

# ANMJ

AUSTRALIAN NURSING & MIDWIFERY JOURNAL  
VOLUME 26, NO.3, SEPTEMBER 2018



## NAVIGATING **THE HIGHS AND LOWS** OF EARLY CAREER NURSING

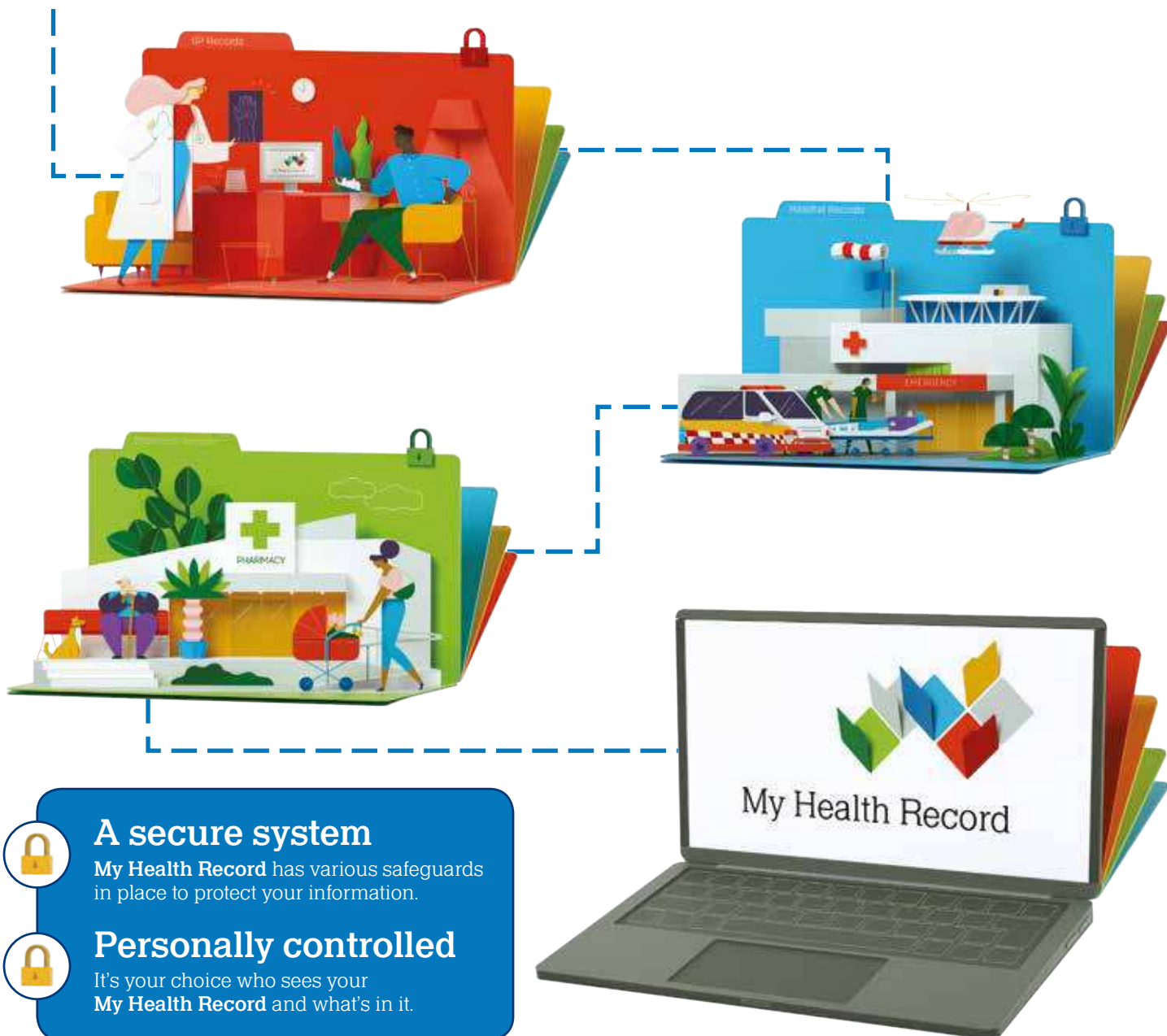
[www.anmj.org.au](http://www.anmj.org.au)





# My Health Record

## An online summary of your key health information



This year, you will get a **My Health Record** unless you tell us you don't want one by 15 November 2018.

For more information go to:

**MyHealthRecord.gov.au | Help line 1800 723 471**





## Editorial

Annie Butler ANMF Federal Secretary

The September issue of the journal marks not only the end of an era but also the beginning of an exciting new one for the ANMJ.

As from next month the ANMJ will be published quarterly as opposed to monthly. The journal will have a fresh new look, maintaining some of its regular columns, while also introducing many other thought-provoking and educational articles. The Journal will complement the new ANMJ website, which was launched in July this year.

The ANMJ in all its platforms has been fundamental to the Australian Nursing and Midwifery Federation. Its purpose, of keeping members informed on a variety of professional, industrial and political issues, helps create unity within the nursing and midwifery professions. From unity comes strength, which is integral to the union and to its membership.

The ANMF, then known as the Royal Australian Nursing Federation, launched its first journal, *The Australian Nurses'*

*Journal*, for members in 1971. In the inaugural issue the President of the union, Olive Anstey, talked about those who had strived for a national journal to "strengthen and maintain the status of the nursing profession so that it can be a dynamic force now and in the future".

By the second issue, published a month later, Acting Publisher Barbara Sanderson wrote, "If we can judge by the initial response of the 'journal', it is well clear of the launching pad and soaring into orbit."

Since then the union and the publication have seen a number of transformations including name changes over the years to what we are now known as, the Australian Nursing and Midwifery Federation and the *Australian Nursing and Midwifery Journal*, respectively.

Yet the comments made by Olive Anstey and Barbara Sanderson about the journal decades ago still ring true today.

Just as the *Australian Nurses' Journal* in the 70's, the ANMJ remains as a good source of information and a way of sharing of ideas for the nursing and midwifery professions today. The new ANMJ website, after only three months, is also proving popular with an ever-growing following of the site.

If you have not yet been to the website [anmj.org.au](http://anmj.org.au) I encourage you to visit. The site holds a wide variety of informative articles, which are constantly updated throughout each week.

I am confident the new look quarterly publication will be equally as inspiring and of value to the membership as the publications that have gone before it.

This month, ANMJ's feature details the experiences of graduates as they navigate the transition from student to practising nurses. The focus section looks at the latest in wound management and infection control practices, while education addresses chest pain assessment and management.

I hope you enjoy reading ANMJ's final monthly publication.

Annie

**FROM UNITY COMES STRENGTH,  
WHICH IS INTEGRAL TO THE UNION  
AND TO ITS MEMBERSHIP.**



@ANMJAUSTRALIA



ANMJ.ORG.AU



## Canberra

3/28 Eyre Street, Kingston ACT 2604

Phone (02) 6232 6533

Fax (02) 6232 6610

Email [anmffederal@anmf.org.au](mailto:anmffederal@anmf.org.au)

## Melbourne & ANMJ

Level 1, 365 Queen Street,

Melbourne Vic 3000

Phone (03) 9602 8500

Fax (03) 9602 8567

Email [anmffederal@anmf.org.au](mailto:anmffederal@anmf.org.au)



Australian  
Nursing &  
Midwifery  
Federation

COVER: EARLY ENTRY REGISTERED NURSE  
CLAIRE AZZOPARDI  
PHOTOGRAPHER: MICHELLE DUNN

## Editorial

Editor: Kathryn Anderson  
Journalist: Natalie Dragon  
Journalist: Robert Fedele  
Production Manager: Cathy Fasciale  
Level 1, 365 Queen Street,  
Melbourne Vic 3000  
Phone: (03) 9602 8500  
Fax: (03) 9602 8567  
Email: [anmj@anmf.org.au](mailto:anmj@anmf.org.au)

## Advertising

Heidi Adriaanse  
E: [heidi@anmf.org.au](mailto:heidi@anmf.org.au)  
M: 0415 032 151

## Design and production

Senior Design: Erika Budiman  
Printing: Bluestar Web  
Distribution: D&D Mailing Services

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

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

## Moving state?

### Transfer your ANMF membership

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



PEFC Certified  
This product is  
from sustainably  
managed forests and  
controlled sources  
Recognized in Australia  
through the Australian  
Forestry Standard  
[www.pefc.org.au](http://www.pefc.org.au)

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

121,358  
TOTAL READERSHIP

Based on ANMJ 2014 member survey pass on rate

Circulation: 83,122  
BCA audit, March 2018



### Federal Secretary

Annie Butler



### Assistant Federal Secretary

Lori-Anne Sharp



### Australian Capital Territory

Branch Secretary  
Matthew Daniel

Office address  
2/53 Dundas Court,  
Phillip ACT 2606  
Postal address  
PO Box 4,  
Woden ACT 2606  
Ph: (02) 6282 9455  
Fax: (02) 6282 8447  
E: [anmfact@anmfact.org.au](mailto:anmfact@anmfact.org.au)



### Northern Territory

Branch Secretary  
Yvonne Falckh

Office address  
16 Caryota Court,  
Coconut Grove NT 0810  
Postal address  
PO Box 42533,  
Casuarina NT 0811  
Ph: (08) 8920 0700  
Fax: (08) 8985 5930  
E: [info@anmfnt.org.au](mailto:info@anmfnt.org.au)



### South Australia

Branch Secretary  
Elizabeth Dabars

Office address  
191 Torrens Road,  
Ridleyton SA 5008  
Postal address  
PO Box 861  
Regency Park BC SA 5942  
Ph: (08) 8334 1900  
Fax: (08) 8334 1901  
E: [enquiry@anmfsa.org.au](mailto:enquiry@anmfsa.org.au)



### Victoria

Branch Secretary  
Lisa Fitzpatrick

Office address  
ANMF House,  
535 Elizabeth Street,  
Melbourne Vic 3000  
Postal address  
PO Box 12600  
A'Beckett Street  
Melbourne Vic 8006  
Ph: (03) 9275 9333  
Fax (03) 9275 9344  
Information hotline  
1800 133 353 (toll free)  
E: [records@anmfvic.asn.au](mailto:records@anmfvic.asn.au)



### New South Wales

Branch Secretary  
Brett Holmes

Office address  
50 O'Dea Avenue,  
Waterloo NSW 2017  
Ph: 1300 367 962  
Fax: (02) 9662 1414  
E: [gensec@nswnma.asn.au](mailto:gensec@nswnma.asn.au)



### Queensland

Branch Secretary  
Beth Mohle

Office address  
106 Victoria Street  
West End Qld 4101  
Postal address  
GPO Box 1289  
Brisbane Qld 4001  
Phone (07) 3840 1444  
Fax (07) 3844 9387  
E: [qnmu@qnmu.org.au](mailto:qnmu@qnmu.org.au)



### Tasmania

Branch Secretary  
Emily Shepherd

Office address  
182 Macquarie Street  
Hobart Tas 7000  
Ph: (03) 6223 6777  
Fax: (03) 6224 0229  
Direct information  
1800 001 241 (toll free)  
E: [enquiries@anmf tas.org.au](mailto:enquiries@anmf tas.org.au)



### Western Australia

Branch Secretary  
Mark Olson

Office address  
260 Pier Street,  
Perth WA 6000  
Postal address  
PO Box 8240  
Perth BC WA 6849  
Ph: (08) 6218 9444  
Fax: (08) 9218 9455  
1800 199 145 (toll free)  
E: [anf@anfwa.asn.au](mailto:anf@anfwa.asn.au)





06



26



18

## FEATURE

**FIRST FLIGHT: NAVIGATING THE HIGHS AND LOWS OF EARLY CAREER NURSING**



30



35

### REGULARS

**01 EDITORIAL**

**02 DIRECTORY**

**04 NEWS**

**17 WORLD**

**18 FEATURE:**  
Navigating the highs and lows  
of early career nursing

**24 LEGAL**

**26 WORKING LIFE**

**27 PROFESSIONAL**  
Just what the nurse prescribed

**28 RESEARCH**

**30 EDUCATION**  
Chest pain

**34 ISSUES**

**35 FOCUS**  
Wound / infection control

**47 CALENDAR**

**48 LORI-ANNE**  
Stillbirth – a hidden issue that deserves  
attention



## PRESCRIBING – THE TIME IS NOW



An expert advisor to the government on prescribing has called for nurses and midwives to get on board with prescribing reforms.

Professor and Head of the School of Clinical Sciences at Queensland University of Technology, pharmacist Dr Lisa Nissen (pictured) said nurses and midwives were well tasked to prescribing.

Speaking at the Professional Day of the recent NSW Nurses and Midwives' Association (NSWNMA) 73rd annual conference, Dr Nissen said nurses had a rare opportunity in the prescribing space and needed to drive it forward.

"The opportunity is right in front of you and that is rare and it is right now."

Public consultation opened last month

on proposed prescribing in partnership endorsement for registered nurses.

The Nursing and Midwifery Board of Australia (NMBA) has encouraged nurses, health professionals and the public to provide feedback through an online survey, open until 21 September.

Dr Nissen said prescribing needed to be clearly articulated in the nursing and midwifery undergraduate curriculum to ensure development and advancement of skills.

"Prescribing requires expertise development that allows for reflection and time. It requires clinical reasoning and advancing skills. Currently we are retrofitting. We are putting the ice-cream on the cone – and we don't want it to fall off. We want to be building a cornetto.

"Criticisms will be that there needs to be space in the curriculum. Who will teach it? If you want to do it, you will."

Dr Nissen has been a key expert advisor in the development of the National Prescribing Competencies Framework and the Health Professionals Prescribing Pathway.

The gatekeeper in terms of access to medicines for patients was becoming more complex, Dr Nissen said.

"We have gone from one to two people to a myriad of healthcare professionals. It's great for access but there's also fragmentation and issues around continuity of care.

"The PBS costs nearly \$11 billion a year. Medicines hurt people as well, they are not benign of risk – in 10-20% of cases there is harm. Less errors in the system mean better outcomes. We need to look at what training we have and what we bring to the table to get better outcomes for patients.

"The really important part is did it work? It should be a process of continual review."

The nurse practitioner model and different models where nurses and midwives currently prescribe was complex, Dr Nissen said.

According to Dr Nissen nine different models in the literature had been condensed. She said the four main ways to prescribe were:

- Prescribe to administer
- Work under a model such as a protocol or direction
- Work in collaboration
- Autonomously responsible or independent

The degree of autonomy increases as you go across the models, Dr Nissen said.

"RNs and midwives be aware that you do not have to be one of these models. You do not have to be the second model or the first model. It's whatever is relevant to your practice.

"People go down the model rabbit hole but if you go down the hole you will restrict how you can help patients access medicines."

There was much evidence to support different models of practice and there was a breadth of different ways to work with different groups, Dr Nissen said.

"It's the law that gets in the way of what you do. Around the law people just think about the script.

"You do not need a four-year pharmacy degree to expand your practice to build on what you can do. Step through the door. Take the opportunity."

## MIDWIVES SUPPORT WATER BIRTH OPTION



MELISSA DUDEK AND HER CHILDREN AVA AND ARCHIE.

Almost 90% of Australian midwives believe the option of water birth should be offered to all pregnant women, a University of South Australia study has revealed.

Canvassing the views of 234 midwives on water immersion during labour and birth, the study found 95% of survey respondents had flagged the option to pregnant women as an alternative to a traditional birth and that more than a third indicated "a high demand" for the practice from expectant mothers.

"There is overwhelming evidence from women who have had water births around its benefits, including reduced pain, mothers being more relaxed, and women reporting a more positive experience overall," study lead, UniSA lecturer in midwifery and nursing Dr Megan Cooper said.

However, the findings conflict with views held by most paediatricians and obstetricians who believe there is insufficient proof that water birthing is safe, according to the study.

Dr Cooper suggests the controversy surrounding water birth stems from a lack of guidelines and accredited practitioners

across the country, as well as no consensus on what additional training is required to support women who choose a water birth.

"Water births are becoming more popular in the US, Europe and UK, but Australia is yet to fully embrace the practice," Dr Cooper said.

"There is a paucity of literature examining practitioners' experience in this country, which needs to be addressed."

Melissa Dudek, a South Australian mother of two young children, has experienced both a traditional birth and a water birth and described the latter as much more comfortable.

"I had a traditional birth with my first baby, Ms Dudek said.

"After one failed epidural and then a successful one, I was stuck on the bed and forced to give birth laying on my back. I also had a severe tear that needed stitches. It wasn't a great experience by any means.

"For my second baby, Archie, I opted for a water birth. It was far more positive, relaxing, less painful and my labour progressed a lot quicker in the water. There was no need for any medical intervention or pain relief and I was able to move around and find a more comfortable position."



## PUBLIC CONSULTATION OPENS ON RN PRESCRIBING

New proposals to open up prescribing of scheduled medicines to registered nurses are now open for public consultation.

The Nursing and Midwifery Board of Australia (NMBA) has invited feedback on proposed new prescribing in partnership endorsement for RNs.

The NMBA has powers under the Health Practitioner Regulation National Law Act, in force in each state and territory, to endorse registration of a registered health practitioner in regards to scheduled medicines.

NMBA Chair Associate Professor Lynette Cusack said the NMBA had worked with the Australian and New Zealand Council of Chief Nursing and Midwifery Officers to explore



potential models of prescribing to determine a model for RN endorsement to prescribe scheduled medicines. This had included consultation with governments, key nursing stakeholders, nurses and consumers for the basis for a proposed new registration standard.

The proposed endorsement would help Australian healthcare services to meet the growing healthcare needs of the population, Ms Cusack said.

"RNs are the largest number of health professionals in the National Registration

and Accreditation Scheme. They work in all sectors of healthcare and 18% work in outer regional, remote or very remote locations.

"The proposed endorsement will give this vital profession further ability to meet the growing needs of our communities."

Nurses, health professionals and the public are encouraged to provide feedback through an online survey, open until Friday 21 September. Visit:

[nursingmidwiferyboard.gov.au/News/Current-Consultations.aspx](https://nursingmidwiferyboard.gov.au/News/Current-Consultations.aspx)

## NEW COLLECTIVE TO TACKLE AUSTRALIA'S OBESITY

A new collective has formed to combat Australia's obesity crisis.

The Obesity Collective was launched at the 2018 Obesity Australia Summit held at the University of Sydney last month.

The coalition of researchers, health professionals, government and private sector representatives, campaigners, non-profits and consumers has been formed to tackle how Australia thinks and acts on obesity.

"Two thirds of the adult population and a quarter of Australian children are classified as overweight or obese, placing us near the top of the global ranking," Obesity Australia Executive Director Professor Stephen Simpson (pictured) said.

The Collective Plan for Action aims to raise awareness; shift the focus from personal responsibility to collective responsibility; map activity and gaps across the system; highlight current evidence; create a platform for better collaboration; and support new community stakeholders to contribute.

"We intend for the Collective to become a whole-of-society movement for change. We



must transform the way society thinks, speaks and acts on obesity to reduce the impact it has on us all," Professor Simpson said.

"Solutions don't just lie with government, or with individuals. The clear message from across sectors is that the time has come to transform our response to the obesity epidemic – both its prevention and treatment."

PwC Australia for Obesity released a report in late 2015 which found the

economic impacts of obesity in Australia would reach \$87.7 billion and affect one third of Australians by 2025 without further intervention. Since then a series of roundtable discussions and facilitated workshops have been held around the country.

[obesityaustralia.org/the-obesity-collective](https://obesityaustralia.org/the-obesity-collective)  
Join the conversation  
**#obesitycollective**



## FREE TRAINING SET TO IMPROVE HOSPITAL EXPERIENCE FOR PEOPLE WITH DEMENTIA



A new training package developed by the nation's peak body representing people living with dementia is aiming to increase the understanding and empathy of hospital staff towards sufferers when they are admitted to hospital.

Developed by Dementia Australia and funded by the Department of Social Services Aged Care Service Improvement and Healthy Ageing Grants Program, the Insights into the Hospital Dementia Experience toolkit uses simulation and debriefing exercises to help hospital and Multi-Purpose Service staff deliver person-centred care by understanding what it's like to have dementia.

"This training package enables staff to put themselves into the shoes of a person living with dementia, and provides greater understanding of how the condition might impact on an individual's hospital experience," Dementia Australia's Executive Director of Client Services Susan McCarthy said.

"Through the use of simulation and debrief exercises, we aim to inspire participants

to adopt a more sensitive, informed and considered practice leading to a more positive experience for the person living with dementia, their families and carers, as well as for staff who work with them."

The training package focuses on the importance of person-centred care, understanding behavioural responses, and the impact being in hospital can have on a person living with dementia.

It was tested through pilot workshops with educators from across Local Health Districts of NSW where people living with dementia, their families and carers were invited to share their hospital experiences to ensure the final package captured the realities of a hospital or Multi-Purpose-Service stay for people with dementia.

The free training package includes a facilitator guide, participant handbook and simulation resource, and is available for download by educators from hospital or Multi-Purpose Service sites across Australia.

Download the training package: [dementia.org.au/resources/insights-into-the-hospital-dementia-experience-workshop](https://dementia.org.au/resources/insights-into-the-hospital-dementia-experience-workshop)

## PLAN TO IMPROVE UNDERSTANDING OF GRIEF AND BEREAVEMENT AMONG AGED CARE STAFF



Improving the education and understanding of grief and bereavement among residential aged care staff forms one of the key recommendations of a new joint policy statement unveiled by Palliative Care Australia (PCA) and the Australian Centre for Grief and Bereavement (ACGB) that aims to open up conversations regarding death and encourage people to make end-of-life plans.

Launched last month at ACGB's annual conference in Sydney, the policy statement promotes addressing the psychological, spiritual and cultural needs of individuals and how palliative care can offer support to help carers and families cope during the person's illness and after they pass away.

One of the main recommendations focuses on improved education and understanding of grief and bereavement

for staff working in residential aged care, including being able to identify prolonged grief disorder.

"Upskilling the aged care workforce in this area would not only assist in supporting the families and carers of the person who has died, but also foster an environment of support and resilience for other residents and staff themselves," the policy statement reads.

Other recommendations include the establishment of a National Grief Awareness Day and Australian workplaces considering the development of extended bereavement leave policies.

"With 35% of all deaths in Australia occurring in residential aged care PCA and ACGB believe there is a need to ensure awareness of grief and bereavement of all staff who work in aged care, including non-clinical, as often long-term and close relationships are formed with residents and their families," Palliative Care Australia CEO Liz Callaghan said.

Palliative and end-of-life care aims to improve the quality of life of people living

with a life-limiting illness and support families, carers and the community during the dying process and in bereavement.

Released on Dying to Know Day, which strives to raise awareness by building death literacy and improving action toward end of life planning, the policy statement states specialist services should be made available to 7% of the grieving population who experience prolonged grief disorder.

"Everyone at some point will experience the death of someone close to them," Ms Callaghan said.

"Grief is the normal emotional reaction to loss, but the course and consequences of bereavement will vary for each individual."

Statistics show 75% of people have not held end of life discussions and that 70% of Australians die in hospital even though most would prefer to die at home.

Ms Callaghan said bereavement could be emotionally intense, destabilising and exhausting and encouraged the community to take into account the impact grief and bereavement has on many Australians.



The right support and  
advice to help you

*Feel future ready*



 feel future ready

 1300 650 873

**first**  
state super





## NEW SETS OF GUIDELINES TO HELP TACKLE STROKE AND HEART FAILURE

Two distinct sets of guidelines have been unveiled to help clinicians prevent, diagnose and manage adult patients with atrial fibrillation (AF) and those who have heart failure.

Developed by the Heart Foundation and the Cardiac Society of Australia and New Zealand (CSANZ), both guidelines were launched at the 66th Annual Scientific Meeting of CSANZ in Brisbane last month.

The Australian-first guidelines covering AF focus on detecting the hidden condition, which causes a third of all strokes in Australia, in adult patients.

Atrial fibrillation is a type of abnormal heart rhythm that causes the heart not to pump blood around the body as efficiently as it should and is linked to one in 11 deaths in Australia.

Deaths from AF have increased by 82% over the past decade and the condition is projected to double over the next 20 years in people aged 55 and over.

However, incidence is underestimated because many Australians do not realise they have it.

Based on new and emerging evidence covering issues such as the complexities of using newer anticoagulants to prevent stroke and the patients in whom catheter ablation is recommended, the National Heart Foundation and Cardiac Society of Australia and New Zealand: *Australian clinical guidelines for the diagnosis and management of atrial fibrillation 2018* provide

recommendations on screening, diagnosis and treatment.

"[AF] incidence is underestimated because many patients don't have clinical symptoms. This means AF is often only discovered once it triggers serious consequences, such as stroke," the Heart Foundation's chief medical advisor, cardiologist Professor Garry Jennings, said.

An expert working group including cardiologists, electrophysiologists, nurses, GPs and a consumer developed the guidelines.

The guidelines highlight the need to prevent, detect and manage several risk factors linked to AF including hypertension, diabetes, heart failure, valvular heart disease and alcohol excess.

Statistics show AF hospitalisations are increasing more than hospitalisations for other cardiovascular conditions, with 10–30% of people with AF admitted to hospital each year.

"The strokes caused by AF are more commonly severe or fatal than other ischaemic stroke (caused by a clot) subgroups, so detecting and treating this dangerous condition is vital to a person's health," Stroke Foundation Clinical Council Chair Associate Professor Bruce Campbell said.

In a similar vein, the new heart failure guidelines will provide Australian health professionals with the latest evidence regarding prevention, diagnosis and management of adults with heart failure.

Written for practising clinicians across all disciplines, they include a new focus on managing co-morbidities and other

conditions in the treatment of heart failure patients, including those undergoing chemotherapy treatments.

About 480,000 people in Australia aged 18 and over have heart failure, a serious condition where heart muscles get damaged that contributed to one in eight deaths in 2016.

Professor Jennings said the guidelines, updated for the first time in seven years, help the prevention of heart failure through new advice on targets for type 2 diabetes medication and improvements in the criteria to diagnose heart failure.

Co-morbidities addressed in the guidelines include atrial fibrillation, hypertension, diabetes, kidney disease, obesity, gout, arthritis and depression.

"The guidelines provide new advice on the better management of people living with heart failure through new evidence on medications, implantable cardioverter defibrillators, cardiotoxicity advice, and atrial fibrillation ablation techniques," Professor Jennings said.

"There is also new advice on non-pharmacological care for heart failure patients, including telephone support, nurse-led care, exercise, and palliative care.

"By improving outcomes for heart failure patients with co-morbidities, we aim to reduce hospital re-admissions. Avoiding these crises will help patient survival and quality of life."

To access the guidelines visit [heartfoundation.org.au](http://heartfoundation.org.au)



## EXTREME TEMPERATURES IN NURSING HOMES AFFECTS DEMENTIA

Indoor temperatures in aged care homes could have a dramatic impact on the wellbeing of residents, particularly those with dementia.

A University of Wollongong (UOW) study of five aged care facilities in the Illawarra found varying indoor temperatures of 17.2 degrees to 31.6 degrees.

The World Health Organization recommends older people not be exposed to temperatures lower than 20 degrees. While the International Organization for Standardization advises maximum temperatures not above 26 degrees.

UOW researchers found a comfort band between 20 degrees and 26.2 degrees as appropriate for residents in Australian nursing homes.

More than half the residents (53%) in the study were exposed to temperatures colder than those recommended during the warm season. This indicated air conditioning systems were not being operated correctly, according to the researchers.

It was not only for comfort, but indoor temperature affected the wellbeing, health and behaviour of residents, including the frequency and disruptiveness of agitation experienced by people living with dementia, UOW lead researcher Dr Federico Tartarini said.



"Importantly, we found that there was a statistically significant increase in the frequency of agitated behaviour manifested by residents living with dementia for those who were exposed to temperatures outside the comfort band.

"Older people, and in particular those with dementia, may have decreased sensitivity to temperature changes and dementia may impair their ability to adapt to their environment."

There was very little research into how residents of nursing homes perceived their physical environment as well as a lack of guidelines for thermal conditions for the aged care sector, Dr Tartarini said.

"Until specific guidelines for thermal comfort are developed for the sector, many residential care homes may continue to offer less than optimal thermal conditions which may negatively impact the health and wellbeing of residents and staff."

**"OLDER PEOPLE, AND IN PARTICULAR THOSE WITH DEMENTIA, MAY HAVE DECREASED SENSITIVITY TO TEMPERATURE CHANGES AND DEMENTIA MAY IMPAIR THEIR ABILITY TO ADAPT TO THEIR ENVIRONMENT."**

*"Completing medical school was a tough assignment, but with OUM's unique curriculum and continued support, I graduated as a culturally, worldly, more rounded doctor."*

Dr Paris-James Pearce

## RN to MD

**Make the dream of becoming a doctor a reality, earn your MD at Oceania University of Medicine.**

- Attractive fee structure for our Graduate Entry Program.
- Over 200 students currently enrolled and over 50 graduates in Australia, New Zealand, Samoa and USA.
- Home-based Pre-Clinical Study under top international medical school scholars, using world leading Pre-Clinical, 24/7 online delivery techniques.
- Clinical Rotations can be performed locally, Interstate or Internationally.
- Receive personalised attention from your own Academic Advisor.
- OUM Graduates are eligible to sit for the AMC exam or NZREX.

Applications are now open for courses beginning in January and July - No age restrictions

**OCEANIA UNIVERSITY OF MEDICINE**

INTERNATIONALLY ACCREDITED For more information visit [www.RN2MD.org](http://www.RN2MD.org) or 1300 665 343





## PUSH FOR EDUCATION CAMPAIGN AMID OPT-OUT EXTENSION FOR MY HEALTH RECORD

Health organisations have welcomed the federal government's decision to strengthen safeguards for the new My Health Record (MHR).

However, the government's decision to extend the opt-out period by only an extra month has drawn fierce criticism as inadequate.

Under the new safeguards to protect security, legislation will require a court order to release My Health Record information without consent. This will ensure no record is released to police or government agencies without a court order.

It followed backlash after the release of the government's secondary use of data rules and concerns over patient privacy. Under the existing framework, medical information would be made available to third parties for public health and research purposes from 2020 unless individuals opted out.

National Rural Health Alliance CEO Mark Diamond said concerns had been voiced in the rural and remote health sector that online health record information could be accessed by agencies like the Tax Office and Centrelink.

"Even though the Australian Digital Health Agency says that would never happen, and importantly it never has happened, the legislation did not make that clear."

Federal Health Minister Greg Hunt said the changes would remove any ambiguity.

Shadow Minister for Health Catherine King said Labor's 2012 legislation underpinning the My Health Record was designed for an opt-in system.

"The government made the decision to shift to opt-out but was too incompetent to realise it needed to strengthen privacy and security provisions as a result."

"There has been significant and growing community concern about the My Health Record since the beginning of the opt-out period on 16 July."

As many as 20,000 Australians withdrew their consent from the scheme on the first day of the opt-out period amid a technical issue that saw many wait hours to speak with a call centre operator.

Australians who don't want a personal electronic health record had from 16 July to 15 October to opt-out of the national scheme.

That date has now been extended after Minister Hunt agreed to extend the national opt out period by an extra month, at the request of both the AMA and RACGP.

The government would also work with medical leaders on additional

communications to the public about the benefits and purpose of the My Health Record, so they can make an informed choice, Minister Hunt said.

The one-month extension would not give the government enough time to run a comprehensive public information campaign to enable all Australians to make an informed choice about whether to be a part of the My Health Record system, according to the Opposition.

Consumers Health Forum (CHF) CEO Leanne Wells welcomed the prospect of more time for consumers to consider whether to opt out.

"The first fortnight of the opt-out period has indicated there needs to be a more comprehensive and active information and education effort for consumers. The latest changes make such a public information initiative even more worthwhile."

The CHF has proposed the government distribute explanatory letters to all households providing factual details about MHR. It launched its own series of webinars on the MHR for health consumers last month.

"MHR will only succeed in reaching critical mass in terms of its reach and effectiveness if Australians, both consumers and clinicians, can trust that patient information is secure and is seen only by those authorised to see it," Ms Wells said.

Minister Hunt also pledged to update provisions around cancelling a My Health Record, so if a person chooses to cancel their summary it would be permanently deleted from the system, rather than being stored.

Over five million Australians currently have a My Health Record.

[myhealthrecord.gov.au](http://myhealthrecord.gov.au)





1. We value what you:

\$ **r e a l l y m a k e**

At Bank First, we believe what you really make goes well beyond a dollar figure. So while you're investing in others, we're here to invest in you.

Visit **bankfirst.com.au** and find out how we can do more for you.

## First Rate Home Loan

**3.64%**

Per Annum

**3.69%<sup>1</sup>**

Comparison Rate

Interest Rate effective 30 June 2018 and is subject to change. Check website for current rates. Minimum loan amount \$250,000 and maximum loan amount \$1,000,000. 1. Comparison rate calculated on a secured loan amount of \$150,000 for a term of 25 years. This comparison rate is true only for the example given and may not include all fees and charges. Different terms, fees and other loan amounts might result in a different comparison rate. Fees and charges apply. Terms and conditions available upon request. Victoria Teachers Limited ABN 44 087 651 769, Australian Credit Licence Number 240 960.



**bankfirst**  
invested in you



## NSW NURSES AND MIDWIVES RAMP UP ACTION ON UNSAFE STAFFING

The NSW Nurses and Midwives' Association (NSWNMA) has ramped up its safe staffing campaign following the state government's failure to deliver better, more transparent nurse-to-patient ratios in its last Budget.

It comes as the NSW Opposition committed to deliver a new ratios system if state Labor is elected.

NSW nurses and midwives are being urged to take action on any incidences of inadequate staffing or skill mix where patient safety is compromised.

The government had been impervious to nurses' and midwives' claim, despite delivering a surplus Budget, NSWNMA General Secretary Brett Holmes said.

"Our calls for safe staffing continue to be ignored. It's an unfortunate fact that our nurses have to fight and advocate for safe patient care. We have to do it here and now. It's not something we can put off for later."

Evidence showed there were at least 40,000 nursing hours withheld in 13 public hospitals, Mr Holmes said.

"The system we have now is broken. The ugly reality is that we cannot rely on this government nor on private corporations or aged care providers to deliver evidence based nursing and midwifery staffing and skill mix without strong and persistent campaigning. We can make it happen – the

evidence is too strong and health matters. It matters to us as individuals and it matters to the community."

The NSWNMA has sought shift-by-shift ratios based on the actual number of patients in each unit. Ratios for all adult inpatient medical/surgical wards and the introduction of ratios for the first time in paediatric, EDs, EMUs and MAUs, critical care, community, short stay, drug and alcohol and outpatient clinics. The claim includes for revised and better ratios for mental health.

NSW Health Minister Brad Hazard told nurses and midwives at the NSWNMA 73rd annual conference that there were financial implications.

"I don't want to mislead you. We have a very big system and it's a very complex system. There are 15 local health districts and it has to be managed in a sensible, balanced way."

An overwhelming majority (172) of NSWNMA public health system branches endorsed a resolution in favour of campaigning for better, more transparent ratios.

The NSWNMA released a toolkit and app on safe staffing at its conference.

The toolkit is designed to guide nurses and midwives on how to meet their duty of care in protecting patient safety under their Professional Practice Framework.

All nurses and midwives had a professional obligation to deliver safe and quality patient care, Mr Holmes said.

"We have a professional obligation to report any concerns if safety is compromised – if staffing or skill mix is inadequate – and there is risk of harm to patients."

NSWNMA Assistant General Secretary Judith Kiejda urged nurses and midwives to keep the safe staffing toolkit in their handbag.

"This toolkit shows you how to escalate your concerns about staffing and skill mix. We cannot leave it to others, we all need to be engaged. None of us can afford the luxury that someone else will do it."

NSW Opposition Leader Luke Foley guaranteed a new ratios system would be introduced under Labor on the final day of the NSWNMA conference.

"I commit a future Labor government to introducing shift-by-shift nurse to patient ratios. We will work with you to deliver nurse to patient ratios explicitly in your [Nurses] Award in 2019."

NSW Labor's commitment was a giant leap in the right direction for patient safety, Mr Holmes said. "If the current government won't fix it we have to work to change it [the government]."

**"It's currently dangerous. I work in mental health and with clientele who are extremely unpredictable and volatile. The current NHPPD doesn't address acuity, activity or volatility."**

Liz RN

**"When you are understaffed patient care does suffer. It's going home and thinking 'did I do that?' 'Did I document that?' I've phoned the hospital at 2am to check. It's the near misses that eventually become a major incident."**

Valerie RN

**"I work in mental health. Aggression is our biggest issue. We had an incident where a boy the same age as my son was pounded repeatedly by a patient. There was not enough staff on to be able to de-escalate. It was unprovoked and unseen. He was an AIN who was well-trained and worked a long time in the area. The situation was horrendous."**

Maryann RN

**"We are missing the opportunity to educate our younger nurses. Even on the ward, staff are too busy to help new grads who are thrown into the deep end."**

Bradley RN





## DEVELOPING AN ALTERNATIVE FUNDING MODEL FOR RESIDENTIAL AGED CARE

Care burden from end of life needs, frailty, functional decline and technical nursing needs drives residential aged care costs rather than medical diagnoses, initial research from a landmark study charged with reforming the current Aged Care Funding Instrument (ACFI) has found.

Speaking at last month's ANMF (SA Branch) Annual Professional Conference, lead researcher Professor Kathy Eagar, Director of the Australian Health Services Research Institute (AHSRI) at the University of Wollongong, told the conference a report conducted for the government 18 months ago showed ACFI was "beyond being repaired" and required a complete overhaul.

Professor Eagar said ACFI's extensive problems include a lack of focus on what drives care costs, not distinguishing enough between residents and their needs, and "perverse incentives" relating to care assessment.

"What it's done is create a whole ACFI industry with a whole lot of ACFI consultants. So a whole lot of skills are out there and they come into homes, they help you find out ways to get people into a higher paying class and then typically they take a 25% profit share. If you get an extra \$10 for the person they take \$2.50," Professor Eagar said.

"That wouldn't happen if there was a robust funding model. Don't blame the consultancy. Blame the system."

The Department of Health commissioned the AHSRI to undertake a Resource Utilisation and Classification Study (RUCS) to examine the characteristics of aged care residents that drive care costs and develop a new classification and funding model for the sector.

The RUCS comprises three sub-studies looking into developing a casemix system that will classify residents into groups with similar needs and care costs, identifying the costs shared across all residents, and testing the implementation of a blended funding model for aged care with shared and variable components.

The six core elements of the proposed funding model include separate assessment for funding from assessment for care planning, a one-off adjustment payment for new residents recognising additional requirements, and fixed daily payments for care share by all residents.



PROFESSOR KATHY EAGAR. PHOTO BY GREG ADAMS

In her address, Professor Eagar outlined one of the studies that involved 30 aged care homes and every resident being independently assessed by a registered nurse.

Aiming to pinpoint what drives care costs, findings suggested a medical diagnosis itself does not impact costs.

Instead, costs result from care burden due to issues such as frailty, functional decline, end of life needs and technical nursing needs.

"So it doesn't actually matter whether you've got dementia or diabetes. It's not the diagnosis that's the cost driver it's the consequences of the diagnosis," Professor Eagar explained.

Professor Eagar said key results from the studies showed on average, 50% of costs are paid as a fixed cost per day, irrespective of the individual needs of the resident.

Another study involving registered nurses with a minimum of five years' clinical experience assessing 2,100 residents found 70% of assessments were completed in less than an hour, unlike current ACFI assessors who take weeks to undertake the same task.

"That represents a significant change for the sector and the conversation we're having is to convince government that money should stay in homes for investment in quality care," Professor Eagar said.

"We all need to understand that there

is a significant level of resources currently invested in the biggest red tape exercise I have ever seen in my life."

Elsewhere, findings showed 50% of aged care residents had a fall in the last 12 months and that registered nurses identified bariatric care as a rising issue.

Discussing the proposed classification system, Professor Eagar revealed a separate class for aged care residents admitted for palliative care and with a life expectancy less than three months is being considered.

She added AHSRI's experts agreed mobility was the single biggest cost driver when it comes to aged care residents and that the proposed model would reflect this in categorising different care needs.

A fourth study has also just been funded, with researchers set to revisit 1,000 residents they assessed earlier in the year to repeat assessments and chart any changes including who's been to hospital, had a fall or experienced weight gain.

Professor Eagar said she believes there is an appetite for changing Australia's residential aged care system but stressed the "lucrative ACFI consulting industry" and other invested parties would likely put up roadblocks.

Her recommendations to government will include adequate funding to ensure any robust funding model proposed can succeed.

**"SO IT DOESN'T ACTUALLY MATTER WHETHER YOU'VE GOT DEMENTIA OR DIABETES. IT'S NOT THE DIAGNOSIS THAT'S THE COST DRIVER IT'S THE CONSEQUENCES OF THE DIAGNOSIS,"**



## NURSING MUST CAST CRITICAL EYE OVER RESEARCH EVIDENCE

The nursing profession must take a critical view of research examining its value and avoid selective reading of evidence that advances its interests, a leading UK researcher has argued.

Speaking at the ANMF (SA Branch) Annual Professional Conference last month, Professor Peter Griffiths (pictured), Chair of Health Services Research at the University of Southampton, said nursing, like many professions, could be quick to embrace advantageous research but ignore it on the flipside.

"Indeed there's no reason why you shouldn't do it provided that first and foremost you remember that ultimately there's only one legitimate purpose of professional advancement and that's to deliver better healthcare to your patients," Professor Griffiths said.

"Evidence will not always tell you what you want to hear but equipping yourself with knowledge places you in a better position to advocate for both your profession and your patients."

His keynote address, titled *Doing Away With Doctors? Workforce research and the future of nursing*, framed healthcare as an increasingly labour intensive and costly service facing ongoing changes and challenges.

Professor Griffiths, who began researching nursing in the mid-90s, outlined the UK nursing workforce's evolving presence and current fight for relevance.

Despite an expansion in nursing roles, including recent support for training to allow more nurses to become advanced practitioners, Professor Griffiths said key strategies flagged by the National Health Service (NHS) in coming years focus on implementing a more efficient skill mix by introducing more support workers including associate nurses and diminishing the role of



PHOTO BY GREG ADAMS

registered nurses.

"Far from doing away with doctors you might reasonably ask if it's actually nurses and nursing that's being done away with," he proposed.

"It seems the business of professionally qualified nurses delivering nursing care is seen on one hand too expensive and on the other hand a waste of their talent and there are more important things for them to do, although it appears that's doing the work of doctors."

Professor Griffiths stressed challenges facing the UK's nursing workforce and future changes to delivery must be supported by robust evidence showing a proven link to beneficial patient outcomes.

"The ultimate issue at hand here is about the quality of healthcare that is being delivered by people and this should be the preoccupation of workforce researchers and workforce planners."

Professor Griffiths cited several key studies examining the benefits of nursing, including research by Professor Alan Pearson where mortality improved within hospital beds controlled by nurses.

However, Professor Griffiths said his own "stronger study" researching mortality, involving a systematic review of care in nursing-led inpatient units, did not replicate the findings.

Instead, it revealed 18 days of additional hospital stay on average, small improvements

in dependency following discharge, and a dramatic increase in overall costs.

However, Professor Griffiths said more convincing research existed in other fields showing nurses could safely and effectively substitute for doctors, for example in primary care, and deliver equivalent outcomes and potentially improved satisfaction.

Yet he cautioned this did not amount to a viable argument that nurses could in fact replace doctors.

Professor Griffiths proceeded to refer to influential evidence from nursing researcher Linda Aiken, who in her project RN4CAST investigated the association between nurse staffing levels and patient safety in acute hospitals, finding significant benefits.

Specifically, the study found one additional nurse per 25 patients reduces the chance of that patient dying in hospital by 13% and for every 10% increase in the proportion of registered nurses there is an 11% reduction in mortality and improvements across all other outcomes.

"Where staffing is worse, nurses and patients report poorer quality of care. Nurses are more dissatisfied and they experience higher levels of burnout. More importantly, patients are more likely to die," Professor Griffiths said of the study.

Nevertheless, Professor Griffiths argued such findings mean little unless they are properly scrutinised and embody economic arguments needed to help shape healthcare policies.

Professor Griffiths said results from studies showing the correlation between registered nurse staffing and improvements in mortality had been used to argue for more registered nurses yet published economic models did not support the action.

His research, undertaken for England's National Institute for Health and Care Excellence exploring the costs and effects of increasing professional nurse staffing levels found no clear evidence to support a case purely in economic terms.

The research evidence also concluded there was no economic case for increasing assistant staffing or reducing skill mix because it costs money with no benefit.

In another study measuring patients' experience during their hospital stay, Professor Griffiths said results showed for every additional hour of registered nurse time, mortality dropped by 3%.

Professor Griffiths said the results mounted a case for increasing registered nurse hours and improving skill mix.

**"THE ULTIMATE ISSUE AT HAND HERE IS ABOUT THE QUALITY OF HEALTHCARE THAT IS BEING DELIVERED BY PEOPLE AND THIS SHOULD BE THE PREOCCUPATION OF WORKFORCE RESEARCHERS AND WORKFORCE PLANNERS."**



NOW AVAILABLE IN AUSTRALIA

Vaccinate with **TRUMENBA** to help protect your adolescent and young adult patients from serogroup B invasive meningococcal disease (IMD)<sup>1</sup>

Because  
they share

In Australia, serogroup B caused more than 50% of notified IMD cases in 15-24 year olds in 2016<sup>2,3</sup>

 **Trumenba**<sup>®</sup>  
Meningococcal Group B Vaccine

➤ TRUMENBA can be co-administered with<sup>1</sup>

HPV4

MenACWY

Tdap

dTap-IPV

➤ The TRUMENBA clinical trial program included more than 15,000 individuals (10 years of age and older) across 11 clinical trials<sup>1</sup>

**TRUMENBA is indicated for active immunisation of individuals 10 years and older to help prevent serogroup B IMD<sup>1</sup>**

**TRUMENBA is now available from medical wholesalers and community pharmacies.  
Call 1800 316 665 to learn more about TRUMENBA**

**PBS Information:** This product is not listed on the National Immunisation Program (NIP) or the PBS.

**Before prescribing, please review full Product Information,  
available on request from 1800 675 229 or at [www.pfizer.com.au](http://www.pfizer.com.au)**

**MINIMUM PRODUCT INFORMATION:** TRUMENBA<sup>®</sup> Meningococcal group B vaccine Suspension for IM Injection. **Indications:** Active immunisation in individuals 10 years and older to prevent invasive meningococcal disease caused by *Neisseria meningitidis* serogroup B. **Contraindications:** Hypersensitivity to the active substances or excipients. Severe allergic reaction after any previous dose of Trumenba or to any vaccine component. **Precautions:** Safety and efficacy in children below the age of 10 years of age has not been established. Ensure appropriate medical treatment and supervision is available in case of a rare anaphylactic event following vaccine administration. Do not inject intravenously, intradermally, or subcutaneously. Syncope can occur following/before any vaccination. Caution required in thrombocytopenia, coagulation disorders or individuals on anticoagulant therapy, unless the potential benefit clearly outweighs the risk of administration. Immunocompromised individuals, including those on immunosuppressant therapy, may have a diminished immune response. Trumenba may not protect all vaccine recipients. Not studied in adults older than 65 years of age. Only use during pregnancy (Category B1) and/or breast-feeding if clearly needed and advantages outweigh the potential risks. **Interactions With Other Medicines:** Can be given concomitantly with several other vaccines at separate injection sites and using separate syringes. Do not mix Trumenba with other vaccines/products. **Adverse Effects (Very Common/Common):** injection site pain, redness and swelling at the vaccination site, headache, fatigue, chills, diarrhoea, muscle pain, joint pain, nausea, vomiting, fever. Allergic reactions and syncope observed post-marketing. **Dosage and Administration:** For intramuscular use only. Schedule for routine immunisation: 2 doses (0.5 ml each) administered at 0 and 6 months. Schedule for individuals at increased risk of invasive meningococcal disease: 2 doses (0.5 ml each) administered at least 1 month apart, followed by a third dose at least 4 months after the second dose. Trumenba is not interchangeable with other meningococcal group B vaccines due to different vaccine compositions, age indications and dosing schedules. Before prescribing, please review Product Information available from Pfizer Australia Pty Ltd. ©Registered trademark V11117. Pfizer Australia Pty Ltd, West Ryde, NSW 2114. PP-TRU-AUS-0014. Date prepared: Jan 18.

**References:** 1. TRUMENBA Approved Product Information. 2. Meningococcal vaccines – frequently asked questions (FAQ). September 2017. National Centre for Immunisation Research & Surveillance (NCIRS). Accessed online (January 2018): [http://www.ncirs.edu.au/assets/provider\\_resources/fact-sheets/meningococcal-vaccines-FAQ.pdf](http://www.ncirs.edu.au/assets/provider_resources/fact-sheets/meningococcal-vaccines-FAQ.pdf) 3. Meningococcal disease surveillance Australia – public data set. Australian Government Department of Health. Accessed online (January 2018): [http://www9.health.gov.au/cda/source/pub\\_menin.cfm](http://www9.health.gov.au/cda/source/pub_menin.cfm)

**Abbreviations:** dTap-IPV, combined low-dose diphtheria, tetanus, acellular pertussis and inactivated poliomyelitis virus vaccine; HPV4, quadrivalent human papillomavirus vaccine; IMD, invasive meningococcal disease; MenACWY, meningococcal serogroups A,C,W,Y conjugate vaccine; Tdap, tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis vaccine.







## REVISED GUIDE FOR SAFELY ADMINISTERING ORAL MEDICINES

An updated version of a key guide to safely administering oral medicines to people with enteral feeding tubes or swallowing difficulties has made information easier and faster to scan in a bid to further assist the decision-making of nurses.

Released last month, the comprehensively revised third edition of The Society of Hospital Pharmacists of Australia's (SHPA) *Don't Rush to Crush* includes 50 additional entries, a clearer format aiming to enhance the focus on patient-centred care and a new small doses section.

An essential resource on hand in hospital wards, aged care facilities and pharmacies across the country, *Don't Rush to Crush 3* was developed in consultation with 650 health professionals and now includes information on 570 oral medicines plus clear monograph features making material easier and quicker to look over.

The guide is a Pharmacy Board of Australia compulsory text for all pharmacies, which stipulates current editions of certain

references, in hard copy or electronic format, must be available to pharmacists during dispensing, clinical assessment, reviewing and counselling.

"The new format monographs present a series of options for each medicine, clearly showing whether tablets can be dispersed, dissolved or crushed and the potential subsequent impacts on clinical care," Editorial Committee Chair and SHPA Board Director Dr Lisa Pont explained.

"Based on feedback and to aid paediatric care, *Don't Rush to Crush 3* also includes a new section 'What to do for doses less than a whole tablet' for selected medicines, assisting health professionals when giving very small doses, including instructions for preparing aliquots."

The Australian Nursing and Midwifery Federation (ANMF) supported the publication's latest review, which took 18 months, by sending out a survey to its members seeking input on proposed format changes and new advice on part doses.

The call out yielded more than 600 responses, predominantly from nurses.

ANMF Senior Federal Professional Officer Julianne Bryce, a member of the

Editorial Committee since the publication was launched in 2011, described *Don't Rush to Crush* as an incredibly important resource for prescribers and health professionals administering medicines across a variety of settings.

"The handbook is well used, mostly by nurses and authorised prescribers, in a range of clinical settings including hospitals, community pharmacies, rehabilitation services and residential aged care facilities," Ms Bryce said.

"Nurses are working in an environment where they need to be able to quickly access information on providing accurate medicines administration for people who have swallowing difficulties or an enteral feeding tube and *Don't Rush to Crush* enables this ability."

SHPA Chief Executive Kristin Michaels said *Don't Rush to Crush* remained a crucial frontline resource to help manage risk and ensure quality care across all healthcare settings, adding she was confident the latest version and new format would enhance the focus on patient-centred care.

*Don't Rush to Crush 3* is available via the SHPA Bookshop.

**"NURSES ARE WORKING IN AN ENVIRONMENT WHERE THEY NEED TO BE ABLE TO QUICKLY ACCESS INFORMATION ON PROVIDING ACCURATE MEDICINES ADMINISTRATION FOR PEOPLE WHO HAVE SWALLOWING DIFFICULTIES OR AN ENTERAL FEEDING TUBE AND DON'T RUSH TO CRUSH ENABLES THIS ABILITY."**





FIQ'S MR ROBERTO BOMBA AND NANCY BEDARD

## QUEBEC NURSES SHARE THEIR CAMPAIGN SUCCESS FOR PATIENT RATIOS

Canadian nurses shared their trials and success in getting ratio projects off the ground in French Quebec this year with their NSW comrades recently.

Representatives from the Quebec Nurses' Union, the Federation Interprofessionnelle de la sante du Quebec (FIQ) spoke at the recent NSW Nurses and Midwives' Association (NSWNMA) 73rd annual conference *It's Time for Safe Staffing* in Sydney. FIQ's We've Reached our Quota campaign launched in late January 2018, pushed for a law for maximum nurse to patient ratios. The campaign drew enormous community support and resulted in the Quebec Government committing to 17 ratios projects across the province.

Exhausted nurses had been forced to work mandatory overtime shifts and were too understaffed to properly care for patients, FIQ President Nancy Bedard said.

The problems had been going on for years but had become worse by austerity measures brought in by the province in 2015.

The FIQ campaign suddenly gained a groundswell of support following the actions of just one nurse, Ms Bedard said.

"It was a very cold winter, there was lots of rain and ice. The emergency departments were overcrowding with a huge flu season. A nurse, a 24-year old who had been back at work only two weeks after maternity leave left her workplace one day discouraged with her healthcare employer.

"She had done forced overtime for three shifts, including a night shift where she had to subsequently work another eight hours. She went home and put a message on social media – it went viral.

"It was the first time in the province of Quebec where nurses voiced their opinion from huge distances across the province about what was going on in the

healthcare system. Their message was heard loud and clear by the public. We were able to get media coverage on a daily basis where nurses were denouncing the unacceptable working conditions."

Ms Bedard said an irritated Health Minister Gaetan Barrette came to the table and held discussions with FIQ.

From what began as an initial step to secure three pilot ratios projects by 2020, FIQ was able to successfully negotiate 17 permanent projects to regulate workloads and improve working conditions of the healthcare professions.

"We were no longer simply evaluating whether we could have ratio pilot projects but were at the start of implementing ratios and working with the government in setting them up," Ms Bedard said.

As many as 13 ratio pilot projects in medicine, surgery and long-term care facilities are now off the ground. Four others are to be launched in the emergency department, home care, private subsidised institutions and respiratory therapy.

The ratios agreed on were negotiated based on FIQ's proposals.

Ms Bedard said FIQ had worked with their global counterparts, including the NZ Nurses' Organization (NZNO), and National Nurses United (NNU) to gain a better understanding of staffing and ratios.

"You have been an inspiration for us and we thank you. We cannot give up this fight – we are leading in Canada, in Australia, in North and South America – nurses need to stand up. The only way to improve quality care is through safe care with ratios.

"We will do everything we can to see safe staffing and ratios guaranteed by law."

## ICN RELEASES GLOBAL POLICY ON NURSE RETENTION

The International Council of Nurses (ICN) has released a policy brief on nurse retention, aimed to identify which policies are effective in retaining nurses to the profession.

The International Centre on Nurse Migration (ICNM) report identified cost, productivity, care quality and workload and working conditions as the main reasons nurses leave organisations and the profession.

The report was written by ICN Consultant and Adjunct Professor of WHO Collaborating Centre at the University of Technology, Sydney, James Buchan.

"We have a global shortage of nurses. Too often the policy focus on 'solving' nursing shortages is only on recruiting new staff. All organisations must also pay as much attention to improving the retention of scarce, skilled and experienced nursing staff," Professor Buchan said.

The report focuses on developing a framework for policy interventions aimed at improving nurse retention, to inform National Nursing Associations and policy makers.

"Evidence clearly shows that when nurses are enabled and supported to do the job they were trained to, they are less likely to leave the profession. We must provide them with the motivation that led them to join the profession in the first place – that is delivering the best quality care they can for patients," ICN Director of Nursing and Policy Howard Catton said.

This included ensuring supportive/positive working conditions and environments including fair pay, career development, family friendly policies, and work/life balance.

## AUSTRALIA WINS INTERNATIONAL AWARD FOR ETHICS

Australia has won a prestigious international award for developing a framework for ethical practices in health care.

Australia was presented with the 2018 APEC (Asia-Pacific Economic Cooperation) Business Ethics Lighthouse Award last month.

The framework is a model for ethical collaboration across all parts of the health system: patients; clinicians; professional colleges; hospitals and health services; Commonwealth and state and territory governments; and medical technology and biopharmaceutical companies.

A total of 50 signatory bodies signed the consensus framework. Signatories to the Australian Consensus Framework for Ethical Collaboration are committed to delivering the best outcomes for patients.

The consensus framework is available at: [ahha.asn.au/australian-consensus-framework-ethical-collaboration-healthcare-sector](http://ahha.asn.au/australian-consensus-framework-ethical-collaboration-healthcare-sector)



# NAVIGATING **THE HIGHS AND LOWS** OF EARLY CAREER NURSING





There is no 'one-size-fits-all' approach when it comes to graduate nurse programs. So what is the best way to ensure early career nurses negotiate their graduate year with confidence?

**Jessica Gadd** reports it's by implementing a well-designed graduate program and offering a supportive environment.

There is no preparing for your first experience of the death of a patient, says graduate nurse Claire Azzopardi. The 23-year-old had been aware of one or two patient deaths during her student placements, but in hindsight, she realised her preceptors had sheltered her from the full experience.

As an early career nurse in a medical ward with several palliative patients, she found the experience to be different – raw and painful.

When speaking about it, there is a crackle of emotion in her voice.

"It's really hard to push your emotions aside, to hold them back while you help the person that needs helping," Claire says. "At the same time, I don't want to become desensitised to these sorts of situations. I want to be a nurse who can still feel compassion for the patient and their families. I'd hate to get to the stage where I think 'Oh, there goes another one, that's the third this week', or anything like that."

Overall, Claire rates learning to manage the emotional fallout that comes with the death or rapid deterioration of a patient in her care as one of the hardest adjustments to nursing.

Other challenges she has faced include adjusting to the rigours of shift work and the resulting impact that it has on her body clock and life outside work. She has also had to build up her knowledge bank such as learning the vast amount of conditions and medications.

Yet she says these challenges are part and parcel of doing the job she loves – nursing, and there's no question of ever doing another job. "It's hard, but it's great. I love it. I'm very happy to be learning so much."

UniSA's Head of Nursing and Midwifery, Adjunct Professor Carol Grech, says there is a culture in nursing that encourages people to keep their emotions bottled up and to pretend that they are stoic and unaffected by stress.

"But witnessing trauma in the workplace does affect people emotionally, and in different ways," Professor Grech says. "That's why it's so important to have positive role models and opportunities to debrief about those encounters and situations."

Claire is grateful for the supportive culture in her workplace at West Gippsland Healthcare Group. She speaks about multiple debriefing systems including frequent graduate meetings with all of the graduate



UNISA'S HEAD OF NURSING AND MIDWIFERY, ADJUNCT PROFESSOR CAROL GRECH

## CLAIRE RATES LEARNING TO MANAGE THE EMOTIONAL FALLOUT THAT COMES WITH THE DEATH OR RAPID DETERIORATION OF A PATIENT IN HER CARE AS ONE OF THE HARDEST ADJUSTMENTS TO NURSING

nurses and the graduate coordinator. There are also adhoc, informal debriefs organised by senior nurses following highly-stressful or out-of-the-ordinary incidents, and casual conversations with colleagues who provide feedback, both positive and constructive.

"It's these things that make the difference between me going home and being able to switch off, and going home and stewing about something all night," Claire says.

### Helping early career nurses get off to a great start

Claire says she found the two part-time clinical educators on the medical ward invaluable. "As well as checking on us each day, they had an office on the ward, so if I was really drowning I would go in and ask them to help for a moment, or I could page them to come and join me at the bedside. They were always happy to help."

One of the clinical educators, Kerry Sibson, says controlling some elements such as how any given personality copes with stressors, and fits in with the ward culture, can mean extreme differences between the experiences of one early career nurse to the next.

"Some graduates simply fly through, others need a lot more support," she says. "It's so variable because it could come down to a single experience with a patient or colleague that goes on to affect their whole

experience during that rotation, and maybe even their whole grad year."

Ms Sibson says what can be controlled is how well these experiences are managed after they have occurred. She says the support level a graduate receives is vital – it can mean the difference between the graduate going on to have a happy and successful career or leaving the profession altogether.

"We have a good system in place here and I think we're pretty quick to notice when a graduate is struggling," she says. "Then we're proactive at working with the graduate to do things like set objectives, shift plan, manage stress, and build on their critical thinking skills"

Ms Sibson says critical thinking skills can be difficult for graduates to develop, as they are hard to teach in a traditional academic environment.

"For example, on a busy shift, some graduates might get panicked and focus on ticking the boxes of routine care, like general hygiene, rather than engaging critical thinking and prioritising care."

To counter this, Ms Sibson checks in with graduates at the beginning of the shift and, where necessary, helps them use a shift planner to map out their day.

Being positioned in the ward means she can jump in and offer hands-on support to the graduate nurses as required, and an





EARLY ENTRY REGISTERED NURSE CLAIRE AZZOPARDI  
WITH EDUCATOR KERRY SIBSON  
AT WEST GIPPSLAND HEALTHCARE GROUP

open-door policy means graduates can seek out her advice during a shift.

However, she states every ward is different, and that some of the challenges of delivering a good graduate program is managing the skill mix. This includes ensuring there are enough skilled nurses to support graduates on any given shift, and aligning rosters so that preceptors or supernumerary staff are on at the same time as graduates.

In 2019 West Gippsland Hospital will move from four rotations during the graduate year, to three.

Ms Sibson says this is in line with the 2017 review of the Nursing and Midwifery Graduate Transition to Practice, and part of a wider move for fewer rotations in recent years, with many hospitals now only

running one 12-month or two six-month graduate placements on one or two wards, respectively.

At nearly 350 graduates, Royal Brisbane and Women's Hospital and Metro North Hospital and Health Service boasts one of Australia's largest graduate nursing programs.

Executive Director of Nursing and Midwifery, Adjunct Professor Alanna Geary, explains that the Royal Brisbane and Women's Hospital's graduate program features a 12-14 week 'care to transition' supernumerary program into the ward or unit of the graduate's choice, and then a six-month stint as a graduate nurse in that unit or ward.

"We decided that once staff felt confident in an area, there was no reason why they could not be considered for other opportunities or positions in the organisation

– but that it was often beneficial to consolidate learning and stay in one area," Professor Geary says.

Professor Geary explains that the length of the transition to care period varies from ward to ward, and is also dependent on individual graduate needs.

"We all learn at different rates, and we all learn in different ways. So I think it's really important that we don't say to somebody 'you only have two weeks of preceptor time' – they might need six weeks. That doesn't mean they're not any good, it just means that they need a little bit longer to consolidate what they've learnt.

"We also have great educator support, so all of our educators are cognisant of a graduate who might be struggling either emotionally or just with the workload. We





## ... EVERY WARD IS DIFFERENT, AND SOME OF THE CHALLENGES OF DELIVERING A GOOD GRADUATE PROGRAM IS MANAGING THE SKILL MIX.

Ms Reeves says. "That's why a structured graduate program that provides support and opportunities to debrief is so critical."

Danni, currently in her graduate year at Sir Charles Gairdner Hospital in Perth, was an early career nurse who found she needed a lot of support to begin with.

Danni had delayed applying for a graduate program due to life circumstances, including a marriage breakdown and caring for her young son, initially working part-time as a general practice nurse instead.

"Working part-time in general practice was really good for having a three-year-old and coming to terms with being newly separated. But I really missed working in a hospital and I applied for the graduate program. I was still eligible, having not had a year's experience yet and luckily I got it."

But when Danni commenced the graduate program, she realised that the gap between finishing university, and the reduced use of clinical skills in her job as a general practice nurse, had put her on the back foot.

"Also, some of the staff were not very receptive to having questions asked of them, they would say 'I don't have time', and could be quite patronising," Danni says. "That, combined with my personal circumstances as a single mum, and the fact that I was taking a medication called Champix to try and quit smoking, meant I was under a fair bit of personal stress at the beginning of the graduate program. It all hit me at once! I remember thinking: 'Oh my God – I can't do any of this, what am I going to do with my life?' I thought I would lose my position."

Danni credits the heroic efforts of the two staff development nurses who worked on her ward for getting her through her rocky start to nursing.

"They were my biggest help, they really were amazing," Danni says. "They pretty much carried me through those first couple of months, because I was so overwhelmed and stressed out. They gave me extra, supervised shifts for a couple of months, and set goals and objectives that I had to achieve, which really helped me to get my skills up to scratch. So the hospital was definitely supportive – and now, despite the difficult start, I feel confident, capable, and good at my job."

### 'Work-ready' early career nurses for 'grad-ready' workplaces

Professor Grech says that the need for practical experience and opportunities for students to develop critical thinking led to the development of a clinician-led simulation hospital on campus at UniSA.

"It's a safe environment, where students have an opportunity to practise their skills in an authentic setting, and where we can assess students' clinical skills, communication, and decision-making abilities. We also model a very high standard of care, because professional behaviour and practice are not always evident in practical placements due to the complexities and cultures of real-world workplaces."

Professor Grech says that the simulation model has worked well, with far less graduates experiencing difficulties on placements, and industry providing positive feedback. But Professor Grech says that while the aim is to create work-ready graduates, she points out that workplaces also need to be 'graduate-ready'.

"We have to be mindful that hospitals in particular are under enormous stressors, facing the pressure of constrained budgets and therefore often reduced staffing," Professor Grech says.

"There's increasing casualisation and use of agency staff, which affects continuity and knowledge transfer. There are patients with complex needs, and bed pressure to get patients out as quickly as possible."

"All of these things contribute to an environment, in some sectors, which isn't particularly graduate-ready. And unfortunately some of these workplaces are looking to graduates to perform at a high level that is unrealistic, without necessarily having great mentorship or role modelling around them."

The ideal graduate program, Professor Grech says, puts in place a framework where graduates are strongly mentored, where they have the ability to debrief, where they can learn at their own pace, rather than a 'one-size-fits-all' approach.

This is consistent with the graduate program best practice principles outlined in the National Early Career Nurse and Midwife Roundtable *Early Career Nurse Facts and Myths Information Sheet*.

would put in mechanisms, and improvement plans, and some learning KPIs to actually help them. So there's lots of support offered."

### Why good support for early entry nurses is so vital

Professional Officer at the ANMF Federal Office Julie Reeves, and a member of the ANMF – convened National Early Career Nurse and Midwife Roundtable, underscores just how vital support is to the ongoing success of a graduate's career. She points out that the annual attrition rate for early career nurses can be quite high, with reasons for leaving the profession ranging from struggling with shift work, to life circumstances.

"One issue often cited by some nurses leaving the profession is a lack of support,"



THE IDEAL GRADUATE PROGRAM, PROFESSOR GRECH SAYS, PUTS IN PLACE A FRAMEWORK WHERE GRADUATES ARE STRONGLY MENTORED, WHERE THEY HAVE THE ABILITY TO DEBRIEF, WHERE THEY CAN LEARN AT THEIR OWN PACE, RATHER THAN A 'ONE-SIZE-FITS-ALL' APPROACH.

---



EARLY ENTRY REGISTERED NURSE CLAIRE AZZOPARDI  
WITH EDUCATOR KERRY SIBSON  
AT WEST GIPPSLAND HEALTHCARE GROUP



"These are evidence-based suggestions that make up the recommended building blocks for a successful transition to the workplace," Ms Reeves says. "They include things like providing a supportive environment, an appropriate skill mix, a good preceptor or supernumerary, and an environment where graduates are welcomed, appreciated and valued for what they're bringing to the organisation."

The Graduate Nurse and Midwife Roundtable Group was initially formed in 2014 to address a serious disconnect between the amount of nursing graduates, and the amount of graduate placements available. The result of a maelstrom of conditions, including the uncapping of university placements and a lack of funding for graduate programs, these circumstances effectively snuffed the potential careers of hundreds of future nurses. This was quite staggering given that at the time there was a predicted shortfall of more than 100,000 nurses by 2025.

"Are we ever going to get the workforce predictions right? I don't know," Professor Grech says. "But I would hope as we continue to get more sophisticated in the data we are collecting, the better we will get. I think the pendulum is likely to swing back and that it will get either to a place of balance, or perhaps a slight shortfall." Professor Geary says that Royal Brisbane and Women's Hospital employs graduates at 0.8 and occasionally 0.7, rather than full-time, because it allows them to offer more positions to more graduates. It's also

considered a strategy for assisting the graduate's transition from study to shift work, and to avoid graduate burnout.

### Early career nurse pathways

Although most early career nurses are keen to cut their teeth in acute facilities, there is an emerging trend for graduates to undertake programs in non-traditional settings.

"It's becoming more common for graduates to go into facilities other than hospitals as part of their graduate program," Ms Reeves says. "For example, a graduate might do part of their graduate year in an acute facility, and the other part in primary health, such as a general practice. This gives early career nurses a chance to expand into growth areas that we know are significantly increasing."

"Aged care, for example, is quite complex because of the frailty factors and because there are significant comorbidities. If you're working in acute care you're often working with older people anyway. So there's a lot of conversation about how aged care is a good skill for developing your assessment and time management skills. Unfortunately it's viewed by some as unglamorous, when the reality is that acuity in aged care facilities is on the rise."

UniSA's Professor Grech believes that in the future nurses will increasingly work across sectors, from hospital to home. "We know that as more people are living longer, with complex needs and chronic conditions, we need to look at nursing roles that are not essentially based within acute services."

So we're working closely with a number of graduate programs in areas like residential aged care, primary healthcare services, correctional services and mental health."

Professor Geary says that the advantage of Royal Brisbane and Women's Hospital being a part of Australia's largest healthcare service, Metro North Health Service, which employs 7,500 nurses and midwives across a number of facilities, is that graduates can pursue many different career pathways without needing to change employers, which can be beneficial for career development.

"In Metro North Hospital and Health Service we employ graduates in all settings – sub acute, aged care, acute care, community settings," Professor Geary says.

"It's interesting, because at the time of their application graduates think that they want to work in the big tertiary hospitals, but once they have an opportunity in other services we've noticed they actually love the smaller hospitals and the community service models. So we're very blessed in that we have a diverse hospital and healthcare system. It means we can offer our graduates just about any experience they want."

Gaining experience is what the graduate year is all about. Claire Azzopardi advises other graduates starting out to try to do as much as they possibly can. "I used to shy away from doing the things I perceived as difficult, but now I've learned that it's better to practice while no one expects too much of you, and help is still on hand."

## ANMF RESPONSE TO THE ANMAC REGISTERED NURSE ACCREDITATION STANDARDS REVIEW FROM ANMF'S SUBMISSION

The Australian Nursing and Midwifery Accreditation Council (ANMAC) is currently reviewing the Registered Nurse Accreditation Standards (2012). The ANMF response to the draft standards, the *Review of Registered Nurse Accreditation Standards Consultation Paper 2* (July 2018), expresses concern that, at a broad level, the draft standards do not adequately address the core elements of nursing practice: assessment, planning, implementation and evaluation.

The ANMF review calls for an adoption of service agreements between health services that charge education providers for providing clinical education support, a contract that clearly states the model of clinical support being provided, the ratio of students to clinical educator, the minimum qualifications of the educator, and a clear process for conflict resolution and/or escalating concerns.

The ANMF recommends improvements to the clinical learning environment requirements to ensure quality professional learning experiences in entry-to-practice nursing programs, such as: ensuring appropriate sequencing of theory to practice, including consistency of venue; provision of appropriate clinical support from an experienced registered nurse; and ensuring an appropriate skill mix and level of experienced staff to assist students on placement.

The ANMF supports maintaining the current level of professional learning hours for the Bachelor of Nursing at 800 hours. The ANMF supports the notion that simulation remains



exclusive of the minimum practice hours, holding a firm position that while simulation can prepare students for real experiences, it cannot replace clinical care. However the ANMF believes the proposed definition for the new RN Accreditation Standards needs updating to better reflect this view.

With regard to prescribing for graduates on an entry-to-practice program, the ANMF considers that the proposed accreditation standards capture the learning outcomes required to enable graduates to competently supply and administer medicines via the development of a profession agreed protocol.





Linda Starr

## IN THE NEWS... PROSECUTION OF FAKE PRACTITIONERS

The Health Practitioner Regulation National Law governs the regulation of health professionals in every state and territory in Australia and protects the public through ensuring that only properly qualified and educated practitioners can use protected titles of the 14 regulated professions including nurse, midwife, doctor, psychologist and dentist.

There are provisions within the legislation that allow AHPRA to take legal action against anyone using a protected title or holding themselves out to be a registered practitioner if they are not entitled to. The maximum penalty per charge in relation to this conduct is \$30,000 for an individual and \$60,000 for a body corporate.

Fake practitioners put the public at risk and a recent list of successful prosecutions against those holding themselves out to be registered health professionals highlights the value of the national register that enables the public to check and ensure they are consulting with a registered health practitioner. The following are just a few of the cases decided in the courts recently.

In June 2018 a Victorian court fined Mr Lipohar \$65,000 plus \$25,000 in costs after he pleaded guilty on three charges – claiming to be a dental specialist and performing restricted acts on two patients unlawfully including, attempting to fit corrective or restorative dental appliances. Lipohar had never held registration as a health practitioner or student under the National Law, had little knowledge of the procedures and lacked the necessary skills to perform the treatments ([dentalboard.gov.au/News/2018-06-13-fake-orthodontist-convicted.aspx](http://dentalboard.gov.au/News/2018-06-13-fake-orthodontist-convicted.aspx)).

Two further people were prosecuted for claiming to be psychologists.

The first in February 2018, where Mr Carozza pleaded guilty to five charges of holding out to be a registered psychologist and unlawfully using the title of psychologist when representing himself as a clinical psychologist, to a range of organisations and on institutions websites as well as LinkedIn. He was fined \$10,000 plus \$14,325 in costs ([ahpra.gov.au/News/2018-02-08-Victorian-man-fined.aspx](http://ahpra.gov.au/News/2018-02-08-Victorian-man-fined.aspx)). And then, on 9 May 2018, a New South Wales man was convicted of claiming to be a psychologist when he knowingly or recklessly used the title 'Specialist Child, Adolescent and Family Psychologist' in emails that indicated he was either authorised or qualified to practise as a psychologist. He was fined \$9,500 plus \$5,000 in costs ([ahpra.gov.au/News/2018-06-](http://ahpra.gov.au/News/2018-06-21-counsellor-convicted-to-be-psychologist.aspx)

### 21-counsellor-convicted-to-be-psychologist.aspx).

In April 2018 Mr Di Paolo was sentenced in a Victorian court to nine years and six months jail with a non-parole period of six years and six months after being found guilty of five charges of knowingly and recklessly using terms that indicated he was a health practitioner and a specialist health practitioner.

In this case Di Paolo used the titles obstetrician and gynaecologist as well as the initials MD in relation to himself (when he was a homeopath), during a number of consultations with patients. Di Paolo has never completed a medical degree or any other equivalent qualification. Charges were brought by the DDP in Victoria and AHPRA leading to both the custodial sentence, his name being placed on the sex offender registrar for life and a fine of \$5,000 plus costs ([ahpra.gov.au/News/2018-07-06-successful-prosecution-of-fake-doctor-a-signal-for-others.aspx](http://ahpra.gov.au/News/2018-07-06-successful-prosecution-of-fake-doctor-a-signal-for-others.aspx)).

In another case the Adelaide Magistrates court convicted and sentenced Marek Jantos of holding himself out to be a registered psychologist and unlawfully using a specialist title claiming to be a specialist in the field of pain medicine in August 2018. His company 'Behavioural Medicine Institute of Australia' was also fined \$16,000 for misleading and deceptive advertising of a regulated health service.

In this case, Jantos had his registration as a psychologist cancelled in 2007 'in order to protect the public from similar behaviour' following an investigation into conduct that included invasive physical therapy in the context of psychological treatment. However, in 2014 it was discovered that Jantos had signage at his business premises and was using terminology that would lead patients to believe that he was a medical specialist.

He also had advertising material that indicated he was qualified as a specialist medical practitioner in the field of pain medicine and a website that described him as 'one of Australia's pioneering clinicians in the therapeutic management of female


sexual pain disorders' ([ahpra.gov.au/News/2018-08-09-AHPRA-and-National-Boards-prosecute.aspx](http://ahpra.gov.au/News/2018-08-09-AHPRA-and-National-Boards-prosecute.aspx)).

In the last case a Victorian court in June 2017 found a person (who was not named as no conviction was recorded) guilty of using the title 'midwife' in circumstances where it was reasonable to believe that she was authorised to practice as a midwife, however, she was no longer registered as such.

Whilst the previous cases indicate holding out conduct over a period of time, in this case it was once on a single day when the person referred herself to another midwife, Advance Life Support Paramedics, and a Mobile Intensive Care Ambulance paramedic as a midwife when they were providing emergency care to a woman and her newborn child following a problematic home birth.

The court viewed such a claim as serious given the weight the emergency staff would have placed on the information she was providing regarding the clinical management of the woman and her baby in those circumstances. In this case the court imposed a two year good behaviour bond and ordered the person to pay AHPRA's legal costs of \$17,000 (approx.) ([nursingmidwiferyboard.gov.au/News/2017-07-24-former-midwife-found-guilty.aspx](http://nursingmidwiferyboard.gov.au/News/2017-07-24-former-midwife-found-guilty.aspx)).

It is clear that in each of these cases there is the potential for adverse outcomes to the patient in the form of physical, psychological and financial harm. When patients visit their treating health practitioners they are entitled to expect that the person meets the regulatory standards established by that profession. In these cases, patients become victims where the breach of trust central to the therapeutic relationship can have a lasting impact on their future care and engagement with the health professions.

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





TAKE OUT A NOVATED LEASE  
WITH US FOR YOUR  
CHANCE TO **WIN!**\*

**PLUS** WEEKLY PRIZES OF 5 X \$100 BP FUEL CARDS



## Mazda CX-5 Touring

Auto 2.5i AWD

**\$465\*** PER FORTNIGHT

INC. \$206 OF RUNNING COSTS

### Prices include:

✓ Finance ✓ Running costs

#### Hyundai i30 Active 2.0i Auto



**\$326\*** PER FORTNIGHT  
INC. \$198 OF RUNNING COSTS

#### Mazda CX-3 Maxx FWD Auto



**\$340\*** PER FORTNIGHT  
INC. \$182 OF RUNNING COSTS

#### Hyundai Tucson Active X 2.0i FWD Auto



**\$403\*** PER FORTNIGHT  
INC. \$216 OF RUNNING COSTS

#### Subaru Outback Premium 2.5i Auto AWD



**\$505\*** PER FORTNIGHT  
INC. \$218 OF RUNNING COSTS

#### Kia Sorento GT-Line 2.2DT AWD Auto



**\$600\*** PER FORTNIGHT  
INC. \$213 OF RUNNING COSTS

Looking for  
a different  
car?



Request a quote on a car you love  
to see how much you could save!

Find out how much you could save with a novated car lease.  
1300 176 168 | [nurseleasing.com.au](http://nurseleasing.com.au)

\*Based on the following assumptions: living in NSW 2560, salary: \$85,000 gross p.a., travelling 15,000 kms p.a., lease term: 60 months, using the Employee Contribution Method for FBT purposes. All figures quoted include budgets for finance, fuel, servicing, tyres, maintenance and re-registration over the period of the lease. Also includes Vero by Suncorp comprehensive motor insurance, 2 year extended warranty (except for all Mitsubishi, Honda, Hyundai, Kia and Skoda models) and Hydro Platinum Pack (incl Driver Safety Kit & Window Tint), as part of the offer. Vehicle residual, as set by Australian Taxation Office, payable at the end of lease term. Vehicle pricing is correct as of May 2018, and may be subject to change based on availability. \*Terms & Conditions apply, for full details visit [smartleasing.com.au](http://smartleasing.com.au). Promotion period is 02.07.18 at 00:01am – 28.09.18 at 11:59pm. Joint promoters are: Smartsalary Pty Ltd (Smartleasing is a registered trademark of Smartsalary), AccessPay Pty Ltd, Salary Packaging Solutions Pty Ltd, Salary Solutions Australia Pty Ltd, Selectus Pty Ltd and Autopia Management Pty Ltd. The prize pool is shared among the six named joint promoters. This means, for example, that an eligible entrant who is a customer of Salary Solutions will be competing for one (1) Grand Prize adventure holiday with all other eligible entrants, who may be customers of any other of the joint promoters. The shared prize pool consists of (a) one adventure holiday (choice of an African Safari and an Alaskan Cruise) and (b) sixty-five \$100 BP Fuel Cards. Permit numbers: ACT TP 18/01142, NSW LTPS/18/25096, SA. Licence No: T18/1047.



# A SUCCESSFUL TRANSITION FROM THE CITY TO A QUIET LIFE ON THE FARM

By Tash Hawkins

When I embarked on my journey to become a nurse in 2001, I never in a million years thought I would be where I ended up today.



I was your typical city chick, always with a made up face, in a beautiful dress and always in high heels.

Today, I sit here exhausted after being up late helping my husband pull a calf from one of our heifers. I've long ago ditched the heels for flats or work boots.

For those of you that don't know me, my name is Tash Hawkins and I am now a country girl!

Growing up in Brisbane I became very accustomed to the bright lights, endless choices for dining, shopping and of course the socialisation and the nightlife. So naturally, when I finished high school in 2000, it didn't even cross my mind to venture away from my beloved BrisVegas! So I lived at home with my parents, worked part time as a Woolworths front

end supervisor and put myself through university.

Upon finishing my Bachelor of Nursing at Griffith University, I undertook my new graduate program at Greenslopes Private Hospital.

I still recall my first day, petrified, unprepared and quite literally shaking in my boots. So many thoughts raced through my head that morning, but the one that I remember quite clearly was "Damn, I wish I was more attentive on clinical placement!"

I still tell people that it was that first year of nursing practice that I regard as being the hardest year of my life.

I somehow survived the year and found my feet, and very quickly found myself over the next five years working up the ranks and becoming a CNS, acting NUM, and finally

the new graduate coordinator.

I felt like I had found my calling. I purchased a house in Brisbane, and everything was right with the world.

Until one day I was at the Doomben races when I was quite literally swept off my feet by a country larrikin wearing moleskins, RM Williams, and a gorgeous smile. Well that was it, six months later I am hugging my mum and friends goodbye, resigning from my 'perfect' job in the big city and moving to the beautiful Manning Valley with my future husband. It was quite a sight I'm sure. Back then I drove a black Holden Astra convertible and in the back, along with boxes, packed in tightly was my pet Turtle 'Peanut' and my two pug dogs 'Pugsley' and 'Lulu'. I honestly don't think my husband Riley knew what he had signed up for.

I commenced work at the local rural referral hospital, and was very quickly given a crash course in what was expected of rural/regional nurses.

My first shift, we were short staffed and out the window went my supernumerary time. I recall being asked by a doctor to set up for a chest drain, however I worked on a diabetic/endocrine/renal ward at Greenslopes and had not in my life set up or assisted with a chest drain.

I soon learned that in order to thrive and survive I had to become a jack of all trades, and cope with the unexpected.

In 2009, I then commenced work for the University of Newcastle Department of Rural Health.

My role with this organisation is to 'Gain, Train and Retain' nurses in rural/regional areas. Part of this role involves supporting students who come on placement within our very large footprint, and also providing education and training to staff to try to improve the quality and quantity of clinical placements.

Having been in this job now for the past nine years, I truly appreciate the intricacies of rural practice.

I appreciate the relationships and the friendships formed when working in smaller hospitals and communities. I appreciate the immense pressure that rural nurses are placed under and day after day their resilience and vast knowledge base continues to amaze me.

I feel truly lucky to have been accepted into this community and being given the opportunity in my current role to share my love for the beautiful Manning Valley, and its nurses.

So much for my perfect job in the big city. I can honestly now say I have it all.

I have the balance between work and life.

I leave work and head home to our amazing little patch of (not so green) paradise, with my husband, two kids, two pugs, one cat, six chickens, eight pigs, and 27 cows and as of today 24 calves.

Let's just say I would have struggled to fit that tribe into my little backyard in BrisVegas!

**Tash Hawkins is a Nurse Academic, PhD Candidate in the Faculty of Health and Medicine at the University of Newcastle.**





Julianne Bryce



Elizabeth Foley



Julie Reeves

### ANMF Federal Professional Officers



### References

Crisp, N 2018, 'Nursing and Health Policy Perspectives', *International Review*, pp. 145-147.

Fong, J, Buckley, T, Cashin, A & Pont, L 2017, 'Nurse practitioner prescribing in Australia: A comprehensive literature review', *Australian Critical Care*, Sep 30(5), pp. 252-259.

Nursing and Midwifery Board of Australia 2018, 'Public consultation paper: Proposed Registration standard: Endorsement for scheduled medicines for registered nurses prescribing in partnership', NMBA Viewed 3 August 2018, [nursingmidwiferyboard.gov.au](http://nursingmidwiferyboard.gov.au).

NPS MedicineWise 2012, 'Competencies required to prescribe medicines: putting quality use of medicines in to practice', Viewed 6 August 2018, [nps.org.au/scrivito/prescribing-competencies-framework-ab0cc7f2a28cc4a1](http://nps.org.au/scrivito/prescribing-competencies-framework-ab0cc7f2a28cc4a1)

# JUST WHAT THE NURSE PRESCRIBED

The International Council of Nurses and the World Health Organization have joined forces in a global campaign called *Nursing Now*.

With the Duchess of Cambridge as Patron, this campaign aims to improve health and healthcare globally by raising the status and profile of nursing, demonstrating how much more nurses can achieve if they're enabled to maximise their contribution to achieving universal health coverage (Crisp 2018, p.146).

In an article about this campaign in the *International Review* journal, Lord Nigel Crisp (Campaign Co-Chair), recalls the introduction of nurse prescribing in England, in 2003 and says:

*This change ... greatly improved access to medicines for patients ... research now suggests that enabling nurses to prescribe has also increased patient satisfaction. At the time the change was radical and quite controversial, but, 15 years on, it is now quite unexceptional and just normal good practice (Crisp 2018 p.145).*

In addition to the United Kingdom, legislated prescribing models for registered nurses have been in place for some years now in several other countries, for example, the United States, Canada, the Netherlands and Sweden.

Meanwhile in Australia, the profession celebrated, when at the start of this millennium, nurse practitioners were given prescribing rights (Fong et al. 2017). Research on prescribing in Australia to date, has shown that nurse practitioners prescribe safely, and at times have de-prescribed in the interests of quality use of medicines for the people for whom they provide care. Fong et al's. (2017) literature review on nurse practitioners identified barriers to prescribing, attitudes to nurse practitioner prescribing, types of medicines prescribed and prescribing practice behaviours.

With prescribing for nurse practitioners getting a toe in the door for nurses in Australia, discussions began with other health practitioners keen to prescribe. More formalised multidisciplinary discussions led in

2012 to development by the NPS MedicineWise of *A Prescribing Competencies Framework* (NPS MedicineWise 2012) – which describes competencies required of all health professionals for safe and appropriate prescribing.

Hot on the heels came approval from the Health Ministers, in 2013, for a *Health Professional Prescribing Pathway*. Commonly called the HPPP, this identified three models for prescribing: autonomous prescribing, prescribing under supervision, and prescribing via a structured prescribing arrangement.

While nurse practitioners undertake autonomous prescribing, the practise of the majority of registered nurses in Australia has been held at the 'structured prescribing arrangement' level through nurse-initiated medicines, standing orders and protocols.

The stage is being set though for nurses in this country to move beyond this level of prescribing, so that, like their international colleagues, they'll be able to provide more comprehensive healthcare.

Recently, the Nursing and Midwifery Board of Australia (NMBA) and the Australian and New Zealand Council of Chief Nursing and Midwifery Officers initiated exploration of potential prescribing models to establish a model by which registered nurses could be endorsed to prescribe scheduled medicines (NMBA 2018).

A symposium held last year gave the opportunity for frank and fearless discussion on potential prescribing models for nurses and midwives in this country. During the consultation period to follow, the ANMF determined a national position on prescribing, outlined in our statement: Registered Nurse and Midwife Prescribing, available at [anmf.org.au/pages/anmf-policies](http://anmf.org.au/pages/anmf-policies). Not surprisingly, the ANMF position declares support for reforms which enable all nurses and midwives to work to their full scope of practice.

Prescribing reforms will inevitably require amendments to drugs

and poisons legislation in some states and territories, and the PBS nationally.

Currently, the NMBA is conducting a public consultation on a proposed Registration standard: *Endorsement for scheduled medicines for registered nurses prescribing in partnership*, with feedback due by 21 September 2018. To complete the NMBA's survey for this consultation, members are encouraged to go to: [ahpra.au1.qualtrics.com/jfe/form/SV\\_bBf3Vxc1LzSV5mh](http://ahpra.au1.qualtrics.com/jfe/form/SV_bBf3Vxc1LzSV5mh). The ANMF will be reiterating our position that the three models of prescribing should be:

- **autonomous prescribing** (existing): nurse practitioners and midwives with scheduled medicines endorsement
- **prescribing in partnership** (proposed): registered nurses complete postgraduate units in prescribing and at least two years full time equivalent post registration clinical experience; prescribe within their scope of practice in partnership with a health practitioner authorised to prescribe independently such as a nurse practitioner or medical practitioner.
- **prescribing via a structured prescribing arrangement** (existing): registered nurses and midwives prescribe medicines under nurse/midwife-initiated medicines, standing orders and protocols.

The ANMF continues to argue for registered nurses with an existing endorsement for scheduled medicines (rural and isolated practice) to have their endorsement recognised for the life of their registration. These nurses have completed approved programs to enable them to supply medicines under protocol in their rural or isolated area of practice.

This essential prescribing reform will particularly advantage people who are geographically or economically marginalised from mainstream health services.





## UNLOCKING 'NON-MEMORIES' KEY TO PTSD TREATMENT

The potential unrecognised effect of 'non-memories' may compound the plight of people experiencing Post-Traumatic Stress Disorder and hinder beneficial treatment programs, new research has found.

Non-memories include imagined future events related to the trauma and exaggerated versions of the trauma itself, with Flinders University researchers of the

belief tackling the hidden problem could unlock to the key to improving outcomes for PTSD sufferers.

Participants in the study who experienced a traumatic life event described spontaneously occurring traumatic thoughts – both memories and detailed thoughts or images about the trauma that did not occur, called non-memories.

"The complexity of thoughts affecting people suffering from Post-Traumatic Stress Disorder may be compounded by non-memories that potentially strengthen people's beliefs that a feared outcome is likely to occur and contribute to a sense that 'worse is to come'," explained research lead author Dr Jacinta Oulton.

"As a result, the symptoms of PTSD may intensify and be less likely to subside over time."

Published in the journal *Psychology of Consciousness: Theory, Research, and Practice*, the research findings – PTSD and the role of Spontaneous Elaborative "non-memories" suggest current theories of PTSD fail to account for the impact of elaborative non-memories.

"We hope our results will encourage further research into the relationship between PTSD symptoms and non-memories among clinical populations, and using experimental paradigms," Dr Oulton said.

## RESEARCHERS TACKLE HOSPITAL WASTE

Researchers are on the brink of a breakthrough that would convert hospital waste into a product suitable for agriculture or water treatment.

A study undertaken by researchers from Charles Sturt University, James Cook University and The University of Queensland, involving working with a Queensland hospital, has been focusing on pinpointing a new way of treating hospital waste.

Study lead, Charles Sturt University Institute of Land Water and Society's Professor of Rural Health, Linda Shields, said hospitals generate a huge amount of waste and the issue needed addressing.

"The project is working on a new way to treat waste, using a method of breaking it down to produce a safe, char-like material which could be used for agriculture or water treatment."

Professor Shields, who has previously worked as

an operating theatre nurse, said medical waste included significant volumes of plastics and textiles that could be used just once.

As part of the study, Associate Professor Michael Oelgemoller, a chemist at James Cook University in Townsville, is investigating sustainable waste treatment and conversion methods.

"Hospital waste represents an interesting resource and may be converted into low-to-medium value products such as fertilisers and absorbents," he said.

## PEOPLE WITH DIABETES CAN BENEFIT FROM 5:2 DIET

People with type 2 diabetes are as likely to lose weight and control their blood glucose levels if they follow a 5:2 diet than a daily calorie restricted diet, according to a world-first study by University of South Australia researchers.

The study was published in the *Journal of the American Medical Association (JAMA)*, with lead author UniSA PhD student Sharayah Carter arguing intermittent fasting could be a solution for people with diabetes who find it difficult to stick to a diet seven days a week.

The findings are based on a year-long clinical trial of 137 people with type 2 diabetes, half who followed a 5:2 diet and the rest on an ongoing restricted diet, consuming between 1,200 and 1,500 calories per day.

The study found fasting on two non-consecutive days, consuming between 500-600 calories, and then eating normally for five other days each week, results in weight loss and

improved blood glucose control.

However, while fasting is safe for people with diet-controlled type 2 diabetes, for those using insulin and other oral medication likely to cause hypoglycaemia, blood glucose levels must be monitored and medication doses changed accordingly.

Study co-supervisor, UniSA Professor of Nutrition Peter Clifton, said healthcare costs relating to diabetes cost Australia \$14.6 billion per year and presented an ongoing challenge.

"Conventional weight-loss diets with daily energy restrictions are difficult for people to adhere to so we must look for alternative solutions."



# THE BEGINNING OF A NEW ERA



## The ANMJ is changing.

As from October 2018 The ANMJ will move from a monthly to a quarterly publication. Many of your favourite sections will remain along with some exciting new additions. You can still get the ANMJ in hardcopy either as part of your membership in some states\* or by subscription.

The ANMJ is also available free via the ANMJ website in either PDF or ISSUU format. While on the website don't forget to check out the array of other stories specifically written for nurses and midwives.

\* Victoria, South Australia, Tasmania, Northern Territory and ACT are entitled to receive the hardcopy of the ANMJ as part of their ANMF membership. If you are a member in either of those states or territories and do not receive a copy of the ANMJ but wish to, contact your local Branch who will arrange it for you. Likewise, contact your Branch if you wish to cancel your subscription.

All other members and interested parties can subscribe by emailing: [cathy@anmf.org.au](mailto:cathy@anmf.org.au)



@ANMJAUSTRALIA



ANMJ.ORG.AU



# CHEST PAIN ASSESSMENT AND MANAGEMENT

The following excerpt is from the ANMF's Cardiac 1: Chest Pain Assessment and Management Tutorial on the CPE website.

Cardiovascular disease (CVD) is a major cause of death in Australia: CVD kills one Australian every 12 minutes. Cardiovascular disease is one of Australia's largest health problems. Despite improvements over the last few decades, it remains one of the biggest burdens on our economy (Heart foundation of Australia 2018).

In 2010, cardiovascular disease accounted for 25.8% of the burden of disease in Australia based on years of life lost (YLL) – or premature death.

The burden of disease attributable to CVD was slightly higher for women compared to men (26.5% vs. 25.3%). Based on YLL, the burden attributable to CVD in Australia is second only behind cancer (33.7%) (Heart foundation of Australia 2018).

Heart attack, also known as 'acute myocardial infarction (AMI)' is a life threatening event that occurs when a blood vessel supplying the heart itself is suddenly blocked completely, threatening to damage the heart muscle and its functions.

Heart attack claimed 8,443 lives in 2015, or on average, 23 each day. From 2006 to 2015, the number of heart attack deaths fell by 27% from 11,519 to 8,443 (Australian Bureau of Statistics, 2016).

Heart attacks were the main cause for over 54,000 hospitalisations in 2012/13. The number of hospital separations due to heart attack has increased by 15% from 2003/04 to 2012/13 (AIHW 2014).

## Prevalence – morbidity risks

- Men aged 45 years with two or more risk factors had a 49.5% chance of having a cardiovascular event by age 80. Men with no risk factors only had a 1.4% chance of having a cardiovascular event by age 80.
- Women aged 45 years old with two or more risk factors had a 30.7% chance of having a major cardiovascular event by age 80.
- Women with no risk factors only had a 4.1% chance of having a major cardiovascular event by age 80 (Lloyd-Jones et al. 2019).

## Risk factors

Risk factors include high blood pressure, high cholesterol, overweight and obesity, physical inactivity, low fruit and vegetable intake, alcohol and smoking.

Nine in 10 adult Australians have at least one risk factor for CVD and one in four (25%) have three or more risk factors (Heart foundation of Australia 2018).

In 2014/15, six million adult Australians (34%) aged 18 years and over had high blood pressure (systolic or diastolic blood pressure is equal to or greater than 140/90 mmHg or taking medication). In 2011/12, one third of adult Australians aged 18 years and over had measured high cholesterol. This represents 5.6 million adult Australians (Heart foundation of Australia 2018).

- Smoking is the single most important cause of ill health and death in Australia. In 2011/12, one in seven Australians aged 15 years and over smoked daily.
- In 2014/15, close to two in every three (63%) adult Australians aged 18 years and over were overweight or obese, with 27.5% obese and 36% overweight.

In 2014/15, more than two in every three (66%) of adult Australians aged over 15 did very little or no exercise at all (Heart foundation of Australia 2018).

## Chest pain

Chest pain can be caused by a number of physiological factors including:

- **Cardiac** – ischaemia; myocardial infarction (MI); tachyarrhythmia; and pericarditis
- **Respiratory** – pneumonia; pulmonary emboli; pleurisy
- **GIT** – acute pancreatitis; cholecystitis; peptic ulcer; reflux
- **Musculoskeletal** – muscle cramps; rib fractures
- **Psychological** – panic attacks

## Angina

Angina is chest discomfort or pain caused by the heart muscle not getting sufficient blood

flow/oxygen. Often caused by a narrowing of the arteries that carry blood to the heart muscle. Dynamic obstruction of coronary arteries (spasm).

Myocardial oxygen supply/demand imbalance:

↓ **supply:** hypotension/ anaemia/ hypoxia  
↑ **demand:** fever/ tachycardia/ hypertension

## Angina: typical symptoms

- Chest discomfort or pain – pressure, squeezing, centre of the chest
- Pain or discomfort may radiate to one or both arms, back, neck, jaw or stomach
- Shortness of breath/dyspnoea
- Cold, clammy skin and peripheries
- Nausea/vomiting
- Light-headedness







### **What is coronary artery disease (CAD)?**

The most common cause of cardiac related chest pain is coronary artery disease (CAD), which is associated with a build up of fatty plaque in the inner lining of coronary arteries.

Chest pain occurs when a coronary artery becomes occluded by a clot or thrombus which forms on the top of ruptured fatty plaque within the artery.

This causes an obstruction of blood flow to part of the myocardium – leading to an imbalance between supply and demand of myocardial oxygen.

### **Cardiac chest pain**

Patients with cardiac sounding chest pain must have rapid access to appropriate care. This

requires robust recognition of the problem, early ECG and assessment by a health professional trained to assess clinical risk.

The first clinical contact between the patient and the ED is usually at nurse triage. It is essential that cardiac sounding chest pain is identified at this stage, and accorded an appropriately high (very urgent) clinical priority. This will ensure that an appropriate early pathway of care is followed.

Once this group of patients have been identified subsequent management should be presentation sensitive – very urgent cardiac pain patients should be placed in an appropriate area and ECG recording should be automatic (Herren and Mackway-Jones 2017).

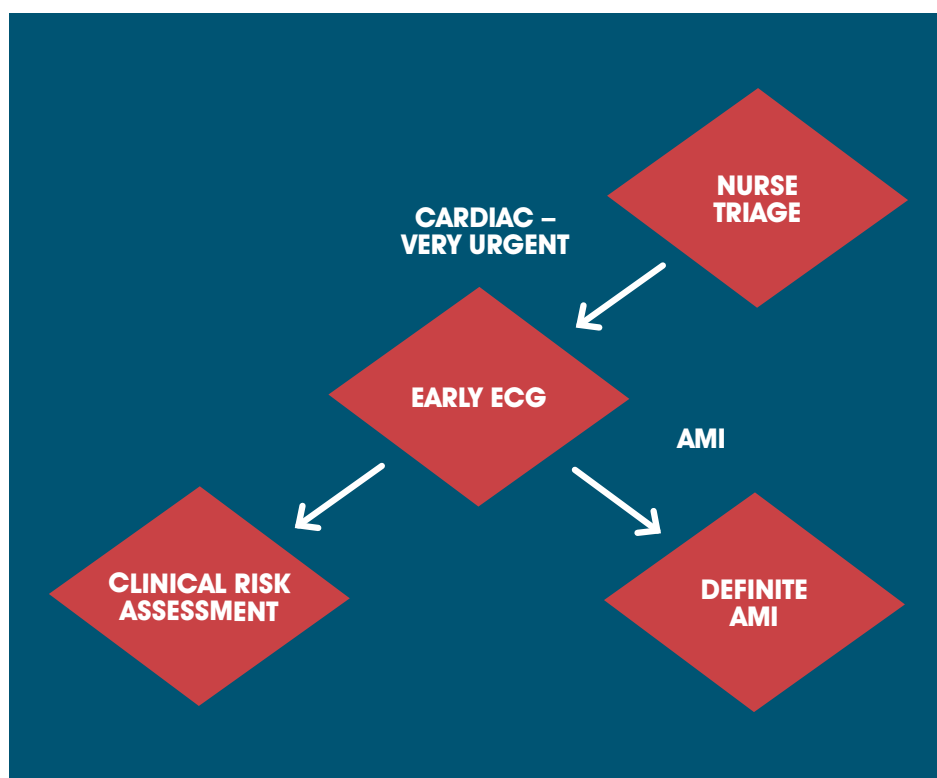
The initial ECG is performed and should be recorded as soon as possible – and

certainly within 10 minutes.

The ECG is an excellent tool for ruling in or out myocardial infarction as it is highly specific (77 -100%) depending on the criteria used. However, the sensitivity of ECG is poor (28- 54%) in the first 12 hours, and the presence of a normal ECG neither excludes AMI nor provides sufficient assurance to discharge the patient from the ED. At this stage, therefore, the ECG is a tool to identify patients for consideration of fibrinolytic drugs (Herren and Mackway-Jones, 2017).

Acute MI patients with ECG changes should be recognised straight away and should be treated appropriately. The patients who remain will range from those with unstable angina to those with musculoskeletal pain.





While the particular diagnosis in individual patients may take some time to establish, the risks of either myocardial infarction or of later complications can be rapidly assessed by considering the ECG, by taking a focused history and by carrying out a brief examination. This will allow appropriate decisions about further care to be made (Herren and Mackway-Jones, 2017).

The ECG findings are considered first – ischaemic changes not known to be old predict both a high risk of myocardial infarction and also a high risk of complications.

Secondly, any findings of either hypotension (systolic blood pressure less than 120 mmHg) or significant heart failure (crepitations not just including the bases) are noted. Blood tests are performed for measurement of cardiac troponins.

If more than two clinical risk factors are present then the patient is at high risk.

If only one risk factor is present or there are none at all, then the history should be reconsidered to see whether moderate risks of myocardial infarction are present (Herren and Mackway-Jones, 2017).

If the ECG is normal then clinical risk factors are sought. Firstly, any history consistent with unstable ischaemic heart disease is obtained. In common with all patients with possible cardiac chest pain they should receive aspirin and appropriate analgesia. The management of the patients will depend on the outcome of the initial screen. Some patients will have an ECG positive diagnosis of myocardial infarction and will need immediate intervention. Others will be at high risk and will need admission for both treatment and further diagnosis. Those at moderate and low risk will need myocardial infarction ruled out, and appropriate follow up arranged (Herren and Mackway-Jones, 2017).

## In summary

The diagnosis of cardiac related chest pain requires:

- patient history, including risk factors;
- 12 lead electrocardiography (ECG); and
- cardiac serum markers.

## PATIENT ASSESSMENT

### Clinical history and physical examination

This should include:

- combined thorough assessment of chest pain and dyspnoea;
- check of blood pressure and heart rate to exclude precipitating cause such as tachycardia;
- questioning re use of Nitroglycerin or Aspirin; and
- Check for signs of peripheral vasoconstriction – pale, cold, clammy extremities and skin.

### Chest pain assessment

Use the “PQRST” approach to chest pain assessment:

- P** **precipitating cause** – provoked by exertion; meals; changes in position; anxiety or stress.
- Q** **quality** – sharp; dull.
- R** **region** – substernal; epigastric; radiation to arm, neck, jaw, back.
- S** **severity** – mild; moderate; severe (pain score); intermittent; continuous.
- T** **timing** – new; chronic; similar to previous pain experienced; onset in relation to possible causes above.

## Dyspnoea assessment

**Dyspnoea** – the patient’s subjective awareness of having to work harder to breathe.

**Orthopnoea** – the patient’s awareness of breathing difficulty when lying flat which is relieved by sitting or standing.

## Past medical history

Pertinent past medical history, medications and cardiac risk factors will provide valuable information on the patient’s cardiac status, and whether they are at higher risk of suffering a myocardial infarction (MI).

## Medical history

- Coronary artery disease (CAD)
- Congestive heart failure (CHF)
- Valvular disease
- Previous cardiac surgery
- Previous Angina/MI
- Vascular disease
- Hypertension
- Diabetes

## Medications

Some medications may precipitate or aggravate the onset of symptoms.

Use letters in the word “SHOPS” to identify medications:

- S** street drugs especially stimulants
- H** herbal remedies
- O** over-the-counter medications (eg. NSAIDs)
- P** prescription medications
- S** sexual enhancement drugs (eg. Viagra)

## Atypical presentation

Women who have myocardial infarction may present with fatigue and shortness of breath – with minimal or absent chest pain.

Diabetics and older adults may also present with atypical symptoms- including denial of pain.

Take special care to assess these groups more thoroughly to avoid missing a possible diagnosis of cardiac related pain.

Patients with established risk factors who present with chest pain are at a higher risk of having a MI. Risk factors are either non-modifiable or modifiable risk factors.

NON-MODIFIABLE	MODIFIABLE
Age	Smoking
Gender	Hyperlipidaemia
Family history	Hypertension
Ethnicity	Diabetes
Post menopause	Diet
	Alcohol
	Physical activity
	Overweight/obese





#### References:

AIHW 2014. Australian hospital statistics 2012–13. Health services series no. 54. Cat. no. HSE 145. Canberra: AIHW

Heart Foundation of Australia website sourced March 2017 Australian Bureau of Statistics. Causes of death 2015 (3303.0). September 2016.

Herren K R, Mackway-Jones K, 2017 Emergency Management of Cardiac Chest Pain. *BMJ Journals*: Accessed online March 2017

Lloyd-Jones DM et al. Lifetime risk of developing coronary heart disease. *The Lancet* 1999 353: 89-92.

## NON-MODIFIABLE

### Age

The risk for heart disease increases with age. Men after 45 years of age and women after 55 or after menopause are known to be at higher risk.

### Gender

Men are deemed to have a higher risk than women because of the protective effects of oestrogen. However, post menopausal women are at increased risk and – during the last decade – there is a rise in CAD prevalence in younger women who have low oestrogen levels.

### Family history

Family history is considered to be significant when a first degree blood relative (mother, father, brother or sister) experiences heart disease before the age of 55 years (males) and 65 years (females). This is considered as having a 'positive family history'.

## MODIFIABLE

The recognition that the risk of developing CAD/ACS and myocardial infarction can be reduced by interventions directed at modifiable risk factors has led to an emphasis on primary healthcare and education.

Nurses and midwives can play a significant role in educating the patient about the importance of healthy eating, cessation of smoking and an active lifestyle to help in reducing modifiable risk factors.

## Risk reduction

The National Heart Foundation of Australia has developed Guidelines for reducing modifiable risks in heart disease.

Treatment goals are as follows:

### BP:

Adults < 65 years < 130/85 mmHg

### Lipid parameter

LDL cholesterol	< 2.0 mmol/L
Total cholesterol	< 4.0 mmol/L
HDL cholesterol	> 1.0 mmol/L
Triglycerides	< 2.0 mmol/L

### Target level

## Physical activity

Every adult should aim to accumulate 30 minutes or more of moderate physical activity (eg. brisk walking) on all or most days of the week to gain a health benefit (Heart foundation of Australia 2018).

## Diet

Consume a varied diet rich in vegetables, fruits, wholegrain cereals, lean meat, poultry, fish, eggs, nuts and seeds, legumes and beans, and low-fat dairy products. Limit foods containing saturated and trans fats. Limit salt to <6g/day (approx. 2,300mg sodium) (Heart foundation of Australia 2018).

## Alcohol

Limit alcohol intake to ≤2 standard drinks per day.

## Smoking

Stop smoking using counselling and, if required, nicotine replacement therapy or other medication.

## Weight

Limit energy intake to maintain a healthy weight (Heart foundation of Australia 2018).



## 30 MINUTES CPD

Reading this excerpt gives you 30 minutes of CPD.

To read the complete tutorial and gain five CPD hours towards your annual CPD registration requirements, please go to the ANMF CPE website via:

[anmf.cliniciansmatrix.com](http://anmf.cliniciansmatrix.com)

For further information contact the Federal Education Team at: [education@anmf.org.au](mailto:education@anmf.org.au)





**Dr Muhammad  
Aziz Rahman**



**References  
on request**

**Dr Muhammad  
Aziz Rahman is  
a Public Health  
Physician and  
Senior Lecturer  
at the Austin  
Clinical School of  
Nursing, La Trobe  
University.**

## SMOKING CESSATION: DO NURSES HAVE ANY ROLE?

Australia is an exemplary for tobacco control activities to many developed countries. Due to the sustained efforts of tobacco control activists and strong political commitment, there was a steady decline of smoking rates in Australia over the last 20 years (Australian government Department of Health 2018)

The most recent achievement was the landmark victory against the tobacco companies in the trade case on Tobacco Plain Packaging on 28th June 2018.

The World Trade Organization (WTO) issued a long-awaited ruling that Australia's pioneering law requiring plain packaging for tobacco products did not violate international trade and intellectual property agreements (ABC 2018).

The latest data arising from the 2016 National Drug Strategy Household Survey showed that smoking prevalence amongst 18+ years was 13%; 15% among males and 11% among females (Greenhalgh et al. 2017).

However, smoking prevalence is still quite high amongst the people living in remote and regional settings (20.9%), people from low socioeconomic status (21.4%) and Indigenous population (40.6%) in Australia (National Cancer Control Indicators, 2017).

Offering help to quit tobacco use is a cost-effective intervention for tobacco control, although such strategy is less effective than interventions focusing on price or image or exposure (Rahman et al. 2015).

Evidence suggests that three-quarters of smokers want to quit smoking, but need several cessation attempts for successful quitting. Although nicotine replacement therapy (NRT) including Varenicline improves likelihood of quitting, those are not appealing to smokers.

Behavioural counselling combined with medications are evidenced to improve success rate of quitting (Rahman et al. 2015).

Nurses working in primary healthcare, hospital or other settings can contribute significantly for providing support to smokers for their quit attempts. A Cochrane review concluded that nursing interventions had an increased chance of quitting when compared to usual care (Rice et al. 2013).

Evidence suggests that even a brief intervention of less than three minutes undertaken by any health professional including nurses is effective. They can educate and motivate smokers to quit, assess dependency to nicotine and provide

assistance to quit. The guideline for Australian general practice suggests using of evidence-based framework for smoking cessation, which is known as 5A's approach: Ask, Assess, Advise, Assist and Arrange. Asking the simple question whether the patient smokes or not, assessing for nicotine dependence, advising to quit in a non-confrontational way, assisting the smokers with intervention such as medicine or referral to Quitline, and finally arranging follow up to monitor their status of quitting (Australian government Department of Health 2012) However, there is a gap in identifying the smokers correctly or advising quitting (Australian government Department of Health, 2008).

Practice Nurses (PNs) in the general practice settings can play a vital role and work closely with the interested General Physicians (GPs). Evidence suggests that smokers attending for four or more counselling visits with PNs are more likely to quit smoking. PNs can have brief training to build their capacity and they can use a simple counselling checklist for each patient visit. Smoking cessation resources can also be made available to the patients and such roles were appreciated by both PNs and GPs in previous research (Zwar et al. 2013).

Hospitalisation or disease diagnosis has been referred to as a teachable moment (TM) for smoking cessation in many studies. The term TM has been used to describe naturally occurring life transitions or health events thought to motivate individuals to spontaneously adopt risk-reducing behaviours (McBride et al. 2003). The barriers to quitting relate to optimistic bias (ie. the denial of one's own vulnerability), failure to associate symptoms with smoking behaviour, nicotine dependence, exposure to smoking cues, craving, withdrawal symptoms and lack of smoking cessation aids (Zhou et al. 2009). Nurses, being the primary care giver and more frequent contacts for the admitted patients, can play a significant role in assisting the smokers to quit during the period of TM.

Nurses usually have positive attitudes towards supporting smoking cessation and are highly motivated, however, they may

be hindered in the delivery of best practice by lack of time or appropriate skills (Berndt et al. 2013).

Evidence suggests that quite often nurses have negative perceptions of smokers, lack confidence regarding knowledge and delivery of smoking cessation care and uncertainty regarding whose role it is to provide cessation advice (Malone et al. 2013).

Many hospitals provide NRTs free of costs for the hospital inpatients; however, anecdotal evidence suggests that nurses are not aware of such resources. Therefore, information about such service availability does not necessarily reach patients. On the other hand, smoking behaviour of the health professionals influence the smoking cessation support provided to patients.

Evidence suggests that nurses, who are smokers, are less motivated to offer quit support and possess less positive attitudes for the values of smoking cessation. They are also less likely to be trained on smoking cessation and less keen to participate in future training programs (Slater et al. 2006).

However, health services should emphasise support to the health professionals for quitting and nurses should receive brief training on smoking cessation as part of induction to their workplaces.

In terms of smoking cessation and new tobacco products, nurses also need to be aware of the new tobacco product, which is electronic cigarettes or e-cigarettes. These are battery powered devices which vaporise liquid solution so that the smokers can inhale the vapours and have the similar sensation of smoking cigarettes (Rahman et al. 2014). There is overwhelming scientific agreement that e-cigarettes are much less harmful than smoking.

In summary, nurses besides other health professionals should consider their role in smoking cessation as a duty of care for their patients. Smoking cessation is the best option they can offer to the patients for averting the preventable causes of deaths and disability. Healthcare authorities should provide adequate training support to strengthen their capacities for offering smoking cessation to patients.





WHAT IF PATHOGENS WERE BRIGHT GREEN?

## USING EXPERIENTIAL LEARNING TO RATIONALISE THE ORDER OF REMOVING PERSONAL PROTECTION EQUIPMENT (PPE)

By Evan Plowman,  
Krishna Lambert and  
Deborah Magee

**If pathogens were bright green, would you remove your personal protection equipment (PPE) in the same way?**

This was the question that we posed to students in the first week of their undergraduate nursing degree.

Compliance in hand hygiene and infection control practices among healthcare workers is often inadequate (Ross et al. 2011).

Knowledge and skill in applying appropriate infection control practices has also been reported to be inadequate in nursing students (Ward 2011). The correct order of the removal of PPE is gloves, eye protection, gown, mask followed by hand hygiene (Siegel et al. 2007). Poor practice in the doffing (removal) of PPE has been linked to increased risk of pathogen transmission, to healthcare workers (Fischer et al. 2015). The order in which PPE is removed and the care the clinician takes when touching the outer parts of all PPE elements, are critical in reducing this risk.

We introduced a novel approach to teaching undergraduate nurses the correct order of removing transmission based precautions.

Kolb (1984) describes the multi-linear dimensions of experiential learning including concrete

experience, abstract conceptualisation, reflective observation and active experimentation.

Reflective of Kolb's (1984) experiential learning methods, students applied full PPE before the academic smeared green paint on the students' gloves and gown, to simulate pathogens that nurses are exposed to in clinical settings.

This visual representation of an otherwise invisible threat, allowed students to collaborate to find the correct order to remove the PPE without exposing themselves to the pathogen (paint).

This lesson was conducted across several different student groups and as a result students were able to identify the correct order and practice of removal of PPE with minimal or no input from the academic.

Prior to the 'green paint' simulation activity, students completed online and face to face theoretical components of transmission based precautions. Combining these modes of delivery supports all learning styles and ensures the process is understood and practised by all learners.

The cost of materials required for the activity was minimal and the risk to the safety of students and the academic was negligible (eg. non-toxic paint used and student agreed to safe behaviour prior to entering the simulation space). Academic and student feedback indicated that this approach to learning was enjoyable. The 'light bulb' or 'A-ha' moment was commonly experienced

in each session as students were able to link theory with practice, and grasp a concept that had previously remained abstract. Students referred to this activity in the next session of study when discussing more advanced aseptic procedures, demonstrating effective scaffolding of skill development.

This learning activity has potential use, across the vocational education sector, the university environment and clinical healthcare settings. More broadly, the use of experiential learning to support the development of any clinical skill should be considered.

Research is needed to determine if this approach could have an impact on the long term compliance of clinicians in proper technique of removing PPE.

**Evan Plowman is a Lecturer in Nursing in the School of Nursing, Midwifery and Indigenous Health, Faculty of Science at Charles Sturt University**

**Krishna Lambert is a PhD candidate and a Lecturer in Nursing in the School of Nursing, Midwifery and Indigenous Health, Faculty of Science at Charles Sturt University**

**Deborah Magee is a Scholarly Teaching Fellow in the School of Nursing, Midwifery and Indigenous Health, Faculty of Science at Charles Sturt University**



### References

- Fischer, W. A., 2ND, Weber, D. & Wohl, D. A. 2015. Personal Protective Equipment: Protecting healthcare Providers in an Ebola Outbreak. *Clinical Therapeutics*, 37, 2402-2410.
- Kolb, D. A. 1984. Experiential learning : experience as the source of learning and development, Englewood Cliffs, N.J., Prentice-Hall.
- Ross, B., Marine, M., Chou, M., Cohen, B., Chaudhry, R., Larson, E., Landers, T. & Behta, M. 2011. Measuring compliance with transmission-based isolation precautions: comparison of paper-based and electronic data collection. *American Journal of Infection Control*, 39, 839-843.
- Siegel, J., D., Rhinehart, E., Jackson, M., Chiarello, L. & The Healthcare Infection Control Practices Advisory Committee 2007. Guideline for Isolation Precautions: Preventing transmission of infectious agents in healthcare settings.
- Ward, D. J. 2011. The role of education in the prevention and control of infection: a review of the literature. *Nurse Education Today*, 31, 9-17.



# NURSES URGED TO SEEK WOUND CARE TRAINING TO DEAL WITH 'HIDDEN AFFLICTION'

The peak body aiming to advance wound care management in Australia is urging nurses to seek evidence-based training to deal with a 'hidden affliction' of chronic wound cases.

For Wound Awareness Week, Wounds Australia encouraged people to begin a conversation with their health professional about problematic wounds.

The same applies to nurses, who are being asked to help their patients understand wound warning signs, if they are at risk, and what action they should take when they have a chronic wound.

Chronic wounds are common, with about half a million people suffering from a chronic wound, costing the health system \$3 billion annually.

People over 65 are more susceptible to chronic wounds and warning signs include pain, fluid, smell, and a wound that takes over 30 days to heal.

Although they can be healed,

chronic wounds often go untreated, sometimes for years, because many people do not access the medical treatment required.

Nurses are a major focus of this year's awareness drive and are being called on to build their expertise in wound management by accessing continuing professional development opportunities available from Wounds Australia.

Wounds Australia CEO Anne Buck said nurses were best positioned to tackle the serious health issue and safeguard the nation's ageing population.

"Nurses are well placed to identify and educate patients at risk of chronic wounds," Ms Buck said.

"It is important that they are able to deliver best practice wound care



to their patients."

Ms Buck urged nurses to build their wound care skills with evidence-based education.

"One of the key barriers we've seen for all healthcare professionals – from GPs and nurses to Indigenous health workers and pharmacists – is a lack of ongoing wound care education. With continual development of their skills, patients will receive the best care, and they will reduce the impact that chronic wounds are having on the population."

For more information visit [woundaware.com.au](http://woundaware.com.au)

# UNDERGRADUATE NURSING STUDENTS' KNOWLEDGE AND ATTITUDES TOWARDS PRESSURE INJURY PREVENTION

By Carey Mather, Andrea Miller and Annette Saunders

Pressure injuries remain a major issue for patients in healthcare environments and continue to be considered as an indicator of quality of care.

Pressure injuries have the potential to cause significant harm to patients. Improved patient outcomes in terms of reduced rates, hospital days, morbidity and financial outputs have been directly related to healthcare workers' level of knowledge and positive attitudes toward pressure injury prevention (Severens et al. 2002).

As part of an Australian cross-sectional study, Tasmanian Bachelor of Nursing students' attitude and knowledge of pressure injury prevention were investigated. The findings were examined to enable progression of an evidence-based curriculum to support prevention of pressure injury.

A sample of undergraduate students were invited to participate

in this ethics approved study. Under supervision, 472 students completed a previously validated questionnaire (Attitude Toward Pressure Ulcer Prevention Instrument and Knowledge Assessment Instrument).

Findings indicated that while Tasmanian students have positive attitudes towards pressure injury prevention, their knowledge was poor (mean score=55.4%). However, these scores were marginally higher than those reported by researchers using the same tool both in Australia and internationally (Simonetti et al. 2015; Usher et al. 2018).

In an effort to improve undergraduate students' knowledge of pressure injury prevention, in 2017 an online learning and teaching

intervention was included into the first year nursing content. The 'Stop the Pressure' online learning tool (NHS Midlands and East n.d) was chosen because when introduced in eastern England, a 50% reduction in the incidence of new pressure injuries was reported.

The survey was repeated and comparison with previous scores will evaluate the effectiveness of this intervention and provide direction for further development of pressure injury prevention learning content within the curriculum.

The study will be undertaken again in 2018 to evaluate a classroom intervention using an image-based visual tool to consolidate the information available in the online package. A retrospective analysis of the data will allow for evaluation of the education provided to undergraduate nursing students about pressure injury prevention with the aim of improving patient outcomes in clinical practice.

**Carey Mather, Andrea Miller and Annette Saunders are all Lecturers in the School of Health Sciences, College of Health and Medicine at the University of Tasmania**



## References

- NHS Midlands and East n.d. Pressure Ulcer Path, version 2, nhs. [stopthepressure.co.uk/path/path.htm](http://stopthepressure.co.uk/path/path.htm) Accessed: June 2018.
- Severens, J., Gabraken, J., Duivenvoorden, S., & Frederiks, C., 2002. The cost of illness of pressure ulcers in The Netherlands, *Advanced Skin Wound Care*, 15: 72-77.
- Simonetti, V., Comparcini, D., Flacco, M. E., Di Giovanni, P., & Cicolini, G., 2015. Nursing students' knowledge and attitude on pressure ulcer prevention evidence-based guidelines: A multicenter cross-sectional study. *Nurse Education Today*, 35(4): 573-579.
- Usher, K., Woods, C., Brown, J., Power, T., Lea, J., Hutchinson, M., Mather, C., Miller, A., Saunders, A., Mills, J., Zhao, L., Yates, K., Bodak, M., Southern, J., & Jackson, D. 2018, Australian nursing students' knowledge and attitudes towards pressure injury prevention: A cross-sectional study. *International Journal of Nursing Studies*, May (81): 14-20.



The 2nd Wounds Australia Conference 2018 is to be held at Adelaide Convention Centre from 24th -26th October 2018.

# The 10 questions

that will show why you need to consider registering for this **exceptional conference?**



- 1 Are you up to date with the science of wound healing in a person with diabetes?
- 2 Have you heard of the flightless I (FliI), a highly conserved actin-remodeling protein and its role in wound healing?
- 3 Are you up to date with the endovascular options in managing lower leg wounds?
- 4 Does low frequency ultrasound debridement work?
- 5 Can biofilms be managed with an Australian Native plant extract?
- 6 Can the incidence of pressure injuries be reduced?
- 7 What is wound infection, have you kept update with the new position documents?
- 8 What is the best management pathway for neuro-ischaemic diabetic foot injuries?
- 9 Concordance-is the patient or the nurse at fault?
- 10 Does web based coaching help reduce pressure injuries?

**These are some of the exciting topics that will be presented. Not sure of the answer or the topic? Then this is right conference for you to gain practical information and insight regarding future treatments for patients with wounds.**



## Wounds Australia 2018

ADVANCING HEALING HORIZONS:  
TOWARDS THE CUTTING EDGE IN WOUND CARE

WOUNDS AUSTRALIA NATIONAL CONFERENCE 2018  
Adelaide Convention Centre, 24-26 October



[www.woundsaust2018.com.au](http://www.woundsaust2018.com.au)

Platinum  
sponsor



Gold  
sponsors



Silver  
sponsors



Bronze  
sponsors





# WOUND INFECTION: A BRIEF OVERVIEW OF THE LATEST EVIDENCE-BASED PRACTICE

By Allyson Waird

In first world countries, approximately 1–2% of the populace have chronic wounds and are usually older persons, often needing assistance with self care (Nussbaum et al. 2018).

With Australia's population close to 25 million (ABS 2018), this percentage equates to approximately 125,000 people who are likely to have a chronic non-healing wound.

While the rates of infection for chronic wounds are not specifically known, it should be noted that infection is the most widespread and preventable impediment to wound healing (Han and Ceilley 2017; Wolters Kluwer 2018) and methicillin-resistant *Staphylococcus aureus* infections are constantly on the increase in hospitals and the community (Cancilleri et al. 2018).

Thus the timely recognition and treatment of an infected wound has considerable positive impact on both wound healing and the patient's physical and psychosocial welfare (Rutter 2018).

Controlling the risk of infection to facilitate uncomplicated healing depends upon the identification of potential biofilm development and its proactive management (Wounds UK 2017).

Complications associated with biofilms increase both morbidity and mortality rates requiring treatment strategies correlating with the biofilm cycle, and having the main intention of preventing its attachment and preventing or delaying its reformation. Biofilm is not usually visible and requires clinical observation of wound characteristics which are indicative of its presence such as, ineffective antibiotic treatment, increased levels of moisture and/or exudate, chronic inflammation and erythema, poor or friable granulation, and delayed healing, notwithstanding the provision of rigorous management (IWII 2016).

Recently, the emergence of biofilm-based wound therapy (BBWT) has directed clinicians to conduct wound care consistent with the presence or absence of biofilms which, at this stage, is difficult without a proven clinical method for detection (Nakagami 2017). The latest evidence-based practice found that using the clean technique when dressing a wound has no impact on the rate of infection provided vigilant hand hygiene is maintained (Kent et al. 2018). Topical antibiotics maintain popularity as a general prophylactic treatment, although new evidence suggests they may be

unnecessary unless the wound is clinically infected. Applying topical antibiotics routinely has no improved outcomes and may lead to antibiotic resistance (Han and Geilley 2017). However, one antimicrobial agent which continues to show efficacy without impeding wound healing or leading to bacterial resistance is povidone iodine.

While there is not extensive evidence available, povidone iodine has been found to be effective for inhibiting formation of biofilms (Hoekstra et al. 2017), including, *staphylococcus aureus* (Bigliardi et al. 2017). Interestingly, there is similar evidence for cadexomer iodine (Fitzgerald et al. 2017).

The International Wound Infection Institute has developed a wound infection continuum with five stages:

- contamination;
- colonisation;
- local infection;
- spreading infection; and
- systemic infection.

In the early stages of contamination and colonisation, no topical antimicrobial treatments are indicated, but in the middle stage of local infection, their use is advised.

In the final two stages of spreading infection and systemic infection, it is recommended that both topical and systemic antimicrobials be administered (IWII 2016).

During the development of a guideline, using an exhaustive systematic literature review, multiple recommendations were made for the prevention and treatment of wound infection. The highest rated included regular monitoring, documentation of issues which may predispose the wound to infection, debridement of non-viable tissue, offloading, management of possible contaminants, and assessment by suitably qualified health professionals (Zakhary et al. 2017).

**Allyson Waird is a Clinical Nurse Consultant in Aged Care for Royal North Shore and Ryde Hospitals. She is a Wounds Australia NSW Committee member as well as a member of the Wounds Australia Education Portfolio.**



## References

- ABS Population Clock. Australian Bureau of Statistics. 2018. [abs.gov.au/ausstats/abs%40.nsf/94713ad445ff1425ca25682000192af2/1647509ef7e25faaca2568a900154b63?OpenDocument](https://abs.gov.au/ausstats/abs%40.nsf/94713ad445ff1425ca25682000192af2/1647509ef7e25faaca2568a900154b63?OpenDocument) (Accessed 23/07/2018).
- Bigliardi P, Alsagoff S.A., El-Kafrawi H.Y., Pyon J.K., Wa C.T. & Villa M.A. 2017. Povidone iodine in wound healing: A review of current concepts and practices. *International Journal of Surgery* 44:260-268.
- Cancilleri F, Ciccozzi M., Fogolari M., Cella E., De Florio L., Berton A., Salvatore G., Dicuonzo G., Spoto S., Denaro V. & Angeletti S. 2018. A cast of methicillin-resistant *Staphylococcus aureus* wound infection: phylogenetic analysis to establish if nosocomial or community acquired. *Clinical Case Reports* 6(5):871-874.
- Fitzgerald D., Renick P.J., Forrest E.C., Tetens S.P., Earnest D.N., McMillan J., Kiedaisch B.M., Shi L. & Roche E.D. 2017. Cadexomer iodine provides superior efficacy against bacterial wound biofilms in vitro and in vivo. *Wound Repair and Regeneration* 25(1):13-24.
- Han G., Ceilley R. 2017. Chronic wound healing: A review of current management and treatments. *Advances in Therapy* 34(3):599-610.
- Hoekstra M., Westgate S.J. & Mueller S. 2017. Povidone-iodine ointment demonstrates in vitro efficacy against biofilm formation. *International Wound Journal*. 14(1):172-179.
- IWII International Consensus Update. 2016. Wound infection in clinical practice: Principles of best practice. Omnia-Med Ltd. [woundinfection-institute.com/2016/11/wound-infection-in-clinical-practice-update2016](http://woundinfection-institute.com/2016/11/wound-infection-in-clinical-practice-update2016).
- Kent D., Scardillo J.N., Dale B. & Pike C. 2018. Does the use of clean or sterile dressing technique affect the incidence of wound infection. *Journal of Wound Ostomy and Continence Nursing* 45(3):265-269.
- Nakagami G., Schultz G., Gibson D.J., Phillips P., Kitamura A., Minematsu T., Miyagaki T., Hayashi A., Sasaki S., Sugama J. & Sanada H. 2017. Biofilm detection by wound blotting can predict slough development in pressure ulcers: A prospective observational study. *Wound Repair and Regeneration* 25(1):131-138.
- Nussbaum S., Carter M.J., Fife C.E., DaVanzo J., Haught R., Nussgart M. & Cartwright D. 2018. An economic evaluation of the impact, costs, and medicare policy implication of chronic nonhealing wounds. *Value in Health* 21(1):27-32.
- Risk factors for impaired wound healing and wound complications. Wolters Kluwer. 2018. [www.uptodate.com.acs.hcn.com.au/contents/risk-factors-for-impaired-wound-healing-and-wound-complications](http://www.uptodate.com.acs.hcn.com.au/contents/risk-factors-for-impaired-wound-healing-and-wound-complications) (Accessed 18/07/2018).
- Rutter L. 2018. Identifying and managing wound infection in the community. *British Journal of Community Nursing* 23(Sup 3):S6-S14.
- Wounds UK. 2017. Best practice statement: making day-to-day management of biofilm simple. [wounds-uk.com/resources/details/best-practice-statement-making-daytoday-management-biofilm-simple](http://wounds-uk.com/resources/details/best-practice-statement-making-daytoday-management-biofilm-simple) (Accessed 23/07/2018).
- Zakhary S., Davey C., Bari R., Bean J., Reber T., Gallagher K., Couch K., Hurlow J., Laforet K., McIsaac C., Napier K., Vilar-Compte D., Zakhary E., Hermans M. & Bolton L. 2017. The development and content validation of a multidisciplinary, evidence-based wound infection prevention and treatment guideline. *Ostomy Wound Management* 63(11):18-29.







CLINIC OPENING, STAFF FROM GV HEALTH, L-R JULYAN HOWARD - DIVISIONAL DIRECTOR OF PRIMARY CARE; ANITA PAVONE - DISTRICT NURSE; TOBY DAFF - PODIATRIST; GABRIELLE MUNRO - NURSE PRACTITIONER CANDIDATE/WEST HUME REGION WOUND CONSULTANT AND BELINDA SANGSTER - CLINICAL NURSE CONSULTANT, WOUNDS/STOMA



## References

Dowsett, C., Hampton, J., Myers, D., Styche, T. 2017. Use of PICO to improve clinical and economic outcomes in hard to heal wounds. *Wounds international*. 8(2). pg. 52-58.

Innes-Walker, K., et al. 2018. Improving patient outcomes by coaching primary health general practitioners and practice nurses in evidence based wound management at on-site wound clinics. *Collegian* doi.org/10.1016/j.collegn.2018.03.004

Munro, G. 2017. Causes and consideration with chronic wounds: A narrative review of the evidence [online]. *Wound Practice & Research: Journal of the Australian Wound Management Association* 25 (2) 88-97. Accessed from woundsaustralia.com.au/journal/2502\_05.pdf

Powers, J., Higham, C., Broussard, K., Phillips, T. 2015. Wound Healing and treating wounds- Chronic wound care and management. *American Academy of Dermatology*. DOI.org/10.1016/j.jaad.2015.08.070

Valle, F., Maruther, N., Wilson, L., Malas, M., Qazi, U., Haberi, E., Bass, E., Zenilman, J. & Lazarus, G. 2014. Comparative effectiveness of advanced wound dressings for patients with chronic venous leg ulcers: A systematic review. *Wound Repair and Regeneration* 22. P. 193-204. DOI:10.1111/wrr.12151.

Wounds Australia. 2018. Accessed from woundaware.com.au/about-wound-awareness-week/

# BUILDING CAPACITY IN A NURSE-LED REGIONAL WOUND CLINIC

By Gabrielle Munro

Wounds Australia (2018) reported 'half a million Australians have suffered a chronic wound'.

A regional health service in Victoria has identified 30% of acute inpatients have a wound. Further, 40% of clients seen by the district nursing service have a wound. The prevalence of wounds supports the need for nurse led wound clinics.

Wound management is regarded as a nurse led speciality, predominately managed by community nurses and primary care (Dowsett et al. 2017).

Goulburn Valley Health is opening a nurse led wound clinic to serve the needs of the community with timely access to expert evidence based wound care.

The clinic will be led by a Nurse Practitioner candidate/Wound Consultant for the West Hume Region.

This clinic will provide a platform to provide mentoring, build confidence and consistency in wound care practice through the rotation of existing Hume Region District nurses into the clinic.

The increased confidence and knowledge within nursing staff will ensure better health outcomes for the community.

Referral to the clinic will have criterion of wounds that have not progressed in a four week timeframe.

A chronic wound does not progress along the normal trajectory of healing. The physiology of the

wound bed and the number of microbes triggering inflammation, infection or even biofilm is considered the tipping point of the wound from acute to chronic. Evidence based practice incorporates the TIME principles. TIME is a framework clinicians are urged to adopt when assessing and managing chronic wounds. The components of TIME includes:

- T** **Tissue** removing non-viable tissue, evidenced as yellow or black in colour, through methods of debridement.
- I** **Infection** identifying where the wound is on the infection continuum and treat accordingly. Local infection requires debridement to disrupt the bioburden and the use of antimicrobial dressing to hinder microbes multiplying.
- M** **Moisture** management requires using advanced dressings to either absorb or donate moisture that sustains an environment for healing.
- E** **Edge** advancement involves effectively measuring the wound and tracking improvement or deterioration to evaluate if the wound treatment being applied is effective.

The components of TIME when rapidly employed ease the economic, physical and psychological impact wounds have on people's lives (Innes-Walker 2018; Powers et al. 2015, Valle et al. 2014). A holistic approach to the impact of chronic wounds is required (Munro 2017).

Nursing is a challenging role that requires clinical decision making and critical thinking to address the needs of individuals with a range of health needs. It is expected that the nurse led wound clinic in the regional setting will enable timely management for people with a chronic wound. Further, the mentoring within the discipline will support the culture of consistent and evidence based nursing practice in the community care setting.

**Gabrielle Munro is a Nurse Practitioner Candidate, Goulburn Valley Health, West Hume Region Wound Consultant and La Trobe University MN (Nurse Practitioner) student**



TIME POSTER



# INFECTION PREVENTION AND CONTROL IN HEALTHCARE SETTINGS: RECOMMENDATIONS FOR PRACTICE CHANGE

By Diva Madan

Infection prevention and control is currently recognised as a number one national priority and a grave concern in healthcare organisations.

Healthcare-associated infection (HAI) today is by far the most common and serious complication affecting millions of vulnerable people in Australian healthcare. HAIs are caused by multi-resistant organisms (MROs) (Australian Institute of Health and Welfare 2013). MROs are defined as organisms which are predominantly bacteria that are resistive to a wide range of broad spectrum antibiotics. Some of the common MROs found in healthcare settings are as: methicillin-resistant *Staphylococcus aureus* (MRSA), vancomycin-resistant enterococci (VRE) and Extended Spectrum Beta Lactamase (ESBL) (Malloy 2016). MROs are highly contagious and easily transmitted from the hands of one person to another or via direct contact with environmental surfaces.

Poor infection control, has been identified as the main cause of HAIs (Boyce 2016). It contributes to the suffering of patients and their families, creates long term disability, increased resistance to antimicrobials (Revelas 2012), huge financial burden on patients and healthcare providers and can even cause unnecessary deaths (Clements, 2016).

It is estimated that nearly 90,000 patients who acquire HAIs die each year (Tawfiq & Tambyah 2014). According to the National Health and Medical Research Council (2010), there are around 200,000 HAIs in Australian healthcare facilities each year.

According to NSW Health: Infection Control Policy (2007), under common law, infection control is everyone's responsibility. However, infection control is of vital importance in nursing. Due to non-compliance to infection control, nurses can impose huge risk of infection to other patients and their own families by becoming the reservoirs for pathogens (Gilbert, Cheung & Kerridge 2009). Based

on the results of various evidence based studies, it has been proven that the introduction of the pathogen from the community into healthcare environments is practically inevitable (Gomara & Lopman 2014).

One of the major issues identified in implementing infection control in healthcare is poor hand hygiene. Further, major challenges to good infection control include incorrect use of personal protective equipment, inadequate training, lack of resources, poor leadership and accountability and poor environmental cleaning (Clinical Excellence Commission 2016). On the other hand, HAIs are not merely a result of poor organisation structures, policies or systems but also ethics as well including behavioural beliefs, inappropriate usage of antibiotics and surveillance programs and patient's own contribution in hand hygiene. There is very limited information available on general practitioners knowledge on prescribing antibiotics to elderly residents (Boyce 2016).

It is paramount to put strategies in place to enhance infection prevention and control measures in order to promote health outcomes

in the community. Hence, great emphasis on infection prevention and control is critical to improve health outcomes. Hence, there is a need for education and awareness for timely identification and management of infections.

Risk assessment is fundamental in reducing HAIs and to implement and evaluate the infection prevention and control measures such as environmental cleaning. Healthcare organisations must have infection control committees or working parties to oversee the processes, to provide leadership, review policies and procedures related to infection prevention and control.

Another suggestion includes, upgrading surveillance systems, which should be ongoing, active and extremely flexible. The need to establish clear guidelines to optimise antibiotic usage in healthcare especially in aged care facilities is highly recommended. General practitioners practising in aged care facilities must also follow the guidelines to prescribe antibiotics based on confirmed pathology results. All these practice change strategies would eliminate HAIs and improve the quality of healthcare.



## References

- Australian Institute of Health and Welfare. 2013. Australian hospital statistics 2012–13. [aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129545750](http://aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129545750) (Accessed July 2018)
- Boyce, J.M. 2016. Consequences of Inaction: Importance of Infection Control Practices. *Clinical infectious Diseases Oxford Journals* 3(1):133-137. [cid.oxfordjournals.org/content/33/Supplement\\_3/S133.full](http://cid.oxfordjournals.org/content/33/Supplement_3/S133.full) (Accessed July 2018)
- Clement, R. 2016. What is the truth about the MRSA superbug? Daily Mail Australia. [dailyemail.co.uk/health/articles-157079/What-truth-MRSA-superbug.html](http://dailyemail.co.uk/health/articles-157079/What-truth-MRSA-superbug.html)
- Clinical Excellence Commission (2016). Programs HAI- Healthcare Associated Infections. [cec.health.nsw.gov.au/programs/hai](http://cec.health.nsw.gov.au/programs/hai) (Accessed July 2018)
- Gilbert, G.L., Cheung, P.Y., & Kerridge, I.B. 2009. Infection control, ethics and accountability. *The medical Journal of Australia*, 190(2):696-698. [mja.com.au/journal/2009/190/12/infection-control-ethics-and-accountability](http://mja.com.au/journal/2009/190/12/infection-control-ethics-and-accountability) (Accessed July 2018)
- Gomara, I., T. & Lopman, B. 2014. Norovirus in healthcare settings. *Current Opinion in Infectious Diseases*, 27(5), 437-443. doi:10.1097/QCO.0000000000000004
- Malloy, D.P. 2016. Multidrug-Resistant Organisms (MDROs): What Are They? Department of Public Health. [ct.gov/dph/cwp/view.asp?a=3136&q=424162](http://ct.gov/dph/cwp/view.asp?a=3136&q=424162) (Accessed July 2018)
- National Health and Medical Research Council. 2010. Australian Guidelines for the Prevention and Control of Infections in Healthcare [nhmrc.gov.au/guidelines-publications/cd33](http://nhmrc.gov.au/guidelines-publications/cd33) (Accessed July 2018)
- Revelas, A. 2012. Healthcare – associated infections: A public health problem. *Nigerian Medical Journal*, 53(2): 59-64. doi:10.4103/0300-1652.103543
- Tawfiq, A.J. & Tambyah, A.P. 2014. Healthcare associated infections (HAI) perspectives. *Journal of Infection and Public Health*, 7(4):339-344. doi:dx.doi.org/10.1016/j.jiph.2014.04.003

**Divya Madan,**  
Nurse Educator –  
Higher Education,  
RN, MN clinical  
education, BN,  
BSc, DN, Cert IV  
TAE







GRADUATE CERTIFICATE COURSES

**FEE-HELP**  
is available for all  
of our graduate  
certificate courses

# Be the best nurse you can be

**STUDY A GRADUATE CERTIFICATE WITH ACN**

**Gets you a step closer to becoming an expert practitioner in your chosen clinical specialty, helping you work towards a higher grade position.**

**ENROL NOW!**  
[customerservices@acn.edu.au](mailto:customerservices@acn.edu.au)  
1800 061 660



Australian College of Nursing

[www.acn.edu.au/anmjseppostgraduate2018](http://www.acn.edu.au/anmjseppostgraduate2018)



**"I want a super fund that understands my industry."**

Anne Mitchell,  
HESTA member

We're the national industry super fund dedicated to health and community services, and have been for over 30 years.

We know how important your work is. And how well you do it. We're your fund. For life.

**HESTA**



Before making a decision about HESTA products you should read the relevant Product Disclosure Statement (call 1800 813 327 or visit [hesta.com.au/pds](http://hesta.com.au/pds) for a copy), and consider any relevant risks ([hesta.com.au/understandingrisk](http://hesta.com.au/understandingrisk)). Issued by H.E.S.T. Australia Ltd ABN 66 006 818 695 AFSL 235249, the Trustee of Health Employees Superannuation Trust Australia (HESTA) ABN 64 971 749 321.





Emily Haesler



Jan Kottner



Keryln Carville



Janet Cuddigan

# CONSUMER ENGAGEMENT IN WOUND CARE GUIDELINE DEVELOPMENT: AN INTERNATIONAL APPROACH

By Emily Haesler, Janet Cuddigan, Keryln Carville and Jan Kottner

The International Pressure Injury Clinical Guideline (NPUAP, EPUAP, PPPIA 2014) is currently being revised.

The guideline is used internationally as a resource for nurses and other health professionals to deliver quality pressure injury prevention to people in all clinical settings. The guideline development team includes over 200 representatives from peak wound care bodies in over 30 countries and is led by the US National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan-Pacific Pressure Injury Alliance.

With the evolution of guideline methodology, engagement of consumers in clinical guideline development is now considered best practice.

Objectives of patient involvement in guideline development include incorporating patient values and preferences in clinical recommendations, increasing comprehensiveness of guidelines, adapting guidelines to target populations and improving uptake and implementation of best practice (Légaré et al. 2011).

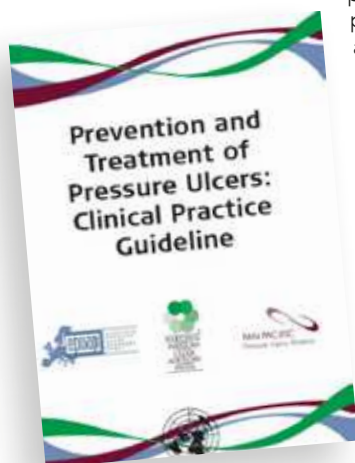
In Australia, the principles of empowering patients/informal caregivers to participate in healthcare is enshrined in the national *Standards for Wound Prevention and Management* (Wounds Australia 2016). Collaborating with consumers to develop best practice recommendations is consistent with this standard, and embraces the

principles of information exchange, patient-practitioner partnerships and patient-centred care that are highlighted in the national wound standards (Wounds Australia 2016).

The *Guidelines International Network* outlines numerous strategies for how patients could be involved in guideline development. These strategies include collecting patient preferences, engaging patients in development groups and communicating regularly using lay-targeted information (Armstrong et al. 2017).

Consistent with best practice in guideline development, the development team for the *International Pressure*

*Injury Guideline* are promoting consumer involvement during the development stages of the third guideline edition. A multi-faceted approach to consumer engagement is being implemented, the first stage of which is an international survey of patients and informal caregivers. The survey, which was designed using lay-English and an easy web interface, is available in nine languages and has been promoted in 30 countries.



PREVENTION AND  
TREATMENT OF  
PRESSURE ULCERS:  
CLINICAL PRACTICE  
GUIDELINE

The survey collects information on patient care goals, the importance of various topics to patients and informal caregivers and the biggest problems faced by patients in preventing and managing pressure injuries. Preliminary data analysis of the over 1,000 responses received from patients/informal caregivers indicates that while preventing any pressure injury is the most common care goal, managing pressure injury pain is as important to patients as healing an existing pressure injury.

Current responses suggest that reducing the size of a pressure injury is almost as significant to patients as achieving complete healing.

Information from the consumer survey will be used by the guideline developers to evaluate the value patients place on different clinical outcome measures and the acceptability, priority and feasibility of research-based recommendation for pressure injury prevention and treatment.

This evaluation will be facilitated by use of the *Evidence to Decision Framework* developed by the GRADE team (Alonso-Coello et al. 2016).

The anonymous patient/informal caregiver survey, which has ethics clearance from the Australian National University (protocol 2018/066), is open until 30 October 2018. If you have patients or informal caregivers you could refer to complete the survey or to register as a potential advisor for the next stage of consumer engagement, the survey is accessible at [internationalguideline.com](http://internationalguideline.com)

**Emily Haesler is Adjunct Associate Professor, Curtin University, School of Nursing, Midwifery and Paramedicine, Perth, Australia and Honorary Senior Lecturer, Australian National University, ANU Medical School Academic Unit of General Practice, Canberra, Australia.**

**Janet Cuddigan is Professor, University of Nebraska Medical Center, Nebraska, United States**

**Keryln Carville is Professor of Primary Healthcare and Community Nursing, Silver Chain Group and Curtin University, School of Nursing, Midwifery and Paramedicine, Perth, Australia.**

**Jan Kottner is Scientific Director Clinical Research, Clinical Research Centre for Hair and Skin Science, Charité-Universitätsmedizin, Berlin, Germany**



## References

- National Pressure Ulcer Advisory Panel (NPUAP), European Pressure Ulcer Advisory Panel (EPUAP), Pan Pacific Pressure Injury Alliance (PPPIA). 2014. Prevention and treatment of pressure ulcers: Clinical practice guideline. Emily Haesler (Ed.). Osborne Park, Western Australia: Cambridge Media.
- Légaré, F., Boivin, A., Trudy van der Weijden, T., Christine Pakenham, C., Burgers, J., Légaré, J., Sylvie St-Jacques, S., Gagnon, S. 2011. Patient and public involvement in clinical practice guidelines: A knowledge synthesis of existing programs. *Medical Decision Making*. 31(6): E45-E74.
- Wounds Australia. 2016. Standards for wound prevention and management. (3rd ed). Osborne Park, Western Australia: Cambridge Media.
- Armstrong, M.J., Rueda, J.-D., Gronseth, G.S., Mullins, C.D. 2017. Framework for enhancing clinical practice guidelines through continuous patient engagement. *Health Expectations*. 20(1): 3-10.
- Alonso-Coello, P., Oxman, A.D., Moberg, J., Brignardello-Petersen, R., Akl, E.A., Davoli, M., Treweek, S., Mustafa, R.A., Vandvik, P.O., Meerpohl, J., Guyatt, G.H., Schünemann, H.J. GRADE Working Group. 2016. GRADE Evidence to decision (EtD) frameworks: a systematic and transparent approach to making well informed healthcare choices. 2: Clinical practice guidelines. *British Medical Journal*. 353: i2089.



# NATURE AND SCIENCE JOIN FORCES TO FIGHT SURGICAL INFECTIONS

A humble dragonfly could reduce the chance of infection after orthopaedic surgery, according to research.

South Australian researchers are embarking on a \$20 million medical and manufacturing research project.

Working with leading surgeons and an Australian orthopaedic medical device company, researchers from the University of Adelaide and University of South Australia (UniSA) will embark on a \$20 million medical and manufacturing research project.

The researchers will use nano-modification technology based on the structure of the dragonfly wing, whose tiny spikes rip bacteria apart.

They hope to create medical implants with the antimicrobial surface to reduce the likelihood of infections after surgery.

The four-year project, co-funded by Global Orthopaedic Technology and the Innovation Manufacturing Cooperative Research Centre (IMCRC), could give scientists and clinicians a critical breakthrough in their global fight against antibiotic resistant bacteria, and is intended to create new technologies and processes to benefit the wider manufacturing sector.

An Australian orthopaedic surgeon Professor Richard de Steiger who is involved in the clinical research, says implant infection post-surgery is a billion-dollar problem worldwide, affecting around 2-3% of medical implants, including devices to stabilise fractures, hip and knee replacements and spinal implants.

"There has been minimal improvement in orthopaedic infection rates for the past 15 years," Professor de Steiger says.

"Infection after surgery is a devastating problem, costing not only hundreds of millions of dollars in additional surgery worldwide, but leading to more trauma for patients. They may need extra recovery time after further operations, which are not always successful and pose an even greater risk of infection," he says.

Leading scientists from the University of Adelaide and UniSA will combine their expertise to create titanium implants with the dragonfly wing surface while confirming their safety and testing their bacteria-killing properties in the University of Adelaide's Centre for Orthopaedic and Trauma Research (COTR) and UniSA's new Musculoskeletal Biotest Facility.

"This research is a combination of cell biology and very clever nanomanufacturing techniques, driven by an unmet medical need,"



says University of Adelaide leading orthopaedic researcher Professor Gerald Atkins, Scientific Director of COTR. "It is game-changing Australian technology."

UniSA Professor Krasimir Vasilev adds: "This is amazing technology that has the potential to improve the quality of life of millions of patients around the world. The project is also a great example of transdisciplinary collaboration between scientists, clinicians and industry, transforming healthcare, manufacturing industry and the Australian economy."

The bacteria-busting qualities of the dragonfly were first identified by Australian researchers who observed bacteria being killed on the insects' wings, characterised by tiny spikes – nanopillars – which are about one thousandth of the thickness of a human hair.

David Chuter, IMCRC's CEO and Managing Director, says this research project is reshaping not only the future of the medical device industry, but potentially other sectors.

"Due to the nature of the nano surface, which is independent of the chemistry and material properties of the substrate to which it is applied, the technology can potentially be used in other manufacturing processes across multiple industries, most notably the hospital supplies and equipment industry, the food industry, the marine industry, the building products industry, and the aeronautical industry.

"The new technology will open many doors, not just in the medical field, as antibacterial surfaces are also valuable in the food industry - in fact, for any surfaces subject to high levels of bacteria."

## MONASH WOUND CARE: COURSES THAT FIT AROUND YOU.

If you're looking to build your skills in an area of growing demand, our graduate wound care course could help you take the next step. And because we realise that scheduling can be tough enough as it is, we offer much of the course online, so you can study when it suits you.

**EARN A GRADUATE CERTIFICATE, A GRADUATE DIPLOMA OR A MASTER'S**

We know a whole master's isn't for everyone. That's why our course is designed with multiple exit points, so you can leave with a graduate certificate or graduate diploma instead if you prefer.

**Applications for semester 1, 2019 close 30 November.**



MONASH University

[monash.edu/wound-care](http://monash.edu/wound-care)



## BLOOD INFECTIONS

Certain antibodies in a patient's blood stream may enable life-threatening bacterial infections to spread instead of fighting them off, a University of Queensland (UQ) study has found.

UQ Diamantina Institute Senior Research Fellow Dr Timothy Wells said the discovery may be the key to treating sepsis in some patients.

Researchers examined how *Escherichia coli* (E. coli) in the blood stream can trigger sepsis, an extreme and damaging inflammatory response to infection with a high chance of mortality.

"E. coli is the most common cause of urinary tract infections, and in some people, the bacteria can enter and survive in the bloodstream, leading to sepsis," Dr Wells said.

"For the bacteria to survive, it needs to be resistant to human serum, which is a component of blood similar in composition to blood plasma."

Antibodies found in human serum normally protect against infection by binding to bacteria, allowing them to be targeted for killing by 'complement' proteins.

"We found that 24% of patients with sepsis caused by E. coli had high amounts of antibodies that inhibited that process," Dr Wells said.

"These inhibitory antibodies actually protected the bacteria by binding to them and forming a protective wall around them.



"Our results suggest that in some of the patients, the bacteria would not have been able to survive in the blood without these 'inhibitory antibodies' being present.

"The high number of patients with inhibitory antibodies suggests this mechanism of serum resistance for E. coli in sepsis is widespread."

Dr Wells said that removing inhibitory antibodies from the blood restored its ability to kill bacteria.

"These inhibitory antibodies are not just limited to E. coli," he said.

"We recently treated two patients with lung infections who also had inhibitory antibodies.

"We used a method called plasmapheresis – when a patient's blood plasma is removed and replaced – removing the inhibitory antibodies.

"This led to an immediate improvement in their health, so new methods that inactivate or remove these 'bad' antibodies may be useful to prevent and treat sepsis."

The study was published in *mBio* and involved School of Chemistry and Molecular.



## ANTIBIOTICS NOT ALWAYS NEEDED FOR MOST COMMON EYE INFECTIONS

An article in the latest edition of *Australian Prescriber* issues a timely reminder that the majority of eye infections in adults are viral conjunctivitis and do not require antibiotic treatment.

This common, self-limiting viral infection rarely threatens vision according to the article. Authors Professor Stephanie Watson, Maria Cabrera-Aguas and Pauline Khoo from Save Sight Institute, University of Sydney, recommend that for comfort, cold compresses, artificial tears and topical antihistamines can be used for viral conjunctivitis.

"Antiviral such as aciclovir ointment should be prescribed if there is evidence of herpes simplex virus conjunctivitis. However, antibiotics are not needed, are costly and

may increase antibiotic resistance," the authors state.

The article reviews current treatment and management of eye infections with summaries on bacterial conjunctivitis, corneal infection, endophthalmitis and gonococcal and chlamydial conjunctivitis. All infections are assessed for the risk they pose to vision and when specialist assessment is needed.

"Urgent referral to an ophthalmologist for microbiological samples and treatment is needed for infectious keratitis and endophthalmitis," the authors advise.



## NEW SOLUTIONS FOR WOUND HEALING

Research, clinical and industry partnerships are developing 3D-printing techniques and materials for wound healing, improving patient outcomes and reducing the burden on the health system as well as creating opportunities for Australian manufacturers.

A review of the latest developments in 3D printing and cell therapy for wound healing, published recently in the journal *Advances in Wound Care*, highlights how 3D printing is being used to fabricate tissue-like products that mimic the structure and function of human skin.

Professor Gordon Wallace, review co-author and Director of the University of Wollongong (UOW) headquartered ARC Centre of Excellence for Electromaterials Science (ACES), said treating skin tissue damaged by burns and other trauma, diabetes or vascular disease was a major challenge and a burden on healthcare systems.

"While several advanced skin graft treatments exist, they are costly, come with risks such as host rejection, excessive scarring and potentially disease transmission, and are limited to treating shallow wounds where formation of blood vessels is less important," Professor Wallace said.

"Combined with the emergence of 3D printing tools and techniques, biofabrication of tissue materials from biologically compatible materials offers the possibility of not only reducing availability and cost of treatment, but also the prospect of treating deep wounds comprising several tissue layers."

The layered fabrication method could also accommodate the use of wound healing proteins, stem cells and anti-inflammatory drugs during the printing process, as well as creating more complex tissue structures that could eventually include vascular networks that facilitate oxygen and nutrient exchange to hair follicles and sweat glands.

Dr Chris Baker, head of dermatology at St Vincent's Hospital Melbourne working with ACES on clinical trials, said that while the biological complexities of human skin are relatively well understood, appropriate repair mechanisms are scarce and often costly.

"The technology and underpinning materials science we're developing with ACES has the potential to be deployed in hospitals and wound clinics, producing replacement tissue for wounds on-demand and at the quantity needed," Dr Baker said.

"That has huge potential benefits for patient recovery and their quality of life after skin loss or damage from any cause."

ACES and Venus Shell Systems (VSS), a South Coast New South Wales marine biotechnology producer, are hosting the first in a series of national workshops bringing together material scientists, tissue engineers, and clinicians with small to medium enterprises to explore commercial opportunities based on the latest research and development highlight

The workshop will highlight how the partnership between ACES and VSS has led to the development of bio-inks from seaweed, which are being accelerated through collaboration with clinicians at St Vincent's Hospital Melbourne.

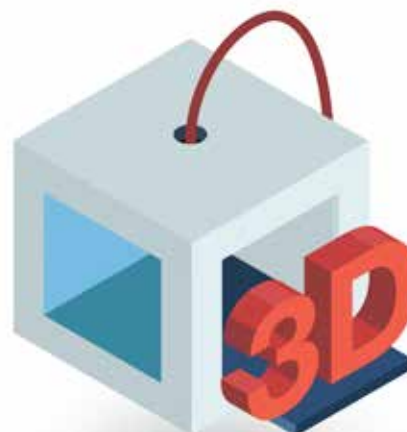
VSS was started in 2014 to create a market for seaweed cultivation. It has been a long-term partner with ACES in developing biocompatible gels, such as the bio-ink, for 3D printing and regenerative medicine.

VSS Director and Chief Scientist Dr Pia Winberg said seaweed extracts contain molecules that are similar to the connective tissue in human skin.

"Gel molecules taken from seaweeds are ideal candidates for medical implants and tissue engineering because they provide the necessary structural support and have also been found to act as a frontline defence and communication system in supporting or inhibiting the interaction with microorganisms such as viruses, bacteria and fungi," Dr Winberg said.

"These gels are highly cell compatible and even stimulate the health and development of human stem cells, so in the instance of looking for new polymer materials for medical implants, seaweed extracts are a key candidate."

The workshop, supported by funding from MTPConnect – the Medical Technologies and Pharmaceuticals Industry Growth Centre – will be held at UOW's Innovation Campus, is designed to help small to medium enterprises connect with researchers to develop commercial opportunities from bioprinting and the growing field of regenerative medicine.



### Glenn Pannam Accounting

- ✓ Specialising in Nurses' Tax Returns
- ✓ Electronic lodgement
- ✓ Salary packaging advice
- ✓ Returns can be completed by email or by appointment

Ph: 03 9258 1600  
Address: Level 9, 24 Albert Road, South Melbourne 3205  
Email: [glenn@dblegal.com.au](mailto:glenn@dblegal.com.au)  
Website: [Glennpannamaccounting.com.au](http://Glennpannamaccounting.com.au)  
Facebook: [www.facebook.com/glennpannamaccounting](http://www.facebook.com/glennpannamaccounting)

Discount given to ANMF members  
**CALL OR EMAIL US NOW**



Making your money  
transfer count.



**OrbitRemit**  
Online money transfer.

**Are you sending  
money home?**

We've got the best rates and  
even better service. Fast &  
secure overseas remittances.

[orbitremit.com](http://orbitremit.com)



# ASSISTANTS IN NURSING: SCOPE OF PRACTICE AND PRESSURE INJURY PREVENTION

By Bernadette McNally and Nicole Blay

New nursing models of care have been implemented to meet the changing healthcare environment and the needs of patients.



There is greater focus on patient-centred care supported by the National Safety and Quality Health Service Standards (ACSQHC 2017) as well as a focus on Hospital Acquired Complications (ACSQHC 2018).

In NSW one model has been the introduction of Assistants in Nursing (AIN) as part of the nursing skill mix. The AIN role was initially introduced to provide basic support to qualified nurses by assisting patients with personal care needs (Afzal et al. 2018). With current nursing workforce shortages and changing healthcare environments hospitals are increasingly utilising AINs in the acute care environment (Duffield et al. 2014). The AIN role now includes activities that were previously undertaken by regulated nurses. The AIN has become a member of the nursing acute care team.

As an unregulated position, qualifications for AINs are not mandatory (Mason 2013). Courses designed for AINs are available in both the public and private sector but these courses vary in both length and content. In NSW, an AIN can have completed preparation for the role ranging from a six week course; a nationally recognised qualification such as the Certificate III Health Services Assistance; one year of an undergraduate nursing course,

or 'equivalent experience' (NSW Health 2018). Therefore, an individual AIN's knowledge and experience can vary, leading to confusion around AINs scope of practice and clinical competency.

## Scope of the role

Despite being unregulated, AINs in NSW work under the direction of a Registered Nurse (RN), and are guided by state and local policies (NSW Health, 2010). In NSW, a list of tasks that may be performed by the AIN working in acute care is available (NSW Health 2010). Tasks include showering patients, repositioning, pressure area and skin care and 'simple wound dressings'. However, as these tasks are not defined further, RNs responsible for AINs may interpret some of these tasks in different ways. 'Simple' dressings are one such example. The lack of definition around scope of the role and lack of regulation of AINs can be demonstrated by Afzal et al. (2018) who found that AINs were working outside the scope of their role either due to pressure from other clinicians or managers, or their own decision-making. It is therefore essential that AINs, nurse managers and RNs are provided with education regarding the AIN scope of the role (Butler-Williams et al. 2010)

## Impact of AINs on health outcomes

There is limited evidence of the impact of adding AINs to the skill mix and subsequent impact on pressure injuries and wound care. Twigg et al. (2016) reported that introducing AINs to the acute setting had a negative effect on the incidence of pressure injuries. Reasons for the increase are not known but could include a lack of understanding by managers and clinicians of the AIN role (Twigg et al. 2016) and possibly because pressure injury prevention was not included in their described list of activities.

The overall prevalence of pressure injuries in NSW in 2017 was 7.9% (CEC 2017). With an estimated cost to the Australian health system of \$983 million per annum (Nguyen et al. 2015) more needs to be done to assist with pressure injury prevention. The AIN, as a member of the nursing team, can contribute to the prevention of pressure injuries by providing fundamental care such as personal hygiene, and skin care. It is essential however, that AIN training is standardised, roles are clarified and scope of the role is well defined.

**Bernadette McNally is Clinical Nurse Consultant – Wound Care at the Fairfield Hospital in NSW**

**Nicole Blay PhD, is Research Fellow at the Centre for Applied Nursing Research, Ingham Institute for Applied Medical Research, Western Sydney University & SWSLHD**



## References

- ACSQHC. 2017. National Safety and Quality Health Service Standards. 2nd ed. Sydney: Australian Commission on Safety and Quality in healthcare.
- ACSQHC. 2018. Hospital-acquired Complications Information Kit. Sydney: Australian Commission on Safety and Quality in healthcare
- Butler-Williams, C., James, J., Cox, H. & Hunt, J. 2010. The hidden contribution of the healthcare assistant: a survey-based exploration of support to their role in caring for the acutely ill patient in the general ward setting. *Journal of Nursing Management*, 18, 789-795.
- CEC 2017. 2017 NSW Pressure Injury Point Prevalence Survey Report. Sydney: Clinical Excellence Commission.
- Duffield, C.M., Twigg, D.E., Pugh, J.D., Evans, G., Dimitrelis, S. & Roche, M.A. 2014. The Use of Unregulated Staff: Time for Regulation? *Policy, Politics, & Nursing Practice*, 15, 42-48.
- Mason, J. 2013. Review of Australian Government Health Workforce Programs. Mason Review. The Department of Health.
- Nguyen, K.-H., Chaboyer, W. & Whitty, J.A. 2015. Pressure injury in Australian public hospitals: a cost-of-illness study. *Australian Health Review*, 39, 329-336.
- NSW Health. 2010. Position Description Assistant in Nursing Acute Care [Online]. Available: [health.nsw.gov.au/workforce/Pages/Working-with-Assistants-in-Nursing-AIN.aspx](http://health.nsw.gov.au/workforce/Pages/Working-with-Assistants-in-Nursing-AIN.aspx) [Accessed 27 June 2018].
- NSW Health 2018. Employment of Assistants in Nursing (AIN) in NSW Health Acute Care.
- Twigg, D.E., Myers, H., Duffield, C., Pugh, J.D., Gelder, L. & Roche, M. 2016. The impact of adding assistants in nursing to acute care hospital ward nurse staffing on adverse patient outcomes: An analysis of administrative health data. *International Journal of Nursing Studies*, 63, 189-200.



# SEPTEMBER

**Indigenous Literacy Day**  
5 September

**Annual Association of Stoma Care Nurses UK Conference**  
9–11 September, ICC Birmingham, UK.  
[ascnuk.com/ascn-uk-annual-conference-2018](http://ascnuk.com/ascn-uk-annual-conference-2018)

**ANMF Vic Branch Nurses and Midwives Conference**  
10 September, Melbourne Convention and Exhibition Centre. The 2018 Australian Nurses and Midwives Conference brings together nursing and midwifery professionals from across Australia. This intensive program features a range of international, interstate and Victorian speakers exploring professional and clinical issues and innovations in nursing, midwifery, mental health and aged care. Nursing and midwifery clinicians, researchers, academics and leaders will present on a range of contemporary professional issues and clinical practice innovations. The breadth of speakers and topics makes the Australian Nurses and Midwives Conference the most comprehensive nursing and midwifery event in Australia. Earn 8 hours of CPD.  
[anmfvic.asn.au](http://anmfvic.asn.au)

**Australian College of Nursing CPD Face to Face: Wound Management Update**  
10 September, Hobart. This face-to-face course is conducted over two days and is equivalent to 14 (CPD) hours. The course is designed for registered and enrolled nurses from all health sectors, who are engaged in providing wound care to patients or residents. This is an in-depth review of pathophysiology, pharmacology, assessment strategies, clinical aetiologies and interventions.  
[acn.edu.au/wound-management-update-2018](http://acn.edu.au/wound-management-update-2018)

**Anniversary of the UN Declaration on the Rights of Indigenous People**  
13 September

**Congress of Aboriginal & Torres Strait Islander Nurses & Midwives (CATSINaM) National Professional Development Conference**  
Honouring our past, empowering our present, growing our future  
17–19 September, Hilton Adelaide, SA.  
[catsinam.org.au](http://catsinam.org.au)

**International Rural & Remote Nursing & Midwifery Conference in conjunction with CRANAplus 36th Annual Conference**  
Leading primary healthcare in a challenging world  
20–22 September, Pullman Cairns International Hotel, Qld.  
[cranaconference.com](http://cranaconference.com)

**3rd International Conference on Pediatric Nursing and Healthcare**  
*Exploring Innovations and Latest Advancements in Pediatric Nursing and Healthcare*  
21–22 September, Vancouver, Canada.  
[pediatricnursing.nursingconference.com](http://pediatricnursing.nursingconference.com)

**Australian Public Health Conference**  
26–28 September, Pullman Cairns International Hotel, Qld.  
[phaa.net.au/events/event/australian-public-health-conference-2018](http://phaa.net.au/events/event/australian-public-health-conference-2018)

**22nd Nursing Network on Violence Against Women International Conference**  
Transforming Health Services, Policies and Systems through Research, Education, Innovation and Partnerships  
26–28 September, Pillar and Post Conference Center, Niagara on the Lake, Ontario, Canada.  
[nnvawi.org](http://nnvawi.org)

# OCTOBER

**51st World Nursing Leadership & Management Conference**  
Exploring the leadership practices in nursing and management  
4–5 October, Moscow, Russia.  
[nursingleadership.nursingmeetings.com](http://nursingleadership.nursingmeetings.com)

**Lactation Consultants of Australia and New Zealand Breastfeeding Conference**  
*Breastfeeding, Research, and Infant Nurturing (B.R.A.I.N)*  
5–6 October, Stamford Grand Adelaide, Glenelg, South Australia.  
[lcanzconference.com](http://lcanzconference.com)

**33rd Euro Nursing & Medicare Summit**  
Accelerating Innovations & Fostering Advances in Nursing and Healthcare  
8–10 October, Edinburgh, Scotland.  
[europe.nursingconference.com](http://europe.nursingconference.com)

**42nd International Hospital Federation World Hospital Congress**  
10–12 October, Brisbane Convention & Exhibition Centre, Qld.  
[event.icebergevents.com.au/whc2018](http://event.icebergevents.com.au/whc2018)

**19th South Pacific Nurses Forum hosted by Cook Islands Nurses Association Aotearoa**  
Transforming leadership – Nurses as change agents for non communicable diseases in the Pacific  
15–19 October, Rarortonga, Cook Islands.  
[spnf.org.au/2018/19th\\_SPNF\\_Registration\\_Form.pdf](http://spnf.org.au/2018/19th_SPNF_Registration_Form.pdf)

**4th Australian Association of Nurse Surgical Assistants Conference & AGM**  
Discover the difference  
20–21 October, Launceston, Tas.  
[aansa.org.au](http://aansa.org.au)

**44th International Mental Health Nursing Conference**  
Mental health is a human right  
24–26 October, Pullman Cairns International, Cairns, Qld.  
[acmhn2018.com](http://acmhn2018.com)

**27th National Conference on Incontinence**  
24–27 October, Hotel Grand Chancellor, Hobart Tasmania.  
[ncoi.org.au](http://ncoi.org.au)

**Transplant Nurses Association National Conference**  
*The future is now: aspire, achieve, advance*  
24–26 October, Rydges World Square, Sydney NSW.  
[tnaconference.com.au](http://tnaconference.com.au)

**Wounds Australia National Conference**  
*Advancing Healing Horizons: Towards the cutting edge in wound care*  
24–26 October, Adelaide Convention and Exhibition Centre, SA.  
[woundsaustralia.com.au/home](http://woundsaustralia.com.au/home)

**Australian Resuscitation Council – Victoria conference: From Kerbside to Critical Care, Maintaining the Chain for Survival**  
27 October. A full day conference (9am to 5pm) that takes a look at the management of mass casualty emergencies – from first aid, through pre-hospital to in-hospital care. Further details: [resus.org.au/conferences](http://resus.org.au/conferences).  
Bookings: [trybooking.com/wkwi](http://trybooking.com/wkwi)

**Lung Health Promotion Centre at The Alfred Asthma Educator's Course**  
31 October – 2 November  
Ph: (03) 9076 2382  
Email: [lunghealth@alfred.org.au](mailto:lunghealth@alfred.org.au)

# NOVEMBER

**Australian College of Nursing CPD Face to Face: Wound Management Update**  
1 November, Canberra. This face-to-face course is conducted over two days and is equivalent to 14 (CPD) hours. The course is designed for registered and enrolled nurses from all health sectors, who are engaged in providing wound care to patients or residents. This is an in-depth review of pathophysiology, pharmacology, assessment strategies, clinical aetiologies and interventions.  
[acn.edu.au/wound-management-update-2018](http://acn.edu.au/wound-management-update-2018)

**Australian College of Nursing CPD Face to Face: Wound Management Update**  
8 November, Darwin. This face-to-face course is conducted over two days and is equivalent to 14 (CPD) hours. The course is designed for registered and enrolled nurses from all health sectors, who are engaged in providing wound care to patients or residents. This is an in-depth review of pathophysiology, pharmacology, assessment strategies, clinical aetiologies and interventions.  
[acn.edu.au/wound-management-update-2018](http://acn.edu.au/wound-management-update-2018)

**Remembrance Day**  
11 November

**22nd International Conference on Global Nursing Education & Research**  
Innovation & advancements in nursing education and research  
12–13 November, Melbourne, Australia.  
[nursingeducation.conferenceseries.com](http://nursingeducation.conferenceseries.com)

**Lung Health Promotion Centre at The Alfred Smoking Cessation Facilitator's Course**  
15–16 November  
**Spirometry Principles & Practice**  
22–23 November  
Ph: (03) 9076 2382  
Email: [lunghealth@alfred.org.au](mailto:lunghealth@alfred.org.au)

**8th Biennial Australian and New Zealand Falls Prevention Conference**  
28–20 November, Hotel Grand Chancellor, Hobart, Tasmania.  
[anzfpconference.com.au](http://anzfpconference.com.au)

**Mercy Perinatal Global Obstetric Update**  
Dealing with the 'placenta gone rogue'... pre-eclampsia, growth restriction and accreta  
29 November – 1 December, Park Hyatt, Melbourne.  
[gou2018.com.au](http://gou2018.com.au)

# DECEMBER

**World AIDS Day**  
1 December.  
[worldaidsday.org.au](http://worldaidsday.org.au)

**STOP Domestic Violence Conference**  
3–5 December, QT Gold Coast, Surfers Paradise Qld.  
[stopdomesticviolence.com.au](http://stopdomesticviolence.com.au)

**World Congress of Cardiology & Cardiovascular Health**  
5–8 December, Dubai, United Arab Emirates.  
[world-heart-federation.org/wcc-2018](http://world-heart-federation.org/wcc-2018)

# NETWORK

**Alfred Hospital 3/78 Group, 40-year reunion**  
6 October, 5pm at the Stamford Plaza, 111 Little Collins Street, Melbourne. Contact Phillipa Parsons  
E: [parsonspj1@hotmail.com](mailto:parsonspj1@hotmail.com)

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

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

**Royal Adelaide Hospital, Groups 793/4, 40-year reunion**  
May 2019. Past students register your interest with Julie Hoyle (nee Lloyd) E: [djhoyle@bigpond.net.au](mailto:djhoyle@bigpond.net.au) or

Andrew Booth  
E: [andrew.booth@sa.gov.au](mailto:andrew.booth@sa.gov.au)  
**Western General Hospital 60th PTS reunion**  
16–23 June 2019, Port Vila, Vanuatu.  
Contact Wendy  
E: [Wendyflahive@gmail.com](mailto:Wendyflahive@gmail.com)

**EMAIL [cathy@anmf.org.au](mailto:cathy@anmf.org.au) if you would like to place a reunion notice**





## STILLBIRTH – A HIDDEN ISSUE THAT DESERVES ATTENTION

Lori-Anne Sharp, Assistant Federal Secretary

I distinctly remember the stillbirth education session that my partner and I attended when we were expecting our first child 17 years ago. Conducted at our local public maternity hospital, it was part of the routine antenatal education program that was offered to all first-time parents.

The evening classes happened over a six week period and were something we both looked forward to as the anticipation and excitement of becoming parents was realised.

This class stood out – the usual energy of high hopes and promise was replaced by a more sombre mood. The session reminded us all of the tragic reality of stillbirth and that it could happen to any one of us. Our delightful and experienced midwife, handled it with such care, sensitivity, skill and wisdom. I vividly recall observing the reactions of the group and appreciating how important open discussion of this often taboo subject was to us as first-time parents.

Despite the many advances in medicine, technology and research we have seen no reduction in our stillbirth rates. Tragically, stillbirth (when a baby dies before or during birth at any time from 20 weeks until full term or later), affects more women in Australia than those in other developed countries.

We know that six babies are stillborn each day. While infant mortality rates have declined in Australia over the past two years, there has been no reduction in the rate of stillbirth. Stillbirth rates for Indigenous women are over twice that of non-Indigenous women.

We understand that some stillbirth deaths are preventable and that there are unacceptable variations about how they are dealt with across our health settings.

For these reasons, ANMF welcomed the opportunity to provide a submission to the Senate Select Committee Inquiry into Stillbirth Research and Education. As the largest component of the health workforce in Australia, midwives and nurses are well placed to care for and help women and families throughout and following an experience of stillbirth, as well as be effective agents of change when research provides new ideas for our practice.

The committee was established in March this year to inquire and report on the future of stillbirth research and education in Australia. In collaboration with the states and territories ANMF presented evidence at the public hearing in Melbourne on 9 August. A total of 241 written submissions were received.

### A national approach to timely data collection in all jurisdictions

It is important that stillbirth is addressed and form part of the national health agenda. It is crucial for the wellbeing of future parents that the midwives and nurses who care for them and their babies are well-equipped and supported to deliver evidence-based care. Comparable developed countries have reduced their stillbirth rate, and we should be able to do so too.

We know for example that the efforts focussed on understanding and preventing sudden infant death syndrome (SIDS) from 1987 onwards reduced the rate of SIDS by 86%, primarily through education programs and research. In fact, for every baby that dies of Sudden Infant Death Syndrome (SIDS) in Australia, 35 are stillborn ([stillbirthfoundation.org.au/stillbirth](http://stillbirthfoundation.org.au/stillbirth)).

I believe that through a coordinated national effort, we can achieve improvements in our rates of stillbirth.

Closer to home, we welcomed four healthy newborns to our street recently. I was surprised to learn that stillbirth information

had not been mentioned in any part of their antenatal education. With more than 2,000 stillbirths a year in Australia, it's essential for parents to know that stillbirth still exists, and to understand any potential preventative steps that can be taken during pregnancy and birth. We must also ensure that in the tragic event of stillbirth, timely and accessible bereavement support that is evidence-based is available.

I am pleased that this hidden issue is being addressed and hope that the report and recommendations that come out of the Senate Select Committee Inquiry lead to reduced rates of stillbirth in our country and systemic improvements to our ability to offer appropriate, well evidenced bereavement support to those who experience the loss of stillbirth. I am confident that with midwives and nurses as the leaders of education and research on stillbirth, we can bring about these important changes.

If this article has caused distress please contact SANDS support line on 1300 072 637, Lifeline on 13 11 14 or visit [panda.org.au](http://panda.org.au)

### IN SUMMARY, OUR SUBMISSION TO THE SENATE INQUIRY CALLED FOR:

- Midwives leading and contributing to research and education initiatives.
- Exploring evidence regarding the effect of increased maternal awareness and action when decreased foetal movement is noted.
- Appropriately resourced midwifery services and midwifery continuity of care models.
- Ensuring midwives have the education and necessary skills to support women through antenatal, labour and postnatal care and are equipped to manage the clinical, bereavement and referral needs of women and families.
- Nationally consistent guidelines for the prevention of stillbirth, which address science, technology and the social determinants of health.
- A national approach to timely data collection in all jurisdictions.



# AMH Children's Dosing Companion 2018 Release Available Now



The Royal Children's  
Hospital Melbourne

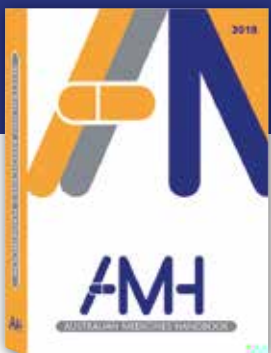
**Paediatric  
Injectable  
Guidelines**

The AMH Children's Dosing Companion is Australia's national independent dosing guide for prescribing and administering medicines to children from birth to 18 years with evidence-based, peer-reviewed and up-to-date information. The July 2018 release extends the number of monographs included to over 400 drugs. Available now in print or online. Go to [www.amh.net.au](http://www.amh.net.au) for more information.

The July 2018 CDC Online release now includes direct links to The Royal Children's Hospital Melbourne new online Paediatric Injectable Guidelines (separate subscription required).



## Stay up to date with the 2018 AMH Book or Online



The Australian Medicines Handbook offers clear, concise, up-to-date and clinically relevant information. Designed to find information quickly. Recommendations incorporate the latest research and best practice advice. Available now in print or online. Go to [www.amh.net.au](http://www.amh.net.au)





# ChloraPrep™ with Tint

Cutaneous solution  
minimises hospital acquired infections

Here's how you could  
single-handedly reduce  
CVC\*-related bloodstream  
infections by\*\*

62%.<sup>1</sup>



ChloraPrep™ cut surgical  
site infections by\*\*

41%.<sup>2</sup>

Product code	Description	Packaging	Shelf life	Temperature-control recommendations <sup>3</sup>
600415	3 mL tint	25/bx., 100/cs. UOM cs.	24 months	Store below 25°C.
600715	10.5 mL tint	25/bx., 100/cs. UOM cs.	24 months	
600815	26 mL tint	25/bx., UOM cs.	24 months	

Please contact your local representative for more information.

#### References

<sup>1</sup> Garcia R, Jendresky L, Landesman S, Maher A, Nicolas F. Three years experience in implementing HICPAC recommendations for the reduction of central venous catheter-related bloodstream infections. *Manag Infect Control*. 2003;10:42-49. <sup>2</sup> Darouiche RO, Wall MJ, Itani KMF, et al. Chlorhexidine-alcohol versus povidone-iodine for surgical-site antisepsis *N Engl J Med*. 2010;362:18-26. <sup>3</sup> CareFusion Data on file as per Instructions for Use (IFU).

\* Central venous catheter.

\*\* When compared to 10% povidone-iodine.

#### ChloraPrep™ with Tint

Cutaneous Solution  
2% w/v chlorhexidine gluconate (CHG)  
70% v/v isopropyl alcohol (IPA)

CareFusion Australia 316 Pty Ltd  
Unit 3/167 Prospect Highway  
Seven Hills NSW 2147  
Ph: 1800 833 372

CareFusion NZ 313 Ltd  
14B George Bourke Drive  
Mt Wellington Auckland 1060  
Ph: 0508 422 734



CareFusion is a wholly-owned subsidiary of BD.

© 2016 BD. BD, the BD Logo and ChloraPrep are trademarks of Becton, Dickinson and Company. SU6146 (0316). Ref: IP006/v2/Feb16