



ANMJ

AUSTRALIAN NURSING & MIDWIFERY JOURNAL

VOLUME 26, NO.4
OCT-DEC 2018

LASTING LEGACY

INDIGENOUS LEADER LEAVES HER MARK

INSIDE

CATSINaM leader bows out

Janine Mohamed is planning to take a new direction after successfully building an organisation that Aboriginal and Torres Strait Islander nurses and midwives are proud to call their own

Keeping up with best evidence for nursing and midwifery practice
How to get evidence into practice

National Inquiry into sexual harassment at work

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Welcome to the first new-look quarterly *ANMJ*. As you will see, we have made some significant changes to the way we have presented the journal, with the aim of keeping you up to date and better informed about healthcare, nursing and midwifery.

Annie Butler

ANMF Federal Secretary

One of the changes to the journal is incorporating a number of features. In this issue we have a feature on ANMF's affiliations with international nursing organisations.

The ANMF supports and leads global initiatives with these organisations for the purpose of growing the work of nurses, midwives and carers, and improving health outcomes, particularly in developing countries.

These organisations include the International Council of Nurses, Global Nurses United, the Commonwealth Nurses and Midwives Federation, the South Pacific Nurses Forum and recently launched three-year global campaign Nursing Now.

On the *ANMJ* website, we will be highlighting in depth each of these organisations and our affiliations with them. This will help to better inform you how they drive the advancement of the professions and influence positive outcomes.

Also featured is a story about Chief Executive Officer of the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), Janine Mohamed, who is stepping down after five years in the position.

Janine has played a pivotal role in highlighting the value of Aboriginal and Torres Strait Islander nurses and midwives and achieving health equality across the country's health system for Indigenous Australians.

The ANMF has always had a strong relationship with CATSINaM since its inception 20 years ago. The commitment and diligence of CATSINaM representatives over the years has ensured meaningful outcomes within the nursing and midwifery professions and Aboriginal and Torres Strait Islander communities.

I commend Janine for the outstanding work she has done for CATSINaM during her time as CEO of the organisation and, on behalf of the ANMF, I wish her the best for the future.

The ANMF Federal Council convenes annually to review, endorse and direct the activities of the ANMF Federal Office. The meeting, held late in August, resulted in a number of new priorities. These include the Federal Office pursuing a review of the definition of neonatal qualification by the Australian Institute of Health and Welfare and/or COAG. Currently this definition precludes newborn babies being counted

as patients for workload and staffing purposes in Australian hospitals if they are kept with their mothers.

The Federal Council also resolved to sign a declaration from the Medical Association for the Prevention of War, as a healthcare organisation, calling on the Australian government to support a nuclear weapons ban treaty and to encourage individual ANMF members to sign up to the campaign as well.

Further, the Federal Council endorsed a motion that ANMF becomes a member of the International Campaign to Abolish Nuclear Weapons (ICAN). More on both these initiatives will be detailed on the *ANMJ* website in upcoming months.

Last month I gave evidence at a Senate Economics Reference Committee to investigate the financial and tax practices of Australia's for-profit aged care providers. The Senate Inquiry came about as a result of ANMF commissioning a report, prepared by Jason Ward from the Tax Justice Network Australia, that showed Australia's top for-profit aged care providers had posted large profits while taking advantage of \$2.17 billion in Australian taxpayer funded subsidies. This is despite chronic understaffing which has resulted in dangerous workloads for nurses and missed care for vulnerable residents.

At the Inquiry I was supported by a number of ANMF representatives including Brigitte from South Australia who works as a personal care worker in aged care. I was appalled when Brigitte, an avid supporter of ANMF's Ratios in Aged Care campaign, told me that only the week before she and the registered nurse on duty looked after over 180 residents on the afternoon shift.

Attending a Senate Hearing can be quite tough but Brigitte's enthusiasm for safe staffing levels and for the evidence I was giving at the Inquiry was inspiring.

I have always been determined to get ratios into aged care, but witnessing Brigitte's resolve for the campaign on top of other countless harrowing stories of the lack of staffing in nursing homes has further strengthened my own fortitude that we need to fix this crisis now.

Annie

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Moving state?**Transfer your ANMF membership**

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

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For-profit aged care providers probed



The Australian Nursing and Midwifery Federation (ANMF) presented evidence at a Senate Inquiry investigating the financial and tax practices of Australia's for-profit aged care providers in Melbourne last month.

The ANMF highlighted how the country's top six nursing home companies, who receive billions in taxpayer funded government subsidies, are using a range of loopholes to avoid tax and maximise profits while Australia's aged care system is in crisis.

"These companies have the financial capacity to provide better care for their residents by employing more nurses and carers but are focusing on maximising profits and shareholders first," ANMF Federal Secretary Annie Butler told the Senate Economics Reference Committee.

The Inquiry was triggered by a Tax Justice Network Australia report, commissioned by the ANMF, which found the top six for-profit providers (Bupa, Allity, Estia, Regis and Japara) received over \$2.17 billion in government subsidies – 72% of their total revenue – yet paid minimal tax.

At the hearing, the ANMF made recommendations including residential aged care companies having to publicly report their staffing levels and prove funding is spent on care, and any aged care company receiving more than \$10 million in funding in any year having to file complete, audited, annual financial statements with the Australian Securities and Investments Commission.

Ms Butler told Senators mandating staff ratios offered the best mechanism to provide proper care to Australia's elderly and that full transparency marked the first step to change.

Medicine shortage law



New laws that force medicine companies to report on shortages of critical and life saving medications as soon as they occur were passed last month.

In addition if a critical drug is being removed from the market the Department of Health must be notified by the manufacturer at least 12 months in advance, or as soon as possible.

The new law protects patients on vital medicines. It also gives the community, medicine company and patients the opportunity to take action to mitigate against a medicine shortage.

Medicine shortages have become an increasing problem in recent years, as medicine companies (manufacturers or importers) have failed to comply with the current voluntary reporting scheme.

Earlier this year, Australia was one of several countries hit by shortages of EpiPens, which provide lifesaving adrenalin for people who have had an acute allergic response. The shortage was not reported in advance and as a result patients and doctors were not alerted in time for them to make alternative arrangements.

Making work fairer for women



The Australian Council of Trade Unions (ACTU) has called on politicians to trigger reform of Australia's workplace relations rules so they become fairer for women.

The restructure would include overhauling paid parental leave and removing restrictions in bargaining.

A report commissioned by the ACTU, outlines recommendations for reform aiming to address structural bias against women within current workplace laws.

The recommendations include the abolishment of the concept of 'primary' and 'secondary' carers, to be replaced by 26 weeks' parental leave that a family can decide to use how they want, and removing restrictions on bargaining so women can negotiate with someone who has the capacity to say yes to a fair pay rise.

Other recommendations include the payment of superannuation on every dollar women earn, including during paid parental leave, stronger powers for the Fair Work Commission to tackle gender inequality and the establishment of an expert Gender Equality Panel, and the restoration and protection of penalty rates.

The ACTU said women are more likely to be working casually than men are and thus prone to being Award-dependent and vulnerable to penalty rate cuts.

They are also paid 14.6% less than men are and retire with 43% less superannuation.

Safer hospitals could save billions

Australia's health system could save \$1.5 billion per year if all hospitals lifted their safety surrounding patient care to match the performance of the country's best 10%, a new report from the Grattan Institute has found.

Titled *Safer care saves money: How to improve patient care and save public money at the same time*, the report states one in nine patients admitted to hospital suffers a complication, costing public hospitals more than \$4 billion a year and private hospitals over \$1 billion.

It found an extra 250,000 patients would go home complication-free each year and that the health system would save \$1.5 billion if all Australian hospitals matched the safety performance of the top 10%.

The improvements would also free up beds and resources so a further 300,000 patients could be treated.

Public hospitals receive extra funding for treating a sicker patient even if the patient becomes sicker because of a complication suffered at the hospital, yet the Grattan analysis suggests the costs of complications to the hospital outweighs any increased revenue.

The report claims hospitals do not require extra financial services to reduce complications and instead need better information and accreditation systems that encourage improvements.

It recommended replacing 'one size fits all' accreditation with a system based on measurable safety outcomes, tailored to each hospital's situation.

The report suggested complication rates and accreditation outcomes should be made public so that governments are held to account, and also endorsed surveyors conducting unannounced safety tests.

New path for healthcare delivery

Australia's healthcare system must shift in focus from treating illnesses to proactive management and prevention in order to improve the nation's health over the next 15 years, according to a new CSIRO report.

Released last month, the *Future of Health: Shifting Australia's focus from illness treatment to health and wellbeing management* report outlines a new pathway for national healthcare delivery it claims will streamline the health system, improve health outcomes and lead to a more productive and satisfied workforce.

The report provides a list of recommendations for improving the health of Australians geared around five core themes – empowering people, addressing health, unlocking the value of digitised data, supporting integrated and precision health solutions and integrating with the global sector.

Despite ranking among the healthiest people worldwide, Australians spend an average of 11 years in ill health, the highest among OECD countries, the report states.

It found clinical care only influences 20% of a person's life expectancy and quality of life, with the remaining 80% shaped by external factors such as behaviour, social and economic support and physical environment.

According to the report Australia's greatest health challenges include 63% (over 11 million) of adult Australians are overweight or obese, a 10-year-life expectancy gap between the health of non-Indigenous Australians and Aboriginal and Torres Strait Islander peoples, and the majority of Australians not consuming the recommended number of serves from any of the five food groups.

PROCEDURE UPDATE

Treatment standard for colonoscopies

Colonoscopies should only be offered to patients if the benefits outweigh the risks, new national treatment standards for the advanced procedure state.

Launched last month by the Australian Commission on Safety and Quality in Health Care, the *Colonoscopy Clinical Care Standard* advises patients with a positive bowel cancer screening result to consult their GP to discuss further investigation.

In most cases, this involves a colonoscopy, to diagnose and treat a range of bowel diseases including bowel cancer, which claims thousands of lives in Australia each year.

Almost one million Australians undergo a colonoscopy each year but research shows the rates of colonoscopies performed vary considerably and having the procedure unnecessarily could extend the wait time for those who really need it.





Lori-Anne Sharp

ANMF Assistant
Federal Secretary

The path to a peaceful future

In order to protect the survival of humanity it is vital that our Federal Morrison government act now to sign the treaty to prohibit nuclear weapons.

In the event of a nuclear detonation, nurses, midwives and other medical professionals would be among the first to respond. Any such response would prove incredibly difficult, with hospitals, electricity supply and other essential infrastructure destroyed or totally overwhelmed. The largest humanitarian organisation in the world, the International Red Cross Committee, acknowledges there would be no effective means of providing aid to the dying and wounded. The atomic bombs dropped on Japanese cities of Hiroshima and Nagasaki in 1945 killed hundreds of thousands of people and destroyed 70% of buildings and infrastructure.

Radioactive material lingered with many survivors later dying from radiation related illnesses.

During the 1950s and 1960s, Australia was the site of British nuclear testing. These nuclear tests occurred at Maralinga and Emu Field, South Australia and at Montebello Islands off the coast of Western Australia.

The testing had devastating effects on many Australians, particularly Indigenous Australians. At Emu Field and Maralinga, detonations led to radioactive material contaminating the local environment. The Aboriginal people that lived in the area called it 'puyu' or black mist. Tjamu Yami Lester, an Aboriginal man (now deceased) was blinded at the age of ten because of this "black mist" that came down on the Anangu Pitjantjatjara Yankunytjatjara Lands (APY Lands).

Given the devastating humanitarian impacts of nuclear weapons, it is in the interest of all people to ensure that these weapons are never tested or used again. Frustration with the failure of nuclear-armed nations to disarm gave rise to a movement; the International Campaign to Abolish Nuclear Weapons (ICAN), which was launched by the Medical Association for the Prevention of War in Melbourne in 2007.

ICAN brought together hundreds of organisations worldwide, including the Australian Nursing and Midwifery Federation, to denounce the use of and prohibit the development and possession of nuclear weapons.

The prohibition of nuclear weapons treaty has proven highly successful for the stigmatisation and reduction of other classes of weapon, such as chemical and biological weapons, landmines and cluster munitions. The banning of these weapons is a crucial step on the path to elimination, as it codifies in law the unacceptability of the weapon and sets the same standard against which all nations are judged equally.

In 2017 in New York, a majority of UN member states negotiated and adopted the UN Treaty on the Prohibition of Nuclear Weapons, finally banning the bomb and setting out a pathway for the total abolition of these horrendous weapons.

Tjamu Yami Lester's daughter Karina Lester spoke at the historic UN negotiations stating "My father Yami Lester was blinded by the British nuclear test. Many of his family and people died and many still suffer today. The emotional, mental and physical suffering is felt by generations".

Tjamu Yami Lester inspired his daughter to continue the fight for nuclear weapon abolition, and recognition and compensation of the contamination of Aboriginal lands and the dispossession of Anangu.

Of the 122 nations that supported the treaty, disappointingly Australia was not one of them and boycotted the negotiations. All eight nuclear-armed countries, which include United States, Russia, China, France, Pakistan, India, Israel and North Korea and their allies boycotted the negotiations. Australia claims that US nuclear weapons are essential for its security.

ICAN's role in the treaty-making process won them the 2017 Nobel Peace Prize, the first to be awarded in Australia. ICAN say that this is only the beginning. The International treaty will enter into force once 50 countries ratify. Currently over 60 states have signed and 14 ratified.

The stakes are high; it is up to all of us to ensure Australia sides with international law and becomes part of the solution, by signing and ratifying the nuclear weapon ban treaty. I hope that every nurse and midwife reading this considers what action they will take in calling for our Federal government to act now and join the movement for global nuclear disarmament by signing the treaty to prohibit nuclear weapons. We need to act now, and show our support for a peaceful future, where nobody is at threat of a nuclear attack or disaster.

SOME WAYS YOU CAN TAKE ACTION

- Write to your local MP or Senator and ask them to sign the Treaty to prohibit nuclear weapons
- Start a conversation about nuclear disarmament with your colleagues or neighbours
- Check out further information below:
 - icanw.org
 - mapw.org.au
 - nuclearban.org
 - dontbankonthebomb.com
 - mapw.org.au/news/please-support-our-call-for-australia-to-sign-the-nuclear-weapons-ban-treaty/

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CELEBRATING THE ANMJ

In this first edition of the new look quarterly *ANMJ*, we take a look back in the archives and celebrate the journal's history.

By Natalie Dragon

If truth were known, the launching of a sophisticated national journal in a span of time not much greater than two months is a feat equivalent to performing an appendectomy, in a rowing boat, at the height of a Port Phillip storm with the sole aid of a blunt bread knife," an early editorial described the initial launch.

The first edition of the *Australian Nurses' Journal* of the Royal Australian Nursing Federation (RANF) hit the press in July 1971.

Although the journal was a new one, its name had been established in the Australian nursing world for nearly 70 years, having been published first in 1903 by the Australasian Trained Nurses' Association (NSW).

The first edition covered the Federation's news and activities, state affairs, the Student

Nurses' Unit, nurses at work, and updates on the profession, the industry and education.

"This challenge is an individual one, the responsibility a collective one, to prove in Australia and abroad that we have the professional skill and creative ability to use such a powerful medium as the press to strengthen and maintain the status of the nursing profession so that it can be a dynamic force now and in the future," wrote RANF President Olive Anstey.

From the start, the journal highlighted the union's role in advocating for the professions and the public.

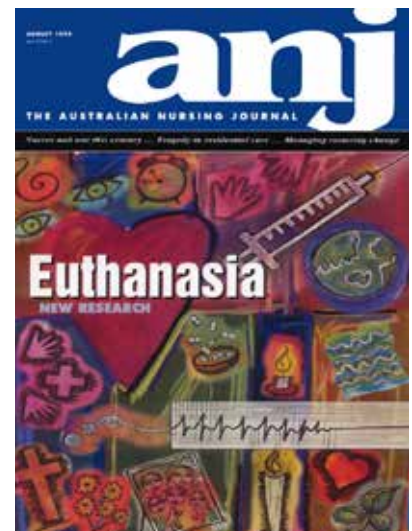
Nurses packed into the Nurses' Memorial Centre in Melbourne on 15 July 1971 to debate the strategic and tactical position they were placed in over their dispute with the Victorian Hospitals' Association Industrial Council over their wage claims.

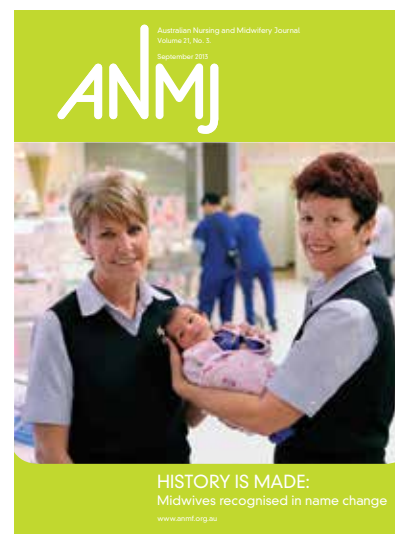
RANF supported the national wage case in 1971 and advocated for a uniform allowance for nurses.

The journal covered international nursing issues of unfair recruiting practices by governments and employment agencies, the cholera epidemic in India, the work of the RANF overseas and the ICN.

"At last Australian nurses have a journal which reflects the word and the spirit of their profession: at last Australian nurses have a magazine which can take its place among those of other countries," wrote Editor G C Thallon.

In subsequent editions, the volume and variety of material being contributed meant that the *Journal* was serving the purpose for which it was designed, according to publisher and RANF Federal Secretary Mary E Patten: "a platform for the dissemination of news and information of every kind likely





to be of value and interest to nurses in all parts of Australia."

The journal has continued to hold to that mission to this very day. Other regular items appeared, including law and ethics, research, health economics and policy and social justice issues as nurses and midwives increasingly spoke out on matters of controversy and in advocacy for fairness and equity.

The journal has covered significant times in the political landscape of the country and in health, nursing and midwifery and indeed of the Federation itself. RANF became the Australian Nursing Federation in May 1993. The *Australian Nurses' Journal* became the *Australian Nursing Journal*. Some 20 years later, ANF incorporated midwifery into its name in 2014, becoming the ANMF and the *Australian Nursing & Midwifery Journal*.

The ANMF has continued to campaign on crucial issues impacting the nursing and midwifery professions such as the shortage of highly-educated nurses; the continued non-employment of nursing graduates; the urgent need for nurse to patient ratios; delivering better wages for aged care nurses; and mandated skills and training for those working in the aged care sector. The *ANMJ* has been the voice of the union, and the medium through which its members have had their own voice.

Industrial issues have included job losses, career restructuring and service cuts to workloads, skills mix and wage and conditions claims. Professional issues have included the national review of nursing education, underfunding of clinical placements, student numbers to match workforce needs and national registration.

As times have changed, including digital communication, increasing costs of print publication and the environmental impact, the ANMF and the journal has endeavoured to keep pace.

The *ANMJ* became freely available online earlier this year. It recently launched its own website anmj.org.au and Facebook page and the *ANMJ* print publication will reduce to four times a year.

The relevance of the journal today is as great to members as it was in 1971. The *ANMJ* is the voice of the ANMF, the voice of nurses, midwives and assistants in nursing. It will remain here to inform, educate, share, influence, motivate and inspire the best for the professions and for all Australians.

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FEATURE



Congress of Aboriginal and Torres Strait Islander
Nurses and Midwives CEO Janine Mohamed
Photographer: Scott McNaughton

END OF AN ERA: AN INSPIRING ABORIGINAL LEADER

In 2013, Janine Mohamed assumed the role of Chief Executive Officer of the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) and set about realising her vision to build an organisation which members would be proud to call their own.

By Robert Fedele

“That it had a sense of identity,” Janine recalls of her aspiration.

“That the membership forged. I think looking back we’ve achieved that. People are really proud to be a part of CATSINaM and because of that pride, they’ve brought in other people.

“The members are the people that own the organisation and I think we’ve really forged some wonderful relationships with our peak nursing partners that I hope will continue into the future.”

After five years at the helm, Janine will step down as CEO in February next year to take up a Fellowship at the University of Melbourne within its Atlantic Fellows for Social Equity Program, established to train a new generation of leaders, particularly those representing Indigenous communities, committed to tackling social disadvantage.

Janine will focus on improving social equity across the globe with a focus on New Zealand and Australia.

“One of my long held passions has been about ensuring that Indigenous nurses’ voices around the globe are heard in our governance structures so I’ll be exploring how that currently happens and how we can improve it.”

Formally established in 1998, CATSINaM celebrates its 20th anniversary this year and marked the milestone at its annual conference in Adelaide last month by bringing back foundational members who led the way.

Over the past two decades, the organisation has risen to become one of the nation’s peak bodies advocating for nurses, midwives and Indigenous health.

The Professional Development Conference ran under the theme “Honouring our past, empowering our present, growing our future” and reinforced the difference made by members in improving outcomes for Aboriginal and Torres Strait Islander Australians.

Janine says this year’s theme represented a reminder of the need to continually honour the legacy of trailblazing founding members and also grow and empower the next generation of Aboriginal and Torres Strait Islander nurses and midwives.

“The unification of Aboriginal and Torres Strait Islander nurses and midwives and really projecting what the uniqueness is of our workforce and our members,” she replies when asked to list the organisation’s greatest influence.

“We have over 3,000 Aboriginal nurses and midwives and I’m sure there are more out there.”

Over the past two decades, the organisation has risen to become one of the nation’s peak bodies advocating for nurses, midwives and Indigenous health.

CATSINaM plays a pivotal role in highlighting the value of Aboriginal and Torres Strait Islander nurses and midwives in achieving health equality across the country’s health system for Indigenous Australians.

In a sign of progress, Janine and fellow Indigenous leaders were called on to

“Cultural safety provides the means to challenge and eradicate the institutional barriers that Aboriginal people face in accessing healthcare.”

canvass strategies to improve healthcare for Aboriginal and Torres Strait Islander people when the Council of Australian Governments (COAG) federal, state and territory Health Ministers met in Alice Springs in August to bring attention to the issue.

Janine was the sole Indigenous leader asked to deliver a keynote address to the nation's health ministers, with her speech focussing on Indigenous governance and leadership and outlining the bold action she says is required to close the gap.

She argued improving Aboriginal health demands addressing the cultural and social determinants of health such as access to healthcare, housing, education and justice.

She also called on Health Ministers to listen, help build respectful and trustful relationships, and provide national leadership to work together with Aboriginal people on their lifelong journey to triggering change.

Notably, her speech called on governments to engage meaningfully with the Uluru Statement that is seeking a constitutionally enshrined ‘First Nations Voice’ able to report to Parliament. She also congratulated the Australian Commission on Safety and Quality in Health Care for launching the second edition of the *National Safety and Quality Health Standards* and accompanying *User Guide for Aboriginal and Torres Strait Islander Health*.

Overarchingly, Janine implored the COAG Health Council to prioritise efforts to identify and fill service gaps to ensure equitable access to health services for Aboriginal and Torres Strait Islander people.

Indigenous leadership would be key to putting systems in place to improve outcomes, she added.

“With the mortality gap widening that’s what it’s going to take,” she says.

“For the first time in a long time we’re not seeing it closing but we’re actually seeing it widening and that was certainly a message that we needed to get across to ministers; that we didn’t want to go backwards.

“It’s an opportunity to fix that and try get us back on track, or at least to narrow that gap, and certainly we told that through

the picture of expenditure, particularly in primary healthcare with preventable disease and preventable death. We can actually stop conditions such as rheumatic heart disease and trachoma.”

During her address, Janine also emphasised the importance of cultural safety and suggested a movement was now emerging to embed it within the health profession.

“Cultural safety provides the means to challenge and eradicate the institutional barriers that Aboriginal people face in accessing healthcare,” she told Health Ministers.

“These barriers destroy our lives and prevent our people from establishing true trust and respect in their healthcare encounters.”

The concept of cultural safety was thrust into the media spotlight earlier this year after misleading media reports regarding new codes of conduct for nurses and midwives wrongfully claimed nurses and midwives needed to announce their ‘white privilege’ before treating Indigenous patients.

The codes do require nurses and midwives to take responsibility for improving the cultural safety of health services for Aboriginal and Torres Strait Islander clients and colleagues and demand care that is ‘holistic, free of bias and racism’.

Janine says in a roundabout way the negative publicity helped spark a constructive conversation.

“It got a lot of clarification amongst the profession. Particularly, nurses and midwives on the ground began having this discussion because it was brought to the fore in the media and what was certainly uncovered was that it was sensationalised.

“What nurses and midwives got out of that was that we’ve been learning about cultural safety for some time and now it’s actually embedded systemically.”

Elsewhere, the COAG Health Council discussions prompted a pledge for greater national collaboration to improve health outcomes for Aboriginal and Torres Strait Islander Australians.

Janine welcomed the progress and singled out the impact of Indigenous Health Minister Ken Wyatt, who she says has

significantly improved accountability.

“Although we did highlight nursing and midwifery, we spoke to the broader social determinants as well and how we all need to work in collaboration to improve health outcomes,” Janine says.

“It’s a fantastic start. Actions speak louder than words and certainly in undertaking this type of meeting it was a very good start for what can happen in the future.”

While Janine’s departure from CATSINaM signals the end of an era, the organisation is well poised to continue its advocacy and leadership on behalf of Indigenous nurses and midwives and improve health outcomes.

For the first time, CATSINaM has received funding for the next four years from the Department of Health, which will safeguard its operation.

The organisation also launched its new Strategic Plan for 2018-2023 at last month’s Professional Development Conference to help steer its future direction.

The plan’s four priorities over the next five years include:

- Develop and support recruitment and retention strategies for Aboriginal and/or Torres Strait Islander Peoples in nursing and midwifery
- Inform national Aboriginal and Torres Strait Islander health and education policy agendas
- Provide a cultural hub for resilience and leadership development of members
- Inform best practice in culturally safe learning, workplace and health service delivery environments for Aboriginal and/or Torres Strait Islander Australians

Janine says COAG Health Ministers’ commitment to developing a National Aboriginal and Torres Strait Islander Health Workforce Plan now offers a sound basis for the hard work that lies ahead.

“What we need is six and a half times more Indigenous nurses right now than what we currently have and that’s just to reach population parity and to contain our burden of disease,” she says.

“We’ve got a long way to go but we’ve got great mentors out there, role models out there through our workforce.”



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Kristen Wischer

ANMF Federal
Industrial Officer

National Inquiry into sexual harassment at work

On 19 June 2018, the Sex Discrimination Commissioner Kate Jenkins launched the Australian Human Rights Commission National Inquiry into sexual harassment at work. The Inquiry is the first of its kind in Australia and the world.

Michele O'Neil, President of the ACTU has been appointed to the panel conducting the Inquiry.

The Inquiry has been prompted by the Commission's most recent sexual harassment survey results, which indicate the prevalence of the problem has increased since the last survey in 2012.

Sexual harassment disproportionately affects women with one in five experiencing sexual harassment at some time, compared to one in 20 men.

Sexual harassment is any unwanted or unwelcome sexual behaviour, which makes a person feel offended, humiliated or intimidated.

It may include conduct ranging from leering, unnecessary familiarity, insults of a sexual nature, intrusive questions about your private life, displaying images of a sexual nature, sending sexually explicit emails or texts, unwanted requests for sex or dates to behaviour that may be considered a criminal offence, such as assault, stalking or indecent exposure. The conduct can occur between an employee and employer, colleagues or other people in the workplace such as clients.

Commissioner Jenkins commented that she has had many men and women come forward to her in recent months to tell their stories of sexual harassment in the workplace and that she recognises the devastating impact sexual harassment has on individuals' lives, as well as the significant costs to business and community.

The National Inquiry will review and report on:

- the prevalence, nature and reporting of sexual harassment in Australian workplaces, by sector;
- the use of technology and social media to perpetrate work-related harassment;
- the drivers of workplace sexual harassment, including looking at whether some individuals are more likely to experience sexual harassment and whether workplace characteristics and practices are more likely to increase the risk of sexual harassment;
- the current legal framework;
- existing measures and good practice being undertaken;
- the economic impacts; and
- recommendations to address sexual harassment in workplaces.

The Inquiry will run over the next 12 months and submissions are due by 31 January 2019.

The Commission will also be running public consultations. In a recent press release, Commissioner Jenkins said the purpose of the consultations will be to speak with individuals and organisations from all over Australia about their experiences in order to develop concrete, practical strategies to prevent and better respond to workplace sexual harassment.

The ACTU will make a submission to the Inquiry and is in the process of developing a survey to gather information. Such work will need to be done sensitively, confidentially and provide access to support to members who have experienced the impacts of sexual harassment.

The Inquiry provides an opportunity to raise the systemic issues that make some workplaces more susceptible to sexual harassment occurring, such as gender inequality, unsafe work practices and the impact of insecure work. Casual, fixed term or agency employees may, for example, feel more vulnerable in their workplaces and therefore more at risk of inappropriate workplace behaviour. It is harder to speak out when your next shift or job is not guaranteed.

An examination of the legislative framework for dealing with complaints of sexual harassment will form part of the Inquiry. Currently, the *Sex Discrimination Act* allows for individuals to make a complaint about behaviour, but this is dependent on the individual and such complaints are often resolved out of court. Changes to the *Sex Discrimination Act* and the *Fair Work Act* may provide greater opportunity for unions to make claims on behalf of individuals or groups of individuals and to ensure employers are held accountable for poor workplace practices.

Workplace health and safety legislation could be strengthened to create a greater obligation on employers to take all reasonable steps to ensure a workplace is safe from harassment. There are many measures set out in the *Change the Rules* campaign that are aimed at decreasing workers' vulnerability in the workplace. These measures are designed to produce multiple benefits to workers, not least, a reduction in sexual harassment in the workplace.

Our membership, of nurses, midwives and assistants in nursing are predominantly women. We know, therefore, that a disproportionate number of our members will have been affected by sexual harassment in some form over their working lives. The national Inquiry will be an important opportunity to contribute to identifying workplace measures and legislative changes that will reduce the incidence and impact of sexual harassment in the workplace.



Micah D J Peters

Dr Micah D J Peters is the ANMF National Policy Research Adviser (Federal Office) based in the Rosemary Bryant AO Research Centre, School of Nursing and Midwifery, University of South Australia

Keeping up with best evidence for nursing and midwifery practice

In the June issue, I discussed how nurses and midwives can and should engage with evidence-based healthcare as an important and effective way of getting evidence from research papers into clinical practice to make a real difference in the way that patients are cared for.

I noted a barrier to engaging with research is the gigantic volume of evidence that is produced every day. Indeed even in 2014, it was estimated the scientific output worldwide was doubling almost every decade (Van Noorden, 2014).

These estimates don't include evidence or resources produced by non-scholarly sources either, such as clinical guidelines, textbooks, position statements and policy documents, so it's highly likely that this estimate is quite conservative.

The challenges faced by healthcare professionals to keep up with evidence is well examined, and has become its own growing field of literature that itself is difficult to keep up with (Haynes et al. 1986; Philips and Glasziou, 2008).

This column summarises some of the popular and recommended techniques for keeping up with the evidence for healthcare professionals that nurses and midwives from novice through to advanced practice could use as well as some key points in getting that evidence into practice.

It would be impossible to keep up with the sheer volume of research and non-research evidence produced and even for specific and specialised fields, it would be a challenge to stay abreast of each piece of new evidence, guideline, and policy in amongst busy clinical workloads and administrative duties.

Journal clubs, online databases, reputable scientific/clinical blogs, and conversations with colleagues and mentors are excellent resources for busy healthcare professionals but even so, there is still a huge number of articles to wade through.

However, one must eat the elephant in portions, so read what is relevant to your work first and foremost.

But how to prioritise where to begin?

Publication date and 'high impact' journals are often a good place to start, as usually newer evidence should (but doesn't always) build upon and advance previous knowledge in a field and is often published in the higher-ranked publications first. Newer sources of evidence will ideally contain information regarding the latest advances in an area and be the most relevant to the way nurses and midwives work and deliver care using contemporary technologies, procedures, and drugs.

There are however a range of different types of evidence, from case studies of single patients, large

experiments or population studies with hundreds or even thousands of participants, studies reporting peoples' experiences, to evidence syntheses including literature reviews and systematic reviews (and many, more).

Evidence syntheses of many types are designed to bring bodies of evidence together on specific topics; these enable the reader to more efficiently absorb evidence from the multiple studies that have been included (Grant and Booth, 2009). However, literature reviews are selective – the authors have included only the papers they have chosen to, and that not all systematic reviews (which should have a rigorous approach to the inclusion of evidence) are created equal. They can themselves be at risk of bias and the authors' own preferences or accidental oversights (Ioannidis, 2016).

This takes us into the realm where it is important to know what we're reading (Is it of good quality? Should I take the advice it recommends?) and is where we must also start thinking about *how* to read a paper.

Trisha Greenhalgh's "How to read a paper: the basics of evidence-based medicine" is an excellent (readable and brief, too!) book that covers many key elements of what a reader must keep in mind when critically reading evidence (Greenhalgh, 2014). Greenhalgh covers issues from where to search for evidence, how to appraise its quality, how to interpret statistics, and how to apply the evidence you've gained from critically reading papers with your patients.

This last point is vital, as I don't wish to stray away from clinical practice, the patient, and clinical experience and knowhow. Evidence from the literature cannot generally be applied wholesale or fresh from the press; evidence from any source must be incorporated carefully with what nurses and midwives know about what their patients want and desire as well as what they know and are skilled at themselves (Scott and McSherry, 2009). Remember most evidence you'll encounter was developed by researchers and clinicians who don't have a clear and specific understanding about your local context and practice.

This means nurses and midwives must critically read and appraise evidence from many diverse sources and bring it together for implementation in their own local settings with their own patients, resources, and challenges.

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ANMF Federal Secretary Annie Butler (second from left) at the 2016 South Pacific Nurses Forum

ANMF FOSTERS GLOBAL PARTNERSHIPS

The Australian Nursing and Midwifery Federation (ANMF) has long recognised the importance of developing an international network of affiliations to advance the interests of the professions and safeguard the health of communities worldwide.

By Robert Fedele

Current international affiliations include the International Council of Nurses (ICN), Global Nurses United (GNU), the Commonwealth Nurses and Midwives Federation (CNMF), the South Pacific Nurses Forum (SPNF) and recently launched three-year global campaign Nursing Now.

As the largest union within a powerful nation, Federal Secretary Annie Butler says the ANMF holds a responsibility to use its influential voice to support and lead global

initiatives aimed at growing the work of nurses, midwives, and carers, particularly in developing countries, and improving health outcomes.

“The ANMF actively builds relationships with nursing and midwifery organisations, unions and other groups around the world to help drive the advancement of the professions and influence positive outcomes,” Ms Butler said.

“In an increasingly connected global arena, the opportunity to engage with international organisations and share knowledge regarding policies, strategies and workforce issues has never been greater. Maintaining meaningful partnerships

is essential to maximising benefit to our members and improving the health of all communities.”

The ANMF's strategic priorities for its work during 2018-2023 include a focus on fostering new and existing international affiliations and helping boost the capacity of nursing associations within the Asia-Pacific region and others where required.

In March this year, the ANMF developed its first Framework for International Relations and Affiliation so it could review and assess current and potential opportunities for international engagement and identify how to best utilise the organisation's available resources.

Over coming months, the ANMJ will run a series of indepth articles on its website outlining the ANMF's current international affiliations and their impact.

During the coverage, the ANMF will ask members to provide their feedback, and then use the data to help shape future partnerships.

"We believe it is important that the views of ANMF members underpin and guide our international engagement and activity," Ms Butler said.

"Their direction will prove invaluable and we look forward to working together as we strive to enhance our international footprint and cement our position as a strong and respected global voice."

COMMONWEALTH NURSES AND MIDWIVES FEDERATION (CNMF)



The ANMF has been a member of the CNMF since 1973.

Based within the Royal College of Nursing in the UK, the CNMF is a nursing and midwifery federation that draws its membership from national nursing and midwifery associations from the 53 Commonwealth nations.

Its key priorities surround influencing health policy throughout the Commonwealth, developing nursing networks, enhancing nursing education, improving nursing standards and competence and strengthening nursing leadership.

Other targets include membership development, conducting in-country projects with national nursing organisations involving capacity building and training, and conducting and facilitating research on nursing and midwifery within Commonwealth countries.

INTERNATIONAL COUNCIL OF NURSES (ICN)



The ANMF has been affiliated with the International Council of Nurses (ICN) since 2002.

Founded in 1899, ICN represents over 20 million nurses worldwide and is a federation of more than 130 national nursing associations striving to advance the profession globally, influence health policy and improve health outcomes.

Earlier this year, Australian remote area nurse/research academic Dr Isabelle Skinner

was appointed the new chief executive officer (CEO) of ICN.

Outside nursing-focussed organisations, ICN maintains working relationships with specialised agencies within the United Nations system including the World Health Organization (WHO) and advocates for national delegations of nurses to contribute to policy development processes.

Every two years, ICN hosts triad meetings of its member organisations in Geneva, Switzerland, ahead of the World Health Assembly, bringing together national nursing and midwifery organisations, chief government nursing and midwifery officers and regulatory bodies.

ANMF Assistant Federal Secretary Lori-Anne Sharp represented the ANMF at meetings in May this year where discussions focused on the theme *health is a human right*.

GLOBAL NURSES UNITED (GNU)



GNU comprises affiliate national healthcare worker unions from 22 countries.

Established in 2013 by the USA's National Nurses United, GNU's mission is to carry out collective action against instances of austerity measures, privatisation, and healthcare service cuts globally.

Universal healthcare incorporating safe nurse-to-patient ratios, income equality, poverty and climate change also form key targets.

The ANMF is affiliated with GNU on both a state and national level, with the Federal Office and Queensland, New South Wales and Victorian state branches holding membership.

ANMF Federal Secretary Annie Butler attended a GNU meeting held in July this year in Sydney hosted by the New South Wales Nurses and Midwives' Association (NSWNMA).

The meeting covered issues including violence against healthcare workers, Indigenous health in remote areas, tax justice, and legislated nurse-to-patient ratios.



SOUTH PACIFIC NURSES FORUM (SPNF)

The South Pacific Nurses Forum was established in 1982 by a group of South Pacific Nurses who attended the 1980 ICN conference in Los Angeles.

The SPNF involves a meeting held every two years where nurses from across the South Pacific come together to debate key issues facing the profession.

The next meeting, the 19th SPNF, will be held this month in the Cook Islands and focus on encouraging nurses to take the lead in addressing problematic non-communicable diseases (NCDs) in the Pacific.

The ANMF Federal Office acts as Secretariat for the SPNF and considers the partnership a valuable opportunity to support and grow the nursing and midwifery professions in developing countries that face barriers to the provision of optimal nursing care such as workforce shortages and fewer training opportunities.

NURSING NOW



Launched in February, *Nursing Now* is a landmark three-year

global campaign aiming to improve health and lift the profile of nursing.

It evolved from a global nursing review undertaken by the UK's All Party Parliamentary Group on Global Health that produced a report titled *Triple Impact*, which argued strengthening nursing would trigger a threefold effect – improving health, promoting gender equality and supporting economic development.

Backed by ICN and WHO, the campaign will run until the end of 2020 to mark the 200th anniversary of nursing pioneer Florence Nightingale's birth.

Prominent ambassadors include The Duchess of Cambridge, Kate Middleton, selected as the UK's official patron due to her family lineage of nurses.

Nursing Now's goals include greater investment in nursing and midwifery, promoting innovative practice in nursing, and ensuring more nurses secure leadership positions.

Australia's contribution to the campaign, led by *Nursing Now* campaign board member for the WHO's Western Pacific Region, Emeritus Professor Jill White, is focusing on pushing for greater access to healthcare.

In August, the ANMF Federal Council committed to supporting the *Nursing Now* campaign over the next year and exploring ways to contribute.

Professor White and leading nursing organisations including the ANMF are currently discussing ideas for potential formal projects in Australia.



Elizabeth Foley

ANMF Federal
Professional Officer

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The case for ratios in aged care

Quite rightly, Australia has strict staff ratios for child care centres, (Australian Children's Education & Care Quality Authority 2018) but this is not the case in residential aged care facilities.

Does society value small children more than it does elderly people with complex care needs?

A 13% reduction in qualified nursing staff working fulltime in aged care facilities occurred between 2003 to 2016, resulting in a significant decrease in minimum hours of care received by residents (Willis et al. 2016).

Older people have contributed to society and should be respected in return. As a wealthy, democratic country, all people in Australia should expect to feel safe in paid-for care environments.

Repeated studies overseas and nationally (Aiken et al. 2017, Duffield et al. 2011, Twigg et al. 2015 and ICN 2006), have demonstrated safe staffing saves lives: safe care is the right numbers of nurses leading clinical care and the right skills mix of nurses and care workers to meet care requirements. These studies have proven a skills mix with registered nurses produces statistically significant decreases in pressure injuries, falls, pneumonia and infections. This is no different whether the care is provided in acute care settings or residential aged care facilities, as a study of 195 nursing homes in the United States (Hyang et al. 2014) found higher registered nurse hours were associated with fewer pressure ulcers.

The *Aged Care Act 1997* states approved providers have a responsibility to *maintain an adequate number of appropriately skilled staff to ensure that the care needs of care recipients are met* (Australian Government 1997). Use of ambiguous terms 'adequate' and 'appropriate' has led to variable interpretations on staffing numbers and qualification levels.

Worryingly, while the complexity of care requirements for residents has unquestionably increased over past years, particularly in terms of increased complexity of care and behavioural needs, medicines regimes and comorbidities, (Willis et al. 2016 p.14) the numbers of registered nurses and enrolled nurses have noticeably decreased in many aged care facilities (Mavromaras 2017). In the absence of registered and enrolled nurses, residents face missed or compromised care.

The impact of nurse and carer staffing in aged care was not examined nationally until 2016 when the ANMF commissioned a study by researchers from Flinders University and the University of South Australia. The National Aged Care Staffing and Skills Mix Project Report 2016 titled *Meeting residents' care needs: A study of the requirement for nursing and personal care staff*, provides an evidence-based methodology for both minimum staffing requirements and the ratio of qualified staff to carers to 'ensure safe residential and restorative care' (Willis et al. 2016 p. 9). This methodology specifies an average of four hours and eighteen minutes of care per day per resident, with a skills mix requirement of: registered nurses 30%, enrolled nurse 20% and carers 50%.

The ANMF's national aged care campaign calls on federal politicians to legislate ratios for a more transparent aged care staffing structure, to give certainty for residents and their families that the right numbers of staff, and the right skills mix of qualified staff and carers are available for safe care.

...the numbers of registered nurses and enrolled nurses have noticeably decreased in many aged care facilities (Mavromaras 2017). In the absence of registered and enrolled nurses, residents face missed or compromised care.



Linda Starr

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

Risks of dual relationships in delivering care

Complaints against health practitioners generally arise from a series of complex circumstances that raise questions about the practitioner's competence to practice.

This may be due to a health impairment or the practitioner's conduct. In some cases, the conduct is such that the complaint will be referred to a disciplinary tribunal to determine whether the practitioner has engaged in unprofessional conduct or professional misconduct. This article will identify what these terms mean in a regulatory sense and then illustrate this through a recent example as to what conduct attracts such findings.

According to the National Law (2009) unprofessional conduct refers to professional conduct that falls below the standard that ought reasonably be expected of the practitioner by both the public and other health professionals. Whereas professional misconduct is a more serious finding and consists of conduct that is substantially below the standard reasonably expected of a registered health practitioner of an equivalent level of training or experience or several instances of unprofessional conduct that collectively amount to professional misconduct or circumstances where the practitioner would not be seen as being a fit and proper person to hold registration in the profession whether or not this occurs in connection with their practice (Health Practitioner Regulation National Law Act 2009 s 5).

In some cases a practitioner may be found to have engaged in both, as illustrated in the following case.

Here the practitioner was the sole GP in his rural practice but not the only MO in town: he saw approximately 200 patients over his seven day working week, was the only GP doing on call and after-hours work and also serviced the nursing home.

The complaint in this case related to:

- inappropriate prescribing and/or medical treatment;
- inappropriately treating persons and inadequate keeping of notes or records of those he treated with whom he shared a close personal or family relationship;
- prescribing of DDA's where he knew or ought to have known that the patient was a drug-dependent person; and
- breaching permit obligations in relation to prescribing Schedule 8 poisons.

Poor documentation and breaches in prescribing medication were recognised to some degree to be attributed to the GP's excessive workload, failure to have adequate systems in place for checking currency of prescribing permits and having access to records when out of the practice.

The more serious complaints refer to the issues arising from the dual relationship the practitioner had with his patients. Although there is no absolute prohibition on treating patients with whom a practitioner has a close personal relationship, best practice would be to avoid doing so in all cases other than for example, where the patient may need a one off script for treatment that needed to be commenced immediately.

The tribunal noted that the risks in dual relationships rises from the potential for the practitioner to lose objectivity and succumb to pressure advanced by the patient for ongoing treatment. This it was noted, was particularly so in cases where the treatment involved providing scripts for DDA's including opioids and benzodiazepines and where there are mental health concerns.

Indeed, this risk materialised here where the practitioner failed to recognise and manage the risks associated with treating people he had a close relationship with and who had drug dependency and mental health issues.

Furthermore, he continued to prescribe these drugs, when he ought to have known it was in the patient's best interest to refer them on for specialist assessment.

As such the tribunal held that the practitioner had breached his obligations as a MO and that in some instances this represented a substantial departure from accepted standards (professional misconduct), and in others a departure, but to a lesser degree, from those standards (unprofessional conduct). The practitioner was reprimanded, suspended from practice for three months and had conditions placed on his license to practice regarding education, audits and mentoring.

The continued shortage of health practitioners in rural communities and the very nature of these will continue to expose health practitioners to high workloads and circumstances where friends and family may also become patients requiring treatment. As such it is critical that health practitioners in these areas recognise and understand how close personal relationships can interfere with the therapeutic relationship and the potential for their professional judgement to be clouded with these competing interests that could be detrimental to the patient's welfare and ultimately not be in their best interests. Whenever this is the case, good practice requires recognition and careful management of these issues (Medical Board of Australia v Griffiths (Review and Regulation) [2017] VCAT 822).

The effects and impact of second-hand cannabis smoke exposure on nurses working in the community

By Dr Miguel A Iglesias, Joy Pertile, Luke Molloy and Alex Chan

ABSTRACT:

This article explores the work, health and safety risks that may be associated with the exposure of nurses to second-hand cannabis smoke while working in the community. Emerging evidence suggests the benefits of cannabis in the treatment of several chronic and terminal illnesses. This has led to some countries, like Australia, decriminalising or legalising the use of cannabis for medicinal purposes. Smoked cannabis is one of several routes of administration. However, cannabis smoke may have an impact on those in close proximity to the consuming patient. As a result, community healthcare workers, including nurses, may passively inhale cannabis substances while visiting patients in their home. This poses a work

health and safety risk to the community nurses and other healthcare workers. This review intends to raise awareness of this fact and reveals that more research and education is needed to strengthen policies and procedures around the nursing practices in the care of patients who choose to use smoked medicinal cannabis for symptom management.

The successful use of cannabis in the treatment of a range of chronic or terminal medical conditions, such as chemotherapy-induced nausea and vomiting, palliative care patients or childhood epilepsy, is currently widely discussed and reported around in the media and specialised literature (Suraev et al. 2017; Wong & Wilens 2017; Hausman-Kedem & Kramer 2017; Abrams 2018). The use and cultivation of cannabis for any purposes in Australia, including medical research for acute and chronic disease management, has been prohibited since the early twentieth century (Rodman 2015).

OVERVIEW OF THE ISSUE:

Possession of cannabis is illegal in most countries, and even the death penalty may apply for the sale and possession of cannabis in some countries (Edwards et al. 2011). In general, the negative portrayal of cannabis is not only associated with drug addiction and health behavioural issues (Agrawal et al. 2016; Agrawal & Lynskey 2006; Agrawal et al. 2017), but also associated with criminal offences by the media and general public (Pedersen & Skardhamar 2010; Morris et al. 2014).

However, emerging evidence suggesting the usefulness of cannabis as medical therapy, and the increase in patients supported who are suffering these conditions in the community has led several countries, including Australia, towards legalising or decriminalising the use of cannabis for medicinal purposes.

RISKS TO HEALTH IN THE TARGET GROUP (COMMUNITY NURSES):

While smoking cannabis is not a route of administration supported by the Australian Therapeutic Goods Administration, patients may choose to inhale cannabis smoke as a treatment modality at home, unaware that this may pose a work health and safety risk to the nurses and other healthcare workers who visit patients in the community.

PROJECT OUTLINE:

This article represents a synthesis of relevant literature for nursing practice exploring the effects and possible impact of second-hand medicinal cannabis smoking on nurses working in the community. The authors examine key findings identified and provide analysis of their relevance to nursing and healthcare workers working in the community.

A literature review was undertaken to find publications related to second-hand cannabis smoke. The databases searched were Web of Science, Scopus and CINAHL. The search terms used were *cannab** OR *marijuana* AND ("*secondhand*" OR "*second-hand*" OR "*second hand*") AND *smok**. A total of 88 papers were identified across the search: CINAHL (42), Web of Science (9) and SCOPUS (36). The search highlighted a limited evidence based on the impact of second-hand cannabis smoke on human subjects. There was no primary research on health professionals' exposure to second-hand cannabis smoke, using either qualitative or quantitative methods.

RESULTS

THE EFFECTS OF CANNABIS SMOKE

With the increased use of cannabis, there has been a growing concern about its possible adverse effects. While there are a variety of modes of delivery, the fastest route of absorption of the active components of cannabis, tetrahydrocannabinol (THC) and cannabidiol (CBD), is via the respiratory system (Grotenhermen 2003). Thus, smoked cannabis is the most common form of consumption of cannabis for recreational use (Newmeyer et al. 2017).

Although smoking cannabis is the only route of administration not recommended by the Australian Therapeutics Goods Administration due to the harmful effects of smoke, its fast absorption (Grotenhermen 2003) could facilitate the titration when

used for medicinal purposes, and may be the chosen route by the patient looking for fast symptom relief. Cannabis can be smoked alone, but it is most regularly mixed with tobacco (Meier & Hatsukami 2016).

Smoke from both cannabis and tobacco contains a mixture of compounds, including carcinogenic molecules and tars known to be the culprit of damaging effects of smoking (Hoffmann et al. 2001), although to differing degrees depending on which substance is smoked (Melamede 2005).

A logical inference is that the effects of cannabis smoke could also affect second-hand smokers (Holitzki et al. 2017), including nurses working in the community who may unconsciously and/or passively be exposed at times to the smoke of cannabis.

THC is the compound in cannabis that causes hallucinogenic results (Johannigman & Eschiti 2013). The THC from a typical cannabis cigarette that is absorbed by the mainstream smoker is found to be in the range of 20-37%.

Pyrolysis further destroys approximately 30% of the THC and the remaining 40-50% is released as side-stream smoke into the environment. In addition, there are further contaminants from the exhalation of the mainstream smoke. Therefore, regardless of the many factors that affect absorption of THC, there is a likelihood of passive inhalation of THC in non-smokers in an environment where cannabis is being smoked (Berthet et al. 2016).

HEALTH RISKS OF SECOND-HAND CANNABIS SMOKE

The effect of second-hand cannabis smoke (SHCS) must be considered in the discussion of using cannabis products as a treatment modality in the community. SHCS is defined as a combination of the side-stream smoke that is emitted from the cannabis cigarette and the exhaled smoke from the mainstream smoker (Office on Smoking and Health 2006). The effects of second-hand tobacco smoking have been extensively investigated. It is known that non-smokers exposed to second-hand smoke from tobacco have a 30% increased risk of cerebral vascular attack (CVA) (Malek et al. 2015), and that it can affect cognitive function (Heffernan & O'Neill 2013) and even future dependence (Wilson-Frederick et al. 2011).

However, the effects of SHCS are less well known due to cannabis being illegal until recently in most countries, which made research difficult to conduct.

SHCS from combustible cannabis has similar health risks to second-hand tobacco smoke due to the combustible organic material, which creates carcinogenic and mutagenic effects (Cone et al. 2015a). Cannabis contains many of the same toxins in tobacco, which are responsible for cardiovascular damage. In fact, many toxins such as ammonia, nitric oxide and hydrogen cyanide, are found in levels between three to 20 times higher in cannabis than in tobacco (American Chemical Society 2007). Studies in rodents (Wang et al. 2016) have demonstrated that exposure to cannabis smoke for as little as one minute impairs cardiovascular function for the following 90 minutes. Long-term effects of repeated endothelial dysfunction can lead to cardiovascular disease including thrombus formation, CVA and myocardial infarction (Rajendran et al. 2013).

The study by Wang et al. (2016) also noted a longer deleterious cardiovascular effect after second-hand exposure to smoke from cannabis versus tobacco. This is a very significant finding, because the nurse visiting a patient who may be smoking cannabis for medicinal purposes would most likely be exposed for more than 60 seconds. In attempts to decrease the THC levels, and thus the hallucinogenic effects, of medical cannabis by changing environmental factors, the study found that the endothelial dysfunction was independent of the level of THC of the cannabis (Wang et al. 2016). Thus, even if medicinal cannabis has reduced levels of THC, SHCS exposure may still affect the nurse's endothelial function.

In humans, subjective drug effects of cannabis smoke inhaled passively have been found to be dose-dependent (Cone et al. 2015b). Therefore the impact on health practitioners of SHCS used by patients should not be underestimated, particularly since few health providers, including nurses, felt completely knowledgeable about marijuana (cannabis) health risks (Brooks et al. 2017), and may not avoid exposure during their home visit to patients utilising smoked medical cannabis.

A question that often arises is whether SHCS will cause blood levels to be high enough to test positive in the nurse who is exposed and if so, what effect may that have on the nurse's cognition? Hours after secondary exposure to cannabis smoke, THC can be detected in screening tests of urine (Cone et al. 2015a) and oral fluids (Cone et al. 2015b), although only after exposure to high smoke concentrations. However, adequate room ventilation may reduce the level of secondary exposure to cannabis compounds (Herrmann et al. 2015; Cone et al. 2015a).

A question that often arises is whether SHCS will cause blood levels to be high enough to test positive in the nurse who is exposed and if so, what effect may that have on the nurse's cognition?



This is an important issue that health practitioners should pay attention to when carrying out their duty at the patients' home. A study conducted by Cone et al. (2015a) demonstrated that short-term exposure to cannabis smoke in an unventilated space produced absorption of sufficient amounts of THC for non-smokers to test positive for THC up to three hours following exposure. In their systematic review of passive exposure to cannabis smoke, Berthet et al. (2016) advised 'experts should clearly inform persons who have to demonstrate prolonged abstinence from cannabis to avoid heavily smoky and unventilated areas' (p. 110). Similarly, Holitzki et al. (2017) also recommend that clinicians advise cannabis users to smoke only in open outdoor spaces due to the effects of SHCS. This research would seem to indicate the need for nurses to avoid exposure to cannabis smoke in unventilated spaces, not just for potential negative implications on their health, but also potential legal implications. It also poses the question as to how this may impact a nurse's performance as well as driving ability after visiting a patient who has been smoking medical cannabis during the visit.

POTENTIAL WORK HEALTH AND SAFETY RISKS TO THE COMMUNITY NURSES

Nurses working in the community are often required to commute between visits. All states and territories in Australia have laws making it an offence to operate a vehicle while under the influence of drugs. These laws allow the police to initiate drug testing if they suspect a driver of a vehicle is under the influence of an illicit substance.

In addition to this, over the last decade random roadside drug testing of drivers has become a common feature on Australian roads. Road-side drug testing determines the presence or absence of cannabis, ecstasy or amphetamines in oral fluid samples (Wilson 2012). The approach to the results differs by state.

For example, Queensland Police (2016) note in their guidelines on random roadside drug testing 'any trace of the nominated drugs in your system and you can be penalised'. While there is no universal threshold to differentiate active smokers from SHCS (Holitzki et al 2017), the government of South Australia (2017) has reported the level of THC present in saliva as a result of passive smoking is considerably lower than the lowest level of THC able to be detected by the saliva testing devices. After a positive result in a drug test, penalties include fines, licence disqualification and imprisonment, depending on the nature of the offence. In addition, the healthcare registration board may require them to go through the disciplinary hearing process because it constitutes a breach of the professional conduct, as they are under the influence of illicit substances while on duty. Importantly for nurses, their registration may be suspended until the hearing process is completed.

The advice of Berthet et al. (2016) on avoiding exposure to cannabis smoke in unventilated areas has particular implications for those nurses who have conditions placed on their registration as a consequence of substance related impairment. Australian Health Practitioner Regulation Agency (AHPRA) and the Nursing and Midwifery Board of Australia (NMBA) have drug testing for

all practitioners with substance related impairment (AHPRA 2015). These nurses have routine hair and urine testing of a wide range of drugs, not just based on the nurse's drug taking history (AHPRA 2015). Moosmann et al. (2014) have noted that 'considering the severe consequences people concerned may experience, contamination issues in hair analysis still do not seem to be investigated to an extent that would be desirable' (p.125).

Exposure to medicinal cannabis through SHCS could lead to the external contamination of hair, yielding false-positive results (Baciu et al. 2015).

Furthermore, SHCS can lead to enough cannabinoid presence in oral fluids, blood and urine so as to give a positive result in a drug test (Holitzki et al. 2017). Therefore, given the potential impact that SHCS can have on a nurse, appropriate consideration should be included in the discussion of the use of medical cannabis, including education of the health practitioners on these aspects.

It should be noted that each state and territory has its own regulatory frameworks for the access to medicinal cannabis (Commonwealth of Australia 2017).

According to the *Guidance for the use of medicinal cannabis in Australia* (Commonwealth of Australia 2017), nabiximols (an oro-mucosal spray) is the only registered cannabis product in Australia.

All other cannabis products must be accessed through clinical trials and limited Special Access Schemes, regulated and monitored by the Therapeutic Goods Administration (TGA).

In principle, the routes of medicinal cannabis administration may include oral administration, oro-mucosal sprays, topical and vaporising.

However vaporised cannabis may pose a risk of SHCS to the nurses during the patient visit, especially as no vaporisers are currently registered as medical devices in Australia (Commonwealth of Australia 2017).

The impact of cannabis administered by routes other than smoking on nurses, and the use of other cannabis products such as oils or sprays requires independent analysis.

A final work health and safety factor to consider is the effect of SHCS on the foetus in the case of a pregnant nurse. There are studies that show prenatal exposure to cannabis is linked to higher rates of stillbirth, shorter length at birth and smaller head circumference. Therefore, there is suspicion that SHCS may have similar effects on the foetus.

In fact, the American College of Obstetrician and Gynecologists (ACOG) have stated that there is data of the negative impact on the foetus of prenatal cannabis exposure including neurological development, visual problem solving, visual-motor coordination and visual analysis, decreased attention span and behavioural problems. Therefore since 2015 ACOG has repeatedly warned obstetricians to deliver the message to pregnant women not to smoke cannabis or be exposed to SHCS (Gynecologists 2015).

CONCLUSION:

In Australia, medicinal cannabis has been a legal treatment modality since 2017 for several approved medical conditions. The current available medicinal cannabis products that may be prescribed and approved by the TGA include both plant-based and synthetic products. The route of administration may be in the form

of a vapour (Queensland Health 2017) but currently, no vaporisers have been approved and registered as medical devices in Australia (Commonwealth of Australia 2017). Therefore, smoking is still the most common route of administration of medicinal cannabis. In this case, community nurses may inhale cannabis substances while they are carrying out the duty of care in the patients' home. Exposure to the cannabis substances at work may pose some serious work health and safety issues. This review found that the effects and impact of SHCS may include:

- increased risk of cardiovascular diseases;
- deleterious effects on the foetus if the nurse is pregnant;
- altered cognitive function leading to increase the risk of medical errors and car accident while commuting between visits;
- risk of drug addiction;

- positive road-side drug tests; and
- loss of nursing registration due to misuse of illegal substances.

If a nurse tests positive in a drug test, the court may impose penalties for the charge. In addition, it is a breach of the professional conduct while providing direct patient care under the influence of illicit substances. The healthcare registration board may require them to go through the disciplinary hearing process. The nurse may be suspended from work or on restricted duty until the hearing process is completed.

The use of medicinal cannabis as a treatment modality is new to Australian nurses. More research and education are required in this area to strengthen policies and procedures around the nursing practices relating to the care of patients who choose to use smoked medicinal cannabis to manage their chronic or terminal medical conditions.

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The Role of Schools of Nursing in Continuing Professional Education Provision

Nurses in Australia are required to undertake continuing professional education (CPE) in order to maintain registration.



By Jennie E Haarsager

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CPE is defined as coursework undertaken by practising nurses with the aim of maintaining standards of clinical practice (Hegney et al. 2010). In Australia, nurse practitioners, registered nurses, and midwives are required to complete 20 CPE hours per 12-month registration period.

CPE can involve the revision or acquisition of new knowledge and skills. However, best practice for CPE in nursing is to create an individual learning plan based on career direction and concentrate on CPE opportunities which match this plan (Ross, Barr and Stevens 2013).

There are numerous providers of CPE for nurses. Most accessible to the working nurse are online providers of quick coursework to meet necessary

CPE requirements for registration. In addition, there are other specialised courses available through professional nursing and medical associations.

However, there are barriers to accessing CPE with cost being the most frequently cited factor (Hegney et al. 2010). Nurses cite the need for support to complete CPE which includes financial aid and leave from regular duties during paid work time to complete study. Additional barriers to accessing CPE include geography, method of course provision, work/life balance and work conditions.

For nurses, CPE opportunities are often serendipitous and offered by the employer. However, there is an emerging role for Australian universities in the provision of CPE for nurses.

There are opportunities for university nursing programs to partner with organisations who employ advanced practice nurses in providing continuing education.

in providing continuing education. One role of these partnerships is to educate staff in very specialised areas of nursing practice.

CPE OFFERINGS BY AUSTRALIAN SCHOOLS OF NURSING

A number of Australian Schools of Nursing offer CPE for nurses in three broad categories: overseas experience-based education, general/allied health courses, and area-specific short courses. Some schools also offer short courses to overseas nurses to meet Australian registration requirements. There is no agreed-upon standard for enrolment prerequisites, fees, or course content across universities. Professional education is available both online and in person. There is some overlap between courses offered as postgraduate certificate qualifications and short courses. Common CPE courses at Australian Schools of Nursing are listed below. Apart from leadership coursework, the content offered tends to focus on specialised areas of nursing practice that may be used across many specialty areas.

- Chronic care
- Dementia
- Disease outbreaks
- Immunisation nurse
- Leadership
- Mental health
- Ophthalmic nursing
- Palliative care
- Pharmacology
- Prescribing
- Sexual health
- Wound management

BENEFITS OF UNIVERSITY PROVISION OF CONTINUING EDUCATION IN NURSING

Australian nurses have an emerging role in the provision of extended levels of care and health service providers are negotiating the expansion of nursing roles. Recent years have seen the development of nursing roles to advanced practice roles and, with this expansion, the addition of capabilities such as prescribing and disease diagnosis and management (Douglas et al. 2017).

CPE programs will need to include course offerings that support the ongoing professional development of this new group of nurses with clinically expanded roles. Effective CPE partnerships in schools of nursing should address both educational and career advancement and the future of nursing practice (Beal 2012). In conclusion, Schools of Nursing have an emerging role in the provision of CPE offerings, particularly to advanced nurses seeking opportunities for targeted continuing professional education.

Recently multidisciplinary partnerships between universities and organisations have emerged to provide professional development opportunities (Ryan 2009). Partnerships between universities and government or not-for-profit organisations are motivated by a desire to align leadership, professionalisation and disciplinary expertise. There are several beneficial functions of these partnerships including improving patient outcomes and healthcare delivery.

The growth of these partnerships coincides with a move in nursing toward a postgraduate level profession and an increasing role in advanced practice care (Rolfe 2012). As such, there are opportunities for university nursing programs to partner with organisations who employ advanced practice nurses

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FEATURE

An aerial photograph of a small, isolated rural town. The town is nestled in a valley, surrounded by vast, dry, golden-brown fields and low hills. A dirt road winds through the landscape, leading towards the town. The town itself consists of several small buildings, mostly with blue roofs, and some trees. In the background, more hills and a clear blue sky with scattered white clouds are visible.

SIZING UP A STRONGER RURAL HEALTH STRATEGY

As part of the May 2018 federal Budget, the then Minister for Rural Health, Deputy Leader of the National Party Senator Bridget McKenzie, issued a 'Stronger Strategy for Rural Health'. But according to some of Australia's rural health experts, including former National Rural Health Alliance CEO Gordon Gregory, it's not very 'strong'.

By Jessica Gadd

In fact, it's not even a strategy according to Mr Gregory who describes it as a bundle of programs, focused on pro rural general practice. He says it's good so far as it goes – but a real rural health strategy would be quite different, and go much further.

There is an old country saying – 'If you've seen one rural town, you've seen ... one rural town.' Meaning, every rural town is so different that it's a mistake to talk about a single 'rural Australia'.

One area might have higher mental health issues or a higher burden of disease, for example, while another area might have more young families, or more elderly citizens. One area might have a hospital, others might be within a few hours' drive of an urban centre, and of healthcare services. Other populations might rely on the Royal Flying Doctor Service for access to the bulk of their healthcare.

Additionally, at any one time, the states and territories are at different stages of their electoral cycles, and therefore at differing stages of planning and policy-making. Some, for example, might be just beginning to build a rural health plan, while others might be finished; some might have just come in to power, others might be facing an election.

All of which can make coming up with a national strategy for rural health challenging. Challenging but not impossible, says Gordon Gregory, former long-term CEO of the National Rural Health Alliance (NRHA) of which the Australian Nursing and Midwifery Federation is a part of.

He points out that national rural health strategies have existed before – most successfully in the form of the *Healthy Horizons Framework* (1999 to 2007).

"Accountability for *Healthy Horizons* lay with all governments, including the states, because its targets, goals, and objectives had been adopted by all ministers for health, at all levels," Mr Gregory says.

In a series of articles published in July 2018 on the independent health journalism website **Croakey.org**, Mr Gregory points out that the May 2018 Budget's 'Stronger Rural Health Strategy' is anything but a strategic document, and to call it that is muddying the waters. A strategy, he explains, is a high-level, long-term view that should ideally include bipartisan support – not a low-level 'bundle of programs' existing purely at a short-term, tactical level.

"To call it a 'strategy' is a misnomer, because it's not a strategic document at all," Mr Gregory tells the *ANMF*. "It's a bundle of programs relating mainly to rural medical workforce issues, which is important, but it is not strategic. Also, it is spread over the period of the Budget, which is four years, and therefore by definition to consider it a 10-year plan doesn't make any sense, unless it is accompanied by support from all parties, including the rural health sector itself."

The Stronger Rural Health Strategy's commitment to medical workforce issues is commendable, Mr Gregory says, but it is merely an extension of existing programs, and hardly 'transformational', as Senator Bridget McKenzie has claimed. He also makes the point that a focus on the medical workforce alone is shortsighted. In order to address healthcare workforce shortages, it is important to include nursing, allied health, and dentistry.

"In rural areas, you need the whole lot," Mr Gregory says. "A doctor is not going to go to a small country town unless the others are there – indeed, they won't succeed without them. Without nursing and allied health the scope of practice for doctors becomes impossible."

"City general practice is quite different. In more remote areas GPs don't have the same ready access to pathology; and all of the health specialists that city doctors can refer a patient to. Also the time spent travelling is quite different, and the basic state of health of the people you are looking after is worse."

According to Australian Institute of Health and Welfare figures, the 29% of Australians who live in remote and very remote areas

have a lower overall standard of health and poorer life expectancy than urban Australians.

They are 140% more likely to die than those in major cities, up to 400% as likely to die due to diabetes, and up to 220% more likely to commit suicide.

Yet rural regional and remote Australians make an incalculable contribution to our national, cultural identity – not to mention economically, contributing two-thirds (by value) of Australia's export income, through industries including agriculture, tourism, and the resources sector.

MEASURING ACCESS TO RURAL HEALTHCARE SERVICES

Director of the Melbourne University Department of Rural Health in Shepparton, Professor Lisa Bourke, is a National Rural Health Alliance council member representing the Australian Rural Health Education Network, and a member of the NRHA Service Access Standards Work Group. This group is charged with developing a measure for assessing levels of access to healthcare services in rural and remote areas.

"It's pretty well known that access to healthcare in rural and remote areas is poorer than in urban areas," Professor Bourke says. "But there's also a lot of diversity across rural and remote areas. Not all rural people have the same access to health services."

"I think most rural and remote Australians would suggest that they don't want access to absolutely everything – nobody expects to get brain surgery out in remote areas. But people do need to have access to quality primary healthcare – to a GP, or a nurse practitioner, or ongoing chronic disease management, or general mental health services – that sort of thing. Also to be able to access support for particular conditions relevant to particular populations. If a large proportion of the community is retired, for example, then obviously it will need more aged care services," she says.

“So all that is understood, but the issue is, how do you measure it? And how do you know when a particular level of access to healthcare is unacceptable?”

Professor Bourke says that in order to answer these questions the NRHA Service Access Standards Work Group is looking at a mix of factors including geographical classification, population sizes, distances to larger regional centres and hospitals, indicators of workplace quality and safety, health workforce distribution, and demographic and burden of disease profiles.

“It is the right of all Australians to have access to healthcare, and it is the responsibility of national, state and local governments to provide that,” Professor Bourke says. “But unfortunately, in some regions it is falling short.

“The National Rural Health Alliance wants to go beyond highlighting that access to healthcare in rural areas is poorer – it’s looking for a stronger statement than that,” she says. “Developing the Service Access Standards is a way to clearly identify the areas where the level of access to healthcare is unacceptable – and if we can measure that, then I think governments really will have to act.”

The Australian Rural Health Education Network is focused on providing educational opportunities in regional areas, with a view that training healthcare students from rural areas, in rural areas, will more likely result in an increased number of them joining the rural health workforce.

“It keys into the concept of growing your own workforce,” Professor Bourke explains. “And one of the regions where this is particularly important is out in remote Aboriginal communities – looking at growing your own health professionals and practitioners from those communities, rather than flying people in.”

LAST PERSON STANDING: A NURSE OR MIDWIFE

“From a rural perspective, the further from the cities you go we know that the last person standing is usually a nurse or midwife,” says ANMF Senior Federal Professional Officer and National Rural Health Alliance Board and Council member Julianne Bryce.

Ms Bryce says that nurses comprise the bulk of the rural health workforce. For every 100,000 members of the population, there are 135 GPs – and a staggering 1,007 nurses.

She says this figure is even higher when you add midwives and enrolled nurses. Though some regionally-based midwives also work as nurses, depending on work availability.

“The Alliance has done a huge amount of work in raising awareness about the importance of multidisciplinary teams, but the focus for a lot of governments, and indeed, for many communities, is ‘But oh, we don’t have a doctor,’” Ms Bryce says.

“It’s a complex scenario. For example, often we associate maternity services largely with the availability of obstetricians or GP obstetricians, when in actual fact they

are just part of a workforce and having an obstetrician in town alone won’t make enough of a difference if you don’t have midwives.

“Take Renmark, in South Australia. Everywhere you look there are young people with young families, yet it is a town where the maternity service closed because while they had obstetricians, they didn’t have midwives. So when it comes to providing fair and equitable access to healthcare services, it needs to be a ‘whole of workforce’ solution, incorporating nursing, midwifery, allied health and dentistry as well as medicine.”

Despite the fact that nurses are by far the largest component of the rural and remote health workforce, they aren’t represented on the Australian government’s Rural Health Stakeholder Roundtable, which last met in August 2018.

Coincidentally this was one of Senator Bridget McKenzie’s last days as Minister for Rural Health, as the change of Liberal party leadership from Turnbull to Morrison saw her title change to Minister for Regional Services, Sport, Local Government and Decentralisation.

“Nurses are the backbone of the rural health community,” Ms Bryce says. “They are already out there working in rural areas. We need to ensure that they’re supported to do the work they need to do, with adequate leave, high-quality, accessible professional development, a positive work environment in order to achieve better health outcomes for rural people.

“In the same way as a nurse working in the emergency department in a big metropolitan hospital doesn’t know what’s coming through the door, the nurses and midwives working in rural areas face the same challenge. They need to be supported to maintain a broad scope of practice to safely and effectively service their communities.”

WHY WE NEED A NATIONAL RURAL HEALTH STRATEGY

- A ‘real’ National Rural Health Strategy – a document about the principles to be agreed and adhered to by governments at all levels (from all sides of politics) and by the rural health sector itself – would give rural health the national focus and prominence it deserves, Gordon Gregory argues.
- It would help give overarching direction and clarification for mid-level federal, state and territory rural health plans or road maps, and a framework for lower-level tactical programs and policies.
- It would help distribute resources according to health-related needs, responding to the greatest needs first, such as Indigenous health.
- It would ensure that rural Australian communities and businesses receive opportunities equivalent to those available to Australians living in the major cities, including access to basic healthcare services, irrespective of location.
- It would consult regional Australians on the issues that affect them, and celebrate the unique characteristics, lifestyle opportunities and strengths of regional Australia. It would be accountable, with agreed targets and outcomes, take a principled, bipartisan approach, and build on the large number of existing state and territory health strategies.

See croakey.org for Gordon Gregory’s full response to the Stronger Rural Health Strategy.

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James Lloyd

ANMF Federal
Vice President

Nurses, gun control and why we have a stake

The possible loosening of gun control laws raised its menacing head in Tasmania during the 2018 state election.

As most Australians remember, in April 1996, 35 people were killed and 23 wounded at Port Arthur, Tasmania by a lone gunman with a high powered semi-automatic rifle. One individual with a lethal weapon caused the largest loss of life (from gun violence) that Australia had ever experienced.

The massacre at Port Arthur resulted in support from all sides of politics and state governments across the political spectrum to pass into law the National Firearms Programme Implementation Agreement. This law restricted the ownership of private semi-automatic rifles, shotguns and pump shot guns, and introduced national uniform gun licensing.

Australia has not experienced such a massive loss of life due to gun violence since 1996.

But in Tasmania, the prospect of loosening of gun laws was raised just before the March 2018 Tasmanian state election. Just days before the election, it came to public attention that the police minister had promised the Tasmanian gun lobby and other groups that certain aspects of the national firearms laws would be relaxed. This included allowing ownership of silencers, allowing pump action shot guns and self-loading rifles (category C firearms) to be used by farmers (and agricultural workers), doubling the licensing duration from five to 10 years for some category C firearms, and relaxing penalties for minor gun storage offences.

As expected, there was a significant uproar from the Tasmanian community, including from gun control advocates, ANMF, health professionals and those who had been directly or indirectly affected by the Port Arthur Massacre.

On Friday 17 August the Tasmanian Premier announced he would no longer pursue gun law changes until a Legislative Council Inquiry had been completed.

He did however state future changes were not off the table. And this is of concern.

Australians understand that allowing high powered weapons into the community will change the nation.

Using the US as an example, easy access to these weapons enables frequent mass shootings and a society that becomes anaesthetised to such events and normalised to gun violence.

The media chronicles the outcomes of violence to our community, but there is one group who is rarely acknowledged as a casualty - the first responders, and in particular, nurses.

Nurses are at the coalface in all areas of health, and sometimes we are the only health professional

available to manage the physical and mental wounds of those who stagger through the door.

In 1996 at the Royal Hobart Hospital, nurses dealt directly with the result of this inconceivable gun violence. Nurses in ED, ICU, OT and on the ward had to triage, treat, bind the wounds, wash the deceased and hold the hands of the wounded.

A colleague who was working on that day shared her personal experience:

"It's been 22 years since Port Arthur and the emotions are still raw. As well as treating the injured, we had to deal with an angry public due to the offender being treated for his injuries in our hospital, intrusive media, and a hospital that was full of police and security. As nurses, we had to treat all the injured without fear or favour, and this included the offender and those who had been injured".

What stood out most powerfully for me about this moment was how my colleague's body language altered as she spoke. It appeared as if a surge of adrenaline had entered her bloodstream. Before she spoke, she became quiet, sighed and revealed that 100 metre stare. Her words and body language moved me and I reflected on how trauma, like gun violence, can have long impacts, possibly scarring individuals forever.

Australia, fortunately, does not nurture the same gun culture as in the US, and it is not embedded into our psyche and identity. We understand that guns do have a role in some aspects of our country, such as on farms, in sport shooting and for genuine antique collectors. From 1996 to 2016, gun deaths in Australia halved (gunpolicy.org/firearms/region/australia).

The ANMF Tasmanian Branch has put in a submission to a Legislative Council Inquiry, opposing proposed changes to Tasmanian gun laws. The submissions to the Inquiry can be found at parliament.tas.gov.au/ctee/Council/LC%20Select%20Firearms%20Law%20Reforms.

Although the Tasmanian government has momentarily stepped back from changes on gun laws in Tasmania, the Premier has not fully committed to never making changes. He has publicly stated he will review his position after the Legislative Council Inquiry.

The Premier's reconsideration is a powerful example of how organised public opposition can change the mind of any elected official. In Tasmania, the ANMF, with other unions and a group called Medics for Gun Control lobbied the state government to maintain the strength of Tasmania's gun laws. This united stand shifted government policy.



Sally-Anne Jones
ANMF Federal President

Our role in the prevention of nuclear war

At the August ANMF Federal Council meeting, the Council had the rare privilege of holding in our hands a recently awarded Nobel Peace medal.

The Nobel Peace Prizes were established in 1895 through the will of Swedish scientist Alfred Nobel and the very first prize was awarded in 1901.

There are five medals awarded for Physics and Chemistry; Physiology or Medicine; Literature; Economic Sciences and Peace.

The Peace medal's two sides show a group of three men forming a fraternal bond and the inscription *Pro pace et fraternitate gentium* translated as 'For the peace and brotherhood of men'.

The Nobel Peace Prize has been awarded 98 times to 131 Nobel Laureates between 1901 and 2017, 104 individuals and only 24 individual organisations, so it was very special to hold one and see it up close.

This 2017 medal was awarded to a group called ICAN, whose birthplace is in Melbourne, and we were privileged to have Dr Tilman Ruff speak to us about this work and why it is important to nurses and midwives.

Dr Tilman Ruff AM is a public health and infectious diseases physician, international medical advisor for Australian Red Cross, Co-President of International Physicians for the Prevention of Nuclear War (Nobel Peace Prize 1985), and founding international and Australian chair of ICAN.

His message was compelling and clear. The threat of nuclear catastrophe seems so remote, and so disconnected from our everyday lives and yet its imminence and stark reality should bring us to urgent reflection and action.

He works with ICAN – the International Campaign to Abolish Nuclear Weapons which is a coalition of non-governmental organisations in 100 countries promoting adherence to and implementation of the United Nations nuclear weapon ban treaty.

In July 2017, following a decade of advocacy by ICAN and its partners, an overwhelming majority of the world's nations adopted a landmark global agreement to ban nuclear weapons, known officially as the Treaty on the Prohibition of Nuclear Weapons.

It will enter into legal force once 50 nations have signed and ratified it. It opened for signature on 20 September 2017, and Australia is yet to sign it. It is permanent in nature, and will be legally binding on those nations that join it.

Prior to the treaty's adoption, nuclear weapons were the only weapons of mass destruction not subject to a comprehensive ban, despite their catastrophic, widespread and persistent humanitarian and

environmental consequences. The new agreement fills a significant gap in international law in that it prohibits nations from developing, testing, producing, manufacturing, transferring, possessing, stockpiling, using or threatening to use nuclear weapons, or allowing nuclear weapons to be stationed on their territory. It also prohibits them from assisting, encouraging or inducing anyone to engage in any of these activities.

Why does this matter to nurses and midwives?

Nuclear weapons are unique in their destructive power and the threat they pose to the environment and human survival. They release vast amounts of energy in the form of blast, heat and radiation. No adequate humanitarian response is possible. In addition to causing tens of millions of immediate deaths, a regional nuclear war involving around 100 Hiroshima-sized weapons would disrupt the global climate and agricultural production so severely that more than a billion people would be at risk of famine.

From 1952 to 1963, the British government, with the active participation of the Australian government, conducted 12 major nuclear test explosions and up to 600 so-called 'minor trials' in the South Australian outback and off the West Australian coast. Radioactive contamination from the tests was detected across much of the continent.

For many Australians, nuclear weapons are not a distant, abstract threat, but a lived reality – a persistent source of pain and suffering, of contamination and dislocation. Indigenous communities, long marginalised and mistreated in Australia, bear the ongoing effects.

Now more than ever, it is time for nurses and midwives all over the world and in Australia, as the advocates for the health and wellbeing of the population and the planet to get on board and understand the issues and participate in the movement to get the Treaty signed. It is one of the most important call to arms ever ... there is a lot at stake.

There is a vast array of materials on this topic, as well as the Treaty on ICAN's website. The Pledges are there as well, for individuals and organisations to lobby for the Australian government to sign the Treaty. I encourage you to visit it and sign the pledge at icanw.org/projects/pledge

Falls Prevention

Falls can affect individuals in many ways. These impacts can cause physical injuries, have negative social consequences and induce psychological distress.



Therefore, falls prevention programs are essential in order to decrease the risk of an individual falling and experiencing these negative effects. All healthcare workers have a role in assisting in falls prevention programs with organisational policies and procedures in place to guide their care in this area.

The World Health Organization (WHO) defines a fall as 'an event which results in a person coming to rest inadvertently on the ground or floor or other lower level'.

Any falls related injuries are classified as fatal or non-fatal, with most falls being within the non-fatal category.

Although most falls are non-fatal, worldwide 37.3 million people require medical attention every year due to falls (WHO 2016).

FALL FACTS:

- Worldwide, falls are the second leading cause of death resulting from accidents of unintentional injuries.
- People over 65 years of age have a higher risk of falling.
- Thirty percent of Australians over the age of 65 experience at least one fall per year.
- In Australians over the age of 65, falls account for 40% of all injury related deaths.
- With the population ageing, the number of people experiencing falls is also expected to rise.
- In 2010, 240,000 bed days were related to falls.
- Over 80% of injury related hospital admissions for people over the age of 65

years are due to falls and their injuries (Australian Commission on Safety and Quality in Health Care 2009; Australian and New Zealand Falls Prevention Society 2015).

In sub acute and rehabilitation settings, more than 40% of patients with specific clinical problems (such as stroke) will fall at least once during their admission with injuries resulting in 30% of these falls (Australian Commission on Safety and Quality in Health Care 2009; Australian and New Zealand Falls Prevention Society 2015).

There are many different injuries associated with falling including:

- cuts and abrasions;
- soft tissue damage and bruises;
- fractures; and
- head injuries.

The hip and thigh are the most commonly injured areas following a fall that requires hospitalisation.

Most hip fractures (91%) are caused by falls and they are one of the most common reasons for hospital admission.

Hip fractures cause increased morbidity and increase the risk of death for the individual. They can also result in increasing the likelihood that the individual will need to be admitted into a residential aged care facility following their fall and injury.

Wrist fractures are also a common injury following a fall due to the instinct to use your hands to break your fall.

use of prevention strategies to decrease the incidence of falls and includes the management of a patient following a fall. The Standards are nationwide, but may be applied differently depending on the different types of health services eg. the falls risk assessment and interventions needed would be different for a day procedure unit (such as a fertility clinic) than a large tertiary hospital or rehabilitation facility (Australian Commission on Safety and Quality in Healthcare 2012).

Falls can occur in all age groups and in all environments. Adults over the age of 65 are more at risk of falling due to both environmental risk factors (extrinsic) and

antidepressants, benzodiazepines and antiepileptics;

- haematological and oncology conditions;
- history of alcohol and drug use;
- hesitation to ask for assistance;
- if the patient is in denial about their falls history;
- postural hypotension;
- poor condition of feet;
- nutritional deficiency;
- lower limb arthritis; and
- acute infections (Mauk, 2012).

Environmental (extrinsic) risk factors include:

- inappropriate type and/or height of chair or bed;
- no use of breaks on bed or chair;
- call bell left out of reach;
- walking aids left out of reach;
- bad condition of walking aids;
- walking aids not used properly;
- slippery floor surfaces;
- loose floor coverings;
- clutter;
- inadequate lighting;
- inadequate rails and supports; and
- use of restraints including the cot sides on beds (The Victorian Quality Council: Safety and Quality in Health 2004).

People who have fallen can also develop a fear of falling and lose their confidence in their ability to walk. This can then reduce their independence and consequently their quality of life.

These injuries can be severely debilitating for the individual and result in a decrease in their level of independence. People who have fallen can also develop a fear of falling and lose their confidence in their ability to walk. This can then reduce their independence and consequently their quality of life. An increased burden can then be placed on their family and care givers to undertake more care responsibilities for the individual (Australian Commission on Safety and Quality in Health Care 2009; Australian and New Zealand Falls Prevention Society 2015).

The National Safety and Quality Health Service (NSQHS) Standards were developed to improve the quality of care provided by health services and to protect the community from harm.

They consist of 10 Standards which allow health service organisations to ensure their quality improvement programs are aligned with the framework provided by the NSQHS.

STANDARD 10: PREVENTING FALLS AND HARM FROM FALLS

The aim of Standard 10 is to 'reduce the incidence of patient falls and minimise harm from falls'.

This Standard aims to identify a patient's falls risk promptly and ensure that the appropriate prevention strategies are undertaken. It guarantees health services have falls prevention systems in place, which include screening and assessing the falls risk of patients. It also covers the

personal risk factors (intrinsic). The more risk factors an individual has, the more likely it is they will fall.

Both genders are at risk of falls equally however, some studies have shown that males are more likely to suffer from fatal falls than females. Increased length of stay in a hospital setting increases falls risk and falls occur more commonly in the immediate time following a transition between settings. Individuals with underlying medical conditions including neurological and cardiac conditions are more likely to fall and individuals with limited access to health and social services are more likely to fall than those with adequate access.

Socioeconomic factors including poverty can impact on an individual's risk of falling (The Victorian Quality Council: Safety and Quality in Health 2004).

Intrinsic risk factors include the following:

- advancing age (those over the age of 65 are more likely to fall);
- history of falls;
- impaired physical abilities such as abnormal gait and poor balance;
- altered mental state such as dementia, delirium, sleep disorders;
- altered elimination patterns including incontinence and urgency;
- cognitive and sensory impairments such as impaired vision, poor judgement and impaired memory;
- altered proprioception;
- multiple medications including diuretics, narcotics, sedatives,

THE IMPORTANCE OF FALLS RISK SCREENING AND ASSESSMENT

Falls risk screening and assessment tools identify patients at an increased risk of falling. They then prompt us to implement strategies to help decrease this risk of falling. These tools have been evaluated across different hospital settings and are good predictors of the risk of falls.

They allow the development of an individualised plan of care to be implemented focusing on falls prevention.

Often the terms 'falls risk screen' and 'falls risk assessment' are used interchangeably, however there are some differences and they are considered to be separate practices (Australian Commission on Safety and Quality in Health Care 2009; The Victorian Quality Council: Safety and Quality in Health 2004).

So what is the difference between a falls screening tool and a risk assessment?

A falls screening tool: Screens patients for their falls risk; is a brief process; classifies people as either being low risk or an increased risk; usually contains five brief



Nurses and midwives play an important role in preventing falls. They are often the ones recognising a change in the patients' falls risk status and communicating this change to other members of the healthcare team.

items; it isn't designed as a comprehensive assessment, however it can still assist in determining any interventions needed to decrease the patient's falls risk (Australian Commission on Safety and Quality in Health Care 2009; The Victorian Quality Council: Safety and Quality in Health 2004).

A falls risk screen: Should occur on admission to hospital, when a person's health or functional status changes and when their environment changes.

If the falls screen shows the patient is at an increased risk of falling, a falls risk assessment should then be completed.

If any item on the falls risk screen shows the patient is at risk of falling, interventions should be implemented for that item regardless if the patient has a low overall risk score. Falls risk screening tools are more relevant in acute care settings than residential care as most residents will most likely exceed the falls risk, therefore a falls risk assessment should be completed on all residents (Australian Commission on Safety and Quality in Health Care 2009;

The Victorian Quality Council: Safety and Quality in Health 2004).

Nurses and midwives play an important role in preventing falls. They are often the ones recognising a change in the patients' falls risk status and communicating this change to other members of the healthcare team.

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30 minutes
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This excerpt is from the ANMF's Falls Prevention tutorial on the Continuing Professional Education website.

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Applying the partnership model of care to facilitate health and wellbeing of preschool aged Aboriginal children

By Naomi Sprigg dos Santos, Garth Kendall and Ailsa Munns

The early years of life are of critical importance for health and wellbeing across the life course (Kelly 2018). There is increasing recognition of the importance of supporting women during pregnancy, and families with young children (Moore et al. 2017).

The partnership model of care has been widely adopted by community health nurses (CHNs) in Western Australia and it is applied to facilitate the optimal health and wellbeing of preschool aged Aboriginal children (Department of Health WA 2017).

The approach is strength-based and focuses on interpersonal relationships and mutual goal setting (Keatinge et al. 2008). While the partnership approach has great potential, it is questionable whether all CHNs currently have the knowledge, attitudes and skills required to implement it effectively with Aboriginal families. The successful implementation of the model, as with all programs designed to benefit Aboriginal people, requires that nurses are culturally competent. In a recent 'Closing the Gap' document, Bainbridge et al. (2015, p3), state that cultural awareness training, alone, is not sufficient to prepare non-Aboriginal staff to work effectively in the delivery of health services for Aboriginal people.

In the experience of the first author who has been living and working with Aboriginal people in remote communities for 20 years, there are several factors that may, potentially, limit the capacity of CHNs to partner successfully with the primary caregivers of preschool aged Aboriginal children. Firstly, CHNs often have limited knowledge and understanding of the positive aspects of Aboriginal culture and family life. Secondly, while attitudes toward Aboriginal people in Australia have improved in recent years, there is still considerable progress that needs to be made. Thirdly, CHNs frequently lack key skills required to facilitate healthy behaviour changes. More specifically, many have considerable difficulty communicating effectively and setting mutual goals, and they do not always take account of the physical and psychosocial contexts of Aboriginal people's lives.

The aim of this research is to highlight the views of Aboriginal primary caregivers, Aboriginal community leaders, Aboriginal health workers, community health nurses, medical professionals, and allied health staff regarding the way that CHNs implement the partnership model of care.

Data will be collected through focus group discussions and one-on-one indepth interviews. The focus groups will be undertaken using the culturally sensitive method of conversation, yarning. Yarning is an Aboriginal form of conversation which is non-confrontational for the participants (Bessarab & Ng'andu 2010). It is anticipated that this research will inform the ongoing implementation and evaluation of the partnership model of care with Aboriginal families in Australia.

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While attitudes toward Aboriginal people in Australia have improved in recent years, there is still considerable progress that needs to be made.

Midwifery students' perception of their ability to provide culturally safe maternity care for Australian Aboriginal women

By Lorene Kirkby

Registration to practise as a midwife is dependent on midwifery students meeting national competency standards. This includes demonstrating cultural knowledge and understanding.

As midwives are expected to provide care in a non-judgemental and culturally safe manner (Nursing and Midwifery Board of Australia 2018), this study asked midwifery students about their perception of their ability to provide culturally safe maternity care for Aboriginal women, and about the formal education they received in relation to Aboriginal women's maternity needs.

Questions were designed to assess the level of cultural understanding midwifery students were able to demonstrate. Midwifery students were also asked about their experience of culturally safe clinical practice and whether policies and procedures were in place within their health facilities to be supportive or disempowering of their efforts to provide culturally appropriate care. The aim of this study was to identify midwifery students' perceived understanding of Australian Aboriginal women's maternity needs.

A mixed methods study, using qualitative and quantitative questions, was used in an anonymous online survey completed by midwifery students to gather empirical data on their experiences and opinions. This data was analysed using thematic analysis to identify common themes in the responses. Twenty-five participants responded to the survey. Less than 50% claimed to have received education on any unique maternity requirements of Australian Aboriginal women, either through university or their clinical placement, at this point in their midwifery course. Only six of the 25 respondents reported that they felt supported by their clinical workplace to provide culturally safe care.

Three main themes were extracted from the data collected in this study. The first theme concerned the formal education of midwifery students regarding Aboriginal women and maternity care. Education

appeared to have not been received or recognised by some of the students, and from those students who stated that they had received education, some did not necessarily translate the education into cultural understanding.

The second theme concerned the insight into Aboriginal women's needs, that was demonstrated by some students but not all. The third theme to emerge from the data was that students expressed a distinct lack of organisational support in clinical placement environments, limiting their ability to provide culturally safe care.

This study highlights the need for further research to be conducted into potential improvements that could be made in the formal education of midwifery students, in relation to understanding the maternity needs of Aboriginal women. Midwifery students have the potential to enter the midwifery profession fully equipped to make a difference to the maternal and fetal outcomes for Aboriginal women and their families, and should be provided with the education, tools and support to do so.

Author

Lorene Kirkby is an RN/RM.

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The development of Indigenous Australian cultural competence in nursing

By Jessica Biles

Health outcomes for Aboriginal and Torres Strait Islander people are significantly worse than for non-Indigenous Australian people (AIHW 2016).

Culturally specific health practice is believed to be vital to health outcomes for Indigenous Australian people (Clifford et al. 2015).

One way of achieving this is through embedding Indigenous Australian cultural competence within curriculums. The term 'cultural competence' first emerged in the

1980s in the United States of America in response to the need for human services providers across a range of disciplines to better meet the needs of an increasingly multicultural population.

More recently cultural competence has gained momentum within the higher education system (Universities Australia 2016) with the commitment from key nursing bodies to the development of a cultural safe healthcare landscape for all Australia (NMBA 2018).

Specifically, Indigenous Australian cultural competence has been well explored (Universities Australia 2016). An implementation framework was developed and in the discipline of nursing has been well implemented in undergraduate nursing curricula (CATSINaM 2017).

The development has seen many resources, professional development and learning in this space. How this learning translates into health service responsiveness requires further exploration.

There is a growing body of work on cultural competence responding to Australian contexts as the professions engage and work with Indigenous Australian peoples (Si et al.

2006). Educational resource development is seen as key in ensuring that students within Australian universities have access to a range of opportunities to move thinking in the wider space of cultural competence development. However, with the focus spent on resourcing, we need to question whether the true meaning of cultural competence is being left behind.

Privileging the voice of Aboriginal and Torres Strait Islander clients within our health constructs remains unquestionably the highest priority in nursing practice.

While resourcing is important, particularly in the educational landscape the validity of the resources come into question when not aligned with meaningful engagement with Indigenous Australian communities and strategic direction and governance of the embedding of resources into curriculum.

Cultural competence is much more than awareness of cultural differences, as it focuses on the capacity of the health system to improve health and wellbeing by integrating culture into the delivery of health services

Perspectives on cultural competence are seen to have applications on both institutional and the individual level. The practice aspect of cultural competence adds the important skills component to the domains of knowledge and awareness (Ranzijn et al. 2009). An additional important aspect of cultural competence is the notion of reciprocity (NHMNC 2018). This emphasises that the development of cultural competence involves a two-way learning process between the organisation and the individual (that is, the nurse and/or client).

Cultural competence is much more than awareness of cultural differences, as it focuses on the capacity of the health system to improve health and wellbeing by integrating culture into the delivery of health services (NHMRC 2005).

With the implementation and advancement of cultural safety within nursing standards we see a level of individual, health service and professional responsibility emerging (ANMAC 2018). This landscape will bring professional development, support and resourcing. The facilitation of meaningful authentic and continued engagement with Aboriginal and Torres Strait Islander leaders and communities will stimulate the development of Indigenous Australian cultural competence. The strategy and

governance to achieve this remains at large questioning whether health services are indeed prepared for nursing practice that is responsive to the cultural needs of Indigenous Australian clients. Privileging the voice of Aboriginal and Torres Strait Islander clients within our health constructs remains unquestionably the highest priority in nursing practice. The systemic challenges we face as clinicians to enact the true sense of Indigenous Australian cultural competence through our practice and professional standards remains one of our challenges for the future.

Author

Dr Jessica Biles is Associate Head (South), Lecturer in the School of Nursing, Midwifery and Indigenous Health at Charles Sturt University in NSW

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Health Coaching: Empowering patients to improve health outcomes in Rural Australia.

By Amanda Moses

In 2016 15% of the population were aged over 65, and of these, one third live with a chronic disease (Australian Institute of Health and Welfare [AIHW] 2017). It is also acknowledged that many in this population group hold their health professionals (HP) in high regard, and accept their medical instruction without question (While et al. 2011). The importance of empowering these people to understand their health and wellbeing, and support improved outcomes is identified as

one of the critical requirements to reduce mortality and healthcare costs (Harris & Sharma 2018).

An effective approach to addressing this is to implement health coaching strategies, and provide education to empower people in understanding and managing their health with more independence (Wroth 2015) and appropriately address unhealthy behaviours (Huffman 2010).

A need to educate and develop a HP team approach to health coaching and utilising this approach to support their patients has become apparent (Brook & McGraw 2017). For the population that live in rural and remote areas, this is even more important, as access to healthcare can be limited.

Peter (pseudonym) is a 74 year old male living in rural Australia with a diagnosis of moderate Chronic Obstructive Pulmonary Disease (COPD). Peter is currently a smoker, which is known to be one of the main contributors to COPD and cessation is known to reduce disease progression considerably and improve wellbeing (Yang et al, 2018). The community nurse caring for Peter is trained in health coaching (HC) and utilises this approach to support him in smoking cessation and improving his

outlook. HC is a patient centred approach to identifying issues, which may not align with the concerns the HP sees as the main priority (Brook & McGraw 2018). They begin by asking Peter about his understanding of his health, using open ended questions and active listening, which assists him to identify the issues that are of greatest concern to him. To facilitate this, it is possible to utilise the 5A's approach, which has been shown to assist in developing goals the patient might agree to, in order to address the issues identified. The 5A's involves:

- Asking the patient's perspective;
- Assessing readiness to change;
- Advising of the options to work toward the goal;
- Assisting to develop a plan; and
- Arranging referrals and follow up as appropriate (RACGP 2014).

Motivational interviewing is a critical component of supporting anyone to achieve behaviour change, and needs to be incorporated through exploring and exposing possible barriers.

The community nurse worked with Peter in a collaborative manner, prompting deliberation by the patient and encouraging autonomy, with the goal of developing

Empowering Peter to identify his concerns overlaps his understanding of health and increasing independence in managing his condition.

a rapport that reduces resistance and encourages consideration of opportunities to change (Butterworth et al. 2007).

Once Peter identifies the issues most pressing, it is possible to establish potential goals to work toward, changing lifestyle and improving health. Empowering Peter to identify his concerns overlaps his understanding of health and increasing independence in managing his condition. For Peter this is critical, as his rural location has the potential to compromise his access to healthcare. The use of telehealth is an innovation that can be utilised to provide health coaching and overcome the barriers distance may create, especially for those rural or isolated patients.

Whilst the patients' goals may not align with those of the HP, evidence suggests that as patients are supported to resolve the issues that are most concerning to them, they are more willing to engage in addressing the behaviours that are impacting on their health and wellbeing. HC can be conducted in one session and patient understanding increased through

this, there is evidence that ongoing support and follow up enhances goal achievement (RACGP 2014), and allows for ongoing counselling and progress to addressing the issues that are of concern to the HP (Lindner et al. 2003).

As more HPs embrace the concept of health coaching, and support patients in engaging in their own health and wellbeing, it will be possible to empower them and potentially reduce morbidity and improved wellbeing. This is especially true for patients living in rural Australia.

Author

Amanda Moses is a Lecturer in the School of Nursing, Midwifery and Indigenous Health, Student Marketing and Engagement Academic, Online and Master programs at Charles Sturt University in NSW

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Person first and business second: towards cultural competence in nursing and midwifery

by Cate Nagle

This article presents the transcript of an interview with Norma Lane, Clinical Nurse Consultant – Indigenous Health, Townsville Hospital Health Service (THHS) and Judy Morton, Executive Director of Nursing and Midwifery THHS

CN: Who are you?

NL: I am an Aboriginal Registered Nurse and Midwife employed as Clinical Nurse Consultant – Indigenous Health, within the Townsville Hospital and Health Service. Dad was born under the *Act* on Mornington Island. Mum was the great granddaughter of an English convict so she was never under the *Act*. Mum and dad married and grannie and dad's younger brothers and sisters came off Lorraine Station to live with mum and dad in Cloncurry.

CN: Why did you choose nursing?

NL: My father's younger sister Gladys was raised within our immediate family. My aunty chose to do general nurse training at Mt Isa Base Hospital. When Gladys graduated as a registered nurse, that was when I decided to do nursing, just like my aunty.

CN: What for you is the essence of nursing?

NL: For me to be a complete nurse I need to engage with the patient. Focus on the patient first and the business second. Once you get to know the person and start the conversation, compassion will flow.

CN: Tell me about your work history.

NL: I did my general nurse training at the old Townsville Hospital, and completed midwifery at the Royal Women's Hospital in Melbourne. I began my nursing in rural and remote areas of Queensland and Western Australia. I worked in all types of nursing environments including 15 years at Townsville Correctional Centre. I had the wonderful experience of nursing refugees in detention centres on Christmas Island



Norma Lane and Judy Morton

and in Lenora. The highlight of my career was working in the old peoples' home on Mornington Island.

Once the family connections became known, I was welcomed as one of their own children. I cannot begin to explain the feelings of honour and privilege of repaying those old grannies and granddads who helped care for my dad in his childhood days during those difficult times. I returned home to Townsville and secured a Registered Nurse position within the Townsville Hospital and Health Service.

CN: The role of the Clinical Nurse Consultant – Indigenous Health, commenced in 2017. Why is this an important nursing and midwifery innovation at Townsville Hospital and Health Service?

JM: This role is central to our strategy ensuring we develop a nursing and midwifery workforce that is much more representative of our patient population.

CN: What does your role as CNC – Indigenous Health involve?

NL: It involves cultural education for nurses and midwives with the aim of improving cultural understanding and developing a culturally competent workforce within Townsville Hospital and Health Service. The role involves mentoring and supporting Aboriginal and Torres Strait Islander students during their clinical placements so that they become proud, confident professionals and contribute towards Closing the Gap. The role also includes supporting Indigenous liaison officers caring for our Aboriginal and Torres Strait Islander patients and families with complex clinical issues.

CN: What do you bring to this position?

NL: Firstly my Aboriginality – recognition and acceptance from the Aboriginal community. I also bring my valuable knowledge of North Queensland Aboriginal history and culture that I have gained from family and work experiences. I have a good sense of humour and connect easily with people.

CN: What are the highlights of your role so far?

NL: Being a part of the cultural change within the Townsville Hospital and Health Service.

CN: What benefits do you expect will flow from this position?

JM: I envisage that the mentorship provided to nurses, midwives and students will improve their understanding of the cultural needs of our patients and translate to further developing the provision of culturally sensitive care.

CN: What are some of the challenges of this position?

NL: The main challenge is raising the awareness of nurses and midwives so that they understand and value the Aboriginal journey.

CN: How will you know that you have been successful in your role?

NL: When cultural awareness, cultural sensitivity and cultural competence become the norm within nursing and midwifery practice within Townsville Hospital and Health Service.

Norma Lane is a Clinical Nurse Consultant – Indigenous Health and Judy Morton is Executive Director of Nursing and Midwifery at Townsville Hospital and Health Service in Qld. Cate Nagle is Professor of Nursing and Midwifery at Townsville Hospital Health Service and James Cook University in Qld.



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Australia's rural hospital nurses

By Sarah Smith, Jenny Sim and Elizabeth Halcomb

It is estimated that 31% of Australia's population live outside major cities and this places pressure on rural health services, especially nurses, who are the largest group of rural healthcare workers (Francis et al. 2014).

Nursing workforce shortages and the retention of skilled nurses in rural areas continue to be a concern (Francis et al. 2016). Despite their important role in rural areas little is known about the experiences of nurses working in rural hospitals and what factors affect their intentions to stay or leave.

An underlying principle of the Australian healthcare system is that healthcare is accessible to all, despite geographic location (Duckett and Willcox 2015). Delivery of sustainable, quality healthcare to rural areas requires a skilled workforce and suitable models of healthcare delivery.

Throughout Australia there is an unbalanced distribution of healthcare workers between urban, rural and remote areas which results in challenges for people living in rural areas to access health services (Willis et al. 2016).

Currently, there is limited research focusing on the rural nursing workforce, particularly in terms of specific clinical environments such as small rural hospitals. Sarah Smith is currently conducting a nationwide study to learn more about the experiences of nurses who work in small rural hospitals throughout Australia. The study will explore the professional practice environment in small rural hospitals and examine factors impacting on job satisfaction and career intentions of nurses.

This mixed methods study is being undertaken for Sarah's doctoral program at the University of Wollongong's School of Nursing. The research is being supervised by Professor Elizabeth Halcomb and Dr Jenny Sim. The first phase of the study, an online survey, received over 500 responses from across Australia.

Phase 2 of the study, involving interviews with a sub-group of survey participants, will commence soon.

This research will reveal new knowledge about how the challenges faced by nurses working in small rural hospitals affect their experiences, job satisfaction and intention to stay in the workforce. Findings will provide an insight into working conditions

which may inform future nursing curricula to better prepare nurses to consider rural nursing and assist in planning educational support and professional development programs for existing nurses. The new information may also inform future policy initiatives to increase successful recruitment of skilled clinicians to rural small hospitals and promote the sustainability of the rural nursing workforce.

Rural health services rely on nurses to provide and drive healthcare; as such ensuring the viability of this workforce is a national priority (Hegney et al. 2002).

If you would like further details about this study contact Sarah via email at: ss889@uowmail.edu.au

Author

Sarah Smith RN BN (Hons), Dr Jenny Sim and Professor Elizabeth Halcomb RN BN (Hons) PhD. All are in the School of Nursing at the University of Wollongong

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Building resilience in health providers working remote

By Cathy Beadnell

A nationwide support service for remote area health workers is the 'best job in the world' according to senior clinical psychologist Dr Annmaree Wilson.

Dr Wilson heads up a team of 11 psychologists, including two Aboriginal psychologists, as part of the CRANAp^{plus} Bush Support Service 1800 support line. Dr Wilson and her team are focussed on working with remote area health practitioners to build and maintain psychological resilience.

"The key issues for health workers in remote locations are similar in some ways to issues facing workers in the city, but also unique. The stressors of modern life seem to be increasing for all of us and there is a growing understanding in the psychological literature that resilience can be developed and worked on," she says.

"I think nursing itself is a risk factor for stress as nurses often take on a lot and remote nursing presents some added challenges," Dr Wilson says. "There is an increasing demand for nurses to be more highly skilled and do more with less resources. On top of that you have the tyranny of distance and the likelihood of being frequently exposed to traumatic events which increases the risk of being stressed and burnt out."

Having a 24-hour telephone support service for remote area health workers is a great acknowledgement of the challenges that come with working in the bush, Dr Wilson says.

"I think it is really hard for people who haven't worked remote to know what that experience is like. It presents some unique contextual factors in terms of the isolation and the lack of access to coping strategies people in the city can draw on.

"Most of us can call on a friend or family member to catch up with and debrief if we've had a particularly hard day at work. Nurses and health workers in remote settings are less likely to have access to those

networks," she says. "That's the beauty of the CRANAp^{plus} bush support service. We are available 24/7, every day of the year, to talk to people and help them build and maintain their resilience and coping strategies."

Organisations and individuals are becoming increasingly aware of the need to develop psychological resilience, but it often gets overlooked in busy clinical settings, Dr Wilson says.

"I think we need to keep this issue of building psychological resilience in our health workforce at the top of the agenda. Stress can lead to burnout and burnout can lead to serious mental health issues," she says.

"We need to raise awareness of resilience being essential to prevent burnout. It needs to be prioritised. Clinical skills are often privileged over the need to work on selfcare and psychological resilience, but they go hand in hand. We are no good to our patients if we are running on empty."

Dr Wilson says the latest psychological research coming out of the positive psychology field offers some practical activities people can build into their daily lives to enhance emotional wellbeing and build resilience.

"The research suggests a regular mindfulness meditation practice is a core element of thriving psychologically. By mindfulness I mean just tuning into a specific thing like your breathing and taking a break from the critical thinking that induces stress.

"Another thing is the importance of creating and maintaining positive relationships and social interaction. Keeping a journal to track emotional wellbeing and identify stress triggers is also encouraged. This is a kind of reflective practice that gives an individual more insight into what is going on for them and why it might be going on. Finally, but equally important is engaging in a creative activity that takes you away from thinking about work and makes you happy. It's really about getting some insight into what works for you and making time for these activities when you're working in remote locations."

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