic disorder during their lifetime.

The Australian Institute of Health and Welfare (AIHW) estimates \$8.5 billion is spent each year on mental health services in Australia.

Various healthcare professionals deliver care, including 20,834 mental health nurses.

Mental health nurses work in both public and private healthcare settings, yet the discipline isn't present in all mental health settings.

Specifically, many Commonwealth funded programs continue to exclude nurses from being funded to be direct providers of specialist healthcare, favouring other health practitioners and subsequently depriving communities of nursing services without barriers.

Conceivably, core issues facing mental health nursing aren't unique to the

profession – staffing ratios, skills mix, chronic bed shortages, limited community mental health nursing positions, increasing workload burdens and an overarching lack of funding head the list.

However, as reforms continue to shift the system's architecture, the speciality faces shared challenges that will likely determine its impact moving forward.

One major test concerns safeguarding the employment of mental health nurses across all levels of healthcare through promoting nursing care and the profession's unique skill-set.

Having a fragmented public mental health system has contributed to the frustration felt by consumers and workers, together with historical policy directions that focused on a generic approach to specialist service provision that have created barriers for discipline specific nursing care.

The push for recognition stems partly from the Nursing and Midwifery Board of Australia's (NMBA) move to a national register, which brought all nurses and midwives under the one umbrella, but left some specialties like mental health lamenting lost identity.

The ANMF has continued to lobby for the National Register to recognise nursing specialties including mental health nursing.

Another important reform involves the Abbott/Turnbull government's Mental Health Nurse Incentive Program (MHNIP) last year having its funding switched to Primary Health Networks (PHNs).

The incoming model entails PHNs no

## INGRID COTHER

**"It's a fundamental shift because it's actually about people with mental illness being able to live in the community just like anyone else and there's a fundamental principle underlying that which is essentially human rights – the right for people to choose how they live their life and supporting people with their personal recovery to live the best life possible with or without their symptoms."**

longer being obliged to employ community mental health nurses, leading to uncertain times and redundancies where services have cut the position.

Optimists view the reform as a chance to advocate the integral role mental health nurses play but remain hopeful rather than confident of renewed uptake.

Elsewhere, issues confronting the sector extend to the contentious debate surrounding the seclusion and restraint of people with mental illness.

The conversation around practices has seemingly reached an important juncture.

Earlier this year, the NSW government launched an independent review into the state's practices following the death of a patient at Lismore Base Hospital.

Victoria, notably proactive within this space, this year rolled out its \$2.4 million Safewards program across all public mental health units.

Based on a successful UK model, Safewards involves a range of nursing interventions that authorise the use of validated measures and strategies to reduce conflict, potentially reducing violence and aggression that can escalate to harm and the need for stressful restrictive interventions.

## CHAMPIONING MENTAL HEALTH NURSING

At high school, Donna Hansen-Vella undertook work experience in one of Victoria's largest asylums, the exposure



cementing her aspirations of becoming a mental health nurse and leading positive change within the sector.

It led to a rewarding clinical career across mental health services, then joining the ANMF (Vic Branch) to represent the state's mental health nurses.

Donna, now the Branch's Mental Health Nursing Officer, oversees the union's organisers covering mental health and more broadly promotes the value of mental health nursing in key discussions facing the workforce.

One of her current posts includes sitting on a workforce group where she applies a mental health nursing lens when advising the overarching work of the Mental Health Expert Taskforce.

She describes her vision for the future incorporating approaches where every person and their support system, such as family and friends, has access to nursing services at all time when they need it, without barriers.

The ideal system would focus on preventative strategies and involve the employment of mental health nurses supported by organisations to utilise their unique skill-set across all levels of healthcare, including acute and sub-acute and non-traditional settings.

Donna continues to work clinically in a role she considers crucial to keeping her connected to the profession.

She cites changes to the state's *Mental Health Act 2014*, which opened the doors to supported decision making and providing patients with greater choice and opportunities to collaborate, as an exciting development.

"I'm not the decision maker; the people I care for are," Donna explains. "It's their life. It's their experience of mental illness. It's their journey of recovery. In some aspects I feel like mental health nurses are being

allowed, through changes in the legislation, to actually practise nursing how we should practise nursing and how we were trained to practise nursing."

While mental health nurses operate across the health spectrum, Donna believes their influence is often compromised by ongoing barriers, chiefly relating to resources such as the lack of beds and pressure to discharge patients.

## LACK OF FUNDING

It's a dilemma confronting Tasmania, where mental health bed shortages at the Royal Hobart Hospital is placing the system under pressure.

The hospital's 42-bed mental health ward was slashed to 32 beds as a result of recent redevelopments.

The state government says the situation will be ironed out once the redevelopment is completed in two years' time, yet the notion seems improbable given it doesn't plan to restore bed numbers at the revamped site.

According to the National Mental Health Report 2013, Tasmania should have 105 acute mental health beds to cater for its population.

Right now the state has just over 70, leaving it well short of the preferred average.

The human impact of insufficient services was underscored by a recent case involving a man diagnosed with depression and admitted to Royal Hobart Hospital for treatment before being granted leave from the Emergency Department to go home and have a shower due to no mental health beds being available.

Sadly, the man, who had been assessed as a moderate suicide risk, took his own life not long after returning home.

A Coronial Inquiry into the incident last year concluded the man would likely not have committed suicide if sufficient mental

health beds were available.

Mental health nurse Amy Boon, an Information Officer at the ANMF (Tas Branch), says the shortfall must be fixed.

"It's not about needing in-patient beds because we think that's where people should be. We want people in the community. But we know that there needs to be something there in the acute stage so that people are safe and able to be cared for."

Amy cites skills mix as another critical issue, pointing to changes in the state's 2013 *Mental Health Act* that removed the requirement for nurses working in the field to hold specific mental health qualifications and adequate training as worrying.

"We are getting more and more nurses who are entering mental health with their general training but they haven't got the surrounding experience with them." Amy says.

"If you've got a breadth of skill-set that you've been formally taught, as well as the experience to go along with it, you're looking at someone who's going to hopefully have a few more skills in order to get better outcomes for the patients."

Nevertheless, Amy remains confident mental health nursing can flourish.

"We need the government to pay attention. We need the skill-set required to be a mental health nurse to be fully appreciated and recognised again. We need a system that is connected – in patient, community, NGOs – all running on a continuum of care to assist consumers to be in their best state of wellness."

## PERSON-CENTRED CARE

Glenn Hayes is a Clinical Nurse Specialist (CNS) at Shellharbour Hospital's Eloura West mental health observation unit in NSW, treating patients with high-care needs through a strengths-based approach to recovery.



**GLENN HAYES**

**"Nowadays, we need to start looking at environments that are a little bit more therapeutic, more relaxing, more normal, so that when people come to a place like this they aren't feeling as if they're imprisoned or feeling as if they're going to be traumatised again."**



**CAROLYN McDONALD**

**"I would say that nurses and midwives are more vulnerable to experiencing mental health issues because of the nature of the work that we do and the stresses that we have to deal with on a day to day basis."**



**MARGARET MCALLISTER**

**"I suspect mental health nurses experience more stress and I think it's because these days in acute admissions, patients are coming in acutely unwell, but also having used substances, partly to self-medicate, to help them settle down in whatever way they can. It makes the picture of what's going wrong quite complicated."**

Drawn to mental health nursing because it allowed greater opportunity to engage with patients, Glenn entered the profession three decades ago as asylums were being phased out and a community-based style of care was being activated.

Countless changes have since transpired, with Glenn listing the emergence of Trauma Informed Care, which acknowledges how past distress can contribute to conditions, as among the most progressive.

Glenn believes mental health services need more funding to improve the design and layout of many outdated hospital wards which aren't conducive to getting well.

"Nowadays, we need to start looking at environments that are a little bit more therapeutic, more relaxing, more normal, so that when people come to a place like this they aren't feeling as if they're imprisoned or feeling as if they're going to be traumatised again."

Glenn's unit continually explores emerging models of care and has made recent attempts to reduce practices such as seclusion and restraint.

"The main thing is to realise why we're there. We're not there to challenge people to be aggressive. We're not there to try and impose our will upon people. We're there to try and be as therapeutic and helpful as we can."

Like others, Glenn agrees mental health nurses aren't being utilised to their full scope. But he remains confident positive change can occur if restrictive delivery methods are loosened and mental health

nurses are empowered to forge meaningful, person-centred care.

"People just want to be heard. They want to be listened to and know that people have their genuine concern at heart. That's what we're there for. We're there to be therapeutic and we're there to actually try and get things better."

## INCREASING SCOPE

A Mental Health Nurse Practitioner at the Northern Community Mental Health Service in South Australia, Paula Larsen specialises in affective disorders such as depression and bipolar.

As an NP, Paula is permitted to undertake assessments, diagnose conditions, draft up management plans, prescribe and deliver evidence based psychotherapy.

Working within an integrated community health team, Paula owns a higher level of autonomy and suggests more mental health nurses should be encouraged to undertake advanced practice.

However, she says ongoing restrictions around Medicare rebates leaves little incentive for nurses to pursue the role where at the moment viability is limited under the Medicare Benefits Schedule (MBS).

Questioned about the mental health sector, Paula believes longstanding stigma attached to mental illness is fading as more people access healthcare.

With the sector poised to make a greater impact, Paula pictures a growing role for NPs. "Hopefully, there's a lot more

emphasis on prevention, early intervention and the community being provided care in the home, effectively reducing hospital admissions and involuntary care."

## MENTAL ILLNESS AMONG NURSES AND MIDWIVES

Nurses and midwives aren't immune to mental illness.

RN Carolyn McDonald has worked within mental health for 11 years, primarily with the Nursing and Midwifery Health Program Victoria (NMHPV) where she supports nurses and midwives experiencing health issues relating to mental health or substance abuse.

The confidential service aims to engage and connect with clients one-on-one whilst providing them with links to other services and further help.

An addiction specialist, Carolyn, says the NMHPV has recently treated more nurses and midwives for anxiety and depression. A maladaptive coping strategy for mental ill health is self-medicating with substance use that can then, escalate into addiction.

It speaks volumes for the profession and confirms the growing need to tackle mental health.

In June, SBS's *Insight* program shone the spotlight on the high rates of mental illnesses among junior nurses and doctors, highlighting a 2016 study of suicides over 12 years that found female nurses and midwives had a suicide rate almost triple that of



women in non-health professions.

"I would say that nurses and midwives are more vulnerable to experiencing mental health issues because of the nature of the work that we do and the stresses that we have to deal with on a day to day basis," Carolyn says.

Carolyn says shift work is one part of the job that can lead to isolation, a major trigger for anxiety and depression.

When working with clients, Carolyn aims to create a safe space for someone to explore their story, support them to manage their health problem and develop more resilience and sustainable coping strategies.

"I feel really lucky to be in this position. I work with my colleagues, helping them get back on the wellness side of the mental health continuum really."

Critically, Carolyn says nurses and midwives, who identify as caregivers, are often reluctant to seek help themselves. It's a cultural mindset she hopes unique programs like the NMHPV can continue to shift to the point mental health becomes a priority.

## BUILDING RESILIENCE

In a similar vein, CQ University academic and mental health nurse Margaret McAllister is encouraging the profession to better understand and foster resilience.

Margaret, who teaches a Graduate Diploma of Mental Health Nursing and has written a book on resilience, considers nurses one of the most stressed health professionals.

"I suspect mental health nurses experience more stress and I think it's because these days in acute admissions, patients are coming in acutely unwell, but also having used substances, partly to self-medicate, to help them settle down in whatever way they can. It makes the picture of what's going wrong quite complicated."

Margaret's research, framed by her beliefs in a strengths-based approach to care, examines resilience in the context of nurses, patients, and society banding together to

improve the system.

"It can provide a focus with consumers to improve self-understanding or personal and social strengths can be harnessed and activated," she says.

"It can be trained onto the community to assess strength, resources and willingness and agility to change and develop.

"And it can be used amongst the nursing profession itself to see that emotionally and socially there are things nurses can do to enjoy the work and respond proactively to workforce and social conditions that need reform."

Margaret says the government's transition into primary mental healthcare has diversified the profession and created ongoing need for training.

"For that to be sustained, there also needs to be an education and training program alongside it. The whole healthcare system needs to be inextricably linked with education providers, otherwise, those nurses won't get the professional development they need to sustain in their workforce and also develop their skills."

Margaret believes the future of mental health nursing now rests in the profession's ability to promote its unique set of skills.

## THE ROAD AHEAD

ANMF Vic Branch Mental Health Nursing Officer Donna Hansen-Vella agrees, predicting mental health nursing could decline unless the profession can better strengthen and market its worth.

Twenty years ago 80% of the mental health sector's workforce comprised nurses, but today the figure has dropped to 60%.

The fall reflects some services substituting mental health nurses with allied health workers, unqualified to carry out the full scope nurses can, and in other cases not replacing positions altogether.

The ripple effect could create shortages that lead to the diminishment of the speciality, along with depriving the community of vital nursing care.

"It becomes hard to stop the slide. As you have areas of health that have less and less nurses, the task to then get the nursing presence back up becomes more of a challenge and our community is deprived of access to specialist nursing services."

Donna suggests the broad scope of mental health nursing isn't widely understood due to historically implemented policies that triggered generic mental health care models still prevalent today.

She says supposed multidisciplinary teams, a group of healthcare workers managing treatment, haven't been able to achieve their objective.

"It's not really giving multidisciplinary care it's having multi disciplines employed in the one team but they're all employed to do this generic approach."

Donna maintains there needs to be greater access to mental health nurses across all levels of healthcare.

This includes the establishment of proper multidisciplinary teams so that a person with a mental illness isn't discriminated against and can theoretically receive the same level of wide-ranging healthcare that a patient does when walking through the doors of a general hospital following an event like a heart attack.

"That's not the experience of most people that go into the public mental health system. It's luck of the draw and who you're allocated to."

"Ultimately, through integrated employment of mental health nurses at all levels of healthcare people with altered mental health would be able to commence their recovery journeys early, inclusive of effective nursing services that are capable of decreasing acute phases of mental illness."

Essentially, Australia's fragmented mental health system works in silos, but if synergy and funding is improved, Donna believes mental health nurses are poised to spearhead better health outcomes. "Usually, most people who get a taste of being able to have the opportunity to work in mental health as a nurse usually love it and choose to stay there."

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Gay Taylor



## NURSE MANAGERS: WHY EMOTIONALLY-INTELLIGENT LEADERSHIP MATTERS

Nurse managers frequently spend more time managing staff than dealing directly with patients, yet their management practices often dictate how care is delivered to those patients, which means that sound, relational leadership is vitally important to quality care.

Transformational leadership practices have been described as contributing positively to job satisfaction and staff retention (Lavoie-Tremblay et al. 2015) but more importantly, research shows that creating a 'culture of regard' (Olender-Russo, 2009, p75) in nursing workplaces improves bedside communication and reduces adverse patient outcomes.

The qualities of a transformational leader have been conceptualised to include four main elements:

1. idealised influence: leaders who earn trust and respect from staff by role-modelling desired behaviours;
2. inspirational motivation: nurse managers who are able to inspire staff to achieve the goals and mission of the organisation;
3. intellectual stimulation: managers who support and encourage staff to keep learning, to propose new ideas and to innovate;
4. individualised consideration: nurse managers who take a genuine interest in each individual staff member, providing specific feedback and personal encouragement. (Lavoie-Tremblay et al. 2015).

Of these elements, the fourth idea is probably the easiest for managers to implement immediately, with no need for special resources other than time and a willingness to start. Spending time 'on the floor' with staff, even for a few minutes a day sends a message that frontline work is recognised as the central purpose of the nursing unit. Episodes of hands-on assistance, which can be

as simple as pushing the control button on a hoist, or replacing a knee rug, show that management see themselves as part of the team, and are not solely concerned with paperwork and accreditation. Using these occasions as opportunities for positive feedback, rather than as fault-finding missions can also help to build trust and respect within the nursing or care team, although valuable information about potential problems or communication issues can also be picked up at these times.

The benefits of supportive and emotionally-intelligent leadership have been well documented, through several studies (Case and Maner 2014; Lavoie-Tremblay et al. 2015). Nursing teams who are managed by such leaders report higher job satisfaction and productivity and are more likely to stay longer in the job, which enhances continuity of care. Additionally, managers who create 'environments of learning and healing in a visible way' (Olender-Russo 2009, p80) are building a workplace culture where bullying has difficulty gaining traction. Bullying in nursing is a significant issue, contributing to absenteeism and high staff turnover, which in turn become organisational problems. Of greater concern is the fact that the effects of workplace bullying have been associated with chronic illness amongst staff, including depression and cardiovascular disease, and an increased risk of medical errors by nurses (Lavoie-Tremblay et al. 2015; Olender-Russo 2009).

By contrast, transformational

nurse leaders subvert the power imbalances that support bullying, and purposefully model behaviours that demonstrate regard for others, placing an emphasis on developing and maintaining relationships with staff (Olender-Russo 2009).

Most people who enter the nursing and care professions are motivated by a desire to make a meaningful and heartfelt difference to the lives of others. For these people, feeling appreciated, consulted and supported are fundamental to their engagement with their work. When staff believe that management has a genuine, relational interest in them and their work, they not only provide a higher quality of patient care, but are more likely to align themselves with their organisation's mission and values. (Lavoie-Tremblay et al. 2015).

It is interesting to note that the kind of people who become transformational leaders are more likely to be 'prestige motivated' rather than 'dominance motivated'. In a study done at Florida State and Northwestern Universities (Case and Maner 2014), researchers tested the hypothesis that leaders who were dominance motivated would try to prevent talented subordinates from communicating and forming bonds. They found that these leaders were willing to sacrifice group success to maintain their own power and authority over others. By contrast, leaders who were motivated by respect, admiration and appreciation were prepared to put the wellbeing of the group above their own social rank, and actively encouraged communication among group members. Given the importance of cohesive and cooperative relationships to healthy team functioning, it is clear that the right kind of leader is essential to building a safe and effective nursing team. Although dynamic and powerful individuals may look like great leaders, it is important that organisations look closely at other personal qualities when hiring managers to lead nursing and care teams.

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

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Julianne Bryce



Elizabeth Foley



Julie Reeves

**ANMF Federal  
Professional  
Officers**

## ONE FOR ALL AND ALL FOR ONE

Anyone using the protected titles of 'registered nurse' 'enrolled nurse' or 'midwife' in Australia can only do so if they are registered with the Nursing and Midwifery Board of Australia (NMBA).

Under the *Health Practitioner Regulation National Law Act 2009* (the National Law) which governs this registration, there is no distinction made about your registration status depending on your work position or type of work.

In order to have gained registration, the individual must have successfully completed the educational preparation prescribed by the NMBA, demonstrated they have met the standards for practice in their area of registration, and gained the qualification required by the Board to practice as a registered nurse, an enrolled nurse or a midwife.

Having gained the status of a regulated health professional as either a nurse or midwife, all registrants must abide by the standards, codes and guidelines set by the NMBA, under the National Law.

Again, no distinction is made in complying with these requirements of regulation depending on your work position or type of work – all registered nurses, enrolled nurses and midwives are responsible and accountable for their practice, wherever that may occur. In addition registered nurses retain accountability for all care delegated to an enrolled nurse. The NMBA (2016) provides a very nice summary of the 'wherever that may occur' in the description to follow:

*Practice is not restricted to the provision of direct clinical care. Nursing/midwifery practice extends to any paid or unpaid role where the nurse/midwife uses their nursing/midwifery skills and knowledge. This practice includes working in a direct non-clinical relationship with clients, working in management, administration, education, research, advisory, regulatory, policy development roles or other roles that impact on safe, effective delivery of services in the professional and/or use of the nurse's/midwife's professional skills.*

Some examples may help to reinforce the fact that, as regulated health professionals, our practice is governed by the same legal and professional practice requirements,

whether clinical or non-clinical, as a nurse or midwife.

The first relates to what were originally known as 'competency standards'. The NMBA has been progressively revising the standards by which all registered nurses and midwives practice. In order to remove any confusion with 'competency-based assessment' as applied in the vocational education and training sector (VET) the NMBA has moved to the terminology of 'standards for practice'. Thus, in 2016, after consultation with the profession and stakeholders, the NMBA published the newly revised *Registered nurse standards for practice*. The fact sheet accompanying these standards for practice emphasises that 'the criteria are to be interpreted in the context of an individual RN's practice' and they 'are for all RNs across **all** areas of practice'.

**HAVING GAINED THE  
STATUS OF A REGULATED  
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THE NMBA, UNDER THE  
NATIONAL LAW.**

In early July 2017 the NMBA commenced public consultation on *Midwife standards for practice*, with the NMBA Chair, Associate Professor Lynette Cusack, saying in NMBA's news publication that "The draft Midwife standards for practice have been thoroughly researched so they're suitable for midwives in all contexts of practice".

The second is the decision making framework (DMF) which facilitates a consistent approach for registered nurses and midwives to make decisions about their practice across all areas of practice.

The NMBA (2010) says the DMF is 'most relevant for the clinical practice setting, but may be modified or adapted for decision making in other areas of nursing or midwifery practice such as education, research and management'.

Registered nurses and midwives are accountable for the decisions they make and the information or actions that follow, this applies whether in the context of deciding on appropriate care, delegation to

subordinate workers, management of staff according to competence, or providing information on a policy submission. The DMF can be also used by staff in management positions to effectively negotiate with non-nursing/midwifery executives for appropriate staffing numbers and skills levels to provide safe, competent care.

The NMBA will be reviewing the DMF later this year and we will advise ANMF members so that you can participate in the consultation process of this important document for our professions.

While highlighting these features of the professional practice framework under which nurses and midwives practice, it should be noted that aspects of the National Law also apply equally to all regulated nurses and midwives regardless of where you work.

This includes: the common registration standards relating to criminal history, professional practice indemnity, continuing professional development, recency of practice, English language skills; and mandatory reporting and notifications of unprofessional conduct.

In a nutshell it's a case of 'One for all and all for one'. Whether clinical or non-clinical, the NMBA standards for practice, and in fact, the whole of the professional practice framework, applies!



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# Pre-and Post-Operative Care

During the perioperative period, specialised nursing care is needed during each phase of treatment. For nurses to give effective and competent care, they need to understand the full perioperative experience for the patient.



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## Perioperative refers to the three phases of surgery:

1. Preoperative stage
2. Intraoperative stage
3. Postoperative stage

Within these stages there are many different roles for nurses and different care needed for the patient dependent on which stage they are in.

As with any nursing care, the goal during these stages is to provide holistic care, evidence based care as well as support to

the individual.

There are different nursing roles throughout the perioperative process including: admissions nurse, anaesthetic nurse, circulating nurse or scout nurse, instrument or scrub nurse, post anaesthesia care unit (PACU) nurse and the surgical ward nurse. Other nurses may be included in the perioperative process such as, pain management specialist nurses, diabetes educators, hospital in the home nurses and wound care specialists.

For those working in these roles or wishing to work in this specialised area, it is

best practice to have an understanding of the complete perioperative process from the patient's point of view as well as a sound understanding of your role requirements.

Day surgery is now common practice in Australia which involves the patient being admitted and prepared for the procedure, undergoing the procedure and being discharged home on the same day. It is generally done for less complex surgical procedures or invasive procedures in which limited anaesthesia is required.

Approximately 60% of all procedures are done as day surgery procedures within

Australia.

Individual patients will have different psychological and emotional responses to surgery influenced by the type of surgery they are having and why they require that surgery.

Think of Mary as your patient. She is a 63 year old woman with colorectal cancer who has had a bowel resection with the formation of a stoma. The surgery removed the entire cancerous portion of her bowel and potentially left her cancer free.

Now let's think of Jane. She is also 63 year old and has had a bowel resection due to severe Crohn's disease. She was told the resection was necessary for a certain abscess in her bowel and she may experience some relief from her current symptoms but they can't be certain. She is also informed there is no cure for her condition and she may require further surgery.

As you can imagine, the psychological and emotional responses of these two women will be vastly different. Mary is most likely relieved and happy about her prognosis whereas Jane may be angry that her disease will be a part of her life forever, she may become depressed, anxious and fear the future.

How do you as a nurse respond to these two women?

Providing reassurance and support is one of the most important roles for a nurse during the surgical process. Providing information to the patient and their family can allay fears. Anxiety of the unknown can be decreased when information is provided. It is also important to encourage the patient to communicate their fears and concerns so you can have an opportunity to address their concerns.

Regardless if the patient is undergoing minor or major surgery, the prospect of any procedure can cause anxiety in individuals.

### This might be related to:

- fears of changes in body image;
- loss of control;
- fears of pain;
- fears of potential death;
- what will happen whilst in surgery;
- what if the surgeon starts the operation before the anaesthetic is effective;
- what if they wake up mid surgery;
- what will they have to deal with after the surgery;
- pain management;
- how long will they be in hospital;
- work and life commitments whilst they are in hospital.

It is also important to remember that a person's spiritual and cultural beliefs can also impact on how they cope with preoperative fear and anxiety.

Information may also need to be repeated at times.

Due to anxiety about the procedure the individual may have difficulty retaining information. Information should also be presented to the individual in language that they understand. Sometimes written information can also be presented to the individual for assistance with the retention of information.

The goal of effective preoperative care is to 'ensure the individual is in the best physical and psychological condition possible before undergoing surgery'.

Preoperative care begins when the decision to have surgery is first considered, and ends when the patient is transferred onto the operating table and the intraoperative phase begins.

The length of the preoperative phase can vary.

For example, it may be a planned surgery such as a total knee replacement in which the preoperative period would be longer than when compared to an emergency surgery such as an appendectomy.

It also depends on the amount of time it takes to adequately prepare the patient for surgery such as if bowel preparation needs to take effect prior to the surgery or if the patient needs to be fasting.

Data must be gathered about the individual's health status including baseline observations and an accurate nursing history.

This will help identify any actual or potential problems which may impact on the individual and allow prevention strategies to be implemented.

Every surgery comes with risks, and these risks are often dependent on a number of factors. Some of the main factors that increase the risk of complications developing during and following surgery include:

- **The patient's age:** the very young and very old are generally more at risk of complications because of their physiological status.
- **Nutrition:** compromised nutritional status can lead to impaired tissue repair and decreased resistance to infection.
- **Obesity:** obesity can impact on respiratory and cardiac function during surgery. There are also other factors to consider such as the presence of diabetes and cardiovascular disease. They generally also experience decreased wound healing ability and are at an increased risk of infections.

Preoperative information required to be provided to the patient includes; postoperative activities to be expected such as deep breathing and coughing and early mobilisation. Pain management and any other specific information relevant to the type of surgery they are having and to the individual themselves.

Providing this information is not only important to reduce the risk of postoperative complications but it also gives the individual a positive role to play in their own recovery and can help to decrease potential anxiety.

This information should be provided over a period of time, starting at the preadmission visit rather than just prior to the surgery when the individual is likely to be at their most anxious.

If you have the opportunity, getting the individual to practice deep breathing and coughing prior to surgery is beneficial as they then know what to expect. Explain why early mobilisation is important such as in the prevention of a Deep Vein Thrombosis (DVT)



The CPE team have added new topics to ANMF's CPE website including, Medication Safety, Interpersonal and Domestic Violence and Pre and Postoperative Care.

This extract is from the Pre and Postoperative Care tutorial which was authored by Sally Moyle, BNurs, MNurs, RN, CNS.

**Undertaking the complete tutorial will give you 2.5 hours of CPD.**

occurring. If your patient is at risk of a DVT you would want to inform them of the use of TED stockings including measuring and ordering of them prior to the surgery.

The taking of a comprehensive medical and nursing history of the patient is vital to provide holistic care. Individuals often present with comorbidities in addition to their surgical presentation and these can impact on their recovery and vice versa. It is also important to ensure these factors are stabilised prior to surgery. Consider if the person is a diabetic and needs to fast prior to surgery; they are most likely one of the first on the surgery list in order to prevent hypoglycaemia. If the patient is on anticoagulants which must be ceased prior to surgery to ensure excessive bleeding post-surgery does not occur. Is the person a smoker? They will need to cease smoking a few days prior to surgery to increase their respiratory function or they have a disability that requires special considerations such as assistive devices.

The complete tutorial on Pre and Postoperative Care discusses the information presented here in more detail and covers, preoperative preparation, surgical risk factors, preoperative checklist including consent, patient with special considerations, barriers to effective preoperative care and complications of surgery.

Even if you do not work in this specialised area of nursing, this is an informative tutorial to undertake as it gives detailed information of the patients surgical experience from beginning to end.

**Reading this excerpt and reflecting on it will give you 30 minutes towards your annual CPD.**

To access the complete tutorial go to

<http://anmf.cliniciansmatrix.com>

If you have any questions please contact us via [education@anmf.org.au](mailto:education@anmf.org.au)



# PERIPHERAL INTRAVENOUS CANNULA IN THE EMERGENCY DEPARTMENT

By Jessica Suna and Tracey Hawkins

The healthcare system is experiencing pressure to reduce expenditure and optimise use of existing resources. Healthcare professionals are being urged to carefully consider the need for tests, treatments and procedures (Fry et al. 2016).

In the emergency department (ED) an area for potential optimisation lies in the use of peripheral intravenous cannulation (PIVC). PIVC is the most commonly performed invasive procedure in the ED, however evidence suggests that up to 50% of PIVC placed in the ED are unused (Limm et al. 2013).

A study was recently undertaken at the Royal Brisbane and Women's Hospital ED to optimise PIVC placement and usage. The study aimed to provide a better understanding of current departmental PIVC insertion practices; and implement an inexpensive, reproducible strategy to optimise PIVC insertion.

Reducing the number of unnecessary PIVC is important; insertion can be painful for patients, consumes staff time, costs money and poses a risk of infection (Stuart et al. 2013; Rickard et al. 2012; Dychter et al. 2012; Trinh et al. 2011).

The key message delivered as part of the program implored all clinicians to think critically and place a PIVC only if they believed it was

80% likely to be used within the next 24 hours. The study message was delivered using a multi-modal approach including short teaching sessions, posters, social media and dynamic clinicians as cultural 'change champions'. Change champions also disseminated the study message by wearing shirts with the study '80%' logo whilst working clinical shifts.

Results of the study are currently under submission for publication, however our findings suggest that the intervention was effective in decreasing insertion rates and minimising unused PIVC in the ED. Investigators also identified the potential for large cost savings.

This strategy was successful due to:

1. early consultation with key stakeholders to develop and sustain the study intervention;
2. local needs assessment and planning;
3. strong leadership and engagement of local 'change champions';
4. sustained education and dissemination of information;
5. adoption of a strength-based

approach that focused on clinician strengths and abilities rather than problems or deficits (Friedman and Baum 2016; Pluskota 2014); and

6. adoption of translation science strategies including facilitation, engagement, active learning, collaboration, training, surveillance and feedback (Bolton 2010).

This study has built nursing research capacity by involving and engaging staff of all levels in the research process. It has highlighted the invaluable role nurses play in improving patient care through research and demonstrated the impact that a simple intervention may have. In this study, clinicians acted upon evidence that cannulation practices could be improved. Staff united to implement a strategy to optimise patient care. Time spent not inserting PIVCs could be utilised positively in the future for improved patient care and flow through DEM.

*This article has not been peer reviewed and is the opinion of the authors.*

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Linda Starr

## DISCIPLINARY ACTION FOR FAILING TO REPORT AN ERROR

All nurses and midwives are accountable for their own practice ensuring that they practice in accordance with the standards of their profession and within the law.

The Code of Conduct and the Code of Ethics also regulate nursing and midwifery practice and conduct that breaches these codes may be subject to disciplinary action.

Nurses and midwives are expected to act in a manner that not only protects the public from harm but will also ensure that the public has trust in the health professions.

As such it is imperative that concerns about a health practitioner's competence or conduct are managed appropriately. Not only is this a legal requirement under the *Health Practitioner Regulation National Law Act 2009 (QLD)* adopted in each jurisdiction (The Act) it is also an ethical one.

The code of ethics and conduct for midwives and nurses require them to take positive action where there is a concern about a colleagues conduct. For example Value statement 1 (3) of the *Code of Ethics for Nurses* states that:

'Nurses take steps to ensure that not only they, but also their colleagues, provide quality nursing care. In keeping with approved reporting processes, this may involve reporting to an appropriate authority, cases of unsafe, incompetent, unethical or illegal practice.' (*Code of Ethics for Nurses NMBA 2008: Value Statement 1 (4) Code of Ethics for Midwives NMBA 2008*).

The Code of Conduct also requires these health professionals to practice in a safe and competent manner, in accordance with the standards of the profession and maintain and build upon the community's trust in the professions (*Code of Conduct for Nurses Statements 1,2,3,8,9; Code of Conduct for Midwives Statements 1,2,3,8,9 NMBA 2013*). However equally important is the need to be familiar with and follow your organisations policy.

According to Gurry DP had the nurses in the following case followed the hospital's medication management policy – the incident

that led to disciplinary action would not have occurred.

A successful claim of professional misconduct was taken against an enrolled nurse (EN) and a registered nurse (RN) concerning the failure to take appropriate action, indeed any action, when a medication error occurred (*NMBA v Palmer and Ghazy [2016] SAHPT 7*). In this case, the EN who was 'tired and flustered ... made a careless mistake' by giving an elderly female resident in an aged care facility the wrong medication and reported this to another EN(S) and the RN. However, the RN did not make any inquiries regarding what medication the resident ought to have received, neither the RN or EN took any steps to notify the medical officer or other nursing staff nor did they make any notes regarding the incident or assessment of the resident. As such a course of concealment began with the RN telling the EN not to tell anyone about the medication error. The resident died the next day.

AS SUCH IT IS IMPERATIVE THAT CONCERNS ABOUT A HEALTH PRACTITIONER'S COMPETENCE OR CONDUCT ARE MANAGED APPROPRIATELY. NOT ONLY IS THIS A LEGAL REQUIREMENT UNDER THE HEALTH PRACTITIONER REGULATION NATIONAL LAW ACT 2009 (QLD) ADOPTED IN EACH JURISDICTION (THE ACT) IT IS ALSO AN ETHICAL ONE.

Clearly a failure to report such an error could prove to be detrimental to the ongoing management of the resident's health status. If other staff members are not made aware of the error they may not understand any changes to the resident's condition thereafter. In fact, a further opportunity to make staff aware of the error occurred later that evening when the resident had a fall and the RN who had commenced her nightshift examined the resident in the EN's presence: she did not mention the medication error and so the RN was not made aware of all possible reasons for the resident's fall.

Taking steps to conceal an error clearly falls below acceptable standards of practice regardless of the motive which in this case arose from misplaced sympathy for the EN. The RN in concealing this error was trying

to prevent her colleague who had previous performance issues, from facing any adverse consequences from her employer.

Whilst the error seemed to be an innocuous incident initially the death of the resident now meant that the nurses were keeping secret conduct that might have had bearing on the patient's death. EN(S) reported the matter two days later which lead to the investigation and findings including that the medication error did not have any bearing on the resident's death.

It was argued that the nurses acted intentionally placing their own interests above those of the resident. In doing so, it was clear that neither nurse adhered to the code of ethics where it is stated that nurses will contribute to the reporting of adverse events and errors and will follow their organisation's policy regarding disclosure of these events (Value statement 6). Furthermore, it raised a question as to whether the RN was a suitable practitioner to hold the responsible role of supervising other staff.

The tribunal found that the EN's conduct regarding the medication error, constituted unsatisfactory professional performance.

Furthermore, both nurses were found to have behaved in ways that constituted professional misconduct by failing to report the incident to the resident's treating team and failing to adequately assess and document the incident and the resident's condition.

Disciplinary proceedings are undertaken to protect the public, not punish the practitioner. With that in mind, it is open to the Tribunal to impose a number of sanctions with the purpose of preventing unfit practitioners from practising, deterring practitioners (and others in the profession) from any future departure from appropriate standards, restricting the practitioner's right to practice and securing the maintenance of professional standards. In this case, the Tribunal found that the potential for harm was significant and required more than a reprimand; consequently both nurses were suspended for three months and ordered to pay the costs of the proceedings.

This case serves as a reminder to all practitioners of the importance of reporting errors no matter how innocuous they seem, to follow organisational policy and to ensure their practice is in accordance with both the law and professional codes of conduct and ethics.



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Code of Conduct for Nurses 2013

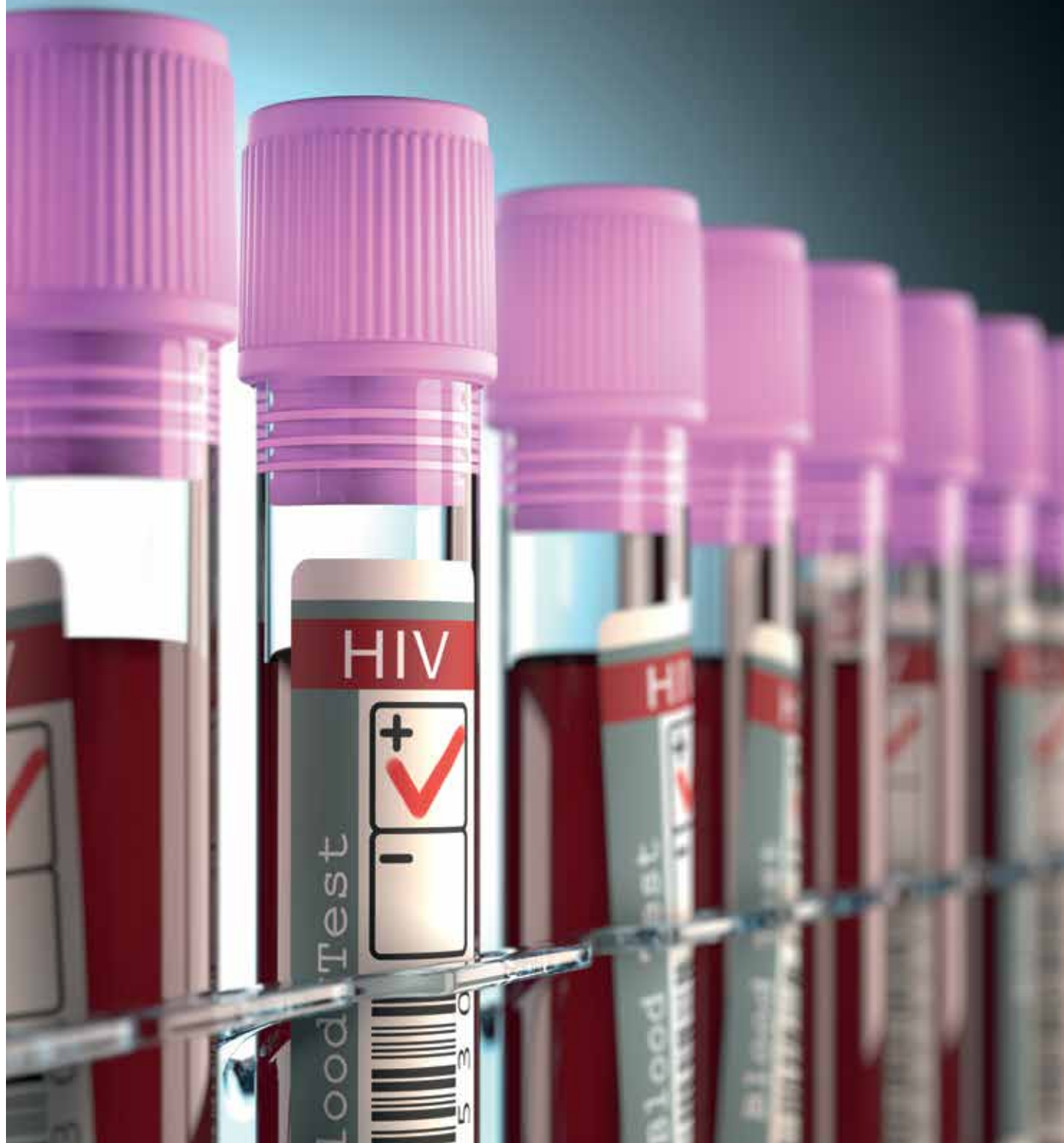
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# VOODOO HEALTH POLICY – THE PERSECUTION OF HIV+ PERSONS WHO ARE APPLYING TO IMMIGRATE TO AUSTRALIA

Duncan A McKenzie RN

The current policy and process of health screening in regards to the HIV (Human Immunodeficiency Virus) status of those applying to settle in Australia is irrational, flawed, prejudicial and discriminatory.



The following is a review of the current policy in regards to HIV positive persons who are applying for Australian residency from the perspective of someone who is a Registered Nurse. It is my contention that a person's HIV status in 2017 should not be considered to be of any significance in the context of residence visa applications beyond the requirement the disease is under control and the individual agrees to follow-up with a nominated medical service.

In 1980, despite an emerging huge fiscal deficit, Ronald Reagan while campaigning to become President of the United States, promised to cut taxes and increase government spending in such areas as defence while reducing the deficit. Due to the inherent and irrational contradictions this policy was referred to at the time as 'Voodoo Economics' by critics (Niskanen 1992). It is my aim in this paper to highlight one area of government health policy and legislation that in 2017 presents as irrational and unfounded and which we may well describe as 'Voodoo health policy'.

HIV is a condition which has undergone a revolution in regards to treatment. The original inclusion of HIV and AIDS as conditions for initial refusal of a residence visa occurred in the days of 'The Grim Reaper', when a person contracting the HIV virus would likely progress to AIDS within a matter of a few years.

They would then require intensive medical care for the treatment of opportunistic infections, however despite such care the condition would inevitably lead to death. Following seroconversion, subsequent diminishment of the CD4 count and immune suppression there would usually be a rapid decline in health. HIV infected individuals would have a life expectancy of perhaps another five to 10 years at most. As of 2017 long-term survival in HIV-positive populations with access to effective treatment appears to be approaching that of the general population (van Sighem et al. 2010).

It is now considered, with appropriate treatment through the use of medications, that HIV positive individuals will live an almost normal life span. This remarkable progress has occurred due to the effective development and use of antiretroviral medications which suppress the HIV virus and thus prevent the progression of the disease to a state of immunosuppression due to a diminished CD4 count. Although this

is central to the issue of HIV there is a whole plethora of other factors that would contribute or otherwise to the health of an individual and to the determination as to expected life span, and to the degree of resources that would be required by them from the Australian healthcare system.

The other issue of trending that needs to be stated is that of cost of HIV treatment. As with the trend of improved life expectancy, the cost of HIV treatment with established first and second-line regimens has been on a downward course (MSF 2013). HIV retroviral medications have declined in price due to generic brands becoming available. There is no reason why this downward trend should not continue.

In the era of 'The Grim Reaper' there was a perception that AIDS would be the public health emergency of our era. The perception was that vast sums of money would be required to care for the millions of individuals who were going to be infected by AIDS in Australia. With no effective antiretroviral treatments hospitals were going to be inundated with sick, immunosuppressed individuals who would require intensive medical care. The perception and the fears have been far removed from the reality. In Australia in 2017 HIV is simply no longer a public health issue. And in this year of 2017 we may well ask: What are the real major public health problems of our time? We know that these include cardiovascular disease, diabetes, obesity and Alzheimer's disease. Compared with these other healthcare problems HIV and AIDS are dwarfed in terms of any required outlay or healthcare expenditure within Australia. The issue of cardiovascular disease, obesity and diabetes are highly significant due to the fact that they are in many ways considered to be 'lifestyle diseases'. They are conditions that are considered to be caused or exacerbated by lifestyle factors.

It therefore can only be regarded as discriminatory and irrational that while an immigrant wishing to live in this country fails the health requirement due to their HIV status, others who may be obese and who may smoke and live an 'unhealthy' lifestyle would pass through the immigration health assessment process unhindered.

The Australian Institute of Health and Welfare in 2012 published a report titled 'Risk Factors Contributing to Chronic Disease.' The report states: 'Health determinants can influence our health in either a positive or a negative way. Determinants

affecting health in a negative way are commonly referred to as risk factors which can increase the likelihood of developing chronic disease, or hinder the management of existing conditions. For example high blood pressure can increase the likelihood of developing cardiovascular illness' (AIHW 2012). The report goes on to tabulate the relationship between selected chronic conditions and determinants. For example, a stroke (cerebro-vascular accident) is given as having the behavioural determinants of tobacco smoking, physical inactivity, risky alcohol consumption and poor diet with the biomedical determinants of obesity, hypertension and high blood fats. The report states that in 2003 smoking was considered to be responsible for the greatest disease burden in Australia. This was followed by high blood pressure, high body mass, high blood cholesterol and physical inactivity. On the other hand, 'Protective factors are health determinants that affect health in a positive way. For example, regular physical activity has definite health benefits as it can help with the control of blood pressure or excess body weight. A good diet can also be protective.'

THE ORIGINAL INCLUSION OF HIV AND AIDS AS CONDITIONS FOR INITIAL REFUSAL OF A RESIDENCE VISA OCCURRED IN THE DAYS OF 'THE GRIM REAPER', WHEN A PERSON CONTRACTING THE HIV VIRUS WOULD LIKELY PROGRESS TO AIDS WITHIN A MATTER OF A FEW YEARS.

For those applying for immigration to Australia who are HIV+ and have an Australian citizen partner there is the possibility of a 'health waiver'. This health waiver is not automatically granted and involves what can be a long and costly process of application and review. The health waiver application may be rejected due to the overseas partner's HIV+ status. Cost determinations are made by the Department of Immigration in regards to projected whole of life treatment costs. A process that I view as flawed due to the fact that costs are being projected over a lifetime and cannot factor in changes in treatment costs or new methods of treatment that may become available that are more effective and less costly. Further these costings do not take into account in any way the financial contribution that the HIV+ immigrant will be making to Australia.

At this juncture let us examine the





process of a partner visa application in regards to the health requirement. And let us consider two hypothetical cases. We will match them for gender however the significant and multiple variables along the health spectrum are immediately apparent:

Jim is a 30 year old British male. His Australian same-sex partner is sponsoring him for a partner visa. Jim is a smoker and he has 'a sweet tooth', he just cannot resist pastries and one or two meat pies while watching the footy. These are washed down with 'a few beers.' He enjoys reading, watching TV and gardening. He has been 'putting on the weight' over the last few years. Jim does not have a 'health and fitness mindset', he's just not the 'sporting type'. Further to this Jim's father died at the age of 52 years of heart disease. Despite this there is no impediment on health grounds to him obtaining a partner visa. He does not at this moment in time have any health conditions that would result in him failing the health requirement. He therefore sails through the process. Partner visa granted. Jim happily becomes an Australian resident and can live with his partner in Australia happily ever after.

Yan, on the other hand, is a 30 year old Asian HIV+ person. His Australian partner, who is HIV negative, is sponsoring him to come to Australia to live. They have been in a relationship for five years. Yan, especially since his HIV diagnosis, has resolved to look after his health. He is of slim build; he goes to the gym four times a week. He eats lots of fruit and vegetables. His parents are both alive and well. He does not smoke and

he does not drink alcohol. Yan has been commenced on antiretroviral medications. His CD4 count is within normal limits and his viral load has steadily diminished since he commenced on the antiretroviral medications. Medications that continue to come down in cost over time. However due to his HIV status he is required to undergo further immigration review. He in fact fails the immigration health test. He can only hope that he can obtain a health waiver, through a complicated, expensive and stressful process. Partner visa denied.

**THE PROBLEM WITH AUSTRALIAN GOVERNMENT POLICY IN REGARDS TO IMMIGRATION BY HIV+ PERSONS IS THAT IT IS BASED ON WHOLE OF LIFE DECISIONS, ASSUMPTIONS AND PROJECTIONS THAT ARE UNTESTED AND WILL NEVER BE REVIEWED.**

The problem with Australian government policy in regards to immigration by HIV+ persons is that it is based on whole of life decisions, assumptions and projections that are untested and will never be reviewed. A judgement is made at the time of initial presentation for immigration review by the department. These assessments, beyond determining whether a person is HIV+ or not or has any other acute medical condition requiring treatment, do not review or take into account any other of the

health determinants that as we have outlined above are critical to health outcomes.

When looking at the above two cases in 2017 one could say that it is actually Jim, who passed the health requirement without difficulty, who would be the more likely to present as needing intensive medical input in later years. It is Jim who has a whole range of adverse health variables that would suggest the early development of cardiovascular disease and diabetes. It is Jim who based on reasonable probability estimates is more likely to present as a drain on Australian healthcare services. Further, the effective working life span, and therefore the economic contribution to the economy, of Yan may be greater than that of Jim. Thus he and his partner will pay more tax and thus over time contribute more to the tax base of this nation. The problem is that a 'whole of life' health and cost determination is made at the time of the visa application. A person who is HIV+ at the time of the application is immediately penalised, even though the actual cost of any treatment may be negligible in comparison with other public health disasters of our time, such as diabetes and obesity. And any treatment costs they may occur would be offset by the contribution to the nation's tax base that they and their partner make. This is in contrast to individuals who may have poorer 'whole of life' health outcomes due to the fact that they smoke, are obese or don't exercise, however are determined to not require any immediate medical intervention. In years to come however their health may well deteriorate and their need for health

resources may be greater than that of the HIV infected individual who has other more favorable health determinants.

Jim does not give up his sedentary lifestyle. He is HIV negative but within the next decade since settling in Australia he begins to suffer hypertension and the early symptoms of diabetes. His cholesterol levels are elevated also. Jim's GP is required to prescribe statins to reduce his cholesterol levels, oral hypoglycemic medications to control his emerging type 2 diabetes, and antihypertensive medications. Jim feels tired a lot of the time and gives up work. He has thus withdrawn from the workforce and is not paying taxes. At the age of 56 his genetic predisposition to cardiovascular disease catches up with him and he suffers a myocardial infarction. He requires surgery in a public hospital to place stents in his coronary arteries. He has to spend time in intensive care at the hospital. While all this is happening at the same time Yan has carried on going to the gym and is in great health. His viral load is low, his CD4 count remains within normal limits and he has had nothing worse than the 'flu. Over time the antiretroviral drugs have continued to diminish in cost.

When all of the multiple health variables are taken into account an HIV positive person could live longer than others who meet the health requirement but who may have other adverse health variables. The HIV positive person could well be far less of a burden to the healthcare system in the end. The automatic refusal to grant a partner visa on the basis of a person being HIV positive is therefore discriminatory and prejudicial. The


Department of Immigration and Border Control has never completed the necessary studies to validate or refute the contention that a HIV positive person in 2017 with appropriate antiretroviral treatment and a full range of positive, protective health and genetic factors will be a greater burden to the Australian healthcare system than someone who is unfit, genetically predisposed to cardiovascular disease and who is obese. There are a whole range of variables that go into determining the likely life expectancy of a person. For HIV positive persons it is now a nearly normal lifespan, all other factors being equal. And during that lifespan that person and their partner will be working, contributing to the tax base and to the economy in general. If this is the case then the practice of discriminating against a condition such as HIV has no validity, either in a theoretical sense or in practice.

If the government seeks to protect the Australian healthcare system from chronic conditions that will prove to be a drain on its resources then it should ban from immigrating to this country those who smoke, those who are obese, those who eat a poor diet high in saturated fat, sugar and salt, and those who take no responsibility for engaging themselves in regular physical activity. Despite these determinants leading to the greatest burden on the healthcare system in terms of leading to chronic health conditions the Australian government has no immigration screening as to these determinants but chooses instead, in a prejudicial and discriminatory way, to exclude those who are HIV+, a condition that can be managed with relatively small amounts of resourcing.

Persecution is defined as cruel and unfair treatment of a person or group. I can come to no other conclusion that HIV+ migrants attempting to come to Australia are being persecuted. They may have great talents, a wonderful health prognosis, and the prospect of a long life contributing and working within Australia as taxpayers, however they are unfairly excluded.

The process and the concept of singling out, for the 'health requirement' specific health conditions such as HIV and then subjecting them to a cost based analysis, the methodology of which is highly suspect, is absurd and irrational for the reasons that I have outlined above.

Whilst in office President Barack Obama announced that the 22 year travel and immigration ban on persons with HIV/AIDS to the USA would be overturned. The ban was enacted in 1987 by the Department of Health and Human Services and resulted in the exclusion of thousands of students, tourists, and refugees. As the scientific understanding of the HIV virus has grown and the efficacy of its treatment grown exponentially, the rationale for its inclusion in the list of diseases that serve as a ground for exclusion to this nation has become progressively weaker (Howell 2010). Australia should immediately follow his example.

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## CLINICAL UPDATE CONTRIBUTORS

The ANMJ is looking for contributors willing to write a best practice 'how to guide' for nurses and midwives in an area of nursing or midwifery practice.

The focus should be on nursing interventions and practice and may include a case study/ies, guidelines, graphs, tables, or illustrations.

For more details go to ANMJ's writers guidelines: <http://anmf.org.au/pages/anmj-contribute>

## MILITARY CHARACTERISTICS PUT VETERANS AT GREATER SUICIDE RISK

A new report has found certain military-related characteristics that could put ex-serving defence personnel at greater risk of suicide.

The Australian Institute Health and Welfare (AIHW) report on suicide among serving and ex-serving Australian Defence Force (ADF) personnel was released last month.

Between 2001 and 2015, there were 325 certified suicide deaths among people with at least one day of ADF service since 2001. More than half (166 deaths) had no longer been serving in the ADF; 28% (90 deaths) were serving full time and 21% (69 deaths) were serving in the reserve.

Due to the small number of suicide deaths among female ADF, the report focused on male suicide deaths.

Men who were currently serving full time or in the reserve were considerably less likely to die by suicide than Australian men generally.

HOWEVER MEN WHO WERE NO LONGER SERVING IN THE ADF WERE 14% MORE LIKELY TO DIE BY SUICIDE THAN MEN IN THE GENERAL COMMUNITY.

However men who were no longer serving in the ADF were 14% more likely to die by suicide than men in the general community.

Men aged 18-24 and who were no longer serving were twice as likely to die by suicide than their male counterparts in the Australian population.

Certain military-related characteristics were associated with higher suicide rates, including involuntary discharge, particularly for medical reasons and men who had left the ADF after less than one year of service. Also at risk were men who did not hold a commissioned officer rank at discharge.

"Continued attention is needed to ensure efforts are effective in preventing suicide and self-harm amongst Australia's current and former serving personnel and their families," Federal Minister for Veteran's Affairs Dan Tehan said.

The federal government has committed to collecting data on the health and welfare of Australian defence personnel and their families.

"From 1 July 2017, the AIHW will commence a three-year strategic relationship with the Department of Veterans' Affairs to monitor and report on the current status and future needs of Australia's veterans and their families, and to develop a comprehensive picture of their health and welfare," AIHW Director and CEO Mr Barry Sandison said.

## CLOSE THE GAP IN COMMUNICATION WITH INDIGENOUS PATIENTS

Health professionals need to have a stronger focus on communication with Indigenous people, according to a leading South Australian linguistics expert.

A paper published in last month's *Medical Journal of Australia* raised concerns not just about language but a lack of cultural awareness that impacts on communication with Indigenous patients.

University of Adelaide's Head of Linguistics and paper author Dr Robert Amery said poor communication led to mistrust and disengagement with the health sector among Indigenous patients. This could lead to a lack of compliance with treatment and ultimately poor health outcomes.

"Miscommunication isn't just about

language. Some of these difficulties also arise from the interface of communication and culture, which are often derived from differences in worldview," Dr Amery said.

This included causation of disease for traditionally oriented Aboriginal people.

Research had shown health professionals and Indigenous patients had often come away from conversations with very different understandings, Dr Amery said.

"Silence plays an important role in Indigenous cultures. Indigenous people often respond to questions after a prolonged pause, a concept foreign to those doctors who see silence as impolite in their own cultures. They compensate by filling the silence and disrupting Indigenous patients' thoughts."

Healthcare professionals should avoid the use of 'intangible' conceptual English words and vague sentences, Dr Amery suggested. Instead, focus on factual communication; demonstrate how a medical procedure works; and use simple diagrams to explain medical issues.



## GUT HORMONE TO INFORM DIABETES DRUGS

Latest research into food digestion has found exactly how a key metabolic hormone is released from the human gut in response to food eaten.

South Australian researchers identified how human gut cells react to glucose. The Flinders University study focused on the secretion of hormone glucagon-like peptide 1 (GLP-1) from the lining of the gut. When released after a meal, GLP-1 triggers insulin secretion from the pancreas and signals fullness to limit further food intake. GLP-1 has been the focus of significant new drug development for type 2 diabetes and obesity for the past decade.

"We have now recorded how the arrival of glucose in the upper intestine triggers the release of this

important hormone, which has been a therapeutic target for a number of diabetes and new anti-obesity drugs," lead researcher Flinders University Professor Damien Keating said.

"By learning more about the gut's mechanism to process glucose and produce this hormone, we can begin to develop potential new therapies which may be much more targeted and effective."

The research was published in the International American Diabetes Association's journal *Diabetes*.



# TOWARDS A NEW MODEL OF CARE

By Timothy Haas and Angela J McKay

The Australian Nursing and Midwifery Board are committed to a relevant practice-theory nexus, but acknowledging independent theoretical contributions are important enlivenments to intelligent practice.

Many entering nursing today have endured very different lives and livelihoods. These students are not naïve teenagers to be moulded and sculpted, but have already well formed views about humanity which may well be antithetical to what has traditionally been regarded as nursing's core interests.

The founders of tertiary education, at least in Tasmania, were, as witnessed firsthand, motivated solely at the recognition of nursing as a 'profession'.

The American nursing theorists such as Virginia Henderson (1964), Martha Rogers (1970) and Sr Callista Roy (1980) offered the impression of an intellectualised justification for nursing's status, a notion that has always felt bewilderingly unnecessary. Nightingale, I suspect, would be incensed.

Nightingale's seminal *Notes on Nursing* published in 1969 prescribe a distinct mandate for management of the patient's environment, matched by a professional attitude to caring unsullied by gender or station in life. But the situation of justification of nursing's worth remains today in the plethora of checklists which seek to prove that 'quality' care has been provided, and, almost exclusively, seems confined to nursing.

Moreover, no longer can the feminist lobby claim it as evidence of ongoing medical dominance; nursing evolved the protocols and procedures.

The irony is that there are many exemplars of the documentation occupying more duty time than face-to-face patient care. Thus, it is hardly surprising to suggest a return to consideration of some essential attitudes. Nurses must be intelligent interrogatories in the clinical battleground; a clarified focus on clinical attentiveness is required.

Theories of nursing have, in the past, been less than satisfactory, from many a practitioner perspective in relating concepts to clinical practice realities. Meleis, as recently as 1985, identified that the "decision to become a nurse may have depended on an image of nursing that was glamorised in the media but that was also paradoxically servile" (p37). This is a clue to the slew of American theories of nursing that, despite aggressively defending their contributions, concedes students are

now attracted by motives that are more utilitarian.

Leslie Weatherston (1979) asserted that "effective nursing care requires a theory of nursing" (p357). Our view is that an examination of nursing theory and the creation of a new model of care is needed that reflects current attitudes, yet revisits core values of care, that Nightingale would recognise. Current clinical care is as much driven by institutionalised legalisms as any model of caring; the steadily increasing burden of documentation has become an activity we call nursing. This activity demonstrably detracts from concentrating on the patient as a person, and is possibly the greatest threat to nursing as a vital element of patient management. An unfortunate example of this is the latest version of the Surgical Safety Checklist. Atal Gawande (2009) and the World Health Organization who devised the original forms would be appalled at the volume of repetitive questions demanded.

A nursing model that concentrates on ethical elements appears as a fresh interpretation.

For some time, nursing theorist Jean Watson suggested a nurse must locate oneself in a caring model or theory. Her Theory of Human Caring (1988) demonstrated this as an equilateral triangular form with 'courtesy' at the apex, as an ineluctable attitude, with 'competence' and 'compassion' at the base angles.

Following on Benner (2001) described proficient practice as interested and engaged nurses. Christine Tanner (2006) developed a Clinical Judgement Model to provide guidance for students to focus their attention in ways that she describes as a form of 'engaged moral reasoning'.

In addition, she emphasised that students needed to develop as 'moral agents' with genuine concern for the wellbeing of their patients. Further thinking strategies for students have been theorised such as the Clinical Reasoning Model (Levett-Jones et al. 2010) with a further emphasis on the model helping students to understand how to pay attention to patient cues and context as a prerequisite to managing health problems.


The purposeful teaching of clinical judgement and clinical reasoning is

an excitingly positive sign. This is, in part, because young fit and 'healthy' graduate nurses can have little real insight, so need to 'pay attention' to the patient, instead of being on an occupational survival frolic, often imposed.

A deceptively simple phenomenological attitude is required in a new model of care. One designed to refocus on the patient, not documentation procedures that have become nursing work. Subsequent to the original triangulated model, it also identified the serious inadequacy of this, adding that there is a moral imperative to include genuine concern and curiosity. Without these elements purposeful reflective practice does not occur. Becoming a nurse now does not come attached to the openly avowed condition of 'this is your life'.

Such commitment is no longer socially acceptable. The imperatives of ethical clinical practice have not changed in the last half century however societal changes have been astonishing. In the combined years of the writers there have been another forty years of tumultuous social change transpired, and a review of the nursing model is entirely justified.

*This article has not been peer reviewed and is the opinion of the authors.*

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## FOCUS EDUCATION PART 2



TEACHING AND  
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## LEARNING TO TEACH: SUPPORTING NURSES AND MIDWIVES TO SUPERVISE STUDENTS

By Carey Mather and  
Annette Marlow

The provision of guidance and support of students within healthcare is integral to the role of many health professionals.

Within the nursing and midwifery domain, students are often supported by a preceptor who provides one-to-one supervision on a daily basis (Newton et al. 2015). It is anticipated and expected the preceptor will guide the students' learning related to healthcare practice.

Given this, a taken for granted assumption is that preceptors have an understanding of the learning and teaching domain. Research has identified that preceptors require access to contemporary and relevant resources on the 'how' of learning and teaching (McSharry & Lathlean 2017), to inform their role as mentor, coach and teacher. The importance of educationally prepared and capable preceptors to support and guide student learning cannot be

underestimated (Taylor et al. 2015).

In response to the need for easily accessible and contemporary supervision information the University of Tasmania has developed a suite of open-access digital resources. Subsequently, enabling supervisors of learners the opportunity to learn 'on the go', refresh strategies and in conjunction with Tasmanian Clinical Education Network, undertake more structured learning through completion of online activities related to how to be a capable teacher of learners.

**THE IMPORTANCE  
OF EDUCATIONALLY  
PREPARED AND CAPABLE  
PRECEPTORS TO SUPPORT  
AND GUIDE STUDENT  
LEARNING CANNOT BE  
UNDERESTIMATED (TAYLOR  
ET AL. 2015).**

By joining the @PEPCommunity Twitter microblog nurses and midwives have access to daily information, tips or links to articles about supervision of students. Participants can ask questions and seek information from other members of this virtual community of practice. This microblog links to a blog that has disseminated information impacting supervision each week since 2012 <http://blogs.utas.edu.au/snm-pep/>

In particular, it curates information related to the teaching perspective and provides analysis of related

journal articles on a weekly basis.

Also, If supervisors are seeking information about learning and teaching in healthcare settings they can view the 'Supporting Students in the Workplace' website at [www.supportingstudents.org.au/](http://www.supportingstudents.org.au/) to gain a depth of understanding of the principles of learning and teaching which relate to their everyday work activity. The impact of the availability and use of these resources are currently being evaluated (Courtney-Pratt et al. 2015; Mather & Cummings 2014).

These learning opportunities can contribute to continuing professional development and provide relevant information that can be transferred to many healthcare contexts. In turn, modelling the continuing professional development behaviours to students demonstrates the inherent requirement for life-long learning within the profession. Within a healthcare context the acquisition of knowledge and its application is constant, seamless and has no boundaries. So ensuring nurses and midwives have easy access to resources that are relevant, meaningful and user-friendly is essential to the development of the next generation of safe and capable healthcare professionals.

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# THE ART OF ESTABLISHING THERAPEUTIC RELATIONSHIPS BETWEEN FACILITATOR AND NURSING STUDENTS AND CONSUMERS OF COMMUNITY BASED NGOS

By Ulrike Radtke

Supervising nursing students for mental health and women's health placements in non-government organisations (NGOs) can be a rewarding experience.

Clinical facilitators have the opportunity to be involved in the process of passing on the baton to the next generation of nurses and drawing on their professional experience and imparting their lived and accumulated wisdom.

However, there are reports that clinical supervisors, rather than educating and supporting, actually cause harm to students, either through inattention or active hostility (Budden et al. 2017).

Unfortunately, this reflects a more longstanding problem that has been articulated horribly as a kind of cannibalism – 'when nurses eat their young' (Rowe and Sherlock 2005; Bartholomew 2006; Sauer 2012). Farrell's findings two decades ago in which he states that peer to peer hostility is experienced as the most hurtful (Farrell 1997, 1999), remains salient today (Budden et al. 2017; Farrell 2012). Students often express feeling invalidated and/or scared of their supervisors.

To move on from this situation, facilitators need to ask themselves what it is that they can empower in a student. What is it that turns the shy and withdrawn student into a person who is willing to aim for new heights? How can a student's ambivalence and discomfort regarding their placement be transformed into an experience that is meaningful, rewarding and

memorable?

One important first step is for facilitators to appreciate that they should **become** a facilitator of learning and not just **do** things as an excellent clinician. Jon Kabat-Zinn (2012) differentiates between the **Doing** and **Being** modes. Clinical facilitators need to discern between the task-orientated, or doing, work and the work of creating safe and supportive relationships with students. The task-orientated mode is goal directed, evaluative, and guided by evidence based practices. The **being** mode, on the other hand, is mainly sensory and intuitive, centred in the here and now and open to whatever emerges. It involves being non-judgemental, and appreciative of uncertainty. Kabat-Zinn calls it being driven by Mindfulness.

THE BEING MODE, ON THE OTHER HAND, IS MAINLY SENSORY AND INTUITIVE, CENTRED IN THE HERE AND NOW AND OPEN TO WHATEVER EMERGES.

**Doing** contrasts starkly with the **being** mode because **doing** involves making judgements, applying labels and these cognitive practices actually prevent the development of authentic relationships with others, with God or faith, and even with ourselves (Tolle 2009).

Initially on placement students can be very much focused on the **doing** mode, and cognitively alert. The **being** mode may not be a priority, yet facilitators may be able to help them by reminding them when and how to turn this mode on. Undertaking a placement in a soup kitchen or homeless shelter, for example, may lead to objection because it seems that there are few tasks to complete. But once the student is guided to understand that the "being mode" will yield both a learning experience and a therapeutic action, the placement can be rich and rewarding. Moving into a being mode, where one is explicitly non-judgemental, open to uncertainty and mindfully present, may help students to learn how to build meaningful nurse-patient relationships.

The uncertainty and not-knowing of the being mode is often a challenge for new nurses, and time is needed to discuss ways of developing a therapeutic relationship with diverse and vulnerable people such as those that are homeless, hungry, struggling

with addiction, or affected by mental illness. The facilitator can encourage students to venture out into this territory by simply noticing how the consumer is different or the same, and thus become aware of their own boundaries and values.


Consider this example. Recently three students from culturally and linguistically diverse backgrounds were placed in a clinic that provides terminations of pregnancies. They did not know the services the clinic offered before they were placed and initially struggled when they found out that abortions were the most common procedure performed.

As the facilitator, I aimed to assist the students by making a conscious effort to meet them where they were at. That is, I moved into the being mode. I suspended judgement, did not label them, and empathised with their anxiety and unknowingness. I encouraged the students to be guided by their own conscience and in those brief encounters with the women focus on building beginnings of a therapeutic relationship of one human being to another. All three students completed their placement saying it was one of their best.

In modelling this being mode, I also encouraged the students to imitate what I was doing. In this way, I was hoping that they would be able to move beyond their own pre-existing biases shaped by gender, religion, family values and use this emerging 'beginner's mind' to engage with consumers (Kabat-Zinn 2012). Facilitation is a balance between 'being with the student', the modelling of the beginnings of a therapeutic relationship and encouraging the student to critically reflect on their experiences to discern areas of growth and areas that need improvement. Both sides are equally needed.

## Acknowledgments

I would like to acknowledge and thank Professor Margaret McAllister for her assistance with the manuscript. I would also like to thank the numerous students I have had the privilege to meet over the years, your willingness to explore your self has been outstanding. I have become a better nurse for having met you.

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# FROM COMPETENCE TO CAPABILITY

By Patricia Bromley

Historically competency-based national frameworks of vocational qualifications were developed from industry standards as indicators to ensure minimum performance requirements were met (O'Connell et al. 2014; Stephenson 1998).

Clinical competence was conceived around the manual job market, where a high level of intelligence was not considered necessary, only skill proficiency, and workers were trained in performing such skills (Watson et al. 2002). The 1990's saw the nursing profession embrace competency standards and clinical competence; regulatory authorities measured practice and licensure against them, curricula was designed around them, and students were assessed against them (O'Connell et al. 2014).

## Why competence is no longer applicable

However, for university nursing education, competence has a narrow perspective (Sasso et al. 2016), limited to the acquisition of knowledge and skills and fails to empower people to reach their full potential (Hase & Davis 1999). Competence is simplistic and prescriptive (O'Connell et al. 2014), where assessing workplace tasks is often reduced to a tick box of skills to achieve proficiency, and the evaluation tools present a 'reductionist' approach to the assessment (Griot 2000).

This is partly due to a lack of clarity around the terminology; competence, competent, competency, and competencies, and this ambiguity has produced a number of inconsistencies in assessment methods (Bromley 2014; Watson et al. 2002). "There continues to be no consensus on the definition of competence, [it is a] highly abstract phenomenon...complicated to assess and measure" (Flinkman et al. 2017, p1036)

## From competence to capability

In June 2016 the Australian 'Competencies for Registered Nurses' were superseded by the 'NMBR Registered Nurse Standards for Practice', where Standard 3 indicates the registered nurse 'Maintains Capability for Practice' (Nursing and Midwifery Board of Australia 2016).

Although the concept of graduate capability, has been gaining strength in the higher education sector, nursing education has been slow in taking up the mantle, and has remained firmly embedded in a competency based agenda. The need to move beyond competence, and apprise clinical practice through a more holistic lens is essential to encourage the work-ready graduate. Capability is best considered within a holistic framework in which competence is viewed as only one aspect (O'Connell et al. 2014; Sasso et al. 2016), using competence in new contexts to problem-solve unfamiliar problems (Hase 2000).

## What is Capability?

Stephenson (2012) first introduced the concept of *Capability\** and *quality in higher education* in 1990s, where he declared Capability as a broader concept than that of competence:

*Capability embraces competence but is also forward looking, concerned with the realisation of potential...Capability is an integration of knowledge, skills, personal qualities and understanding used appropriately and effectively – not just in familiar and highly focused specialist contexts but in response to new and changing circumstance...to take actions in uncertainty, and to see initial failure as a basis of learning how to do better .*

Contemporary definitions of Capability have evolved from Stephenson's (2012) original ideas. Capable people are "creative, have a high degree of self-efficiency, know how to learn, can take appropriate and effective action to formulate and solve problems, can apply competencies in unfamiliar and familiar situations, and work well with others" (O'Connell et al. 2014, p2731). Capability "involves a mixture of emotional and cognitive intelligence including the ability to determine when and when not to deploy these competences (Scott et al. 2010, p27-28). Capability extends "well beyond discipline knowledge and understanding. [It includes] communication, reflective skills, team function, conflict resolution and client-centred care...[requiring] a sophisticated, integrated set of capabilities that encompass more than discipline specific knowledge, skills and understandings" (Brewer et al. 2014, p30).

## Capability and 'graduateness'

Capable graduates are required to be work ready with easily transferable skills and capabilities (The Foundation for Young Australians 2016). It behoves institutions of higher education to develop graduates who are employable in a rapidly changing occupational world (Coetzee 2014).

Coetzee (2014) identified eight core skills and attributes that constitute graduateness within the three domains of; scholarship (problem-solving and decision-making skills, analytical thinking skills, enterprising skills), global and moral citizenship (ethical and responsible behaviour, presenting and applying information skills, interactive skills), and lifelong learning (goal-directed behaviour and continuous learning orientation). Similarly Scott et al. (2010) identify Capabilities of the successful graduate as; personal capabilities, interpersonal capabilities, cognitive abilities and, generic skills and knowledge.

*\*In this paper Capability is indicated with a capital 'C' as defined by Stephenson and Yorke (2012) and for the purpose of this paper, specific to nursing practice.*

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# NEW GRADUATE JOB APPLICATIONS AND INTERVIEWS: THE ROLE OF HIGHER EDUCATION FACILITIES FOR STUDENT NURSES AND MIDWIVES

By Nikki Meller, Stacy Blythe, Stephen McNally, Paul Glew, Mitch Hughes and Rebecca O'Reilly

Higher education strategic plans are increasingly focussed on employability outcomes for students, and for students graduating with a degree in nursing or midwifery, employment is not necessarily guaranteed.

Nursing and midwifery students head into a competitive employment environment during their last year of undergraduate studies as they start to apply for new graduate positions at various public and private healthcare facilities for the year following the successful completion of their degree. Higher education facilities are under pressure to help students comprehend and prioritise the concept of employability as an approach encompassing more than clinical skills and experience, and distinct from academic performance (Taylor 2016; Kuokkanen et al. 2016). Students need to gain a range of skills to successfully navigate the transition to employment, and key among these is the ability to

interview well (Christian et al. in press). Therefore, providing resources with specific job readiness and self-directed employability assistance can potentially encourage and define a structured transition to professional practice.

In light of this, Western Sydney University School of Nursing & Midwifery has developed a series of job readiness resources for students. It includes a central online site that directs students to video podcasts and resources on key topics such as job application preparation, job interview skills, documentation and English language requirements for their registration. These topics are delivered through self-directed learning activities, which utilise online

learner engagement techniques. There is a paucity of literature on discipline specific employability strategies of undergraduate nursing and midwifery students in Australian higher education settings. Therefore, the job readiness pilot program also has a research component that aims to understand the students' experiences of using the online resources, and to gain insights into successful practices for online learner engagement with extra curricula resources. Measures of success will include access data for the online resources, use of the Online Student Engagement survey (OSE) to all final year students in the Bachelors of Nursing and Midwifery, and follow-up interviews with a sample of the students. The first iteration of the project will be evaluated at the end of 2017.

 **Nikki Meller is a PhD candidate and Associate Lecturer; Dr Stacy Blythe is Lecturer, Director Engagement & International; Dr Stephen McNally is Deputy Dean, Learning and Teaching; Dr Paul Glew is Senior Lecturer; Dr Rebecca O'Reilly is Lecturer, Director of Academic Programs Undergraduate and Mitch Hughes is Curriculum Advisor, Office of the Pro Vice-Chancellor (Learning Transformations).**

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# IS REFLECTION 'OVERDONE' IN NURSING EDUCATION?

By Rebekkah Middleton

Nursing educators, and indeed almost every healthcare practitioner, advocates the notion of reflection on practice (deVries & Timmins 2016).

With healthcare aspiring to bridge the theory-practice gap, critical reflection is required so that healthcare professionals are empowered and have capacity for change. Then they are able to contribute to improving health outcomes. We know this is true, but can reflection be overdone with nursing students so that the meaning and value of reflection is lost?

Reflection can make sense of an experience, and is fundamental to

improving practice. However, when it is a part of numerous aspects of student learning – individually and in groups, assessment, and clinical placement, it can be perceived by students as indulgent and not important or relevant to real world practices and pace. How can reflection be seen as meaningful and consequently transform students' learning?

When reflection does occur, its effectiveness can be questioned, particularly personal reflection which tends to focus on feelings. Introspection is the dominant approach to personal reflective practice, with prime focus being on individual and personal thoughts, feelings and behaviours. This often is seen by students as adequate and appropriate reflective practice, but a practice that is 'fluffy' and irrelevant. Perhaps it is purely naval gazing and needs to be challenged in students so that *critical* reflection occurs that can lead to change, development and growth.

Mutual and reciprocal sharing in a more critically reflexive approach

seems to be lacking in students. If this occurs, will students see value and the necessity for inclusion of reflection and reflective practices throughout a curriculum?

I consider critical reflection to be transformational learning and should focus on consistency and inconsistency of compassionate care in alignment with values, standards and regulatory requirements (in any setting and context). It should perhaps also be viewed as a touchstone for our effectiveness in doing our work and believing we are good healthcare practitioners.

This is important so learning can be evaluated through the individual's lived experience and learning can then be connected to relevant theory and personal understandings. This perspective may, perchance, influence and challenge student nurses to connect to the value of reflection.

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## Reference

de Vries, J. and Timmins, F. 2016. Care erosion in hospitals: problems in reflective nursing practice and the role of cognitive dissonance. *Nurse Education Today*, vol.38, pp.5-8. DOI: 10.1016/j.nedt.2015.12.007.





## THE ROLE OF THE LECTURER-PRACTITIONER IN BRIDGING THE THEORY-PRACTICE GAP IN POSTGRADUATE EDUCATION

By Sam Miller, John Thompson, Olivia Sonneborn and William McGuinness

In an ideal world, teaching and research are informed by clinical practice. However, for the nursing profession, maintaining links between academia and clinical practice can be challenging.

Nursing academics are often viewed as being out of touch with clinical practice and preoccupied with research while clinical nurses are viewed as too busy to educate or research.

### La Trobe University Post-Graduate model

Over the last decade, the School of Nursing and Midwifery at La Trobe University have actively explored mechanisms to eliminate the theory-practice gap. Strategic investments in a clinical school model, dedicated time to practice in academic workload models and legally binding relationships with healthcare providers to collaborate on the provision of nursing education and research are examples of this endeavour.

The establishment of the Lecturer-Practitioner role is a key aspect of these models. The vision for this role is clinician endorsed as an expert nurse within a speciality area and recognised by the academic environment as a Professor.

However, in reality, appointments are commonly made to nurses who are experts in their fields and working towards achieving nurse practitioner and professor titles. This dual accreditation across both academia and advanced clinical practice places the individual in a unique position to

move seamlessly between practice, education and associated research activities.

The core attributes of the Lecturer-Practitioner model are:

- a clinician recognised as an expert in their specialisation: clinical teacher, clinical nurse consultant (CNC) or nurse practitioner (NP);
- an agreement that the individual remains employed under the healthcare organisation's EBA to prevent any loss of privileges often experienced when moving to an academic post;
- the individual assumes a course coordinator role for their clinical speciality stream of the Master of Nursing Degree while also informing relevant undergraduate curriculum;
- an agreement between the university and the healthcare organisation that a predetermined fraction of the individual's wage will be paid for by the university as recognition of their contribution to academia;
- an agreed program of research that builds on the clinical challenges of the relevant clinical setting and which is mutually beneficial to both the university and the clinical area.

### Achievements

The theory-practice gap remains a

strong theme in nursing education literature. The appointment of a position that branches both areas addressed any boundaries between what is taught and what is practised. By incorporating the role of stream coordinator into the model adopted by La Trobe, the Lecturer-Practitioners are ideally situated to influence curriculum to best suit the needs of the practice area while also delivering current evidence based practice into the clinical areas.

Individuals with dual lines of reporting and access to both clinical and academic resources are well placed to relate theory to practice and vice versa thus eliminating the theory-practice gap. In addition, the capability of undertaking research which overarches education and clinical practice is understandably desirable for both the university and the clinical area.

Studies interviewing students, mostly undergraduate, that had access to a Lecturer-Practitioner broadly reported feeling more supported both in the clinical area and the classroom, with some identifying a clear link between theory and practice which they attributed to the appointment.


### Limitations

Several publications have made reference to the pull from both academia and clinical practice. The Lecturer-Practitioner has dual lines of reporting both within the university and the healthcare organisation which can create two distinct work streams. The key to successfully managing this is to integrate the goals of both areas and drive that process forward by undertaking research and informing curriculum.

Studies involving interviews with practicing Lecturer-Practitioners have demonstrated a lack of clarity as to what the role entails on a day-to-day basis. It is agreed that the position is flexible to an extent to best meet the needs of the relevant clinical area.

The majority of research on the effectiveness of the Lecturer-Practitioner role is dated and from a European population. Further research focusing on the Australian experience would be of great benefit.

The theory-practice gap in nursing has frequently been attributed to the physical and often intellectual separation of academics and practitioners. When universities and healthcare organisations share the approach of the Lecturer-Practitioner model in delivering post graduate nursing education, both institutions show a collaborative effort towards reducing the theory practice gap and integrating theory and practice.

 **Sam Miller,  
John Thompson,  
Olivia  
Sonneborn  
and William  
McGuinness are  
all at La Trobe  
University in  
the School of  
Nursing and  
Midwifery;  
Alfred Clinical  
School, The  
Alfred Hospital,  
Alfred Health in  
Victoria**

# ADAPTING ONLINE LEARNING TO OVERCOME DISADVANTAGE IN RURAL AUSTRALIA

By Evan Plowman, Judith Anderson and Jane Douglas

Poor access to tertiary education is known to disadvantage people living in rural areas (Anderson and Malone 2014).

Online learning addresses some of these issues and has been demonstrated to be at least as effective as face to face learning in post-graduate education (Campbell et al. 2008), leading to greater introduction of online and blended modes of delivery for undergraduate nursing students. This presents some specific challenges and opportunities to expand the learning experiences provided.

Students' perceptions of studying in the online mode can be evaluated with five key comparisons to face to face learning including, general equivalence, comparative flexibility, level of interaction, knowledge gained and ease of study (Platt et al. 2014).


Blended learning offers a potentially more rounded adult learning experience than either the fully online mode, or the conventional face to face mode of learning (Lotrecchiano et al. 2013).

Fully online models of learning can fail to adequately meet the adult's need to engage with others and learn from interactions, whereas the face to face model lacks the flexibility for learners to progress at a self-regulated pace. In a nursing course, the need for handling equipment to assist in developing psychomotor skills cannot be overcome, making blended learning a sound alternative to fully online learning. First year nursing students studying in the online environment face the challenge of learning how and where to access online support and learning materials and require the skills and confidence to ask for and accept assistance. Indeed, navigating the university online environment is one of the first challenges faced by this group.

Strategies to overcome the challenges of commencing tertiary study as an online student are varied. Intuitive and interactive online materials, including the university and subject home pages and the content modules and interactive, online assessment tasks requiring students to engage with each other across campuses and study modes, increases engagement with the material and other students.

Engaging and user-friendly subject sites will result in easier access. Students will spend less time adapting to the online space and more time engaged in learning. Maintaining a clear 'lecturer presence' ensures students feel connected with the teaching team and with other students. Close consideration as to which content can be effectively delivered online ensures that 'Residential Schools' (or face to face component) is meaningful, limiting the time students are away from their families.

Online students can fare as well as the conventional face to face cohorts. However blended learning is more suitable for some students than others depending on their degree of motivation and readiness for self-directed learning activities (Gagnon et al. 2013; Gibb et al. 2004). For students in rural Australia, their motivation to complete a nursing course with the minimum disruption to their family life can be a significant incentive.

 **Evan Plowman and Jane Douglas are Lecturers and Dr Judith Anderson is Senior Lecturer. All are in the School of Nursing, Midwifery, Indigenous Health at Charles Sturt University**



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# ACCREDITING EDUCATION PROVIDERS

By Fiona Stoker

The Australian Nursing and Midwifery Accreditation Council (ANMAC) is the independent accrediting authority for nursing and midwifery education under Australia's National Registration and Accreditation Scheme.

ANMAC develops program accreditation standards for registered nurses, enrolled nurses, nurse practitioners, midwives, re-entry to practice and entry programs for internationally qualified nurses and midwives. In all there are nine standards which are updated every five years in consultation with stakeholders from both professions.

ANMAC was established at the commencement of the National Registration and Accreditation Scheme in 2010. Until 2010 state Nursing and Midwifery Boards undertook accreditation using standards developed by the Australian Nursing and Midwifery Council (ANMC). After ANMAC was established it continued to refine the accreditation assessment model that had previously been utilised until now.

ANMAC has now completed a six year cycle of accrediting education providers and, following feedback from our stakeholders, we have modified the process to incorporate risk. Stakeholders identified that the process for accreditation was too long and duplicated the work of other regulatory authorities, which have also moved to a risk based approach.

The ANMAC Board commissioned an independent review to support the move to a risk based framework. The Review team was also requested to examine how the accreditation process could be streamlined through better administrative processes. The outcome of the review enabled

ANMAC to develop a new process that maintains the rigour and integrity of accreditation. A robust accreditation process ensures the quality of nursing and midwifery education in Australia which is vital to the health and safety of the community.

**ANMAC HAS NOW COMPLETED A SIX YEAR CYCLE OF ACCREDITING EDUCATION PROVIDERS AND, FOLLOWING FEEDBACK FROM OUR STAKEHOLDERS, WE HAVE MODIFIED THE PROCESS TO INCORPORATE RISK.**

The Accreditation Services Risk Framework was launched in February 2017 and is based on the principles of the ISO 31000:2009 Risk Management Standard. The Risk Framework is designed to be a timely, transparent, accountable, efficient and effective process and influences three key areas of the Accreditation Framework:


1. Program accreditation
2. Program changes
3. Monitoring

A risk matrix has been developed that is based on factors that are known to pose a risk to education

programs meeting the accreditation standards. Each education provider's program is assessed against the risk matrix by an Associate Director of Accreditation and ranked as high, medium or low risk. The risk rating determines how the education provider completes the accreditation application package and to what level evidence must be provided against the standards. Education providers will be assessed using a risk matrix on the annual anniversary of their accreditation. ANMAC is required to monitor programs that are accredited. We aim to improve the monitoring process and are streamlining the process for assessing modifications and changes to programs to make the exercise less resource intensive for both education providers and ANMAC.

ANMAC has scheduled evaluation points as we implement this revised accreditation process so we can gain feedback from our stakeholders and staff and modify if required.

To complement the accreditation process ANMAC has reviewed its standards development process following feedback from stakeholders. ANMAC is due to review the Registered Nurse Accreditation Standards this year so please look out for the discussion paper on key issues in the near future. For further information regarding ANMAC's risk based approach to accreditation please go to [www.anmac.org.au/program-accreditation](http://www.anmac.org.au/program-accreditation)

 **Clinical Professor Fiona Stoker is Chief Executive Officer at the Australian Nursing and Midwifery Accreditation Council (ANMAC)**



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# PUTTING STUDENT LEARNING FIRST: RESHAPING THE UNDERGRADUATE NURSING EXPERIENCE

By Rachel Cross, Sandra Connor, Therese Worme, Sean Parker, Kathryn Hill, Yangama Jokwiro and Michelle Newton

Student centred learning ensures that learners are exposed to diverse teaching approaches to enhance deeper learning and foster quality teaching environments (Estes 2004).

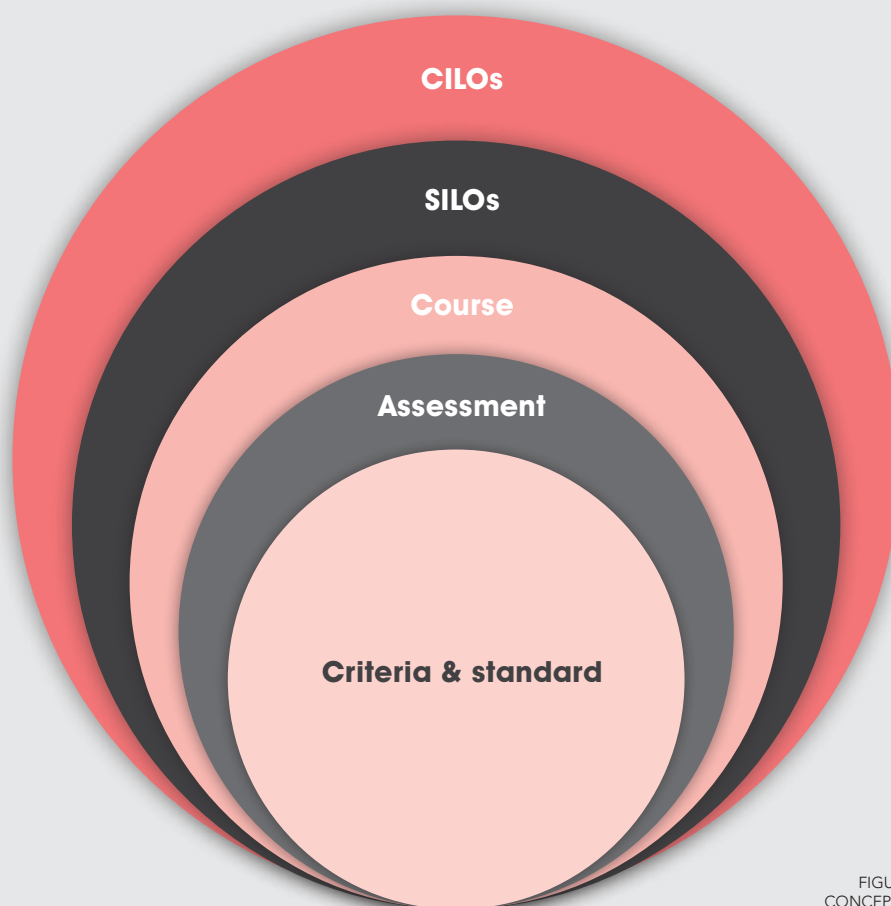


FIGURE 1:  
CONCEPTUAL  
APPROACH FOR  
CONSTRUCTIVE  
ALIGNMENT


The promotion of such environments is integral for student success (Biggs and Tang 2007). Preparing students to be work and career ready is an important focus for undergraduate nursing studies. Therefore the requirement for nursing course curricula to ensure students are ready to join the workforce is of high importance.


In May 2017 a quality improvement activity was undertaken by subject coordinators of four second year nursing subjects at one university. Arising from a critical examination of student progression and clinically-related course content throughout the second year of nursing studies, this project aimed to enhance student learning and success via the alignment of subject assessment across the second year of nursing studies. It is anticipated that aligning curricular activities will maximise preparation for clinical placement and enhance the successful transition into third and final year of studies. A conceptual approach integrating constructive alignment of course and subject intended learning outcomes was used to provide a framework to guide the project (Figure 1). An external peer review was provided by


the university's Teaching and Learning Unit to ensure rigour of the project.


Subject intended learning outcomes (SILOs) for each of the four core subjects were revised to remove any overlap and ensure they were aligned with course intended learning outcomes (CILOs) and accreditation requirements. Levels of complexity were also reviewed to ensure an appropriate level of challenge for second year nursing students. Course content was reorganised to remove duplication and to promote a scaffolded approach for learning in order to improve preparation for student clinical placement. Assessment tasks were also restructured to form a constructive, organised and coherent sequence across all second year nursing subjects.

Putting students at the centre of learning is integral for their success. A formal evaluation of secondary outcomes for the project including student satisfaction and academic progression will be undertaken in late 2017 and throughout 2018.


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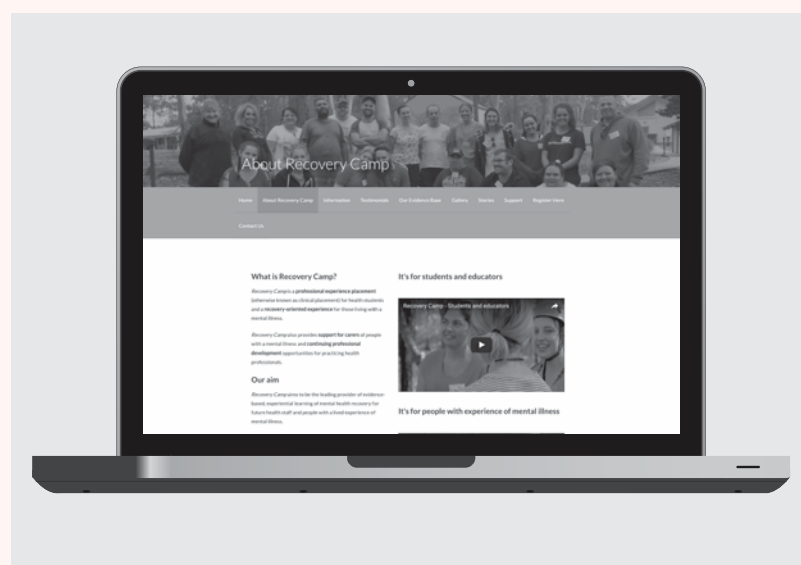
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# RECOVERY CAMP: AN INNOVATIVE, POSITIVE EDUCATION

By Christopher Patterson, Anita Cregan, Lorna Moxham, Dana Perlman, Ellie K Taylor, Renee Brighton, Luke Molloy, Natalie Cutler and Caroline Picton

Mental health has been a national health priority area since 1996 and its current emphasis in the media signifies its importance for the Australian community and thus its place in nursing curricula.

The hesitation though of students to pursue mental health nursing for their future practice is well recognised in literature (Hastings et al. 2017). Negative attitudes toward people with mental illness and fear of mental health nursing are recognised as factors that negatively impact student interest. This is of concern, not only for mental health nursing, but, given that one in four Australians experience mental illness, it can be expected that no matter where nursing students practice upon graduation, it is likely they will regularly be in contact with people who have experienced or are experiencing mental illness. Cultivating positive regard for people with a mental illness as well as

**RECOVERY CAMP IS A RE-CONCEPTUALISATION OF CLINICAL PLACEMENT IN THAT IT BRINGS TOGETHER PEOPLE WITH A LIVED EXPERIENCE OF MENTAL ILLNESS AND HEALTH STUDENTS TO PARTICIPATE IN A COLLABORATIVE, INTERDISCIPLINARY THERAPEUTIC RECREATION CAMP.**

generating student interest to pursue mental health nursing as a career is in the interest of the community.

Clinical placements are an integral part of pre-registration nursing education with compulsory clinical experience providing the opportunity for the application of nursing theory and the development of clinical confidence. However, some mental health nursing clinical placements may negatively influence the desire and motivation of students seeking mental health careers upon graduation and affect nursing student attitudes towards people with mental illness (Moxham et al. 2016; Happell & Gaskin 2013). Fear and anxiety of mental health nursing experienced by students are considered to be, in part, attributed to placing nursing students in mental health settings where people are experiencing the acute stages of mental illness (Szapak & Kameg, 2013).

Students in these settings are exposed to a cohort of consumers that are not necessarily representative of the majority of people who live with mental illness - this exposure potentially reinforcing pre-existing stigma and anxiety of mental illness,

and its treatment.

There are positive experiences of mental health nursing clinical placement (see for example Moxham et al. 2016; Gillespie & McLaren 2010). Clinical experiences have been considered as an approach to improving nursing attitudes towards mental health nursing and selection of mental health nursing as a career (Hemingway et al. 2016; Edward et al. 2015). According to O'Brien et al. (2008) when nursing students are provided with a positive learning experience they perceive the care of people with mental illness and mental health nursing to be an interesting and attractive nursing option. Indeed, it is important that mental health placements are positive and that students are provided with a positive learning experience (Happell and Plantania-Phung 2012). One such example is that of Recovery Camp.

Recovery Camp is a re-conceptualisation of clinical placement in that it brings together people with a lived experience of mental illness and health students to participate in a collaborative, interdisciplinary therapeutic recreation camp. Pre-registration health students (such as nursing, dietetic, psychology and exercise science students) spend five days and four nights together with people with a lived experience of mental illness – all facilitated by nurse academics and practicing registered nurses.

Attendees engage in a program underpinned by principles of therapeutic recreation – that is, using recreational activities as a therapeutic means to improve health and quality of life. Attendees participate together in activities ranging from giant swings, rope courses, flying foxes, bush dancing and rock climbing.

The focus: providing a positive clinical placement and learning experience for students so they may realise their contribution to the mental health recovery of others.

For more information see [www.recoverycamp.com.au](http://www.recoverycamp.com.au)

**Christopher Patterson is a Lecturer at the School of Nursing, Anita Cregan RN, BN Hons, Lorna Moxham RN, PhD, Professor of Mental Health Nursing, School of Nursing, Dana Perlman PhD Senior Lecturer, School of Education, Ellie K. Taylor PhD Candidate (Health Science), Renee Brighton RN, PhD, Senior Lecturer, School of Nursing, Luke Molloy RN Lecturer, School of Nursing, Natalie Cutler RN, Lecturer, School of Nursing, Caroline Picton RN, PhD Candidate, School of Nursing. All are at the University of Wollongong**



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## STUDENT SUPPORT CENTRE: A COLLABORATION AND INNOVATIVE APPROACH

By Marian Martin and Rebekah Carter

In 2016 an informal student support service was offered by staff from the School of Nursing and Midwifery, Campbelltown Campus, Western Sydney University to encourage students to work collaboratively and improve their academic outcomes.

Each week students would meet in a designated room where light refreshments were provided.

There wasn't any particular focus each week but the opportunity allowed students to raise concerns, ask questions and work on assessment tasks due for submission. The sessions were facilitated by staff and student volunteers providing academic support and mentoring. The opportunity was open to all students from all three years of the Bachelor of Nursing curriculum. The benefits were profound. Not just an anticipated improvement in grades for students who participated in the program but development in self-confidence and leadership skills. Students in second and third year were able to assist students in first year to work with ideas and suggestions from their past experiences.

The students who utilised the services in 2016 were looking forward to the service continuing in 2017. However, the facility used was no longer available. In addition, it was also found that students who worked or had childcare responsibilities during the day were not available to engage with this service and consideration was given to locating a space which facilitated the mentoring

process in a safe and supportive environment.

Concurrently, another innovative program had been commenced in 2016, Student Support Centre (SSC). The Chaplain of the Multi Faith Centre and his team received a grant from the University to provide a hot meal, every Wednesday at lunchtime. Utensils and ingredients were purchased and a hot lunch was made available to very appreciative students.

During an informal discussion between a volunteer and the Chaplain from the Multi Faith Centre it was identified that we had a shared goal and a collaborative effort had the potential for greater results. The opportunity to obtain good, healthy and hearty food after hours on campus is non-existent. The only service available is convenience foods from vending machines.

The Chaplain offered the Centre for students to use from 4.00pm until 9.00pm every Wednesday. A decision was taken to move the hot lunch to a hot evening meal every Wednesday at 5.00pm, prepared by the team of staff, volunteers and students.

Students and staff from all disciplines from the university are encouraged to collaborate each Wednesday evening. A nutritious hot meal is provided for everyone tailored

to meet all cultural preferences. The location has several side rooms which can be used for individual or group consultation with volunteering academic and support staff facilitating the sharing of knowledge whilst enjoying a meal (Parsons 2016).

We are 12 weeks into the program now and it has been a resounding success with approximately 50 students and staff attending each week from Nursing, Law, Medicine, Occupational Therapy, Paramedicine and Health Sciences. This is a wonderful, collaborative effort which we are proud to be a part of.

**Marian Martin is a Professional Communication and Literacy Advisor in the School of Nursing Rebekah Carter teaches at the School of Nursing and Midwifery. Both are at Western Sydney University**

TOP LEFT: NURSING STUDENTS, PRAB, NASRIN AND ADELPHA, WESTERN SYDNEY UNIVERSITY

TOP RIGHT: SIGN POSTING FOR STUDENT SUPPORT CENTRE, WESTERN SYDNEY UNIVERSITY, NSW

BELOW: ROSETTA (NURSING STUDENT), DANIEL (CHAPLAIN) AND JULIE (COMMUNITY VOLUNTEER)



### Reference

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## EDUCATION: A POWERFUL RELATIONSHIP – CLINICAL EXPERIENCE IN A POWER STATION: A UNIVERSITY COLLABORATION WITH AGL LOY YANG (GIPPSLAND)

By Catherine Chung, Simon Cooper, Shane Bullock and Sheryrn Linton

Federation University aims to produce a dynamic and competent graduate nurse recognised for innovative student experiences that have a positive impact on the health and wellbeing of our community.



To achieve this, Federation School of Nursing, Midwifery & Healthcare is committed to quality teaching and learning practices supported by authentic and relevant clinical experiences.

In collaboration with power company AGL Loy Yang, the School has developed a student led health education program that provides innovative and authentic clinical experiences for nursing students. The aim of the program is to improve health outcomes for AGL Loy Yang employees in areas such as smoking cessation, mental health, diabetes and high blood pressure.

This unique clinical experience allows students to develop their leadership and teamwork skills, to undertake peer teaching, and to practice key assessment skills with the aim of early identification of chronic disease and mental health, and improving client self-management.

For example, one student commented

*"(This) has made a huge difference to my learning experience by encouraging me to get involved in the Loy Yang Education Program - teaching employees about health conditions and health promotion. This experience improved my teaching and leadership skills and has also improved my chances of getting a nursing graduate year".*

The program was highly evaluated by students and by AGL Loy Yang staff with notable health benefits.

*"It was beneficial to consolidate skills and practice peer teaching by working with the 1st year nursing students"* (Student feedback)

*"It made me more confident in educating individuals and groups"* (Student feedback)

*"The sessions were great considering men do not go to the doctors as often as they should"* (Employee feedback)


*"It makes you aware of the little things that you can learn - can make a big difference to your health and loved ones"* (Employee feedback)


A number of employees were referred to their GPs with conditions such as high blood pressure, high blood sugar readings and some staff stopped smoking. This work was also in line with AGL values of 'one team' and the promotion of a 'safe and sustainable' workplace. Such initiatives are also in line with commonwealth and state agendas such as Latrobe City 'Healthy Initiatives' and the Latrobe Valley Health Zone. Due to the success of this program, the collaboration continues and now includes medical students from Monash School of Rural Health.


For further information, please contact Catherine Chung [chung@federation.edu.au](mailto:chung@federation.edu.au)


AGL LOY YANG EMPLOYEES BEING SHOWN HOW TO PERFORM BASIC LIFE SUPPORT BY A 2ND YEAR FEDERATION UNIVERSITY NURSING STUDENT

BELOW: AGL LOY YANG EMPLOYEE UNDERTAKING A VITAL SIGNS ASSESSMENT BY A 1ST YEAR FEDERATION UNIVERSITY NURSING STUDENT

 **Catherine Chung is a Lecturer in the School of Nursing, Midwifery and Healthcare, Faculty of Health at Federation University Australia**

 **Professor Simon Cooper, PhD is Professor of Emergency Care and Research Development, in the School of Nursing, Midwifery and Healthcare, Faculty of Health at the Federation University Australia**

 **Associate Professor Shane Bullock is Director and Deputy Head of School in the School of Rural Health at Monash University in Victoria**

 **Sheryrn Linton is Health and Rehabilitation Coordinator at AGL Loy Yang in Traralgon, South Victoria**



# IMPLEMENTATION OF A MULTI-MODAL PATIENT DETERIORATION EDUCATION PROGRAM

By Lauren Kite

Patients can develop high levels of physiological disturbance at any stage of their healthcare journey. A delay in responding to patient deterioration can lead to mismanagement and further deterioration (McQuillan et al. 1998; Naeem and Montenegro 2005).

This paper describes the development of a multi-modal education program concerning the recognition and response to patient deterioration, which was targeted at experienced clinicians.

## Method:

The project aimed to develop the clinicians' skills in recognising and responding to patient deterioration by developing the following abilities:

- systematically assess a patient;
- understand and interpret abnormal physiological parameters and other abnormal observations;
- escalate using local protocols when clinical deterioration occurs;
- initiate appropriate early interventions for patients who are deteriorating;
- communicate information about clinical deterioration confidently in a structured and effective way to the attending medical officer or team of clinicians providing emergency assistance to patients, families and carers.

The curriculum utilised the Airway, Breathing, Circulation, Disability, and Exposure (ABCDE) structured primary survey approach.

As described by Considine & Curry (2014) the primary survey has three major safety advantages over other assessment models; data is collected in order of clinical importance, the primary survey approach is aligned with the rapid response criteria for the activation of a Medical Emergency Team, and the approach acts as a safety checklist. The mnemonic ISBAR

**THE INITIAL IMPLEMENTATION OF THIS MULTI-MODAL APPROACH TO EDUCATION CAPTURED A LARGE NUMBER OF CLINICIANS AND PROVIDED ENCOURAGING INITIAL EVALUATION DATA.**

(Identification, Situation, Background, Assessment, Recommendations) was used to aid the communication of clinical concern. A video animation titled 'ISBAR Patient Safety' produced by Western Health, (2014) was viewed by participants prior to the face-to-face session.

The curriculum content was delivered using two modes. Firstly an electronic learning (eLearning) package was developed using a clinical scenario. The online interactive platform allowed participants to establish pre-requisite knowledge and familiarise themselves with the ABCDE and ISBAR mnemonics in preparation for the face-to-face simulation. Varied 30 to 45 minute face-to-face simulations were delivered in the clinical environment using an age appropriate simulated patient.

The simulated patient was a volunteer who offered an element of realism to the scenario and real time feedback that a mannequin could not. Observer checklists on assessment and communication were incorporated into the simulation to

provide a focus and role for those not actively participating. During the debriefing both the simulated patient and observers were invited to share their comments and feedback.

## Implications for nursing practice

In excess of 630 predominantly nursing participants underwent the two education activities over the initial 14 months of implementation. Participants reported an increase in knowledge and confidence in assessing, recognising and responding to the deteriorating patient. Participants were asked to list three take home messages. The most common answers were, "complete a systematic A-E assessment", "clear communication", "reassure and involve the patient", and "calling for help and escalating early".

## Next steps

The initial implementation of this multi-modal approach to education captured a large number of clinicians and provided encouraging initial evaluation data. Future recommendations include designing the simulation as an inter-professional education activity and incorporating more complex scenarios. Moving forward the program is to be aligned with the new national safety and quality standards, including deterioration in mental state.

**Lauren Kite RN is a Clinical Nurse Educator at Barwon Health and a Adjunct Lecturer at the University of Melbourne Commercial.**



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# INTEGRAL ROLE OF NURSES IN REDUCING STIGMA AND DISCRIMINATION IN THE CARE OF PEOPLE WITH BLOOD BORNE VIRUSES (BBVs)

By Melinda Hassall, Sami Stewart and Elizabeth Crock

## Barriers to healthcare for people with blood borne viruses (BBVs)

Nurses are integral to the provision of care in the treatment and management of people with hepatitis B (HBV), hepatitis C (HCV) and human immunodeficiency virus (HIV).

There are now increasing opportunities for nurses to provide care to people with BBVs due to:

- introduction of direct-acting antiviral medication for HCV;
- increase in nurse led models of care for management of BBVs in community settings;
- availability of pre-exposure prophylaxis (PrEP) and post exposure prophylaxis (PEP) for HIV; and
- a population of people living longer and more people ageing with HIV due to successful treatment.

Despite these advances, significant barriers can exist within health systems that impact people with BBVs accessing treatment and care. Stigma and discrimination can sometimes be both an intended consequence of certain practices, or a direct cause of healthcare avoidance. For example, generic intake policies, excessive use of infection control precautions and

policies implemented by healthcare sites and healthcare workers (HCW) can support discriminatory behaviour and influence individuals' decisions to access care (Crock 2013; Crooks 2016; Paterson et al. 2007; Richmond et al 2007).

Studies undertaken with HCW, including nurses, have highlighted myths surrounding transmission of BBVs, misconceptions about potential transmission, lack of trust in standard precautions, fears/stereotypes about people who inject drugs, and concerns about behaviours due to mental health, as issues that affect HCW decisions about care (Crock 2013; Paterson et al. 2007; Richmond 2007).

If not addressed, these issues can influence nurses' responses to people with BBV (Richmond, 2007) and negatively impact health outcomes (Crooks 2016).

## A strategy for action

A key objective of Australia's National BBV strategies is to eliminate the negative impact that stigma and discrimination have on an individual's health (Department of Health 2014). To support this objective, a Commonwealth funded collaborative project is developing

AUSTRALIA ENJOYS  
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FROM OPTIMISING THESE  
ACHIEVEMENTS.

an online learning module (OLM) for nurses. The OLM aims to reinforce knowledge about transmission, prevention and management of BBVs, outline nurses' role in reducing stigma and discrimination and enhance their capacity to identify these experiences of people with BBVs. The OLM will enable nurses to reflect on structural workplace barriers, individual perceptions and encourage change. Development of the OLM is guided by an expert working group (with representation from ASHM, ANMF, health services, research, community partners) and feedback obtained from focus groups held at the Australian Primary Health Care Nurses Association Conference.

## Outcomes

This OLM combines interventions to build skills and develop strategies to identify opportunities to change behaviours, review approaches to identify discriminatory policies within the workplace and discuss biomedical advances in BBV treatment (Hopwood 2016). The OLM will be accessible in early 2017. Completion of the OLM will enhance nurses' potential to enact changes to practice and assist with reducing stigma and discrimination experienced by people with BBV seeking to access healthcare.

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**Sami Stewart is Project Officer-Nursing Program at the Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM)**

**Dr Elizabeth Crock is HIV Clinical Nurse Consultant and HIV Team Coordinator at the Royal District Nursing Service HIV Program**



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# AUGUST

**Tradies National Health Month**  
www.tradieshealth.com.au

**Inaugural International Conference on Non Communicable Diseases**  
*Global Responses to a Global Epidemic*  
1-2 August, Kuala Lumpur, Malaysia.  
http://ncdcongress.co/

**National Homelessness Prevention Week**  
1-7 August.  
www.homelessnessaustralia.org.au

**Lung Health Promotion Centre at The Alfred**  
Smoking Cessation Course  
3-4 August  
Influencing Behaviour Change – a formula  
10-11 August  
Influencing Behaviour Change – Theory & Practice  
10 August  
Influencing Behaviour Change – Intensive Workshop/Case Studies  
11 August  
Spirometry Principles & Practice  
14-15 August  
P: (03) 9076 2382  
E: lunghealth@alfred.org.au

**18th Victorian Collaborative Mental Health Nursing Conference**  
3-4 August, Moonee Valley Race Course, Moonee Ponds, Victoria. This annual, two-day conference showcases the specialist practice of mental health nursing across the full range of service settings and therapeutic approaches. It's a relaxed, 'grassroots' event that's open to students and nurses at any stage of their career. http://cpn.unimelb.edu.au/conferences/vcpnc

**National Aboriginal and Torres Strait Islander Children's Day (NATICD)**  
4 August. www.snaicc.org.au/children

**Nursing Informatics Australia (NIA) Conference**  
*Consumer participation and the nurse's role in the digital future*  
6 August, Brisbane Convention and Exhibition Centre, Qld.  
https://www.hisa.org.au/hic/nia/

**25th Health Informatics Conference**  
6-9 August, Brisbane Convention and Exhibition Centre, Qld. Australia's premier digital health, health informatics and ehealth conference and expo. www.hisa.org.au/hic/

**Australian New Zealand Intensive Care Society - Safety and Quality Conference: The Deteriorating Patient**  
7-8 August, Sofitel Sydney Wentworth.  
www.sqao-anzics.com

**International Day of the World's Indigenous People**  
9 August.  
www.un.org/en/events/indigenousday/

**Australian Viral Hepatitis Elimination Conference**  
10-11 August, Cairns.  
www.avhec.com.au

**Drug and Alcohol Nurses of Australia 'Endurance' Forum**  
11 August, Park Royal Darling Harbour NSW. www.danaonline.org/dana-conference/

**International Elvis Week**  
11-19 August. Celebrate the 40th anniversary of Elvis' passing with music, movies, and legacy of Elvis Presley.  
www.graceland.com/elvisweek/

**National Left-Handers Day**  
13 August. www.lefthandersday.com

**12th New Zealand Dermatology Nurses Conference**  
17-18 August, Queenstown New Zealand. www.nzdermatologynurses.nz/

**25th Annual Scientific Conference on Diving and Hyperbaric Medicine**  
Back to the beginning  
17-19 August, Adelaide Convention Centre, SA. www.htna.com.au

**Vietnam Veterans Day (Long Tan Day)**  
18 August  
www.vietnamvetsmuseum.org/node/vietnam-veterans-day-long-tan-day

**Australian College of Nursing - National Nursing Forum**  
*Make Change Happen*  
21-23 August, The Star, Sydney, NSW.  
www.acn.edu.au/nnf2017

**National Daffodil Day (Cancer Council Australia)**  
25 August. www.daffodilday.com.au

**Annual Foundation for Prada Willis Research Conference**  
*Dream Believe Achieve*  
25-27 August, The Westin Indianapolis, Indiana, USA. www.fpw.org/events/2017annualconference/

**12th National Allied Health Conference**  
**Allied Health: Stronger Together**  
26-29 August, Sydney International Convention Centre, NSW.  
https://secure.hotelnetwork.com.au/12thnationalalliedhealthconference/home

**National Legacy Week**  
27 August-2 September.  
www.legacy.com.au/LegacyWeek

**Endocrine Nurses' Society of Australasia Annual Symposium**  
*Endocrinology: A problem of too much or too little*  
28 August, Perth Convention & Exhibition Centre WA.  
www.ensa.org.au/ensa2017/

**Aeromedical Society of Australasia and Flight Nurses Australia 29th Conference**  
*Aeromedicine. Learning from the past - Adapting for the future*  
30 August-1 September, Doltone House, Darling Island, Sydney NSW.  
www.aeromedconference.com

**Australian Diabetes Society and Australian Diabetes Educators Association Annual Scientific Meeting**  
30 August-1 September, Perth Convention & Exhibition Centre WA.  
http://ads-adea.org.au/

# SEPTEMBER

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

**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

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

**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

# OCTOBER

**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/

**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

**21st Australasian Menopause Society Congress**  
*Menopause: Exploring the evidence*  
13-15 October, Sofitel Sydney Wentworth, NSW.  
http://www.ams2017.org/

**National Anti Poverty Week**  
15-21 October. www.antipovertyweek.org.au/about/about-anti-poverty-week

# NOVEMBER

**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

# NETWORK

**St Vincent's Hospital, Melbourne, August '87 PTS**  
August 5, 2017  
Contact Deb May (Carey)  
Email: amaybuild@bigpond.com or M 0418 391 968

**The Southern Grampians Maternal and Child Nurses Regional Network will be celebrating 100 years of Maternal and Child Health Nursing in Victoria and closure of the group**  
18 August, 6.30pm, Ballarat Golf Club. All past and present M&CH nurses working in the local government areas of Golden Plains, Pyrenees, Moorabool, Hepburn and Ballarat are warmly invited to attend a dinner. Contact E: belindajoyce@ballarat.vic.gov.au

**Royal Hobart Hospital, PTS 8/84, 30-year reunion**  
19 August, 4pm, New Sydney Hotel, Hobart. Contact Chrissie Webster E: christine.webster@hotmail.com M: 0413 774 049 or facebook page PTS 8/84

**St Vincent's Graduate Nurses Luncheon**  
7 September, Melbourne Park Hyatt. Contact Liz Ferguson E: stvnga@gmail.com

**Royal Canberra Hospital (Acton) reunion Luncheon**  
16 September, 12-3.30pm.  
For more information E: rchreunion2017@gmail.com

**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

**Sturt College Nurses, 40-year reunion**  
4 November. Hoping you can join us for a casual and fun reunion of the first year of Sturt College nurses. It will be for drinks and dinner with time and venue TBA. 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. Planning well underway. Trying to locate Carol Ball, Sue Ball, M de Graaf, Barb Gilmore, Sue Gladigau, Hilary Hammond, Barb Dunne, Narelle Harley, Chris Horton, Sue Ramage and Pam Walsh. 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. We would love to hear from you. Please 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](mailto:cathy@anmf.org.au) if you would like to place a reunion notice

# "DELEGATES ARE DIAMONDS"

Lori – anne Sharp, ANMF Vice President

Last year I ran as an independent candidate in my local council elections. Looking back on the experience it felt like a self-directed professional development course, albeit an expensive one.



**BECOMING A JOB REP WAS NOT A CONSCIOUS DECISION BUT RATHER CAME FROM A PROMPT, 'TAP ON THE SHOULDER', FROM AN ANMF INDUSTRIAL ORGANISER.**

I needed to take three weeks annual leave to run a very grassroots campaign and I had severely underestimated the cost of printed material to reach the 33,000 constituents. For this reason I was forced to think creatively and it was here that my experience as a job representative (job rep also known in some states as delegates or worksite representatives) for the last fourteen years played a significant part.

Becoming a job rep was not a conscious decision but rather came from a prompt, 'tap on the shoulder', from an ANMF Industrial Organiser. I had just returned to community nursing after a three-year stint working overseas. There had been some local workload issues and an upcoming enterprise bargaining agreement (EBA) to negotiate something many of you may be familiar with.

Without really knowing what the role entailed I thought, why not? There was no job rep for the region and I remember thinking that, somebody needs to do it.

I had the opportunity to attend the job rep training within the Branch and participated in the Anna Stewart Memorial Project.

This program, a two-week structured internship conducted by Victorian Trades Hall Council in conjunction with unions, gave me the opportunity and confidence to grow into the job rep role.

Anna Stewart was a journalist and an active Victorian union official from 1974 to 1983. She highlighted many issues facing women at a time when working women represented only one third of the workforce, and was instrumental in the first blue-collar union campaign for maternity leave provisions. Sadly Anna died tragically at the age of 35, but her legacy continues today.

Becoming a job rep has become part of that legacy and is about much more than updating the tea room notice board or getting members on buses for EBA meetings. Although, if you're doing these things already you're well on your way to becoming a job rep.

Being a job rep is also about recruiting, bringing members together, listening to concerns, organising and building relationships with colleagues and managers and maintaining strong links to your union.

Committed job reps are vital in advancing our profession both industrially and professionally. You don't need to look far in each state or territory for examples of how this has happened.

It was the brightly coloured windcheater with the words 'support nurses support patients' written across the front that my colleague Marg remembers wearing to the Dallas Brooke Hall in 1971 to win the fight in obtaining penalty rates for nurses. Nurse to patient ratios are embedded in EBAs in most states now, and the *Safe Patient Care Act 2015*, legislating safe nurse to patient ratios are in place in Victoria. Continual improvements in pay and conditions through collective enterprise bargaining agreements have cemented nursing and midwifery as reputable and respected professions. None of these achievements could have happened without the work of dedicated delegates.

It is my belief that nurses and midwives have both the ability and responsibility to shape the industrial and professional framework in which they work. They are

also in the ideal position to participate in and influence social and political reform.

Typically, my experience of nurses and midwives is that they are compassionate, hardworking, excellent communicators and well connected to many walks of life. This adds great strength when advocating for both themselves and their patients. Equipped with a strong sense of social justice, we have the ability to influence and drive the change needed in society to achieve fairness and equality.

Activism typically involves three key elements:

- **ANGER** – identifying issues that people are angry about;
- **HOPE** – equip people with the necessary tools/skills to fix the problem;
- **ACTION** – having support and structures in place to enable the actions required for change.

It is the latter two where a good job rep with a strong union can be of the most benefit. As health professionals we have a lot to stand up for and work on, adequate qualified staffing and pay parity in aged care, end of life choices, workplace safety, penalty rate attacks and the impacts of climate change on health, are to name but a few.

Delegates are the 'diamonds' of the union movement. (Clarke, Pocock and Peetz, 2005) It is our collective responsibility that they continue to be recruited, supported and appreciated. Without them supporting and driving union activities we would not enjoy advances in our work conditions, influence health policy and be the 259,000-member strong union that we are today.

With competing demands on our time I appreciate it can be difficult to find that bit extra to fulfil the job rep role. However, I encourage all to give it some thought or consider giving a 'tap on the shoulder' to prompt someone who you think would be suitable. Think about the benefits to our workforce, our patients and your own personal development. Give it a go, you can make a difference. You will also meet some fantastic people along the way, some who may even go on to be lifelong friends. You may even have the crazy idea of running for local government at some stage!

Whilst I wasn't elected to local government (coming fifth out of a field of 25!), I am proud of myself for giving it a go, of standing up for issues I feel passionately about and as a job rep, you too can experience that feeling and more importantly, you too can make a difference.

*'The title of this article is taken from Clarke, J, Pocock, B and Peetz, D 2005 Extracts from Delegates are diamonds, Learning from union delegates experiences in Australia.'*



## Reference

Clarke, J, Pocock, B and Peetz, D 2005 Extracts from Delegates are diamonds, Learning from union delegates experiences in Australia.



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