ANMJ
AUSTRALIAN NURSING & MIDWIFERY JOURNAL
VOLUME 26, NO.6
APR–JUN 2019

INSIDE

BLOWING THE WHISTLE

What happens when nurses make the call to act?

A PUBLICATION OF THE AUSTRALIAN NURSING AND MIDWIFERY FEDERATION

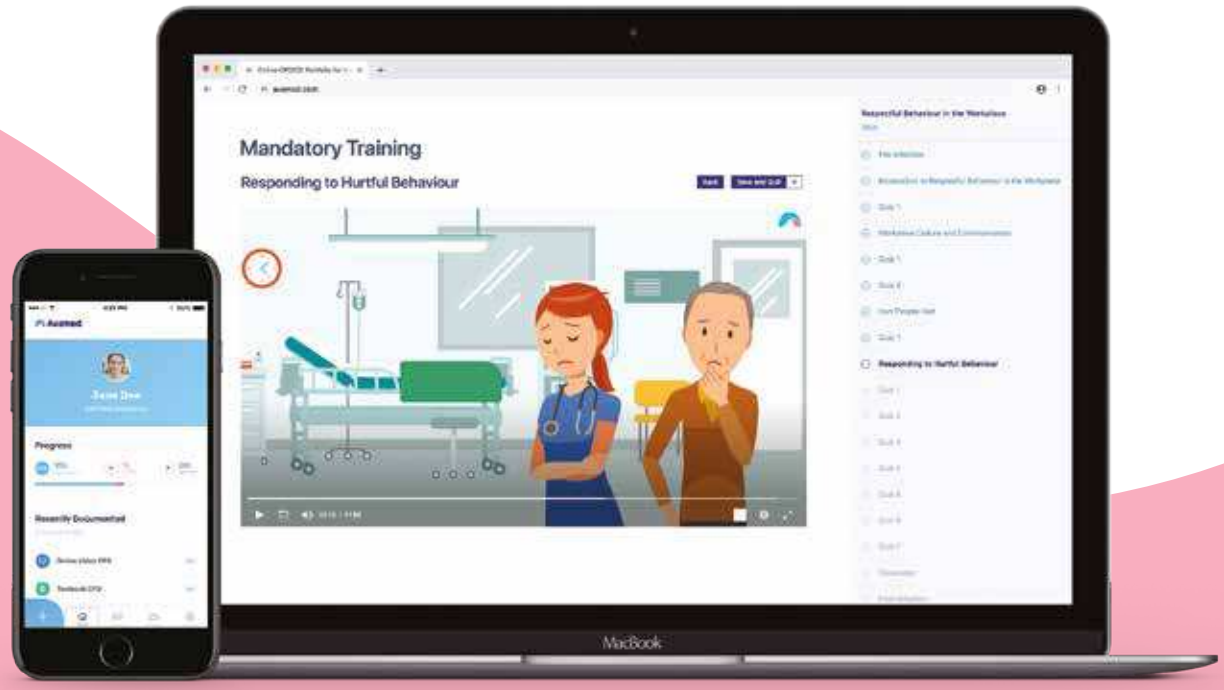
Ausmed

Need CPD?

Find, learn and document your CPD with Ausmed.

www.ausmed.com

Find CPD now!



It's important that we don't let politicians off the hook this federal election. Each of us has a civic responsibility to consider the options and make an informed decision when electing representatives into office.

Annie Butler

ANMF Federal Secretary

The ANMF has certainly hit the road running this year, particularly in relation to our aged care campaign.

After more than 18 months of hard campaigning and building evidence around the need for mandated minimum staffing levels and skill mix in aged care, I gave evidence at the first hearing of the Royal Commission into Aged Care Quality and Safety.

Quite honestly, as I prepared to give evidence, my heart was racing.

I felt the weight of responsibility of stepping up to represent 275,000 ANMF members and the crucial importance of doing the very best job I possibly could on your behalf.

But I only had to think of the daily struggles of thousands of nurses and carers, trying to do their best for their elderly residents and clients in intolerable and unsafe conditions and my fear evaporated.

Armed with this knowledge I was more determined than ever to create positive change for those members and their vulnerable residents.

Giving evidence, I was able to outline the shortcomings of the aged care system and demonstrate that inadequacies in care were not isolated events, but reflective of systemic problems in the structure of the aged care framework. And on many occasions, the result of chronic understaffing.

Inadequacies that included inappropriate regulation of the sector, a lack of responsiveness to the changing needs of Australia's ageing population and the lack of transparency and accountability across the industry.

With the accumulation of many years work from the ANMF's Branches and Federal Office, I was able to showcase the evidence showing widespread understaffing and establish how this could be fixed by introducing mandated minimum staffing levels and skill mix matched to actual care needs. I was also able to demonstrate how this could, if implemented, deliver safe and best practice care in residential aged care facilities.

The Commission also allowed me to tell real stories from members about the impossible conditions they have to deal with.

Given the Royal Commission will continue for some time, the outcomes of the hearings and potential actions on their findings may still be a while away.

This means the ANMF must maintain pressure on politicians in the lead up to the federal election to act now and guarantee safe staffing for aged care.

Not only will we be asking the major political parties to commit to this issue but also to commit to other key issues for nurses, midwives and carers.

These issues are detailed in the *ANMJ* and the parties' responses to these questions will be published on the *ANMJ* website.

It's important that we don't let politicians off the hook this federal election. Each of us has a civic responsibility to consider the options and make an informed decision when electing representatives into office.

We all play a part in the ultimate choices that the voters collectively make. So weigh up the evidence and make sure your vote counts this election for the benefit of nurses, midwives, carers and the community.

DIRECTORY

CANBERRA

3/28 Eyre Street,
Kingston ACT 2604
Phone (02) 6232 6533
Fax (02) 6232 6610
anmffederal@anmf.org.au

MELBOURNE & ANMJ

Level 1, 365 Queen Street,
Melbourne Vic 3000
Phone (03) 9602 8500
Fax (03) 9602 8567
anmffederal@anmf.org.au

FEDERAL SECRETARY

Annie Butler

ASSISTANT FEDERAL SECRETARY

Lori-Anne Sharp

ACT

BRANCH SECRETARY
Matthew Daniel

OFFICE ADDRESS
2/53 Dundas Court,
Phillip ACT 2606

POSTAL ADDRESS
PO Box 4,
Woden ACT 2606
Ph: 02 6282 9455
Fax: 02 6282 8447
anmfact@anmfact.org.au

NT

BRANCH SECRETARY
Yvonne Falckh

OFFICE ADDRESS
16 Caryota Court,
Coconut Grove NT 0810

POSTAL ADDRESS
PO Box 42533,
Casuarina NT 0811
Ph: 08 8920 0700
Fax: 08 8985 5930
info@anmfnt.org.au

SA

BRANCH SECRETARY
Elizabeth Dabars

OFFICE ADDRESS
191 Torrens Road,
Ridleyton SA 5008

POSTAL ADDRESS
PO Box 861
Regency Park BC SA 5942
Ph: 08 8334 1900
Fax: 08 8334 1901
enquiry@anmfsa.org.au

VIC

BRANCH SECRETARY
Lisa Fitzpatrick

OFFICE ADDRESS
535 Elizabeth Street,
Melbourne Vic 3000

POSTAL ADDRESS
PO Box 12600, A'Beckett Street,
Melbourne Vic 8006
Ph: 03 9275 9333 / Fax: 03 9275 9344

INFORMATION HOTLINE
1800 133 353 (toll free)
records@anmfvic.asn.au

NSW

BRANCH SECRETARY
Brett Holmes

OFFICE ADDRESS
50 O'Dea Avenue,
Waterloo NSW 2017
Ph: 1300 367 962
Fax: 02 9662 1414
gensec@nswnma.asn.au

QLD

BRANCH SECRETARY
Beth Mohle

OFFICE ADDRESS
106 Victoria Street
West End Qld 4101

POSTAL ADDRESS
GPO Box 1289
Brisbane Qld 4001
Phone 07 3840 1444
Fax 07 3844 9387
qnmu@qnmu.org.au

TAS

BRANCH SECRETARY
Emily Shepherd

OFFICE ADDRESS
182 Macquarie Street
Hobart Tas 7000
Ph: 03 6223 6777
Fax: 03 6224 0229
Direct information
1800 001 241 toll free
enquiries@anmftas.org.au

WA

BRANCH SECRETARY
Mark Olson

OFFICE ADDRESS
260 Pier Street,
Perth WA 6000

POSTAL ADDRESS
PO Box 8240
Perth BC WA 6849
Ph: 08 6218 9444
Fax: 08 9218 9455
1800 199 145 (toll free)
anf@anfwa.asn.au

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

Advertising
Heidi Adriaanse
heidi@anmf.org.au
0415 032 151

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

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

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

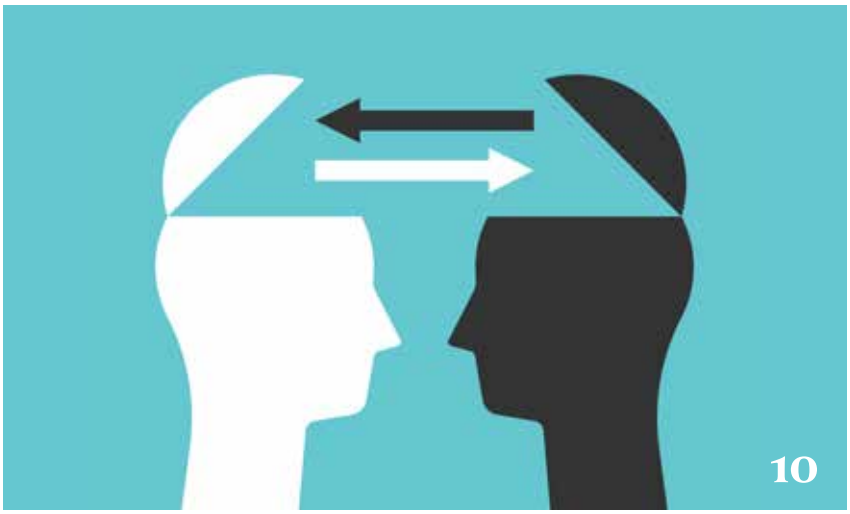
Moving state?
Transfer your ANMF membership
If you are a financial member of the ANMF, QNMU or NSWNMA, you can transfer your membership by phoning your union branch. Don't take risks with your ANMF membership – transfer to the appropriate branch for total union cover. It is important for members to consider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

ANMJ is printed on
A2 Gloss Finesse,
PEFC accredited paper.
The journal is also
wrapped in biowrap,
a degradable wrap.

121,358
TOTAL READERSHIP
Based on *ANMJ* 2014 member survey pass on rate
Circulation: 86,122
BCA audit, March 2018

CONTENTS

ANMJ
AUSTRALIAN NURSING & MIDWIFERY JOURNAL
APR–JUN 2019
VOLUME 26, NO.6



REGULAR COLUMNS

FEATURES

CLINICAL UPDATE

EDUCATION

FOCUS

Evidence in support of midday napping

People who take a midday snooze are more likely to have a noticeable drop in their blood pressure (BP) compared with those who don't.

Taking a nap during the day was associated with an average 5 mm Hg drop in BP, on par with other known BP-lowering interventions.

For every 60 minutes of midday sleep, 24-hour average systolic BP decreased by 3 mm Hg.

The study included 212 people with a mean BP of 129.9 mm Hg; 62 years on average; and just over half were female. About one in four were smokers and/or had Type 2 diabetes.

"These findings are important because a drop in blood pressure as small as 2 mm Hg can reduce the risk of cardiovascular events such as heart attack by up to 10%. Napping can be easily adopted and typically doesn't cost anything" Greece's Asklepieion General Hospital cardiologist Manolis Kallistratos said.

The research was presented at the American College of Cardiology's 68th Annual Scientific Congress held in New Orleans.

Videos launched to help patients and practitioners during notifications

The Australian Health Practitioner Regulation Agency (AHPRA) has unveiled a set of videos to help the public and registered health practitioners understand the notification process.

Titled 'Let's talk about it', the video series explains what happens when concerns are raised with AHPRA, whose core role lies in protecting the public, including information about the notification process and answers to common questions.

One of the videos, geared towards practitioners who have had a notification made about them, features guidance from AHPRA clinical advisors on how to navigate the "stressful" notification process.

AHPRA CEO Martin Fletcher said the videos made information about notifications available to a broad range of people.

"We received more than 7,000 notifications last year about registered health practitioners." Mr Fletcher said.

"It's important that the public and health practitioners are clear about what happens when we receive a notification. It takes courage to raise concerns about a health practitioner and we hope these videos will smooth the path for a more satisfying and well-informed engagement with the process."

View the videos – **ahpra.gov.au/News/2019-03-04-lets-talk-about-it.aspx**

Exercise to shift body clock

Exercise can shift the circadian body clock which may counter the effects of shift work, according to US research.

The study involved 101 participants who exercised at one of eight different times of day and night for up to five and a half days. Results showed that exercise at 7am or 1–4pm advanced the body clock to an earlier time; and exercise at 7–10pm delayed the body clock to a later time.

"This is the first study to compare exercise's effects on the body clock and could open up the possibility of using exercise to help counter the negative effects of jet lag and shift work," researcher Shawn Youngstedt said.

The Journal of Physiology

Seven to 13 alcoholic drinks a week linked with high BP

Moderate alcohol consumption substantially increases the risk of hypertension, according to research presented at the American College of Cardiology's 68th Annual Scientific Congress.

Some previous studies have associated moderate drinking with a lower risk of some forms of heart disease.

Data was analysed of 17,059 US participants split into three groups: those who never drank; those who had 7-13 drinks per week (moderate); and those who had 14 or more drinks per week (heavy).

Compared with those who never drank, moderate drinkers were 53% more likely to have stage 1 hypertension (systolic BP 130-139 or diastolic BP 80-89); and twice as likely to have stage 2 hypertension (systolic BP above 140 or diastolic BP above 90). Heavy drinkers were 69% more likely to have stage 1 hypertension and 2.4 times as likely to have stage 2 hypertension. The average BP was about 109/67 mm Hg among never drinkers; 128/79 mm Hg among moderate drinkers; and 153/82 mm Hg among heavy drinkers.

"It's the first study showing that both heavy and moderate alcohol consumption can increase hypertension," study lead author and cardiologist Amer Aladin said.

Nationwide political protests to Change the Rules

The Australian Council of Trade Unions (ACTU) is expecting more than 250,000 workers to strike on 10 April as part of nationwide political protests calling for greater job security and a fair go in the lead up to the federal election.

ACTU Secretary Sally McManus said the mass rallies reflect the "deep anger and a deep disappointment" felt across the nation due to living standards and wages going backwards and the cutting of penalty rates.

She said the government's inaction threatened the working conditions and standards of the next generation and that the Australian trade union movement was standing up for a fair go.

"Without job security people don't have the security they need to ask for a fair pay rise," she said at a recent press conference.

"They don't know how much money is coming in every single week and this puts an enormous amount of stress on families."

Ms McManus said the ACTU, who is encouraging employers to support the protests, was "sounding the alarm" to ensure governments take action.

"If we do not take action as a country now we will end up Americanising our society. We will end up in a situation where working people have to work two, three, four jobs just to support themselves and their families."

To participate and for more details on the rally in your state go to:

actu.org.au

ANMF takes the stand at Aged Care Royal Commission

Australian Nursing and Midwifery Federation (ANMF) Federal Secretary Annie Butler gave evidence to the Royal Commission into Aged Care Quality and Safety in Adelaide in February.

Ms Butler said implementing mandated minimum staffing levels and skills mix in aged care was not the sole indicator of a quality system yet one could not be achieved without taking this action.

"What we hear most often from our members now is the increasing pressure they're experiencing with workloads," Ms Butler said.

"Many of them across the country describe their workloads as unsafe. They're untenable. They report to us that that's why they're increasingly leaving the sector."

Counsel assisting the Royal Commission, Paul Bolster, drew attention to several pieces of evidence, including the ANMF's 2016 National Aged Care Survey, describing it as "quite confronting when you read it", and an independent economic analysis of the ANMF's 2016 aged care staffing report that found implementing minimum staffing hours outweighs the costs.

Ms Butler also provided a witness statement to the Royal Commission, declaring mandated staffing ratios and skills mix would fix the crisis in aged care.

She said the ANMF has developed an evidence-based staffing methodology that if implemented would deliver safe, best practice care in residential aged care facilities.

The methodology recommends aged care residents require an average of 4 hours and eighteen minutes of care per day, delivered by a skills mix of 30% registered nurses, 20% enrolled nurses and 50% personal care workers.

Lori-Anne Sharp

ANMF Assistant Federal Secretary

No place for political spin … Why the Medevac Bill matters

Hamid Khazaei, a 24-year-old Iranian detainee on Manus Island died in 2014 from sepsis originating from a minor leg wound. It was a preventable death. A coroner's inquest found there had been a failure by Australian immigration officials to urgently grant a doctor's request for Hamid's transfer to Australia (Robertson, 2018).

As human rights advocates and those who care about the health and wellbeing of all in our community, nurses and midwives are aware of Australia's tough offshore mandatory detention policy, treatment of refugees and the impact political scaremongering can have in shaping beliefs.

The passing of the Medical Evacuation legislation (*Medevac Bill*) in parliament earlier this year that allows the transfer of refugees for urgent medical care is welcomed by most health professionals and hopefully will prevent similar tragedies like the one that befell on Hamid.

Unsurprisingly, the Coalition voted against the legislation, making it the first government in 82 years to lose a vote in the House of Representatives.

In voting against this Bill, the government demonstrated yet again a lack of compassion for vulnerable asylum seekers.

Australia's asylum seeker policy, which involves imprisoning individuals fleeing atrocities in their own country, is considered by many in the Australian and international community as an abuse of human rights. The complex health issues suffered by people fleeing oppression, persecution, torture and separation from family are enormous and difficult to comprehend. These can include severe physical and mental illness including risk of suicide. Asylum seekers are then further impacted by being incarcerated in offshore mandatory detention centres with waits of up to six years in detention.

In the lead up to this year's federal election, it is vital we know the facts and are not influenced by political scaremongering.

Prior to the *medevac Bill* being passed, the decision to evacuate a patient to Australia rested solely with the Minister for Home Affairs.

As a result, asylum seekers were regularly denied the urgent medical treatment they required.

This was the case with Hamid and as a consequence of this political decision, he lost his life. On many occasions, health professionals, left with no alternatives, have had to resort to initiating proceedings in the courts to enable their patients access to clinically determined medical treatment in Australia. In a recent example, a 46-year-old man who had suffered loss of vision in one eye and rapidly deteriorating vision in the other eye, following the outbreak of a riot, needed urgent, specialised medical attention that Manus Island was not equipped to provide.

A court order eventually allowed his transfer to Australia for assessment and treatment, but only after many delays, leading to frustration and unnecessary pain on the part of the patient.

The nursing and midwifery professions believe quality healthcare is a human right for all.

Many nurses and midwives are well aware of the serious mental and physical health conditions that asylum seekers on Manus and Nauru are suffering, and have been advocates of a humane asylum seeker policy.

For this reason, we must speak out against the political point scoring and fear campaigns that this legislation will in some way threaten our national security.

Scaremongering campaigns are already evident in the lead up to the May federal election. Just recently, the Minister for Home Affairs Peter Dutton claimed Australians would be kicked out of their homes and off hospital waiting lists to make way for a 'flood' of refugees seeking urgent medical attention.

With more than 90,000 public and private hospital beds in Australia, this is extremely unlikely, particularly given the recent estimate of 70 refugees needing immediate care. Mr Dutton's statement is an example of fearmongering for political advantage. Thankfully, St Vincent's Health immediately contradicted this baseless claim and confirmed that St Vincent's would be happy to make its hospitals available to care for asylum seekers without affecting waiting lists.

In the wake of the *Medevac Bill* and proximity to the federal election, expect the passing of this legislation to be used as a tool to promote fear and divide the community on refugee issues. It should in fact be applauded as a human rights initiative to ensure all people regardless of their status, race, creed or religion have access to healthcare. We are well-respected leaders in our communities and we all have a responsibility to stand up and call out the mistruths.

Reference

Robertson. J, 2018 Asylum seeker Hamid's death from leg infection was preventable, Queensland Coroner finds.

What's the chance she'll complete the course?

Up to 54% of patients studied did not complete their full course of ferrous sulfate as prescribed[1–3*]

Maltofer® restores iron levels with significantly less side effects and better treatment compliance.[1,2*] Ensure they get the iron you intended.

For more information, visit maltofer.com.au

Maltofer contains iron as iron polymaltose.

Maltofer is for the treatment of iron deficiency in adults and adolescents where the use of ferrous iron supplements is not tolerated, or otherwise inappropriate. For the prevention of iron deficiency in adults and adolescents determined by a medical practitioner to be at high-risk, where the use of ferrous iron supplements is not tolerated, or otherwise inappropriate. If you have iron deficiency, your doctor will advise you whether an oral iron treatment is required.

*In studies comparing iron polymaltose with ferrous sulfate in iron deficient patients. **References: 1.** Ortiz R *et al. J Matern Fetal Neonatal Med* 2011;24:1–6. **2.** Toblli JE and Brignoli R. *Arzneimittelforschung* 2007;57:431-438. **3.** Jacobs P *et al. Hematology* 2000; 5: 77-83. Maltofer® is a registered trademark of Vifor Pharma used under licence by Aspen Pharmacare Australia Pty Ltd. For medical and product enquiries, contact Vifor Pharma Medical Information on 1800 202 674. For sales and distribution enquiries, contact Aspen Pharmacare customer service on 1300 659 646. Date of preparation August 2018.

Maltofer®
Body-friendly iron

ANMF calls on political parties to commit to priorities

ANMF's Federal Secretary Annie Butler and Federal President Sally-Anne Jones recently met with the leader of the Opposition and Australian Labor Party Bill Shorten to discuss the union's priorities leading up to the federal election in May.

At the time of going to print Mr Shorten was the only political leader who had agreed to meet Ms Butler and Ms Jones, to consider the key priorities for nurses, midwives and carers across Australia.

The ANMF also contacted the Prime Minister and the Greens Leader for a meeting with the Federal Secretary and Federal President to discuss the ANMF federal election priorities. The politicians' responses will be published on the *ANMJ* website.

The following is a summary of the commitments ANMF is seeking for nurses, midwives and carers:

UNIVERSAL HEALTH, DISABILITY, AND AGED CARE

Ensuring the sustainability and enhancement of Australia's universal healthcare system through:

- Mandating publicly reported minimum staffing levels and skills-mix across the health, maternity, and aged care system to ensure the best health consumer outcomes and the delivery of safe, high-quality care in all settings.
- Supporting nurses, midwives, and carers to be appropriately recognised and valued by the community through dedicated, sustainable funding for nurse- and midwife-led models of care, research, and workforce research.
- Ensuring that the Australian health, maternity, and aged care system prioritises genuine evidence-based, person-centred care and patient safety.
- Transitioning toward a fully integrated, outcome-focussed, value-based healthcare system that recognises and addresses social determinants of health and incentivises high-quality clinical performance and improved consumer outcomes, health, and wellbeing.
- Committing to the provision of long-term, sustainable funding for health, maternity, and aged care that drives optimum health and wellbeing outcomes for all.
- Committing to the provision of long-term, sustainable funding for initiatives that develop high-quality research, data collection, and public reporting of health, maternity, and aged care performance and outcomes as well as evidence regarding the impact of workforce composition and health outcomes.
- Increasing flexibility in the funding arrangements for public hospitals, the PBS, the MBS, maternity service funding, and aged care so that regional health services can 'pool' some of these resources to meet the needs of their communities.

Ensuring an effective and accessible National Disability Insurance Scheme through:

- Continuing to monitor and assess the rollout of the NDIS and ensuring equitable access and coverage for underserved or marginalised groups.
- Implementing the recommendations in the Productivity Commission report, National Disability Insurance Scheme (NDIS) Costs; and from the Joint Standing Committee on the National Disability Insurance Scheme.

EDUCATION AND TRAINING

Supporting a future-ready workforce through:

- National comprehensive health and aged care education, training, and workforce planning to underpin a future-ready supply of appropriately qualified and prepared health and aged care staff including the projected additional 74,200 registered nurses, enrolled nurses, and midwives and 90,600 additional personal carers and assistants in nursing including aged and disabled carers.
- Dedicated funding to ensure Australian universities and nursing, midwifery, and carer education and training providers can educate and train the future nurse, midwifery, and carer workforce.

Boosting nursing, midwifery, and carer education and workforce recruitment and retention through:

- Utilising the best available evidence and indepth expert stakeholder consultation to identify and implement initiatives to improve nursing, midwifery, and carer education enrolment, completion, and workforce retention across health and aged care sectors.
- Working with health and aged care, education and training providers, health and workforce researchers and nursing and midwifery peak bodies to enable improved retention of the nursing, midwifery, and assistant in nursing workforce.
- Dedicated funding to implement effective graduate nursing and midwifery transition to practice programs across diverse health and aged care sectors with adequately resourced preceptorship from experienced registered nurses and midwives.

- Funding the development of comprehensive, evidence-based nursing and midwifery workforce plans at the state/territory level. For example, subsidise mental health training for nurses to increase the qualified mental health workforce across rural/regional/remote and metropolitan locations.

NURSE PRACTITIONERS AND MIDWIVES WITH SCHEDULED MEDICINES ENDORSEMENT

Supporting the expansion and utilisation of nurse practitioners (NPs) and midwives with scheduled medicines endorsement through:

- Supporting the recommendations made by the MBS Review Taskforce Report from the Nurse Practitioner Reference Group and Participating Midwife Reference Group that increase MBS item payments, enhance 'request and refer' and after-hours services.
- Ensure ongoing transparency throughout the MBS review process including stakeholder consultation involving NPs, feedback, and final decision making.
- Providing sustainable and dedicated infrastructure and incentive funding for NPs and midwives with scheduled medicines endorsement to establish private practices particularly in districts of workforce shortage.
- Providing sustainable and dedicated funding to employ NPs and midwives with scheduled medicines endorsement in the public health sector particularly across rural, regional and remote communities and in Primary Health Networks to support the aged care sector.
- Allowing NPs to employ other nurses via the Practice Nurse Incentive Program.

WORKFORCE UTILISATION

Supporting the use of full nurse and midwife scope of practice through:

- Initiatives enabling nurses and midwives work to their full scope of practice and by working with stakeholders to remove unnecessary barriers to this.
- Providing dedicated funding to support the trial, implementation, evaluation, and expansion of evidence-based nursing- and midwifery-led models of care such as nurse-led clinics in primary and acute healthcare, chronic disease, and cancer care, rural/regional/remote health and maternity care and health and maternity care for Aboriginal and Torres Strait Islander people.
- Legislating that all registered nurses be authorised to facilitate advance care planning.

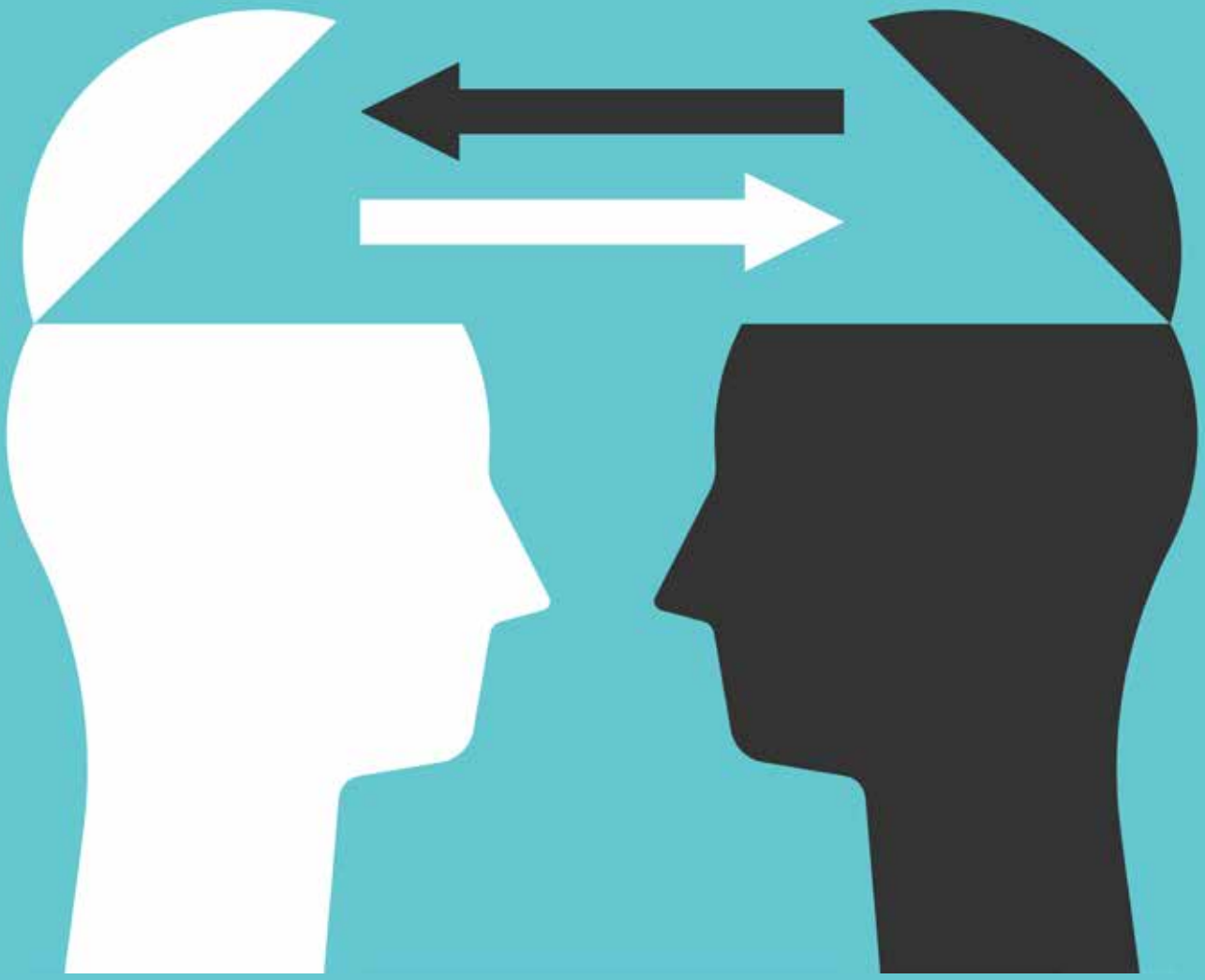
WORKFORCE AND WORKPLACE CONDITIONS

Supporting the nursing, midwifery, and carer workforce in all health and aged care settings through:

- Mandating minimum staffing levels and skills-mixes across the entire health and aged care system to ensure that nurses, midwives, and carers can deliver safe, high-quality care and to combat widespread workforce recruitment and retention problems.
- Supporting policies that ensure that remuneration includes a minimum living wage that improves over time, that penalty rates are retained, and that workers have access to a fair bargaining system.
- Supporting policies that give women equal rights, entitlements, and pay.
- Supporting policies that stop employers from unreasonably terminating enterprise agreements.
- Supporting policies that promote greater investment and provision for people to enter appropriate, high quality vocational education and training in health and aged care.
- Supporting policies that enable those who work regular hours to convert to permanent employment.
- Supporting policies that give workers on temporary visas equal rights, entitlements, protections, and remuneration to Australian nationals under workplace enterprise agreements.
- Supporting policies that give labour hire workers equal rights, entitlements, protections, and remuneration to permanent workers under workplace enterprise agreements.
- Supporting policies that give 'gig economy' workers equal rights, entitlements, and protections as well as a minimum living wage.

MENTORING MATTERS

By Robert Fedele



Mentoring in nursing and midwifery offers meaningful rewards for both parties. The collaborative confidential relationship gives mentors the opportunity to give back to the professions and support career development. On the flipside, mentees gain knowledge, become empowered to build confidence, and develop skills to set and achieve goals.

When utilised in nursing and midwifery mentoring typically involves an experienced member of the professions or broader health sphere connecting with a nurse or midwife to share knowledge, build leadership and support career development.

Nurse Practitioner Terry Swanson, a wound expert at South West Healthcare (SWH) in Victoria, has experience of both sides of mentoring during a three-decade clinical career.

Ms Swanson's first exposure involved informally seeking a second opinion or help when dealing with complex patients.

It led to aligning herself with like-minded clinicians and eventually asking them to become her mentor.

She's had several mentors throughout her career but has principally retained a relationship with both a clinical and ethical mentor, enabling her to discuss issues in everyday practice and broader dilemmas that tested her moral code.

"When I lecture I encourage other nurses to have a mentor or at least a support person and ideally that would start in their graduate year to traverse those pitfalls and the inadequacies that are revealed during the culture shock of [entering nursing]," Ms Swanson says.

"I always advocate for nurses to have a mentor and depending on my phase of nursing it has been formal or informal. Certainly when I was going from a clinical nurse consultant to an NP there were formal arrangements. I had a surgeon who was my clinical mentor and supervisor and to this day we have an informal relationship where if I have a case [to discuss] I can call him and he always picks up."

A member of the ANMF (Vic Branch) Branch Council for six years including a stint as Vice President, Ms Swanson suggests mentoring within nursing and midwifery is often misunderstood.

"I feel people are afraid of it or don't have the courage to ask somebody to mentor them. They don't realise saying to a colleague 'would you mind having a cup of coffee after work or a drink on the way home so I can run something by you' and asking those professional questions is a form of debriefing."

"I think seeking a second opinion and support is at the core of mentoring," Ms Swanson explains.

"There's a lot of connotations of what that looks like and it varies from person to person."

Ms Swanson says the wisdom of mentors over the years has helped her tackle a variety of professional situations, such as developing the confidence to charge appropriately when embarking on private work, and confronting everyday ethical dilemmas within the hospital.

She credits her positive experiences with inspiring her to become a mentor herself, a role she has carried out numerous times both formally and informally, particularly with emerging NPs.

"I like to pay it forward. People have been very generous in my career to tap me on the shoulder and say 'I think you can do this' and I've taken a leap of faith and benefited tremendously by doing so.

"I try to see potential in other people and tell them when they've done a good job. If I see an internal job advertisement I might call somebody up and say 'listen you've got all the qualities why don't you give it a go' and then we'll talk through that process of how to do the job application as well as being a referee for them."

Ms Swanson believes mentors require a range of attributes in order to act as a positive role model and advance nursing leadership for generations to come.

"Humility and confidence," she says of the key characteristics.

"I know they sound contradictory but they're not. The best mentors I've had are people who've had international and national fame but are so humble of heart and confidence in their skills. Because in order to give confidence you have to be confident in yourself."

Recently qualified registered nurse Tammie


Tammie Breneger

Breneger was accepted into the Australian College of Nursing's Emerging Nurse Leader (ENL) program when a third year student at Southern Cross University (SCU).

The ENL program supports up-and-coming nurse leaders and includes a component that facilitates ongoing formal mentoring relationships that provide expert support and professional networking opportunities.

Ms Breneger, who pursued a nursing career when she was 39, applied for the ENL program because of the chance to further her professional development and collaborate with industry and educational mentors while navigating her early career.

Last year, while undertaking her graduate year at Kempsey District Hospital in NSW, she was matched with mentor Rhonda Griffiths, Professor and Dean of the School of Nursing and Midwifery at the University of Western Sydney.

Over the course of the year, Ms Griffiths and Ms Breneger spoke regularly over skype to set professional goals and discuss strategies.

"We met about every three weeks to a month," Ms Breneger recalls.

"Last year I looked a lot at the differences between leadership styles, management versus leadership, and some personal development goals.

"The biggest goal we were working on was being able to develop a more open communication style with a variety of staff members and personalities because an effective leader is someone who can speak to all people."

Ms Breneger credits Ms Griffiths with helping her set targets and understand that effective leaders must set boundaries, adapt


Marni Tuala and Graduate midwife Taneeka Hyatt

on the job and create open communication channels with staff.

"She terrified me. I was terrified of her reputation because she is so well regarded within both professions but I found it so beneficial it was amazing.

"I think the greatest thing that came out of this last year with Rhonda was being able to take a step back in situations to more objectively filter a situation to then developing my responses in a more professional manner for the greater benefit.

"It's [also] made me a better nurse by being able to step back and look at clinical situations and then formulate appropriate responses to them."

Ms Breneger lists time constraints as the biggest barrier along the mentoring journey.

"That was the single greatest issue given Rhonda's position within the university sphere and still being a practicing clinician one day a week. Our greatest barrier was having timetables that were mutually beneficial but we managed to do it quite successfully it just took a bit of realignment."

Much like Ms Swanson, Ms Breneger, who aspires to work with NSW Health in policy and clinical governance, believes in giving back to the profession.

"I'm actually an industry mentor for my old university (SCU). I mentored third year students on their interview preparation and getting their resume sorted. It was an informal process but I really enjoyed that. I had three students that I mentored and that was via telephone conversations and emails whenever they had questions."

At the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) mentoring is considered a key tool in addressing some of the workforce's challenges entering Australia's health system.

Last December, the peak national body ran a mentoring workshop in Sydney geared at nurses, midwives and educators interested in mentoring Aboriginal and Torres Strait Islander students and staff.

CATSINaM President and midwife Marni Tuala co-facilitated the mentoring workshop, describing it as an opportunity to link with non-Indigenous health professionals across all levels from various LHD's across the city.

"One of the reasons we run it is that Aboriginal and Torres Strait Islander students are more than twice as likely to jump out of tertiary study and the evidence shows that if they're better supported and mentored through their studies they have a higher chance of succeeding," Ms Tuala explains.

"The other reason is we know we need a culturally safe health system not only for patients and women and families that are accessing those services but also for the health professionals that are working within them, including our students."

The workshop examined the historical policies that have triggered health disparities faced by Indigenous people, the social and cultural determinants of health, and the differences in how Indigenous people live, work and learn.

"It's a lot of self-reflection. It's getting them to self-reflect on what their internal narrative is in regards to Aboriginal and Torres Strait Islander people. That narrative that they've got playing in their head when they work with our people and really addressing the stereotypes they may have, dispelling those myths and giving them the tools to best communicate."

Afterwards, participating health professionals enter into formal mentoring agreements and are matched with Indigenous nursing and midwifery students as they undertake clinical placements.

Ms Tuala says informed clinicians taking Indigenous students under their wing can help break down problematic issues such as racism.

"When you talk about having a culturally safe system we need to look at where the responsibility of providing that system lies and it's not with the 3%, the percentage of the population that identifies as Aboriginal and Torres Strait Islander. The responsibility lies with the 97%, the majority of the population.

"Ideally, we would have students being mentored by Aboriginal and Torres Strait Islander nurses and midwives but there's just not enough of us across the country. In midwifery itself, there's only 230 Aboriginal and Torres Strait Islander midwives in all of Australia."

On a personal note, Ms Tuala, the Aboriginal Liaison Midwife at Tweed Hospital, says mentoring by both Aboriginal and non-Aboriginal mentors continues to play a significant role in her professional career.

"I don't think there's ever a time in one person's career where that need for mentoring ceases," she says.

"It's ongoing and I hope to continue to learn throughout my entire career. I don't think there's ever a point where I'll think that I know it all."

Ms Tuala also mentors others, including a student midwife who recently secured one of just two graduate positions at the Tweed Hospital.

"She just started her graduate year and our mentoring relationship continues. We've moved on now from that student midwife and making sure she has the clinical and theoretical knowledge to become a midwife, to shifting into that next phase of mentoring where I'm mentoring her on consolidation of her clinical knowledge as well as building up her resilience within the health system."

Join the health fund that's all about *you*.

Nurses & Midwives Health is dedicated to caring for the carers.
And as a member of ANMF, you're eligible to join!

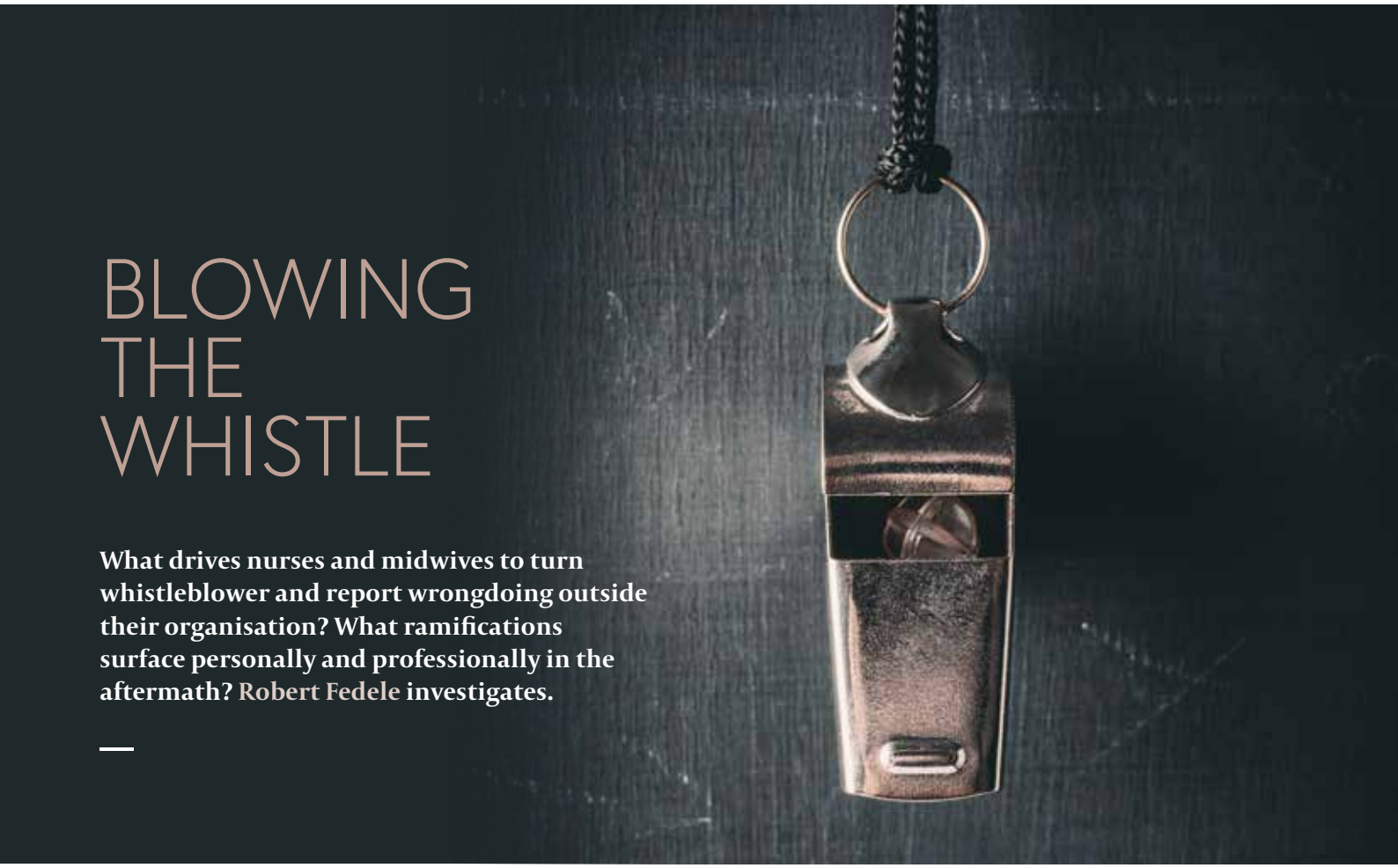
When you're a member, you're part of our family. So that's why your family members are also welcome to join us.

NURSES MIDWIVES HEALTH

Caring for the carers

For your free, side-by-side comparison, and our latest offers, visit **nmhealth.com.au** or call **1300 344 000**

MEMBERS OWN HEALTH FUND



BLOWING THE WHISTLE

What drives nurses and midwives to turn whistleblower and report wrongdoing outside their organisation? What ramifications surface personally and professionally in the aftermath? Robert Fedele investigates.

"If you've got a gut feeling that something is wrong it probably is wrong," says Toni Hoffman, perhaps Australia's best-known nurse whistleblower.

"Even if it takes a bit of investigation and it's not wrong, well that's fine, at least you've checked it out."

Ms Hoffman made national headlines in the mid-2000s after she blew the whistle on the lack of action by the Bundaberg Base Hospital in Queensland after she and other nurses reported concerns about the poor surgical outcomes and patient deaths related to surgeon Dr Jayant Patel.

She was the Nurse Unit Manager (NUM) of the Intensive Care Unit (ICU) at the hospital at the time.

She felt compelled to act in a bid to protect patients following a string of 'disastrous events' related to Dr Patel's clinical and surgical competencies.

Ms Hoffman lodged numerous complaints internally, beginning just six weeks after the US trained Dr Patel started at the hospital, which fell on deaf ears.

"What they [the hospital] did was they tried to discredit me and turned on me and said I had poor communication skills and gave me a book to read on how to deal with difficult people," she tells the *ANMJ*.

Ms Hoffman still vividly remembers the extensive harm caused by Dr Patel.

Like the middle-aged man who had a caravan roll on his chest needing transferring to Brisbane that Dr Patel put a stop to who later died from serious complications.

Or the teenage boy who presented to Bundaberg following a motorbike accident and after three unsuccessful operations at the hospital failed to restore his circulation was flown to Brisbane where he lost his leg.

"In two years he had operated on 1,400 or so patients and out of them 1,200 had to have some form of corrective procedure. If you think of that statistically that's just phenomenal," Ms Hoffman claims.

Ms Hoffman did not plan on becoming a whistleblower and says reporting her concerns outside the hospital was a last resort.

While she was supported by the then Queensland Nurses Union (QNU, ANF Queensland Branch) after she spoke out, she recalls feeling undermined by management and fellow nurses because of her actions.

At that point, she turned to MP Rob Messenger for assistance as she had already followed the appropriate channels, including her Director of Nursing (DON), and had even phoned the police and the Coroner.

"We sort of knew that whatever we did [the complaints] wasn't going to help," she says.

Mr Messenger raised the issue in March 2015 in a Matters of Public Interest speech in the Queensland Parliament.

Anomalies in Dr Patel's registration became public when *Courier Mail* journalist Hedley Thomas published them in a front-page article later that year.

The actions triggered Commissions of Inquiry that investigated malpractice allegations against Dr Patel, the Director of surgery at Bundaberg Hospital between 2003 and 2005, and led to his eventual resignation and downfall.

The Davies Inquiry found the hospital executive repeatedly failed to act on dozens of serious complaints against Dr Patel and highlighted nine separate findings including performing surgical procedures restricted by previous medical boards, negligent treatment of 13 patients who died and others who suffered adverse outcomes, and failure to report 13 deaths to the Coroner.

Other findings showed he worked as a general surgeon without being registered in Queensland and failed to perform surgical audits.

The Davies Inquiry recommended Dr Patel be investigated for fraud, assault and manslaughter.

After being extradited back to Australia from the US in 2008 to face charges, he was eventually convicted of three counts of manslaughter in 2010 and sentenced to seven years jail.

But after serving two years behind bars, Dr Patel appealed to the High Court of Australia and the process eventually led to him being given a two-year suspended sentence after he pleaded guilty to four counts of fraud for failing to disclose his previous deregistration in the US.

In the end, Ms Hoffman's actions helped change the system, with subsequent healthcare deaths requiring reporting to the Coroner and nurses given the power to report to a Member of Parliament.

"I felt vindicated but I also felt very angry and upset that what happened didn't have to happen if a lot of people had done their jobs," says Ms Hoffman, who was named Australian of the Year Local Hero in 2006 and received the Order of Australia (AM) for her part in advocating for patient safety.

Ms Hoffman continued to work clinically at Bundaberg up until 2012 before she took a voluntary redundancy and became a lecturer in nursing at CQUniversity.

While she would 'absolutely' blow the whistle again if it meant protecting patients, the impact of her decision more than a decade ago has taken an immeasurable toll.

These days, she refers to herself as 'still a work in progress'. "The personal toll has unravelled as the years have gone on. I've always worked in intensive care and I was always a really good nurse, a really good clinician, and I lost all that," Ms Hoffman says.

"The effect on me professionally, personally, financially… it's just been horrendous. It really more or less just stops your life and you have to start over again."

Ms Hoffman believes in the importance of nurse whistleblowing but warns it can prove catastrophic for everyone involved and should not need to happen.

Alanna Maycock

Toni Hoffman

Photo credit: National Australia Day Council

"I think that our organisations should be robust enough that we should be able to deal with internal complaints correctly. In a robust organisation whistleblowers aren't necessary."

Dr Sonja Cleary, Associate Dean Student Experience, in the School of Health and Biomedical Sciences at RMIT University, and a practicing clinical nurse, was lecturing in Bundaberg as the hospital was thrust into the limelight.

She saw an opportunity to follow the events taking place and use the thought-provoking publicly available data at her fingertips to compile her PhD thesis, *Nurse Whistleblowers in Australian Hospitals: A Critical Case Study*, published in 2015.

"It occurred to me that on very few occasions will you ever get to see that level of organisational structure put in the public domain, to help us understand why it occurred," Dr Cleary recalls.

"I remember at the time when it hit thinking nurses don't go outside the hospital for no reason. We're very loyal to the organisation and the medical team and you can question them inside the hospital, but it's a significant action to go outside."

Dr Cleary's thesis examined the 'social phenomena of nurse whistleblowing' by tracing over two high-profile Australian cases – Hoffman's at Bundaberg and the Macarthur Health Service in New South Wales – to find out what drives nurses to expose the truth.

"The theme that came out of all of them was a failure to be heard and a wilful blindness," a term Dr Cleary identifies with organisations that ignore reports about sub-standard care out of fear of liability or reputational damage.

Key findings from Dr Cleary's thesis suggest nurse whistleblowing occurs when there is a fundamental breakdown in clinical governance and incident reporting processes.

In the cases examined, organisational responses were retaliatory, leading to a 'social crisis' shaped by four elements – the need to assign blame, the exercise of wilful blindness on the part of the hospital administrators, the presence of a network of hierarchal gaze and discipline, and the use of confidentiality as a mechanism to silence dissent and prevent external disclosures.

The thesis found the need to find internal psychological peace emerged as the main motivation behind nurses taking action, which they believed would come from making 'the choiceless choice' to stand up for patient safety.

But nurses who blew the whistle were hampered by a 'false consciousness' that action would be taken to address their concerns.

Recommendations were headed by calls for more effective clinical processes, so whistleblowing need never occur and investing in further research into patient safety and the experiences of healthcare staff who report wrongdoing.

"If hospitals want to stem whistleblowing then they have the power to make sure their clinical governance systems are set up to

allow nurses to be heard and feedback about what actions were taken to remediate the condition they had raised," Dr Cleary argues.

Dr Cleary's message to nurses contemplating blowing the whistle is do your homework and get early legal advice from professional and industrial bodies such as unions.

"If you take the step of going outside the hospital and you don't have what I call objective evidence and just have hearsay from other people, then you are in an incredibly vulnerable position."

While Dr Cleary agrees nurses who blow the whistle are undeniably inspiring she stresses their capacity for work in the aftermath is often compromised.

"It's not a choice you take lightly because it's going to affect every part of your future career.

"Healthcare in the context of reputation is risk-averse. If you have somebody who has demonstrated bringing concerns to light outside the organisation, despite the fact they are admired as heroes in protecting patient safety, there is something in the back of the mind of future employers who may think 'would they do this in my organisation?'."

Nurse whistleblower Alanna Maycock, who spoke out on Australia's offshore detention policy and the horrors she witnessed on Nauru, concedes there is a stigma that comes with lifting the lid.

"People assume you're a troublemaker," she says.

"Whistleblowers are demonised and belittled. I was told that I was "exaggerating" and even "sensationalising". It was made very difficult by the fact that I was exposing information about a group of people that at the time the Australian public weren't that sympathetic about."

A paediatric clinical nurse consultant, Ms Maycock spent five days on Nauru in 2014 providing healthcare to asylum seekers in detention after being recruited as a consultant by the Australian government and contractor International Health and Medical Services (IHMS).

She encountered shocking incidents including the rape of a mother, a guard assaulting the father of a child she was caring for, and a six-year-old girl attempting to hang herself with fence ties.

Ms Maycock helped write a 17-page report for IHMS that outlined recommendations on how to improve services on Nauru; but they were ignored.

Upon returning to Australia, she and colleague Professor David Isaacs turned to the media and began writing a series of newspaper articles exposing what they saw and the damage to the health of refugees, particularly children.

"It's not a decision that was taken lightly [whistleblowing]. I lived in fear that I wouldn't receive any support amongst my colleagues and may even lose my registration to practice," Ms Maycock recalls.

"You're encouraged to go up your usual reporting lines if you feel something's incorrect in the workplace but actual whistleblowing is something very different. I was reporting a whole culture of abuse, not just a single incident."

Ms Maycock continued to speak out despite facing the prospect of up to two years' jail time when the *Australian Border Force Act* came into force in 2015 in an attempt to silence the reality experienced at the detention centres.

She was the sole nurse among 40 health workers and humanitarian staff, both former and current workers at Australia's offshore detention centres, who wrote an open letter defying the government's then new law, emphasising the absence of adequate child protection and legal obligation to report abuse.

"This for me was more than just whistleblowing within the nursing profession," Ms Maycock explains.

"I found myself involved in the politics of this issue. The Australian government had introduced a policy to supress doctors and nurses, escalating incidents that would affect the health of their patients, such as child abuse. Nurses are mandatory reporters."

Ms Maycock admits blowing the whistle over the past few years has taken a toll both personally and professionally.

However, instead of wavering, her advocacy grew.

Ms Maycock, who coordinates a Refugee Clinic at Sydney's The Children's Hospital at Westmead, last year recruited several paediatricians from across the country and trained them, along with her internal team, to undertake medical assessments via video link calls on children and families in detention on Nauru.

The medical assessments and medico-legal reports, which uncovered children as young as six not eating or drinking and "resigning from life", were then used to assist lawyers in court to advocate that children were transferred from the island to Australia for lifesaving medical treatment.

"We said we are going to do them [the assessments]. This is the right thing to do. These children are dying and we need to get them specialist medical treatment immediately."

The efforts contributed to major change and earlier this year the last of the remaining children in detention on Nauru were taken to safety.

Reflecting on her experience as a whistle-blower, Ms Maycock says it wasn't easy but nurses have a duty of care to their patients.

"I really believe that we need to support nurses when they think about whistleblowing. We report because we care for our patients. Unfortunately, nurses are isolated and bullied when they blow the whistle. This has created a culture of fear in the nursing profession and if nurses are too scared to report, this will ultimately affect the health of patients."

Kristen Wischer

ANMF Senior Federal Industrial Officer

The Aged Care Royal Commission: What does it mean for the ANMF?

The Royal Commission into Aged Care Quality and Safety provides a 'once in a lifetime' opportunity to identify, examine and address the multitude of issues facing the aged care sector. Paramount being the objective of ensuring the safety, health and wellbeing of older Australians who rely on care.

The ANMF is uniquely placed to participate in this Inquiry as the organisation that represents the core of the workforce who provide that care.

The terms of reference for the Royal Commission go to the very matters the ANMF has sought to bring attention to over many decades.

The ANMF has campaigned, made submissions and conducted extensive research in support of mandated staff ratios and skills mix in residential aged care. Transparency and accountability in funding and reporting would provide the structural oversight to ensure that what is required to be delivered for safe and best care is in fact delivered.

Of course, the ANMF is not alone in calling for major reform to the sector. The voices of families and advocates of consumers are perhaps the most compelling and were instrumental in prompting the federal government to call a Royal Commission.

The ANMF's message has always been consistent across the many forums to which it has contributed submissions and evidence.

What distinguishes the Royal Commission is that it is not confined to one aspect of aged care, it will take a broad and comprehensive approach to all facets of the delivery of aged care. This in turn makes the opportunity to address the Royal Commission a special chance to bring all these threads together in a public forum that has the capacity to result in lasting systemic change.

Hearings commenced on 11 February 2019 in Adelaide with the purpose of providing background information about the aged care sector and the issues that need to be addressed. To do this, the Commission heard evidence from witnesses on behalf of some of the principal representative organisations that have deep interest and involvement in the aged care system.

ANMF Federal Secretary, Ms Annie Butler, along with a range of industry representatives from organisations such as COTA, ACN, AMA, other unions, various advocacy groups and government bodies gave evidence in the opening weeks of the hearing.

This provided a significant opportunity for the ANMF to explain why mandated minimum staffing levels and skills mix are central to the delivery of safe and best quality aged care.

Concerns with increasing pressures of workload, disparity in remuneration between aged care and public sector health services and lack of professional opportunity in the aged care sector were all brought to the Commission's attention.

The Royal Commission will of course not only identify problems – it will also make recommendations as to how to solve problems and introduce reform. The Commission recognises that witnesses will wish to put forward possible solutions. The ANMF's evidence does just that.

The ANMF commissioned a report 'National Aged Care Staffing and Skills Mix Project Report 2016' which sets out an evidence based methodology in support of minimum staffing levels and skills mix. That report is expanded upon with a plan demonstrating how the introduction of minimum ratios and staffing mix can be economically sustainable. This substantial academic work now forms part of the evidence to be considered by the commissioners.

In the coming months the ANMF will make further detailed written submissions to the Commission and may be requested to provide more background material or evidence as the hearings progress. In order to prepare submissions and be responsive to requests from the Commission, the ANMF has established a working group of aged care experts from the federal office and each branch.

This in itself has already proved a highly productive exercise – providing a forum for exchange of ideas and knowledge across the branches.

The Royal Commission has provided the impetus to bring our knowledge and skills together – for example a central database of aged care resources will be created and members of the working group have already shared a lot of insight that can be taken back to state branches.

The work we are doing now will inform and assist both the federal office and the branches to continue to advocate for improvements for members working in aged care.

Most importantly, we believe the work we are doing for the Royal Commission will contribute to real and much needed improvement to the lives of elderly Australians.

Seasonal influenza immunisation for older adults in Australia: vaccine options for 2019

By Magali De Castro, Alan Leeb and Paul Van Buynder

ABSTRACT

The burden of seasonal influenza is particularly high in older adults. In 2017, 91% of the deaths from influenza disease and related complications in Australia were in adults ≥ 65 years of age.

Immunosenescence, an age-related decline in immune function, contributes to both an increased risk of developing influenza disease, and a poorer response to influenza vaccination, compared with younger adults. Furthermore, older persons are more likely to have severe disease and residual deficits in functional capacity after recovery.

Whilst vaccination is still regarded as the best method of protection, standard non-adjuvanted trivalent and quadrivalent influenza vaccines have suboptimal effectiveness in older adults, especially against the A/H3N2 strain.

An MF59®-adjuvanted trivalent vaccine was introduced for use in adults ≥ 65 years of age in the 2018 influenza season, because this vaccine showed superior protection in older adults in clinical trials and real world studies.

Nurses are often in close contact with elderly patients, and play a critical role in seasonal influenza vaccinations and disease prevention in this age group. In this review, we discuss the burden of influenza disease in older adults, the vaccine options available for the 2019 influenza season, and how nurses can help encourage influenza vaccine uptake among older adults.

BURDEN OF INFLUENZA IN OLDER ADULTS

Influenza is a global disease, with epidemics occurring mainly in the winter in temperate areas, and throughout the year in tropical climates. Worldwide, seasonal epidemics cause three to five million severe cases and 300,000 to 650,000 deaths annually (WHO 2018).

In industrialised countries, deaths from influenza disease and related complications occur predominantly in older adults; in the 2017 influenza season in Australia, more than 91% of influenza-related mortalities occurred in people aged 65 years and over (Australian Government 2017).

Presentation of influenza symptoms can be different in older versus younger adults; older adults often have a lower incidence of fever, more frequent lower respiratory symptoms such as cough, wheezing, and chest pain, and atypical disease, with the only presenting symptoms being anorexia, mental status changes, or unexplained fever (Minnesota (USA) Department of Health 2018; Falsey et al. 2015).

Immunosenescence, an age-related decline in immune function, impairs the ability of older adults to fight natural infections, and also results in suboptimal immune responses to influenza vaccines (Haq and McElhaney, 2014).

This makes this age group particularly vulnerable to influenza disease and influenza-related complications, which are among the leading causes of mortality in older adults (US Government 2016).

In addition to mortality from influenza disease, the influenza season is also associated with higher rates of all-cause mortality from cardiovascular diseases, strokes, and pneumonia in the older adult population (Reichert et al. 2004).

Rates of hospitalisation from influenza disease are highest in young children and older adults; the non-pandemic 2006–2013 years in Australia saw an average of 30 hospitalisations per 100,000 population for adults aged 65–74 years, and 46 hospitalisations per 100,000 for adults aged ≥ 75 years (Fielding et al. 2013; Li-Kim-Moy et al. 2016).

Hospitalisation is also associated with a loss of independence and diminished quality of life in older adults, even after discharge (Covinsky et al. 2003).

The estimated cost of influenza to the Australian healthcare system across all age groups is $115 million annually (Newall and Scuffham 2008). Because older adults have the highest burden of disease, the economic cost of influenza-related illness is expected to further increase as the population ages (Australian Bureau of Statistics 2013).

Vaccination is the best method available for preventing influenza disease, and annual seasonal influenza vaccination is recommended by the Australian Department of Health for all adults aged ≥65 years (Australian Government 2018).

Whilst prevention of influenza disease is the major aim of immunisation, minimising the consequences of disease and preserving the functional capacity of older persons is also important. Vaccination of older adults can also decrease the incidence of hospitalisations for pneumonia, and can reduce exacerbations in people with chronic obstructive pulmonary disease (Poole et al. 2006).

Influenza viruses change constantly due to small genetic mutations, a process called antigenic drift. Viruses circulating in one year are often not identical to those circulating in the previous year, hence the need for the strains included in seasonal influenza vaccines to be updated annually (**Table 1**). Individuals need to be vaccinated every year to provide the best level of protection, because the immune system may not recognise novel surface antigens expressed on the most current viral strains.

WHAT HAPPENED DURING THE 2017 AND 2018 INFLUENZA SEASONS IN AUSTRALIA?

The 2017 influenza season in Australia was the most active since the 2009 pandemic (Australian Government 2017). The A/H3N2 strain was the most prevalent (55% of subtyped strains), and, consistent with previous seasons where A/H3N2 predominated, the ≥65 years age group were disproportionately affected. Hospitalisation rates from confirmed influenza disease were 2.3 times higher than the average of the previous five years, and over 91% of influenza-related deaths occurred in older adults (≥ 65 years old) (Australian Government 2017). The effectiveness of the 2017 vaccine was low overall (10–57% across strains), with lowest rates of vaccine effectiveness (VE) observed against the A/H3N2 strain (10%), thought in part to be caused by the genetic diversity in circulating A/H3N2 strains (Sullivan et al. 2017). In contrast to 2017, the 2018 season was less active. The A/H1N1 strain predominated (58% of subtyped strains) and accounted for the majority of hospital admissions.

As in 2017, the majority of influenza-related deaths were in older adults (≥80 years) (Australian Government 2018). Interim estimates of VE against GP visits and hospitalisation due to A/H1N1 were 77 and 83%, respectively, with a considerably higher VE overall than in the 2017 season, although estimates against the A/H3N2 strain were not calculable due to small sample sizes.

ADJUVANTED INFLUENZA VACCINE FOR USE IN ADULTS ≥ 65 YEARS OF AGE

Given the high burden of influenza disease in older adults during the 2017 season, the Australian Government's Chief Medical Officer highlighted the severity of influenza disease and the importance of influenza vaccination for individual and community-wide protection (Australian Government 2017).

Because conventional (ie. non-adjuvanted or standard-dose) seasonal influenza vaccines are less effective in older adults (Goodwin et al. 2006) – in part due to immunosenescence, an adjuvanted trivalent influenza vaccine (aTIV; Fluad®, Seqirus USA Inc., Summit, NJ, USA) and a high-dose TIV (Fluzone High-Dose®; Sanofi Pasteur Inc., Swiftwater, PA, USA; 180 µg antigen per dose) were made available for use in adults ≥65 years of age in Australia for the 2018 influenza season.

aTIV has recently been recommended as a priority for adults aged ≥75 years for the 2018–2019 season in the UK (UK Government 2018).

aTIV has demonstrated higher effectiveness than non-adjuvanted vaccines in older adults, particularly in reducing rates of influenza-related illness and hospitalisation (Domnich et al. 2017).

aTIV differs from non-adjuvanted trivalent influenza vaccines (TIVs) because it contains the adjuvant, MF59® (Novartis International AG, Basel, Switzerland), which enhances the immune response to vaccine antigens and promotes cross-reactive antibody responses (Ansaldi et al. 2010; Bihari et al. 2012; Khurana et al. 2011).

aTIV (needle- and latex-free) contains the same quantity of A/H1N1, A/H3N2, and B strain antigens as are found in non-adjuvanted TIVs.

In a phase 3 clinical trial including 7,082 subjects ≥65 years of age, aTIV demonstrated higher immunogenicity, particularly against the A/H3N2 strain, a longer duration of enhanced immune response, and a greater degree of cross-reactivity against mismatched A/H3N2 strains, when compared with non-adjuvanted TIVs (Frey et al. 2014).

Because the vaccine antigen strain/clade may not be identical to the circulating viral strain/clade (termed mismatch), cross-reactive antibodies afford some level of protection against influenza infection when mismatch occurs.

In addition, aTIV has demonstrated an increased immune response in older adults with comorbidities, who have a higher risk of influenza-related complications (Frey et al. 2014).

Real world studies have also shown the VE of aTIV to be higher than that of standard-dose TIV in terms of laboratory-confirmed disease and reduced hospitalisations (Mannino et al. 2012; Van Buynder 2013).

In a recent study conducted to evaluate all-cause hospitalisation rates among elderly residents of nursing homes vaccinated with either aTIV or TIV, aTIV was shown to reduce the risk of hospitalisation during A/H3N2-dominant seasons (Gravenstein et al. 2018).

Residents from 412 (n = 26,300; 78% vaccination rate) and 410 (n = 26, 474; 79% vaccination rate) nursing homes received aTIV alone and TIV alone for the 2016–2017 influenza season, respectively.

Times to first hospitalisation were assessed from November 2016 to June 2017. Hospitalisations occurred in 20.8% of the residents in the aTIV-assigned nursing homes, and in 22.1% of residents in the TIV nursing homes (hazard ratio 0.94; confidence interval 0.88–0.99).

Because aTIV contains an adjuvant, a heightened immune response is generated initially at the injection site, which is associated with slightly higher rates of mild and transient injection site reactions (pain, erythema, and induration) compared with non-adjuvanted TIVs (Frey et al. 2014). To date, 107 million doses of aTIV have been distributed worldwide since first being approved in 1997; the vaccine is considered to be well tolerated with a good safety profile (O'Hagan et al. 2013).

HELPING TO INCREASE INFLUENZA VACCINE UPTAKE IN OLDER ADULTS

Improving influenza vaccination coverage is one of the priorities in the National Immunisation Strategy for Australia (Australian Government, 2013). Despite the high influenza disease burden in older adults, the vaccination rate across Australia in people aged ≥65 years was estimated to be 74.8% since funding began in 1999, meaning that over a quarter of this age group remain unvaccinated (Dyda et al. 2016). A number of strategies have been shown to aid vaccine uptake in older adults, including proactively inviting patients for vaccination, educational outreach, and home visits (**Table 2**).

Recommendation and advice about influenza vaccines from primary care professionals is one of the main factors associated with increased vaccine uptake in this age group (Dyda et al. 2016).

Many older adults are not aware of the potential seriousness of influenza disease, or are hesitant about receiving influenza vaccine (Horby et al. 2005). Often issues such as accessibility of clinics, unawareness of the need for vaccination, or the absence of reminders about the need for vaccination can be significant barriers to uptake (Nagata et al. 2013).

Nurses play a key role in overcoming vaccine hesitancy and educating patients about the benefits of seasonal influenza vaccination. Many patients are concerned about the effectiveness and safety of influenza vaccines, given the reports of poor VE in recent years. Poor VE may result from mismatch between the vaccine antigen strains/clades and circulating virus; however the MF59-adjuvanted vaccine may provide some cross-protection, depending on the degree of mismatch (Frey et al. 2014).

Patients may also be concerned about the misconception that vaccines can cause influenza disease. The vaccines available for use in older adults in Australia are all inactivated vaccines, and cannot cause influenza disease.

Whilst patients may experience flu-like symptoms such as muscle aches, headaches, and fatigue after receiving a vaccine, they can be reassured that these are just indicators of an immune response to the vaccine, rather than influenza disease.

Finally, because nurses are often the healthcare providers who work most closely with older adults, they are in an ideal position to give advice on additional lifestyle measures that can reduce the risk of influenza infection. Good overall health, including regular exercise, stress-reduction, and good nutrition, can help prevent influenza disease or reduce the likelihood of complications.

Preventative measures such as frequent hand-washing, and avoiding contact with people who are sick can also help to reduce disease transmission (US Government 2018). In addition to these measures, and receiving the seasonal influenza vaccine every year, keeping up to date with other recommended vaccines (eg. pneumococcal vaccine for all adults ≥65 years old, and herpes zoster vaccine for all adults ≥70 years old) is beneficial to overall health and can help to reduce the risk of influenza-related complications, such as pneumonia.

CONCLUSION

Annual seasonal influenza vaccination is particularly important for older adults, who are at higher risk of morbidity and mortality from influenza disease and related complications. An adjuvanted TIV has been shown to be more effective than non-adjuvanted TIVs in older adults, and is available for use in adults ≥65 years of age for the 2019 influenza season in Australia. Nurses play a role of critical importance in increasing national rates of vaccination coverage, and are encouraged to be aware of and mindful of the availability and potential benefits of this adjuvanted vaccine for their older patients.

TABLE 1

Australian Influenza Vaccine Committee recommendations on the composition of seasonal influenza virus vaccines for the 2019 season in Australia (AIVC, 2019)

EGG-BASED QUADRIVALENT VACCINES

- A/Michigan/45/2015 (H1N1) pdm09-like virus
- A/Switzerland/8060/2017 (H3N2)-like virus
- B/Colorado/06/2017-like virus (B/Victoria/2/87 lineage)
- B/Phuket/3073/2013-like virus (B/Yamagata/16/88 lineage)

EGG-BASED TRIVALENT VACCINES

- A/Michigan/45/2015 (H1N1) pdm09-like virus
- A/Switzerland/8060/2017 (H3N2)-like virus
- B/Phuket/3073/2013-like (B/Yamagata/16/88 lineage)

A/H3N2 COMPONENT FOR NON-EGG-BASED VACCINES

- A/Singapore/INFIMH-16-0019/2016-like virus

TABLE 2

Strategies for increasing seasonal influenza vaccine uptake in older adults (Dexter et al. 2012; Newby et al. 2016; Thomas and Lorenzetti 2014).

- Have a lead member of staff who is responsible for the seasonal influenza program
- Use IT systems to identify eligible patients throughout the season
- Identify high-risk and high priority patients
- Proactively phone patients to invite them for vaccination
- Proactively ask patients if they have received their influenza vaccine yet
- Personally have a positive attitudes towards vaccination
- Opportunistically vaccinate patients
- Educate patients via posters, leaflets, and in-clinic information screens
- Provide information leaflets about influenza vaccination to patients collecting prescriptions
- Provide home visits for vaccine administration
- Host specific influenza vaccination clinics

Acknowledgements

Author contributions: All authors made a significant intellectual contribution to the development of this paper, and approved the final draft of the manuscript for submission.

Conflicts of interest: MDC, AL, and PVB have no conflicts of interest to declare. The authors did not receive any form of payment from any source for writing this scientific report.

Funding statement: The preparation and publication of this manuscript were funded by Seqirus Vaccines Ltd.

The authors would like to thank Dr J Engelmoer (Sula Communications BV, Utrecht, The Netherlands) and Dr J Stirling (OLC Bioscience Ltd., London, UK) for editorial assistance in the preparation of this manuscript.

Magali De Castro RN, BNursing, Dip (Mgt) is the Clinical Director at HotDoc Ltd., Melbourne, Victoria, Australia

Alan Leeb MBBCh, DTM&H, DCH, DFM, FRACGP is the Principal GP at Ilawarra Medical Centre, Ballajura, Western Australia, Australia

Paul Van Buynder MBBS, MPH, FAFPHM is Professor at Griffith University, School of Medicine, Southport, Queensland, Australia

References

Ansaldi, F., Zancolli, M., Durando, P., Montomoli, E., Sticchi, L., Del Giudice, G. et al. 2010, Antibody response against heterogeneous circulating influenza virus strains elicited by MF59- and non-adjuvanted vaccines during seasons with good or partial matching between vaccine strain and clinical isolates. *Vaccine*. 28:4123-9.

Australian Bureau of Statistics. Population Projections: Australia 2012 to 2101. Available at: abs.gov.au/ausstats/abs@.nsf/Lookup/3222.0main+features52012%20(base)%2010%202101 (Accessed November 2018).

Australian Government. Department of Health. National Immunization Strategy for Australia 2013 to 2018. immunise.health.gov.au/internet/immunise/publishing.nsf/Content/B2D3E81EEDF2346ACA257D4D0081E4BC/$File/nat-immune-strategy-2013-18-final.pdf (Accessed November 2018).

Australian Government. 2017 Influenza Season in Australia: A summary from the National Influenza Surveillance Committee. Available at: health.gov.au/internet/main/publishing.nsf/Content/cda-ozflu-2017.htm (Accessed November 2018).

Australian Government. Australian Influenza Surveillance Report No. 11 2018: 8 to 21 October 2018. health.gov.au/flureport#current (Accessed November 2018).

Australian Government. Statement from the Chief Medical Officer on Seasonal Influenza Vaccines. beta.health.gov.au/news-and-events/news/statement-from-the-chief-medical-officer-on-seasonal-influenza-vaccines (Accessed November 2018).

Australian Government. Statement on the Administration of Seasonal Influenza Vaccines in 2018. beta.health.gov.au/resources/publications/atagi-advice-on-seasonal-influenza-vaccines-in-2018 (Accessed November 2018).

Bihari, I., Panczel, G., Kovacs, J., Beygo, J., Fragapane, E. 2012. Assessment of antigen-specific and cross-reactive antibody responses to an MF59-adjuvanted A/H5N1 prepandemic influenza vaccine in adult and elderly subjects. Clin Vaccine Immunol. 19:1943-8.

Covinsky, K.E., Palmer, R.M., Fortinsky, R.H., Counsell, S.R., Stewart, A.L., Kresevic, D. et al. 2003. Loss of independence in activities of daily living in older adults hospitalized with medical illnesses: increased vulnerability with age. *J Am Geriatr Soc*. 51:451-8.

Dexter, L.J., Teare, M.D., Dexter, M., Siriwardena, A.N., Read, R.C. 2012. Strategies to increase influenza vaccination rates: Outcomes of a nationwide cross-sectional survey of UK general practice. *BMJ* Open. 2.

Domnich, A., Arata, L., Amicizia, D., Puig-Barbera, J., Gasparini, R., Panatto, D. 2017. Effectiveness of MF59-adjuvanted seasonal influenza vaccine in the elderly: A systematic review and meta-analysis. *Vaccine*. 35:513-20.

Dyda, A., Karki, S., Hayen, A., MacIntyre, C.R., Menzies, R., Banks, E., et al. 2016. Influenza and pneumococcal vaccination in Australian adults: a systematic review of coverage and factors associated with uptake. *BMC Infect Dis*. 16:515.

Falsey, A.R., Baran, A., Walsh, E.E. 2015. Should clinical case definitions of influenza in hospitalized older adults include fever? *Influenza Other Respir Viruses*. 9 Suppl 1:23-9.

Fielding, J., Grant, K., Franklin, L., Sullivan, S., Papadakis, G., Kelly, H., et al. 2013. Epidemiology of the 2013 influenza season in Victoria, Australia. *Western Pac Surveill Response J*. 4:42-50.

Frey, S.E., Reyes, M.R., Reynales, H., Bermal, N.N., Nicolay, U., Narasimhan, V., et al. 2014. Comparison of the safety and immunogenicity of an MF59(R)-adjuvanted with a non-adjuvanted seasonal influenza vaccine in elderly subjects. *Vaccine*. 32:5027-34.

Goodwin, K., Viboud, C., Simonsen, L. 2006. Antibody response to influenza vaccination in the elderly: a quantitative review. *Vaccine*. 24:1159-69.

Gravenstein, S., Davidson, E.H., Mcconeghy, K., Han. L., Canaday, D., Saade, E., Baier, R.R., Mor, V. 2018. A cluster-randomized trial of adjuvanted trivalent influenza vaccine versus standard dose in U.S. nursing homes. Abstract number 996. *ID Week*. idsa.confex.com/idsa/2018/webprogram/Paper72986.html (Accessed November 2018).

Haq, K., McElhaney, J.E. 2014. Immunosenescence: Influenza vaccination and the elderly. *Curr Opin Immunol*. 29:38-42.

Horby, P.W., Williams, A., Burgess, M.A., Wang, H. 2005. Prevalence and determinants of influenza vaccination in Australians aged 40 years and over-A national survey. *Aust N Z J Public Health*. 29:35-7.

Khurana, S., Verma, N., Yewdell, J.W., Hilbert, A.K., Castellino, F., Lattanzi, M., et al. 2011. MF59 adjuvant enhances diversity and affinity of antibody-mediated immune response to pandemic influenza vaccines. *Sci Transl Med*. 3:85ra48.

Li-Kim-Moy, J., Yin, J.K., Patel, C., Beard, F.H, Chiu, C., Macartney, K.K., et al. 2016. Australian vaccine preventable disease epidemiological review series: Influenza 2006 to 2015. *Commun Dis Intell Q Rep*. 40:E482-e95.

Mannino, S., Villa, M., Apolone, G., Weiss, N.S., Groth, N., Aquino, I., et al. 2012, Effectiveness of adjuvanted influenza vaccination in elderly subjects in northern Italy. *Am J Epidemiol*. 176:527-33.

Minnesota Department of Health (USA). Influenza-Like Illness in Elderly Persons. Available at: health.state.mn.us/divs/idepc/diseases/flu/ltc/fluelderly.html (Accessed November 2018).

Nagata, J.M., Hernandez-Ramos, I., Kurup, A.S., Albrecht, D., Vivas-Torrealba, C., Franco-Paredes, C. 2013. Social determinants of health and seasonal influenza vaccination in adults ≥ 65 years: a systematic review of qualitative and quantitative data. *BMC Public Health*. 13:388.

Newall, A.T, Scuffham, P.A. 2008. Influenza-related disease: the cost to the Australian healthcare system. *Vaccine* .26:6818-23.

Newby, K.V, Parsons, J., Brooks, J., Leslie, R., Inglis, N. 2016. Identifying strategies to increase influenza vaccination in GP practices: a positive deviance approach. *Fam Pract*. 33:318-23.

O'Hagan, D.T., Ott, G.S., Nest, G.V., Rappuoli, R., Giudice, G.D. 2013. The history of MF59 ((R)) adjuvant: a phoenix that arose from the ashes. Expert Rev *Vaccine*. 12:13-30.

Poole, P.J., Chacko, E., Wood-Baker RW, Cates CJ. 2006 Influenza vaccine for patients with chronic obstructive pulmonary disease. Cochrane Database Syst Rev.:Cd002733.

Reichert, T.A., Simonsen, L., Sharma, A., Pardo, S.A., Fedson, D.S., Miller, M.A. 2004 Influenza and the winter increase in mortality in the United States, 1959-1999. *Am J Epidemiol*.;160:492-502.

Royal Australian College of General Practitioners. Smoking, Nutrition, Alcohol, Physical Activity – A Population Health Guide to Behavioural Risk Factors in General Practice. racgp.org.au/your-practice/guidelines/snap/ Accessed November 2018.

Sullivan, S.G., Chilver, M.B., Carville, K.S., Deng, Y.M., Grant, K.A., Higgins, G., et al. 2017; Low interim influenza vaccine effectiveness, Australia, 1 May to 24 September 2017. *Euro Surveill*. 22.

Thomas RE, Lorenzetti DL. 2014. Interventions to increase influenza vaccination rates of those 60 years and older in the community. *Cochrane Database Syst Rev*. Cd005188.

UK Government. National Health Service, England. Update on Use of Adjuvanted Trivalent Flu Vaccine for 2018-19 Flu Season. england.nhs.uk/wp-content/uploads/2017/12/2018-19-aTIV-vaccine.pdf (Accessed November 2018).

US Government. Centers for Disease Control and Prevention. CDC Says "Take 3" Actions to Fight the Flu. Available at: https://www.cdc.gov/flu/protect/preventing.htm [Accessed November 2018]

US Government. 2016. Centers for Disease Control and Prevention. National Center of Health Statistics. Health, United States. cdc.gov/nchs/data/hus/hus16.pdf#020 Accessed November 2018.

Van Buynder PG, Konrad S, Van Buynder JL, Brodkin E, Krajden M, Ramler G, et al. 2013. The comparative effectiveness of adjuvanted and unadjuvanted trivalent inactivated influenza vaccine (TIV) in the elderly. *Vaccine*.;31:6122-8.

World Health Organization. Influenza (Seasonal) Fact Sheet. Available at: who.int/en/news-room/fact-sheets/detail/influenza-(seasonal) Accessed November 2018.

World Health Organization. Recommended Composition of Influenza Virus Vaccines for Use in the 2019 Southern Hemisphere Influenza Season. who.int/influenza/vaccines/virus/recommendations/2019_south/en/ Accessed November 2018.

James Lloyd

ANMF Federal Vice President

A hospital is the place to heal a ravaged body, but what about a wounded spirit?

The human spirit is stronger than anything that can happen to it. – C.C. Scott

Hospitals are designed to care for the sick. Our therapies, medications and instruments are designed to treat our physical ailments. But what about the wounded spirit that often accompanies the physical ailments? That patient can no longer stand tall because life has crushed her and made her small.

Nurses are trained to heal the physical wounds of our patients. Our training teaches us the physiology of illness and injuries and we apply this knowledge to treat and provide pain relief.

But what makes a nurse is more than our ability to treat a physical injury or illness. It is our ability to use empathy to heal the spirit. (When I use the word spirit, this is not the religious connotation, but our life force that gives us the will to live, love and endure).

But sometimes that spirit can be broken – either through illness, pain, or mental health issues.

Hospitals are loud, busy, confusing places for patients. Patients are often broken physically but are also likely to be scared, traumatised, embarrassed, exhausted and confused. This downcast spirit will be hidden from view and the broken body will take priority.

Back in my day as a student nurse, I learnt a valuable lesson on a broken spirit and how it can be mended. I was working on a medical rehab ward and in a two-bedroom were two women – Ms Smith and Ms Bird (not their real names). Both were in their 70s and had suffered strokes with similar disability.

Ms Smith had a strong spirit and wanted to recover. She participated in her rehab program with a fire in her belly and wanted to reach her maximum potential.

Ms Bird, however, lacked that passion, was uninterested in her rehab program and made little eye contact. Her spirit was shattered; she looked and acted defeated. Yet, Ms Bird ended up going home with only minor disability from her stroke.

What changed Ms Bird's outcome? It was Ms Smith, who understood the dispirited Ms Bird. She encouraged, motivated, cajoled, and made her see that despite physical ailments, she had a worthwhile life ahead.

What I learned is that there is more to recovery than healing a physical wound and that empathy is one of the most important skills I needed to develop.

This wasn't a skill that came naturally for me, but a hospital is crowded with learning opportunities.

A few years later, an experience with a traumatised child taught me that simple kindness can set a new path. I met this eight-year old young boy who was deeply withdrawn and seldom made eye contact – the victim of parental abuse.

He was playing with some toy cars, so I took the box of Legos and sat on his bed with a smile and said I wanted to build a bridge with him. He looked at me with disinterest but muttered, "okay".

We built this rather impressive bridge while I chatted with him, served juice, smiled and connected with that child-like innocence. By the end of our build, he was flickering a smile, making eye contact and chatting about our big bridge build.

For several days after this, he was engaging more with others.

I'm not claiming that I healed his broken heart, but through simple acts of kindness and engagement, opened another door where he could trust in a more benevolent world.

As nurses, we need to look beyond the physical symptoms and injuries and peer into a person's heart. Not all have the skill to contend with broken souls, but even simple gestures can have an enormous effect on a person's psyche.

We use our knowledge to mend our patients' bodies. But there is also an important role to tend the trauma of the spirit. Our healing hands and compassionate words can help those patients to trust the world again and realise that life is worth living.

Reach out to those patients whose inner fire has dwindled. Don't be afraid to smile and reassure them with a gentle hand on their forehead. These are often as healing as medications, splints or injections.

Anaphylaxis

The following CPD extract from ANMF's Continuing Professional Education (CPE) website describes what anaphylaxis is as well as its causes and symptoms. It also discusses the diagnosis and treatment of anaphylaxis and compares it to different types of sensitivities and allergic reactions.

An allergic reaction is an immunologic reaction that occurs between a specific antigen and an antibody. Anaphylaxis is the most severe form of allergic reaction that can occur.

The Australian Society of Clinical Immunology and Allergy (ASCIA), define anaphylaxis as:

"Any acute onset illness with typical skin features (urticarial rash or erythema/flushing, and/or angioedema), plus involvement of respiratory and/or cardiovascular and/or persistent severe gastrointestinal symptoms OR any acute onset of hypotension, bronchospasm or upper airway obstruction where anaphylaxis is considered possible, even if typical skin features are not present" (Australian Society of Clinical Immunology and Allergy, 2016).

Because anaphylaxis sudden onset and rapidly progressing course, it can be life-threatening. This is due to vascular collapse, which then can lead to systemic shock and also death. However with prompt treatment, anaphylaxis can be treated resulting in a good prognosis for the individual.

There are many allergens which can be the cause of an anaphylactic reaction. These allergens can range from medications, to foods, to insect bites. Often the reaction will occur within minutes of being exposed to the allergen, however it can also occur up to one hour after exposure to the allergen.

Something that might of initially caused a mild allergic reaction following initial exposure to the allergen, after repeated exposures can then also produce an anaphylactic reaction (Australian Resuscitation, 2016).

COMMON CAUSES OF ANAPHYLACTIC REACTIONS:

LATEX

Populations at a higher risk of latex allergies include healthcare workers, patients with atopic allergies and multiple surgeries, people working in factories manufacturing latex gloves, females and patients with spina bifida.

Roughly 1–3% of the population has a latex allergy and 10–17% of this number are healthcare workers (Farrell & Dempsey, 2013).

MEDICATIONS

Certain medications can also cause allergic reactions and anaphylaxis in individuals. These reactions are unpredictable and often occur as a consequence to either the medication, the chemical preservative or a metabolite present in the medication. However, less than 20% of all adverse drug reactions are immune mediated. It is important to distinguish between what is an allergic reaction in an individual, and what is a side effect of the medication (Australian Society of Clinical Immunology and Allergy, 2016).

Antibiotics are one of the classes of medication in which the highest incidence of allergic reactions occur. Radio contrast, intravenous anaesthetics, aspirin and other non-steroidal anti-inflammatory agents and opioids also have an increased incidence of allergic reactions. Antibiotics and radio contrast have been found to produce anaphylactic reaction in one out of every

5,000 exposures (Australian Society of Clinical Immunology and Allergy, 2016).

FOODS

Foods can also be an allergen and cause an anaphylactic reaction in an individual. The foods that carry an increased risk of anaphylaxis include peanuts, tree nuts, shellfish, fish, milk, eggs, soy and wheat. Food allergies occur in up to 2% of adults and between 4-10% in children.

Very small amounts of food can cause anaphylaxis in individuals, in these same individuals, just by touching or smelling the food may trigger an allergic reaction but is unlikely to cause anaphylaxis as the food usually needs to be ingested.

One of the most common causes of reoccurring anaphylaxis in Australia is the accidental ingestion of nuts or nut

products. In regards to food allergies, it is also important to remember that these allergies can develop at any age, not just in childhood (Australian Society of Clinical Immunology and Allergy, 2016).

STINGS AND BITES

These are often from bees, wasps and different species of ants. However, most reactions to stings and bites are local swellings and not life threatening and these allergies generally do not coexist with other allergies such as food allergies. It is also interesting to note that in people having severe reactions to drugs and insect venom that cardiovascular compromise is common (Australian Society of Clinical Immunology and Allergy, 2016).

BLOOD AND BLOOD PRODUCTS

Individuals can also have allergic or anaphylactic reactions to blood or blood products.

This is significant to nurses as it results in the close monitoring of the patient during administration of blood or blood products, because as with any anaphylactic reaction, it can be life threatening.

A mild allergic reaction can occur if the individual is sensitive to the foreign plasma and proteins present in the blood or blood product and this can cause flushing, itching and urticaria. This type of reaction can be treated with antihistamines and if directed by a medical officer, the transfusion may continue.

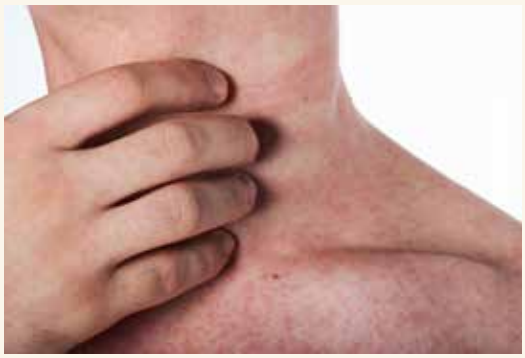
However if the patient develops a fever or pulmonary symptoms, the infusion is generally not restarted. As with any blood transfusion reaction, the first line of treatment is to stop the infusion and if needed, begin basic life support measures (Crisp & Taylor, 2012).

DIAGNOSING ANAPHYLAXIS

Unfortunately, there is no one single diagnostics test or procedure that can identify anaphylaxis.

A comprehensive clinical history of the patient and physical examination can be useful in the provision of data to aid in the diagnosis and management of people with allergy disorders.

This should include a history of allergic symptoms, any improvements and also previous treatments as well as the relationship with symptoms and exposure to any potential allergens.



DIAGNOSTIC TEST OF PATIENTS WITH ALLERGIC DISORDERS CAN INCLUDE:

Full Blood Count with differential; Eosinphil count; Total serum immunoglobulin levels; Skin tests; Challenge testing; Radioallergosorbent test (RAST) (Farrell and Dempsey, 2013). (These tests are discussed in detail within the tutorial).

Diagnosis of Anaphylaxis can also be made when any one of the following three criteria is fulfilled, however using this criteria doesn't mean it is definitely anaphylaxis, but just that anaphylaxis is highly likely.

1. Acute onset of an illness (from minutes to several hours) that involves the skin, mucosal tissue or both (hives, pruritus, flushing, swelling etc) and as well as this, needs to involve at least one of the following:
   - **a.** Respiratory symptoms such as wheeze, dyspnoea, bronchospasm, stridor, hypoxemia.
   - **b.** Reduced blood pressure or any other associated symptoms of organ dysfunction such as syncope or incontinence.
2. After exposure to a likely allergen, two or more of the following occurring within minutes or several hours:
   - **a.** Skin involvement such as hives, flushing, itching, swelling.
   - **b.** Respiratory symptoms such as dyspnoea, wheeze, bronchospasm, stridor or hypoxemia.
   - **c.** Reduced blood pressure or other associated symptoms such as syncope.
   - **d.** Persistent gastrointestinal symptoms such as cramping, abdominal pain or vomiting.
3. After exposure to a known allergen, the individual will experience a reduced blood pressure.
   - **a.** In adults this is either a 30% or more decrease from that person's baseline or below a systolic blood pressure of 90mmHg.
   - **b.** For children it is once again a 30% or more decrease from their baseline or dependent on the normal blood pressure range for that child's age (Muraro et al. 2014).

One of the difficulties with diagnosing anaphylaxis, is that there can be many other differential diagnoses that can also occur with the symptoms that the patient presents with.

IMMEDIATE TREATMENT

For any type of allergic reaction, the nurse must initially assess the patient for any signs and symptoms of anaphylaxis. This includes assessing their airway, breathing pattern and vital signs as well as observing the patient for signs of increasing oedema and respiratory distress.

Management and treatment of an anaphylactic reaction depends on the severity of the reaction. The initial priority should be ensuring their respiratory and cardiovascular functions are evaluated. If the person becomes unresponsive and isn't breathing normally, then basic life support measures will need to be commenced (Australian Society of Clinical Immunology and Allergy, 2016).

IMPORTANT

The 2018–2019 registration period ends on 31 May 2019. Nursing and midwifery registration requires at least 20 hours of CPD to be completed between 1 June 2018 and 31 May 2019.

After reading this extract be sure to add it to your portfolio on the CPE website as evidence of your CPD.

30 minutes
CPD

The following excerpt is from the ANMF's **Anaphylaxis** tutorial on the Continuing Professional Education (CPE) website. The complete course is allocated 2 hours of CPD; the reading of this excerpt will give you 30 minutes of CPD towards ongoing registration requirements.

The complete tutorial covers the following:

Defining anaphylaxis, pathophysiology, signs and symptoms, causes, diagnosis, cofactors and risk factors, fatal anaphylaxis, immediate treatment, emergency kits and EpiPens, anaphylaxis management plan and strategies for healthcare professionals.

To access the complete tutorial, go to **anmf.cliniciansmatrix.com**

For further information, contact the education team at **education@anmf.org.au**

anmf.org.au/cpe

References:

Australian Resuscitation Council (ARC), 2016, First aid management of anaphylaxis, available from resus.org.au/guidelines/;

Farrell, M & Dempsey, J (eds) 2013, Australian Society of Clinical Immunology and Allergy (ASCIA) 2016, ASCIA Anaphylaxis Clinical Update, available from allergy.org.au/health-professionals/papers/anaphylaxis

Better Health Channel, 2014, Anaphylaxis, available from betterhealth.vic.gov.au/health/conditionsandtreatments/anaphylaxis

Crisp, J & Taylor, C (eds), 2012, ' Potter and Perry's Fundamentals of Nursing', 4th edn, Elsevier Marrickville

Farrell, M & Dempsey, J (eds) 2013, Smeltzer & Bare's Textbook of Medical-Surgical Nursing, 3rd edn, Lippincott, Williams & Wilkins, Broadway

Holmes, NH (ed) 2002, Atlas of Pathophysiology, Springhouse, Pennsylvania

Marrickville; Farrell, M & Dempsey, J (eds) 2013, Smeltzer & Bare's Textbook of Medical-Surgical Nursing, 3rd edn, Lippincott, Williams & Wilkins, Broadway

Muraro, A, Roberts, G, Worm, M, Bilo, B, Brockow, K, Fernandez Rivas, M, Santos, AF, Zolkipli, ZQ, Bellou, A, Beyer, K, Bindslev-Jensen, C, Cardona, V, Clark, AT, Demoly, P, Dubois, EJ, DunnGalvin, A, Eigenmann, P, Halken, S, Harada, L, Lack, G, Jutel, M, Niggermann, B, Rueff, F, Timmermans, F, Vlieg-Boerstra, BJ, Werfel, T, Dhami, S, Pansar, S, Akdis, CA & Sheikh, A 2014, Anaphylaxis: Guidelines from the European Academy of Allergy and Clinical Immunology, Allergy, vol. 69, no. 8, pp. 1026-1045, available from onlinelibrary.wiley.com/doi/10.1111/all.12437/full

Smeltzer & Bare's Textbook of Medical-Surgical Nursing, 3rd edn, Lippincott, Williams & Wilkins, Broadway; Holmes, NH (ed) 2002, Atlas of Pathophysiology, Springhouse, Pennsylvania

Turner, PJ, Gowland, MH, Sharma, V, Lerodiakonou, D, Harper, N, Garcez, T, Pumphrey, R & Boyle, R 2014, Increase in anaphylaxis-related hospitalizations but no increase in fatalities: An analysis of United Kingdom national anaphylaxis data, 1992-2012, Journal of Allergy and Clinical Immunology, vol. 135, no. 4, pp. 956-963, available from sciencedirect.com/science/

MBS changes proposed for nurse practitioners

Almost a decade after first gaining access to the MBS, changes are finally being recommended which will allow nurse practitioners (NPs) to provide more efficient, effective, person-centred care.

Julianne Bryce

ANMF Senior Federal Professional Officer

The Australian Nursing and Midwifery Federation (ANMF) has been a lead organisation in the conception and development of the NP role in Australia, with most NPs ANMF members. We are a staunch advocate for this peak clinical role for registered nurses; the role is integral to improving access for people to evidence-based, safe and effective health and aged care.

There are 1,784 endorsed NPs in Australia (Nursing and Midwifery Board of Australia 2018). However, not all of these expert nurses are employed in NP positions or working to their full scope of practice. There remains much to be done, including MBS change, to ensure a substantial increase in the numbers of registered nurses electing to undertake the pathway to NP endorsement.

Established in 2015, the MBS Review Taskforce has been responsible for determining better alignment of more than 5,700 MBS items with contemporary evidence-based practice and better health outcomes. NPs currently use just ten of these items.

Review of those ten NP item numbers was undertaken between June and August 2018 by an expert Nurse Practitioner Reference Group (NPRG) led by Associate Professor Tom Buckley, Director, Postgraduate Research, Sydney Nursing School, University of Sydney.

As the MBS Review is a clinician-led process, the Reference Group consisted of NPs, registered nurses with involvement in NP practice and policy, consumer representatives, and medical colleagues.

Over three months the NPRG met frequently to develop recommendations based on a thorough review of evidence, their clinical practice and policy expertise, and information provided by the profession.

Following first round support by the overarching MBS Taskforce, the NPRG's proposed 14 recommendations and associated report have been released for stakeholder consultation.

Forums will be conducted and written submissions can be made in March/April 2019. When this process is completed, the Taskforce, in consultation with the NPRG, will review feedback. The Taskforce will then determine whether to endorse the report for consideration by the government.

Initial feedback from NPs and the profession indicates wide support for the long overdue recommendations.

Particularly well received were: removal of the mandated requirement for a collaborative arrangement, significant increases in schedule fees, access to rebates for after-hours and emergency care, less restrictions on MBS-rebated diagnostic imaging investigations, and rebates for procedures.

The recommendations, supported by strong, relevant evidence are:

- Enable patients to access MBS rebates for long-term and primary care management provided by NPs
- Improve access to MBS rebates for NP services in aged care settings
- Enable Domiciliary and Residential Medication Management Reviews, undertaken by pharmacists, to be initiated by NPs
- Significantly increase the schedule fee assigned to current MBS NP professional attendance items
- Create a new MBS item for longer NP attendances to support the delivery of complex and comprehensive care
- Enable patients to access MBS rebates for after-hours or emergency care provided by NPs
- Enable patients to access an MBS rebate for NP care received outside of a clinic setting
- Remove the mandated requirement for NPs to form collaborative arrangements
- Remove current restrictions on MBS-rebated diagnostic imaging investigations when requested by NPs
- Enable patients to access MBS rebates for procedures performed by an NP
- Add GPs as eligible participants in NP patient-side telehealth services
- Add patients in community aged care settings to residential aged care telehealth items
- Create new MBS items for direct NP-to-patient telehealth consultations
- Allow telehealth consultations to take place via telephone where clinically appropriate

The potential benefits to NPs, consumers and the health and aged care systems are thoroughly detailed in the report:

"The Reference Group's recommendations will benefit NPs by enshrining a more accurate representation of their scope of practice in the MBS, and through increased financial recognition of the care they provide. More broadly, NPs will benefit from increased choice in working models as NP care becomes a financially and structurally viable option.

Consumers, NPs and the Australian healthcare system will benefit from overall increased investment in NP continuity of primary care…These benefits will accrue from high-quality, cost-effective health outcomes that benefit families and the community." (Medicare Benefits Schedule Review Taskforce Report from the Nurse Practitioner Reference Group 2018).

All nurses and midwives are encouraged to read the **report** and provide feedback to the consultation **MBSReviews@health.gov.au**

If implemented, these recommended changes will enable people to access rebates for a wider range of services, provide more timely delivery of healthcare, reduce fragmentation of care, and support NPs to work to their full scope of practice, increasing their contribution to integrated, efficient healthcare for the Australian community.

References

Nursing and Midwifery Board Australia, Registrant data Reporting period: 1 October 2018-31 December 2018: *nursingmidwiferyboard.gov.au/About/Statistics.aspx*

Medicare Benefits Schedule Review Taskforce Report from the Nurse Practitioner Reference Group 2018: *health.gov.au/internet/main/publishing.nsf/Content/58EFEA022C2B7C49CA258396083C4EA/$File/NPRG%20Final%20Report%20-%20v2.pdf*

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

Avoiding an avoidable adverse outcome

Working with patients who have a high or imminent risk of suicide is complex and challenging clinical work even for the most experienced practitioner.

Patient safety is paramount, often requiring patients to be kept under close observation.

What this means varies on the circumstances, treatment orders and local policy.

A failure to follow these orders can and has ended in tragedy where unsupervised suicidal patients have taken their own life.

In many cases, familiar and often valid arguments are brought forward relating to shortfalls in staff numbers and skill mix. In other cases, workplace culture, assumptions or individual choice not to follow the most basic orders has led to these avoidable outcomes.

In the matter of *Health Care Complaints Commission v Thomas, Hayden, Rumble* (2017) a finding of unsatisfactory professional conduct against three nurses, who received a reprimand and conditions placed on their registration, was found in circumstances where a 29 year old man committed suicide whilst an inpatient.

The claim against the nurses was that they failed to observe the patient at the appropriate intervals as determined by the treating psychiatrist (Level 2 order – to be observed every 15 minutes) and either falsified or recklessly made entries in the case notes that indicated they had completed observations they did not do.

Admitted as a voluntary patient with symptoms of depression, somatic pre-occupation, hopelessness and suicidality, 'A' was later detained under the *Mental Health Act 2008* (NSW).

He was transferred from the ICU to a sub-acute ward although still considered to be at a significant risk of self-harm; the Level 2 order remained in place.

CCTV evidence showed on the day of his death 'A' entered his room at 1441 hrs he did not leave his room again.

This footage showed that he was not observed by staff until 1719 hrs when he was found unresponsive – resuscitation efforts were unsuccessful.

The professional standards committee (PSC) noted that in this case the conduct of concern did not involve 'sophisticated aspects of nursing' that were related to 'performance of technical procedures or matters outside the normal realm of mental health' [82]. Rather the matters were '….fundamental to the practise of nursing and which [would have been] fulfilled by exercise of diligence in care and of integrity with record keeping' [82].

Indeed, it appeared that a cavalier attitude to following observation policy and protocols existed in the unit, which led to assumptions being made on the frequency of observations to be conducted on 'A'- assumptions which proved to be inconsistent with the actual orders made by the treating psychiatrist.

There is also evidence of other observation entries at 15 minute intervals being made when in fact no observations were undertaken at all.

On this point the nurse concerned having viewed the CCTV footage, admitted to having never left the nursing station and merely filling in the chart, a practice she claimed to be standard '… particularly on night shifts' [180].

The committee noted that if this was the case it is possible that a culture of misreporting was acceptable within the team and unit.

Regardless, it was noted that it is never acceptable for practitioners to 'slip to a level of conduct that is below the professionalism and clinical excellence required' [193] merely because 'everyone is doing it' [193].

The committee found that '…for reasons of protection of the public, specific and general deterrence, and by way of denouncing the conduct and upholding the standards of integrity of the profession, findings of unsatisfactory professional conduct [were] made [against all three practitioners] [193].

Whether such behaviour or culture exists because of complacency, carelessness or reckless indifference, individually or collectively it is unquestionably below acceptable professional standards to not uphold the most basic principles of nursing care.

Regrettably, as observed by the committee '… it is not the first time where a failure to observe patients and falsification of records of observations have ended in the death of a patient [192]' and sadly this has not been the last case.

I wonder if the committee's observation that a megaphone is needed to sound to the profession that such conduct is not acceptable had been followed through – would we be watching this familiar story unfold in yet another Coroner's Inquest now?

Reference:

Health Care Complaints Commission v Thomas, Hayden, Rumble [2017] NSWNMPSC 1 (28 April 2017)

End of financial year sale

Don't miss out!

Quoted prices include:

Finance | Rego | CTP | Fuel | Maintenance | Insurance

Mazda 3 Maxx
Sport Auto Hatch

$327* PER FORTNIGHT
INC. **$134** OF RUNNING COSTS

Toyota Corolla Ascent
Sport Hybrid Hatch

$333* PER FORTNIGHT
INC. **$115** OF RUNNING COSTS

Subaru XV
2.0i Auto

$381* PER FORTNIGHT
INC. **$145** OF RUNNING COSTS

Honda CR-V
Vi FWD

$388* PER FORTNIGHT
INC. **$154** OF RUNNING COSTS

Mazda CX-5 Maxx
AWD Auto

$412* PER FORTNIGHT
INC. **$149** OF RUNNING COSTS

Looking for a different car?

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

Salary package your next car and save...

- **When you buy** – our buying power with over 850 dealers ensures our best car pricing, plus you'll enjoy a further 10% GST saving on the purchase price.
- **On time** – we'll arrange no-pressure test drives, organise your paperwork and bundle your lease expenses into one regular payment on pay day.
- **As you drive** – enjoy tax savings from using a combination of pre- and post-tax dollars to pay for your finance, insurance, rego, fuel and other running costs.

Find out how much you can save with a novated car lease.

1300 176 168 | nurseleasing.com.au

smartleasing

* Based on the following assumptions: living in NSW 2560, salary: $70,000 gross p.a., travelling 15,000 kms p.a., lease term: 60 months, using the Employee Contribution Method for FBT purposes. Images shown may not be the exact car that the calculations have been based on. All figures quoted include budgets for finance, fuel, servicing, tyres, maintenance, Vero by Suncorp comprehensive motor insurance, Hydro Platinum Pack and re-registration over the period of the lease. Vehicle residual, as set by Australian Taxation Office, payable at the end of lease term. The exact residual amount will be specified in your vehicle quote. Vehicle pricing is correct at the time of distribution but may be subject to change based on availability.

NURSES IN POLITICS: ADVOCACY AND LEADERSHIP

Ged Kearney MP (centre)

Australian politics is heating up with a federal election on the way. Three Australian nurse MPs are leading the charge, showing that politics and nursing are not mutually exclusive. Ged Kearney, Joe Kelly and Nat Cook are working to make a difference beyond the realm of healthcare. Natalie Dragon reports.

"This is a watershed moment for politics in this country," says Federal Member for Cooper Ged Kearney speaking to the *ANMJ* from Canberra, shortly after the Refugee Medevac Bill was passed in February.

After two days of intense negotiation, the Bill to get sick refugees out of offshore detention was passed in Parliament.

"It's been a rollercoaster to use the cliché. Just when you think it's all settled and you are going to make a difference, there's a little change and you start from scratch. But it's really wonderful to watch the process and be part of it and see a fantastic result," says Ms Kearney.

The diverse inner-city electorate of Batman (now Cooper) in Melbourne, in which Ms Kearney ran and was elected in the 2018 by-election, has a tradition of community activism.

The treatment of refugees is a passionate issue for the electorate. "Absolutely this is what I ran for in my platform; making real change," Ms Kearney says. "This couldn't be a more stark and changing approach to refugee policy we have in this country; to a more humane policy. I am really happy to be taking this policy to the election."

Ms Kearney trained as a nurse at the Austin Hospital, where she progressed to become Head of Clinical Nursing Education at Austin Health.

She joined the ANMF in 1993 as a job rep, then became ANMF Victorian Branch President and ANMF Federal President while working full time nursing.

Ms Kearney says she uses the skills she developed as a nurse every day.

"As a nurse, you develop a really good ability to assess a situation and I do that now. I think nurses are really good listeners and they can also see the hidden messages. They have an ability to listen well and they are empathic, and know how to make people feel at ease. Nurses are respectful and never dismiss anyone."

In 2003, Ms Kearney was elected Assistant Federal Secretary and then Federal Secretary of the ANMF, where she worked heavily on aged care funding and policy.

While none of the political parties have yet committed to mandated staffing ratios in aged care, Ms Kearney says she is signed up to support the ANMF's campaign.

"Staffing and skill mix is at a crisis point in private aged care, and it must be fixed.

There are tens of thousands of people waiting for residential aged care packages who want to stay in their own home. We will have to wait and see what comes out of the Royal Commission."

Ms Kearney says she was proud to promote Labor's commitment to climate action as both ambitious and achievable during the by-election. "Labor's recognition of the climate emergency is the framework for our policy deliberations from environmental protection to job creation."

Ms Kearney held the position of ACTU President from 2010 until her move into federal politics. Labor's commitment is to change workplace relations laws to make them fairer for workers. For the last decade, corporate profits have been steadily increasing to an all-time high, while the share of wages is at a record low, she says.

"Workers work longer and harder in less-secure, more fragmented jobs. People are in insecure jobs and on short term contracts; we want to see more job security. We also want to see investment in projects that create jobs."

As one of nine children, Ms Kearney learnt to speak up. The Kearney's had a 'family Parliament' and also a family trade union – the 'Kearney family union'. All nine kids were members and paid their dues and made their demands.

"I look back on my career and I've always been an advocate; as a nurse I advocated for patients; in the union for our membership and for the health system.

"You have to speak up. Sometimes it's really challenging; sometimes it's really hard. As a nurse, I would walk into a room of doctors and health chiefs and I would think my voice was not that important. Now I look back and absolutely that wasn't true.

"Stand your ground. Not to say there's no budging. There's always room to compromise and negotiate but be consistently moving forward on the issue, so people know: 'I am coming back on this'."

Joe Kelly has been the Labor member for Greenslopes in Queensland since 2015. Prior to his election to QLD Parliament, he was a clinical nurse at QEII Hospital, working in rehabilitation.

"It's been a great honour. I think certainly my involvement in the nursing union helped influence my move into politics," he says.

Mr Kelly joined the union on the first day of his nurse training at the Royal Brisbane Hospital in 1998. He became more involved in the union movement after a year travelling in Central and South America.

"I saw what life was like when people do not have the benefits of a democracy. For me democracy is fundamental to good health of a society. I got back to Australia and became very active at Greenslopes Hospital as a job rep. I joined the local branch of the ALP and started contributing in that way, lots of 6am starts and handing out flyers in the heat."

Mr Kelly worked at the Public Sector Union for 10 years before he went back into nursing, prior to politics.

"I've always been interested in politics. I wasn't sure I was the sort of person that was able to make a contribution in that way. To be honest I guess in nursing we don't necessarily see ourselves as leaders of society. We are pretty humble."

Like Ms Kearney, Mr Kelly says he uses his nursing skills every day as a MP. "Nurses are used to dealing with a diverse group of people with differing views and really listen to people. They really try to understand what people's issues are rather than pre-judging what's best for that individual.

"Nurses are good at having difficult conversations. 'I know you really want that I can't deliver that – no one can. As much as I would like to tell you, no amount of my telling you that is going to make it happen'."

Mr Kelly and his wife have lived in the Greenslopes electorate for over 17 years; they have two daughters Molly 14 and Brenna 11. The biggest issues in the high density electorate are education, public transport and jobs, he says.

"For me it's having the opportunity to be part of a government that passes legislation that reflects my values. We are living more closely together but seem to be drifting further apart. Better communities make sure people look out for one another and are taking care of each other."

Mr Kelly believes that access to high quality healthcare and education is fundamental to building a strong community.

"I am really pleased that I am part of a government that has introduced nurse to patient ratios, we have really led the way. We are a government that is supportive of nurses and graduates.

The Newman government drastically cut graduate positions from full time to part time, there were no opportunities for graduates to work in the profession. It was so short-sighted.

Nat Cook MP with partner Neil Davis and son Sid

Joe Kelly MP and Premier Annastacia Palaszczuk

Joe Kelly MP at a Heart Foundation event he organised in Parliament House

"We have been quite innovative with nurse led programs including nurse navigators. There are people in the community who need skilled nurse navigation to work their way through the complexities of the healthcare system including refugees, those accessing the NDIS, and the My Aged Care system."

Mr Kelly believes the issues in aged care will not be fixed until mandated ratios are introduced. "We [the QLD government] have got an Inquiry into all aspects of aged care which was announced before the Four Corners program aired and the federal government announced the Royal Commission. We hope our Inquiry will make a meaningful contribution and look at all issues, including palliative and end of life care."

Australia needs a strong and carefully managed economy that benefits all, argues Mr Kelly.

"It's about the quality of employment. Statistics show 30% precarious employment which affects social cohesion. It's hard to know where you are if you don't know if you're working three hours or 30 hours in the week."

Mr Kelly's wife is also a nurse, a NUM at Greenslopes Hospital.

"I have a grandmother who is a nurse, my mother was a nurse, my older sister is a nurse and one of my nieces is a nurse. We are well represented by nurses," he laughs. "It's been a great opportunity. I hope to continue to support the numbers of nurses in healthcare, with high levels of professionalism and quality care; continue to promote advances in technology and teaching; and support nurses to continue to provide leadership roles right across the breadth of our communities."

Natalie Cook became South Australia's Member for Fisher in the 2014 by-election. The most marginal seat in Parliament, it resulted in the Weatherill Labor government's changing from a minority to majority government. "I won by nine votes. It was notionally the most marginal seat in the country; I've never taken it for granted," says Ms Cook.

An ANMF member and former worksite rep in the 1990s, Ms Cook worked at Flinders Medical Centre for 12 years as an ICU nurse.

Four years on in government, Ms Cook says she's had the opportunity to learn her craft.

"What I found very early on is that being a MP is very similar to the role of a nurse. Listening, engaging, understanding the complexities people face in the community and the need for advocacy.

"The skills we have are needed to address the many diverse problems and requirements of the job. The assessing, triaging, caring, responding and advocating -and not giving up on someone is as important to me as a MP as it was as a nurse."

Ms Cook was Parliamentary Secretary for Housing and Urban Development from March 2017 to Labor's loss at the 2018 state election.

Ms Cook successfully contested the seat in Hurtle Vale when new boundaries came into effect becoming its first representative.

Ms Cook is Opposition Spokesperson for Human Services; the portfolio includes disability, housing, homelessness, youth, youth justice, and social inclusion.

"A right-wing government that focuses on financial capitalism, trickle-down economics is not in the best interests of working families and the vulnerable. We have a massive challenge to give vulnerable people a voice.

"What we are going to see in South Australia is a very challenging time for those with a disability. For both those who do not qualify for the NDIS and those whose needs are not fully met because of the service model."

Ms Cook says she has a very supportive and close family, with partner Neil Davis and children Sheree, 33, Ty, 17, and Sid, 6. She became an anti-violence campaigner after the death of her 17-year old son Sam in a one-punch attack in 2008.

"Three decades of nursing has kept me grounded and a son that was assaulted I understand that life can change in a minute and not always in a good way. You've got to make the most of what you've got."

Nurses can provide leadership in politics, from providing evidence to a Parliamentary Inquiry, to representation at local, state or federal government level, says Ms Cook.

"Nurses are fantastic leaders. They listen, prioritise and assess. They are genuine."

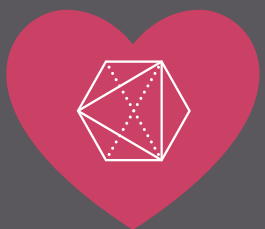
As a MP Ms Cook loves the role and loves the job. "It's much more than I expected. The amazing part is the difference you can make. People need representation and leadership; we need advocacy for diverse populations and communities. I make myself as visible as I can. I can show what it's like to be a leader if I'm visible to my community."

We are NURSES.

We are AUTONOMOUS HEALTH CARE PROFESSIONALS

We are CONFIDENT AND KNOWLEDGEABLE, *as well as* EMPATHETIC AND CARING

We are TERTIARY EDUCATED *and many of us hold* POSTGRADUATE QUALIFICATIONS



The Australian College of Nursing (ACN) brings together thousands of like-minded nurses to raise the profile of nursing.

Join the ACN tribe to support your profession.

Personal reflection on conducting nursing research in a regional emergency department

By Edward Davis

One of the initial challenges I faced with undertaking a Nursing with Honours degree was conducting scholarly research within my own workplace.

I was confronted with, and surprisingly conflicted by, the anthropological concepts of Emic and Etic perspective.

The thesis concept itself had its genesis in numerous Emic observations; defined as studying a culture from within (Holloway & Galvin 2017, p6).

However, to effectively undertake research I had to adopt a more scientific Etic perspective; defined as studying a culture from an outside viewpoint (Holloway & Galvin 2017, p7).

This paradigm shift of perspective gave cause to examine some of the potential reasons for the sense of conflict I experienced when commencing the research.

Turning to the musings of other researchers it is immediately apparent that this sense of conflict is a known issue of conducting data collection in your existing workplace. Reflecting on experiences as an ethnographic researcher in her own workplace Simmons (2007, pp14-15) discusses how conflict issues did occur relating to her existing Emic professional role and that of the Etic ethnographer. However, the issues she highlighted as being problematic when undertaking the new role of ethnographer did not seem to fully reveal and explain the sense of conflict I had initially felt.

From my own Emic experience, the Emergency Department (ED) is a workplace that is both intoxicatingly challenging and equally laden with personal stressors.

These stressors are due to the very nature of clinical practice in a contemporary ED; with all its complexities and contradictions, professional and personal demands, its highs, its lows, its wins, its loses and its occasional dangers.

This personal perspective is mirrored by Adriaenssens et al. (2015) in their systematic review of qualitative studies focused on emergency nurses between the years 1989 to 2014.

In this paper they highlight some of these same stressors as contributing to ED nurses having an increased risk of professional burnout (Adriaenssens et al. 2015).

To help mitigate this personal stress, and thereby reduce the risk of professional burnout in this demanding environment, the reliance on a team approach is arguably a paramount strategy.

From her examination of stress and how it affects men's functional behaviour Seppala (2012) highlights the fundamental human need for social connection as it has been ubiquitously linked to physical and psychological wellbeing.

The benefits of belonging to a group not only fulfil our profound human need for social connection but also act in a protective fashion for individuals experiencing stress (Seppala 2012).

However, the bonds that are created and fostered within a team environment can also act upon the individuals at a level that reaches far beyond the usual professional supportive structures.

One analogy of this phenomenon that can both illustrate and support this statement are the well documented, and culturally celebrated, bonds that form amongst people who experience disastrous events as a group.

Events such as those in armed conflict. Seppala (2012) makes specific mention of war veterans talking about the profound bonds that can form on the battlefield, which she states is understandably one of the most stressful situations that exist. She highlights the research in to physiological reactions to stress by neuroendocrinologist Professor Robert Sapolsky who hypothesises that moments of acute stress, such as those in a theatre of war, can lead to this profound social bonding (Seppala 2012).

When considering the human drive to seek succour from their close social group during times of great

References

Adriaenssens, J., De Gucht, V., & Maes, S. 2015. Determinants and prevalence of burnout in emergency nurses: a systematic review of 25 years of research. *International Journal of Nursing Studies*, vol. 52, no. 2 pages 649-661.

Holloway, I., & Galvin, K. 2017. Qualitative Research in Nursing and Healthcare, 4th edn., John Wiley & Sons Ltd, West Sussex, UK.

Seppala, E. 2012. How the Stress of Disaster Brings People Together: New evidence that men are more likely to cooperate in difficult circumstances. Available at: scientificamerican.com/article/how-the-stress-of-disaster-brings-people-together/# Accessed 20 March 2017.

Simmons, M. 2007. Insider ethnography: tinker, tailor, researcher or spy? *Nurse Researcher* vol. 14, No. 4, pages 7-17.


Photo credit: Cecily Graham

ED nurses at Launceston General Hospital

stress and the potential for unusually strong bonds to form in groups under such circumstances.

It starts to become clear to me the source of conflict I initially felt may be not only due to the academic transformation from Emic to Etic in perspective.

The swapping of lenses actually evoked a visceral reaction due to it jarring against the long-standing bonds that have been created through crux moments of acute stress shared with my own professional social group.

As a group, ED nurses frequently hear others describe us in various ways. Some descriptions flattering – some not.

The truth is we tend to revel in these colourful viewpoints as we view them as acknowledgment that we do something that is difficult to do.

However, does belonging to this group give me the right to lay claim to a sense of conflict because of ethereal concepts such as powerful interpersonal bonds? Are there any similarities between the moments of acute stress soldiers are hurled into on a battlefield compared to those of health professionals in a regional ED? From my own insider's viewpoint, the sense of loyalty to the group and inner conflict was palpable. However, from my developing outsider's perspective I am obliged to question if the environment has potential to catalyse such powerful interpersonal bonds.

In the context of sharing an almost overwhelming tide of work and labouring together to somehow lessen the seemingly endless abyssal of human mishap and suffering. Bearing witness to catastrophic losses and tragedy while also frequently seeing the most amusingly bizarre of human behaviours. Conducting ourselves throughout all of these experiences in an utterly professional manner but sometimes hiding away from this chaos to tell an amusing story that sparks utterly inappropriate but rejuvenating laughter. To not only survive in this environment that draws us like moths to a flame but to ultimately accomplish the unspoken but binding doctrine that others rely upon us for; ED nurses never give up.

All of our shared moments in time and the bonds they create go a long way in explaining the internal conflict I felt at the beginning of my research journey.

Because this reflection strikes an indelible chord of certainty within my culturally embedded Emic self and is also suggestive of an empirical truth to my emerging Etic perspective.

Author

Edward Davis is a senior RN at the Emergency Department, Launceston General Hospital. He is also a Lecturer in Nursing (Contracted) at the University of Tasmania

Dr Micah D J Peters

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

Leaders in person-centred care through practice and research

Nurses and midwives take the spotlight with a growing acknowledgement of the importance of nurses and midwives both in Australia and globally.

International Midwives' and Nurses' Day fall on 5 and 12 May respectively.

Further, 2020 has been declared by the World Health Organization (WHO), as 'Year of the Nurse and Midwife' coinciding with the 200th anniversary of Florence Nightingale's birthday, the culmination of the global Nursing Now campaign, and launch of the WHO's first 'State of the World's Nursing' and second 'State of the World's Midwifery' reports (WHO 2018).

This focus on nursing and midwifery is an opportunity to reflect on the contributions of the professions to care in all its contexts, and to consider how nurses and midwives continue to champion the interests and perspectives of patients.

Along with providing care, engaging with research is vital to nursing and midwifery practice and a key contribution the professions make to healthcare and research more broadly.

Nurses and midwives utilise knowledge and outcomes from research daily and may undertake quality improvement projects and accreditation processes. However despite many having an interest in doing so, not all nurses and midwives undertake formalised research.

While challenging to balance with clinical responsibilities, supporting nurses and midwives to lead and collaborate on research projects during their education and careers could be one avenue for attracting and retaining a skilled and engaged workforce.

Nursing and midwifery research may focus upon factors that affect the ability of people or populations to maintain or enhance wellbeing and minimise the impacts of illness as well as broader issues of health, illness, health services development and management, workforce, models of care, policy, and education.

Nursing and midwifery research also often involves health consumers and can be an important way of partnering with and advocating on their behalf.

Arising from the dementia care context, person-centred care is an important concept in health and aged care and a growing focus in nursing and midwifery research and practice.

Person-centred care, and the related concept of women centred care must be distinguished from the related concept of patient-centred care.

Both concepts emphasise individualised care appropriate to each person's preferences and needs and also encompasses the perspectives of significant others.

Both concepts refocus imbalances in healthcare from the historically disease and medically-dominated perspective to enable collaborative partnerships between health consumers and their healthcare team.

Perhaps the clearest way of discerning patient versus person-centred care is understanding that patient-centred care has the primary goal of achieving a functional life for the patient, while person-centred care is focussed on achieving a meaningful life for the person.

Person-centred care is thus an extension of patient-centred care and is more aligned to the notion of holistic care rather than simply in the context of them as a patient (Håkansson Eklund et al. 2019).

Nurses and midwives have a role in collaborating with and advocating for those they care for in all contexts eliciting each person's choices, preferences, and perspectives and ensuring that the care they engage in with the person is considerate of and responsive to these.

Because in many contexts they provide the bulk of face-to-face care to health consumers, nurses and midwives are ideally placed to take a central role in the provision of and research in person-centred care.

This will be vital to many contemporary and future issues and challenges facing Australian health, maternity, and aged care from ensuing appropriate, safe, high-quality care for those in aged care (Marriott-Statham 2018), to closing the gap between Aboriginal and Torres Strait Islander people's health and wellbeing and mainstream populations (McMillan et al. 2010).

Micah Peters would like to acknowledge the valuable comments provided by Dr Nadia Corsini.

References

Håkansson Eklund, J., Holmström, I.K., Kumlin, T., Kaminsky, E., et al. 2019. Same same or different? A review of reviews of person-centered and patient-centered care. *Patient Educ Couns*;102(1):3-11.

Marriott-Statham, K., Mackay, M., Brennan, N., Mackay J. 2018. Empowering aged care nurses to deliver person-centred care: Enabling nurses to shine. *Nurse Educ Pract*; Jul(31):112-7.

McMillan, F., Kampers, D., Traynor, V., Dewing. 2010. Person-centred care as caring for country. *Dementia*; 9(2):163-7.

World Health Organisation (WHO). 2018. State of the Worlds' Nursing Report/State of the World's Midwifery 2020 Report. World Health Organization. Geneva. Available: who.int/hrh/nursing_midwifery/state-of-the-worlds-nursing-and-midwifery-2020-get-engaged.pdf?ua=1

INTERNATIONAL NURSES' DAY 12 May 2019

Purple House

By Natalie Dragon

2019: CELEBRATING NURSE-LED MODELS OF CARE

The International Council of Nurses (ICN) is highlighting nurse-led initiatives that push the boundaries and showcase the abilities, skills and knowledge of the nursing profession across the globe for International Nurses' Day 2019.

The ICN's 2017-2019 campaign, **Nurses: A Voice to Lead** focuses on the need for nurses to become more active and vocal in policy development and implementation. **Nurses: A voice to lead health for all** completes the ICN's three year campaign.

"This year, ICN has chosen to highlight through the 2019 International Nurses' Day resources, how nurses all over the world are advocating for Health for All in the most challenging circumstances with limited resources, delivering healthcare to those most in need," ICN President Annette Kennedy told the *ANMJ*.

"There is no doubt that there is an increasing need for educated competent nurses to play a critical role in improving the health of the population and achieving universal health coverage."

ICN is hopeful that by 2020 the value of nurses and their vital contribution to healthcare will be much more widely recognised in all countries, Ms Kennedy says.

Australian nurses are leading the way with such innovative practices, which are being recognised nationwide.

A MODEL OF CARE BASED AROUND FAMILY AND COUNTRY

An innovative community-led model of care started out with an RN doing dialysis in a corner of her lounge room in the Northern Territory.

Run from its headquarters in a suburban house in Alice Springs, Purple House's mission is 'Making all our families well'. The Purple House model of care is based around family, country and compassion.

"Flexibility and cultural safety is at the centre of everything we do. It's the Purple House way," says CEO/Founder and RN Sarah Brown, who was awarded HESTA Australia's Nurse of the Year for 2017.

In November 2000, collaborative paintings of Papunya Tula artists from Walungurru and Kiwirrikurra auctioned at the Art Gallery of NSW raised $1 million.

The independent money kicked off the Western Desert Nganampa Walytja Palyantjaku Tjutaku Aboriginal Corporation, now called Purple House.

Purple House


Purple House


Purple House / Sarah and Patrick

"It's been through the dogged determination of those old fellas and some artists, the custodians of that country that wanted to see people at home," says Ms Brown.

Since the opening of the first dialysis clinic in Kintore in 2004, Purple House now runs 15 remote dialysis clinics, three in WA and the rest in NT employing 35 nurses. By the middle of 2019, it will have expanded to SA totalling 18-19 clinics.

"We have the best survival rates of patients on dialysis in the country. We have better survival rates of people on dialysis in Purple House than the white fellas in Sydney," says Ms Brown.

Data shows people who get back home to country on dialysis have less than half the hospitalisations than people who do not get home, says Ms Brown.

"People who have to leave their community and come to a regional centre with no hope of returning get sick, homesick and disengaged and are being admitted to hospital."

A Medicare item number for nurses and Aboriginal health workers to provide dialysis in a very remote community in Australia was announced in the last federal Budget.

"Up until now we kept afloat by lots of government grants to keep the doors open.

"Staff were working minimum hours; the machine wasn't working in the afternoons because we didn't have the money for staff. Now as long as the patient is stable we can do dialysis out bush. What this means is that people in very remote communities can have dialysis three times a week in their homes," says Ms Brown.

Purple House headquarters had also grown organically to meet people's needs, she says. "It's a crazy share house where people come in to play guitar or ring their family or have their toenails cut. There is bush making medicine where people are passing on their cultural heritage and valuing their cultural knowledge."

"As a nurse it's been fantastic to do all sorts of creative things to help improve healthcare."

A NP MODEL OF CARE

A rural and remote nurse practitioner (NP) model of healthcare in a small rural public health facility in northwest Victoria has improved access to timely healthcare and reduced the number of patient transfers to the regional hospital.

The NP model of care was implemented in 2011 at Rural Northwest Health which provides the bulk of health services of the northern Wimmera and southern Mallee. The local rural health facility at Warracknabeal has a 24 hour 12-bed unit and urgent care service. The lack of emergency care especially after-hours meant the majority of patients requiring treatment for even minor health conditions were referred or transferred to the regional hospital, 60 km away.

Rural Northwest Health Campus Manager and RN Wendy James says the organisation saw the NP role as an adjunct to what was being offered and made a commitment to the role.

"We had local support from the GPs and CEO who could see the vision of the NP model had a lot to offer and didn't get bogged down in the finances."

Initially a locum NP was contracted to provide an 'on-call' service every third weekend where there was no medical practitioner cover. In 2013, a local NP candidate became endorsed and then worked fulltime in the role.

"The NP role in the rural area is a generalist role. Rural areas really need the specialist generalist role. You have to have those high level assessment skills to deal with anything that comes through the door," says Ms James.

"It's a collaborative model with the GPs. The NP prescribes and works within her scope of practice which means for a rural hospital we can care for people here and keep them close to home."

The NP's clinical expertise has contributed to a reduction in transfers to regional hospitals. Patients are seen in a timely manner," says Ms James.

The role has extended to provide collaborative care for acute inpatients, residents in the aged care facility and in the community.

"The NP role has been highly beneficial for palliative care. We have a high rate of cardiac disease and cancer so we do get a lot of palliative care clients. The NP will visit the person and change the syringe driver or change the dose of medication. She will liaise with the family and talk to them about options such as an advanced care directive or advanced care plan if they don't already have one. She can sit down and spend the time making sure people are able to make informed choices."

The unique model progressed from not only filling a gap in treating unplanned urgent care presentations to providing support and mentorship to three RIPPERN nurses.

"If you have the right people, in the right place, there are endless possibilities to improve timely, appropriate, cost effective healthcare to our local rural communities."

Grainnie Lowe

Kathy Tori

Tash Jennings

Nurse Practitioners and Director for Nurse Practitioner Locum Solutions

Nurse Practitioners filling in the gaps in care delivery

Nurse Practitioner Locum Solutions (NPLS) is a new, innovative service model developed by three nurse practitioners with backgrounds in emergency and acute care, clinical leadership, research and academia.

The NPLS founders identified gaps in the delivery of high-quality care initially in regional and rural healthcare settings.

NPLS aimed to fill these gaps by promoting the potential of nurse practitioner roles to meet these needs. The NPLS philosophy is to provide high quality, focused outcomes for all patients, their families and the community; that is, to deliver healthcare where it is most needed.

Rural and remote healthcare service delivery has workforce challenges that not only exist due to tyranny of distance but also as a result of access to ongoing professional development, which in turn affects retention and supply of skilled health professionals. There is evidence that healthcare delivery is creating a strain on existing services, both locally and internationally.

While rural and regional areas have their own specific needs, and therefore specific deficits in terms of the provision of responsive services, these communities are not alone in their predicament.

Addressing the rural, regional and remote community needs, requires a different response than that of the metropolitan and urban communities.

NPLS believe they understand these issues, the differing needs of community populations and therefore attempt to address these needs accordingly. The NPLS service promotes a degree of continuity and encourages individual organisations to rethink their own workforce to better meet the population's needs.

With that in mind NPLS strive to deliver healthcare on the afterhours and on call periods to maintain timely and consistent levels of high-quality healthcare to meet the needs of individual communities. The benefits of this model are an improvement in access to quality health services for each community served.

Primarily, in response to these challenges and the opportunities available to improve regional and rural health service delivery, NPLS developed a strategy to add value to the future planning of healthcare services. Following a structured plan to identify how these needs could be met and addressed, NPLS created a service structure model which was submitted to services which were identified as potentially in need. NPLS now provides a service whereby nurse practitioners are empowered to utilise their full scope of practice to deliver a high-level service for the afterhours/on call periods in a number of rural and regional communities.

The NPLS service prides itself on providing quality, cost efficient healthcare able to improve individual and community health outcomes. The value of the NPLS model is the provision of a transparent, reliable service that delivers consistent and accessible healthcare which is dependent upon the clinical need.

The NPLS model of healthcare delivery is flexible and dynamic, dependent upon the needs of the local community and the inherent need of the individual healthcare service provider.

The flexibility of the NPLS services is demonstrated through the various models, including the afterhours and on call healthcare cover to urgent care centres; the adjacent acute wards; and the onsite residential aged care facilities as and when necessary. Working collaboratively with healthcare services, NPLS strives to meet, and at times exceed the requirements of the health service vision, mission, values and objectives in rural, regional and urban areas. NPLS was formed as a business able to deliver necessary clinical services to the community. The company now provides clear nursing leadership in a variety of organisations through actively developing, mentoring and supporting collegial relationships with all members of the healthcare team at the health service.

NPLS founders believe that they have a role and responsibility to the overall healthcare system to enable the provision of quality health outcomes and reduce gaps in service where able. Further, the directors of NPLS are committed to providing further information about the NP role which can influence health policy, leading to a reality whereby all Australian communities have their specific healthcare needs met.

The true benefits of NPLS are evident in:

1. the provision of a service able to augment existing services,
2. provision of a service that can be measured in terms of real outcomes to the health service,
3. key measurable deliverables that result in improvements to the local community.

A number of local rural and regional communities are reaping the benefits of our services in the short term, and this is expected to continue to improve patient focused outcomes in the medium and long term. This is evidenced not only through anecdotal evidence from the services who have accepted our model of care, but also from patient experiences with the service. NPLS hopes to further expand its reach into rural and regional communities and are actively seeking NPs to join our team to enhance our current model.

Currently NPLS are providing services in Maryborough, Seymour, Apollo Bay and Colac in Victoria as well as providing relief cover at Fitzroy Crossing WA and the Mallee Border in SA.

The service is planning to expand throughout Australia, starting with more locations within Victoria.

NPLS are looking for more NPs with a speciality in emergency in any location within Victoria.

FOR MORE DETAILS:

EMAIL:	admin@nplocumsolutions.com
PH:	0473 401 777
WEBSITE:	nplocumsolutions.com
FACEBOOK:	facebook.com/pg/nplocumsolutions/about/

INTERNATIONAL DAY OF THE MIDWIFE: 5 MAY 2019

By Robert Fedele

2019: DEFENDERS OF WOMEN'S RIGHTS

Midwives often play a pivotal role in standing up and speaking out for the rights of women across a number of important areas. Australian midwives are leading the charge at home and abroad.

IMPROVING MATERNAL HEALTH OUTCOMES IN PAPUA NEW GUINEA (PNG)

Papua New Guinea (PNG) has one of the highest maternal mortality rates in the world. In 2015, a woman living in PNG was 35 times more likely to die during pregnancy than in Australia, with 215 women dying per 100,000 live births.

The alarming statistic led the Australian College of Midwives (ACM) to join the Rotary Club of Port Moresby and the PNG Midwifery Society to create a volunteer Buddy Program where Australian midwives visit Port Moresby to undertake workshops aiming to strengthen local midwifery leadership and training so all women have access to safe maternity care.

A team of six Australian Buddy Midwives travelled to PNG last month to meet their new colleagues and begin tackling challenges of current midwifery practice contributing to poor maternal and infant outcomes.

Facilitator Helen Hall, Associate Professor in the School of Nursing & Midwifery at Monash University, says midwives can make substantial impacts in the lives of women and babies.

Care often fluctuates between two ends of the spectrum – 'too little too late' in resource poor countries like PNG and 'too much too soon' in resource rich countries like Australia.

"Too little too late captures problems in PNG where women do not have access to skilled birth attendants and there's all sorts of contextual problems that make life difficult for them.

"In Australia, our outcomes look pretty good but we have an issue where we have too much too soon often where we intervene in what's probably for women a healthy process. Women don't die but we are getting a lot of women traumatised through the process and that's not quality care."

Ms Hall says the Buddy Program is about collaboration and building professional development and leadership capability across both countries.

"The whole thing is about mutual exchange it's not one group going in and fixing the problems of another.

"The PNG midwives are going to teach us about resilience, innovation and commitment. They have amazing capacity to get things done under some very difficult circumstances."

Ms Hall says challenges facing PNG are complex. "About half the women in PNG don't have access to skilled birth attendants for a variety of reasons. Eighty per cent of people live in rural and remote communities.

"We know if midwives are well-educated, regulated and supported they can have a big impact on care and the maternal mortality rate and infant mortality rate.

"We'll spend quite a bit of time looking at advocacy and raising the profile of

Neonatal Resuscitation Obstetric Emergency Workshop during the MCHI

Midwife Jane Menke and PNG mentee Lilian Temo

midwifery. We have a lot of evidence about what midwives can do but we need to share that evidence and look at innovative solutions to some of the problems that are stopping women accessing good quality respectful maternity care."

ACM's Buddy Program builds on the work of the Maternal and Child Health Initiative (MCHI) in PNG, an Australian-government funded project undertaken several years ago by the World Health Organization (WHO) and University of Technology Sydney (UTS) to train and educate midwives.

Experienced midwife Jane Menke, who works at an antenatal clinic at the Mater Mothers' Hospital in Queensland specialising in caring for women from a refugee background, took part in the MCHI, spending three years living in PNG strengthening the midwifery workforce.

She signed up for the Buddy Program and is now looking forward to implementing evidence-based practice, providing support and empowering local midwives to become leaders in their profession.

"The new project to me feels like a continuation of that (MCHI), which is fantastic," she says.

"We doubled the number of properly trained midwives so that was pretty amazing. It's still got one of the highest mortality rates in the world so there's still a huge amount of work to be done. We're such a well-developed country and we have such a good health system, it seems crazy that a country right next door to us has such a poor health system and such poor outcomes for women and babies."

MIDWIVES IDEALLY PLACED TO DETECT DOMESTIC VIOLENCE

Dr Kathleen Baird, Associate Professor with the School of Nursing and Midwifery at Griffith University, ponders the theme of International Day of the Midwife 2019 – Midwives: defenders of women's rights.

"I think midwives have always worked in partnership with women," she says.

"We've never seen women as a patient. Most pregnant women are healthy women. So when I think about midwives working closely with women and working in partnership with women I see it's navigating the maternity services with them to get the best outcome for them and their families."

Dr Baird is also the Director of Midwifery and Nursing Education, Women Newborn and Children's Services at Gold Coast University Hospital.

She says modern midwives, including the recent introduction of midwifery navigators, are working more and more with women from high-risk populations experiencing complex social circumstances, medical issues and with drug and alcohol problems.

"We try to ensure women get the birth choices they want and sometimes for some women they're really clear what they want their birth experience to be like but others really aren't sure what's available.

"So we do a lot of education. We look after women with mental health problems and domestic and family violence. So even though we work with women who may be well and having a normal pregnancy there may be other parts of her life she needs help and support with."

In 2015, Dr Baird co-authored a study on domestic violence that suggested midwives are ideally placed to identify women experiencing domestic violence and provide immediate support and referrals.

"I don't see that midwives have the ability or the time to be engaged in really complex long-term women's lives who are experiencing domestic and family violence," she explains.

"What I do see that role is as a gateway into the services to help women reach out and get the support and help they need. A lot of our midwives now work with community agencies to make referrals into them and work with women to give them the option of what they want to do and just let them know these services are available."

Dr Baird's research revealed pregnancy and the period following birth was a trigger of domestic violence, with nearly 30% of women experiencing DV for the first time during this period.

"Then of course what happens is when you bring a newborn baby home in the post-natal period we sometimes see that spike because of tiredness, a crying baby and more tension in the home. It can exacerbate."

Dr Baird's study made recommendations to develop better training, screening tools and practice protocols to assist midwives to screen for domestic violence.

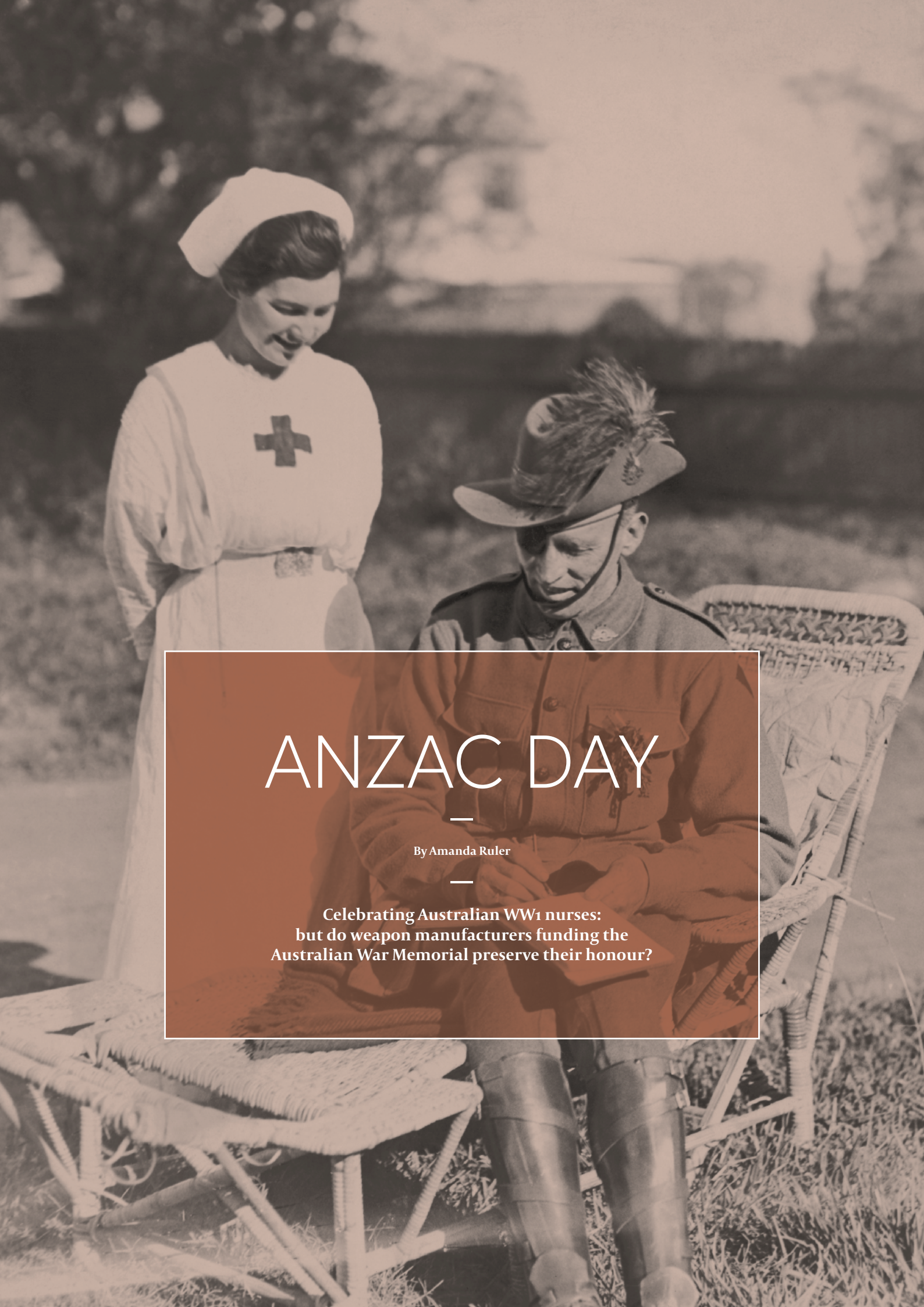
Four years on, she believes a shift has occurred, pointing to widespread improvements in states such as Queensland, who introduced greater tools and training, as an example of progress.

"We work with women wherever women are but really what we want is that one-to-one care. We want to work in close partnership with women and provide continuity of care. That's how we can meet women's needs regardless of their social or medical circumstances."

Midwifery students and academics from the University of Papua New Guinea during the MCHI.

Dr Kathleen Baird

Associate Professor Helen Hall



ANZAC DAY

By Amanda Ruler

Celebrating Australian WW1 nurses: but do weapon manufacturers funding the Australian War Memorial preserve their honour?

Nurses have always played a crucial role in the Australian Defence Force.

Nursing services were part of each Australian colony's defence force prior to Australian Federation. After Federation in 1902 nursing services merged to become the Australian Nursing Service.

This service was part of the Australian Army Medical Corps and was made up of volunteer trained nurses who were willing to serve in times of a national emergency (AANS 2018).

Australian nurses, working at the fronts of World War 1 (1914-1918), performed duties outside the narrow limits of social expectations of women at this time which were traditionally 'home duties' such as housekeeping and caring for their families.

Nursing staff were recruited from both the nursing service and the civilian workforce at the outbreak of WW1.

The nurses served at field and base hospitals in Egypt, England, France, Belgium, Greece, Salonika, Palestine, Mesopotamia and India as well as Australia.

At Gallipoli, the nurses spent a large portion of their time at sea and worked on hospital ships where it was not uncommon for a night duty nurse to look after 250 patients with only one orderly to assist her.

Generally the workload for the nurses was excessive and the lack of staff continued throughout the war. The Australian Army Nursing Service returned to a reserve status after the conclusion of the war (AANS 2018).

In comparison to soldiers, the female nurses who were involved in WW1 have gone largely unrecognised despite facing many of the war's dire consequences.

They experienced shock and terror from the dangerous circumstances and the ongoing burdens of understaffing and lack of resources resulted in demoralisation and exhaustion.

These conditions led them to suffer similar psychological traumas as some of the soldiers, such as depression and ongoing nightmares after returning from the war (AANS 2018; Smith et al. 2015).

Australian nurses gave distinguished service in the war that is highly regarded by society. Throughout WW1, a total of 2,139 nurses served overseas and 423 served in Australian hospitals. Of these 25 died and 388 were honoured for their service, with seven being awarded military medals (Women's Mobilisation for War (Australia) 2018).

The Australian War Memorial (AWM) is Australia's national memorial to the members of our armed forces. Among those honoured at the AWM are Australian nurses who have served in war, devoting their professional lives to the relief of terrible suffering.

However, the Memorial is now being funded in part by weapons companies that help create the suffering, pain and death that our nurses work so hard to overcome.

How would those WW1 nurses feel today if they knew that their service would be commemorated by the same industry that profited as they and others attempted to mend broken minds and bodies?

The AWM now proudly counts some of the world's largest weapons-makers among its corporate sponsors – such as BAE Systems, Boeing, Leidos, Lockheed Martin, Polaris, and Thales. (Don't Bank on the Bomb; Don't Bank on the Bomb/Leidos, Stephens 2018).

The total figure for the value of contributions that the Australian War Memorial received from military and defence firms in the years 2015–2016 was $363,594.40 and for 2016–2017 was $331,900.00.

For the financial year 2017-2018, it was reported that BAE systems had contributed $75,000, Boeing $62,000, Leidos Australia $175,000, Lockheed Martin Australia $213,000, Polaris Industries $20,000 and Thales Australia $30,000 in contributions to the Australian War Memorial (Stephens 2018).

To summarise, the Australian War Memorial has received over $1.2 million in donations over the last three financial years from weapons-making companies. (Stephens 2018)

To preserve and honour the service given by Australian nurses, we must avoid the distorted commercialisation of their memory brought about by the funding of the Australian War Memorial by weapons manufacturers – the industry that profits as others die.

Instead, we must do all that is possible to promote peace, so that, a century on, we can learn that the horrors endured by Australia's courageous and ground-breaking WW1 nurses should not be repeated.

The interests of the war profiteers are incompatible with learning this lesson.

Everyone can assist with having this message acted on by signing the petition at: **actionnetwork.org/petitions/australian-war-memorial-stop-accepting-funding-from-weapon-makers?source=direct_link&**

The petition was initiated by the Medical Association for Prevention of War (Australia) which welcomes the input and membership of all health professionals. Nurses, as our biggest such group, have a key role to play in the promotion of peace. You can learn more at **mapw.org.au**

References

Australia. Army. Australian Army Nursing Service (AANS) (1902-1948). National Library of Australia. trove.nla.gov.au/people/597790?c=people (accessed Sept 2018).

Don't Bank on the Bomb 20 Major Nuclear Weapons Companies dontbankonthebomb.com/wp-content/uploads/2012/02/Producers.pdf (accessed Jan 2019).

Don't Bank on the Bomb/Leidos, dontbankonthebomb.com/leidos/ (accessed Jan 2019).

Smith, K. M., Halcomb, E. J., and Moxham, L. 2015. Stress wasn't a word: Australian nurse's recollections of war-related trauma. *Health, Emergency and Disaster Nursing* 2 (1) 12-22

Stephens, D. 2018. The Australian War Memorial admits receiving $1,271,473 over three years in donations from military and defence firms, johnmenadue.com/david-stephens-the-australian-war-memorial-admits-receiving-1271473-over-three-years-in-donations-from-military-and-defence-firms (accessed Jan 2019).

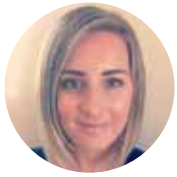
Women's Mobilisation for War (Australia), encyclopedia.1914-1918 online.net/article/womens_mobilisation_for_war_Australia (accessed Jan 2019).

Acknowledgements

The Author would like to thank Michelle Fahey for her contributions to this work.

Amanda Ruler, RN, BA(Hons) Grad Dip Gerontological Nursing, PhD.


COMMUNITY
HEALTH



Samantha Mills

WACHS Kimberley population health graduate nurse program

By Samantha Mills

In 2018, the WA Country Health Service (Kimberley) initiated the Graduate Nurse Program into the Kimberley Population Health Unit.

The program was developed to support the transition of graduates into various community health sites throughout the region. The program placed an emphasis on primary healthcare principles and the importance of providing preventive and comprehensive care within the community.

With the high burden of health inequality, extremely remote communities and challenging weather, the Kimberley provides generous opportunities for learning and adventure alongside our skilled workforce.

Our first graduate nurse started at Broome Community Health for six months and later relocated to Derby for a further three months. A range of opportunities were offered within the specialties of School Health, Child Health and Generalist Community Health Nurse Programs.

L – Charlotte Turvey, Graduate Nurse; R – Samantha Mills, Staff Development Nurse, Community Health at the Derby Community National FASD event

The final three months for this graduate nurse saw her based in Kununurra working on the general ward of the hospital. This provided an opportunity for another graduate to rotate into Kununurra community health for three months. The rotational program was designed to give the graduate nurses a feel for the Kimberley and the opportunity to be exposed to as many new learning opportunities as possible.

Involvement with school health was pivotal to the program as it provided ongoing exposure to early identification, developmental screening and the opportunity to participate in various sexual health and puberty education groups.

The graduate nurses were also involved in multiple community events, such as a pregnancy education during national Foetal Alcohol Spectrum Disorder (FASD) day. Furthermore, during the school health program, the audiometry, tympanometry, vision and immunisation competencies were gained through ongoing educational support.

The nurses were also supported to gain their immunisation certificate, and this learning was consolidated through involvement in school health and child health, as well as the meningococcal and influenza immunisation programs.

Within the Generalist Community Health Nurse role, the graduate nurses trained to deliver the Sexually Transmitted Infections (STI) program.

This included screening, management and treatment of clients diagnosed with STIs. Graduates gained their venepuncture competency and were involved in the management of the current Kimberley syphilis outbreak.

While at community health, our graduates were privileged to work alongside and in partnership with many vulnerable families at each site.

While working in Derby, one of our graduate nurses worked alongside the Aboriginal Health Worker (AHW) to complete Enhanced Aboriginal Child Health Schedule (EACHS) checks.

This provided exposure to different health concerns within various towns of the Kimberley and ensured culturally safe practice was delivered.

The graduate year also included a Population Health component and a two week secondment to public health was organised to provide the option to work alongside the communicable disease team. It was then planned that one of our graduates would spend a further week with the public health team to help with the trachoma screening program. Our graduate travelled to the Fitzroy Valley with the team for one week and was able to participate in health education within small remote communities.

During this time, active cases of trachoma were found, giving the opportunity to contact trace and to work with the environmental health team to deliver client appropriate and preventative health education and treatment.

Graduate Charlotte Turvey said, "not only did my time in a remote community help me to better understand the social determinants of health, but also the complex social conditions and vulnerability that our families within the Kimberley face."

"I feel that this has helped me to further understand and implement a holistic approach to health, which can be used within any health setting."

The Kimberley Population Health Unit Graduate Program will continue in 2019 to ensure future generations of graduates are exposed to the many opportunities that community health nursing in the Kimberley has to offer.

Author

Samantha Mills, RN, Staff Development Nurse, Community Health, Kimberley Region, WA Country Health Service, Kimberley Population Health Unit

A nursing workforce education program to support Australia's Hepatitis C elimination goal

By Olivia Dawson and Melinda Hassall

Globally, viral hepatitis is a leading cause of death and a major public health threat; in 2017, more people were infected with Hepatitis C Virus (HCV) than were cured (Cook et al. 2019).

Following the advent of well-tolerated, simple, short-course direct acting antiviral (DAA) interferon-free regimens with cure rates >95%, there is potential to reverse the rising burden of advanced liver disease and achieve the goal of global elimination.

Nurses have a key role to play in the elimination of hepatitis C in Australia, both for their role in screening, testing and linkage to care, as well as the prescribing eligibility of Nurse Practitioners (NP) following changes to the Pharmaceutical Benefits Scheme in June 2017 (Department of Health [DOH] 2018).

Recognising the need to support NPs to work to their full scope of practice to effectively test for, treat and manage HCV, the Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM), in collaboration with the Kirby Institute, UNSW, held a one-day workshop for NPs alongside the 2018 DANA Conference (Drug and Alcohol Nurses of Australasia).

The workshop, *Hepatitis C in Primary Care and Drug and Alcohol Settings*, was delivered for 26 NPs across Australia and New Zealand.

The workshop was focused on didactic presentations given by local experts, and small group roundtable case study discussions where participants were led through different patient scenarios to increase confidence in translating learning into practice.

Participants were asked to provide feedback after the workshop as to how it would change their clinical practice.

Nurse Practitioner Wendy Blanch noting she would be able to provide *'a more person-centred care for people who have drug and alcohol problems, comorbidities and mental health'*, and *'an exclusive service for patients that feel they are being listened to and have the time to manage their health and wellbeing.'*

The NPs were asked to rate their confidence before and after the workshop against the six core competencies of the program.

The competency where participants reported the greatest shift in confidence was in their ability to advise patients about new therapies for hepatitis C.

Ninety five per cent indicated they felt confident or very confident at the end of the day, this increased from 15% pre-workshop.

NPs are currently leading innovative models of hepatitis C care in settings where there may be a higher incidence of HCV infection, including alcohol and other drugs services, sexual health, needle and syringe exchanges, prison settings, psychiatric services, and in collaboration with peer workers, other nursing and non-nursing specialists.

Nurses and NPs are increasingly well positioned to support Australia's hepatitis C elimination response, as identified in the Fifth National Hepatitis C Strategy (DOH, 2018), through nurse led services, case finding and supporting patients with their treatment and management for improved health and wellbeing outcomes.

The *Hepatitis C in Primary Care and Drug and Alcohol Settings* Workshop will be run as a post conference workshop to the 2019 DANA Conference in Sydney, NSW.

References

Australian Government Department of Health. 2018. Fifth National Hepatitis C Strategy health.gov.au/internet/main/publishing.nsf/Content/ohp-bbvs-1/$File/Hep-C-Fifth-Nat-Strategy-2018-22.pdf Accessed Feb 2019

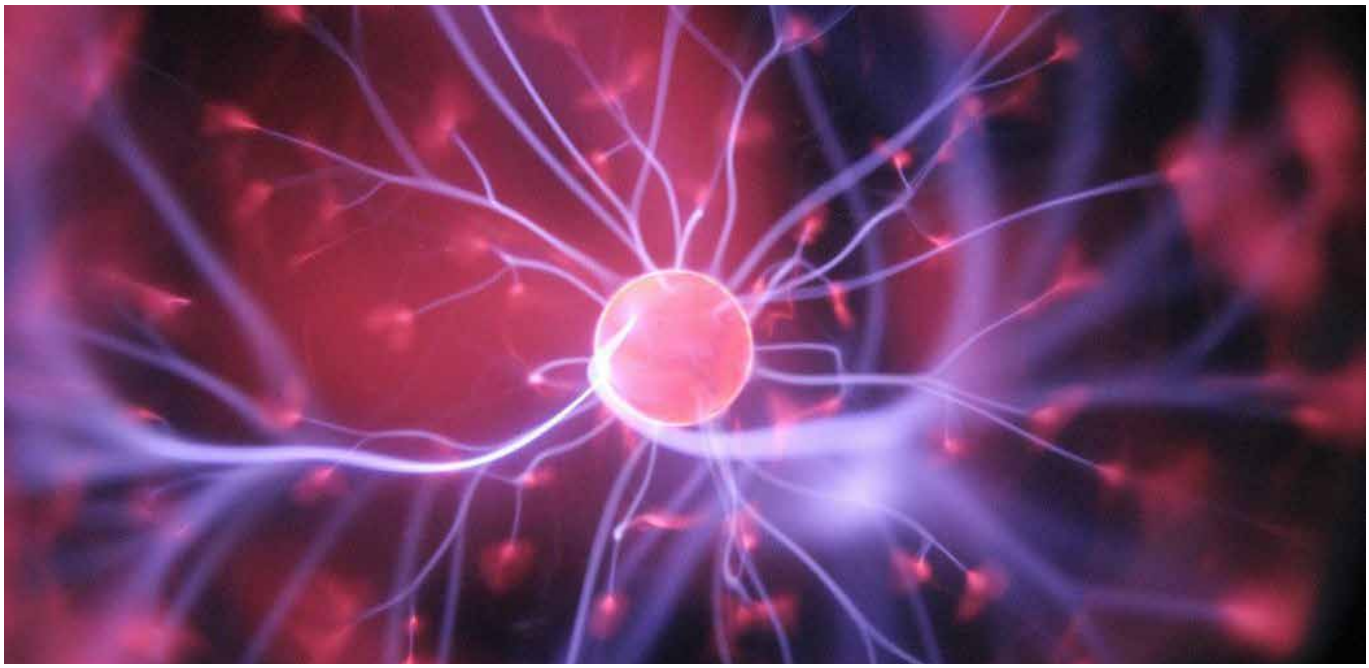
Australia Government Department of Health. 2018. General Statement for Drugs for the Treatment of Hepatitis C pbs.gov.au/info/healthpro/explanatory-notes/general-statement-hep-c Accessed Feb 2019

Cook, G., Andrieux Meyer, I., Applegate, T., Aturn, R., Burry, J., Cheinquer et al. 2019. Accelerating the elimination of viral hepatitis: a Lancet Gastroenterology & Hepatology Commission; *Lancet Gastroenterology & Hepatology;* 4(2):135-184

Authors

Olivia Dawson is Project Officer at the Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM)

Melinda Hassall is Clinical Nurse Lead-Nursing Program at the Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM)



Key findings for Community Health to create a positive ageing experience

By Georgia Tziros, Oliver Burmeister and Maree Bernoth

Social connection with others during later years of life is important and has been found to reduce the negative effects of ageing (Ermer & Proulix 2018). These social relationships can become more relevant or less relevant dependent on an individual's life stage and their own personal circumstances such as being married and/or their connections with family (Ermer & Proulix 2018).

The overwhelming literature in support of the importance of social connection in reducing negative experiences of mental health, shows that social connectedness needs to play a pivotal role in community health policies and community health programs (Holwerda et al. 2016; Burmeister et al. 2016).

These connections and how they build resilience are clear in the preliminary findings in research undertaken on older Greek migrants (Tziros, Burmeister & Bernoth 2019).

An older Greek person's connection to their culture and social connection play an important role in enhancing their mental health. In addition, it is clear that the experiences of migration and the negative impacts that this had has been buffered by connection to culture and social connections.

From a community health perspective, programs need to be formulated which encompass a cultural lense and acknowledge the importance of cultural connection and cultural planning when working with older people.

Our initial research findings demonstrate how imperative social groups are for older people to buffer onset of later life mental health issues.

The early implications of the research are that more work needs to be undertaken in a community health setting by nurses and other health professionals to ensure that older people are given the opportunity to enhance their mental health and overall have a positive ageing experience by being socially and culturally connected.

References

Burmeister, O.K., Bernoth, M., Dietsch, E., & Cleary, M. 2016. Enhancing connectedness through peer training for community dwelling older people: A person centred approach. *Issues in Mental Health Nursing, 37*(6), 406-411, DOI: 10.3109/01612840.2016.1142623.

Ermer, A.E., & Proulix, C. M. 2018. Associations between social connectedness. Emotional well-being, and self- rated health among older adults: Difference by Relationship Status. *Research on Ageing*, 1-26. DOI: 1177/0164027518815260

Holwerda, T. J., Van Tilburg, T. G., Deeg, D. J. H., Schutter, N., Van, R., Dekker, J., Stek, M. L., Beekman, A., & Schoevers, R. A. 2016. Impact of loneliness and depression on mortality: results from the Longitudinal Ageing Study Amsterdam. *The British Journal of Psychatry*, 209, 127-134. Doi; 10.1192/bjp.bp.115.168005

Tziros, G., Burmeister, O., & Bernoth, B. 2019. Respecting the meaning of culture and gender for older Greek women, *Australian Nursing & Midwifery Journal*, 26(5), 48.

Authors

Georgia Tziros, Family Reunification Practitioner, Department of Health and Human Services, BPsychSc, GradDipCoun, MAForMenHlth, MA SocWork. I am completing a Doctor of Health Science (DHlthSc) with my focus being older Greek migrants

Professor Oliver Burmeister, Professor in Information Technology, School of Computing and Mathematics, Charles Sturt University, Bth(Hons), BApSc, DipMin

Associate Professor Maree Bernoth, Research Lead, School of Nursing, Midwifery and Indigenous Health, Charles Sturt University, RN, BHSc(Nurs), MEd(AdultEd&Training)(Hons Class 1), PhD

Ben Chiarella

The future of chronic disease management is here … we just need to fund it

By Ben Chiarella

Across Australia there are small populations of chronically unwell people who are using Telehealth Home Monitoring Service to support them in the home to improve self-care, reduce avoidable hospital admissions and improve both their mental and physical health (LiveBetter 2018).

A short video found on Youtube **youtube.com/watch?v=szsT_OzcWX4** demonstrates how home monitoring works.

It is known that telemonitoring with videoconferencing empowers older people to understand and manage their own health better and has been demonstrated to be associated with improved health outcomes and reduced service use. Having regular, daily access to a Telehealth nurse was shown both to reassure participants and to trigger changes to services and behaviour that are likely to have positively affected patient outcomes (Nancarrow, Banbury & Buckley 2015).

The results speak for themselves. Some of the programs are reporting over a 50% reduction in emergency department presentations and up to a 28% reduction in potentially preventable hospital admissions. These cohorts are self-reporting increased confidence in both self-care and improved mental health scores. Similar programs are reporting reductions across the cohorts in blood pressure, blood glucose levels and resting heart rate as well as improvements in oxygen saturations and management of heart failure weight fluctuations (Barlow et al. 2007; Polisena et al. 2009; Inglis et al. 2011; Purcell, McInnes & Halcomb 2014).

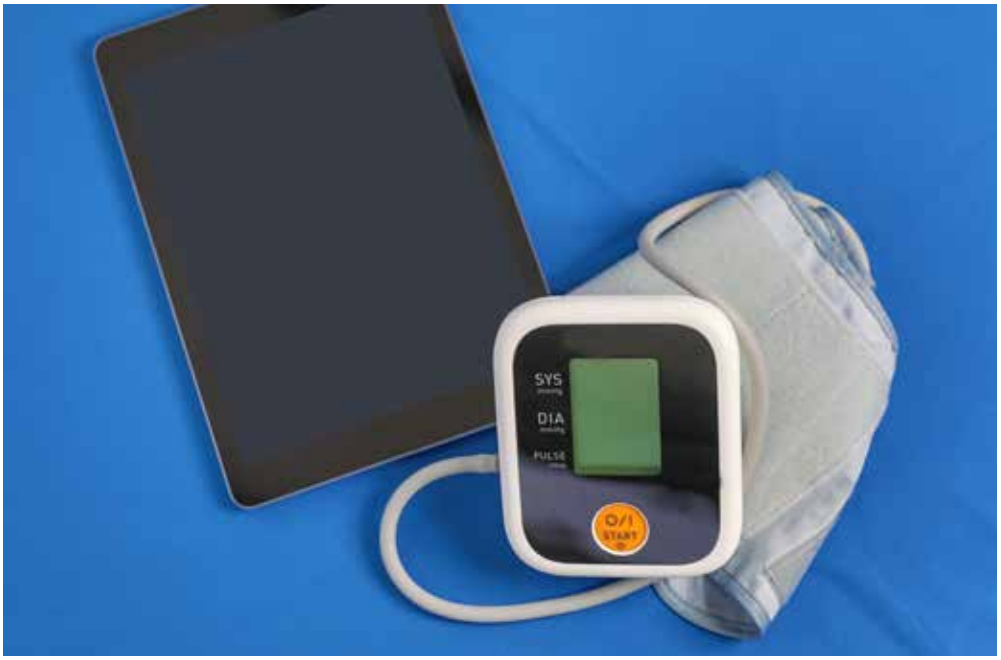
The anecdotal feedback from our patients is they have never felt more in control and better than they currently do.

Others have simply stated "Telehealth home monitoring has saved my life".

But despite these wonderful results, there is still no sustainable funding model for this model of wellness and care. For some reason governments are still happy to pump money into treatment for this population once they are admitted into hospital, funding them with long stays in Emergency Departments, Intensive Care Units and the specialist and general wards in our already bursting at the seams tertiary healthcare system.

So the challenge for the future healthcare policy makers must be how do we change this? How do we move the model of funding to a proven wellness support, illness prevention model, aimed at keeping people at home and cared for in the community sufficiently to reduce hospital bed days, whilst concomitantly improving their physical and mental health?

The solutions to our ever-growing chronic disease burden are everywhere, we just don't fund them yet.



References

Barlow, J., Singh, D., Bayer, S., Curry, R. 2007. A systematic review of the benefits of home telecare for frail elderly people and those with long-term conditions. *Journal of Telemedicine and Telecare;*13,172–9.

Inglis, S.C., Clark, R.A., McAlister, F.A., Stewart, S., Cleland, J.G. 2011. Which components of heart failure programmes are effective? A systematic review and meta-analysis of the outcomes of structured telephone support or telemonitoring as the primary component of chronic heart failure management in 8,323 patients: abridged Cochrane review. *European Journal of Heart Failure;* 13 1028–40.

LiveBetter Telehealth Home Monitoring. 2018. *Telehealth* [Online] livebetter.org.au/services/telehealth/ Accessed 7 February 2019

Nancarrow, S., Banbury, A. & Buckley, J. 2011. Evaluation of a National Broadband Network-enabled Telehealth trial for older people with chronic disease *Australian Health Review* 40(6) 641-648

Polisena, J., Tran, K., Cimon, K., Hutton, B., McGill, S., Palmer, K. 2009. Home telehealth for diabetes management: A systematic review and meta-analysis. *Diabetes Obesity Metabolism* 11, 913–30.

Purcell, R., McInnes, S., Halcomb, E.J. 2014. Telemonitoring can assist in managing cardiovascular disease in primary care: A systematic review of systematic reviews. *BMC Family Practice;* 15: 43

Author

Ben Chiarella RN, MN (Sydney), MBus (Sydney) BEd (Sydney) is Acting Team Leader Community Care & Telehealth Home Monitoring Program Lead, LiveBetter Community Services in Orange, NSW


MENTAL
HEALTH

Mental health risk assessment: Who decides?

By Edward Aquin, Christopher Patterson and Lorna Moxham

Mental health risk assessment practices have largely evolved in response to the perceived 'threat' posed to the community as a result of de-institutionalisation.

The alignment of risk assessment practices to corporate clinical governance structures followed, resulting in legislated and litigated activities for those who work in mental health clinical roles.

Contemporary mental health risk assessment practices have evolved into areas of highly structured and symptomatised clinical language about 'current' risk or 'potential' risk.

Risk is 'assessed' using formal and informal screening tools and documentation of formulations and findings.

Despite these formalities, from a global perspective, risk assessment practices in mental health settings are not standardised beyond a local service level.

Despite the lack of a consistent approach there are commonalities found in the literature which are suggestive that specific domains of risk like suicide, self-harm, harm to others, and vulnerability requires 'measuring'. Areas like these are the domains that are consistently being addressed in clinical practice and form the focus of risk assessment.

A plethora of criticisms regarding risk assessment within mental health literature abounds. Extensive denunciation relates to inconsistencies of practice ranging from assertions of reductionism, critique of the purported 'value' of screening tools, and most commonly the predominant focus upon risk aversion. All of these concepts are posited to having no measureable impact upon the reduction of adverse events involving suicide or violence (Manuel & Crowe 2014).

There are though, broader concepts of risk and in particular issues regarding self-neglect that are in urgent need of consideration.

Additionally, and probably most importantly is the long-standing critique that mental health risk assessment and treatment activities are undertaken without the consultation of people with a lived experience of mental illness.

In a milieu of collaborative recovery where *nothing about me without me* is the 'catch cry' such practices heavily impact upon therapeutic engagement and positive treatment outcomes with consumers.

Trends, practices and approaches undertaken in the clinical environment are often mirrored in tertiary educational environments – after all, students are expected upon graduation to hit the ground running and be ready for clinical practice as an RN. Given the inconsistency of mental health risk assessment approaches, what then, are universities teaching students about risk assessment. Are the processes and practices consistent, and, ultimately who decides what should (or not) be taught? This highlights a knowledge gap and provides an opportunity to discuss and define a more standardised approach for mental health nursing education around the topic and practice of mental health risk assessment (Woods 2013).

The importance of the development of undergraduate and post graduate education around risk assessment, perhaps better termed as safety-planning, that incorporates active consumer engagement and collaboration that is valued and meaningful, recovery concepts and acknowledgement of protective factors, is urgently required.

The participatory Action Research PhD project being undertaken by the first author, and supervised by the latter two, is addressing the knowledge gap of a standardised approach to mental health nursing education pertaining to the topic of mental health risk assessment. Importantly, the development of a contemporary safety planning 'tool' will have lived experience input from the get go.

It stands to reason that consumers are experts by experience and *nothing about me without me* – needs to be seen in action.

Reference

Manuel, J. & Crowe, M. 2014. Clinical responsibility, accountability, and risk aversion in mental health nursing: A descriptive, qualitative study. *International Journal of Mental Health Nursing*, 23(4), 336-343.

Authors

Edward Aquin, RPN, MN (Clinical), PhD candidate, University of Wollongong, Lecturer (MHN- ACU, Victoria)

Christopher Patterson, RN, BN (Hons), MNursing (Mental Health), Lecturer, University of Wollongong.

Lorna Moxham, PhD, RN, MHN, DAS (Nsg), BHSc, MEd, Professor of Mental Health Nursing, Global Challenge Lead – Living Well Longer, University of Wollongong

Cross disciplinary knowledge transfer: The experience of student to RN

By Caitlin Goman, Christopher Patterson and Lorna Moxham

Australian RN students are required to complete a minimum of 800 hours of supervised clinical placement throughout the course of their Bachelor of Nursing (BN) and can undertake these placements in a number of nursing settings.

It is asserted that within these placements students will learn skills and knowledge which they will then implement in their future nursing practice as a RN.

Clinical placements are crucial to producing 'work ready' graduates with placements purported to provide a realistic sense of the hours of nursing, improvements in time management and opportunities to understand what skills are required of a nurse. Once learned, this knowledge needs to be transferred.

Within nursing, knowledge transfer is understood as evidence based knowledge being applied to create evidence based nursing practice. Knowledge is commonly transferred from research and learning environments (the classroom or clinical placement) into clinical practice.

Within nursing the application of knowledge transfer is perceived to have a positive outcome in facilitating improvements in overall nursing care. This honours research explored how knowledge can be transferred from a student mental health clinical placement to RN nursing practice in a non-mental health setting.

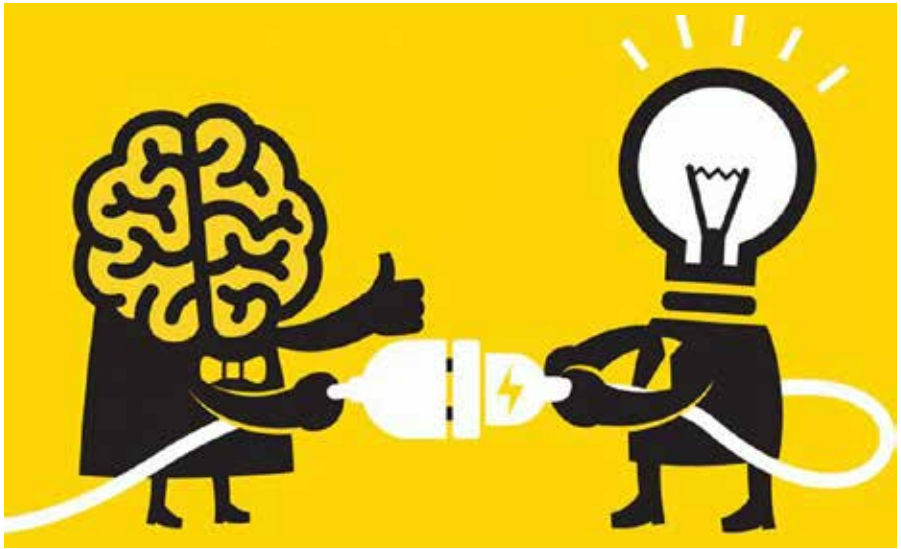
Using a qualitative paradigm, in-depth individual interviews were conducted with five RNs who currently work in non-mental health settings to explore the experience they had as a student nurse on mental health clinical placement (MHCP).

The aim was to examine their understanding of the knowledge transfer between the two settings and from student to RN. Using van Kaam's Psychophenomenological Method (PPM) the following three key themes were identified: Engagement, understanding mental health and holistic care.

All participants expressed that engaging with consumers during their MHCP had an impact then, and has an impact on their practice now.

Engagement in this context refers to being able to establish and maintain meaningful connection and was experienced through the elements of time, communication and building therapeutic relationships.

Because of that experience at XX I try to make time, like I rarely sit around in the nurse's station chatting to staff I generally try to go and have a chat with patients especially where I work with people on contact precautions with infection control it's a big barrier for patients. People sort of pop their head in because having to put on those yellow gowns and gloves and mask and all that is a bit of a pain, so it makes it quite isolating for the patient so I definitely go in and spend more time trying to get to know them and give them someone to talk to restrict that isolation (Tom).



Understanding mental health was identified through participants' descriptions of shifts in their knowledge and understanding of mental health, mental illness and the treatment and interventions options available. Understanding mental health refers to being able to interpret the meaning of mental health and not to be critical or judgemental, which participants said they regularly reflect on.

It has made me not really judge people on a face to face value now. I think as a result regardless whether it's a mental health condition or whatever their illness is I try to be more empathetic and I try not to judge on face value now (Barbara).

Holistic care relates to participants' description of caring for all aspects of a person including social and psychological components of care not just the physical and physiological components. Participants learning of the significance of holistic care was described as being important to their current practice and closely linked with RN practice being person centred.

My student MHCP helped me because when I look at one of the residents at work and they've got some type of illness as well as mental health issues, I don't only see the illness I see them as a person more than just the clinical aspects (Mary).

The elements above informed the overarching theme of meaningful connections. Participants described the importance of forming and maintaining meaningful connections with those who they now termed as 'their patients'.

They described their MHCP as a learning experience that made them really appreciate the importance of person centred care and the value of the person's own experience.

The RN participants stated that if you want to 'know your patients' then you need to connect with them in a meaningful way and suggested that this was the foundation of nursing care.

Having a real meaningful nurse patient relationship and spending time with patients like I said before it's just one of those things that I really focus on and I think my MHCP has a lot to do with that (Gina).

Authors

Caitlin Goman, RN, BN (Hons) candidate, University of Wollongong

Christopher Patterson, RN, BN (Hons), MNursing (Mental Health), Lecturer, University of Wollongong

Lorna Moxham, PhD, RN, MHN, DAS (Nsg), BHSc, MEd, Professor of Mental Health Nursing, Global Challenge Lead; University of Wollongong

Experts by experience sharing personal knowledge to enhance the learning of undergraduate nursing students

By Caroline Picton, Lorna Moxham and Christopher Patterson

The term 'experts by experience' is used to describe people who possess personal knowledge of having a mental illness and their experience of using mental health services (Curran, Sayers & Percy-Smith 2015).

People who are experts by experience are now using their unique knowledge of mental health to assist with the learning of Bachelor of Nursing students. As part of their education, nursing students attend the purposely structured and immersive mental health placement, known as *Recovery Camp,* for 5-days and 4-nights. *Recovery Camp* offers a recovery focussed program for nursing students to participate together with people with a mental illness in recreation activities devised to promote mental health, social engagement and physical activity. The group activities are designed to challenge individuals to extend themselves as well as offering a relaxed social milieu to facilitate the sharing of personal insights. One session intentionally focuses on people who are experts by experience freely sharing their insights on mental health with nursing students.

A PhD qualitative study, examined the perspectives of 25 people with a mental illness (n=25) who participated at *Recovery Camp.*

The findings highlighted a sense of meaningful purpose from sharing their personal insights with nursing students.

Using a phenomenological approach to analyse the narrative data, five elements related to sharing personal expertise with nursing students were identified. These elements are:

1. to be heard;
2. telling it like it is;
3. reducing the power imbalance;
4. boosted self-esteem; and
5. optimism.

All participants described that when sharing their knowledge, they valued the opportunity to be heard, and to be able to tell it like it is from their perspective. In sharing their stories, participants described they had challenged the students' perceptions surrounding having a mental illness and the stigma that exists. Participants described experiencing a more balance of power that would normally exist between themselves and health clinicians, which boosted their self-esteem. Finally, a sense of optimism was described culminating with an overall theme of a deep sense of purpose from their contribution to student learning.

The following quotation from Rory, one of the study's participants, represents the sense of empowerment that was expressed and why participants believe opportunities at *Recovery Camp* make a difference.

I think the camp does make it easier for them [students sic] to listen and take on board our stories and be better nurses because they understand us more. Because of the connections and bonds we already have formed and the large amount of time we have spent together listening, chatting and communicating. I think they will be touched by our stories and our lives. The nursing students here at the camps are going to be, in 10 years' time, in the front line making those decisions about the care [. . .]. It is empowering for me to have this chance to do this. It is incredible really that we do get the chance to make a difference. I am very optimistic for change (Rory; lines 237-250).

The study's findings suggest that *Recovery Camp,* as an atypical and immersive clinical placement, benefit people with a mental illness who described feeling empowered when purposely contributing their expertise of mental health recovery to enhance student learning.

Reference

Curran, T., Sayers, R. and Percy-Smith, B. 2015. Leadership as experts by experience in professional education. *Procedia-Social and Behavioral Sciences.* 186(1): 624-629.

Authors

Caroline Picton, RN, BN (Hons), PhD candidate, University of Wollongong

Lorna Moxham, PhD, RN, MHN, BHSc, Professor of Mental Health Nursing, Global Challenge Lead; University of Wollongong

Christopher Patterson, RN, BN (Hons), PhD candidate, MNursing (Mental Health), Lecturer, Subject Coordinator (undergraduate and post-graduate), University of Wollongong

Should there be a separate emergency department for clients with mental illness?

By Laxmi Bhengra

Dramatic changes have occurred in the area of mental health presentations to emergency departments (ED) throughout Australia during the period from 2004–2005 to 2016–2017.

The results reported from the Australian Institute of Health and Welfare (2017) show a 99.6% increase over this time (138,279 to 276,954 presentations). The rationale behind these changes suggest increased mental health awareness through government funded community programs and increased advertising of support services such as Lifeline, Accessline, Beyond Blue and more.

Such increases in service demand has led to some ED staff considering the question of whether people with mental health concerns would benefit from having a mental health specifically focused ED.

The care of some mental health patients in emergency departments brings its own unique set of challenges.

Providing care to patients presenting with behavioural disturbance, suicidal ideation or self-harming behaviours (often with the added context of drug or alcohol intoxication) is demanding.

Organisational issues such as time pressures, boarding of patients waiting for inpatient mental health beds and the inherent difficulty predicting imminent self-harm sit alongside the clinical reasons for the patient's presentation and add to the complexity of care provision.

Schnyder et al. (2017) discuss stigma as a potential barrier for people with mental health related issues not accessing health services.

Separate EDs are not provided for people with other illnesses.

Providing separate EDs for people with mental health issues is a stigmatising process for this already marginalised group.

Physical health symptomology being attributed to mental illness causation is described by Jones, Howard and Thornicroft (2008) as being widespread.

This indicates that along with mental health issues, the physical health needs of any person presenting to emergency departments need to be considered in a holistic manner.

With any person presenting with what appears to be mental health related symptomology there must always be a comprehensive physical health assessment completed to ensure that there is no organic cause for the presentation.

The stigmatisation impact of providing a separate ED for people with mental health problems has the potential for adding more despair, lowering self-esteem and further disempowering this cohort within society.

This process of providing a separate ED is also likely to further detrimental effects on the patient's physical health, prognosis and wellbeing.

People with mental health challenges are entitled to attend an ED and receive the same standard of care as any other person presenting with some other illness.

References

Australian Institute of Health and Welfare (AIHW). 2017. Emergency department care 2016–17: Australian hospital statistics. Health services series no. 80. Cat. no. HSE 194. Canberra: AIHW.

Jones, S., Howard, L., & Thornicroft, G. 2008. Diagnostic overshadowing: Worse physical health care for people with mental illness. *Acta Psychiatrica Scandinavica*, *118*(3), pp.169-171

Schnyder, N., Panczak, R., Groth, N., & Schultze-Lutter, F. 2017. Association between mental health-related stigma and active help-seeking: Systematic review and meta-analysis. *The British Journal of Psychiatry*, pp.bjp-bp.

Author

Laxmi Bhengra is a CNC at the Mental Health Emergency Consultation Service, Murrumbridgee Local Health District in NSW

Youth the focus of new model of care

By Brian Cowie

With a passionate focus on patient care, the Youth Hospital in the Home (YHiTH) service works out of Graylands Hospital in Western Australia and sets about providing a contemporary service that presents as an alternative to mental health hospital admissions and treatment for youth.

The youth population has been identified as having a set of needs distinct from those of children, adolescents or adults, with a limited number of services targeting their unique needs and stressors.

Born from the recognition that existing services did not adequately meet these needs, care is delivered as a dedicated, youth-appropriate, community-based service to young people aged 16-24 experiencing complex mental health issues, usually in their home instead of a hospital.

It is believed that the YHiTH is the first youth-specific designed model in the world.

The clinical services are equal to that of a hospital setting, but focus on actively accessing additional community services to help support a young person with their day-to-day activities. This is key to patient care and lessens the impact on carers and families.

Registered Mental Health Nurse Chris Ward, who has been part of the service since 2017, put its success down to the desire of staff to bring about the best outcomes for patients.

Chris explains that, "It's about the relationship we build with patients, family and carers that is important. We put a lot of time and effort into ensuring our patients and carers are fully informed and part of the decision-making of their treatment, and this leads to better understanding and acceptance."

The program has never looked back since commencing in early 2017 with over 160 people treated in the first 12 months. Now with eight beds and a staff of 12, they operate at almost full capacity every day.

Clinicians work in partnership with the individual and their families or carers for around 14 days to provide intensive support, education and guidance. Where possible, clinicians work with the individual's general practitioner to enable better communication and continuity of care.

The multidisciplinary team of highly experienced and skilled mental health clinicians conduct daily home visits to provide risk assessment and management, medication monitoring, brief therapeutic intervention, carer support, supportive counselling, and psychoeducation to patients and their families.

Feedback from young people and carers, goes a long way towards the improvement of outcomes and shaping the way the services are provided. Looking forward the YHiTH aims to continue and enhance their working relationship with stakeholders and other mental health services along with putting in place initiatives such as a Carer Support Service and a physical health monitoring program.

On a high point, evaluation after the first 12 months revealed 94.4% of carers were satisfied with the quality of care, and 100% found the service convenient. Additionally, 90% of referrers found the service accessible and all respondents were satisfied with the service.

Author

Brian Cowie is the Media Coordinator at North Metropolitan Health Service in WA.

Nicholas Procter

Preventing refugee and asylum seeker suicide

By Nicholas Procter

For the past 24 months the University of South Australia's (UniSA) Mental Health and Suicide Prevention Research Group (MHSPRG) in partnership with the Australian Red Cross and those with lived experience of suicide related distress, have developed a specialist suicide prevention program for refugees and asylum seekers in the Australian community.

In Australia, policies which promote deterrence, temporary protection and prolonged detention are further contributing to existing pre and post arrival risk factors for mental illness and suicidal behaviour among asylum seekers and refugees. Many among this group have been under significant psychological strain waiting up to six years to have their refugee protection claims assessed.

Living with uncertainty for the future is known to be harmful to mental health. There have been at least 21 suspected or confirmed suicide deaths among refugees and asylum seekers in the past four years; five deaths occurred in 2018. This calculates as a standardised suicide rate of approximately 33 per 100,000 for male asylum seekers, significantly higher than males in the general population of Australia (19.2/100,000).

There is a clear need for targeted suicide prevention initiatives for refugees and asylum seekers. Suicide prevention education or 'gatekeeper training' is one such way to address this need. In response to this dire need the MHSPRG crowdfunded a research project, in 2017. The crowdfunding raised over $50,000.

The funding raised enabled the MHSPRG team to provide a two-day targeted suicide prevention education program for over 450 government and non-government sector workers including nurses, social workers, case workers and volunteers, who work with refugees and asylum seekers, at 13 different sites nationally.

Analysis of the impact of the educational intervention are promising. Findings revealed that a two-day targeted suicide prevention education program has led to significant improvements in workers' confidence, attitudes and competence, key markers associated with a worker's ability to more effectively identify, manage and reduce suicide. Targeted suicide prevention initiatives are vital for understanding and responding to the unique nature of refugee and asylum seeker suicidal behaviour. Qualitative interviews were also conducted with participants. This data is currently being analysed.

What has been critical in this program is the combined elements of expert knowledge, research evidence and lived experience of refugee and asylum seeker suicidality. Such elements formed the basis of developing the content of the program. Those attending were challenged into new ways of thinking around trauma-informed care, a person-centred approach and human connectedness.

Trauma-informed care is an approach that avoids re-traumatisation and fosters a safe environment, promotes an empowerment of the individual in order to enable healing (SLICP 17; **health.harvard.edu/blog/trauma-informed-care-what-it-is-and-why-its-important-2018101613562**).

A person-centred approach to suicide prevention with refugees and asylum seekers enables the individual seeking help to lead the discussion and co-facilitate solutions. Human connectedness – helping vulnerable asylum seekers to 'feel felt' by the nurse – has also been a crucial feature.

Author

Nicholas Procter PhD, MBA, RN, Chair, Mental Health Nursing, School of Nursing & Midwifery, University of South Australia

Borderline personality disorder: Carers need compassion and collaboration when seeking emergency care for their loved one

By Kristy Acres, Mark Loughhead and Nicholas Procter

Borderline Personality Disorder (BPD) is a common mental illness impacting around 1 to 4% of the Australian population (National Health and Medical Research Council (NHMRC) 2012).

People with BPD often have difficulties in regulating emotions and impulses and are at a high risk of suicide and self-harm. The rates of death by suicide are between 3 and 10% for people living with BPD (NHMRC 2012). A rate higher than the general population (NHMRC 2012).

Reviewing the literature on carer perspectives for a person with BPD when seeking emergency care responses, identified that the emergency department (ED) was where most carers and consumers present in a crisis related to BPD.

Carers, often a parent or spouse go the ED when their loved one is in crisis as this is the only viewed option of where to go. However, the emergency care and management of BPD is complex and resource intensive due to suicidal ideation (Acres, Loughhead & Procter 2018).

ED nursing staff are an early contact point, they are tasked with maintaining safety and reducing the impact of the crisis. Despite taking on this role, many nurses have not received training in responding to and managing people with BPD which becomes a barrier to the consumers' recovery (Morphet et al. 2012).

Carers have experienced medical discrimination based on diagnostic label (Lawn & Mcmahon 2015). Many have reported that support and information was not provided by healthcare professionals when requested. Despite the lack of communication carers are often relied upon to make treatment decisions with a lack of information which impacts their ability to make an informed decision (Dunne et al. 2013).

Collaborative relationships and improved communication between nursing staff, healthcare professionals and carers on how to manage crisis and high-risk situations is one way to keep carers informed.

In addition, maintaining a trauma informed approach is vital in the recovery process for the carer and the consumer. By practicing kindness, empathy and developing trust with nursing staff, carers and consumers are encouraged to engage in the recovery process which can lead to improved outcomes (Acres, Loughhead & Procter 2018).

Authors

Kristy Acres RN, BN, ADip MNGT, ADip HR, Cert MH, Cert AOD, Honours Candidate, School of Nursing & Midwifery, University of South Australia

Mark Loughhead PhD, Lecturer: Lived Experience, School of Nursing & Midwifery, University of South Australia*
** A position jointly supported by UniSA and Mind Australia Ltd.*

Nicholas Procter PhD, MBA, RN, Chair, Mental Health Nursing, School of Nursing & Midwifery, University of South Australia

References

Acres, K., Loughhead, M., & Procter, N. 2018 (In press). Perspectives of family carers for people diagnosed with borderline personality disorder: A scoping review on the emergency care responses of nurses and other health professionals. *Australasian Emergency Care*.

Dunne, E. & Rogers, B. 2013, It's us that have to deal with it seven days a week: Carers and borderline personality disorder, *Community Mental Health Journal*, vol. 49, no. 6, pp. 643-648.

Lawn, S. & Mcmahon, J. 2015. Experiences of care by Australians with a diagnosis of borderline personality disorder, *Journal of Psychiatric and Mental Health Nursing*, vol. 22, no. 7, pp. 510-521.

Lieb, K., Zanarini, M.C., Schmahl, C., Linehan, M.M. & Bohus, M. 2004. Borderline personality disorder, *The Lancet*, vol. 364, no. 9432, pp. 453-461.

Morphet, J., Innes, K., Munro, I., O'Brien, A., Gaskin, C.J., Reed, F. et al. 2012. Managing people with mental health presentations in emergency departments: A service exploration of the issues surrounding responsiveness from a mental health care consumer and carer perspective, *Australasian Emergency Nursing Journal*, vol. 15, no. 3, pp. 148-155.

National Health and Medical Research Council. 2012. Clinical practice guidelines for the management of borderline personality disorder, Available from nhmrc.gov.au/guidelines-publications/mh25 (5 February 2019).


DRUGS
& ALCOHOL

The Alcohol Harm Paradox: Rethinking the factors that cause harm

By Scott Steen

Paradoxes in healthcare are interesting as they signify a contradiction, a challenge to conventional thinking, revealing new insights and demand for alternative strategies. There are perhaps none quite so intriguing as the 'Alcohol harm paradox'.

Studies show that alcohol-related harm has a disproportionate effect on people living in lower socioeconomic areas despite consuming similar or lower amounts than their affluent counterparts (Bellis et al. 2016; Livingston 2014; Katikireddi et al. 2017).

Various suggestions have been put forward as to why disadvantaged populations might suffer more harm despite similar or lower levels of alcohol intake. It has been suggested that individuals living in less affluent areas exhibit other harmful behaviours which have multiplicative effects on associated harms including smoking, poor diet, obesity, and lower levels of exercise (Bellis et al. 2016). However, even after controlling for these factors, discrepancies remain (Katikireddi et al. 2017; Livingston 2014).

Another possible explanation relates to consumption patterns within populations. Studies have shown that those from more deprived areas are likely to drink at extreme levels which, when aggregated, become masked by lighter drinkers and abstainers (Lewer et al. 2016).

Other findings suggest these populations are more likely to engage in binge drinking behaviours leading to a greater chance of injury (Bellis et al. 2016), although the evidence is mixed (Katikireddi et al. 2017; Livingston 2014). Equally, alcohol-related harms could be amplified by local factors which limit access to healthcare, including poor transport links, longer waiting times and stigmatising attitudes about alcohol intake and dependence (Jones et al. 2015).

Guidelines on alcohol intake emphasise the weekly limits on consumption to reduce related harms. However, the alcohol harm paradox teaches us those from highly deprived areas might be less protected despite drinking similar or lower levels than their more affluent counterparts. Therefore, it is important as health professionals not to look at alcohol intake in isolation but to recognise the complex nature of an individual's social and environmental circumstances.

Author

Scott Steen is Research Lead, SILC UK, BSc (Hons), PhD, in Birmingham UK

References

Bellis, M.A., Hughes, K., Nicholls, J., Sheron, N., Gilmore, I. and Jones, L. 2016. The alcohol harm paradox: Using a national survey to explore how alcohol may disproportionately impact health in deprived individuals. *BMC Public Health*. 16:111.

Jones, L., Bates, G., McCoy, E. and Bellis, M.A. 2015. Relationship between alcohol-attributable disease and socioeconomic status, and the role of alcohol consumption in this relationship: A systematic review and meta-analysis. *BMC Public Health*. 15(1):400.

Katikireddi, S.V., Whitley, E., Lewsey, J., Gray, L. and Leyland, A.H. 2017. Socioeconomic status as an effect modifier of alcohol consumption and harm: Analysis of linked cohort data. *The Lancet Public Health*. 2(6):e267–e276.

Lewer, D., Meier, P., Beard, E., Boniface, S. and Kaner, E. 2016. Unravelling the alcohol harm paradox: A population-based study of social gradients across very heavy drinking thresholds. *BMC Public Health*. 16:599.

Livingston, M. 2014. Socioeconomic differences in alcohol-related risk-taking behaviours. *Drug and Alcohol Review*. 33(6):588–595.

Driven to drink: Australian-first study sheds more light on factors influencing youth drinking

Stop marketing alcohol to children on television and you would reduce youth drinking according to longitudinal research study on the push/pull factors that influence adolescents' drinking behaviours.

The research found alcohol advertising exposure directly influenced and encouraged adolescents to engage in risky drinking.

The study, *How do alcohol control policies influence Australian adolescent drinking trends?,* is the first Australian study to examine the relative influence of multiple alcohol policies, television alcohol advertising, retail alcohol outlet density and the proportion of alcohol-related articles in daily newspapers, on the drinking behaviour of adolescents.

The research study was led by the Cancer Council of Victoria and funded by National Health & Medical Research Council Partnership Project, the Foundation for Alcohol Research and Education (FARE) and VicHealth.

Lead author Dr Victoria White says the report is important research looking at the policy and social environment variables that influence the drinking behaviour of young people.

"One of the key findings of this report is that the risky drinking of adolescents can be reduced by restricting youth access to alcohol, reducing the availability of alcohol and reducing television advertising," Dr White said.

"The study emphasises the important role of government-led, population-directed policies in cutting the strings on alcohol inducements that pull our young generations towards problem drinking."

FARE Chief Executive Michael Thorn agrees and says the study shows the power the alcohol industry wields over adolescents.

"This study is yet further evidence that when the alcohol industry increases TV advertising and boosts the density of local bottle shops, it directly influences and encourages adolescents to engage in risky drinking," Mr Thorn said.

Opioids and Benzodiazepines: The risk of death

By Olivia Sonnerborn

Death from drug overdose has increased steadily in the past 20 years in the US, with a similar trend in Australia and across the developed world, with the increasing trend in drug overdoses connected to patterns of increased opioid prescribing (Park et al. 2015).

Opioids and benzodiazepines are widely prescribed, and co-prescribed despite concomitant use being contraindicated and dangerous.

Both opioids and benzodiazepines have significant sedative effects, where concurrent use generates a high risk of adverse outcomes and mortality. Opioids play an important role in managing acute, severe pain, but have a limited role in chronic, non-cancer pain (Babalonis & Walsh 2015).

Co-prescribing of opioids and benzodiazepines can occur incidentally from patients attending numerous doctors for different conditions, with multiple prescribers. Additionally, patients can also engage in illegitimate 'doctor-shopping' to receive controlled medications (such as opioids and benzodiazepines) from various sources, especially as benzodiazepines are often used or misused to enhance the euphoric effects of opioids (Babalonis & Walsh 2015; James, Mogali & Comer 2012).

There is a three-fold risk of death from drug overdose for patients prescribed opioids and high-dose benzodiazepines (>40mg diazepam equivalents) at the same time (Babalonis & Walsh 2015; Ekström et al. 2014).

The risk of death from drug overdose in patients prescribed opioids and benzodiazepines increases as the dose of benzodiazepines increases. Although toxicity from benzodiazepines in young adults is considered low risk, over-sedation effects from

benzodiazepines are believed to be magnified when used in combination with other drugs with sedating properties, such as opioids (Park et al. 2015; James, Mogali & Comer 2012).

The significant number of deaths from opioids and benzodiazepines are often under acknowledged.

Deaths from opioids increased three-fold between 2001 and 2013, with benzodiazepines also substantially contributing to drug induced deaths **(Table 1)** (Babalonis & Walsh 2015).

Addiction medicine Drug and Alcohol Services are at the forefront of tackling concomitant use of opioids and benzodiazepines, as high dose benzodiazepine use is most prevalent in persons prescribed opioid replacement substances, such as Methadone or Buprenorphine (James, Mogali & Comer 2012).

Although opioid use alone has adverse effects on morbidity, there is a significant risk of complications and death with the combined use of opioids and benzodiazepines. Education and awareness to prescribers continues to be important to reduce the amount of opioids and benzodiazepines available to individuals, although misuse and diversion of these medicines is difficult to detect and monitor.

Author

Olivia Sonneborn is Lecturer Practitioner – Peri-anaesthetic Care, Stream Co-ordinator Masters of Nursing (Peri-anesthetic Care), Pain Management CPD- Coordinator at Alfred La Trobe Clinical School and Faculty of Health Sciences, La Trobe University

Olivia Sonnerborn

TABLE 1: Drug induced deaths in Australia 2016

DRUG	NUMBER OF DEATHS	DRUG TYPE
Opioids	992	Oxycodone & Codeine (550) Fentanyl, Tramadol, Pethidine (234) Methadone (208)
Illicit Drugs	724	Amphetamine, Ecstasy, MDA, MDMA, Speed, ICE, Caffeine, Methamphetamine
Benzodiazepines	663	Alprazolam, Diazepam, Oxazepam, Clonazepam, Clozapine, Temazepam, Oxazepam

(Australian Bureau of Statistics 2018)

References

Australian Bureau of Statistics. 2018. Drug induced deaths in Australia: A changing storyabs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2016~Main%20Features~Drug%20Induced%20Deaths%20in%20Australia~6 Accessed Jan 2018

Babalonis, S. & Walsh, S.L. 2015. Warnings unheeded: The risk of co-prescribing opioids and benzodiazepines. *PAIN: Clinical Updates*. 1-7.

Ekström, M.P., Bornefalk-Hermansson, A., Abernathy, A.P. & Currow, D.C. 2014 Safety of benzodiazepines and opioids in very severe respiratory disease: National prospective study. *BMJ*, 348. 1-10.

James, J.D., Mogali, S. & Comer 2012 Polydrug abuse: A review of opioid and benzodiazepine combination use. *Drug and Alcohol Dependence*, 125. 8-18.

Park, T.W., Saitz, R., Ganoczy, D., Ilgen, M.A. & Bohnert. 2015. Benzodiazepine prescribing patterns and deaths from drug overdose among US veterans receiving opioid analgesics: Case cohort study. *BMJ*, 350. 1-8.

Exploring undergraduate nursing students' knowledge and attitudes of the management of patients with a drug and/or alcohol substance use disorder: An Australian perspective

By Darren Smyth

Drug and alcohol related problems contribute significantly to acute hospital admissions with estimated rates of 16–35% of patients presenting to Emergency Departments having problematic AOD use (NSW Health 2015; Roche et al. 2006).

However, many healthcare professionals, including nurses, have not been properly educated about drug and alcohol use disorders and their responsibilities regarding patient care. Therefore, upon graduation nurses and midwives are not prepared to manage patients with a substance use disorder, thus resulting in inappropriate treatment (Baldwin et al. 2009; Crothers et al. 2013).

It is the responsibility of registered nurses and midwives to adhere to the policies and guidelines that govern their clinical practices in regard to assessment, treatment and referral, outlined within New South Wales health policy directives and guidelines (NSW Health 2008).

However, with the lack of drug and alcohol content in the undergraduate degree, nurses and midwives are reported to be largely unaware of these responsibilities (National AOD WFD Strategy 2014).

Current evidence available states that as a result of a lack of drug and alcohol education in undergraduate education these disorders are poorly managed within the healthcare setting by all healthcare professionals (Boekel et al. 2013; Nash et al. 2017).

Historically nursing and midwifery students have not received adequate education in the management of substance use disorders (Martinez & Murphy-Parker 2003; Nash et al. 2017).

Research indicates that nurses and midwives' attitudes, stigma and discrimination of patients with a substance use disorder as front-line workers and gate keepers to assessment, treatment and referral has been noted considerably as a barrier to healthcare (Pauly et al. 2015).

A South Australian study of grey literature by Tran et al. (2009) reported discrimination and denial of medical treatment, to vulnerable groups, including Aboriginal people presenting with drug and alcohol problems seeking treatment in public hospitals and health facilities. This has led to poor outcomes such as disability, serious complications and exacerbation of health conditions including death. Patients with AOD use disorders are reported to be categorised as deviants, immoral and criminal, further adding to stigma and discrimination (Nash et al. 2017; Rassoul et al. 2006; Pauly et al. 2015), even though advances in neuroscience classify substance dependence as a legitimate health condition not unlike other medical diseases (Williamson 2012).

Author

Darren Smyth is a Clinical Nurse Consultant Drug and Alcohol at Northern NSW Local Health District

References

Australian Institute of Health and Welfare. 2018. Impact of alcohol and illicit drug use on the burden of disease and injury in Australia: Australian burden of disease study 2011. Australian Burden of Disease Study series no. 17. Cat. no. BOD 19. Canberra: AIHW.

Baldwin, J.N., Bartek, J.K., Scott, D.M., Davis-Hall, R.E., DeSimone, E.M. 2009. Survey of alcohol and other drug use attitudes and behaviour in nursing students. *Substance Abuse*, 30:230-238.

Boekel, L.C., Brouwers, E.P.M., van Weeghel, J. 2013. Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: Systemic review. *Drug and Alcohol Dependence*, 131, 23-25.

Crothers, C.E., Dorrian, J. 2011. Determinants of nurses' attitudes towards the care of patients with alcohol problems. *International Scholarly Research Network ISRN Nursing*, ID 821514

Martinez, R.J.; Murphy-Parker, D. 2003. Examining the relationship of addiction education and beliefs of nursing students towards persons with alcohol problems. *Archives of Psychiatric Nursing*, Vol XV11, No 4 pp 156-164.

Nash, A.J., Marcus, M.T., Cron, S., Scamp, N., Truitt, M., McKenna, Z. 2017. Preparing nursing students to work with patients with alcohol or drug-related problems. *Journal of Addiction Nursing*, 28, (3), 124-130.

National Alcohol and Other Drug Workforce Development Strategy: 2015 – 2018. 2014. National AOD WFD Strategy 2015-2020: Intergovernmental committee on drugs. nationaldrugstrategy.gov.au/

NSW Health. 2008. Nursing & Midwifery Clinical Guidelines-Identifying & Responding to Drug & Alcohol Issues health.nsw.gov.au/policies/gl/2008/pdf/GL20

Pauly, B., McCall, J., Browne, A.J., Parker, J., Mollison, A. 2015. Towards cultural safety - Nurse and patient perceptions of illicit substance use in a hospitalized setting. *Advances in Nursing Science*, 38, (2), 121-135.

Rassoul, G.H., Villar-Luis, M., Carraro, T.E. 2006. Undergraduate nursing students perceptions of substance use and misuse: A Brazilian position. *Journal of Psychiatric and Mental Health Nursing*, 13, 85-89.

Roche, A., Freeman, T., Skinner, N. 2006. From data to evidence, to action: Findings from a systemic review of hospital screening studies for high risk alcohol consumption. *Drug Alcohol depend. 2006*; 83: 1-14.

Tran, D., Stone, A., Fernandez, R., Griffith, R. & Johnson, M. 2009. Does implementation of clinical practice guidelines change nurses' screening for alcohol and other substance use? *Contemporary Nurse* (2009) 33(1): 13–19.

Williamson, L. 2012. Destigmatizing alcohol dependence: The requirement for an ethical (not only medical) remedy. *American Journal of Public Health*. May 2012, Vol 102, No. 5

Cartoon by Madie Palmieri

Come up with the funniest caption and you could win a $50 Coles/Myer card.
The winning caption will be published in the next issue of the *ANMJ* and on the *ANMJ* website.

Send your caption to
FUNNYCAPTION@ANMF.ORG.AU

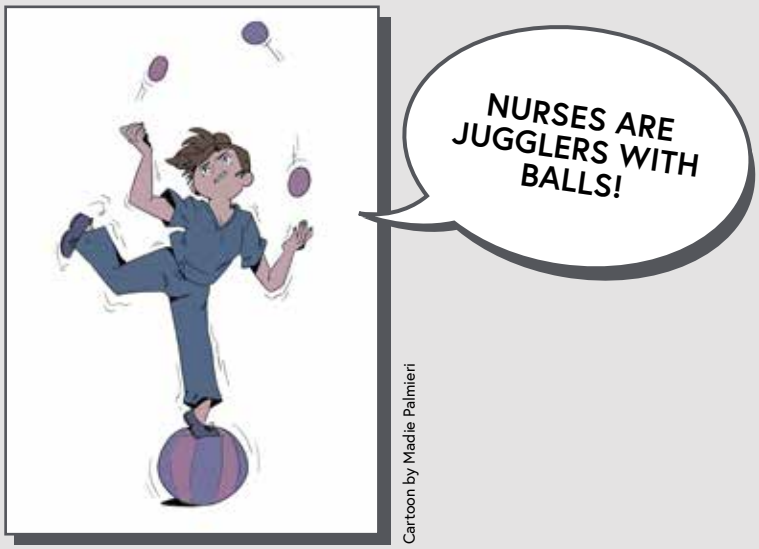
Go to **anmj.org.au** for terms and conditions.
Competition closes 24 May 2019

CONGRATULATIONS!

CHRIS HALL
for your winning entry. A $50 Coles/Myer card is on the way to you.

Thank you to all who entered our funny caption competition in the last issue of the *ANMJ*.

The *ANMJ* staff had a great laugh at all the funny entries. Unfortunately there can only be one winner.



Cartoon by Madie Palmieri

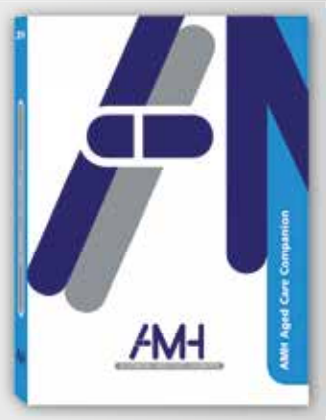
You'd be wise to be up to date.

AUSTRALIAN MEDICINES HANDBOOK

SPECIAL OFFER
For ANMJ readers. Purchase your hard copy for only
$90
incl. P&H
#Conditions apply

AMH Aged Care Companion

The current release of the AMH Aged Care Companion contains updated information on allergic conjunctivitis, dry eyes, gout, heart failure, hypertension, insomnia, osteoporosis, major depressive disorder, pain management, restless legs syndrome, rhinitis, rhinosinusitis (formerly sinusitis), along with changes to several other topics. New drug names have been incorporated in accordance with the TGA's adoption of changes to approved drug names in the Australian Register of Therapeutic Goods (ARTG). AMH Aged Care Companion available now in print or online. Go to www.amh.net.au for more information.



ORDER DETAILS (All prices include GST)	AMH Retail Price (Single Item)	ANMJ Reader Price (Single Item)	P & H (Single Location)	Quantity Required	Total Price (including P & H)
AMH Aged Care Companion Book 2018	$105.00	$90.00#	FREE#		

#DISCOUNT PRICE & FREE P&H: Place your order before 30th May to receive the ACC Book at the discounted price with free postage & handling.

	TOTAL	$

PURCHASER DETAILS Please complete all sections Electronic version purchasers MUST provide email address

Company / Business Name

Contact Name | Title

Delivery Address | State | Postcode

Email | Daytime Phone | Mobile Phone

From time to time you will receive AMH marketing communications such as information on new product releases and updates, special offers and other marketing material. In keeping with our privacy policy you can choose to opt out by ticking the following options. By email NO ☐, by post NO ☐. You can change your preferences at any time once you have an active account.

Personal information will only be accessed and used for the primary purpose for which it is collected, and for purposes related or ancillary to the main reasons we collect it, such as invoicing, reminder notices and services offered by us. We engage third party contractors to perform services for us which involve the contractor handling personal information we hold. We will take all reasonable steps to ensure that personal information is protected against loss, unauthorised access, modification or disclosure, and other misuse.

PAYMENT DETAILS Full payment (Cheque/Money Order/Credit Card Details) MUST be included with Order

TOTAL AMOUNT $

PAYMENT METHOD: Please tick applicable box

CREDIT CARD DETAILS

VISA ☐ MASTERCARD ☐ AMEX** ☐ ***A surcharge of 2.5% applies to any purchase made using AMEX*

NUMBER

NAME ON CARD

EXPIRY DATE _____/_____ CCV _____ SIGNATURE

CHEQUE/MONEY ORDER ☐
(Send by post; make payable to Australian Medicines Handbook)

EFT ☐
(Invoice will be forwarded with bank details enclosed. Use invoice number as reference when paying.)

SEND THIS ORDER FORM

SCAN & EMAIL to: sales@amh.net.au

BY FAX: 08 7099 8899

BY MAIL: Australian Medicines Handbook PO Box 240, Rundle Mall, SA 5000

Prices are subject to change without notice. Australian Medicines Handbook Pty Ltd as Trustee for The Australian Medicines Handbook Unit Trust. Level 13, 33 King William Street, Adelaide SA 5000. ABN 73 586 204 918. Effective date 1st Nov 2018.

Low fees and strong long-term performance, so I can retire with more

The right support and advice to help you feel future ready

An industry fund

first state super

first state super