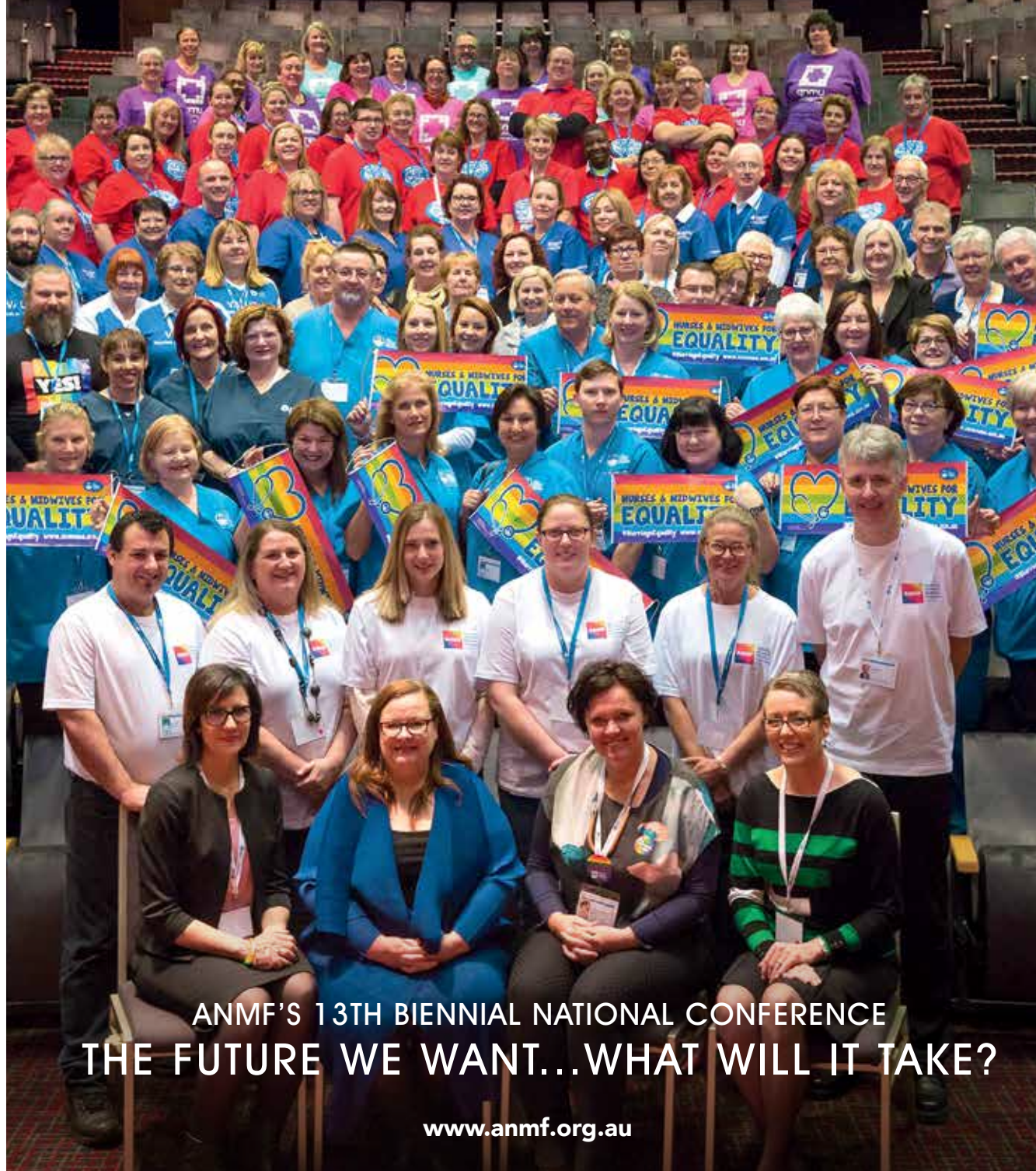


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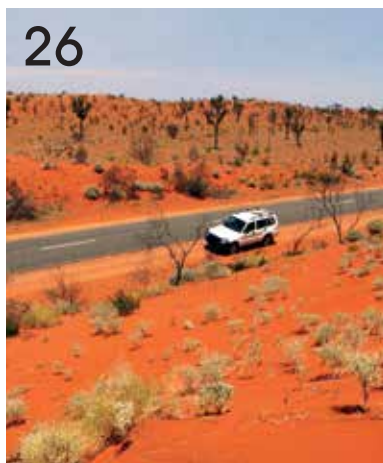
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Editorial

Lee Thomas, ANMF Federal Secretary



After an exhilarating two days of passion and inspiration at ANMF's 13th Biennial in Hobart last month, I can now sit back and reflect on what has been yet another successful national conference for the Federation.

This conference has meant a lot to me, not only because it has left me with great hope for the future, but because this was my last biennial conference.

After 20 years in the union movement I have decided to call it a day for a new career in law. I will officially step down from my position on 8 December 2017.

While I am very excited about this new chapter, it is hard leaving the ANMF, which has been a part of my life for such a long time. There is no denying the union gets under your skin but all

in a good way. It has been an amazing ride made all the better because of each and every member.

It's been an honour and a privilege to lead the ANMF, working on behalf of you all.

Over the past eight years as Federal Secretary, I am proud to say membership has increased by more than 12% and continues to grow rapidly. Membership currently stands at a record 270,000 making the ANMF the biggest union in the country.

Throughout my time as Federal Secretary, we have run many campaigns nationally and on a state level, resulting in tangible outcomes to be proud of.

Without doubt we have been a force to be reckoned with in health, aged care and the industrial and professional arenas.

I am extremely confident of the union's future as I am sure the ANMF will continue to support and stand up for the rights of nurses and midwives, healthcare and social justice issues. The gumption, determination and leadership shown by delegates at the conference is clear evidence of this prospect.

One of the biggest issues discussed at the conference was the state of aged care. Nurses, carers and residents continue to be at risk by employers putting profits before people. The ANMF has been consistently working hard to protect them, but the fight continues.

AFTER 20 YEARS IN THE UNION MOVEMENT I HAVE DECIDED TO CALL IT A DAY FOR A NEW CAREER IN LAW. I WILL OFFICIALLY STEP DOWN FROM MY POSITION ON 8 DECEMBER 2017.

To this end the ANMF is launching a new national campaign to fix the crisis in aged care, where pressure will be mounted on political parties, particularly leading up to the federal election.

The ANMF will also publicly name providers who compromise care as a result of inadequate staffing ratios. A key component of the campaign will be to hold aged care providers to account on how they use taxpayers' money.

This campaign needs the courage of conviction, unity of purpose and strength in numbers. I am confident the ANMF and its members will rise to the occasion to ensure we have an aged care system we all rightly deserve.

lee

TO READ
MORE ON THE
BIENNIAL TURN
TO PAGE 4



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ANMF'S 13TH BIENNIAL NATIONAL CONFERENCE INSPIRES A POSITIVE FUTURE



ANMF FEDERAL LEADERSHIP TEAM. ASSISTANT FEDERAL SECRETARY ANNIE BUTLER, FEDERAL PRESIDENT SALLY-ANNE JONES, FEDERAL SECRETARY LEE THOMAS, FEDERAL VICE PRESIDENT LORI-ANNE SHARP.
PHOTOGRAPHER: GRAZIANO DI MARTINO

More than 100 passionate delegates converged in Hobart last month for the ANMF's 13th Biennial National Conference.

The conference theme, *The Future We Want...What Will it Take?*, was enthusiastically embraced as delegates discussed and debated important issues on healthcare and social justice issues they wanted action on. Common themes included aged care, safe staffing levels, the environment and marriage equality.

At the conference's opening address ANMF's Federal President Sally-Anne Jones said nurses and midwives had a responsibility to check the health and safety of all global citizens. "It will take vision and determination to create strategy to address the complex issues of the health system today such as the burden of disease, an ageing population and our workforce."

Ms Jones said having the future we want will take some courage. "The courage of

conviction, unity of purpose and strength in numbers. It's not easy being a nurse or a midwife and a union leader, no matter what your working environment is.

"To cut through public mistrust of the union movement means that we have to work harder to demonstrate this additional responsibility of a much trusted profession. This is vital in maintaining and improving some of the basic tenets of the workforce and workplace rights."

The future we want is ours for the making despite what may seem like overwhelming competing priorities and difficult choices and challenges, said Ms Jones. "Nurses and midwives of this union are well equipped. I know we already have what it takes it's just a matter of getting on with it."

ANMF Federal Secretary Lee Thomas, who also spoke at the conference, said reflecting on the theme *The Future We Want...What Will it Take?* reminded her of the gains the union had made over the years.

She said the growth of the membership was an outstanding example of the ANMF's strength. "Membership is sitting on around 270,000. We have continued to grow over the last decade without falter.

"The ANMF is the largest union in the country and because of our continued growth and the massive work you do every day in your workplaces I am very confident we will continue to be the largest union in Australia for many years to come."

Ms Thomas said while union growth was a tangible indicator of success the campaigns run at a state and national level have made the ANMF a creditable well-run union.

Such campaigns have included fighting cuts to Medicare and privatisation of hospitals across the country. "We've suggested logical solutions to hospital funding in recommending to governments tax changes such as the Robyn Hood Tax," Ms Thomas said.

"IT WILL TAKE VISION AND DETERMINATION TO CREATE STRATEGY TO ADDRESS THE COMPLEX ISSUES OF THE HEALTH SYSTEM TODAY SUCH AS THE BURDEN OF DISEASE, AN AGEING POPULATION AND OUR WORKFORCE."

"We have joined the campaign for assisted suicide and we have fought against the reduction of penalty rates and we have also fought for marriage equality- these are just a few of the campaigns we have been involved in".

Yet Ms Thomas said the union still needed to achieve much more.

"Like a healthy planet for our children and our grandchildren. A well financed public health system for all, assurance that all graduate nurses and midwives get jobs, exemplary wages and best conditions of employment possible.

"We also need a *Fair Work Act* and a modern award system that is fair and works for us all as well as mandated minimum staffing and skill mix in aged care and decent standards in aged care.

Ms Thomas said it would take the union and its members working at a state and national level to make this happen.

"We need to campaign effectively- as we always do. We need an Australian government that responds to our reasonable requests- after all we are the ones that know what is needed in our private and public hospitals, in aged care, in doctors' rooms, in schools. In fact wherever there is a nurse or midwife I can guarantee any government that we will know what it takes to solve any problem. We are the biggest, now let us be the loudest."



ANMF FEDERAL SECRETARY CALLS IT A DAY

After 20 years with the union ANMF Federal Secretary Lee Thomas has decided to hang up her boots for a career in law.

Ms Thomas made the announcement at the ANMF's Biennial National Conference last month.

"After 20 years with the union including 18 years as an elected official, on 8 December I am leaving," she said.

Ms Thomas has been the Federal Secretary for the union for almost eight years. Under her leadership, the ANMF has grown to become Australia's largest union, with a membership of almost 270,000.

"It's been my great privilege and passion to work for you all over the past 20 years. I have seen us grow and change. I have seen seemingly insurmountable hurdles overcome," she said to delegates.

Nursing and midwifery leaders praised Ms Thomas for her achievements over the years. Former Commonwealth Chief Nurse and Midwifery Officer Rosemary Bryant said Ms Thomas had worked to bring all strands of nursing and midwifery together and stay together. "As you know

unity is power and I am sure Lee's legacy in this arena will be long lasting".

"Lee has been a really strong advocate for the nursing and midwifery professions and has helped advance the conditions we work under. Lee we thank you for all the work you have done," said CRANA plus' CEO Christopher Cliffe

Janine Mohamed CEO of the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) thanked Ms Thomas for all she had done for their organisation. "With your leadership we have forged a close relationship. We have achieved so much in our partnership and our time together."

"You have had an amazing career as an elected official and you should be rightly proud of what you have achieved. On a midwifery front I would like to thank you so much on behalf of the members from the Australian College of Midwives. We have been delighted to work with you over this time. We will miss you," said CEO Anne Kinnear from the Australian College of Midwives.

"Good luck for the future. Thank you for the memories and your fabulous contribution to the profession and thanks for your friendship and advice over the years," said University of Technology Sydney's Professor Christine Duffield.

"You have had some very big obstacles running the union and you have done it with such skill and such great outcomes not only for the union but for members," said ACTU President Ged Kearney.

DELEGATES URGE EQUALITY FOR ALL

Marriage equality was widely supported at this year's Biennial National Conference.

A multitude of rainbow vote yes flags and banners were proudly displayed amongst the NSW delegation in support of same sex marriage.

NSW Delegate O'Bray Smith highlighted the importance of marriage equality when she addressed politicians, Federal Labor Opposition Spokesperson on Mental Health and Aged Care Julie Collins, Senator for Tasmania Jacqui Lambie and Australian Greens Senator for Tasmania Peter Whish-Wilson, on the issue.

O'Bray argued without marriage equality, inequity and discrimination would continue on many levels.

"Can I ask how you will all be voting to improve acceptance equality and inclusiveness which is a social determinant of health for all Australians moving forward," she asked the politicians.

Ms Collins and Senator Whish-Wilson indicated their support for marriage equality while Senator Lambie said she would support the will of the Australian people.

When speaking about marriage equality Assistant Federal Secretary Annie Butler said it was unfortunate the unnecessary approach the federal government had taken on this issue, which had led to some divisive debate in our community and needless criticism in many sectors of our society. "We think this approach is completely misguided and wrong," she said. "What we are saying is that sexual orientation does not matter it's about love and commitment and everyone should have the same rights."



ANMF (VIC BRANCH) SECRETARY
LISA FITZPATRICK SPEAKING OUT
ABOUT BUPA



AGED CARE CAMPAIGN

ANMF members voted unanimously for a new national campaign to fix the crisis in aged care last month.

Members at the ANMF Biennial National Conference held in Hobart passed a special resolution to mount pressure on political parties in the lead up to the federal election.

"This will be the biggest national aged care campaign we have ever had," ANMF Assistant Federal Secretary Annie Butler said.

"We have seen recently what is happening – with Blue Care in Queensland, Southern Cross in Tasmania, and Bupa in Victoria.

"In Victoria, this is why we have seen 171 new members in aged care. And why Bupa members voted to take protected industrial action. We are starting to see what we haven't seen before and we need to harness all of that in this national aged care campaign. We have to do things differently – so far we have been ignored by both sides of government."

The ANMF will publically name providers who compromise care as a result of inadequate staffing ratios. A key component of the campaign will be to hold aged care providers to account on how they use taxpayers' money.

"At nursing homes across Australia, highly-trained nurses are being sacked and thousands of care hours slashed. It's clear that providers are putting profits before their staff and the people they care for," Ms Butler said.

WHAT DELEGATES SAID

VIC Liz Barton

"I am all fired up. I am absolutely delighted that there will be a national aged care campaign. We have been campaigning for eight to 10 years and the problems aren't fixed in aged care. I work in palliative care. People in aged care facilities are unwell, have multiple comorbidities and require nursing care. I think if the government can solve the problems in aged care it will help solve problems in other sectors including waiting times and hospital beds."

NSW Lucille McKenna

"There is a lack of skill mix and a reduction in the number of RNs working in aged care. It's a huge problem. I am absolutely passionate about having a RN on duty 24/7. We have run a 24/7 campaign in NSW. It has not been supported by our state government or any level of government. It's creating huge issues. I feel we are on a downhill slide."

DELEGATES SUPPORT INDUSTRIAL ACTION AT BUPA SITES

Delegates at ANMF's 13th Biennial National Conference unanimously passed a special resolution to stand in support of ANMF members working at Bupa sites who are currently undertaking protected industrial action.

The ANMF (Vic Branch) has been negotiating for a fair and reasonable enterprise bargaining agreement with Bupa for members since July 2016.

Bupa has 26 for profit aged care facilities across Victoria. Nurses and carers, who work at these facilities, are amongst the lowest paid in the Victorian aged care sector despite the organisation's 2016 calendar year profits being \$585 million.

Negotiations with the union and Bupa stalled after the health corporation made an offer of a 2.1% wage increase over one year and no changes to conditions. Subsequently nurses and carers began protected industrial action resulting in Bupa increasing its offer to 11.25% over three years.

However, the wage offer did not address significant issues of inadequate staffing, including the number of nurses and carers rostered on every shift, particularly night shift where one carer can be allocated 20-25 residents, or the failure of management to replace nurses and carers on leave.

Soon after the offer, Bupa also announced senior clinical nursing redundancies.

Consequently, nurses and carers have continued stage-one of protected industrial action by holding stop work meetings and community barbeques across the state. Nurses and carers are also wearing red aged care campaign t-shirts every shift, distributing campaign information to residents, their families and speaking to members.

Bupa has threatened to dock members' laundry allowance if they continue to wear the campaign t-shirts and have attempted to stop community barbeques through local councils.

As the ANMF was going to print the ANMF (Vic Branch) was in negotiations with the Fair Work Commission about the agreement.

Around the same time the Federal Court of Australia heard the Branch's case about failing to consult staff and the union as part of its decision to make nurses redundant. ANMF Federal Secretary Lee Thomas said Victorian members had taken courageous industrial action against an employer who had very deep pockets. "These nurses and carers are standing up against employers who frankly just want to continue to push nurses harder in their daily work. Congratulations to the Victorian Branch and those members. We will be watching in solidarity."

ANMF Biennial National Conference special resolution

"That the 2017 Biennial National Conference stands in absolute unity with Victorian Branch members in Bupa aged care facilities in their industrial action seeking fair and just wages, improved staffing and conditions. This conference condemns in the strongest possible terms the behaviour of Bupa management and their attempts to intimidate and harass nurses and carers undertaking protected industrial action."

NEW CODES OF CONDUCT FOR NURSES AND MIDWIVES

The Nursing and Midwifery Board of Australia (NMBA) has released new codes of conduct for both nurses and midwives that set benchmarks across a range of areas including professional behaviour, practicing cultural safety and promoting health and wellbeing.

Last reviewed in 2008, the updated codes provide a contemporary guide that reflects current nursing and midwifery practice. Seven principles, categorised into four domains, frame the new codes.

For nurses, they include providing safe, person-centred and evidence-based practice; embracing cultural safety and building a health system free of racism and inequity; promoting health and wellbeing; and mentoring junior nurses in order to develop the workforce's next generation.

Notably, under the principle regarding cultural practice and respectful relationships, nurses are encouraged to help stamp out bullying as well as play a pivotal role in providing quality end-of-life

care. The separate codes of conduct for midwives share much of the same principles, but feature woman-centred practice instead of person-centred practice.

This principle calls on midwives to take a woman-centred approach to managing a woman's care and concerns; supporting the right of women to seek second opinions; promoting shared decision making; and openly disclosing when something goes wrong.

The NMBA regulates the practice of nursing and midwifery in Australia and developing codes is one of the ways it helps support nurses and midwives to provide safe practice as part of their professional roles.

Taking effect from March next year, the new codes outline the legal requirements, professional behaviour and conduct expectations for nurses and midwives across all practice settings.

They also inform the public about the standards of conduct and behaviour they should expect from nurses and midwives.

"All nurses and midwives have their own personal values and beliefs but the codes of conduct provide specific standards of conduct and behaviour that all nurses in Australia need to meet," NMBA Chair, Associate Professor Lynette Cusack RN said.

"These codes provide a foundation for safe practice and give guidance on crucial issues such as bullying and harassment, professional boundaries, and cultural safety."

For more information go to:

www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx



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DIGITAL ASSETS ON DEATH AND DISABILITY POSES A PROBLEM

Most Australians are unprepared for death and disability when it comes to their digital assets, a study from the Adelaide University and the Charles Sturt University has found.

The study showed Australians have multiple digital assets, which includes anything that can be accessed and held online in digital form. Social media, iTunes accounts, banking and other financial and medical records, domain names, online businesses, bitcoins and emails, are such examples.

Results from the national survey, Estate Planning in Australia, indicated only 18% of those surveyed did not own anything while over 71% of those that had digital assets indicated they were unaware of what would happen to them when they die or became disabled.

OVER 71% OF THOSE THAT HAD DIGITAL ASSETS INDICATED THEY WERE UNAWARE OF WHAT WOULD HAPPEN TO THEM WHEN THEY DIE OR BECAME DISABLED.

The lack of understanding presents serious potential problems for individuals and businesses, the report said. Online service providers implement different strategies in dealing with accounts belonging to deceased users. In most cases, closing the account requires close family

to provide documentation to prove they have the right to request that the account is terminated. This does not usually allow the relatives to get access to the accounts, leaving families without access to digitally stored memories of their deceased family member.

Other issues include when service agreements are held by individuals rather than business. Death and disability could result in significant business disruption and loss, said project lead Professor of Finance Adam Steen from Charles Sturt University. "Aside from the obvious personal issues involved, the results should be a wakeup call for business owners," he said. "Appropriate action and planning is needed to ensure businesses rather than individuals have licencing and other arrangements with service providers to ensure business continuity and minimise disruption in the event of death and disability of key people."

Legislation, which allows executors of deceased estates to manage a decedent's digital assets, has been enacted in most US states but not in Australia.

BIRTHING ON COUNTRY BOOST

A maternity program designed to achieve better health outcomes for Aboriginal and Torres Strait Islander women and their babies has received a \$1.1 million grant from the National Health and Medical Research Council (NHMRC).

The project, led by the University of Queensland's Professor Sue Kildea along with researchers from the University of Sydney and the Institute for Urban Indigenous Health, will establish Birthing on Country across two sites before pushing for an Australia-wide roll out.

The NHMRC grant will help determine the sustainability of the Birthing on Country service model in each community, along with the impact on Indigenous women, their communities and health services.

"The Birthing on Country program focuses on the year before and the year after birth, as these are the most important time in life," Professor Kildea said.

"It is informed by Indigenous knowledge and community control with a redesigned health service to provide 24/7 continuity of midwifery care and birthing in an Indigenous birthing centre."

Institute for Urban Indigenous Health



PROFESSOR SUE KILDEA, CENTRE, WITH MOTHER KARINA HOGAN AND BABY ELLIOT

CEO Adrian Carson said Indigenous control and governance of services was a key element of the project, entitled 'Building on Our Strengths (BOOSt): Developing and Evaluating Birthing on Country Primary Maternity Units'."

"This program has a strong emphasis on culturally and clinically safe care, strengthened support for families, and growing a culturally capable workforce and the Indigenous maternal and infant workforce," Mr Carson said.

"It also allows us to review the effect on three of the most costly health outcomes across the lifespan for Aboriginal and

Torres Strait Islander peoples – preterm birth, low birth weight and hospital admissions in the first year of life."

Professor Kildea said the project team was calling on all Australian governments and health organisations to support the implementation of the Birthing on Country programs.

"After two decades of research, including consultation with Indigenous elders and communities, we can now enact state and federal health policy and put into practice national and international evidence of the safety, benefits and cost-effectiveness of culturally safe care."

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AIM TO HALVE MEDICATION ERRORS IN NEXT FIVE YEARS

The Society of Hospital Pharmacists of Australia (SHPA) has welcomed a pledge by the Australian Commission on Safety and Quality in Health Care to support global efforts to halve medication errors within the next five years.

The Commission's bid aligns with the World Health Organization's (WHO) third Global Patient Safety Challenge, unveiled last month.

The drive to reduce the harm caused by medication mix-ups aims to help countries strengthen their health systems and save an estimated \$54 billion annually.

WHO's Western Pacific launch of 'Medication Without Harm' took place in Brisbane last month, with SHPA Chief Executive Kristin Michaels backing the importance of focusing on curbing the largely preventable aspect of patient injury and harm.

"It is fantastic to see the weight of WHO driving this global campaign, which will help health systems improve each stage of the medicines management pathway, including influencing prescribing, dispensing, administering, clinical review and monitoring, and supporting improvements in patient understanding of the medicines they are taking," Ms Michaels said.

About 230,000 hospital admissions across Australia each year are medicines related and involve errors in prescribing, dispensing, administration or poor monitoring and transitional care arrangements, costing an estimated \$1.2 billion annually.

Ms Michaels said hospital pharmacists play a significant role in reducing medication errors.

"Local and international research shows time and again that the expertise of hospital pharmacists is indispensable in multidisciplinary medical teams and that they provide a crucial link to ensure seamless care and quality use of medicines when patients leave hospital and head home."

Ms Michaels highlighted that hospital pharmacists were committed to leading the way in research in a bid to influence nationwide improvements to how risk minimisation innovations are advocated for, and medications safety education framed.

TAMIFLU STOCK RUNS OUT

Stocks of Tamiflu have run out in the wake of one of the worst flu seasons recorded in Australia.

Tamiflu was added to the list of unavailable medicines by the Therapeutic Goods Administration (TGA) last month.

Government statistics show more than 160,000 people have contracted severe influenza this year, more than double that for the same period last year. More than 120 flu-related deaths have been reported nationally.

The number of people who had been struck down with the flu had been staggering, National Custom Compounding head pharmacist Matthew Bellgrove said.

"Our counterparts in the US and in Europe are very concerned and are watching what we're doing here closely as they countdown to the start of their own flu season."

It's unknown when new stocks of Tamiflu will arrive in the country.

Unavailability of Tamiflu has raised concerns for those in high risk groups of contracting influenza.

MIDWIFERY NAVIGATORS TAKE FLIGHT ON GOLD COAST

A midwifery navigator service on the Gold Coast is the first in Queensland's public health system to specialise in supporting pregnant women with substance dependence and mental health issues.

Three experienced midwives lead the new Midwifery Navigator service to coordinate care between the mother, her primary carer, specialists and allied health professionals, prior to, during birth, and for up to six weeks after birth.

The Queensland government has committed to more than 400 nurse navigators, with 50 at the Gold Coast Hospital and Health Service. Statewide, up to 121 nurse navigators have started in the role, with 119 more to begin over the next year.

Gold Coast Health Midwife Navigator Bee Schaeche said it was important for those

vulnerable women who often didn't engage with health services, to have continuity of care. "The service is aimed to support these very vulnerable women who often require multiple additional services outside of obstetric care. They and their babies are often at high risk during pregnancy and beyond because of their potential exacerbation of their mental health issues.

"These women are often completely lost and need someone to help navigate them through the system. We case manage them and coordinate the appointments that they need."

The midwifery navigator service had 40 referrals when it opened on 1 August.

Eligibility criteria for the midwifery navigator service includes recent substance use and/or mental health issues.

"We look after those who need the most support and potentially have limited support in their life," Ms Schaeche said.

The three midwifery navigators have experience in caring for women in high risk models of care, including women who may be: refugees, teenagers, victims of sexual/other abuse, substance dependant, living with mental illness or intellectual impairment.

The midwife navigators are involved with the care of mothers throughout pregnancy and for up to six weeks after birth and hope to follow up with clients at three, six and 12 months after birth.



MIDWIFE NAVIGATORS AT GCH DI TAMARIKI, BETHAN TOWNSEND AND BEE SCHAECH (RIGHT) WITH ALANA GLASSEY AND DAUGHTER IMOGEN

"THESE WOMEN ARE OFTEN COMPLETELY LOST AND NEED SOMEONE TO HELP NAVIGATE THEM THROUGH THE SYSTEM. WE CASE MANAGE THEM AND COORDINATE THE APPOINTMENTS THAT THEY NEED."

SECURITY GUARD INCREASE AT VIC HOSPITALS

More security guards will be rolled out at Victorian hospitals in a bid to stamp out occupational violence experienced by healthcare workers and likewise boost safety for patients and visitors.

Last month, the Andrews Labor government revealed 30 health services operating across 44 hospital sites would share almost \$6.7 million in funding to increase security staffing and mobile security patrol services at hospitals.

The initiative equates to an extra 123 full-time equivalent security guards patrolling hospital grounds and potentially preventing and de-escalating violent and aggressive situations including responding to Code Grey calls and duress alarms.

Along with beefed up security on hospital grounds, both Kooweerup Regional Health Service and Rochester and Elmore District Health Service will benefit from the introduction of nightly

mobile security patrol services that will visit hospitals and respond to incidents.

Victorian Health Minister Jill Hennessy said the government was committed to stamping out aggression towards health workers.

"There is just no excuse whatsoever for aggression towards staff in our hospitals," she said.

"Like us all, our dedicated doctors and nurses deserve to feel safe at work. Sadly, too often health workers are confronted with abuse and threats, all while doing their best caring for us at our most vulnerable."

The funding will help play a key role in facilitating the recently announced Australian-first standardised Code Grey policy, which all hospitals must have in place and guides how they prevent, respond and reduce violence against healthcare workers and patients and visitors.

It is estimated up to 95% of healthcare workers have experienced physical or verbal attacks while on the job.

Importantly, the Labor government is investing a further \$20 million in its *Health Service Violence Prevention Fund*, taking the total to \$40 million, with strategies including new behavioural assessment rooms at 16 Victorian hospitals.



NIGHT SHIFT LINK TO OBESITY

Nurses who do night shifts are at a 29% increased risk of becoming obese or overweight, international research shows.

Night shift workers were more likely to develop abdominal obesity than other obesity types, the analysis of 28 published studies found. Permanent night shift workers were at higher risk than rotating shift workers.

Globally, nearly 0.7 billion workers were engaged in a shift work pattern, study senior author Dr Lap Ah Tse said.

Abdominal obesity increased the risk of other adverse health outcomes, such as breast cancer and cardiovascular disease, Dr Ah Tse said. "Modifying work schedules to avoid prolonged exposure to long-term night shift work might help reduce the risk of obesity."

The study was published in journal *Obesity Reviews*.

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HESTA EXECUTIVE ENGAGEMENT STRATEGY, NEIL SAXTON, WITH CATSINaM CEO JANINE MOHAMED.

UNEARTHING THE CONTRIBUTIONS OF INDIGENOUS NURSES

The stories of Aboriginal and Torres Strait Islander nurses and their impact on the Australian healthcare system will be documented in a bid to highlight their enduring commitment to championing health equality.

Launched by HESTA at the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) conference last month, the Innovate Reconciliation Action Plan (RAP) includes a key focus on the history and influence of Indigenous nurses working in Australia.

"Committing to this action is our way of recognising the incredible contributions of Aboriginal and Torres Strait Islander nurses past and present to our healthcare system," HESTA CEO Debby Blakey said.

"By collaborating with associations like CATSINaM to record and share their stories we hope to acknowledge the barriers they may have overcome,

while raising awareness of the pivotal role they continue to play in achieving health equality in Australia."

The Innovate RAP builds on the 2015 Reflect RAP and reinforces a commitment to reconciliation and achieving equity between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians.

The Innovate RAP also outlines a pledge to support the development of Indigenous nurse leaders within the healthcare sector.

"We recognise the vital role these future health professionals play in achieving health equality between Aboriginal and Torres Strait Islander people and the wider Australian community," Ms Blakey said.

CATSINaM CEO Janine Mohamed said celebrating the stories of Indigenous nurses, told from their own perspectives, was an important step in taking pride in their contributions to health equity.

"It's really important our stories are told by our people. So much of Australia's history is told through a non-Indigenous lens," Ms Mohamed said.

"It's really important for our Indigenous nurses and midwives to see their predecessors' contributions to their professions. We hear so much about Florence Nightingale and non-Indigenous nurses. It's vital that both Indigenous and non-Indigenous nurses know the beautiful rich history of Aboriginal and Torres Strait Islander nurses and midwives in this country."

STOOL TRANSPLANTS TO PREVENT CHRONIC DISEASE

By Monique Eccles

Faecal or 'poo' transplants are emerging as an accepted procedure in the medical fight against autoimmune diseases and allergies, a GUT conference heard recently.

In Faecal Microbiota Transplant (FMT), also known as stool transplant, faecal bacteria from a healthy individual is transplanted into a recipient to achieve a specific health outcome.

Keynote speaker at the recent A5M Gut Health conference held in Melbourne gastroenterologist Dr Paul Froomes said while unusual or unpalatable, increased use of FMT was due to the benefits to manipulate human gut microbiome for long-term positive results.

Evidence supported a strong link between bowel diseases and the intestinal microbiota.

Research presented showed diseases such as ulcerative colitis and Crohn's disease had seen positive outcomes with (FMT) treatment.

Endoscopic healing increased by 32% in patients treated with FMT for ulcerative colitis; and 76% of patients experienced remission in a four week period with Crohn's disease.

Where pharmacological therapies had failed, it was only fresh probiotics from another human being that retained the capability to be implanted to reverse damage and side effects for long-term gut health, Dr Froomes said.

"Gut health is linked to the differing levels of good and bad bacteria in the bowels. Increasing the level of probiotics in the gut can reverse the damage and associated problems caused by the bad bacteria."

Commercial oral probiotics were unable to permanently implant into gut flora, Dr Froomes said. "It is only fresh human probiotics that implant in the gut and activate long-term results at a cure rate of 90-95%."

Other conditions such as autism, and diseases such as Parkinson's and autoimmune had also shown positive results with FMT therapy.

FMT had recently shown outcomes in obese patients. Dr Froomes presented a randomised controlled trial (RCT) of 18 men with metabolic syndrome who received FMT from a lean donor with a BMI <23. After six weeks of therapy, their insulin resistance became normalised.

When faecal matter from an obese person was transplanted into the bowel of a lean recipient, the lean individual experienced an increase in BMI from 26 to 34.5. The patient continued to gain weight over a three-year period, even despite an exercise and diet program. FMT procedures may have more promising outcomes, Dr Froomes said. "FMT's high success rate could mean it has the potential to extend its treatment to other areas and we need to explore this."



DOT ANGELL DELIVERING HER KEYNOTE ADDRESS DURING NATIONAL VIETNAM VETERANS' DAY.

VIETNAM WAR CIVILIAN NURSES KEEP UP FIGHT

It's been five decades since former civilian nurse Dot Angell travelled to Vietnam in the thick of war to serve in the relief effort but the lasting physical and emotional toll endures.

Since 1998, Dot and the fading number of civilian nurses that served in Vietnam have been campaigning for recognition and claims to the same health entitlements accessed by the military under the Veteran's Entitlement Act 1986 (VEA).

After serving as part of the Southeast Asia Treaty Organization (SEATO) project in 1967, where civilian surgical and medical teams treated patients caught in the crossfire of war, many civilian nurses suffered adverse health conditions such as cancers, multiple sclerosis and post-traumatic stress disorder (PTSD) later in life.

Ms Angell was one of them, developing two autoimmune conditions and PTSD.

Despite repeated attempts for recognition, the federal government has dodged the issue over the years by suggesting worker's compensation claims should be made under Comcare.

The recommendation is considered insufficient however because assistance stops at age 65, meaning most nurses are ineligible.

The unwavering fight for recognition was recently re-ignited by a new petition presented to the House of Representatives calling for Gold Cards to be granted to all surviving Australian nurses, doctors, physiotherapists, radiographers and laboratory technicians who served as part of civilian teams from 1964 to 1972.

The federal government is due to respond in coming months.

Adding significant momentum to the push, Ms Angell delivered a keynote address at the Shrine of Remembrance in Melbourne in August to mark National Vietnam Veterans' Day.

"Today brings back memories of the stoicism and friendliness of the Vietnamese people and the collegiality or 'mateship' between the team members with whom I worked and lived, in what can only be described as the most chaotic and primitive conditions," Ms Angell said.

Ms Angell recollected her role providing treatment as part of a civilian surgical team sent by the Alfred Hospital to South Vietnam in 1967.

She painted a chaotic picture where about 1.5 million refugees from North Vietnam were attempting to find safety in the south.

She explained how overcrowding and squalid conditions contributed to numerous diseases and that health professionals had to deal with limited surgical supplies.

Civilian volunteers bore witness to broken men, women and children, and battered people with seemingly no escape, she added.

Despite the bleak outlook, Ms Angell said health professionals stuck to the task of treating all patients who came through the gates of each hospital.

She closed by reiterating that remaining civilian nurses suffer the same medical and psychological conditions as military personnel and should be recognised by being eligible for repatriation benefits.

"I stand here before you as one of the survivors for approximately one third of us have died," Ms Angell said. "Like you we honour those who have died but we will continue to fight for those who live and suffer."

RESEARCH CENTRE TO STUDY MEDICAL CANNABIS

A world-first research centre investigating medical cannabis use has been given the green light thanks to a \$2.5 million funding injection from the National Health and Medical Research Council (NHMRC).

A team of national researchers and clinicians from over a dozen Australian universities and institutions will spearhead the new venture, titled the Australian Centre for Cannabinoid and Research Excellence (ACRE).

According to one of the research centre's co-leaders, Professor Jenny Martin, from the University of Newcastle, access to medical cannabis remains problematic due to difficulties in sourcing reliable, consistent and clinically suitable products that are safe and effective to treat specific medical conditions.

"RECENT LEGISLATION HAS IMPROVED THE SITUATION BUT APPROPRIATE RESEARCH IS NEEDED TO ENABLE EVIDENCE TO GUIDE DOCTORS ON PRODUCTS AND DOSAGES THAT ARE SAFE AND EFFECTIVE."

Doctors have also expressed concerns about rapid changes to legislation without sufficient information to guide their prescribing, Professor Martin added.

"Recent legislation has improved the situation but appropriate research is needed to enable evidence to guide doctors on products and dosages that are safe and effective."

ACRE will set out to undertake medical cannabinoid research, consolidate existing data into guidelines and learn from positive health outcomes of people currently accessing local and imported products in order to shape new plant growing and product formulation into effective medicines.

Researchers will link scientific teams with specialist and national primary health care infrastructure to support information sharing, national monitoring and collaboration with government regulatory and advisory groups, as well as help train a new highly skilled medical research workforce in the field able to lead research into clinical trials and improve health outcomes for Australians.

"At this critical juncture where legislation around cannabis and cannabinoids is rapidly changing worldwide, there is tremendous opportunity for Australia to establish world leadership in cautious and appropriately balanced management of the implantation of medicinal cannabinoids into specialist primary and healthcare settings," Professor Nadia Solowij, from the University of Wollongong said.



ONE HOUR OF EXERCISE PER WEEK CAN THWART DEPRESSION

Undertaking as little as one hour of exercise per week can help prevent the onset of depression, an international research team led by the Black Dog Institute has shown.

The landmark study found regular exercise of any intensity can protect against depression,

even just one hour making a difference to mental health regardless of age or gender.

The most extensive study of its kind, the analysis involved 33,908 Norwegian adults who had their levels of exercise and symptoms of depression and anxiety monitored over 11 years.

Results showed 12% of cases of depression could have been prevented if participants had undertaken just one hour of physical activity each week.

"We've known for some time that exercise has a role to play in treating symptoms of depression but this is the first time we have been able to quantify the preventative potential of physical activity in terms of reducing future levels of depression," said lead author Associate Professor Samuel Harvey, from the Black Dog Institute and the University of New South Wales.

RESULTS SHOWED PEOPLE WHO REPORTED DOING NO EXERCISE WERE 44% MORE LIKELY TO DEVELOP DEPRESSION COMPARED TO THOSE WHO EXERCISED ONE OR TWO HOURS A WEEK.

Professor Harvey said the research team was still trying to pinpoint why exercise could stop depression.

"We are still trying to determine exactly why exercise can have this protective effect, but we believe it is from the combined impact of the various physical and social benefits of physical activity.

"These results highlight the great potential to integrate exercise into individual mental health plans and broader public health campaigns. If we can find ways to increase the population's level of physical activity, even by a small amount, then this is likely to bring substantial physical and mental health benefits."

Researchers used data from one of Norway's most comprehensive population-based health surveys ever undertaken, which was conducted from 1984 to 1997.

Results showed people who reported doing no exercise were 44% more likely to develop depression compared to those who exercised one or two hours a week.

However, the benefits did not extend to protecting against anxiety.

According to the Australian Health Survey, 20% of Australian adults don't exercise regularly, while more than a third spend less than 1.5 hours per week being physically active.

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NEW BLOOD COMPONENT LABELS IN 2018

By Sue Ismay, Scientific Director, Manufacturing, Australian Red Cross Blood Service

The Australian Red Cross Blood Service is introducing new blood component labels using the Information Standard for Blood and Transplant (ISBT 128), starting in June 2018.

The new labels, which are a global standard for the labelling and information transfer of Medical Products of Human Origin, will provide internationally recognised codes for blood component labelling that offers improved accuracy and safety for patients and donors.

These changes are significant and will impact all health professionals who receive, test, handle and transfuse blood components supplied by the Blood Service.

To enable health providers who are yet to have ISBT 128 capability, the Blood Service will implement an ISBT 128 transition label to help manage blood component inventory without interruption. This transition label will include the new ISBT 128 barcodes as well as the current Codabar barcodes.

What does this change mean for me?

The ISBT 128 transition label is very



different to the component label currently in use. Therefore, it is important health providers prepare for this change regardless of whether they are intending to adopt ISBT 128 or continue to use the existing Codabar barcodes in the interim.

Some of the key changes to the labels include:

The ISBT 128 transition label is much larger in size than the current blood component label and the barcodes and blood component information are located in different positions.

Nurses and health professionals using the packs will need to understand how to read the new label and how to use the information it contains.

ISBT 128 uses a different barcode symbology. Nurses and Health providers who are using barcode scanners to capture information on the blood component

labels, must know which barcodes they will need to scan and where the information required is located. Health providers planning to adopt ISBT 128, will need to consider the impact on existing Information Systems and software. Are they ISBT 128 compatible?

The Donation Identification Number (DIN) will be changing from a seven-digit number to 13 alpha-numeric characters, plus flag characters and a manual entry check character. How the DIN is currently being used and where it is being captured must be considered; for example, whether it is being recorded on forms and/or being entered into electronic records. If the DIN is being captured in this way, will the longer alphanumeric DIN be accepted?

Nurses and health professionals using Blood Service packs will need to consider how these changes will affect existing processes, procedural documents and forms, and how staff are to be informed of the changes and trained.

Reviewing current processes is the first step for nursing staff and health providers in getting ready for ISBT 128 and will form the basis of planning for this change. The Blood Service will provide more information and details over the coming months to support preparations.

For information on this labelling change go to: www.transfusion.com.au or contact the Blood Service for an information pack at: ISBT128enquiries@redcrossblood.org.au

An online learning module is accessible via the resources section of the Blood Service website. This is an introduction to ISBT 128 labelling which is a resource to nursing staff who need to prepare.

"Australian governments fund the Australian Red Cross Blood Service for the provision of blood, blood products and services to the Australian community".



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NO REGRETS FOR AUSSIE NURSE WHO CALLS IRELAND HOME

"I didn't know a single soul when I moved over here and they all thought I was completely insane because why would anyone from Australia move over to Ireland not knowing anybody," Australian nurse Elizabeth Bakker recalls about her decision to uproot her life and work abroad.

Elizabeth had been working in the operating theatre at Cabrini Hospital in Victoria for two years when the urge to travel struck.

"I had not travelled at all. I hadn't been out of Australia and I got into my head that I wanted to go overseas and travel around Europe and I thought what better way to do that than work to finance that travel."

She settled on Ireland, believing it would be easier than the UK to get approved, and swiftly set about plotting her path. However, the complex process took about two years from the time Elizabeth made the call to when she finally began her first day of work at the Hermitage Medical Clinic in Dublin in early 2016.

The core steps in attaining Irish Nursing Registration involved passing a comprehensive English test, completing paperwork and undertaking a six-week adaptation program to prove her competency where she was paired up with a buddy nurse and supervised.

Fast forward to today and Elizabeth has been working at the Hermitage, a small private hospital, for almost two years.

She credits the role with allowing her to branch out and develop professionally.

"I think a positive nursing experience is going to make anybody more employable. I have learnt different specialty areas. I've just changed specialties again only a few weeks ago and now I'm working in an orthopaedic

WHEN I COME HOME I KNOW
I'LL HAVE MORE SPECIALTIES
UNDER MY BELT AND WILL FEEL
MORE CONFIDENT ENTERING
ANOTHER JOB."

setting which I never did back in Australia. When I come home I know I'll have more specialties under my belt and will feel more confident entering another job."

As for travel, being based in Ireland has certainly allowed Elizabeth to tick off much of her bucket list. "I came here to travel and I am travelling. I've been out to about 14 different countries since I moved here and the ability to travel so cheaply from country to country is fantastic.

"I've got friends now from all over the world. Some of them that I met in my very first week in the country and they're spread all over."

Elizabeth, who plans to return home in the next year or two and settle down, says she'll be forever grateful for the opportunity to test her nursing skills in a foreign environment.

"I hope I've really grown as a person. It's been eye-opening. It's been challenging and it's been rewarding".



INSUFFICIENT NEW ANTIBIOTIC DEVELOPMENT

There is a serious lack of new antibiotic development to combat the growing threat of antimicrobial resistance according to a World Health Organization (WHO) report.

Most of the drugs currently in the clinical pipeline are only short-term solutions, the report, *Antibacterial agents in clinical development- an analysis of the antibacterial clinical development pipeline, including tuberculosis*, said.

The report found few potential treatment options for those antibiotic-resistant infections that were the greatest threat to health, including drug resistance tuberculosis, which kills around 250,000 people each year.

"Antimicrobial resistance is a global health emergency that will seriously jeopardise progress in modern medicine," said Director General of WHO Dr Tedros Adhanom Ghebreyesus. "There is an urgent need for more investment in research and development for antibiotic-resistant infections including TB, otherwise we will be forced back to a time when people feared common infection and risked their lives from minor surgery."

In addition to multidrug-resistant pathogens, WHO has identified 12 classes of priority pathogens. Some of them could cause common infections such as pneumonia or urinary tract infections and are increasingly resistant to existing antibiotics.

"Pharmaceutical companies and researchers must urgently focus on new antibiotics against certain types of extremely serious infections that can kill patients in a matter of days because we have no line of defence," said WHO'S Director of the Department of Essential Medicines Dr Suzanne Hill.

According to WHO new treatments alone will not be sufficient to combat the threat of antimicrobial resistance. Responsible use of antibiotics in their human, animal and agricultural sectors as well as improved infection prevention is also required.

Glad I booked “The Book” early last year!

***Greg Mapp**

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*Here's what Greg had to say:

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Adj Assoc Prof Greg Mapp.

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THE RISE OF BURNOUT

AN EMERGING CHALLENGE FACING NURSES AND MIDWIVES

Stress. Physical and emotional exhaustion. Irritability. Loss of motivation. Reduced productivity. Detachment. Skipping work. Using food, drugs or alcohol to cope. Burnout is a debilitating condition which research shows is increasingly affecting nurses and midwives. **Robert Fedele** investigates the rise of burnout and need for key stakeholders charged with managing the workforce and sector to recognise its importance and find solutions.

It knocked the stuffing out of her seemingly overnight. The alarm bells thundered when sitting in her car and crying before shifts became the norm.

Enrolled Nurse Carol Hyndes suffered burnout over a year ago.

The condition turned a job she once cherished and found meaningful into an unrelenting uphill struggle.

Initially, the 51-year-old attributed her deteriorating physical and mental state to being run down from the inherent pressures of the job.

"After a while you get to a point where you just can't shake it off," Carol explains.

"It affects your work. It affects your home life. You don't want to go to work."

Carol has been an EN for three decades and aside from time out to have children has worked nonstop across everything from aged care to the surgical ward.

She currently works in Mental Health, Drug & Alcohol at a New South Wales hospital where she says problematic nurse to patient ratios make delivering quality care challenging.

Carol's husband raised red flags when he noted her irregular sleeping patterns and fluctuating moods. Soon she stopped socialising with family and friends.

"I had no incentive to get up," she recalls.

After divulging her symptoms to both her workplace's Employee Assistance Program (EAP) and her GP, Carol took a month-long holiday. But the situation did not improve.

At the time she remembers speaking to one manager who suggested changing wards might help. "I thought to myself, really? We are working short everywhere. The demands are the same it's just that the age group changes. I didn't feel that was an answer to the problem."

One day Carol came across a social media post detailing nurse burnout and recognising the warning signs. "I thought

'Oh lord! I've got seven of the eight of these!'"

A trip back to the GP led Carol to a psychologist, who diagnosed severe burnout.

Carol blames developing burnout on a combination of factors including increased workloads and demands, inadequate skills mix and workplace culture.

She says the scope of an EN has changed considerably throughout her career and now includes tasks such as drawing blood and cannulating.

Most recently, Carol concedes grappling with having to learn new electronic systems and juggling ever-increasing paperwork, rising work demands and obligations surrounding continual professional development (CPD).

"I've just battled through. My sick leave's spiked. Once a month I was having a mental health day and my health did suffer; constant colds, getting run down, not eating properly, not drinking enough water. So physically, I started not looking after myself as well as I had been. I lost all interest in out of work activities so that down time that I made sure I was having right through my career suddenly all stopped."

Carol visits a psychologist regularly and has taken up meditation. Her self-awareness has grown, allowing her to spot triggers and tweak her roster so she gets enough days off to manage.

Despite coping with burnout and remaining passionate about the profession, she plans to leave nursing within the next three years.

"I've actually looked around and applied for packing shelves at Woolworths. Just anything at this point. The more mundane it could be the better because I don't want to get to a point where I'm not the nurse I want to be.

"I still have the passion for it. I really do. I love what I do. But I'm just feeling like it's all becoming too much. There's got to be a trade-off. I'm either going to lose my husband and have a job or I give up the job and concentrate on my

family which has gone by the by."

Carol estimates half her colleagues are also experiencing burnout but invariably soldier on. "It's something people are frightened to talk about for fear of getting judged. Feeling that you are incompetent. That you're not doing your job well. You can see other staff members going through the same thing but no one is willing to talk."

WHAT IS BURNOUT?

Nursing and midwifery are stressful professions that can take a mental and physical toll. Burnout saps energy, leaves you feeling hopeless and at its most damaging can lead to mental health issues like depression.

Signs and symptoms include physical and emotional fatigue, loss of motivation, detachment, reduced productivity, cynicism and low self-esteem.

The effects of burnout contribute to more mistakes, absenteeism and turning to food, drugs or alcohol to cope.

Burnout is fundamentally different to regular stress. It is characterised instead by feelings of emptiness, loss of motivation and as though life is not worth living.

The causes of burnout range from unrealistic workloads to shift work, exposure to trauma, staffing shortages, and lack of recognition.

Regrettably, nurses and midwives who suffer burnout often feel they are no longer able to fully commit to the job, begin to view it as a chore and eventually slowly fall apart, some of them unable to return.

Registered Nurse Carolyn McDonald, who supports nurses and midwives experiencing mental health or substance abuse at the Nursing and Midwifery Health Program Victoria (NMHPV), likens burnout to the petrol gauge reading empty.

Carolyn says half the clients the confidential service treats display burnout symptoms. "Someone just being exhausted. Lack of motivation. Feeling isolated. Potentially using coping strategies that are not great, like food. There's a lot of nurses that tend to use food just to try and stay on top of stuff and it can end up with weight issues or using drugs and alcohol as well."

RISING TOLL

Monash University's Business School began conducting national surveys examining the workplace climate and wellbeing of nurses and midwives several years ago.

Releasing data every three years from 2010, the collective research paints an increasingly bleak picture of workforce perceptions.

The latest survey released in 2016, *What Nurses & Midwives Want: Findings from the National Survey on Workplace Climate and Well-being*, alarmingly found almost a third of nurses and midwives have considered leaving the professions due to rising work demands and burnout.

According to the report, increasing workloads, work intensification and budget cuts leading to unrealistic nurse to patient ratios underscore leading triggers.

Data revealed 71% of nurses and midwives feel they often have to do more work than they can do properly several times a day, while 67% listed work intensification as a major issue.

Disturbingly, 54% of nurses and midwives

felt reluctant about voicing their concerns to management due to fear of negative consequences.

Study co-author Tse Leng Tham said mounting evidence now provides a platform for intervention strategies.

The nursing and midwifery workforce is reaching a tipping point in regards to work intensification, she says, and management, health organisations and policymakers must take action.

"Contributing factors of such increasing workloads largely relate to aspects controllable by either management or policymakers," Ms Tham claims. "These include inadequate nurse-to-patient ratios, poor scheduling of shifts not allowing sufficient recovery time, increasing administrative work and unrealistic expectations of nurses/midwives to shoulder added work tasks without the provision of additional time or resources."

"In an environment where respondents indicate they receive little support from management and are faced with declining opportunities for effective voice, qualitative data suggests such factors are pushing nurses and midwives to the point of exhaustion, burnout, and likely departure from the professions."

TICKING TIME BOMB

"I didn't realise until after I'd fallen in a bit of heap," reveals nurse practitioner Kate Sloan of her encounter with burnout.

"I had a lot of stuff going on in my personal life. My Dad was sick and my daughter's partner died and it went on and on – all these things."

"It was cumulative. I've always dealt with work by coming home. Home's been terrific and then home wasn't that terrific. I sort of didn't get that balance right."

Kate has been a nurse for 34 years and currently works as a NP in the emergency department at the Warrnambool Base Hospital in Victoria.

It's a bustling unit which treats rising numbers of patients with increased acuity.

Kate believes the challenging environment within the ED, where she is exposed to trauma and sorrow, geared her to burnout.

She knew she had a problem when a child being treated at the hospital died and she "did not feel a thing".

Kate exhibited typical signs of burnout including lack of emotion and detachment.

She also developed anxiety and had trouble sleeping. The situation soon spiralled out of control to the point where she struggled to cope.

"You're just exposed to so much sadness [in the ED]. I don't think it was about working too hard. I love working hard. I go home at the end of a shift buggered, but I expect to do that. That's part of my job."

"I think a lot of it is the trauma. You see terrible things often. You're dealing with a lot of heightened emotions in patients and I think certainly the aggression has got so much worse over the last number of years. People are very intolerant of waiting or not getting what they want. When I first started nursing no one would have ever been rude to a nurse."

After reaching a tipping point, Kate accessed counselling through the hospital's wellbeing program, then took a few months off.



"IT'S SOMETHING PEOPLE ARE FRIGHTENED TO TALK ABOUT FOR FEAR OF GETTING JUDGED. FEELING THAT YOU ARE INCOMPETENT. THAT YOU ARE NOT DOING YOUR JOB WELL. YOU CAN SEE OTHER STAFF MEMBERS GOING THROUGH THE SAME THING BUT NO ONE IS WILLING TO TALK."

EN Carol Hyndes



"IT [BURNOUT] IS VERY UNDER-RECOGNISED. I THINK I'VE BECOME MUCH BETTER AT PICKING UP THE SYMPTOMS. I THINK WE JUST ALL PRESS ON AND THINK WE'RE BULLETPROOF. BUT WE'RE NOT."

NP Kate Sloan



She was diagnosed with depression, a condition she now manages with medication, and got back on track by starting meditation and exercising more.

Initially fearing stigma, Kate chose to own her experience by opening up to her colleagues and thankfully discovered crucial support.

She now prevents future episodes by looking out for warning signs and taking a step back when needed, like last month, when she reduced her hours for a short period.

"I guess I'm wary of it happening again," she admits. "I'm a bit more protective of myself. Making sure I leave work on time. Having breaks. Not letting myself get overwhelmed by things."

"It [burnout] is very under-recognised. I think I've become much better at picking up the symptoms. I think we just all press on and think we're bulletproof. But we're not."

WHY NURSES AND MIDWIVES SUFFER BURNOUT

Professor of Health Research at Murdoch University, Anne Williams, runs education sessions at Sir Charles Gairdner Hospital in Perth on identifying and managing stress, developing coping mechanisms and resilience, and analysing wellbeing.

"Just about every single group I go to, when you ask them what stresses them out at work, the main thing that will come

up will be the workloads and things about the environment in the hospital," Professor Williams says.

"Very rarely will they ever mention the stress related to caring for dying patients or patients in pain."

Professor Williams began a career in nursing in London in the early 90s, working on general surgical wards, then moved into research. She began researching nurse burnout in 1998 when undertaking her Masters on the perceptions of quality care.

"The results showed nurses were struggling to deliver quality nursing care because of various reasons such as excessive workloads and then the relationship with that impacting on their personal satisfaction and causing them stress."

Professor Williams believes unrealistic workloads are the main cause of burnout.

Her latest project examining the condition began last year, a pilot education program set to be rolled out at two Western Australian hospitals, which will arm cancer nurses with coping skills to deal with stress and burnout. The project was prompted by a survey of cancer nurses which confirmed high levels of workplace stress and substantial scope to improve resilience through an education program.

The program will target four key areas – knowledge and understanding, self-discipline and motivation, organisational culture and environment, and strategies

and resources.

Professor Williams says nurses and midwives are driven by the value of caring and that the ideal can be hard to turn off.

When the body is stressed, she says it produces excessive levels of adrenalin and cortisol that can lead to high blood pressure, muscle pain, sleep disturbance, headaches, depression and anxiety.

"Nurses get to a point where they just can't provide the care that's needed by the patient because they're in such a poor condition psychologically themselves."

Professor Williams' project draws on past literature surrounding wellbeing and aims to help nurses understand what stress is, why they're experiencing it, and how to cope.

"Psychologically, the more control you have over a situation, the better your wellbeing. Often in the nursing environment, nurses don't have a lot of control."

She says simple strategies like eating healthy, getting enough sleep and exercising can boost wellbeing.

She believes more and more nurses and midwives will leave the professions unless burnout is addressed.

"We can't just say toughen up. We've got to be realistic about the conditions they're working in and perhaps what's needed is more research and a rethink in terms of the changing environment and what are patterns of work and what might be better ways of working that are less stressful for people."

5 TELL TALE SIGNS OF **BURNOUT**

Burnout is a state of emotional, physical and mental exhaustion caused by prolonged stress. It can emerge due to a variety of reasons – excessive workloads, a traumatic event, toxic workplace cultures or outside pressures. Nurses and midwives are susceptible to burnout and should watch out for warning signs to avoid reaching breaking point.



1



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Fatigue

Burnout saps energy, leaving nurses and midwives feeling physically and emotionally drained and unable to cope with constant demands. This usually leads to diminished immunity and increased illnesses like colds and flu, as well as frequent headaches or muscle pain, changes in appetite and sleep habits, and skipping work.

Loss of motivation

Nurses and midwives suffering burnout tend to find it difficult to muster up the energy to care and eventually may feel like they have nothing left to give. Once inspired and motivated, they dread going to work and go through the motions, pulling back, and avoiding any unnecessary interactions with patients or colleagues.

Irritability and cynicism

The negative effects of burnout can spill over into every area of one's life, including work, home, and social networks. Common indications of burnout include exhibiting an increasingly cynical and negative outlook when it comes to the job and feeling irritable and angry. Nurses and midwives sometimes feel overworked and undervalued, and quickly become disenchanted, viewing patients as objects.

Mistakes

Nurses and midwives work in high-pressured environments and when burnout strikes, mistakes become more frequent. Every day starts to feel like a bad day and the unrelenting stress associated with reduced productivity can bring about a sense of failure and self-doubt and feelings of helplessness and as though the work is meaningless.

Detachment

When nurses and midwives reach a tipping point they often withdraw from responsibilities, isolate themselves from others and feel like they are alone. In the thick of burnout, many nurses use food, alcohol or drugs to cope. At work, they can feel empty and beyond caring, losing all sense of compassion for their patients, viewing them as objects and displaying apathy.



"WE CAN'T JUST SAY TOUGHEN UP. WE'VE GOT TO BE REALISTIC ABOUT THE CONDITIONS THEY'RE WORKING IN AND PERHAPS WHAT'S NEEDED IS MORE RESEARCH AND A RETHINK IN TERMS OF THE CHANGING ENVIRONMENT AND WHAT ARE PATTERNS OF WORK AND WHAT MIGHT BE BETTER WAYS OF WORKING THAT ARE LESS STRESSFUL FOR PEOPLE."

Professor Anne Williams

MANAGING BURNOUT

Victorian nurse Linda (not her real name) has endured burnout at different stages of her career.

She describes nursing as a difficult job to switch off and one that can easily fall apart when you lose your support mechanisms.

"It's a job where you're looking after someone but then you've got all the other people you work with that you have to communicate with and you've got families that are distressed. Hospitals are pressure cookers I think."

The death of her daughter and subsequent separation from her partner sparked one episode of burnout about 10 years ago.

Linda took a couple of years off from work, and then returned to the profession wanting to make a difference.

Her most recent bout of burnout struck two years ago. It was triggered by a combination of factors including a toxic workplace culture, changing hospital policies and work intensification. There were countless symptoms.

"I think it was low self-esteem. You're just trying and you're trying and you're not getting there and you just start questioning yourself. You keep trying harder when you've got less and less reserves to give out and then you don't sleep well and you don't eat well and you put on weight and they all make it harder. Some people use food. Some use drugs. I know quite a lot of nurses that suicide as well."

Linda often uses food to cope with burnout. When she's feeling overwhelmed,

her good intentions fly out the window and her weight balloons.

Linda accessed the Nursing and Midwifery Health Program Victoria (NMHPV) two years ago and regularly sees one of its counsellors, RN Carolyn McDonald.

As well as discovering mindfulness and yoga, Linda has also learned to manage her expectations.

"What I really like about it [the NMHPV] is that I get encouragement, first of all. Because that's rare in nursing and it's really nice to have. To be told your work's valuable. Usually you're being told you're not working hard enough or doing good enough or you forgot this or that. So it's really nice to stop and reflect on the fact that I am a good nurse."

Linda's advice to other nurses experiencing burnout is to seek out support and develop coping mechanisms.



"I THINK ONCE YOU'VE HAD THAT EXPERIENCE OF GETTING TO THAT POINT [BURNOUT] YOU WILL NO LONGER NURSE IN THE SAME WAY AS YOU EVER DID BEFORE. THEN YOU HAVE TO BE CAREFUL ABOUT WHAT YOU DO AND HOW YOU LOOK AFTER YOURSELF. IT'S GOT TO TAKE PRIORITY OR ELSE YOU WON'T HAVE ANY FUEL LEFT."

Senior Clinician RN
Carolyn McDonald

For example, Linda puts a lot of preparation into getting into the right mindset for work the day before, making sure her clothes are ready, she has the right food and gets to work on time so she can tackle the day's challenges.

"I think it's important to look for support and keep looking. To resource yourself."

PRIORITISING HEALTH

Registered Nurse Carolyn McDonald is a counsellor at the NMHPV, supporting nurses and midwives like Linda experiencing health issues relating to mental health or substance abuse.

When it comes to combatting burnout, Carolyn specialises in building resilience and helping nurses and midwives reframe the way they view work.

Carolyn says nurses and midwives are often

the ones always giving and the NMHPV offers them an outlet where they can be heard, collaboratively re-evaluate their priorities and build on their strengths and resources.

"It's building that relationship with someone and being a good listener. A lot of the work that's been done in burnout is that someone needs to have someone listen," she says. "It can just be giving someone some encouragement and some value. Some self-worth so that they realise that actually they're worthy of setting boundaries and they're worthy of actually doing the things that are going to keep them well."

To deal with burnout, Carolyn encourages nurses and midwives to take time out immediately if required, before taking steps to prioritise health. Investing time in social relationships, trying to find value in the job and reassessing hopes, goals and dreams are important steps.

So too is maintaining a healthy diet and getting enough sleep and exercise in order to stabilise mood and boost one's ability to manage tasks.

Carolyn regards resilience as nurses and midwives being able to respond to stressful situations with the ability and resources to 'bounce back'.

"When nurses have very little psychological flexibility and are faced with stressful situations and lack of resources, their sympathetic nervous system is activated, the 'flight or fight' response. This leads to one becoming reactive, not responsive. A consequence of this is hyper arousal.

"Nurses can add to their own anxieties about things because of the future thinking. Anticipating what's going to happen on the day when you don't actually know what's going to happen on the day. The body wears that. Even thoughts of stressful situations can trigger the sympathetic nervous system."

However, while building resilience is progressive, Carolyn stresses it's worth little if nurses and midwives are thrown back into traumatic situations.

"It's really hard to build someone's resilience up and then put them back in the firing line. When places where people work are unsafe or under-resourced and the system is failing the nurses themselves; it's really tough."

A qualified yoga teacher, Carolyn was one of the speakers at this year's ANMF (Vic Branch) Wellness Conference and was buoyed by the sizeable turnout, which she says indicates a significant shift in nurses and midwives taking ownership of their health and wellbeing.

Carolyn imparted one of her strategies on the audience, a simple, five-minute mindfulness technique that uses controlled breathing to reduce stress.

She says it's crucial nurses and midwives experiencing burnout put themselves first.

"I think once you've had that experience of getting to that point [burnout] you will no longer nurse in the same way as you ever did before," she says. "Then you have to be really careful about what you do and how you look after yourself. It's got to take priority or else you won't have any fuel left."



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DIVERSITY IN SEXUALITY COMBINED WITH A DIAGNOSIS OF DEMENTIA LEADS TO POOR HEALTH OUTCOMES FOR LGBTIQ OLDER PERSONS.

By Sally Hogan

People who identify as lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ) are collectively grouped as a single community yet their only commonality is sexual identity that varies from the perceived norm (Westwood 2016; Department of Health and Ageing [DOHA] 2012).

Historically, many within this community have suffered persecution and discrimination, leading to reluctance to access healthcare services (Crameri et al. 2015; Duffy and Healy 2014).

Perceived stigma associated with a diagnosis of dementia escalates this fear, leading to later diagnosis and generally poorer health outcomes (Westwood 2016).

Within western societies, the choice to make independent decisions about sexuality is considered a fundamental human right (Tarzia et al. 2012), yet it was not until 1997 that mutually consensual male homosexual acts were decriminalised in Australia (Crameri et al. 2015).

Homosexuality was classified as a mental illness until 1973, while transgender people continue to be classified as disordered in psychiatric manuals (Reynolds et al. 2015).

This long discriminatory history has led many LGBTIQ people to feel unsafe in the revelation of their sexual orientation within health services (Barrett et al. 2015; Crameri et al. 2015).

Despite recognition of same sex partners as equal rights de-facto spouses within Australia (Duffy and Healy 2014), members of the community do not uniformly recognise LGBTIQ people and nurses may lack knowledge or understanding of these rights (Carabez and Scott 2016).

The history of inequitable rights for LGBTIQ people intensifies the need for advanced planning of legal arrangements, to remove ambiguity surrounding substitute decision makers (Carabez and Scott, 2016; Duffy and Healy 2014). As these arrangements need to be confirmed while the individual maintains legal capacity, early diagnosis of dementia may lead to significantly improved outcomes for individuals as the disease progresses.

Age increases the need to access and rely on support services and a diagnosis of dementia further increases this dependence (Herron and Rosenberg 2017; Duffy and Healy, 2014).

For LGBTIQ people the need to rely on support services will be unsettling as they confront past discriminatory experiences alongside the stigma associated with dementia (Reynolds et al. 2015; Duffy and Healy 2014). Anticipation of loss of connection with their community of choice and resultant loneliness negatively affects quality of life and impacts the decision to access services (Crameri et al 2015; Duffy and Healy 2014). For those who do access services, there is a very real concern that their sexual identity will be lost if they enter residential aged care facilities (RACFs) (Duffy

and Healy 2014).

Many RACFs provide an environment that is not conducive to sexual expression and lacks awareness of the needs of older LGBTIQ people (Crameri et al. 2015; Tarzia et al. 2012). There is a history of sociocultural stereotyping and asexualisation within RACFs with all individuals being treated the same (Kontos et al. 2016; Tarzia et al. 2012).

For LGBTIQ people, loss of connection to like-minded people, an inherent desire for sexual privacy and diminished cognitive capacity will lead to reduced freedom of expression and ultimate loss of identity (Kontos et al 2016; Crameri et al. 2015).

In 2012, the Australian government released the National LGBTIQ Ageing and Aged Care Strategy (DOHA, 2012) that identified five key principles of inclusion, empowerment, access and equity, quality and capacity building, in the provision of person-centred care. Additionally, in 2013 amendments to the *Sex Discrimination Act 1984* prohibit discrimination based on issues of sexuality (Reynolds et al. 2015). These legislative initiatives acknowledge the previous discrimination and persecution of LGBTIQ people and set goals for LGBTIQ inclusive RACFs and equity of access to healthcare for all (DOHA 2012). RACFs require LGBTIQ inclusive action plans that address staff knowledge and policy deficits in both dementia-care and understanding that human sexuality and gender identity continue across the lifespan (Carabez and Scott 2016; Crameri et al. 2015; Tarzia et al. 2012).

Acknowledgement is required by aged care service providers that the experiences of LGBTIQ people living with dementia is different to heteronormative life experiences, ensuring that dementia is not a barrier to expression of sexuality (Barrett et al. 2015; Bauer et al. 2014). Participation of LGBTIQ individuals with dementia is central in creating policy and practices that are inclusive and support integrated participation recognising the uniqueness of every individual (Herron and Rosenberg, 2017).

People with dementia often enter into RACFs as the disease progresses and there is an acknowledged need for provision of LGBTIQ inclusive services. Staff education, policy change and participation by people from the LGBTIQ community with an understanding of dementia will be critical in addressing inequities and providing personalised services that recognise an individual's sexuality regardless of the presence of dementia.



Nick Blake,
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FIGHTING FOR NEW GLOBAL RULES

Over the past 20 years, one of the biggest trends in the Australian workplace has been the move away from full-time secure jobs to precarious employment.

Indeed, in 2016/17 for the first time in Australian history fewer than 50% of the national workforce was classified as being in permanent full-time employment, with the majority in part-time or casualised, often sporadic jobs that offered little if any certainty or security.

Take nursing as an example; in 2016, almost half (49%) of employed registered nurses, midwives, and 59% of the enrolled nurse population worked less than 35 hours per week.

Precarious work is frequently associated with the following types of employment: casual, part-time employment, self-employment, fixed-term work, temporary work, on-call work, home based work, agency and independent contract work.

Precarious work is non-standard employment that is usually poorly paid, insecure, unprotected, and cannot support a family. In recent decades, there has been a dramatic increase in precarious work due to such factors as globalisation, the shift from the manufacturing sector to the service sector, and the weakening of employment and workplace laws.

For many the increasing uncertainty and insecurity in employment was a necessary result of the "winds of globalisation"; or the "nature of the modern economy", outcomes required to ensure Australian business could compete on the world stage. Globalisation, the unfettered economic expansion across borders that, along with free trade, many viewed as the unstoppable and immutable ideology that would maximise productivity and efficiency.

For a long time, supporters of globalisation argued the advantages would benefit all. These acolytes were also adept at convincing governments

and commentators that the containment of labour costs through a cap on wages, cuts to staff and penalty rates and outsourcing of work would lead to a boom in productivity and prosperity.

THE LOSERS HAVE BEEN INDIVIDUALS WHO LOST THEIR JOBS, THE FAMILIES WHO NOW COPE WITH REDUCED INCOMES AND COMMUNITIES THAT HAVE LOST CONTACT WITH THEIR CITIZENS.

In retrospect, this faith has proven to be naïve or intentionally misleading. There have clearly been winners and losers. The winners have been the top echelon and the shareholders of multinational corporations. The losers have been individuals who lost their jobs, the families who now cope with reduced incomes and communities that have lost contact with their citizens.

Many multinational companies now stand accused of waging a war against working families, using the global economy as a way to free themselves from regulation and responsibilities to their employees and communities, drive down employment standards and ship jobs overseas.

The evidence of the devastation of globalisation has led to a call for new global rules – rules that require an economic system where people and communities matter.

International bodies including the International Labour Organization,

global unions, and church and community groups are calling on all governments to ensure their business and workplace laws have as its lodestone the aim of improving the rights, livelihoods and opportunities of people, families and communities. Fundamental to this is the approach to labour and employment laws and the need to remind governments and employers that labour is not like an apple or a television set, an inanimate product that can be negotiated for the highest profit or the lowest price. Rather work is part of everyone's daily life and is crucial to a person's dignity, wellbeing and development as a human being. Accordingly, economic development should include the creation of jobs and working conditions in which people can work in freedom, safety and dignity.

In Australia the ACTU is campaigning to "Change the Rules" calling on governments to bring back fairness to our workplace laws. They cite the Subway, 7 Eleven and Caltex exploitation of vulnerable workers as examples of our current laws that allow dodgy employers to cut pay and slash conditions. More broadly the ACTU points to wages growth in Australia at record lows, cuts to penalty rates in the hospitality and retail sectors, high youth unemployment and falling household incomes at a time of booming company profits as evidence the laws are failing working people and need to change to improve equality and fairness.

ANMF supports the ACTU campaign. We join in the call for changes that will promote the employment of nurses and midwives on conditions that support job security and wages and employment conditions that provide for a decent life.

REMOTE EXTERNAL VISITS – Service Provision

CPD
HOURS

This course is designed for health service staff who are performing duties that require a remote or external visit to provide a service or treatment. Staff who travel outside of the initial workplace take on additional risk (often unknown risk) and therefore require systematic assessment tools to manage the additional risk. Staff need to know how to identify risks and then make the appropriate decisions to keep themselves safe.



Before we look at practical ways of managing unsafe or dangerous situations, we need to understand the likely safety and security challenges that will confront us when we perform remote or external site visits – these potential challenges are called ‘risk’.

Potential risk can usually be classed into three groups – high risk, medium risk, and low risk (your organisation may have another way to classify levels of risk). All risks are potentially hazardous to a staff member's health and safety.

For staff who perform remote visit duties there are **three** main types of risk to be considered. Different organisations may have other names for the risks we are about to discuss – this is OK. These risks are:

- **Security risks** – is a risk that usually constitutes human physical interference such as violent acts.
- **Safety risks** – may be an environmental risk (caused by nature or otherwise), a risk caused by human activity, or may include security risks. A staff member carrying out specific duties in an unauthorised manner may cause a safety risk.
- **Emergency risks** – is a risk posed by a predicted hazardous situation that requires immediate action or response to maintain health and safety of persons involved. Emergency risks, such as fire in a building, may cause an organisation to plan for an emergency response, such as coordinated building evacuation.

Where possible, organisations conducting external site service visits should perform an external site risk assessment on designated sites **before** commencement of external site visit duties by health professionals.

For identification of potential risks, staff responsible for performing the external site risk assessment should request risk information from the remote site or centre. Where this information is not available, a standard or generic risk assessment process should be used.

It is recommended that every staff member performing external site visits receive an External Site WH&S Risk Assessment Checklist (usually in a laminated document form).

This document allows for a site assessment where no risk assessment information exists, or the site is visited on priority or short notice.

Where risk information is available, this information (whether from an assessment process or from report histories) should be adapted into any risk assessment process, preferably in the form of a checklist.

All organisations requiring staff to perform external site visits should develop a Risk Policy, and Risk Assessment Procedures for external site visits.

The policy and procedures should allow the parent organisation to perform the Site Risk Assessment, but when this is not viable the process should be carried out by the attending staff professional (via physical site assessment).

Once the risk assessment is complete,

the risk assessment information should be disseminated to the staff who are to perform the external site visit, so staff can properly prepare for the expected risk exposure.

After external site visits are completed, feedback and review of risks should be fed into the risk assessment process for updating of the process – this will lead to an overall risk assessment process improvement.

In theory, no external site visit should be carried out without acknowledgement of an External Site Visit Risk Assessment (ESVRA) process, including a documented report in an authorised format.

The policy should contain references to all the **procedures** developed to enable staff to conduct Remote Visit Service. Procedures allow you to follow a specific procedural instruction in cases of performing difficult or hazardous tasks. Procedures for remote visits are extremely important as often, the staff member has only him or herself to rely on.

Please read all your procedures carefully and make sure you comply with the instructions contained in them. Discuss with your supervisor anything that you don't understand. Remember that if the situation is high or medium risk, you need a procedure to protect yourself and your organisation.

By strictly adhering to a procedural process, a staff member will have the support of the employer organisation, if the service fails and an injury of some kind is caused either to staff or clients, or other organisations.

It is your responsibility to understand and implement your organisation's policy and procedural guidelines. To be able to do this you need to carefully read those policies and procedures. Yes - you need to read all of them, as one day you will be faced with a difficult choice that may contain an element of risk, so the better prepared you are, the better the choice you will make. Always have your procedural guidelines with you so you can refer to them when you need them.

Some other tasks included in the ESVRA form may be:

- assess for persons present on site (general);
- service staff authorised and trained to provide treatment services;
- deliver treatment and services;
- disruption to services or treatment due to security incident;
- evacuate site due to security or emergency incident;
- other administration;
- site hazards or inspections;
- review process/environment.

Managing your risks and day-to-day health and safety is not just best practice; **it is also a legislative duty of care.** This means that your organisation has a legal responsibility to protect your health and safety, and you, under law must follow your authorised processes- this includes not undertaking any undue risks at work. Remember, if it is high or medium risk, you need a documented procedure.

Exposure to risk can be reduced through



This excerpt is from the ANMF's course on Remote External Visits (Service Provision). The complete course is available on the CPE website.

Cost is \$7.70 for members. Go to anmf.org.au or contact ANMF education via education@anmf.org.au or phone 02 6232 6533

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

regular training and review.

Wherever there is a significant risk, a training element should be added to ensure staff can manage that risk.

A training element does not have to be a typical classroom situation, the element may be a discussion involving documents, apparent levels of risk and a sign off process by staff that they have attended a training/discussion session.

The most important training that an organisation can facilitate is induction sessions to manage significant changes in workplace risk; change in workplace conditions means a change in the risk environment, usually pushing risk upwards.

Inexperienced staff require training the most because they lack situational experience. For inexperienced staff, a mentor system plus good induction training is an effective tool to assist this type of staff member in managing the difficulties of remote visit service.

Some significant issues that can be dealt with by providing specialist training sessions are:

- four wheel driving for remote regions;
- vehicle preventative maintenance and breakdown strategies;
- remote region survival skills – flood, drought, lack of water, fire and heat management;
- site risk assessment for beginners;
- advanced driving for long distances;
- occupational violence and aggression strategies;
- first aid (non-medical staff);
- emergency management – responding to emergencies;
- managing a safety incident on your own;
- professional and cultural communication;
- radio and phone – preventative maintenance/repairs;
- other training sessions for the local workplace environment- eg. working with helicopters, and
- crime prevention and your essential safety equipment.

One of the most important issues for



THE ONLY WAY YOU CAN ACCURATELY ALLOCATE RESOURCES TO MAKE YOUR WORKPLACE SAFER, IS TO BE AWARE OF THE CURRENT SAFETY AND SECURITY CHALLENGES. THE ONLY WAY TO FIGURE THESE CHALLENGES OUT IS THROUGH ACCURATE INCIDENT REPORTING THAT BUILDS A HISTORIC PICTURE OF CURRENT ISSUES AND CHALLENGES

managing remote visit services is performing tasks well when there is significant risk involved. Good knowledge of your workplace environment and the equipment in it is crucial. You need to make instinctive decisions – meaning that you make a professional and common sense assessment of the situation and solution with confidence in the outcome. Your actions and decisions should be confident and efficient.

To achieve confidence and efficiency, you need to undergo simple, regular training, dealing with the likely challenges that you will face in your workplace environment and acknowledging that in many cases, the only person who will be there to physically assist you will be yourself.

Giving and receiving feedback on your training performance is also important. Regular training will assist you in performing your tasks safely and efficiently when an incident occurs. When you are confident, you will know what to do and your fear and anxiety will be reduced.

Training scenarios should be based on the actual incidents that have occurred in your workplace within the last 12 months. Look at the information contained in safety incident reports for your region- this will show staff what sort of incidents you and your colleagues should be training for.

Training scenarios should also be based on incidents that have not occurred in your health service but have taken place at similar

organisations.

The only way you can accurately allocate resources to make your workplace safer, is to be aware of the current safety and security challenges. The only way to figure these challenges out is through accurate incident reporting that builds a historic picture of current issues and challenges. The more information available, the better the picture of what is currently happening in the workplace, then, the better the resource allocation to meet those challenges.

We have looked at risk management for staff who attend service sites, but there are other risks involved with providing a Remote Visit Service, the other risks involve travelling from your office base to a remote site or a series of sites that make up a scheduled service trip.

Staff need to consider a number of elements that would make up a scheduled service trip:

- qualified and properly trained staff nominated to make the trip;
- clients to be serviced during the trip including how many, health status, equipment /supply needs, resources that may be required, self-care (time for breaks and documentation);
- nominated duties and tasks to be carried out during the trip;
- adequate vehicle and equipment, including emergency equipment such as first aid kit, puncture repair kit, spare

tyre/s, water, oil, petrol if required and any other emergency equipment deemed necessary;

- adequate training in the use of all equipment is also necessary;
- knowledge of the environments to be encountered on the trip;
- identified risks eg. driver fatigue/security risks;
- the history of safety and security of previous staff who made the trip;
- miscellaneous issues such as natural seasonal events;
- planned and mapped route;
- scheduled service stops;
- scheduled rest stops including sleepover stops;
- solutions to known risks eg. vehicle breakdown, flood disaster interference, and;
- regular communications with base office.

All relevant information should be documented, with a planning and schedule document available to the staff undertaking the service trip and any relevant supervisors who may be responsible for the service delivery and trip in general. After these documents have been checked and discussed with all aspects of the trip meeting professional operational standards, staff can agree that they are ready to make the service trip.

It is advisable to obtain a designated map of your trip route. These elements need to be indicated on your mapped route including:

- service sites;
- scheduled rest stops;
- rest and sleepover stops;
- likely fuel stops;
- any areas of significance or of high risk that may require specialist tasks such as four wheel driving areas/desert/wilderness;
- estimated times of arrival and departures; and
- reference to your schedule document.

Driving is something most service staff do every day, but it is also regarded as one of the most dangerous activities that people

undertake on a regular basis.

Generally, having scheduled points along your route allows your base office to estimate where you should be at any one point on your trip route. If you do have documented schedules, it is in your interest to keep to that schedule. A schedule should make you easier to find if you encounter any problems on your route.

One good tool to have is a GPS, a Global Positioning System, especially in the vast rural areas that make up Australia. A GPS system will allow your base to track you to within at least 100 metres of your physical position.

Remember that if you break down in a wilderness area, it is advisable to stay with the vehicle because people can track you via GPS. If you leave your vehicle, you may be on your own. If you must leave your vehicle, take the GPS with you. Many mobile phones are equipped with a GPS too.

It is advisable to regularly check in with your office base for reasons of safety. The more regularly you check in, the easier you are to find in an emergency situation. It is also advisable to schedule in your check with the base office for reasons of safety.

Looking at the route that you will be taking on your trip, there will be several issues that you will want to guard against, depending on the type of environment that you will encounter on your trip. These may include:

- your own personal safety;
- motor vehicle breakdown, and;
- being out of contact with your office base for long periods, such as being in communications black out areas (unable to be contacted).

Depending on your trip environment, you will need suitable safety equipment to manage the safety issues that risk analysis and incident history tell you that you are likely to encounter.

Always test your equipment to ensure that it works properly. If necessary take back up batteries or back up equipment. If things go wrong, you may only have yourself to depend on to get yourself out of difficulties.

Check maintenance schedules to ensure that your safety equipment has been regularly serviced and document any maintenance requests or faults.

Sign out your equipment and make sure you take everything that you may need. To assist you in accounting for everything you should take, there should be an equipment inventory to 'tick off'.

What is Situational Awareness and why is it important?

Situational Awareness is a state of mind that a staff member will adopt when the staff member realises that risk and hazard levels are rising because a situation is developing in the workplace that is making the work environment less safe or unsafe. The staff member recognises the developing situation and recognises that there may be an immediate need to formulate a plan to negate the unsafe situation, by making

decisions based on safety needs.

It may be time to start managing the apparent risks and safety issues rather than providing services (services can resume once the safety issues have been dealt with, and negated). The staff member evaluates the risks and hazards, formulates a plan, and decides whether action is required.

Staff should never enter an environment where there is a risk that the environment will be unsafe.

It is important that when you are in charge of your work motor vehicle, and you are driving, you are representing your organisation – meaning you should drive courteously and within the law/speed limits.

- Keep in mind, policy and procedures for:
- fatigue and driving;
 - parking for safety and in line with the local laws;
 - access to equipment for service delivery when the vehicle is stationary;
 - parking at night, and security of vehicle;
 - do not leave valuables visible in the vehicle;
 - driving at night is not advised as animals wander on to roads at dusk and in the evening;
 - driving in poor weather (rain and storms);
 - being involved in an accident;
 - assisting with an accident on the road;
 - breakdown procedures;
 - liability of a driver involved in an accident (what to say to other parties);
 - alcohol/drugs and driving, and
 - use of fuel debit cards.

IT IS ADVISABLE TO REGULARLY CHECK IN WITH YOUR OFFICE BASE FOR REASONS OF SAFETY. THE MORE REGULARLY YOU CHECK IN, THE EASIER YOU ARE TO FIND IN AN EMERGENCY SITUATION. IT IS ALSO ADVISABLE TO SCHEDULE IN YOUR CHECK WITH THE BASE OFFICE FOR REASONS OF SAFETY.

If you have a vehicle break down while driving in an isolated area, park your vehicle as best as possible in a safe location, furthest away from dangerous passing traffic. If there are no buildings around, stay with the car, call for assistance via your phone or VHF, UHF or HF radio, then notify your supervisor or manager. If you cannot get help from Roadside Assistance such as the RACV, RACQ or NRMA, call the local police.

The police (when they attend) will have access to a number of services they can call on to get you going.

If the car is in a dangerous position on the road and cannot be moved, turn on hazard lights, get out of the car and move to a safe location.

Keep conversations and contact with strangers to a minimum when in this position. Do not tell people that you are stuck, waiting for help; they don't need to know – especially when roadside assistance is coming to rescue you from your situation.

Working in a remote environment, means that you, at most times, have to depend on yourself. This also includes your own personal security needs.

It is important to follow a basic process, whenever you happen to find yourself in a new or unfamiliar situation.

If your 'gut' is sending you alarm signals, this is something you need to listen to. Investigate why you are feeling this way, often, it is a sign that something is not right and you are uncomfortable. To perform well and to be productive, you need to be comfortable, so check out that feeling and make sure that your environment is okay.

When entering a site for the first time, or entering a site that has not been visited for a while, it is important to ask some basic questions about the security environment that you are walking into.

During the initial greeting of persons, ask the person who you are greeting:

"How are you? How have you been? How are things around here? Who is present today? Any problems that we can help with?"

Often, the occupants of a site will volunteer information that you can use during your risk assessment process. The more information that you have the better your risk assessment. The one issue that you want to assess is:

Is there anyone present on site who may cause a security risk, or cause you problems in some way?

Now that you have assessed the site and are happy to begin to deliver your service, you still have to be mindful of the security situation. Always set up your service station in a place that you can leave if you have to – always have an escape path. Keep your essential and expensive belongings where you can see them or in a secure place – local office or your vehicle if you are not using it. Have a basic plan to move or evacuate if an emergency arises.

Stay calm and remain positive if the situation becomes unsafe.

If a fire plan/map is available, take some time to read it.

How can you tell that conditions are becoming unsafe on the worksite that you are visiting? Usually, the focus of current issues goes from service delivery to being concerned about issues that are interrupting service delivery. Once again, your own situational awareness will tell you that it is time to make preparations to withdraw to a safer location – make a decision and/or consult with your host (if one is present).

Sometimes you need to evacuate to a safe area because of security or emergency situations. Sometimes it is only you that has to evacuate, or sometimes it's every person in the building/environment. You can never be sure of what the future holds and that is why it is important to plan your evacuation before you need to evacuate.

UNIVERSITY OF CANBERRA IMPLEMENTING AUGMENTED REALITY INTO NURSING EDUCATION

By Jane Frost, Lori Delaney,
Robert Fitzgerald

While simulation is recognised as a safe and effective way to teach health students, the evolution of spatial mapping technology and 3D applications has the potential to change nurse education, and enhance the understanding of both anatomy and physiology and physical assessment.

Currently, immersive technologies are being used in primary and secondary education to enhance learning and increase engagement. However, there is sparse research exploring how these technologies could be used in nurse education.

University of Canberra's Assistant Professors of nursing Dr Jane Frost and

Lori Delaney along with Professor Robert Fitzgerald are investigating how the emerging hololens technology can be utilised within the Nursing Curriculum.

Consequently, Assistant Professors of Nursing Dr Jane Frost and Lori Delaney have been introducing the technology into the nursing classroom to the delight of their students.

"WE BELIEVE THIS NEW
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The technology, which is a collaboration with Pearson Publishing and Microsoft HoloLens, has been providing nursing students with an innovative way of learning and developing their physical assessment skills. Through augmenting the nursing classroom experience, students have been able to interact with a holographic patient and explore complex scenarios, while developing their clinical reasoning skills.

The implementation of the Holopatient Application provides educators access to virtual, standardised patients that can be downloaded and placed in any environment.

Augmented reality can provide users

with an interactive and immersive approach to explore anatomical and physiological structures. This knowledge can be used to guide clinical assessment as a means to integrate knowledge to formulate plans of care and develop clinical reasoning skills.

"Using a holographic patient which displays various symptoms and behaviours allows students to learn assessment and clinical reasoning skills. Being able to walk around the hologram and view the patient from 360 degrees gives an added dimension to the experience," Dr Frost said.

"We believe this new technology has the capacity to engage learners and increase their understanding. Ultimately, it will benefit patient care."

Pearson's Global Director of Immersive Learning, Mark Christian is visiting the University's nursing labs to see the technology in action in the classroom.

"UC was chosen as a key Australasian partner for both the nursing school trial and an education-focused project," Mr Christian said.

The research team will be presenting their findings at the 2017 SERC (Spatial Reasoning) Conference.

Jane Frost is an Assistant Professor of Nursing at the University of Canberra, Lori Delaney is an Assistant Professor of Nursing at the University of Canberra and Australian National University, and Robert Fitzgerald is a Professor of Nursing at the University of Canberra



MORNING SICKNESS AFFECTS EXPECTANT FATHERS

More support for partners of women experiencing nausea and vomiting during pregnancy is needed according to research from Edith Cowan University (ECU).

Researchers asked expectant fathers about their partner's condition and their own mental health and found a significant increase in dads' anxiety levels.

Lead researcher Julie Sartori from ECU's School of Medical and Health Sciences said although there was some support available for pregnant women during pregnancy, often the fathers were left to fend for themselves. "The study showed that in families where the mother experienced moderate to severe morning sickness, fathers reported much higher levels of anxiety."

The anxiety was linked to five major themes:

- disruption at work where partners were forced to take leave to care for their partner;
- fathers feeling frustrated and helpless due to the symptoms of morning sickness being out of their control;
- concern over depression with their partner;
- concern for the developing baby and,
- a sense of being manipulated associated with the increased demands being put on them at that time.

Ms Sartori said fathers could benefit from support to adapt to the role of a carer to their partner. For many it may be their first role as a carer.

"There needs to be an active approach from medical practitioners and antenatal care providers, towards expectant fathers in cases where morning sickness is moderate or severe," she said. "Prenatal support for expectant fathers is vital. This can have a flow on effect for his family during and after pregnancy and allow positive parental bonding."



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(Dabrow Woods, 2017)

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Access the full white paper and Australian Seminar by Dr Anne Dabrow Woods
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Wolters Kluwer
When you have to be right



CRUNCH TIME FOR VOLUNTARY ASSISTED DYING LAW IN VICTORIA

By Nia Sims

With the proposed Voluntary Assisted Dying law (VAD) tabled in the Victorian Parliament, a conscience vote looms. Now is the time for Victorians to make their views known to their state MP.

I had never heard of scleroderma when diagnosed at age 24. I had been a registered nurse for just two years at the time.

Twenty years later, I have a severe case of the disease. I'm frail and likely to die relatively young of progressive lung fibrosis, or failure of my gut.

Most likely a slow decline ending in extreme shortness of breath, starvation, or both. This is why VAD is important to me.

The topic of VAD is considered controversial in this country. While there are some, including some nurses, that do not agree with it, there is much support for it from many Australians. The Australian Nursing and Midwifery Federation (ANMF) has also backed the need for such legislation.

A framework for a VAD Bill was recently tabled in Victorian State Parliament. The Bill was explicitly detailed in The Ministerial Advisory Panel's Final Report on Voluntary Assisted Dying (the 'Final Report') <https://www2.health.vic.gov.au/about/publications/researchandreports/ministerial-advisory-panel-on-voluntary-assisted-dying-final-report>

The proposed Victorian legislation is considered the most stringent in the world, with rigorous assessment and reporting processes, and emphasis on the voluntary nature of VAD care for both patient and practitioners.

What about palliative care?

Most deaths in palliative care do not involve

the kind of undignified, tormented gasping and desperate agitation that my father had endured in his last weeks of death by brain cancer. He died after days of death-rattle, under terminal sedation, from which he would regularly wake, choking and thrashing, to be held still for suctioning and mouth swabbing, causing him to gag, before another sub-cut Morphine would put him out for up to perhaps two hours at a time.

Nurses understand that for a significant minority of patients, not all pain and suffering can be relieved, and that death for some is inevitably a long and horrendous process.

Without doubt good palliative care remains important. Currently, palliative care in Australia is rated the second highest in the world, according to the Quality of Death Index, part of a 2015 report.

Yet one of the most common concerns of nurses is that VAD may draw resources away from this area.

Currently, both major state parties have committed to substantial funding increases to palliative care. The ANMF has also been lobbying for further funding and for improved nurse to patient ratios in palliative care environments.

VAD will shine a bright-hot spotlight on the need for improved resourcing and availability of palliative care.

Also what will be illuminated is the historical fear and stigma around death, with an opportunity for that to change- a new

pathway open for the dying to talk about end-of-life choices in all care environments including hospital, hospice, GP and specialist rooms, community health centres, and the home.

If this legislation is accepted, time will be given to form an Implementation Taskforce that will provide the leadership and resources to prepare for commencement. The Victorian VAD Board, a multi-disciplinary body to review every instance of VAD care, will ensure compliance with legislated safeguards.

Will I ask or won't I?

From my perspective, I want peace of mind now- today, tomorrow, every day.

I'm not terminally ill today, but I may become so at any point in time. I want to know that if in the future I am assessed as having weeks or months to live, and I'm suffering intolerably, that I may initiate an assessment process and choose to die where and when I wish, and with whom I wish to be with holding my hand.

Whether or not I use that choice is a separate question. A significant minority of people around the world who are eligible for VAD do not in the end use it.

What they do consistently report is what I personally hope for- lasting peace of mind for the rest of my life, be it long or short. Terminal sedation - morphine induced coma until death - is far from my preferred option.

At least one terminally ill person suicides each week in Australia, many of them violently - the status quo isn't good enough. Some may remember the suicide of palliative care expert Clive Deverall, who was terminally ill. He committed suicide in a local park in order to make a point. His note read "suicide is legal, euthanasia is not".


A brief historic window of opportunity

As my own case demonstrates, this vote affects nurses personally and professionally. As frontline carers for the imminently dying, our voices are an important influence on members of Parliament.

The most effective way to be heard is a hand written letter to your state MP. You can find out who represents you here:

<https://www.parliament.vic.gov.au/members/results>

For some MPs, this is in the too-hard basket, with their vote defaulting to a no - the cruel status quo. It's not too hard. The groundwork has been laid based on years of research by our most qualified experts, with decades of successful, safe practise and research overseas on which to draw. For me, as nurse, patient and carer, having done my research, my task is to convince MPs to be brave and compassionate enough to offer patients the autonomy to make a choice for themselves.

 **Nia Sims was a Registered Nurse for 15 years and currently volunteers with Go Gentle Australia.**



Emeritus Professor Margaret O'Connor AM, Deputy Chair, Ministerial Advisory Committee on Voluntary Assisted Dying, Nursing & Midwifery, Monash University.

VOLUNTARY ASSISTED DEATH: A POIGNANT/CLINICAL DILEMMA

By Emeritus Professor Margaret O'Connor AM

At the time of writing, the Voluntary Assisted Dying Bill was being presented to the Victorian Parliament. Whether it passes or not, the process has raised significant concerns for nurses, particularly those who work in palliative care.

During the Ministerial Advisory Panel's consultation process, many representations from nurses were evident, in written responses, community meetings, and a meeting organised for nurses by the ANMF. Unsurprisingly, opinions heard on voluntary assisted death were many and varied, mirroring those views of the community.

Concerns from palliative care nurses are quite specific; that dying people are at a vulnerable time of life and may be demoralised or depressed, making them susceptible to suggestions for a 'quick way out'; that palliative care expertise can always find a way to relieve suffering; and that the end of life is as valuable a time of life as any other.

Life itself is precious, and palliative care clinicians encapsulate this by the emphasis on assisting people to live until they die. Some of this stance can be understood through a historical lens, when palliative care grew in response to the perception that dying was not done well across healthcare systems. Thus developed an expertise which in Australia at least, is world-class. Most importantly, has been the need to educate health professionals about the multi disciplinary skills required for a good death. Over the last 30 years or so, palliative care services have had a huge influence on how people in Australia die.

Receiving care from a palliative care service, will most likely provide relief from aspects of suffering for most people. Palliative care provides expert end-of-life care – physical, emotional, spiritual and social – using medical and non-medical interventions and 'impeccable assessment' (WHO 2003), to meet the needs of each individual facing the end of their life.

However, those who work with the dying are not unfamiliar with requests for assistance to end life; they are part of everyday conversations. Assisting a person to navigate necessary decisions at this stage of life requires significant skill, but it is a core skill of palliative care clinicians. People's wishes about all aspects of their care, including the manner and timing of their death, are often a starting point for conversations about care; they require sensitive acknowledgement and interpretation and, a request

for assisted death should always be respected.

In Europe, where a few countries have legalised forms of assisted dying, there has been a strong argument that where euthanasia is legalised, there should be no devaluation of palliative care practice (European Association for Palliative Care, Radbruch et al.2015). Indeed evidence shows that where assisted dying has been legalised, requests for palliative care increase.

WE CANNOT ABDICATE THE CARE OF PEOPLE SEEKING ACCESS TO VOLUNTARY ASSISTED DYING, BECAUSE WE DISAGREE WITH IT; IT IS NOT OUR DECISION, IT IS A DECISION FOR EACH INDIVIDUAL.

Arguments about palliative care and euthanasia are predominantly seen as oppositional. This gives rise to positions which highlight differences, instead of seeking commonalities like the shared intention of aiming to relieve suffering. Perhaps in working through what this current proposed legislation means, there is an opportunity to find some clinical common ground, for the sake of those who need care. Palliative Care Australia holds a position of 'studied neutrality' (Johnstone 2012), in relation to assisted death, with the goal of not excluding anyone, regardless of the choices they make about the end of their life. I believe this statement attempts to hold the complexities of these decisions, sitting in the 'grey', rather than holding firm to black or white, for or against, positions.

I argue that it is possible for a clinician to work with a person, as they work through their decisions, regardless of one's own position on assisted death; and to be a conscientious objector without abdicating one's duty of care for a person until the time they choose

to die. Palliative care clinicians are best placed to use their well-developed skills in expert symptom management, intense communication and multi disciplinary teamwork offering holistic psychosocial and spiritual care.

An individual's decision to seek voluntary assisted death is complex, involving not only the person themselves, but those who support them, family members or others. Reasons for requesting death vary, from seeking relief of suffering, an aversion to loss of dignity and independence, to honouring a long-held belief in autonomous control over one's life.

While there is no formal role in the proposed legislation for nurses to be involved in actions around voluntary assisted dying, it is still essential that nurses not shy away from the hard questions that will inevitably be asked of them. If the legislation passes, the care of people who may wish to access voluntary assisted dying, needs to continue. The care will be as expert as it always is; but is all the more poignant because (under the legislation), people requesting voluntary assisted dying need to be experiencing un-relievable suffering and at the end of their life. So the end point of these people's journey may be different, but meeting day to day care needs to assist the person to live until their death, remains as always, at the forefront of nursing work.

Obviously there is much work to be done in developing clinical guidelines to assist clinicians as they discern their own response to legislation. And because people die in all settings, all healthcare and aged care systems too, will need to develop organisational responses to requests for voluntary assisted dying, with guidance and support for staff at all levels.

Nursing care has always been provided to any person when they are in need, regardless of what we may think of them. We provide care to criminals, to people who have a lifestyle different to our own, to people who resist common-sense treatments. We cannot abdicate the care of people seeking access to voluntary assisted dying, because we disagree with it; it is not our decision, it is a decision for each individual.



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Megan-Jane Johnstone

THE ETHICS OF CRUELTY

In 2014, *The Age* and the *Sydney Morning Herald* respectively published a commentary by human rights advocate Julian Burnside in which he accused both major political parties in Australia of attracting political support by 'promising cruelty to boat people' (Burnside 2014, p16).

He went on to contend that Scott Morrison (who was leaving his portfolio as Immigration Minister to become the Minister for Social Services in the Turnbull government) had resoundingly delivered on that promise by presiding over a 'border protection' system calculated to 'humiliate, degrade, damage and break people' (Burnside 2014, p16). Morrison's legacy, Burnside's views suggested, would be one of 'a calculated cruelty'.

Three years later, in a move described by the Executive Director of the Human Rights Law Centre as 'an act of shocking cruelty', the Australian Federal government revealed its plans to cut the income and accommodation support for up to 100 asylum seekers who had originally been transferred to Australia from offshore detention centres for medical reasons (The Guardian, Aug 2017).

Those affected were given just three weeks to find alternative accommodation and work.

Cruelty punctuates our everyday lives in different ways and contexts – at home, at school, in the workplace. It is perhaps not until the actual word 'cruelty' makes the headlines that we are given pause for thought and an opportunity to reflect more deeply on how we should think about and respond to cruelty – what it is and why it is morally wrong.

A question of nursing ethics

The nursing profession has a role to play in speaking up about, challenging and condemning human cruelty. Because of the predictable and serious harmful consequences that cruel behaviours can have on the health and wellbeing of vulnerable people the nursing profession also has an obligation to intervene in purposeful ways. But what is 'cruelty'? What sense should we make of it as an ethical issue? And are our conventional systems of ethics up to the task of obligating its repudiation?

Cruelty defined

Cruelty has been defined as primarily involving 'the disposition of human agents to take delight in or be indifferent to the serious and unjustified suffering their actions cause to their victims' (Kekes 1996, p838). This and similar definitions capture

four essential elements of cruelty:

- *the victim's suffering* (vulnerable individuals suffer when treated cruelly; this suffering is unjustified – ie. there are no morally sound reasons to justify this treatment or the suffering and moral harms it causes);
- *the perpetrator's state of mind and motives* (agents delight in/ take 'hedonistic gratification' in or are indifferent to the suffering their behaviours cause victims);
- *the perpetrator's actions* (these are voluntary/uncoerced, are unreasonably and excessively executed, result in victims' suffering predictable non-trivial morally significant pain and misery);
- *cruelty violates the boundaries of our humanity* (cruel behaviours infringe the norms upholding the dignity and worth of human beings and the structural foundations of social justice in society) (Barrozo 2008; Kekes 1996; Taylor 2009).

AT THE VERY HEART OF CRUELTY AS A MORAL ISSUE IS THE VULNERABILITY OF VICTIMS AND THE UNJUSTIFIED SUFFERING THEIR BRUTAL TREATMENT CAUSES.

Making moral sense of cruelty

There is a sense in which cruelty is 'obviously wrong'. As Kekes (1996, p843) reflects 'cruelty is very bad'. Yet cruelty stands as a 'contested' notion: it is the subject of various objections and counter objections concerning its rationalisation in certain contexts, when exceptions to its condemnation might apply (eg. conditions of imprisonment), and the conditions under which it might be defended as 'deserved'. Framing cruelty as a moral issue is especially difficult in political contexts hyper-charged with moral panic and where politicians have invested in retribution (eg. against

asylum seekers, prisoners, etc.) as 'electoral currency' (Barrozo 2008). The moral significance of cruelty cannot be side-stepped, however.

At the very heart of cruelty as a moral issue is the vulnerability of victims and the unjustified suffering their brutal treatment causes. The suffering caused is especially significant in moral terms due to its foreseeability (and *ipso facto* its intentionality), its preventability, and the unfair burden of unjustified harm it imposes on victims.

The failure of ethics

Conventional systems of ethic have not always worked to obligate the condemnation and repudiation of human cruelty. Moreover, as Taylor (2009, p42) notes, 'moral judgements, paradoxically, have been used to justify extraordinary cruelty' – torture being a case in point. It is troubling that people are rightly outraged by reports of cruelty to animals yet are more reticent in their responses to reports of cruelty to human beings (such as the above). This is perhaps a reflection of the indifference many people have come to feel towards vulnerable people in our society and the moral imperative to maximise human welfare and minimise human suffering in our shared world. As the Russian novelist, dramatist and historian Solzhenitsyn (1974, p288) reminds us, however, 'no cruelty whatsoever passes by without impact'. Thus, to do nothing is not an option.

Tolerating cruelty or turning a blind eye to it – whatever forms it might take – risks undermining the normative values and beliefs necessary to sustain the moral order of our communities and society. Public policies, processes and laws might not change the personalities of cruel agents. They can, however, be set to the purpose of maximising the welfare and minimising the unjustified suffering of victims. To this end it is incumbent on all of us to take a stand against cruelty and the suffering and vulnerability it causes. We must also make clear our expectation that those in power have a responsibility to prevent the dreadful consequences of cruelty and to protect not endanger the humanitarian values that are revered by many and which ultimately hold our society together.



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

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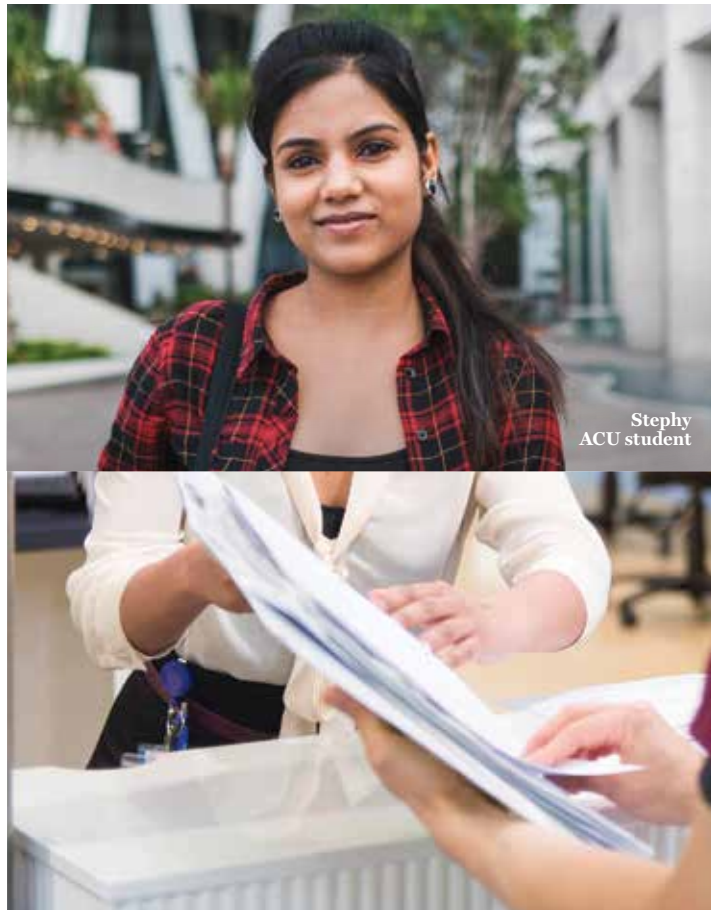
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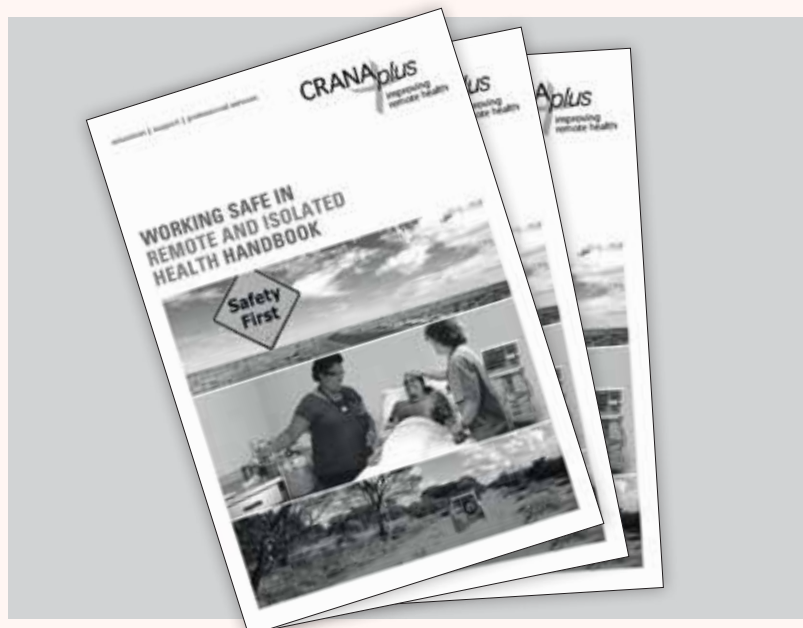
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WORKING SAFE
IN REMOTE AND
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HANDBOOK

REMOTE AREA NURSE SAFETY AND SECURITY

By Rod Menere

The murder of nurse Gayle Woodford resulted in a significant focus on safety and security of remote health staff. But what has happened since? And how can we best make use of recent efforts to improve staff safety?

There have been a number of employer-led responses. Government and non-government health services in different states and territories have developed and implemented *Never Alone* guidelines. In some areas, security staff have been employed to accompany health staff. In other locations, community members have been employed to accompany staff on call-outs. Personal communication and tracking equipment has also been provided or upgraded in a number of areas.

Queensland has introduced mandatory punishment for anyone convicted of assaulting health staff. The Northern Territory has produced a report with binding safety recommendations for NT health facilities. Western Australia Country Health Services is near to completing a similar safety audit, while South Australia is proposing *Never Alone* legislation to formalise safety requirements of government health services.

CRANaplus, with Commonwealth Department of Health funding, recently completed Remote Health Workforce Safety and Security project. The project developed a number of resources for use by health services and individual health staff. These are accessible on the CRANaplus website: <https://cranaplus.org.au/professional/safety-security-in-remote-healthcare>

Unfortunately, improved safety guidelines have not been implemented consistently by health services or staff. There are reports of employers that still expect remote area nurses to work on-call alone, or with inadequate support. There have also been occasions in which individual clinicians have not made use of available security guidelines and equipment.

It is difficult to sustain a focus on the safety and wellbeing of staff, especially when workers have a primary mindset of responsibility to others, even at the expense of their own wellbeing if necessary.

So how can the remote health workforce make use of recent changes to optimise their own safety? All staff, whether new or experienced in remote health work, should make time to inform themselves of the following activities:

- ask for and read up on workplace safety guidelines;
- talk with team members and managers about how to resolve identified safety issues;
- read and make use of CRANaplus safety and security resources and;
- consider signing up for the new CRANaplus courses in *Responding to Aggression and Violence*, and *Mental Health Emergencies*

Rod Menere
is **Safety & Security Professional Officer** at **CRANaplus**

CRANAPLUS FOR REMOTE AREA NURSING EDUCATION

By Sue Crocker

CRANaplus provides education, support and professional services, while representing the remote health sector Australia-wide. Established in 1983 as the Council of Remote Area Nurses of Australia, CRANaplus has built on a proud heritage of remote area nursing – evolving into a multidisciplinary organisation that reflects the diverse nature of all health disciplines working in remote and isolated communities.

CRANaplus is an independent, member-driven, non-profit organisation, and one of the longest established bodies of its kind in Australia. To better serve the education needs of remote communities of Australia, CRANaplus became a Registered Training Organisation in 2013 and is accredited to deliver a number of Units of Competency.

CRANAPLUS AS THE PEAK PROFESSIONAL BODY FOR REMOTE AREA NURSES IS IN A UNIQUE POSITION TO ENSURE A RESPONSE TO THE NEEDS OF THE REMOTE AREA WORKFORCE AS THEY EMERGE

The Education division of CRANaplus delivers a large suite of both face-to-face workshops and online learning courses that are relevant to the practice of remote area health professionals. The existing suite of courses are continually reviewed and updated to ensure the most current clinical evidence is presented as it applies to the unique context of remote area health. The online learning environment is used

to assist in the delivery of pre-course theory to ensure that when participants arrive at the face-to-face component of the course they are ready for the 'hands on components' of the course.

Contextualised case scenarios and case studies are utilised to reinforce theory during simulated skill station rotations and to ensure participants can get hands on experience to practice clinical skill development and mastery. Assessment tasks are undertaken at the end of the face-to-face workshop to assess the participants' knowledge and skills acquisition. CRANAp_{plus} as the peak professional body for remote area nurses is in a unique position to ensure a response to the needs of the remote area workforce as they emerge; one example of this recently is the development of a free online Safety and Security Course for remote area health professionals.


CRANAp_{plus} prides itself on delivering courses close to where the remote area workforce lives and works. It recognises the challenges faced by remote health services to provide professional development opportunities for its staff in a timely and affordable manner. To ensure equity and access for the remote workforce and their employing organisations, CRANAp_{plus} carefully plans course delivery locations every year.

Freight and travel for our education teams, including our highly valued volunteer facilitators, requires highly sophisticated systems and processes to ensure all arrive safely and in a timely manner.

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For CRANAp_{plus} eRemote Courses go to <https://crana.org.au/education/eremote>

 **Sue Crocker is Director of Education Services at CRANAp_{plus}**



REMOTE HOSPITAL,
KIMBERLEY WESTERN
AUSTRALIA

DIFFICULT DECISIONS FOR REMOTE UNIVERSITY NURSING GRADUATES

By Sally Clark and
Carol Piercey

The dwindling numbers of rural/remote nurses was the genesis for conducting a study to investigate the influences on graduates from the University of Notre Dame Australia, Broome campus, in deciding to remain or leave the region.

Decision making theories have proposed actions cannot be evaluated in isolation, but need to be considered within the context of the situation (Maton 2012). Thus, this study considered the constraints, compromises and controls undertaken within the social context of nursing in the Kimberley region of Western Australia.

A major underpinning of all influences was local exposure. Graduates as students were immersed in the nursing workforce, culture and climate of the Kimberley, which included lifestyle and exposure to the community within the context of remote area living.

An overriding inhibiting factor was the notion that graduates would have to leave the Kimberley following their completion of a graduate program, either because they were advised they would need more experience, or because there was a lack of

permanent positions.

Given the age of graduates and their lifestyle factors, it could be argued that promoting more experience in the city had the propensity for graduate attrition from the Kimberley. This study found that graduates who had moved to the city were not always supported and were frustrated at not being allowed to work independently. This disconnect between the city centric view and remote living, concurs with other studies that found there was little awareness of the context of nursing practice, in rural and remote areas (Hegney et al. 2002).

Graduates in their first year of practice, experience increasing levels of knowledge and an expansion in their scope of practice. As such they need support in making the transition from theory to practice. The first year of nursing practice has been characterised as a predictable, non-linear involvement of intellectual and emotive changes; an evolution pattern of personal and professional experiences (Duchscher 2008).

In this study, the dichotomy between hospital policy and the reality, concerning graduates' skills and knowledge, was apparent.


In conclusion, there were numerous interrelated and overlapping factors that were interpreted with respect to the context of the study. The issue in deciding to stay, or leave the Kimberley at graduation was based on a number of alternatives that the graduate may or may not have controlled. Within this decision making construct, graduates displayed self-direction in the face of competing influences such as local exposure, personal and professional factors. Ultimately, it was the balance between the demands of reality and the graduates' needs that compelled them in their final choice.



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- Ensure the operation of the University's agreed quality assurance mechanisms, in such areas as programme approval, programme review, student evaluation of teaching, assessment and responses to external examiners/reviewer
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CHALLENGES EXPERIENCED TRANSITIONING TO RURAL, REMOTE OR METROPOLITAN PHC EMPLOYMENT

By Christine Ashley

Transitioning from acute care to primary healthcare (PHC) nursing requires a major shift in philosophical approaches, clinical skills and models of care. How nurses adjust to this transition has attracted limited research to date (Ashley et al. 2016).

A study undertaken by Doctoral Candidate Christine Ashley from the University of Wollongong has explored the transitioning experiences of registered nurses (RNs) who have recently moved from acute care to PHC employment. This mixed methods study consisted of a national survey, and semi-structured interviews with a subgroup of survey respondents (Ashley et al. 2017a). Of the 111 survey respondents, 39.1% (n=43) identified themselves as working in rural or remote areas. PHC positions were located in clinical settings such as general practice, community nursing, school nursing and remote area nursing (Ashley et al. 2017b).

Interview and survey data revealed that nurses working in rural and remote employment reported better transition experiences than those working in metropolitan PHC settings (Ashley et al. 2017b; Ashley et al. 2017a). In the early transition period, rural and remote nurses were less likely to report negative experiences associated with their orientation ($p=0.01$), were more likely to be offered learning resources, and were more likely to have access to a dedicated preceptor than their urban colleagues ($p=0.02$) (Ashley et al. 2017b). Nurses in rural areas were also less likely to experience role ambiguity (unclear role expectations) than nurses working in metropolitan PHC employment ($p=0.03$). However,

in contrast, nurses working in metropolitan settings reported that adjusting to the new technology associated with PHC nursing was easy, or very easy (Ashley et al. 2017b). This differed from rural and remote nurses who found the technological aspects of their new roles difficult, and reported limited exposure to technology, and poor mobile and internet access ($p=0.03$).

COGNISANT OF THESE FINDINGS, PHC NURSING IN RURAL AND REMOTE LOCATIONS PROVIDES DIVERSE AND EXCITING CAREER OPPORTUNITIES FOR NURSES SEEKING TO MOVE FROM ACUTE CARE NURSING.

This study has provided an evidence base to identify the support needs of experienced RNs transitioning to PHC employment. It has also highlighted the need for employers and policy makers, regardless of location, to be cognisant of the factors, which may impact positively or negatively on nurses moving to PHC employment.

As found in previous studies, access to preceptors, resources,

training, and structured orientation programs were important indicators of job satisfaction (Tabvuma et al. 2015) which may impact on recruitment and retention (Carlson 2013). Our findings indicate that some rural and remote employers are being more successful than in metropolitan settings in ensuring availability of these supports. However, difficulties with technological aspects of the PHC nursing role in rural and remote locations still need to be addressed (University of Canberra 2016). Cognisant of these findings, PHC nursing in rural and remote locations provides diverse and exciting career opportunities for nurses seeking to move from acute care nursing.

The author acknowledges the support received from her supervisors in undertaking this study: Professor Elizabeth Halcomb (University of Wollongong), Associate Professor Kath Peters (Western Sydney University) and Dr Angela Brown (Honorary Professorial Fellow, University of Wollongong).

Christine Ashley is a Registered Nurse working in rural NSW. She is currently undertaking Doctoral studies at the University of Wollongong exploring the experiences of acute care nurses who transition to primary healthcare



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RN KATIE CLAVARINO AND OLIVER DEMONSTRATING RURAL NURSING PRACTICE OCCURS IN A MULTITUDE OF SETTINGS, AS SUCH STUDENTS UNDERTAKING RURAL PLACEMENTS CAN GAIN A BROAD RANGE OF EXPERIENCES

RURAL HEALTH WORKFORCE DEVELOPMENT: STUDENT PLACEMENT PROJECT

By Keryn Bolte and Lisa Bourke

With the assistance of funding from the Australian government, The University of Melbourne, Department of Rural Health, has established the Going Rural Health program to support nursing (and allied health) students to undertake some of their clinical placements in rural areas.

The aim is to train students in rural practice and provide them with the inspiration to consider a rural career once qualified. The project trains students in authentic rural settings and provides relevant education programs that work to frame the rural practice experience. Accompanied with clinical placements in community, primary health and non-acute based settings, the program provides financial, travel and accommodation assistance, education in rural and Aboriginal health, mentoring and community engagement opportunities.

However, education is only as good as its educators; staff who supervise the students are provided with ongoing education, mentoring and support so as to capitalise and build upon the skills and knowledge that already exist in rural and regional areas. Frequently education is 'outsourced' to external providers, often from urban areas where the healthcare needs are distinct to that of rural practice. Through the Going Rural Health program we aim to expand the number and quality of rural educators so they highlight the level of skill required to practice rurally as well as the diversity and flexibility of rural practice. The aim is to train nurses in rural settings so they

THE AIM IS TO TRAIN NURSES IN RURAL SETTINGS SO THEY ARE READY TO WORK IN RURAL SETTINGS.


are ready to work in rural settings.


The Going Rural Health program has been in place since 2015 and student satisfaction with the program is consistently rated as positive by 96% of students surveyed (2015-16). In addition, the program is developing new placements in contemporary nursing settings, such as in primary healthcare, community health and research. Education programs are being developed in innovative ways with simulated patients, online learning, cultural skills and evidence based practice, and instilling an approach of lifelong learning. While it is still a resource intensive task for small, rural health services to provide student placements, with support and training for staff, financial assistance for students and some student education provided regionally and via technology, the Going Rural Health team contributes to developing the

future rural nursing workforce.

Furthermore, the program is learning from the well established nursing education model and implementing similar approaches in allied health. The aim is to learn from nursing so as to increase the number of dedicated student supervisors, continuing to value the contribution made by educators to student and staff learning, and increasing staff training. One of the goals of the Going Rural Health program is for allied health disciplines to reap the benefits of such a culture of education, training and workforce development that has been established in rural nursing practice.

For more information on the Going Rural Health Program, go to the website: www.goingruralhealth.com.au

 **Keryn Bolte is Student Placement Manager for the Going Rural Health Program, Department of Rural Health at the Faculty of Medicine, Dentistry and Health Sciences at The University of Melbourne**

 **Lisa Bourke is a Social Worker and the Director of the University Department of Rural Health at The University of Melbourne**



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RURAL AND URBAN NURSE PRACTITIONER EDUCATION WITH LA TROBE UNIVERSITY

By Maria Murphy, Andrew Scanlon, Jacqueline McGregor and Kathy Tori

Approximately one third of the Australian population resides outside the capital cities (ABS 2013).

Geographical areas are classified according to their relative remoteness as well as the degree to which a population is organised, characterised and classified. Classifying areas assists with planning and provision of services in particular healthcare. The initial Australian nurse practitioner (NP) pilot programs were trialled in New South Wales in the 1990s with the first NP endorsed in 2000 (Australian College of Nurse Practitioners 2017).

Today, there are more than 1,500 NPs, endorsed across Australia (Nursing and Midwifery Board of

Australia 2017). Nurse practitioners deliver healthcare in a variety of settings in both rural and urban, primary and tertiary care. NP responsibilities include advanced patient assessment, diagnosis and management of diseases, referral, medication prescribing, and the ordering and interpretation of diagnostic investigations (Centre for International Economics 2013). As a workforce, NPs are expanding to meet the healthcare needs of millions of Australian residents irrespective of postcode.

To become a NP in Australia, registered nurses must have completed a program of study accredited by the Australian Nursing and Midwifery Accreditation Council and/or approved by the Nursing and Midwifery Board of Australia to be eligible to submit for NP endorsement. The La Trobe University Masters in Nurse Practitioner Degree was established in 2006. The core teaching group are appropriately qualified, with over 50% being endorsed NPs and actively involved in research and publishing within areas of NP practice.

The delivery mode for the accredited program caters for the diverse needs of the student cohort. The online course delivery requires internet capabilities, this suits the geographical diversity of the students. The flexibility to attract students from a range of geographical locations in Australia is a program strength.

Enquiry based learning is the

predominant method of course delivery to encourage students to think holistically and prepare for an advanced role in the workforce. A blending of traditional and contemporary teaching and learning modes to promote life-long learning such as the incorporation of online lectures, webinars and Zoom (form of video conferencing) delivered assessments augment traditional face to face workshop style teaching and learning. Students are required to complete a minimum of 500 hours of clinical placement working in partnership with healthcare professionals during their clinical internship. Further, an additional 480 hours of placement associated with the Therapeutic Medication management subjects is a program requirement. Online postgraduate study enables access to education wherever online capabilities are situated in Australia.

Maria Murphy RN PhD is located at La Trobe University and Austin Health.

Andrew Scanlon RN DNP NP is located at La Trobe University, Austin Health and Montclair State University in the US

Jacqueline McGregor RN MHS and Kathy Tori RN PhD NP are located at La Trobe University



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CAREER AND EDUCATION FRAMEWORK SUPPORTING NURSES TO UNDERSTAND THEIR ROLE IN PRIMARY HEALTHCARE

By Brie Woods, Emily Wheeler and Jacqui Richmond

Have you considered what a career outside the four walls of a hospital looks like? Would you like to work within a community, to make a difference throughout people's lives?

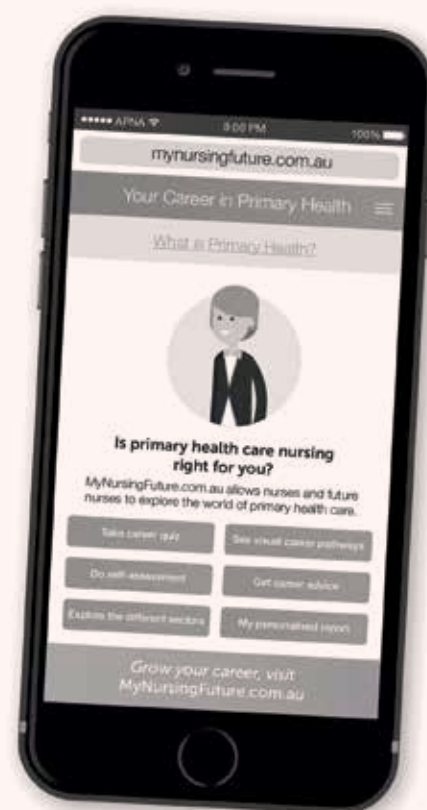
In 2015 the Australian Primary Health Care Nursing Association (APNA) received funding from the Commonwealth Department of Health to develop a Career and Education Framework to support the current and future nursing workforce in primary healthcare, by addressing recruitment and retention issues in the nursing profession. From start to finish the framework has been developed using a co-design approach by nurses, for nurses, which led us to deliver it through a mobile-responsive website platform.

Integral to the development of the framework was an extensive consultation conducted throughout 2016 and 2017. This included 53 semi-structured interviews with nursing and primary healthcare experts, 43 in-depth prototype interviews, five language refinement workshops, 18 workshops across Australia including an online consultation series to facilitate access for non-metropolitan participants (n=254).

In August this year **MyNursingFuture.com.au** was launched, housing the framework and an interactive self-assessment tool.

The self-assessment was designed in response to retention issues identified during the consultations, and is modelled on the Strong Model and Ackerman's work (Ackerman et al. 1996; Mick and Ackerman 2000).

What we found by talking to, many nurses, is that they find it difficult to describe their professional value to their employer,



CAREGIVERS FROM RURAL AND REGIONAL AUSTRALIA ATTENDING A METROPOLITAN HEALTH SERVICE

By Anna Ugalde, Sarah Blaschke and Patricia Livingston

Approximately 30% of Australians live in rural and regional areas, and it is well established that these people can experience poorer health outcomes when diagnosed with cancer.

They can have higher mortality, face later stage diagnoses, suffer higher unmet needs, and have access to fewer services. Additionally, they report poorer psychosocial outcomes, including financial difficulties, depression, distress and anxiety.

While research often focuses on improving health outcomes for the person diagnosed, our program of work seeks to support family members or friends who provide care or support for people with cancer. Caregivers take on complex and extensive roles in care provision for the patient, which can substantially impact the caregiver's own health and wellbeing and their capacity to provide care effectively. Anxiety, depression, loneliness, sleep deprivation, and social isolation are just a few of the known impacts on the caregiver. Our research has shown


caregivers focus on supporting the patient at a significant cost to their own physical and psychological health.


Previous studies show that caregivers require social, psychological and information resources to carry out their role and responsibilities successfully, however it is unclear what types of support interventions are of greatest assistance and benefit. Unfortunately, the caregiver experience has not received enough attention to date, and even less is understood about the unique circumstances of caregiving when living in rural and regional areas and the particular needs of this important group. Deciding to attend a metropolitan service and arranging travel and accommodation can likely add challenges. Caregivers may need to take time off work, arrange for

childcare and organise transport.

Our study sets out to meet this gap by exploring, and giving voice to the experiences of this vulnerable group of caregivers. We are particularly interested in understanding the range of caregiver experiences when tasked with supporting a patient to attend a metropolitan cancer hospital. Inequity in access to cancer treatment services for rural and regional Australians can result in patients deciding to attend a metropolitan cancer hospital for treatment. We aim to identify the challenges involved when caring for a patient throughout this journey from treatment provider decision making to treatment access and return back home.

Our study will also determine the positive aspects of caregiving when living in rural and regional areas. Such insights can direct us towards unexplored support resources already existing within the caregiver's local environment. Understanding caregivers' first-hand experiences, as reported by them, is the first important step towards developing meaningful interventions for this group. Supporting rural and regional Australians who take on the role of caring for a person with cancer will minimise the impacts on their own health and wellbeing, and will assist them in caring more effectively for their loved one.

 **Anna Ugalde and Patricia Livingston are in the School of Nursing & Midwifery at Deakin University**

 **Sarah Blaschke is in the Department of Cancer Experiences Research at the Peter MacCallum Cancer Centre**

to describe the breadth of their role and identify professional strengths, and actively plan their continuing professional development (CPD).

The self-assessment enables registered nurses (RNs) working in primary healthcare to professionally reflect on their level of practice across the five domains of primary healthcare nursing; clinical care; education; research; optimising health systems and leadership (adapted from the Strong Model and Ackerman et al.). The nurse is provided with 30 self-assessment questions, each with four possible answers. Responses are weighted according to whether a nurse indicates they are *learning*, *confident in* or *lead/guide others* in relation to their nursing practice. On completion, the nurse is provided with a personalised report, outlining their strengths, and areas for professional development in accordance with each domain. The terms *Foundation*, *Intermediate* and *Advanced* are used to describe a nurse's level of practice according to their responses. The report also provides nurses with recommendations on how to

strengthen their knowledge, skillset and competence across each domain.

Nurses who participated in the prototype testing (n=43) said the self-assessment would help them actively plan their CPD, discuss and demonstrate their professional value, skillset and knowledge with their employer, healthcare team and patients, and identify new nursing roles for career progression.

It is important that primary healthcare nurses understand and can articulate their professional value, and have the means to continually evolve in their careers – **MyNursingFuture.com.au** provides nurses with the tools and support to do so.

 **Brie Woods and Emily Wheeler are Project Managers and Dr Jacqui Richmond is a Consultant. All are in the Career and Education Framework at Australian Primary Health Care Nursing Association (APNA)**



BRIE WOODS



EMILY WHEELER



JACQUI RICHMOND



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SUPPORTING RURAL EMERGENCY NURSES TO PROVIDE AUTONOMOUS AND LIFE-SAVING CARE DURING RESUSCITATION

By Katherine Riley and Rebekkah Middleton

It is well known that Australian rural communities are confronted with significantly greater health disparities than their metropolitan counterparts (Rural Health Standing Committee 2011).



The Australian Institute of Health and Welfare (2010) identifies that these communities are exposed to higher rates of disease and injury, lower life expectancy, and poorer access to and use of health services than people living in major cities. These challenges highlight the need for healthcare plans, programs and service delivery models to be tailored to meet rural settings (RHSC 2011).

The challenges that Level 2 emergency departments face is that they are required to provide basic primary and secondary assessment, including Advanced Life Support (ALS) and stabilisation of critically ill paediatric, adult and trauma patients prior to arrival of the retrieval service despite having on-call medical coverage (NSW Ministry of Health 2014).

In 2011, the lead author co-developed a nurse-led resuscitation team for their Level 2 rural emergency department in response to a critical incident that occurred within the department. The small scaled project was supported by the Rural Adult Emergency Clinical Guidelines in conjunction with the development of clear role delineation (NSW Department of Health 2007). The

THE IMPORTANCE OF THIS RESEARCH ON FUTURE NURSING PRACTICE IS TO PROVIDE A SUPPORTIVE MODEL FOR NURSES IN RURAL SETTINGS WHO MANAGE RESUSCITATION WITHOUT MEDICAL SUPPORT.

specific roles that were created were based on appropriate nursing staff resources available for each shift as well as the skill mix required to manage resuscitation without medical support. Roles that were developed for this model included team leader/airway nurse, circulation nurse and scribe. These roles have since evolved with feedback from nursing and medical staff during debriefing sessions. Staff have recognised that building leadership capacity in our nursing workforce is paramount to the success of this project as well as cultivating a sustainable rural nursing workforce that is responsive to the management of the deteriorating

patient within the emergency department.

The lead author is currently completing her PhD focusing on the collaborative development of a nurse-led model for resuscitations in rural emergency departments. This project will also provide clarity around the experiences of rural emergency nurses during resuscitations when on-call medical support is not imminently available.

The importance of this research on future nursing practice is to provide a supportive model for nurses in rural settings who manage resuscitation without medical support. It seeks to blend advanced roles that accredited nurses currently undertake in rural settings with non-technical skills such as leadership, situational awareness and communication. It is envisaged that this research will empower nursing staff to challenge and enrich their nursing skills and practice whilst meeting the service gap needs of their rural community.

 **Katherine Riley is a Lecturer and Rebekkah Middleton is Senior Lecturer. Both are in the School of Nursing at the University of Wollongong**



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RURALLY LOCATED ACADEMICS FOR UNDERGRADUATE NURSING PLACEMENTS FOR STUDENTS WHO 'GO RURAL'

By Fiona Little, Jessica Stokes-Parish, Tash Hawkins and Julie Collier

Australia's nursing shortage is predicted to reach 85,000 nurses by 2025 with fewer nurses working rurally, highlighting the need to explore recruitment incentives for developing the rural workforce (HWA 2014; Gorton 2015).

Positive clinical placement experiences are crucial for students to consider pursuing employment rurally. The quality of support during clinical placement correlates to the students' level of satisfaction, influenced by the relationships developed between the student and their supervising nurse (Courtney-Pratt 2012; Edwards et al. 2004; Zilembo & Monterosso 2008).

Challenges to supporting rural clinical placements include difficulties between tertiary institutions and clinical placement sites to develop local relationships and communicate effectively. In addition, the support provided to student supervisors is limited with the majority of nurse education in Australia taking place within large metropolitan hospitals (Edwards et al. 2004).

Less than 5% of nursing students attend rural placements and there is limited reference to rural health in the current undergraduate curriculum (Neill et al. 2002; Playford et al. 2006). As a result, students' understanding of rural issues is impacted and they have less interest in 'going rural' as a career option.

The benefits of rural placements include diverse experiences and opportunities to practice clinical skills improving work readiness (Edwards et al. 2004). The commonwealth government implemented a scheme to increase and improve rural clinical placements in response to workforce needs (Lyle et al. 2006). This scheme involved employing nurse academics rurally within the University of Newcastle Department of Rural Health (UONDRH).

These positions cover a vast geographical footprint in New South Wales across 22 rural clinical sites. The strength of these positions are demonstrated by the academics collaboration and connectedness with the local health services and also the rural community.

Collaboration and connectedness

A key feature of the UONDRH nurse academic

role is the strength of their collaborative relationships with local health service staff and the rural community. The academic understands rural needs, and continually liaises with health service educators and preceptors about challenges specific to students on rural placement. A sense of belongingness is promoted for students as they develop their own interprofessional rapport-building skills through participation in community engagement activities and interprofessional learning. Belongingness is identified as pivotal to nursing students relocating rurally (Sutton et al. 2014), highlighting the importance of social connectedness (Ng et al. 2015).

Flexibility and diversity of the rural learning environment

The academics familiarity with geographical distances between clinical placement sites and the variation between placement facilities provides insight to what affects the students learning experiences. Successful rural clinical practice is reliant on interprofessional relationships where resources are limited. Increased autonomy associated to rural nursing, higher levels of clinical acuity and the need to practice in extended roles is viewed as challenging for students (Neill 2002). Academic support to students has a role in alleviating these concerns, providing opportunity for students to shape their learning. Employing nurse academics has been highly successful; student satisfaction with placement has increased and the frequency of return to rural placement is increasing.

Fiona Little is a Mental Health Nurse Academic; Jessica Stokes-Parish is Associate Lecturer; Tash Hawkins and Julie Collier are Clinical Nurse Educators. All are located at the University of Newcastle



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NOVEMBER

November Month

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

Lung Health Promotion Centre at The Alfred

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

4th International Conference for PeriAnaesthesia Nurses

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

3rd Annual Falls, Fractures & Pressure Injuries Conference

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

Australasian HIV & AIDS Conference

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

Marriage Equality Postal Survey

Final deadline to return forms
Tuesday 7 November at 6pm

Australasian Sexual Health Conference

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

34th International Nurse Education & Nurse Specialist Conference

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

Eureka Climb

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

3rd Annual National Family and Domestic Violence Summit

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

3rd World Congress on Midwifery and Women's Health

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

World Diabetes Day

14 November.
www.idf.org/worlddiabetesday

26th Transplant Nurses' Association National Conference

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

International Men's Day

19 November.
www.internationalmensday.com/

21st World Congress on Nursing Pharmacology and Nursing Education

Grooming the pharmacological boundaries for nursing education
20-21 November, Melbourne, Victoria.
<http://pharmacology.nursingconference.com/>

ICN Regulation & Credentialing Summit

Working in complex and uncertain times
20-21 November. Hotel Palacio Estoril, Portugal. <http://www.icn.ch/>

Breaking Point: Ice & Methamphetamine Conference

20-21 November, Mercure Hotel Brisbane. Earn 11 Hours of CPD (certificate awarded). www.ausmed.com.au/course/ice-methamphetamine

5th Annual National Mental Health Summit

20-21 November, Swissotel Sydney NSW. www.informa.com.au/event/mental-health-conference/

6th International Australasian College for Infection Prevention and Control (ACIPC) Conference

20-22 November, National Convention Centre, Canberra ACT.
<http://2017.acipconference.com.au/>

17th International Conference and Exhibition on Nanomedicine and Nanotechnology in Health Care

Nanomedicine – Advances and clinical challenges
23-24 November, Melbourne, Victoria.
<http://nanomedicine.conferenceseries.com/>

National Indigenous Allied Health Australia Conference

Care, cultures and connections
27-29 November, Rendezvous Scarborough Perth WA.
<http://iahaconference.com.au/>

Key Issues in Women's Health – Singapore

27 November-1 December. This conference, being held aboard the Mariner of the Seas sailing out of Singapore, will explore women's health under three conference themes – conditions, pregnancy and parenting, and healthy lifestyle.
www.nursesforwomen.com.au/events

Nursing and Midwifery Leadership Conference

Celebrating the why
30 November-1 December, Perth Convention and Exhibition Centre WA.
<http://nmlc2017.com.au/>

Mercy Perinatal Global Obstetric Update

30 November-2 December, Park Hyatt Melbourne. This year, GOU is everything that midwives, GPs and specialists need to know in clinic and in the birth suite. <https://mercyperinatal.com/event/global-obstetric-update-2017>

DECEMBER

World AIDS Day

1 December. www.worldaidsday.org.au

Trauma in Aged Care – Nursing Conference

4-5 December, Rydges Sydney Central, Surry Hills NSW. Earn 11 hours and 15 mins of CPD (certificate awarded). www.ausmed.com.au/course/trauma-in-aged-care-a-nursing-conference

46th Global Nursing and Healthcare Conference

Exploring latest innovations in nursing and healthcare
6-7 December, Sao Paulo, Brazil.
<http://global.nursingconference.com/>

International Human Rights Day

10 December.
www.un.org/en/events/humanrightsday/

2018 FEBRUARY

Midwives on Board! – The Panama Canal

An Education at Sea Event
16 February-2 March 2018. Calling

all midwives...Education at Sea is bringing you a fabulous opportunity to be a part of a midwifery cruise on board the Norwegian Star. <https://www.nursesforwomen.com.au/events>

4th Annual Congress and Medicare Expo on Trauma & Critical Care

Advanced traumatic & emergency care
22-23 February 2018, Paris, France. <http://trauma-criticalcare.conferenceseries.com/>

Lung Health Promotion Centre at The Alfred

Perioperative Course
23 February 2018
Ph: (03) 9076 2382
Email: lunghealth@alfred.org.au

MARCH

Lung Health Promotion Centre at The Alfred

Spirometry Principles & Practice
1-2 March 2018
Asthma Educator's Course
7-9 March 2018
Smoking Cessation Course
15-16 March
Ph: (03) 9076 2382
Email: lunghealth@alfred.org.au

47th Global Nursing & Healthcare Conference

Exploring latest innovations in nursing and healthcare
1-3 March 2018, London, UK. <http://global.nursingconference.com/europe/>

5th International Conference Global Network of Public Health Nurses

5-7 March 2018, Safari Park Hotel and Casino, Nairobi. www.icn.ch/

23rd Commonwealth Nurses and Midwives Federation Biennial Meeting

9 March 2018, London UK.
www.commonwealthnurses.org/

APRIL

Lung Health Promotion Centre at The Alfred

Managing COPD – Acute/Chronic
19-20 April 2018
Respiratory Course (Modules A & B)
30 April-3 May 2018
Respiratory Course (Module A)
30 April-1 May 2018
Ph: (03) 9076 2382
Email: lunghealth@alfred.org.au

NETWORK

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

Austin Hospital, Group 76/1, 42-year reunion

February 2018. Seeking fellow students for reunion. Contact Carol B
E: Austin76one@gmail.com

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

17 February 2018. Contact Roslyn Kerr E: gert2@optusnet.com.au or Patricia Marshall (nee Purdy)
E: tapric135@bigpond.com

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

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

NSDN Bendigo School 71, 50-year reunion

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



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

VALUABLE REFLECTION

The *ANMJ* and Megan-Jane Johnstone are providing a valuable reflection for all nurses. Most of us became nurses because we felt a personal ethical commitment to the care and support nurses provide.

In the past, it was easier to reconcile our personal commitment with what our working environment demanded of us. We worked as a close group under the direction of a matron or director of nursing who took responsibility for the leadership of all nurses in the establishment. Whether the incumbent was good or bad, the structure gave us all a common purpose and engendered a team approach.

However, from about the 1980s we became part of a 'corporate culture' and had inflicted on us a 'business' approach that put corporate loyalty and budget balancing above any personal ethic. We tried to resolve this by developing our own professional ethical guidelines, but this was done in isolation to the culture of the large corporation in which we now worked in. And so we face a dilemma.

Those who deliver a clinical service are responsible both legally and ethically for the outcome of that service. But those who deliver actual service are becoming a smaller and smaller component of the total health 'system'. The bulk of people in the system (including many who have their position by virtue of their clinical qualifications) provide administrative services, work on projects, write procedures and policies, and attempt to balance services' costs against financial allocations. There is nothing wrong with any of this, but none of it is concerned with life and death; and the ethical implications of failure are not profound. For many non-clinicians in the system, the worst-case scenario is an embarrassed minister.

I believe the work done to develop a basis for nursing ethics is appropriate and important. And I think that other clinical professionals and workers would benefit from similar work and research.

I also respect the ethical basis of all who work within our health system, but, speaking for nurses, I ask that any code laid down by our professional bodies takes into account that the 'nursing ethic' may at times be in conflict not only with the law, but also with the culture of both the public and private workplace. Should a nurse suffer detriment from his/her employer or the legal system when the professional ethic is given priority, then that person deserves support from the professional organisation and not complicity.

Mick Hawkins MHN, SA

CONCERNS ABOUT COMPUTERISED RECORD SYSTEMS

I am an RN working for an agency and recently I worked on a medical ward in a new hospital using a computerised record system. Computers were at the desk, not the bedside. All documents were electronic except medication charts, a basic nursing care plan and hourly rounding charts.

To document data like vital signs, intake, output one has to leave the patient, go to the desk, log on, log into the program, enter the data, patient by patient, event by event, or write everything on a piece of paper and enter it into the computer later. Interruptions at the desk from visitors or the phone were common.

It was difficult to get an overview of the patient without bedside access to their observations chart, fluid balance chart and other documents. You could not write progress or post op notes by the bedside.

I have serious concerns for patient and nurse safety due to the potential for error and the time taken to enter data. Not only is all this transcribing highly dangerous and a recipe for error but the practices in this hospital I am sure will result in a lawyers' field day, a patient disaster waiting to happen and a nurse's nightmare.

I have been a patient and a victim of medical negligence and have endured the trauma of botched surgery, poor documentation, ongoing serious health issues and 12 years of medico-legal action and what I was required to do that night at work terrifies me.

Time to retire?

RN, ACT

PROVIDING ETHICAL NURSING CARE

In response to Professor Johnstone's article (vol.25 no. 3) that good nursing ethics is not concerned with preventing or resolving moral dilemmas, 'the lady doth protest too much, methinks' (Shakespeare, Hamlet).

Professor Johnstone argues that nursing ethics is about creating virtuous nurses rather than the current emphasis on providing ethical nursing care. Her interpretation supports the old view of nurses as mere handmaidens to doctors rather than individuals with our own expert knowledge. This knowledge enables us to assist the community to consider issues which may affect the healthcare that we can provide, eg. healthcare for refugees, voluntary euthanasia (VE), domestic violence, abortion, aged care. To stand aside and worry only about our own individual moral character rather than the way we ought to treat each other in society risks making nurses subject to the moral values of others rather than becoming better nurses. This is aptly displayed when nurses abide by employer directions in provision of care rather than standing up for the patients under their care.

Mr Mills (Letter to Editor, same issue) asks how the ANMF has consulted its members on the VE debate - the answer is within the many different issues of the *ANMJ*. This vehicle has enabled members like Mr Mills to question, dissent or promote the different moral values nurses assign to this issue.

It is not easy being a human being or a nurse. Just when we thought we understood who we are and how we ought to behave in our society, we are challenged again and again as our society evolves. Nursing ethics is an important vehicle in which a nurse can assess how well they are going as both an individual and as a nurse practising person-centred care within that society. We don't stand separate from those we minister to.

Sandra Bradley RN, PhD SA

LETTER
OF THE
MONTH

The winner of the *ANMJ* best letter competition receives a \$50 Coles Myer voucher. If you would like to submit a letter to the *ANMJ* email anmj@anmf.org.au Letters may be edited for clarity and space.



CELEBRATE DIVERSITY: MARRIAGE EQUALITY MATTERS

Lori-Anne Sharp, ANMF Vice President



Last month I received my postal survey asking me to respond 'yes' or 'no' on changing the law to allow same sex marriage. What followed at home was many dinner table conversations with my three children as we watched and listened to the 'debate' around human rights for LGBTIQ Australians.

My children were curious and a lot of questions followed. I found myself explaining that our Australian government had failed to legislate on basic human rights for one section of the community and instead had decided to send a postal survey to the nation asking their opinion. A survey, that is hurtful, divisive, non-compulsory, non-binding and costing \$122 million dollars.

Many in the lesbian, gay, transgender, bisexual, intersex and queer (LGTBIQ) community did not want the scrutiny, this public commentary about the validity of their relationships, families and lives. It was no surprise that the next question around our dinner table was "so what are you going to do about it mum?"

I explained that while a national opinion poll on basic human rights is a bad idea and the process is completely flawed, it's still important we participate and vote 'yes', in favour of the amendment to the *Marriage Act*.

I explained it's important that we all stand up and fight for equality. In the weeks that followed I talked with many friends affected by the survey and listened to their concerns, worries for their families and the greater community. I got active, went to organised rallies, family fun days, and encouraged the kids to come too. I joined supportive Facebook groups, bought t-shirts, badges, stickers, distributed amongst networks, plastered the street with posters; door

knocked and encouraged all to vote. I met with like-minded straight 'allies' and advocated for the LGBTIQ community at every opportunity.

I am proud to be part of a union that actively supports marriage equality. After all, equality is union business. A core union role is to promote social justice and end discrimination. Unions work towards eliminating discrimination in our workplaces.

The postal survey has given some, particularly on social media, a platform to express views that are distressing and conflate debate.

Some have erroneously implied that religious freedom will be compromised – whereas the change in law is only relevant to civil marriage, a secular, not a religious issue. A 'yes' for same sex marriage acknowledges that same sex attracted people are equal in our society, to enjoy the privilege of marriage as public recognition of our relationships, and the security and binding nature of that union as seen in society and that many of us take for granted.

Homophobia, lesbophobia and transphobia exist and is damaging for individuals and families, young people and the elderly. It affects many broad cross-sections of our community. When the elderly are forced to deny their lifelong partner, or live with anxiety and stress in having to 'come out' again – at times, in nursing homes that are not particularly supportive and respectful of their same-sex



relationships – this is an issue we need to be mindful of. As health professionals, we all need to develop a supportive and respectful practice for working with people of diverse sexualities and family structures. This should be a principal focus of our professional practice. The postal survey reminds us all to be more thoughtful of our tacit views and beliefs, and in my view, should invite all of us to come together in the call for equality and anti-discrimination.

I stand shoulder to shoulder with the LGBTIQ community and am confident that



marriage equality will be achieved in Australia in the near future. We can then join the 25 other countries who have already taken this important step, which include:

Netherlands (2000), Belgium (2003), Canada (2005) Spain (2005), South Africa (2006), Norway (2008), Sweden (2009), Argentina (2010), Iceland (2010), Portugal (2010), Denmark (2012), Uruguay (2013), England and Wales (2013), New Zealand (2013), Brazil (2013), France (2013), Luxembourg (2014), Scotland (2014), Greenland (2015), Finland (2015), Ireland (2015), United States (2015), Columbia (2016), Germany (2017), Malta (2017)

As our dinner conversations continued, my three children observed my activism and started to engage. One night my 11 year old commented, "why are people asked to vote anyway, the government should just make a decision on what is best and do the right thing... there is no difference allowing gay people to marry, everybody else can".

We must strive to live in a society free of discrimination and prejudice. I encourage those to reach out to the LGBTIQ community at this time and offer support. There are so many offensive statements and arguments being made about LGBTIQ families and individuals. There is no doubt that this postal survey has impacted on the LGBTIQ community and many will need extra support in the coming weeks. Let's continue to stand up for equality, no matter what the outcome. Love will rule. Love is love.



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